Public Quality, Safety & Performance Committee

Thu 14 March 2024, 10:00 - 13:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

1.
PRESENTATIONS

1.1.
Velindre Cancer Service - Patient Story

To be led by Tamarha Jones, Gynae Clinical Nurse Specialist

📄 1.1.0 Patient Story CD - SACT Treatment.pdf (4 pages)

2.
STANDARD BUSINESS

2.1.
Apologies

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

2.2.
In Attendance

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

2.3.
Declarations of Interest

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

2.4.
Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 16th January 2024

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

📄 2.4.0 DRAFT Minutes - Public Quality Safety and Performance Committee 16th January 2024 v2.pdf (20 pages)

2.5.
Review of Action Log

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

📄 2.5.0 PUBLIC QSP Action Log Jan-Mar v2.pdf (6 pages)

2.6.
Matters Arising

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

There are no matters arising

3.
MAIN AGENDA

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

3.1.
Committee Functioning 2024-2025

3.1.1.
Proposed future reporting to the Committee and Cycle of Business

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

📄 3.1.1 Future reporting.pdf (5 pages)
📄 3.1.1 QSP Quality Safety Performance Committee Cycle of Business May 24-Mar 25 DRAFT.pdf (4 pages)

3.1.2.
Amendment To Standing Orders - Schedule 3 - Terms Of Reference Review

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 3.1.2 QSPC ToR Review_March 2024 v1.pdf (6 pages)
📄 3.1.2 Appendix 1 QSP TOR (current).pdf (12 pages)
📄 3.1.2 Appendix 2 QSP TOR (revision draft).pdf (13 pages)

3.2.
Integrated Quality & Safety Group Highlight Report

To be led by Zoe Gibson, Interim Head of Quality & Safety and Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience.

Including:

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

📄 3.2.0 IQSG Highlight Report QSP February 2024.pdf (37 pages)
📄 3.2.0 Q3 2023-24 Quality & Safety Highlight Report - QSP.pdf (45 pages)

3.3.
Medical Examiner's Service & Mortality Framework Report

To be led by Jacinta Abraham, Executive Medical Director

📄 3.3.0 MES March 24 v5 QS&PC.pdf (9 pages)

3.4.
Independent Review of Clinical Pharmacy Services in NHS Hospitals in Wales (30th October)

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

Paper withheld for query

3.5.
Quality, Safety and Performance Reports

3.5.1.
Velindre Cancer Service Quality & Safety Divisional Report

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

Including:

- CCTV and Email Audit

📄 3.5.1 FINAL Version QSP October - December 23 sent to LW 07.03.2024.pdf (28 pages)

3.5.2.
Trust Performance Report

To be led by Rachel Hennessy, Interim Director, Velindre Cancer Service; Alan Prosser, Director, Welsh Blood Service; Sarah Morley, Executive Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance

Including:

- SACT Gold Command paper [addendum]

📄 3.5.2 QSP Cttee 14.03.24 JAN PMF Performance Report FINAL version 009.pdf (67 pages)
📄 3.5.2 PMF Addendum- SACT Gold Command.docx1 (003).pdf (5 pages)

3.6.
Workforce Supply & Shape and Associated Finance Risks

To be led by Susan Thomas, Deputy Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance

- Workforce
- Finance

📄 3.6.0 SUPPLY AND SHAPE - QSP - MARCH.pdf (17 pages)

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

To be led by Matthew Bunce, Executive Director of Finance

📄 3.7.0 Month 10 Finance Report Cover Paper QSP.pdf (9 pages)
📄 3.7.0 Appendix 1 -M10 VELINDRE NHS TRUST FINANCIAL POSITION TO JANUARY 2024 QSP.pdf (27 pages)
📄 3.7.0 Appendix 2 - TCS Programme Board Finance Report (January 2024) - Main Report.pdf (16 pages)
📄 3.7.0 Appendix 3 - Velindre 23-24 Month 10 monitoring letter QSP.pdf (9 pages)

BREAK - 10 minutes

3.8.
Integrated Medium Term Plan 2023-2024

3.8.1.
IMTP Quarter 3 Report

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

📄 3.8.1 QSP Cttee 14.03.24 IMTP 2023.24 Quarter 3 Update version 010.pdf (47 pages)

3.8.2.
IMTP Accountability Conditions

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

📄 3.8.2 QSP Cttee 14.03.24 Accountability Conditions Progress version 002.pdf (5 pages)
📄 3.8.2 Appendix 1 - 2023-10-02 VELINDRE- Judith Paget - IMTP Accountability Letter 2023.24.pdf (3 pages)
📄 3.8.2 Appendix 2 IMTP Accountability Letter 2.10.23 Quarterly Monitoring version 017.pdf (9 pages)

3.9.
Trust Estates Assurance Group Highlight Report

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

📄 3.9.0 QSP 14th March 2024 Trusts assurance Group report quarter 3.pdf (6 pages)

3.10.
Trust Risk Register

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

Paper not received

3.10.1.
Trust Assurance Framework

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

Paper not received

3.11.
Policy Management Review and Compliance Status

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

📄 3.11.0 Policy Compliance Report QSPC March 2024 V1.pdf (7 pages)

4.
NHS WALES SHARED SERVICES PARTNERSHIP

4.1.
Transforming Access to Medicine / Clinical Pharmacy Technical Services Update

To be led by Gareth Tyrrell, Accountable Pharmacist, NWSSP

📄 4.1.0 NWSSP PTS QSP Submission.pdf (9 pages)

4.2.
Implementation of Duty of Quality Update

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

Paper not received

5.
CONSENT ITEMS FOR APPROVAL

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

5.1.
Trust Policies for Approval

5.1.1.
Infection, Prevention and Control Policy Register

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

- IPC 00 – Framework Policy for Infection Prevention and Control
- IPC 11 – Transport of Specimens Policy

📄 5.1.1 QSP Policy paper February 2024.pdf (64 pages)

5.1.2.
Planning, Performance and Estates Policies

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

- PP10: Medical Gas Piped Systems Policy
- PP11: High Voltage Electricity Supply Systems using a Contractor as the Authorised Person
- PP12: High Voltage Electrical Supply System Operational Policy
- PP13: Electrical Low Voltage Policy
- PP14: Ventilation Policy

📄 5.1.2 PP 10 Medical Gas Piped Systems Policy_v2 cover paper.pdf (33 pages)
📄 5.1.2 PP 11 High Voltage Electricity Supply Systems With Cover Paper_ (002).pdf (21 pages)
📄 5.1.2 PP 12 High Voltage With Cover Paper.pdf (11 pages)
📄 5.1.2 PP 13 Electrical Low Voltage Policy_v2 Cover paper.pdf (16 pages)
📄 5.1.2 PP 14 Ventilation Policy_v2 with cover paper.pdf (17 pages)

6.
CONSENT ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

7.
CONSENT ITEMS FOR NOTING

7.1.
Professional Nursing Forum Update

To be led by Anna Harries, Head of Nursing Professional Standards & Digital and Tina Jenkins, Interim Deputy Director, Nursing, Quality & Patient Experience

📄 7.1.0 Professional Nursing Paper.pdf (12 pages)

7.2.
Research, Development & Innovation Sub-Committee Highlight Report

To be led by Jacinta Abraham, Executive Medical Director

📄 7.2.0 RDI Highlight Report to QS&P 14.03.2024.pdf (4 pages)

7.3.
15-Step Visits Update Report

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

📄 7.3.0 15 step report QSP 14.3.24 COVER.pdf (8 pages)
📄 7.3.0 ALL APPENDICES.pdf (22 pages)

7.4.
Value Based Healthcare Report

To be led by Matthew Bunce, Executive Director of Finance

📄 7.4.0 QSP_VBH_Programme Update_March 2024.pdf (9 pages)

7.5.
Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee

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

Paper not received

7.6.
Education Strategy Audit

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

📄 7.6.0 EDUCATION STRATEGY AUDIT - QSP - MARCH 24.pdf (18 pages)

8.
INTEGRATED GOVERNANCE

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

8.1.
March 2024 Analysis of triangulated meeting themes

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

8.2.
March 2024 Analysis of Quality, Safety & Performance Committee Effectiveness

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

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

9.
HIGHLIGHT REPORT TO TRUST BOARD

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

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

10.
ANY OTHER BUSINESS

Prior approval by the Chair required.

11.
DATE AND TIME OF THE NEXT MEETING

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

Patient Story

Ceri – Current Patient receiving SACT treatment

Webber,Liane
13/03/2024 14:14:09

Darparu ansawdd, gofal a rhagoriaeth
Delivering quality, care & excellence

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

1/4

1/660

Background

- Consent to share story – keen for reassurance of plans to improve

- 52 year old lady diagnosed with stage 4 cervical cancer not associated with HPV. Previously, the patient was fit and well prior to diagnosis.

- Social background, patient worked full time and is married with 2 teenage children at home.

- Treatment plan – for palliative chemotherapy, if responds well could be considered for radiotherapy. Patient currently still on active treatment

Webber,Liane
13/03/2024 14:14:09

Darparu ansawdd, gofal a rhagoriaeth
Delivering quality, care & excellence

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

Patient Experience

- Out of 9 chemotherapy treatments, the patient has only received 3 treatment times in advance

- On most occasions, patient was contacted less that 24 hours in advance to confirm treatment time

- On one occasion the patient was telephoned and informed that she was 30 minutes late for her appointment. She had not been informed of her treatment time.

- On numerous occasions the patient made multiple attempts to contact Velindre for treatment times but was unable to make contact

- Patient upset and frustrated as currently unable to plan life (childcare, school runs) as has not received treatment times in advance – supported by Key Worker CNS.

Webber-Liane
13/03/2024 14:14:09

Challenges

- SACT Capacity – capacity issues have meant that this patient has been on the SACT escalation list awaiting treatment for the majority of her treatment appointments. Due to capacity issues, patient appointment not able to be booked until day before treatment, therefore patient not informed of time in advance.

Learning

- Current process not patient centred
- Importance of keeping patient informed of treatment dates and times fundamental to service.
- SACT capacity remains an issue, pharmacy capacity identified as current restriction.
- Business Continuity initiated – ongoing actions to improve patient care and experience.

Good Practice

- Patient received good care and communication from medical and CNS team – CNS advocating for patient and escalating concern.
- Patient appreciative of complimentary therapies and supportive care input
- Good documentation on portal.
- Evidence of good support from Treatment Helpline and clinical team.

Darparu ansawdd, gofal a rhagoriaeth

Delivering quality, care & excellence

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date:	16th January 2024
Time:	10:00 – 13:00
Location:	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 *[joined at item 3.2.0]*	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Carl James	Executive Director of Strategic Transformation, Planning & Digital	CJ
Jacinta Abraham	Executive Medical Director	JA
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Workforce & Organisational	SM
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
Carl Taylor	Chief Digital Officer	CT
Tina Jenkins	Interim Deputy Director Nursing, Quality & Patient Experience (for item 4.2.2, 4.2.3, 6.1.0 & 8.3.0)	TJ
Zoe Gibson	Interim Head of Quality & Safety, Welsh Blood Service (for item 8.3.0)	ZG
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Andrew Harris	Head of Donor Engagement [for item 1.1.0]	AH
Susan Thomas	Deputy Director of Workforce and Organisational Development, (Deputising for Sarah Morley)	ST
Chris Kelly	Deputy Head of Quality, Safety & Assurance [for item 3.5.0]	CK
Hayley Harrison Jeffreys	Head of Infection Prevention and Control [for item 3.6.0]	HHJ
Anna Harries	Head of Nursing, Professional Standards & Digital [for item 3.7.0	AHa
Stephen Allen	Regional Director, Llais Cymru	SA

| Emma Giles | Audit Wales [observing/on behalf of Katrina Febry] | EG |

APOLOGIES:

Steve Ham	Chief Executive Officer	SHam
Emma Stephens	Head of Corporate Governance	ES
Cath O'Brien	Chief Operating Officer	COB

1.0.0	**PRESENTATIONS**	ACTION
1.1.0	**Welsh Blood Service - Donor Story** Led by Andrew Harris, Head of Donor Engagement and Alan Prosser, Director of Welsh Blood Service Prior to the meeting the Committee received a video story which offered an insight into some of the actions being implemented in order to meet the Service's annual target to recruit 4000 new bone marrow donors, including: • Patient engagement • Community outreach • Interacting with key groups • Structured pathways The video also outlined the story of Darcey Corria, former Miss Wales and the latest recruit to the Ambassador programme, who has become the face of the Welsh Blood Service campaign to highlight the need for more donors in Wales, particularly those of a minority or mixed-race background. AH gave an overview of the structure put in place to achieve the challenging enrolment target and outlined the Service's strategic approach towards each of the actions above. DM suggested that some potential donors may find the term "bone marrow" off-putting/misleading, as for most it's a stem cell rather than bone marrow donation and suggested that a change of title may help with recruitment. AP recognised the need to dispel the myths in terms of bone marrow donation and suggested further discussion at Board Development. The challenges of competing with other Bone Marrow / Stem Cell collection organisations was discussed. SA queried whether there would be an opportunity to engage in a mutually beneficial discussion with the other organisations. AP gave assurance that although it is a competitive environment in terms of new donor enrolment, the registry is nationally aligned and anyone joining the registry would be included in donor searches internationally.	

	DM advised that the Deans of Healthcare Faculties in Wales have agreed to a meeting with the Trust and suggested that this may offer an opening to discuss recruitment opportunities and suggested that AP and AH also attend this meeting. VM queried whether there had been engagement with the National Federation of Young Farmers across Wales. AH advised that a good relationship had existed prior to the COVID pandemic and that efforts to redevelop this link are underway.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	Apologies were noted as above.	
2.2.0	Additional attendees were noted as above.	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no declarations of interest.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 16th November 2023** Led by Vicky Morris, Quality, Safety & Performance Committee Chair *Accuracy:* DM had submitted some suggested changes just prior to the meeting. It was agreed that these changes would be made, forwarded to DM for approval and the Committee chair for final approval. *Matters Arising:* DM highlighted section 3.4.1 which refers to a harm review of delays beyond 30 days with non-urgent post clinic letters being sent out and asked if the 30-day timeframe to send letters is too long. NW advised that the 30-days for non-urgent correspondence had been initially set, post incident, in the absence of any national timescales and this is being reviewed by the cancer service. The timescale relates to non-urgent communication only. JA advised that any communication requiring action from a GP is considered urgent and as such 30 days would not be acceptable. The minutes of the meeting held on the 16th November 2024 were **APPROVED** pending the above changes and sign off being conducted.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science	

	The action log was discussed in detail and Committee members confirmed their assurance that all actions identified as closed on the action log had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed and will remain open. The remaining action log was reviewed and in terms of those actions due for delivery in January the following was agreed: ***3.1.0 (13/07/2023) - IM's and Committee members to receive Trust Assurance Framework (TAF) as soon as completed in late July, with a formal return to the Committee in September*** - LF confirmed that this action would be completed following presentation of the Trust Assurance Framework to this meeting. **This action can therefore be closed.** ***9.1.0 (13/07/23) - Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future Annual Reports*** - LF advised that due to staff absence this action had not been progressed. LF will review how this will be delivered and what the revised timescale would be. ***3.6.2 (14/09/23) - Committee to have sight of final RAAC report when received*** - CJ confirmed receipt of the report which will be circulated to the Committee **to close this action**. CJ advised the Committee that the report confirms no presence of RAAC within the Trust's buildings.	**LW** **LF** **LW**	
2.6.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair		
2.6.1	**Digital Risk Overview** Led by Carl Taylor, Chief Digital Officer The digital risk paper provided an overview of the digital risks and details of the effective management of these risks in order to provide assurance to the Committee. There was particular reference to risks associated with legacy systems. CJ advised on the recent appointment of a new Head of Data and Insight who brings a wealth of experience and will be an important addition to our capacity, capability and knowledge. VM queried the accuracy of a level 5 assurance rating stated in the paper as some detail within the report appears to contradict this rating. CT advised that plans are in place, these will progress through Executive Management Board and a tactical plan developed, with a view to reviewing the accuracy of this rating in	**CT**	

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	April, to be subsequently brought to the May Committee for approval.

NW highlighted the need for triangulation with the clinical electronic requirements in the cancer service as there remains considerable reliability on paper-based systems.

The Committee **NOTED** the Digital Risk Overview. | | |
| 2.6.2 | **Freedom of Information Act (FOIA) / Environmental Information Regulation Report Quarter 1 – Quarter 3 2023/2024**
Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

The FOIA report provided additional information as requested at the last Committee, specifically to provide more detail on the analysis of the requests, more information on trends and to address accessibility issues.

Compliance with required timescales: compliance had improved following the appointment of a permanent Freedom of Information and Compliance Officer.

DM acknowledged the significant improvements made to the report since its last presentation to the Committee, and requested linking tables to the narrative for future reports.

DM suggested that the high number (44%) of applied exemptions could cause concern from a public perspective and recommended providing a little more detail for assurance around this. LF agreed to benchmark this figure against that of other organisations at the new FOI Officers peer group meeting.

HJ queried the timescale and completion of breached responses, LF agreed this was an omission and will seek to address this in future reporting. MB advised that days beyond the deadline were not significant, with the majority of cases exceeded by, typically, 2-3 days.

SA suggested that detail around each of the exemption sections be added to the Trust website to enable the public to cross-reference with the report, with a link included in the report to signpost the reader to this detail.

The Committee:
• **NOTED** the enhanced level of compliance with the response times | **LF**

LF

LF

LF | |
| 3.0.0 | **MAIN AGENDA** | | |

	(This section supports the discussion of items for review, scrutiny and assurance).		
3.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff LF presented the Risk Register Report, the structure of which has changed significantly following feedback from this Committee and other Trust governance fora. The Committee were advised that positive changes had been made resulting in enhanced assurance. Progress against Risk 3215 was discussed. The Committee noted that although the action was proposed to be closed, the Executive Management Board had requested it remain open until further assurance of compliance with all required standards is received. The associated action plan is to be reviewed by the Executive Management Board prior to resubmission to the March Committee. SA was pleased to note the improvements made around Risk 2465 but suggested that Risk 3230 requires review as there appears to be no change. In terms of the main Risk Register paper, HJ noted that some actions require updating as there appears to be some discrepancy with the main report. LF agreed to review to ensure alignment. The Committee: • **NOTED** the risks of 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework.	**LF** **LF**	
3.1.1	**Trust Assurance Framework (TAF)** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff LF presented the complete Trust Assurance Framework (TAF) which now contains the proposed eight strategic risks. LF advised that email feedback had been provided by VM prior to this meeting suggesting some enhancements which will be incorporated into the TAF before submission to the Trust Board. As TAF01-06 have previously been reviewed the committee focused on the two newly identified strategic risks, TAF07 and TAF08, which were discussed in detail. NW gave an overview of TAF07 noting that although significant work had been undertaken, further refinement is required including mapping current Datix risks into submission and strengthening		

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	actions. This additional work is expected to be completed well in advance of the March cycle and would be circulated to members upon completion to allow adequate time for consideration and final feedback prior to the March Committee. MB gave an overview of TAF08, noting in particular the previous TAF which contained a financial risk specifically around the Trust income and issues around not securing sufficient income from Commissioners. Following general discussion over the past six months and feedback from Independent Members it was agreed that the new format TAF should contain further detail around financial risk, wider that just the income implications for the Trust. This risk theme therefore brings in the longer-term financial sustainability of the Trust, as well as long-term value in terms of the Value Based Healthcare agenda. Although gaps do remain these will be covered within the associated action plan. The Committee **ENDORSED** the Trust Assurance Framework for Trust Board approval pending further development of TAF07.	**NW**
3.2.0	**Workforce Supply and Shape & Associated Finance Risks** Led by Susan Thomas, Deputy Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance The Committee discussed in detail the workforce supply and shape paper that provided an overview of the key workforce risks and the actions and interventions being undertaken to mitigate these. The risks were: • Recruitment and retention • Service and workforce planning • Keeping our valued staff and supporting wellbeing A recruitment & retention and workforce planning audit has been undertaken: one of the recommendations was for the Trust's People Strategy to be communicated more widely and this has been actioned through a number of communication events and regular newsletters. Robust monitoring is in place via monthly Organisational Development and Workforce dashboard reporting to senior leadership teams to highlight any issues around recruitment and retention, vacancies and turnover are regularly monitored and hotspots focused on accordingly. SM highlighted feedback received from VM prior to the meeting in terms of the need for more effective triangulation with other areas, i.e., the Performance Management Framework data around Key Performance Indicators (KPIs), agency spend, bank spend and workforce indicators, and agreed that there is more work to do in triangulation of this data.	**SM**

SM advised the Committee of the anticipated appointment of a new Wellbeing Co-ordinator for which interviews are being held today, one of the priorities will be to develop the metrics and criteria by which wellbeing outcomes are evaluated and to assist in monitoring and evaluating the impact of the implemented interventions and actions.

[Stephen Harries joined the meeting]

HJ highlighted the detail under SACT (Systemic Anti-Cancer Therapy) Nursing which states that many nurses leave the Trust for Band 6 roles in other health boards. NW advised that this would typically be current Band 5 nurses moving to a higher banded role, but that following a review of the workforce undertaken last year, which identified that, given the level of expertise and clinical skills required, the proportion of Band 5 and 6 nurses was not correct, the level of Band 6 nurses has increased, providing more opportunities for career progression within SACT.

In terms of the mitigating actions undertaken in Radiotherapy Physics, HJ queried the statement "skill mix being considered". The Committee were advised that various different approaches to the pathway are being considered, particularly around apprenticeships. Band variation has also been identified and Workforce colleagues are currently looking at this.

Following the publication of reports around the changing ratio of registered to unregistered workforce in England, DM sought assurance of the Trust's intention to ensure an appropriate proportion of registered to unregistered staff at all times. NW advised that, in England, it is the Nursing Associate role which is registered, Assistant Practitioners Wales are non-registered Band 4 Support Workers. A national proposal has been put forward to bring those Nursing Associate roles into Wales. NW reinforced the importance of getting the right staff with the right skills and expertise in place to ensure that highly specialist skilled clinicians are able to focus on their core duties and anticipated that these steps will have a positive impact not only on the retention of staff, but also to the overall patient experience and outcomes.

DM queried the level of student nurses received at the Trust and what steps are taken to encourage them to choose to work at Velindre. NW advised that student nurses have placements within both divisions and that Velindre Cancer Service had, for the first time, recruited four new registrants, post qualification, into the service. There had been a high number of people wanting to be employed at Velindre. NW agreed to advise DM of the exact number of student nurse placements after the meeting, and advised the Trust offers bespoke placements as well as traditional which has received commendation by university colleagues.

NW

	The Committee **NOTED** the workforce supply and shape updates and associated financial impacts as outlined within the contents of the report.	
3.2.1	**Speaking Up Safely Framework – Implementation Update** Led by Susan Thomas, Deputy Director of Organisational Development & Workforce ST gave a brief overview of the paper which gives an update of the implementation of the Speaking Up Safely Framework, part of the Trust's key strategic driver towards a Healthy and Engaged Workforce. Following a self-assessment against the Welsh Government Speaking Up Safely Framework some gaps in delivery were identified, particularly in the following areas: • Communication • Processes • Governance around Speaking Up Safely A programme of work and action plan were subsequently developed and agreed at Executive Management Board to improve these areas and mitigate any associated risks. As Independent Member champion of Speaking Up Safely, SH advised the Committee that discussions had been held with senior staff with regards to the communication channel and the need to offer a direct link to the Speaking Up Safely champion, possibly by way of a dedicated email address, was agreed to eliminate any potential or perceived executive filter. ST advised that a role profile for the Independent Member champion has been drafted and does include these points. The Committee **NOTED** the update on the Trust Action plan to promote a culture of Speaking Up Safely.	
3.2.2	**Recruitment and Retention Audit and Action Plan** Led by Sarah Morley, Executive Director of Organisational Development & Workforce SM advised that a number of recommendations had been made following an Internal Audit recruitment and retention review that are now being taken forward, including: • Developing an implementation plan for the People Strategy - this has been completed and is moving through the appropriate governance cycle. • Communication of the strategy through the Trust - as part of the Trust-wide enabling strategies, the People strategy is subject to the existing communication mechanisms in place since the latter part of 2023.	

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	• Performance measures and effectiveness of recruitment and retention initiatives - previously identified as an area which requires further work. The Committee **NOTED** the audit and action plan in place.	
3.3.0	**Finance Report for the period ended 31st November 2023 (Month 8)** Led by Matthew Bunce, Executive Director of Finance MB presented the Finance Report which outlines the financial position and performance for the period to the end of November 2023. The following was highlighted: • Financial targets - the three KPIs are still forecasting a revenue breakeven position. Public sector performance is well above the targeted 95% with anticipation of sustaining this, and the Capital expenditure limit is expected to be brought within the expenditure budget although Welsh Government approval of funding the new Velindre Cancer Centre (nVCC) project costs is awaited. • A risk was identified in the Integrated Medium-Term Plan which suggested that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity, however November activity performance and associated marginal income more than covers the £3.5M invested in the additional capacity and a small amount of headroom for further investment is anticipated. • Investment Support - £2M of additional cost savings to be delivered by the end of the year to provide financial support re the all-Wales NHS financial pressures, alongside the £1.8M savings target previously signed off as part of the IMTP Financial Plan which is also anticipated to be fully delivered. MB also highlighted the £500K emergency reserve which the Trust has not needed to draw on this year due to other non-recurrent funding and sought endorsement from the Committee to potentially invoke these monies and offer back to system if not spent by end of the year. The Committee: • **NOTED** the contents of the November 2023 financial report and in particular the expectation that the Trust will deliver against its 3 statutory Financial Targets at year end, subject to Welsh Government Capital funding being approved. • **ENDORSED** for Board approval the option that any reserves not required to deliver the Trust revenue breakeven position may be offered to support the NHS Wales position on a non-recurrent basis.	

3.4.0	**Quality, Safety & Performance Reports**	
3.4.1	**Welsh Blood Service (WBS) Quality, Safety & Performance Report** *Including Summary of Incidents reported to the MHRA since January 2023* Led by Alan Prosser, Director, WBS and Peter Richardson, Head of Quality, Safety & Regulatory Compliance AP presented the summary report which gives details of activity for the period August to November 2023. Key points to note were as follows: • Supply chain - the Service has experienced a difficult, almost unprecedented period, particularly during November: running at around 10% sickness absence, this is compounded by vacancies, time required to train new recruits and turnover which has significantly affected capacity. • There has been some infrequency in terms of demand which has not levelled as anticipated and, due to the various operational pressures, the Service has been unable to catch up on the lost activity through November. This has led to the difficult decision of seeking mutual aid from Northern Ireland and NHSBT. AP advised of a nationwide trend with both NHSBT and Scotland under particular strain. Various actions have been taken to mitigate this: laboratory staff assisting with collections, nursing staff outside of the Collections department also stepping in to support collection activity, task and finish group established to look at four specific areas. AP advised that while some relief is evident in terms of O Positive stocks under a blue alert system, the current blue alert has been in place for six weeks, far exceeding the expected upper limit of 72 hours. AP sought to extend formal thanks to staff across the service for their additional support given during this particularly difficult period. A significant number of volunteers have given their time to support the service and this was widely recognised and commended by the Committee. SA queried possible opportunities for Llais to feed into the networks in order to engage the public in their support of the service. AP advised that community engagement had not been identified as a factor as donors are continuing to come forward, although a message regarding ensuring that donors turn up to booked appointments would be helpful as DNA (did not attend) rates have a significant ongoing impact on the service.	

PR highlighted an additional constraint to the service of donors arriving for appointments only to discover they are unable to donate due to other factors they had not considered or were not aware of, such as travel to areas at risk of West Nile Virus, certain cosmetic procedures, etc. PR suggested that better donor education could help to mitigate this constraint, and the Communications team are currently working towards this.

PR outlined the ***Summary of incidents reported to the Medicines and Healthcare products Regulatory Agency (MHRA)***. It was noted that four of the 10 reported instances were one-off incidents, however six were related to issues around donor screening. This is a national trend across all UK blood services and discussions are being held at national level to look at how the screening criteria could be presented in a different, more logical manner.

With regards to the red score noted in the Donor Adverse Events Reporting, PR explained that this was as a result of one donor out of nine (11%) not being made aware in the conversation that there would be a follow up phone call. However, the Committee were advised that should an adverse event occur, the donor is provided with written information regarding access to follow-up care and this literature does advise that the donor will be contacted as part of the Service's ongoing duty of care.

HJ queried the factors leading to the postponement of audits and the likelihood of indefinite postponements. PR advised that any changes to the audit programme would be ratified by the Divisions Quality and Safety Hub, that the decision is made based on a risk assessment and that while the vast majority of requests are for temporary postponements there are occasions where the subject of an audit has recently been audited by an external regulator and no issues found, in which case it may be more appropriate to postpone until the next audit cycle. PR to provide to this Committee more detail of any changes to the audit programme in future reporting. **PR**

With regards to the Corrective and Preventative Actions Summary, HJ noted the "ongoing" status of the actions around four of the five major findings and queried whether a timescale for conclusion of these has been set. PR to look into this further and ensure target dates are applied against actions in future reporting. **PR**

The Committee **NOTED** the comprehensive report.

| 3.4.2 | **Trust Performance Management Framework Report and Supporting Analysis for November 2023/24**
Led by Rachel Hennessy, Interim Director of Velindre Cancer Service and Alan Prosser, Director of Welsh Blood Service |

RH gave a brief overview of the Velindre Cancer Service (VCS) elements of the performance framework, The following points were noted:

- Consistency of performance against targets in Radiotherapy remains despite fragility of equipment and workforce challenges. Up time of the equipment continues to be high and continued improvements can be seen as a result of moving through IRS (Integrated Radiotherapy Solution) implementation. There had been lower than expected demand.
- A number of challenges still apparent within SACT, primarily linked to pharmacy capacity to support chemotherapy treatment. Work being undertaken with both the pharmacy and nursing teams to look at options available to support an increase in capacity.
- Services have been well managed and no adverse impact has been experienced as a result of the Industrial Action. This reflects the significant amount of hard work and support provided by all departments.

With regards to the SACT data, HJ noted that six patients had waited for more than 28 days, with a further 2 patients waiting more than 36 days and queried whether there had been any instances of harm to these patients as a result of the delay. RH advised that a harm review process is followed along with daily prioritisation to ensure that all patients are seen within an appropriate timescale.

HJ also queried the statement that "all patients within a trial were booked within trial timeframes" as this could suggest that patients who are not involved in a trial are at a disadvantage. JA advised that the service capacity is not compromised by trial patient activity as various resourced, trial-specific and commercially funded pathways are in place which actually serves to alleviate some of the pressures. HJ suggested that the paper should clearly reflect this important detail.

With regards to patient experience feedback, VM noted that the current two different ways of capturing feedback (short friends and family and longer national survey) that both had satisfaction levels below 95% target and queried the trends and themes of these surveys and action in response to these in order to improve the patient experience. RH advised that there appears to be a theme around waiting time dissatisfaction although the current format of the survey does not allow for further narrative to support this. A plan is in place with Outpatients to progress a number of key workstreams as part of the pathway improvement programme to look at the management of flow through the department, set up of clinic templates, etc.

SH highlighted the new Digital metrics which have been drafted to demonstrate Trust performance against the various objectives set out in the Digital strategy and suggested that when these measures are in place, supporting narrative will be needed to explain the reasoning behind the targets.

VM highlighted the seven-point improvement in the SPC chart on falls and queried whether particular actions from previous incidents put in place have led to this improvement. NW advised that a Falls and Pressure Ulcer Scrutiny Panel, which takes place monthly, has undertaken extensive work particularly in ensuring appropriate risk assessments and fall reduction plans are in place.

VM highlighted the missing Serious Incident data and noted that the in-year targets in the Healthcare Acquired Infection tables was not clear. CJ to obtain further detail and share with the Committee following this meeting.

In terms of the Welsh Blood Service performance data AP highlighted the following in addition to that already discussed:

- All quality and safety measures are within tolerance,
- Satisfaction remains consistently high for the service,
- Efficiency markers very good. SPC charts show consistent improvement in red blood cell wastage and positive performance in terms of platelets.

The Committee **NOTED**:
- the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3.
- the new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration.

CJ

3.5.0	**Integrated Quality & Safety Group Highlight Report**

Including VCS Patient Administration and Process Improvement Plan
Led by Chris Kelly, Deputy Head of Quality, Safety & Assurance and Tina Jenkins, Interim Deputy Director of Nursing & Quality

TJ presented the report which covers the outcomes and activities of the Integrated Quality & Safety Group up to the 19th December 2023. The following was highlighted:

- Mortality Governance - the Trust is meeting its legislative responsibilities in relation to reviewing inpatient mortality and reviewing all deaths referred to the service through the Medical Examiner Service. Data validity issues remain, preventing robust mortality metric monitoring, though the Digital and

cancer service team are actively working to resolve this. In addition work is underway following external benchmarking to agree mechanisms for reviewing post SACT and Radiotherapy deaths.

- A good number of Quality & Safety Framework actions have been delivered. Some have been delayed and the Committee had oversight of revised delivery dates. An external peer review of the framework has been undertaken and the outcome will inform the framework refresh.
- A considerable increase in concerns raised in respect of Velindre Cancer Service has been seen. The themes relate to appointments and administrative processes.
- There remains work to do in respect of the Quality & Safety Tracker to be able to provide robust assurance in respect of delivery of all Quality and Safety related actions. Targeted work is required in respect of the Brachytherapy Peer review improvement plan.
- The *VCS Patient Administration and Process Improvement Plan*, requested by the Committee at the last meeting, was discussed. RA presented the paper which summarises the high-level improvement actions being undertaken to address the five patient administrative process themes that have been identified through analysis of incidents and concerns across the Velindre Cancer Service:
  - o Patient referral processes
  - o SACT Booking
  - o General Booking Processes
  - o GP/patient letters post appointment.
  - o Response to patient telephone calls into Velindre Cancer Service

VM noted the detailed plans for the 3- and 6-month timelines, but queried what remedial action had been or would be taken in the period immediately following the initial incident reporting. NW advised that when an incident triggers Duty of Candour or National Reportable Incident thresholds an immediate review (make safe) meeting is held at which a number of remedial actions are agreed and implemented whilst the investigation is undertaken.

The Committee:
- **NOTED** the discussions that took place during the meeting held on 19th December 2023.
- **DISCUSSED** the report in particular the issues highlighted.
- **NOTED** the summary of actions being taken by Velindre Cancer Service which will address the emerging incident and concerns themes relating to patient communication and administrative processes.

| 3.6.0 | **Trust Infection Prevention Management Group (IPCMG) Highlight Report**
Led by Hayley Harrison Jeffreys, Head of Infection Prevention and Control

HHJ presented the report which provides a summary of the key outcomes from the IPCMG held on the 6th December 2023. Key points to note were as follows:
• There has been a 100% increase in Klebsiella Bacteraemia cases compared to the same period in 2022/2023. A look back exercise and genomics confirm that there are no links between any of these cases.
• New Velindre Cancer Centre (nVCC) - HHJ advised that Gail Lusardi, Consultant Nurse, Healthcare Associated Infections for Public Heath Wales who is supporting the IPC element of the new Velindre Cancer Centre presented an update on IPC issues requiring action in respect of the hospital design. Further meetings have since been held, progress is being made and escalation processes agreed.
• Bare Below the Elbow (BBE) - compliance with staff in uniform/staff in clinical areas being consistently bare below elbows was highlighted. Targeted and general communications have been undertaken and the role of managers to reinforce standards reinforced.

The Committee:
• **DISCUSSED** the Infection Prevention & Control highlight report, from the Infection Prevention & Control Management Group meeting held on the 6th December 2023 and actions being taken to address the areas where compliance / standards are not at the required level.
• **APPROVED** the revised Infection Prevention & Control Management group Terms of Reference. | |
| 3.7.0 | **Nurse Staffing Levels (Wales) Act Update**
Led by Anna Harries, Head of Nursing, Professional Standards & Digital

AH presented the 6-month report which provides assurance to the Committee in relation to how the Trust is meeting its responsibilities to the Nurse Staffing Levels (Wales) Act. Attention was drawn to the detailed information around Sections 25A and 25B. The following was highlighted:

• The Trust is meeting the legislative requirements in respect of the establishment within the 25B ward (first floor ward). There was no impact on patients due to staffing levels on the ward.
• Three 25A areas do not have the required 26.9% headroom built into establishments which is affecting ability of staff to receive required training and impacts on patient care delivery during | |

	periods of absence (SACT, Clinical Nurse Specialist Team & Assessment Unit). These are being actively reviewed currently and will feature in the 2024 IMTP. The Committee noted the request from Welsh Government to report the position in relation to headroom against all 25A and 25B areas, this will be submitted along with a plan to rectify the issues. The Committee **ENDORSED** the paper and the 25A areas at Velindre Cancer Service that require establishment enhancement.	
3.9.0	**Medical Devices Report** Led by Peter Richardson, Head of Quality, Safety and Regulatory Compliance, WBS PR gave a brief overview of the report which has been prepared to provide the Committee with an update on medical devices and compliance with the medical devices regulations across the Trust. The following was highlighted: • Legislative landscape remains unclear, although clarification is expected imminently. No significant deviation from the framework in Europe is anticipated. Velindre Cancer Service have made good progress in terms of ensuring their quality management system is in place and appropriately accredited to cope with the challenge. • Systems and processes are in place to track the maintenance and repairs of portable medical devices, although some issues have been identified around this. • In terms of Welsh Blood Services, a way forward for both the software and reagents has been identified. The Committee **NOTED** the report.	
4.0.0 **(10 min)** **12:35**	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
4.1.0	**Trust Policies for Approval**	
4.1.1	**Health and Safety Policies** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital • Management of Violence & Aggssion Policy • Safe Use of Display Screen Equipment (DSE) Policy • Safer Manual Handling Policy • Control of Substances Hazardous to Health (COSHH) Policy	

	• Policy for Management of Latex and Latex Allergy The Committee **APPROVED** the revised policies. .	
5.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
4.1.0 **5.1**	**Trust Policies for Endorsement** **Organisational Development & Workforce Policies** Led by Sarah Morley, Executive Director, Organisational Development & Workforce • All Wales NHS Dress Code • Annual Leave Policy • Redundancy and Security of Employment Policy • Recruitment and Selection Policy The Committee **ENDORSED** these policies for onward Trust Board approval.	
6.0.0	**CONSENT ITEMS FOR NOTING**	
6.1.0	**Research, Development & Innovation Sub-Committee Highlight Report** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the key deliberations and highlights from the Public meeting of the Research, Development & Innovation Sub-Committee held on the 7th December 2023.	
6.2.0	**Quarterly Information Governance Assurance Report** Led by Matthew Bunce, Executive Director of Finance The Committee **NOTED** the contents of the quarterly information governance assurance report.	
6.3.0	**Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee - 26th October 2023 and 23rd November 2023** Led by Stephen Harries, Vice Chair & Chair of the Transforming Cancer Services Programme Scrutiny Sub Committee The Committee **NOTED** the Highlight Reports from the Chair of the TCS Programme Scrutiny Sub-Committee - 26th October 2023 and 23rd November 2023.	
7.0.0 **12:50**	**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).	

7.1.0	**January 2024 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members This was discussed at various points throughout the meeting.	
7.2.0	**January 2024 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members Committee members were asked to provide feedback on the Committee via the survey link that will be provided. HJ offered to provide some suggested changes to the survey questions. VM also asked Committee members for suggestions in respect of how the Committee's cycle of business could be revised to ensure that future meetings could be even more productive and afford sufficient time to critical or emerging matters.	**HJ/LW** **All**
7.3.0	**November 2023 Committee Effectiveness: Reflective Evaluation Feedback Report** Led by Liane Webber, Business Support Officer The Committee received the report, compiled following circulation of the new format survey which is now conducted via CIVICA in order to ensure complete anonymity, and noted a response rate of 35% (8 out of 23). Committee members were reminded of the importance of completion of the Committee Effectiveness Survey circulated to all attendees following each meeting and were invited to submit any suggested revisions to the survey questions. The Committee: • **REVIEWED** the November 2023 feedback evaluation. • **DISCUSSED** the 35% (8 out of 23) response rate and **AGREED** to prioritise evaluation completion moving forward. • **AGREED** the proposed next steps.	
8.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members to identify items to include in the Highlight Report to the Trust Board: • For Escalation • For Assurance • For Advising • For Information	

9.0.0	ANY OTHER BUSINESS	
	The Committee were advised that Zoe Gibson, Interim Head of Quality & Safety, Welsh Blood Service will be leaving the Trust to commence a two-year secondment with HEIW as National Retention Lead to implement the staff retention project. The Committee wished Zoe well with her secondment. In addition, the Committee were advised that Stephen Allen, Regional Director, Llais Cymru is due to retire from his post at the end of March. The professionalism, integrity and honesty that Stephen has brought to the role over a number of years was widely commended and the Committee wished to extend their gratitude for Stephen's contribution to the Committee on behalf of our patients and donors.	
10.0.0	DATE AND TIME OF THE NEXT MEETING	
	The Quality, Safety & Performance Committee will next meet on the: **14th March 2024 from 10:00-13:00**	
CLOSE		
The Committee 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).		

Webber Liane
13/03/2024 14:14:09

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					
3.1.0	Risk 3001 - impact of actions and interventions taken towards staff wellbeing to be provided to the Committee	Sarah Morley (Exec. Director of OD & Workforce)	**Update 8/2/24:** The Supply and Shape paper for March highlights the impact of actions and interventions taken towards staff wellbeing via the performance improvement trajectory for wellbeing. Update 5/12/23: The Workforce Supply and Shape Paper that comes regularly to the Committee contains an update in January on the plan to develop evaluation criteria for the wellbeing interventions used across the Trust. It is anticipated that the two phases of the work involved in developing and using the criteria will be underway and can be reported in March QSP.	14/03/24	CLOSED
9.1.0	Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future annual reports	Emma Stephens (Head of Corporate Governance) / Lauren Fear (Director of Corporate Governance & Chief of Staff)	Update 09/01/24: Membership of T&F Group defined and arrangements for first meeting in progress. Update: 31/08/23: - Task & Finish group to be established to take forward.	~~31/01/24~~ 31/03/24	OPEN
Actions agreed at the 14th September 2023 Committee					
2.5.0	Committee to receive the outcome of the Risk 2465 audit	Rachel Hennessy (Interim Director, VCC)	**Update 06/03/24:** Report received by SLT and considered by EMB February 2024. Will be managed via	14/03/24	CLOSED

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			SLT and reported through existing Q&S report where appropriate Update 09/01/24: Report formally received by SLT in December 2023 and is being considered by EMB in February following some further clarification and will be brought to the next QSP (March). Update 16/11/23 - Report to be circulated to QSP Committee immediately following submission to EMB. Update 09/11/23 - report still awaited. Delivery date not yet reached. Update: 23/10/23 - Audit still on track to be completed 31st October, following which it will be presented to the Director and SLT for consideration		
2.6.2	Outcome of CCTV system audit to be circulated to the Committee	Rachel Hennessy (Interim Director, VCC)	**Update 06/03/24:** Audit being managed via SLT and will be reported through existing Q&S report where appropriate. Update 08/01/24: Report formally received by SLT in December 2023 and is being considered by EMB in February following some further clarification and will be brought to the next QSP (March). Update 09/11/23: paper postponed. Due to SLT date not aligning with QSP Committee.	14/03/24	CLOSED

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			Update: 23/10/23: CCTV audit and action plan to be considered by SLT 9/11/23		
3.10.0	Validation of mortality data to be completed	Dr Jacinta Abraham (Exec. Medical Director)	**Update 26/02/24:** Mortality data validation exercise has been completed, with previously identified BI data integrity issues being resolved. During this exercise further issues relating to the consistency of data inputting of treatment source information. Action has been taken to address this going forward and work is ongoing to ensure data accuracy of historical cases. The date that this will be achieved by is currently unknown. Data Integrity issues will continue to be monitored through the Integrated Quality and Safety meeting. Update 10/01/24: Initial validation completed, further issues identified and being addressed by the BI team. Further validation will be undertaken on completion of this work. Anticipated deadline 1st Feb Update 9/11/23: Following the resolution of the integration issues that were impacting on the accuracy of death data in WPAS, an initial validation of mortality data was carried out and completed by 20/09/23. However further discrepancies identified. This will be fixed by 10/11/23 and a further re-run of mortality data is planned for 24/11/23	01/02/24	OPEN

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13/03/2024 14:14:09

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		Actions agreed at the 16th November 2023 Committee				
3.5.1	CJ to confirm that amber risks within the IMTP are sufficiently set out within the TAF	Carl James (Exec. Director of Strategic Transformation, Planning & Digital)	Update 09/01/24: The Trust is currently updating its IMTP. As part of this process all risks will be re-assessed to ensure that they are aligned and included within the TAF. WG confirmed the IMTP submission date is 29/03/2024.	31/03/24	OPEN
		Actions agreed at the 16th January 2024 Committee				
2.6.1	The Digital risk level 5 assurance rating to be reviewed.	Carl James (Exec. Director of Strategic Transformation, Planning & Digital)	Rating reviewed with Carl James / Carl Taylor and on balance we are comfortable with a rating of 5. This can be reviewed again at the Digital operational report for QSP.	9/5/24	CLOSED
2.6.2	Freedom of Information Act report: • Tables to be clearly linked to supporting narrative • Exemption numbers for the Trust to be benchmarked against that of other organisations • Omission of data regarding timescale and completion of breached FOI responses to be addressed	Lauren Fear (Director of Corporate Governance & Chief of Staff)	All points will be addressed for future reporting.	9/5/24	OPEN
2.6.2	Detail of each of the FOI exemption sections be added to the Trust website to enable cross-referencing, with a link included in the report to signpost to this detail	Lauren Fear (Director of Corporate Governance & Chief of Staff)	This action is being addressed as part of the overall review of the FOI website pages.	9/5/24	OPEN

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3.1.0	Risk 3230 to be reviewed and updated.	Lauren Fear (Director of Corporate Governance & Chief of Staff)		14/3/24	OPEN
3.1.0	Actions in Risk Register paper to be reviewed and updated to align with main report	Lauren Fear (Director of Corporate Governance & Chief of Staff)	All actions will be reviewed and updated and reflected in future reporting.	14/3/24	OPEN
3.1.1	TAF07 to be circulated to Committee members once it has been finalised so members can comment prior to next Committee	Nicola Williams (Exec. Director of Nursing, AHPs and Health Science)		14/3/24	CLOSED
3.2.0	More effective triangulation to be undertaken with Workforce Supply & Shape report and areas such as PMF data around KPIs, agency spend, bank spend and workforce indicators.	Sarah Morley (Exec. Director of OD & Workforce)	**Update 8/2/24:** The March Supply and Shape paper to QSP includes a triangulation of Strategic objectives / risks identified and actions taken (inc Audit actions) and resulting improvement performance trajectories for 23/24.	14/3/24	CLOSED
3.2.0	The exact number of student nurse placements in both Divisions to be provided to DM.	Nicola Williams (Exec. Director of Nursing, AHPs and Health Science)	Email sent 23/1/24	14/3/24	CLOSED
3.4.1	Details of any changes made to the WBS audit programme to be reported to the Committee	Peter Richardson (Head of Quality, Safety & Regulatory Compliance / Deputy Director, WBS)	All audits planned for 2023/24 are now complete, The 2024/25 Audit plan is in draft form and awaiting final approval by the WBS Integrated Quality and Safety Hub on March 27th. Any variations to this plan will be reported to the Committee.	14/3/24	CLOSED
3.4.1	Target dates to be applied against all actions in future Performance Management Report.	Peter Richardson (Head of Quality, Safety & Regulatory Compliance / Deputy Director, WBS)	All audits planned for 2023/24 are now complete, The 2024/25 Audit plan is in draft form and awaiting final approval by the WBS Integrated Quality and Safety Hub on March 27th.	14/3/24	CLOSED

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			Any variations to this plan will be reported to the Committee.		
3.4.2	Serious Incident data and in-year targets in the Healthcare Acquired Infection to be added to the Performance Management Report	Carl James (Exec. Director of Strategic Transformation, Planning & Digital)	**Update 5/3/24:** Nicola Williams, Hayley Jeffreys, Tina Jenkins and Peter Gorin met to agree measures and targets for HCAI, National Reportable Incidents and Never Events to appear in April new year PMF.	14/3/24	OPEN
7.2.0	Committee members to offer suggestions in respect of how the Committee's cycle of business could be revised to ensure that future meetings could be even more productive and afford sufficient time to critical or emerging matters.	All		14/3/24	OPEN

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13/03/2024 14:14:09

Action Log - version 05.02.2024

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Velindre University
NHS Trust

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Quality, Safety & Performance Committee

Proposed Future Reporting

DATE OF MEETING	14th March 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Integrated Quality & Safety Group	26/2/24	Endorsed
Executive Management Board	29/2/24	Discussed and proposed approach endorsed

1. SITUATION

This paper provides Quality Safety & Performance Committee with a high-level proposal in respect of future Quality & Safety reporting through the Executive Management Board and Quality, Safety & Performance Committee.

2. BACKGROUND

The Integrated Quality & Safety Group was established in November 2022 and its core function is to undertake and provide triangulated quality and safety assurance and governance. The group has been maturing since its inception and some reporting has aligned. However, there remains a considerable report writing burden with significant duplication and reliance on narrative rather than data. The quality and safety report writing should be predicated on assurance and exception rather than extensive narrative.

One of the key areas of duplication relates to the separate divisional reports that usually provides the same information and data as the corporately produced reports.

A further area of focus must be far greater evidencing of learning and improving as a result of quality and safety analysis.

The post Quality, Safety & Performance Committee attendee survey has identified that further work is required to provide more succinct and triangulated reports to the Committee that demonstrates the analysis and synthesis that has been undertaken prior to reporting through to the Committee.

3. PROPOSED QUALITY & SAFETY REPORTING CHANGE

3.1 Proposed Future Reports

It is proposed that from April 2024 reporting cycle the following will take place:

- Highlight report following each Integrated Quality & Safety Group (i.e. monthly) to Executive Management Board and Divisional Senior Leadership Teams/Senior Management Teams covering key highlights, assurance, exceptions and escalation. The Trust Quality & Safety Team will produce this

and highlights will be agreed during the meeting. Only if there are any significant exceptions / points of serious escalation will a highlight report be provided to the Quality, Safety & Performance Committee.

- Safeguarding, Infection Prevention & Control, Health & Safety, Information Governance, Safety Alert Group highlight reports will come to the Integrated Quality & Safety Group and not to Executive Management Board and Quality, Safety & Performance Committee unless there is a significant exception or escalation. These meetings will need to be arranged to facilitate effective quarterly reporting through to Executive Management Board and Quality, Safety & Performance Committee.

- Divisional quality & safety reports to Executive Management Board and Quality, Safety & Performance Committee will cease unless there is a significant escalation / exception.

- 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 & 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

- o Learning from external reports
- o Clinical audit

- Divisional and staff story reporting to the Quality, Safety & Performance Committee will continue as per Committee cycle of business.

3.2 Evaluation

Ongoing evaluation of the effectiveness of reporting to the Quality, Safety & Performance Committee is undertaken after each Committee meeting via an anonymous survey. Any feedback from this will be considered in real time and necessary changes proposed for future reporting – this will be undertaken by the Head of Quality & Safety. In addition, after each quarterly drafting a review will be coordinated by the Head of Quality & Safety involving all involved to ascertain if anything could be improved.

In addition, a formal review will be conducted after 6 months i.e. in September 2024.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Relates to all Health & Care Quality Standards
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required As relates to future reporting writing
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be legal implications if the legislative reporting requirements in respect of PTR, Duty of Candour & Duty of Quality are not undertaken
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

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5.   **RECOMMENDATION**

The Quality, Safety & Performance Committee are requested to *APPROVE* the proposal to provide a more integrated quality & safety report and the proposed changes to the 2024/2025 Committee cycle of business to reflect these changes.

Quality, Safety & Performance Committee Cycle of Business 2024-25 (commencing May 2024)
Key: ☐ = Annual Report
☐ = Highlight Report
☐ = Exception Report
☐ = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting frequency	May 2024	Jul 2024	Sep 2024	Nov 2024	Jan 2025	Mar 2025
DONOR/PATIENT/STAFF STORY										
Welsh Blood Service Donor Story	Chief Operating Officer	Director of Welsh Blood Service	Public	Three times a year	✓			✓		✓
Velindre Cancer Service Patient Story	Chief Operating Officer	Director of Velindre Cancer Service	Public	Three times a year			✓		✓	
Staff Story	Executive Director of Organisational Development & Workforce	Variable	Public	Annual		✓				
QUALITY, SAFETY & ASSURANCE										
Integrated Quality & Safety Quarterly Report	Executive Director of Nursing, AHPs and Health Science	Deputy Director of Nursing, Head of Quality and Safety and Divisional Quality & Safety Leads	Public	Quarterly	✓	~	✓	✓	~	✓
Medical Devices Report	Chief Operating Officer	Head of Engineering & Radiotherapy Physics, VCC Medical Devices Officer, VCC Head of Quality Assurance & Regulatory Compliance, WBS	Public	Bi Annually		✓ (Annual)			✓	
Infected Blood Inquiry Proceedings	Chief Operating Officer	Business Support Officer	Public & Private	Bi Annually (or by exception)			✓			✓
Value based Healthcare Programme Update	Executive Director of Finance	Head of Value Based Healthcare	Public	Bi-Annually				✓		✓
Trust Values and Culture Report	Executive Director of Organisational Development & Workforce	Head of Organisational Development	Public	Bi-Annually		✓			✓	
Private Patient Service Improvement Group Highlight Report & Improvement Plan Update	Executive Director of Nursing, AHPs and Health Science	Directorate Support Officer, CSMO	Public	May then close down	✓	-	-	-	-	-
Radiation Protection and Medical Exposures Strategic Group Highlight Report	Executive Medical Director	Head of Radiation Services	Public	Bi Annually	✓			✓		
Digital Report	Executive Director of Strategic Transformation, Planning & Digital	Chief Digital Officer	Public	6-monthly		✓ (Annual)			✓	
Workforce Supply and Shape & Associated Finance Risks	Executive Director of OD & Workforce Executive Finance Director	Deputy Director of OD & Workforce Deputy Director of Finance	Public	Each Meeting	✓	(by exception)	✓	✓	✓	✓
Anti-Racist Wales Action Plan	Executive Director of Organisational Development & Workforce	Head of OD	Public	Bi-annually	✓			✓		
Assurance Report Medicines Management Group (including Medical Gases & CDs)	Executive Medical Director	Head of SACT and Medicines Management	Public	Bi Annually	✓			✓		
RD&I Sub Committee Highlight Report	Executive Medical Director	Head of Research & Development	Public	Quarterly	✓		✓		✓	✓
Clinical & Scientific Strategic Board Highlight Report	Executive Medical Director/ Executive Director of Nursing, AHPs & Health Science	Clinical & Scientific Strategy Lead	Public	Bi-annually (from July 2023)	✓			✓		
PERFORMANCE AND ASSURANCE REPORTS										

Quality, Safety & Performance Committee Cycle of Business 2024-25 (commencing May 2024)

Key:
⬜ = Annual Report
🟪 = Highlight Report
⬜ = Exception Report
🟩 = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting frequency	May 2024	Jul 2024	Sep 2024	Nov 2024	Jan 2025	Mar 2025
Performance Management Framework (PMF) Report and Supporting Analysis:	Executive Director of Strategic Transformation, Planning & Digital Chief Operating Officer Executive Director OD & Workforce	Head of Strategic Planning and Performance Director of Velindre Cancer Service Director of Welsh Blood Service	Public	Each Meeting	✓	(by exception)	✓	✓	✓	✓
Finance Report	Executive Director of Finance	Head of Financial Reporting	Public	Each Meeting	✓	✓	✓	✓	✓	✓
STRATEGIC TRANSFORMATION, PLANNING & ESTATES										
Highlight Report from the Trust Estates Assurance Group	Executive Director of Strategic Transformation, Planning and Digital	Assistant Director of Estates, Environment & Capital Development	Public	Bi-Annually				✓		
IMTP Quarterly Actions Progress	Executive Director of Strategic Transformation, Planning and Digital	Deputy Director of Planning and Performance	Public	Quarterly	✓		✓		✓	✓
Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report	Executive Director of Strategic Transformation, Planning & Digital	Business Support Officer	Public & Private	Each meeting	✓	✓	✓	✓	✓	✓
ANNUAL REPORTS										
Gender Pay Gap Report	Executive Director of OD & Workforce	Head of OD	Public	Annually		✓				
Equality, Diversity & Inclusion Report	Executive Director of OD & Workforce	Head of OD	Public	Annually		✓				
Business Continuity & Emergency Planning	Chief Operating Officer	Head of Validation & Risk Management	Public	Annually		✓				
Medical Education Governance Framework	Executive Medical Director	Associate Medical Director of Medical Education	Public	Annually			✓			
Trust Clinical Audit Annual Report	Executive Medical Director	Clinical Audit Manager	Public	Annually		✓				
Trust Clinical Audit Plan	Executive Medical Director	Clinical Audit Manager VCC	Public	Annually	✓					
Health Technology Wales (HTW) Annual Report		Director, HTW (Susan Myles)	Public	Annually				✓		
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Annual Report	Executive Director of Nursing, AHPs and Health Science	Head of Nursing for Professional Standards & Digital	Public	Annually	✓					
Duty of Quality Annual Report	Executive Director of Nursing, AHPs and Health Science	Head of Quality & Safety	Public	Annually		✓				
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Science	Head of Infection Prevention Control	Public	Annually		✓				
Safeguarding & Vulnerable Adults Management Group Annual Report	Executive Director of Nursing, AHPs and Health Science	Head of Safeguarding & Vulnerable Groups	Public	Annually		✓				
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Science	Quality Safety & Assurance Manager	Public	Annually		✓				
Annual Performance Report	Executive Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Planning and Performance	Public	Annually		✓				
Annual Estates Report	Executive Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Environmental, Estates and Capital Development	Public	Annually		✓				
Annual Sustainability Report (inc. decarbonisation)	Executive Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Environmental, Estates and Capital Development	Public	Annually		✓				

Quality, Safety & Performance Committee Cycle of Business 2024-25 (commencing May 2024)

Key:
- ☐ = Annual Report
- ☐ = Highlight Report
- ☐ = Exception Report
- ☐ = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting frequency	May 2024	Jul 2024	Sep 2024	Nov 2024	Jan 2025	Mar 2025
Health & Safety Annual Report	Executive Director of Strategic Transformation, Planning, Performance and Estates	Head of Health & Safety (TBC)	Public	Annually		✓				
Local Partnership Forum Annual Report	Executive Director of OD & Workforce	Deputy Director of OD & Workforce	Public	Annually		✓				
People Strategy Annual Report	Executive Director of OD & Workforce	Deputy Director of OD & Workforce	Public	Annually		✓				
Welsh Language Annual Report	Executive Director of OD & Workforce	Head of OD	Public	Annually		✓				
Professional Registration/Revalidation	Executive Medical Director/ Executive Director of Nursing, AHPs & Health Science	Consultant Clinical Oncologist / Head of Nursing for Professional Standards and Digital	Public	Annually		✓				
Patient & Donor Experience Annual Report	Executive Director of Nursing, AHPs and Health Science	Quality Safety & Assurance Manager	Public	Annually		✓				
Annual progress report – Cyber Security Strategic Plan	Director of Transformation, Planning & Digital	Chief Digital Officer	Private	Annually		✓				
Annual Information Governance Report	Executive Director of Finance	Head of Information Governance	Public	Annually		✓				
Risk Annual Report	Director of Corporate Governance and Chief of Staff	Risk & Assurance Officer	Public	Annually		✓				
Communications Annual Report	Director of Corporate Governance & Chief of Staff	Assistant Director of Communications	Public	Annually		✓				
Wellbeing of Future Generations Act (2015) TBC	Executive Director of Strategic Transformation, Planning & Digital	TBC	Public	Annually		✓				
PROFESSIONAL REGULATION										
Professional Nursing Update Report	Executive Director of Nursing, AHPs & Health Science	Head of Nursing, Professional Standards & Digital	Public	Bi-Annually			✓			✓
INTEGRATED GOVERNANCE										
Trust Assurance Framework and Trust Risk Register	Director of Corporate Governance & Chief of Staff	Risk & Assurance Officer	Public	Each meeting	✓	✓	✓	✓	✓	✓
Freedom of Information Requests	Director of Corporate Governance & Chief of Staff	Freedom of Information and Compliance Officer	Public	Bi Annually		✓ (Annual)			✓	
Trust-wide policies and procedures for endorsement/approval	Executive Policy Lead (various)	Policy Lead (various)	Public	Each meeting (as required)	✓	✓	✓	✓	✓	✓
Trust-wide policies and procedures compliance report	Director of Corporate Governance & Chief of Staff	Freedom of Information and Compliance Officer	Public	6-monthly	✓				✓	
COMMITTEE EFFECTIVENESS										
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance & Chief of Staff	Head of Corporate Governance	Public	Annually						✓
Committee Cycle of Business	Director of Corporate Governance & Chief of Staff	Head of Corporate Governance	Public	Annually						✓
Committee Effectiveness Survey Report	Director of Corporate Governance & Chief of Staff	Head of Corporate Governance	Public	Each meeting	✓	✓	✓	✓	✓	✓
Hosted Organisations (e.g. NHS Wales Shared Services Partnership (NWSSP)										

Quality, Safety & Performance Committee Cycle of Business 2024-25 (commencing May 2024)

Key: 🟨 = Annual Report
🟪 = Highlight Report
⬜ = Exception Report
🟩 = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting frequency	May 2024	Jul 2024	Sep 2024	Nov 2024	Jan 2025	Mar 2025
Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)	Medical Director, Corporate Services, NWSSP / Managing Director, NWSSP	Service Director, TRaMS / Head of Technical Services	**Public**	Quarterly		✓		✓		✓
Implementation of Duty of Quality Update (NWSSP)	Medical Director, Corporate Services, NWSSP / Managing Director, NWSSP	Medical Director, Corporate Services, NWSSP	**Public**	Quarterly		✓		✓		✓
Surgical Materials Testing Laboratory (SMTL) Annual Report (NWSSP)	Medical Director, Corporate Services, NWSSP / Managing Director, NWSSP	Director, SMTL Quality Manager, SMTL R&D Manager, SMTL	**Public**	Annually		✓				
Medical Examiner Service (MES) Annual Report (NWSSP)	Medical Director, Corporate Services, NWSSP / Managing Director, NWSSP	Medical Director, Corporate Services, NWSSP Director of Primary Care Services Division, NWSSP	**Public**	Annually		✓				
Duty of Quality Report (NWSSP)	Medical Director, Corporate Services, NWSSP / Managing Director, NWSSP	Medical Director, Corporate Services, NWSSP	**Public**	Annually or by exception				✓		
CIVAS@IP5 Report	TBC	Head of Technical Services	**Public**							

Ad-hoc reports by exception (dependent on external schedules) e.g. COVID-19, staff surveys, inspection reports, internal audit and Audit Wales reports, internal high level task & finish work e.g. Occult Hepatitis B

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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	14/03/2024

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	Lauren Fear, Director of Corporate Governance and Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff

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
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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.

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 *(Appendix 2)*.

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

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
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 **4.3 By Invitation** • Amendment to reflect change from Community Health Council to Llais
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	☐

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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		☒
	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	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.		

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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

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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);

- 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

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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

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.

- 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.
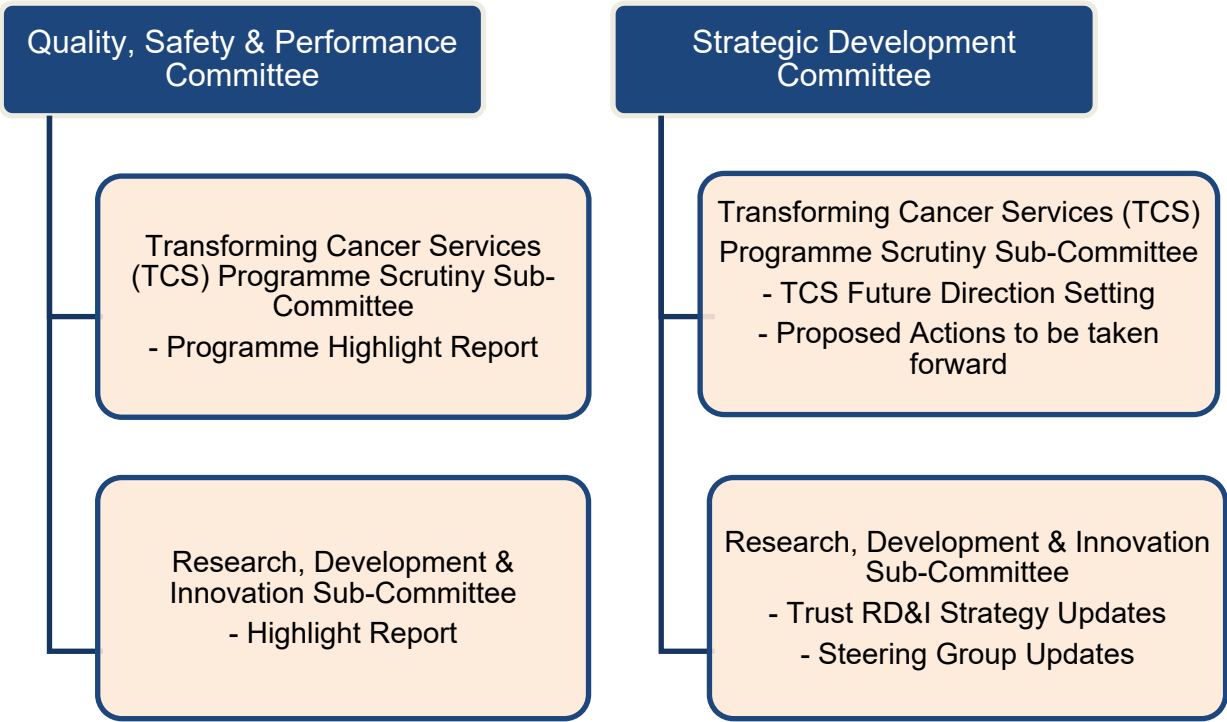
Access

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.

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

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.

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

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.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK

Statutory, Public
Trust Board
Committees

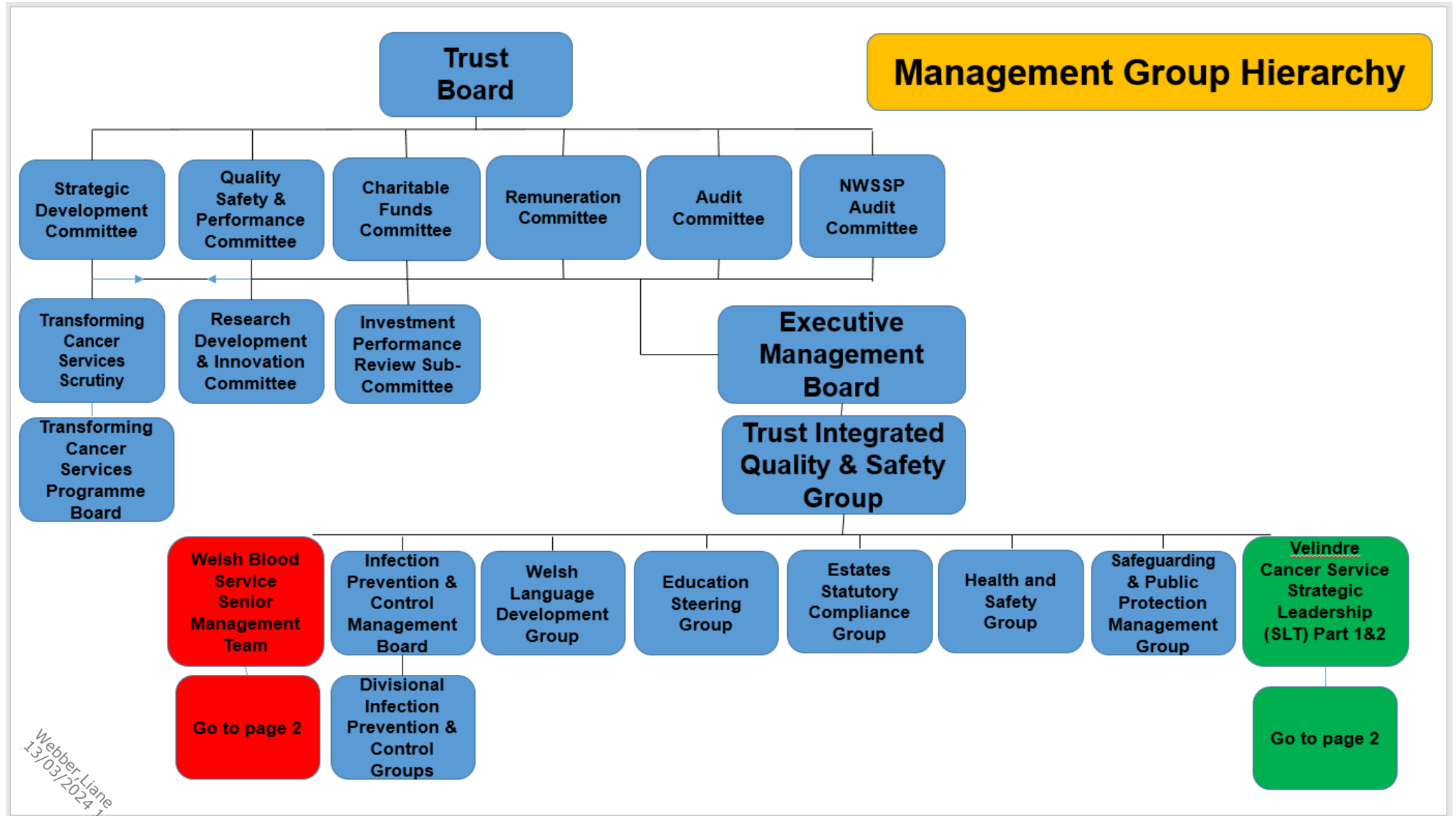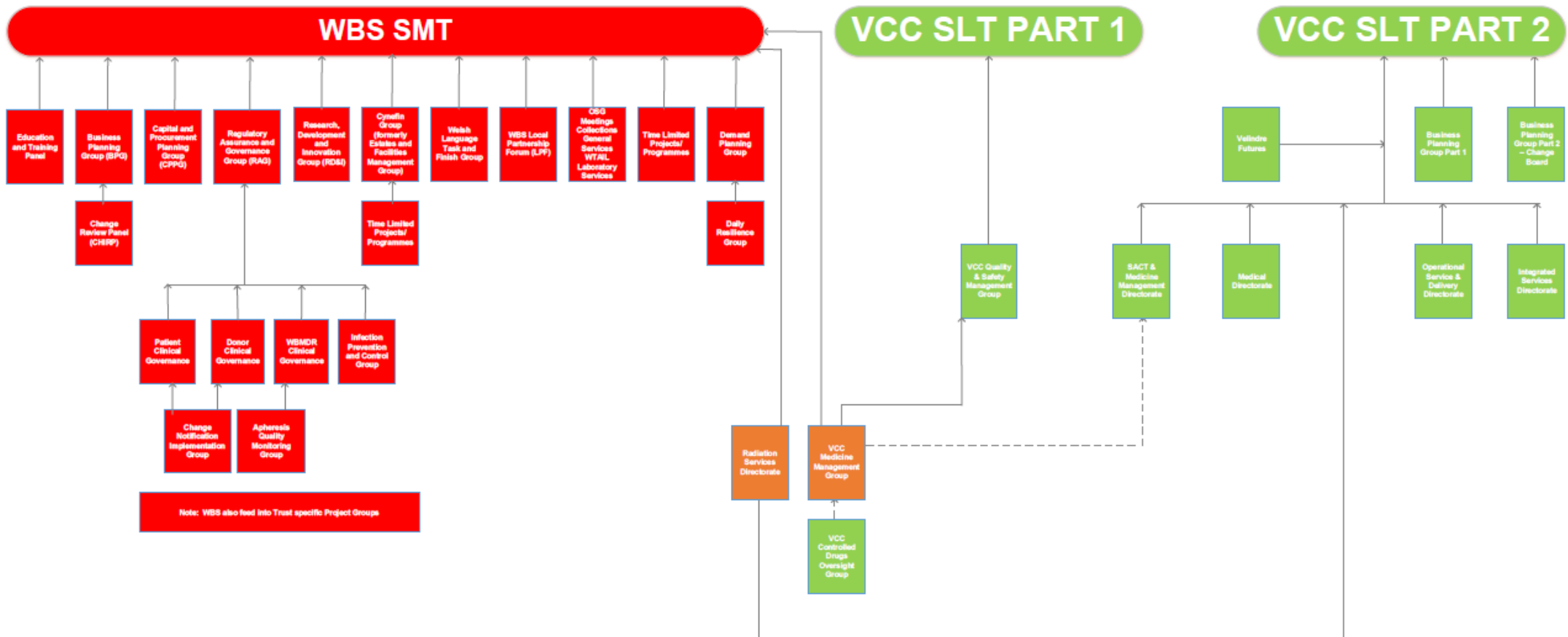| Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)
Quality & Safety Compliance & Standards Commissioning Arrangements Risk Management Trust Assurance Framework Annual Plan / IMTP Monitoring Listening & Learning Workforce Digital Delivery Information Governance	Strategy for Commissioning Innovation TCS future direction setting & other Major Programmes Trust Strategies Development of IMTP Partnerships (Academia / Industry / Third Sector) Digital Developments Organisational Development	Governance & Risk Accounts Internal Audit External Audit Counter Fraud Audit Tracker	Executives Objectives Executive Performance Anonymous Correspondence Voluntary Early Release Scheme (VERS)	Governance & Risk Strategy & Performance Financial Reporting Investment Fundraising Activity Advanced Radiotherapy Programme Board	Partnership Committee between NHS Wales Shared Services Partnership and Velindre University NHS Trust

Sub Committee: TCS Scrutiny
- Programme Highlight Report
- Risks & Issues
- Close Out Report

Sub Committee: TCS Scrutiny
- TCS Future Direction Setting
- Proposed Actions to be taken forward

Sub Committee: R,D & I
- Highlight Report
- Progress against Trust R, D & I Annual Operational Plan

Sub Committee: R,D & I
- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well
Vision: *By 2025 we will have helped more people to live longer, better lives and be the organisation others come to learn from*

Management Group Hierarchy

Trust Board

- Strategic Development Committee
- Quality Safety & Performance Committee
- Charitable Funds Committee
- Remuneration Committee
- Audit Committee
- NWSSP Audit Committee

- Transforming Cancer Services Scrutiny
- Research Development & Innovation Committee
- Investment Performance Review Sub-Committee

- Transforming Cancer Services Programme Board

Executive Management Board

Trust Integrated Quality & Safety Group

- Welsh Blood Service Senior Management Team
- Infection Prevention & Control Management Board
- Welsh Language Development Group
- Education Steering Group
- Estates Statutory Compliance Group
- Health and Safety Group
- Safeguarding & Public Protection Management Group
- Velindre Cancer Service Strategic Leadership (SLT) Part 1&2

- Go to page 2
- Divisional Infection Prevention & Control Groups
- Go to page 2

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WBS SMT

- Education and Training Panel
- Business Planning Group (BPG)
  - Change Review Panel (CHIRP)
- Capital and Procurement Planning Group (CPPG)
- Regulatory Assurance and Governance Group (RAG)
  - Patient Clinical Governance
    - Change Notification Implementation Group
  - Donor Clinical Governance
    - Apheresis Quality Monitoring Group
  - WBMDR Clinical Governance
  - Infection Prevention and Control Group
- Research, Development and Innovation Group (RD&I)
- Cynefin Group (formerly Estates and Facilities Management Group)
  - Time Limited Projects/ Programmes
- Welsh Language Task and Finish Group
- WBS Local Partnership Forum (LPF)
- OSG Meetings Collections General Services WT/BL Laboratory Services
- Time Limited Projects/ Programmes
- Demand Planning Group
  - Daily Resilience Group

Note: WBS also feed into Trust specific Project Groups

VCC SLT PART 1

- VCC Quality & Safety Management Group
- Radiation Services Directorate
- VCC Medicine Management Group
  - VCC Controlled Drugs Oversight Group

VCC SLT PART 2

- Velindre Futures
- Business Planning Group Part 1
- Business Planning Group Part 2 – Change Board
- SACT & Medicine Management Directorate
- Medical Directorate
- Operational Service & Delivery Directorate
- Integrated Services Directorate

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Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	February 2024
Approved:	
Next Review Due:	March 2025

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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:

- 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;

- 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.

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:

Quality, Safety & Performance Committee	Strategic Development Committee
Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - Programme Highlight Report	**Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee** - TCS Future Direction Setting - Proposed Actions to be taken forward
Research, Development & Innovation Sub-Committee - Highlight Report	**Research, Development & Innovation Sub-Committee** - Trust RD&I Strategy Updates - Steering Group Updates

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 outtages/performance*)
- Head of Quality & Safety
- 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
- Llais

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 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.

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Cross referenced with the Trust Standing Orders.

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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.

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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.

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ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK

Statutory, Public

Trust Board

Committees

Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)
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- Programme Highlight Report
- Risks & Issues
- Close Out Report

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- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well
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Management Group Hierarchy

Trust Board

- Strategic Development Committee
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- Remuneration Committee
- Audit Committee
- NWSSP Audit Committee

- Transforming Cancer Services Scrutiny
  - Transforming Cancer Services Programme Board
- Research Development & Innovation Committee
- Investment Performance Review Sub-Committee

Executive Management Board

Trust Integrated Quality & Safety Group

- Welsh Blood Service Senior Management Team
  - Go to page 2
- Infection Prevention & Control Management Board
  - Divisional Infection Prevention & Control Groups
- Welsh Language Development Group
- Education Steering Group
- Estates Statutory Compliance Group
- Health and Safety Group
- Safeguarding & Public Protection Management Group
- Velindre Cancer Service Strategic Leadership (SLT) Part 1&2
  - Go to page 2

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WBS SMT

- Education and Training Panel
- Business Planning Group (BPG)
  - Change Review Panel (CHIRP)
- Capital and Procurement Planning Group (CPPG)
- Regulatory Assurance and Governance Group (RAG)
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    - Change Notification Implementation Group
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Note: WBS also feed into Trust specific Project Groups

VCC SLT PART 1

- VCC Quality & Safety Management Group
- Radiation Services Directorate
- VCC Medicine Management Group
  - VCC Controlled Drugs Oversight Group

VCC SLT PART 2

- Velindre Futures
- Business Planning Group Part 1
- Business Planning Group Part 2 – Change Board
- SACT & Medicine Management Directorate
- Medical Directorate
- Operational Service & Delivery Directorate
- Integrated Services Directorate

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Page **13** of **13**

Quality, Safety and Performance Committee	
Integrated Quality and Safety Group Highlight Report	
DATE OF MEETING	14th March 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	Zoe Gibson, Interim Head of Quality and Safety
PRESENTED BY	Zoe Gibson, Interim Head of Quality and Safety & Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science.
EXECUTIVE SUMMARY	• ***Mortality Reviews***: A presentation was provided to the group and assurance provided that all Medical Examiner Service and inpatient mortality reviews are in place and undertaken in line with regulatory requirements. A process has been developed to ensure 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy reviews are undertaken in line with best practice. This is being rolled out by site team and will be undertaken across all site's specific teams by September 2024. Issues with the validity and accuracy of mortality data persists and the Trust is still unable to receive robust mortality data, to address this work is underway to ensure all SACT delivery is being captured within the required electronic system in real time. • **Incident Management and Learning framework development**: Both documents

are progressing well in line with project timelines, draft documents will be shared at Integrated and Quality Group on 25th March 2024.

- Proposed 2024/25 Quality Priorities have been identified.

RECOMMENDATION / ACTIONS	To **NOTE** the discussions that took place during the during the Integrated Quality and Safety Groups held during January and February 2024. To **APPROVE** the proposed 2024/25 Quality Priorities for inclusion in the IMTP.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	24th January 2024.
Integrated Quality and Safety Group	27th February 2024.
Executive Management Board (Run)	2nd February 2024
Executive Management Board (Run)	29th February 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***Integrated Quality & Safety Group*** - Agreed contents of the reports. ***Executive Management Board*** – Discussed the reports.	

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	Quality Management System Approach
Appendix 2	Overdue Action Report February 2024

1. BACKGROUND

The Trust Integrated Quality and Safety Group was established in October 2022 to provide oversight to support the Board, Executive Team, and Divisional Senior Leadership Teams in meeting their Quality and Safety responsibilities. This includes meeting legislative and national requirements of the 'Duty of Quality' responsibilities to help ensure quality is at the centre of all decision making across the Trust.

The Group continues to mature and brings together the Corporate and Divisional Quality and Safety Hubs to provide integrated analysis and assurance / escalation to the Executive Team and Quality, Safety & Performance Committee in respect of the Trust meeting its Quality and Safety responsibilities in line with legislative and national requirements and ensuring the Trust is learning from internal and external events, and always improving.

2. ASSESSMENT

Meeting Key Outcomes/ Deliberations of the Integrated Quality and Safety Group meetings held during January and February 2024 were:

2.1 Mortality Reviews

A comprehensive presentation was provided by the mortality leads at Velindre Cancer Service to demonstrate the current approach and future developments relating to Mortality Reviews and development of 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy in line with regulatory and the statutory requirements.

The group were assured that the Cancer Service currently meets both the current Statutory requirement in line with the Medical Examiners Service and reviewing all inpatient deaths and the reforms in Death Certification due to be implemented from April 2024. Mortality Reviews and development of 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy processes have been developed by the mortality leads and piloted successfully within one SST. Full process roll out has commenced by working through each site-specific team and roll out will be fully completed by September 2024.

Issues with the validity and accuracy of mortality data persists and the Trust is still unable to receive robust mortality data. Significant technical data fixes have been put in place. However, the inputting of treatment source information is not consistent at service delivery level. Action have been taken to address this and backdate the required data entry. A date for resolution is awaited, this will continue to be monitored through the Integrated Quality and Safety meeting.

This issue is included upon the VCC Divisional risk register.

It was also agreed by the group that any data produced must facilitate national benchmarking.

2.2 Quality Metric Dashboard Development

The business intelligence lead provided a demonstration of the quality & safety dashboard development to date and reported that the project was progressing in line with the project plan and completion date of 31/03/2024. The prototype dashboard was well received by the group and further functionalities for development were discussed.

2.3 Duty of Quality Annual Reporting Requirements

Each Local Health Board, NHS Trust and Wales-only Special Health Authority is required to publish an annual quality report on the steps it has taken to comply with the duty to exercise its functions with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

To ensure alignment with these requirements a Trust wide meeting was held on the 2nd of February 2024, attended by both division's quality representative and support from the NHS Executive Quality team.

Key messages from the Duty of Quality Report Meeting were shared with the group:
- A template will not be prescribed or shared from the NHS Executive or Welsh Government.
- The report should be prepared for the reader as a member of the public.
- The Quality Annual Report should have a chair and chief executive summary.
- We should ask our population what they want to know and how they would like information presented.
- Ensure that the report is linked to the organisation's strategic quality priorities.
- Include the Trust priorities for next year.
- Present your report as a story, this is not an assurance report for the organisation.

To develop a Trust approach to this reporting requirement a working group has been established with membership from all divisions and support from NHS Executive Quality leads.

The Integrated Quality and Safety Group approved this approach and agreed a further update will be provided, and progress reported in March 2024 Integrated Quality and Safety Group.

2.3 Subgroup Terms of Reference Reviews
The following Terms of Reference were endorsed by Integrated Quality and Safety

Group and approved by Executive Management Team:

2.3.*1 Putting Things Right / Redress Panel:* The Putting Things Right Terms of Reference have been amended. The panel will moving forward be split into 2 parts: Part A to identify a breach of duty and potential for harm and Part B for multi professional redress discussions.

2.3.2 Datix User Group: The previous Datix Operational Group has been realigned to function a Datix Operational User Group.

2.3.3 Integrated Quality and Safety Group: Terms of Reference was reviewed in line with schedule updates with limited changes being made.

2.4   Quality Management System Approach

The proposed approach to the development of the Trust Quality Management System (*appendix 1*) was reviewed, discussed, and endorsed by the group. The Integrated Quality and Safety Group acknowledged the benefit of clearly describing our Trust Quality and Management System, however it was considered that the content of the paper could be incorporated within the Trust Quality Management Framework as opposed to being a standalone document to avoid numerous documents and duplication.

2.5   'Person Affected' Datix Issue

The report update from the Once for Wales team relating to the national Datix issue raised on the 25th of January 2024, which identified a small number of incident records where gaps in data relating to the person affected in an incident were apparent, despite field mandating. This issue is believed to be intermittent in nature and only affects a small proportion of the overall number of records, but nonetheless it is being treated as a major incident by RLDatix. From initial information this is considered to be a longstanding issue, which includes records dating back to the commencement of the Datix Cymru system. RLDatix have acknowledged the issue and are investigating it as a Priority 1 incident and have invoked their major incident process to expedite a casual analysis and resolution. They are providing regular updates to the Once for Wales Programme Team. At Velindre University Trust a small number of incidents are affected to date (110) and work is ongoing to resolve and update in complete records as appropriate. Regular updates will be provided.

2.7   Risk Management and Reporting

To enhance risk management, monitoring, reporting, and oversight the Quality and Safety team have devised a real time risk reporting DATIX dashboard. This newly developed dashboard was utilised within the Integrated Quality and Safety Group meeting held on the 26th of February 2024, to review current Quality and Safety risks.

This revised approach was welcomed by the group. However, it was acknowledged that current system functionality linked to the organisation of risk domains has a considerable impact upon the ability to develop a risk dashboard report that can reach the level of detail required to theme and trend risks upon a divisional and departmental basis. To address this, the Trust Quality and Safety team developed a SBAR report that detailed the current dashboard limitations and recommendations in which challenges can be addressed. This will be discussed at the next Trust risk meeting.

2.8 Divisional Monthly Reports

The Velindre Cancer Centre Quality and Safety report for November 2023 was discussed. The areas for highlighting were:

2.8.1 Velindre Cancer Centre

Learning Identification

During this period Velindre Cancer Centre monthly reports have been expanded to include a section upon learning identified through quality indicators to demonstrate opportunities for continuous improvement. Examples of learning identified during this period included:

- The introduction of Advanced Nurse Practitioner and Review Radiographer shadowing programme to increase understanding and awareness of roles and scopes of practice.
- Hyperglycaemia service improvement project
- Amendment of Datix hierarchies to enable identification of themes and trends by SST for incidents and concerns.
- Introduction of spontaneous bacterial peritonitis clinical audit programme.
- Provision of education and training regarding Per Required Need (PRN) medication for first floor staff.
- Implementation of mattress storage audit programme,
- Development of patient education resources aimed at reducing inpatient falls.

Incidents and Concerns

High levels of incidents relating to SACT appointments and patient communications persist, with root causes being addressed through SACT service improvement projects.

During this period, 246 incidents remaining open over 30 days, the divisional quality and safety team continue to address this as a priority. When compared upon a month-by-month basis a downward trajectory is apparent.

2.8.2 Welsh Blood Service

Incident Reporting

The combined performance metric for incident closure < 30 days is 93%. This is a 1% Increase from the previous reporting period where 92% was reported. The number of incidents open over 30 days has significantly improved during this reporting period, with only 1 overdue incident being reported.

Externally Reportable Events
During this period 3 SABRE investigations have been undertaken and root causes identified:
- The need to ensure ageing equipment is replaced in a timely manner.
- The need to ensure staff are reminded of their responsibility not to interrupt critical tasks/ allow themselves to be interrupted.

2.9   Regulatory Quality and Safety Tracker Monthly Report

The monthly Quality and Safety Tracker report was presented and discussed.

Actions by approval status

February 2024
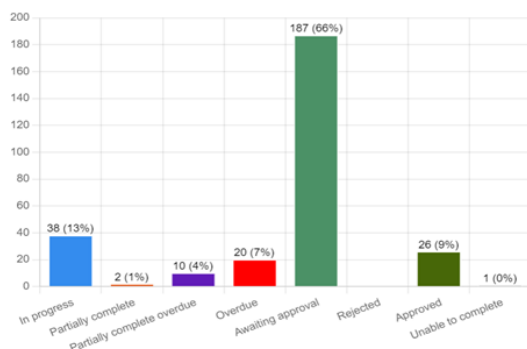
January 2024
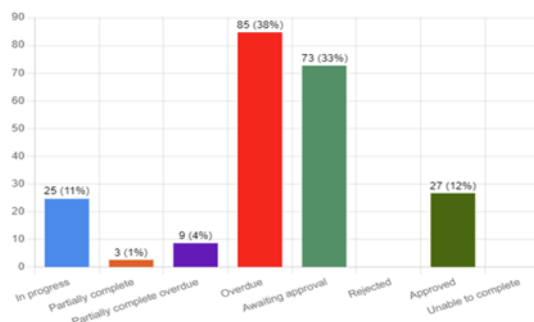
As demonstrated in the graphs above considerable work has been undertaken in developing and updating the tracker. A summary of updates includes:

- Further recommendations and actions have been added to the tracker, reflecting work between the corporate quality & safety and brachytherapy teams to update the following inspections: 'Brachytherapy Peer Review;' 'Brachytherapy SAUE Aug 2022: Datix 7015'; 'HIW Radiotherapy Department Velindre Cancer Centre Inspection 10th & 11th May 2023'.
- 1 inspection has been completed and closed as all actions have been delivered: 'HIW visit to First Floor Ward 12th & 12th July 2022'.

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- There has been a significant reduction in the number of overdue/partially complete actions from 94 to 30.
- There has been an increase in the number of actions completed and awaiting approval from 73 to 187.

A Standard Operating Procedure is under development to ensure there is a robust approval process for competed action, which will be presented to Integrated Quality and Safety group on 25th March 2024. The overdue actions from the tracker are attached in *Appendix 2*.

Inspection Overview.

Title	Date of Inspection	Recommendations	Actions total	In progress	Part. complete	Overdue	Awaiting Approval	Complete
Brachytherapy CCC Peer Review	02/02/23	133	133	27	0	1	104	1
Brachytherapy SAUE Aug 2022: Datix 7015	10/09/23	5	5	2	0	0	3	0
Fuller Action Plan following enquiry	01/03/23	18	18	0	1	0	17	0
HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	10/05/23	16	31	1	0	10	12	8
Loss to follow up NRI steps 1-9	10/09/23	6	6	0	0	4	2	0
Management of unwell patient in radiotherapy	27/10/23	0	0	0	0	0	0	0
NRI 13221 VCC steps 1-7	24/08/23	6	6	0	0	0	5	1
Patient & Donor Experience	05/01/23	4	5	0	1	3	1	0
SACT NRI steps 1-7	11/09/23	7	2	2	0	0	0	0
SACT Treatment Helpline Incidents	01/01/23	1	28	2	0	2	18	6
Urology NRI Recommendation steps 1-12	11/09/23	7	7	0	0	3	3	1
VCC Clinical Audit Action Plan	12/07/23	1	2	2	0	0	0	0
VCC Clinical Audit Tracker	26/09/23	2	9	1	0	4	0	4
VUNHST WRP Concerns Assessment Action Plan Oct 2023	31/10/23	11	23	1	0	1	18	3
WRP Concerns Assessment	17/03/23	1	0	0	0	0	1	0
WRP Validation	22/02/23	1	0	0	0	0	2	0

The table below shows recommendations and number of actions, per inspection as of 16th February 2024.

2.12   Development of Incident Management and Learning Frameworks.

The development of both frameworks is progressing well and are on target for completion on 31/03/2024 in line with project timescales. They will be presented at Integrated Quality and Safety Group on 25th March 2024.

2.13   Putting Things Right Consultation

Welsh Government is seeking opinions from stakeholders across Wales regarding the proposed changes to the PTR process. The revised approach intends to enable a culture shift in NHS Wales to ensure the provision of a system that is always listening, learning, and improving, and that has the trust and confidence of patients and their families. The specific proposal suggested concentrates upon:

- Placing patients at the heart of the process.
- An improved focus on compassionate patient-centred communication.
- Improving the Putting Things Right process to be more inclusive.
- The inclusion of escalation processes for urgent concerns of deliberate abuse or harm from care, or after someone dies.
- Refresh the arrangements to provide free legal advice and medical expert reports.

As an organisation it is key that we are involved in this consultation process, and to ensure this a working group is being formed to develop a collaborative response.

2.14   Quality Priorities 2024/25

The group reviewed and discussed the revised proposed 2024 -2025 quality priorities which have now been aligned with the SMART principles. The group discussed the benefit of developing an infographic that described the quality priorities in an easy-to-understand format that can be utilised within Annual Duty of Quality reports, which will be progressed. The proposed priorities are:

Velindre Cancer Centre

- Further develop administrative and patient communication systems to prevent patient harm and improve patient experience.
- Mortality reviews will be completed for deaths within 30 days of Systemic Anti-Cancer Treatment and 30/90 days of radiotherapy and will align with best practice.
- Integrate Clinical Audit within Velindre Cancer Service Quality and Safety function.
- Develop robust Site-Specific Quality Metrics.

Welsh Blood Service

- Continue to review and update the WBS Quality Management Framework, including the deployment of a new electronic Quality Management System.
- Successfully Introduce West Nile Virus testing.
- 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.
- Review and improve donor selection and screening processes.
- Introduction of all Wales foetal D Screening for RhD negative pregnant women.
- Introduction of electronic result transfer for deceased organ donor Human Leukocyte Antigen typing results to NHS Blood and Transplant -Organ Donation and Transplant, which will reduce risk of manual transcription of results.
- Achieve joint Accreditation Committee ISCT Europe & EMBT (JACIE) status within the Welsh Bone Marrow Donor Registry.
- Commencing rollout of live connectivity of the Blood Establishment Computer System at community-based donation clinics
- Enablement of DATIX and QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact.

Trust

- *TBC % increase in staff psychological safety scores within VUNHST Staff Survey results.
  *Percentage to be confirmed once NHS staff survey results are available.

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 Centered		☒
	Provides Quality, Safety and Performance Committee with the details of discussions held and decisions made at both the Integrated Quality and Safety Group and Executive Management Board which impact upon all domains of quality.		
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required		
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group and Executive Management Board as opposed to service delivery and approach change with a direct impact upon Socio Economic Duty.		

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approaches change that would require an equality assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4.   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	1. Delays in the development of the quality and safety dashboard, prevent consistent and accutane report of quality data. 2. current system functionality linked to the organisation of risk domains with Datix system has impact upon the ability to develop a risk dashboard report that can reach the level of detail required to theme and trend risks upon a divisional and departmental basis.
WHAT IS THE CURRENT RISK SCORE	Risks currently be entered on Risk Register and assessment of Risk
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recommended remedial actions if implemented fully should reduce the risks
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Low Risk
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	

Draft Velindre University NHS Trust Quality Management System

Vision

Velindre University NHS Trust is committed to improving the quality of our services to improve the outcomes for our patients and donors. Within the Trust we view quality as far more than meeting service standards, and aim to provide safe, timely, effective, efficient, equitable and person-centred care, which is supported through enabling a psychologically safe culture of continuous learning and improvement, to ensure our patients and donors have the best possible care and outcomes.

Aim

To achieve this, and to meet our legislative requirements in line with the Duty of Quality the Trust is required to take a system wide approach that actively involves patients, donors, colleagues, and other key stakeholders.

This will be achieved through ensuring the provision and ongoing improvement of a robust Quality Management System.

The key to success requires everyone across the Trust to be engaged and dynamic in ensuring quality is at the heart of everything we do:

Objectives

Our Quality management system aims to:

- Enable a positive and psychologically safe quality culture through the provision of compassionate leadership.
- Enable a shared responsibility and voice for Quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care.
- Embed Quality Driven Decision Making at all levels of the Trust.
- Demonstrate a quality approach based upon learning and continuous improvement.

What is A Quality Management System?

A Quality Management System enables us as an organisation to focus upon understanding what a quality service looks like, knowing whether we are delivering the services that our population needs and ensuring a strong focus continuous learning and improvement.

Every Quality Management System is based upon the continuous Quality Cycle which consists of 4 parts: **Quality Planning: Quality Control: Quality Assurance: and Quality Improvement**, which are all underpinned by provision of a **learning** environment.

Daily Management to monitor quality and sustain results by creating and maintaining the culture and processes for those closest to the work to undertake action to keep the system in control and escalating where appropriate.

Effective structures and standards to provide a clear line of sight across the Trust giving assurance internally and externally to stakeholders, that improvements are being achieved and sustained.

Consistent implementation of strategic and everyday improvements by those closest to the work, using a standardised methodology to learn implement, scale and spread improvements in the quality of services

Planning to improve the quality of services and outcomes for our patients and donors through effective design of strategies, frameworks, policies, structures, systems, and processes.

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Velindre University Trust Quality Management System

Quality Planning	

Aim

The Trust will ensure that all service planning and development is undertaken through a quality and continuous improvement lens which is supported by the feedback of patients, donors, staff, and other key stakeholders at all levels of the Trust to ensure the provision of services which meet the requirements of our population and optimise patient and donor outcomes.

How we achieve this	How we can improve this
Significant focus upon quality within our Trust Strategy 'Destination 2033'	Availability of Quality Metrix and dashboard to improve information available to support decision making
Development of Trust Values that support the quality culture that we require.	Expansion of service User feedback systems and approaches to gain service user insights.
Alignment of Intermediate Medium-Term Plan (IMTP) with Quality requirements	Expansion of always on reporting metrics
Ensuring identification of robust annual quality priorities that align with the Trust IMTP.	Further development of staff feedback mechanisms.
Quality Management Framework	
Introduction of quality-based decision-making tools for all strategic decisions across the Trust.	
Introduction of Quality Impact Assessments to determine impact of proposed service changes, business cases and organisational change upon Quality.	
Development and Implementation of Robust Quality reporting and assurance structures.	
Quality and Safety Policies, procedures, and guidance.	
Development of Incident Management Framework.	
Implementation of CIVICA service User feedback system.	
Introduction of always on reporting	

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Quality Improvement

Aim

The Trust and Divisional Quality improvement priorities will be developed annually and managed through a project management infrastructure. The Trust will further strengthen its clinical effectiveness arrangements.

How we achieve this	How we can improve this
Development of Annual Quality Improvement Priorities.	Review of Trust Quality Improvement Infrastructure
Clinical and Scientific Strategy Board	Development of post learning clinical audit to ensure improvements are achieved and sustained.
Annual Clinical Audit Plan	Source a single trust wide clinical audit system.
Implementation of Clinical Audit systems to support activity.	Identification a single Quality Improvement Methodology
Development and Publish of Patient Reported Experience Measures.	Expanding Patient Reported Experience and Outcome Measures
5-minute improvement programme at the Welsh Blood Service.	Roll out of 5-minute improvement programme across the Trust
Safe Care Collaborative Improvement Projects.	
Service Improvement team support and training.	
Duty of Candour and National Reportable Incident Procedures.	
Learning associated with Incidents, concerns and feedback from staff and service users.	
Quality and Safety Learning System Framework.	
Reflective Learning Events.	

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Quality Control

Aim:

We will develop a quality control infrastructure across the organisation that there are robust arrangements in place to monitor services provided and to detect and respond to quality variances and a culture that supports its delivery through a positive learning and improvement culture.

How we achieve this	How we can improve this
Identified Quality Priorities based upon data findings and quality variance.	Development of Quality Always on Reporting Measures to enable real time reporting.
Clinical Guidance, policies, and procedures	Further development of feedback reporting mechanisms.
Harm Reporting Systems	Enhanced staff training programmes
Duty of Candour and National Incident Reporting procedures.	Enhancing thematic analysis
Incident and Concern Management processes and policies.	
Incident Management Framework	
Harm Reporting Systems	
Patient, Donor, and Staff Feedback Systems	
Quality and Safety Key Metrics	
Trust Values	
Building our Future Together Programme	
Speaking Up Safely Framework	
Compassionate Leadership	
Staff training and education	

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Quality Assurance

Aim: We will understand the quality of our commissioned and provided, how our services compare with others and if our improvement work is making a difference.

How we achieve this	How we can improve this
7 Levels of Assurance	
Clinical and Quality Audits	Development of Quality Measure Reporting Dashboard
Regulatory Inspections	Further development of Always on reporting Metrics.
Peer Reviews and Benchmarking Exercises	
Always on Reporting Measures	
Performance Management Framework	
Quality and Safety Policies, procedures, and Standard Operating Procedures	
Quality and Safety Regulatory Tracker	
Quality and Safety assurance structures	
Building our Future Together Programme	
Speaking Up Safely Framework	
Compassionate Leadership	
Staff training and education	

To enable the successful implementation of our quality management system leadership, beliefs, attitudes, skills, and behaviors that support collaboration, psychological safety, responsibility, accountability, continuous improvement, and a person centred approach are recognised as key requirements by the Trust which have been identified as key objectives for development in 2024/25.

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Appendix 2

Overdue Action Report February 2024.

Corporate Quality & Safety/2023/3	Patient & Donor Experience	As part of the review of quality and safety governance and reporting mechanisms, the Trust should: 1.1a. Review the flow of patient and donor experience reporting 'from floor to Board' to ensure it is clear and efficient, avoiding unnecessary duplication	Corporate Quality & Safety/2023/3/MD1/1	A patient / Donor experience feedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	TRUSTWIDE	TRUSTWIDE	26/09/2023	30/06/2023
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The Trust is required to provide HIW with details of the action taken to review the area used for Brachytherapy to determine whether further environmental changes can be made to help promote patients' dignity and privacy	Health Inspectorate Wales/2023/8/MD1/1	Standard/ Regulation Standard - Person Centred 1.Environmental review already completed and determined Swipe access door controls required 2. Door replacements being installed within 4-6	Velindre Cancer Centre	Radiotherapy	26/09/2023	31/10/2023

National Reportable Incident/2023/12	Loss to follow up NRI steps 1-9 INC 10502	NRI step 2 10502 With immediate effect (1 month) that the process by which a patient is registered to a named consultant on admission to the ward should be clarified, and that this consultant is informed when the patient is admitted and must be consulted before discharge. The registration of the	National Reportable Incident/2023/12/MD1/1	Assurance required	Velindre Cancer Centre	Inpatient, Outpatient	11/10/2023	31/10/2023

weeks
3. Access control permissions to be developed into a Standard Operating Procedure (SOP)
4. Communication of revised access control permission to staff in Velindre Cancer Centre

Responsible officer Infrastructure and Design Manager

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| | | named consultant should also be reviewed during admission in order that the appropriate consultant is assigned responsibility for the care of that patient. All relevant staff must be made aware of this process in this timeframe.

Responsible officer: Nicola Hughes and Ann Marie Stockdale | | | | | | |
|---|---|---|---|---|---|---|---|---|
| National Reportable Incident/2023/10 | Urology NRI Recommendation steps 1-12 | NRI step 2 To ensure that for the 254 patients where a letter was not written, the patients GPs are provided with updated communication.

Responsible officer: EGE/NH/SO | National Reportable Incident/2023/10/MD1/1 | Assurance required | Velindre Cancer Centre | Urology SST | 11/10/2023 | 31/10/2023 |
| Clinical Audit/2023/4 | VCC Clinical Audit Tracker | SSC Projects | Clinical Audit/2023/4/MD1/2 | Create an A4 tutor guide for VCC responsibilities | Velindre Cancer Centre | Crosscutting Sites & Services | 26/09/2023 | 31/12/2023 |

National Reportable Incident/2023/2	SACT Treatment Helpline Incidents	To ensure the treatment helpline is fit for purpose and ensures patient safety	National Reportable Incident/2023/2/MD1/2	Staff to complete UKONS training Produce VCC specific Telephone Triage Training - closed as UKONS developing training which VCC will use (see action below) Produce UKONS Telephone Triage Training VCC will use this as staff training once available Responsible officer: Hannah Russon/Sarah Owen/Rosie Roberts	Velindre Cancer Centre	SACT Medicines Management	21/09/2023	01/02/2024
Clinical Audit/2023/4	VCC Clinical Audit Tracker	SSC Projects	Clinical Audit/2023/4/MD1/3	Create and maintain a log of student enquiries	Velindre Cancer Centre	Crosscutting Sites & Services	26/09/2023	29/02/2024
Clinical Audit/2023/4	VCC Clinical Audit Tracker	SSC Projects	Clinical Audit/2023/4/MD1/7	Schedule virtual presentation event Year 3	Velindre Cancer Centre	Crosscutting Sites & Services	26/09/2023	10/10/2023
Clinical Audit/2023/4	VCC Clinical Audit Tracker	SSC Projects	Clinical Audit/2023/4/MD1/8	Schedule Virtual Presentation event - Year 4	Velindre Cancer Centre	Crosscutting Sites & Services	26/09/2023	10/10/2023

National Reportable Incident/2023/2	SACT Treatment Helpline Incidents	To ensure the treatment helpline is fit for purpose and ensures patient safety	National Reportable Incident/2023/2/MD1/23	Present to Medics Present to Switchboard Manager Update 09/08/23 - BT to arrange mtg with MD Present to Switchboard staff Mop up - dates to be confirmed Responsible officer: Amy Quinton/Rosie Roberts	Velindre Cancer Centre	SACT Medicines Management	27/09/2023	01/11/2023
Clinical Audit/2023/4	VCC Clinical Audit Tracker	Consent Audit	Clinical Audit/2023/4/MD2/1	Register consent audit on AMaT	Velindre Cancer Centre	Crosscutting Sites & Services	26/09/2023	03/10/2023
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration the needs of the patient population.	Health Inspectorate Wales/2023/8/MD2/1	Standard - Equitable Trust Radiotherapy Team are working with Wales Cancer Network (WCN) and the other Wales Radiotherapy centres to review current patient information leaflets in use with the view to reduce duplication, have	Velindre Cancer Centre	Radiotherapy	26/09/2023	31/01/2024

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				consistency and to ensure availability in English, Welsh and other core languages aligned to the needs of the patient population Gap analysis of information leaflets currently in use and available is underway

Responsible officer Radiotherapy Service Manager | | | | | |
| National Reportable Incident/2023/12 | Loss to follow up NRI steps 1-9 INC 10502 | NRI step 3 With immediate effect (1 month) the existing VCC discharge and transfer policy (2019), including the discharge checklist, Discharge Advice Letter, and leaflet (DAL) should be reviewed and implemented across all wards, to ensure that all patients receive (if | National Reportable Incident/2023/12/MD2/1 | Assurance required | Velindre Cancer Centre | Inpatient, Outpatient | 11/10/2023 | 31/10/2023 |

National Reportable Incident/2023/10	Urology NRI Recommendation steps 1-12	NRI step 3 To strengthen communication with the patient's GP and ensure that letters are provided after every significant follow up visit, especially annual or 6 monthly follow up reviews. Responsible officer: EGE/NH	National Reportable Incident/2023/10/MD2/1	Assurance required	Velindre Cancer Centre	Urology SST	11/10/2023	31/10/2023
National Reportable Incident/2023/13	SACT NRI steps 1-7	NRI step 2 Cancer Centre wide mechanism for clinical communication to be urgently developed.	National Reportable Incident/2023/13/MD2/1	Email/ communication SPO to be drafted by Ian Bevan - responsible officer	Velindre Cancer Centre	SACT	27/09/2023	31/01/2024
Corporate Quality & Safety/2023/19	VUNHST WRP Concerns Assessment Action Plan October 2023	R02 VUNHST to establish a process which reviews / validates all incidents upon closure to ensure the	Corporate Quality & Safety/2023/19/MD 2/8	2.6 Review process for managing radiotherapy incidents and reporting to align	TRUSTWIDE	TRUSTWIDE	17/11/2023	01/11/2023

		management review has been completed as well as all necessary fields.		with 90-day closure requirement).					
Corporate Quality & Safety/2023/3	Patient & Donor Experience	3.1 The Trust should incorporate how it effectively communicates patient and donor experience feedback to all staff as part of its review of quality and safety governance and reporting mechanisms. The patient / Donor experience feedback procedure (detailed under 1.1a) to include expectations of how feedback should be communicated to staff at all levels and how staff are involved in the 'so what' analysis.	Corporate Quality & Safety/2023/3/MD3/1	The patient / Donor experience feedback procedure (detailed under 1.1a) to include expectations of how feedback should be communicated to staff at all levels and how staff are involved in the 'so what' analysis. Tina Jenkins	TRUSTWIDE	TRUSTWIDE	26/09/2023	29/09/2023
Corporate Quality & Safety/2023/19	VUNHST WRP Concerns Assessment Action Plan October 2023	R03 VUNHST to review the process for requesting authority on matters to utilise delegated authority options for Claims Managers and Legal &	Corporate Quality & Safety/2023/19/MD3/1	3.1 To review current requesting authority and delegation arrangements.	TRUSTWIDE	TRUSTWIDE	17/11/2023	28/02/2024

		Risk Services where this is considered appropriate.						
National Reportable Incident/2023/12	Loss to follow up NRI steps 1-9 INC 10502	NRI step 4 Within 3 months, that an audit of a selection of patient case notes is undertaken to ensure compliance with the VCC discharge and transfer policy (2019). Responsible officer: Matthew Walters	National Reportable Incident/2023/12/MD3/1	Assurance required	Velindre Cancer Centre	Inpatient, Outpatient	11/10/2023	31/12/2023
National Reportable Incident/2023/10	Urology NRI Recommendation steps 1-12	NRI step 4 To review the follow up Urology pathways to ensure that there is standardisation, to review opportunities for early discharge, and to review opportunities for a change in the model for follow up reviews, including virtual management and undertaken by a Clinical Nurse Specialist rather than	National Reportable Incident/2023/10/MD3/1	Assurance required	Velindre Cancer Centre	Urology SST	11/10/2023	31/10/2023

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		a Clinician What has Sian Dobbin done so far? Lot of work probably been done already Work in progress - being looked at in the deep dive. Part of transformational work Responsible officer: NH/CG/Urology SST							
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The Trust is required to provide HIW with details of the action taken to: • encourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh • to consistently ask patients to confirm their preferred language.	Health Inspectorate Wales/2023/8/MD3/3	Baseline audit to be undertaken to assess current level of information gained on language preference, and detailed actions to target specific aspect of patient pathway to follow. Implement changes based on the audit findings and follow with a review to ensure patients are asked to confirm their preferred	Velindre Cancer Centre	Radiotherapy	26/09/2023	31/01/2024

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				language. Responsible officer: Eve Gallop Evans Clinical Director / Thomas Rackley Clinical Oncologist Lead for Radiotherapy Helen Payne Interim Radiotherapy Services Manager. Samantha Allen Interim Deputy Radiotherapy Service Manager					
National Reportable Incident/2023/12	Loss to follow up NRI steps 1-9 INC 10502	NRI step 5 With Immediate effect (1 month) all relevant staff responsible for producing the Discharge Advice Letter and discharge medication list should be made aware of this incident, and receive training on the importance of oncological follow up, and that repeat medications are	National Reportable Incident/2023/12/MD4/1	Assurance required	Velindre Cancer Centre	Inpatient, Outpatient	11/10/2023	31/10/2023

| Health Inspectorate Wales/2023/8 | HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023 | The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint protocols, taking into account relevant guidance | Health Inspectorate Wales/2023/8/MD4/1 | IR(ME)R - Regulation 6 (5)(a)

Update all joint Clinical protocols and update format more in keeping with template included in Ionising radiation Medical Exposure) Regulations: Implications for clinical practice in radiotherapy. Guidance from the radiotherapy board. Starting with Joint breast protocol in preparation for treatment on Halcyon then each document to be updated at annual review. | Velindre Cancer Centre | Radiotherapy | 26/09/2023 | 31/01/2024 |

highlighted to the GP especially those that are oncology drugs

Responsible officer: Nicola Hughes

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				Each joint Clinical protocols will be updated on rolling monthly update and complete within one year Responsible officer: Claire R Davies, Radiotherapy Clinical Governance Manager Rebecca Windle Deputy Head of Radiotherapy Physics				
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The employer is required to provide HIW with details of the action taken better reflect the governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy document	Health Inspectorate Wales/2023/8/MD5 /1	IR(ME)R - Regulation 11 (1)(d) Update IR(ME)R in RT document to include governance arrangements for research trials Responsible officer: Radiotherapy Clinical Governance Manager	Velindre Cancer Centre	Radiotherapy	26/09/2023	30/11/2023

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Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The employer is required to provide HIW with details of the action taken to better reflect the entitlement of Clinical Oncologists in the local employer's written procedures.	Health Inspectorate Wales/2023/8/MD6/1	IR(ME)R Regulation 6 (1) (a) and Schedule 2 (1)(b) Update IR(ME)R in RT document to include the entitlement of Clinical Oncologists in the local employer's written procedures. Responsible officer: Radiotherapy Clinical Governance Manager	Velindre Cancer Centre	Radiotherapy	26/09/2023	30/11/2023
National Reportable Incident/2023/13	SACT NRI steps 1-7	NRI step 6 A clear and agreed point of contact for clinical management of patients, when the treating clinician is not available i.e., on leave, other commitments outside VCC.	National Reportable Incident/2023/13/MD6/1	To agree some kind of formal Out of Office Responsible officer: Eve Gallop-Evans	Velindre Cancer Centre	SACT	27/09/2023	31/10/2023
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th	The employer is required to provide HIW with details of the action taken to revise the employer's written procedures to	Health Inspectorate Wales/2023/8/MD8/1	IR(ME)R – Regulation 6 (1)(a) Schedule 2 (1)(n) Update IR(ME)R in RT document by adding a statement	Velindre Cancer Centre	Radiotherapy	26/09/2023	30/11/2023

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| Health Inspectorate Wales/2023/8 | HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023 | show carers or comforters are not allowed to remain with patients during any medical exposure. | | to show carers or comforters are not allowed to remain with patients during any medical exposure

Responsible officer: Radiotherapy Clinical Governance Manager | | | | |
|---|---|---|---|---|---|---|---|---|
| Health Inspectorate Wales/2023/8 | HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023 | The Trust is required to provide HIW with details of the action taken to assure staff that when they report concerns about unsafe practice, the organisation will address these. | Health Inspectorate Wales/2023/8/MD10/3 | Standard Safe Trust Safe Care Collaborative leadership priority identified as enhancing psychological safety across the Trust. An element of this is to engender a positive reporting culture

Responsible officer: Executive/Corporate Team | Velindre Cancer Centre | Radiotherapy | 26/09/2023 | 22/02/2024 |
| Health Inspectorate Wales/2023/8 | HIW Radiotherapy Department, Velindre Cancer Centre | The Trust is required to provide HIW with details of the action taken to repair or replace areas of the | Health Inspectorate Wales/2023/8/MD11/1 | Standard - Safe Estates to review all flooring for any hazards and make safe | Velindre Cancer Centre | Radiotherapy | 26/09/2023 | 30/08/2023 |

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	Inspection 10th & 11th May 2023	floor which are visibly worn and presenting a hazard.		Responsible officer: Estates manager					
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The Trust is required to provide HIW with details of the action taken to address the less favourable staff comments described in this report.	Health Inspectorate Wales/2023/8/MD1 2/3	Standard - Workforce Address specific actions within own department as appropriate Responsible officer: Helen Payne Interim Radiotherapy Services Manager Eve Gallop Evans Clinical Director Tony Millin Head of Radiotherapy Physics	Velindre Cancer Centre	Radiotherapy	27/09/2023	31/12/2023	
Health Inspectorate Wales/2023/8	HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.	Health Inspectorate Wales/2023/8/MD1 4/1	Standard - Culture Work ongoing with Velindre Quality and Safety Team to improve CIVICA access. Discussions ongoing regarding increasing the size/access of the touch screen terminal in RT reception. Potential	Velindre Cancer Centre	Radiotherapy	27/09/2023	30/10/2023	

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| Local (Velindre Quality & Safety)/2023/15 | Brachytherapy CCC Peer Review | ID63 Develop competency documents for all staff groups and method for ongoing competency updates | Local (Velindre Quality & Safety)/2023/15/MD21/1 | ID63 Theatres: Competency framework will be developed RT: All training documentation and competency assessments provided to KF to incorporate into exemplar training plans Physics Checker/MPE training for review April 23

Responsible officer: Service leads | Velindre Cancer Centre | Radiotherapy | 27/09/2023 | 15/02/2024 |

second screen in pre-treatment area to promote feedback opportunity

Responsible officer: Helen Payne Interim Radiotherapy Services Manager

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Local (Velindre Quality & Safety)/2023/15	Brachytherapy CCC Peer Review	ID66 Full multidisciplinary team to be involved in regular scenario based contingency practices for removal of applicators, resus, local toxicity, bleed, fire evacuation. Attendance should be documented	Local (Velindre Quality & Safety)/2023/15/MD22/1	ID66 review business continuity plan Responsible officer: Service Planning Business continuity/Head of Brachytherapy	Velindre Cancer Centre	Radiotherapy	27/09/2023	29/02/2024

Quality, Safety & Performance Committee

2023-24 Quarter 3 Quality & Safety Report

DATE OF MEETING	14th March 2024.

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Head of Quality and Safety
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

EXECUTIVE SUMMARY	The Velindre University NHS Trust Quality and Safety Quarter 3, 2023-2024 report covers the period 1st October 2023 to 31st December 2023 and describes the key outcomes, trends and themes in respect of: Complaints; Redress; Claims; Duty of Candour; Safety Alerts; Infection Prevention & Control; and Safeguarding.
	The report includes reporting data for the quarter and to provide appropriate contextualisation, two-year comparison data. Report highlights include:
• **55** concerns were received (**42** Velindre Cancer Service (0.0007% of patient contacts), **12** Welsh Blood Service (0.01% of all donors registered), **1** Corporate) from a total of **35** (63%) were managed successfully as an early resolution (verbally resolved within 48 hours). **20** (37%) were managed as formal complaints under

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Putting Things Right Regulations (2011). Of the **20** formal concerns, **all** were investigated within 30 working days.

- **447** incidents were reported across the Trust: **0** relating to Corporate Services, **395** Velindre Cancer Service and **52** within the Welsh Blood Service. **445** incidents after the initial management review were graded as no or low harm, **1** incident remained graded as moderate harm, and **1** remained as severe and are being managed in line with Duty of Candour procedures.

- Of the **2** Duty of Candour incidents, **1** was graded as **severe** and related to a missed opportunity to dose reduce cycle 2 chemotherapy in line with guidelines and **1** was graded as **moderate,** relating to issues with the provision of Total Parenteral Nutrition (intravenous nutrition) to a patient with bowel obstruction.

- Increased numbers of concerns are being received that relate to communication with Velindre Cancer Service patients regarding appointments e.g. appointment time, location, or type (face-to-face) vs. telephone) changing without patient being informed by phone or letter. Patient's having difficulty contacting Velindre Cancer Service particularly SACT bookings and medical secretaries.

- Overall satisfaction for both Welsh Blood Service **(98%)** and Velindre Cancer Service **(93%)** remain high.

- **Safeguarding training compliance** has increased by **4%** on the last quarter, including an **11%** increase in Mental Capacity Act/Deprivation of Liberty Safeguards training. This has corresponded with an increase in the number of safeguarding reports following concerns identified by our staff.

- **Deprivation of Liberty Safeguards (DOLS):** There has been a decrease in Deprivation of Liberty Safeguards (DOLS) applications made by the inpatient ward within Velindre Cancer Service (VCS), a 33% reduction from quarter 2. To be assured that we are not unlawfully detaining any patients without a required DOLS application the Practice

	Educator has commenced weekly ward assurance visits. These have identified one missed opportunity to make a DOLS application and indicated the need for another to be made for a patient who was receiving treatment on the ward at the time.

RECOMMENDATION / ACTIONS	To *DISCUSS* and *APPROVE* the quarter 3 Quality & Safety report and its findings, in particular the continued trends relating to communication issues at Velindre Cancer Service.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality & Safety Group	24/01/2024
Executive Management Board	02/02/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The report was received in both Integrated Quality and Safety Group and Executive Management Board. The groups discussed the current reporting approach from a quality and safety perspective, issues were identified relating to the duplication of reports. All agreed that reports needed to be more concise, analytical, and learning focused going forward. It was agreed that a task and finish group would be established and supported by the Assistant Director for Insight and Digital to review reporting structures and approach.

7 LEVELS OF ASSURANCE

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

APPENDICES

1	Quarter 3 Trust Quality and Safety Report.

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ⊠ • An internationally renowned provider of exceptional clinical services ⊠ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐

3

3/45

110/660

- areas of priority
- An established 'University' Trust which provides highly valued ☒ knowledge for learning for all.
- A sustainable organisation that plays its part in creating a better future ☒ for people across the globe

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximized and in which choices and behaviours that benefit future health	

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The report contains details of legal claims against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided, all of which has the potential for adverse financial consequences. **Type of Funding: Revenue** Financial impact of the Trust claims is outlined in the Claims Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements.

4

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
	A quarterly outcome report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In addition to litigated claims, the Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated and appropriate Redress remedies offered. When both a breach of duty and harm and/or loss have been identified, amounting to a qualifying liability, the Trust is required to make a suitable financial offer within the PTR threshold (i.e. up to the maximum limit of £25,000). Concerns (consisting of complaints, incidents and claims), have legal and financial implications, as outlined above.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

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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Quarter 3, Trust Quality and Safety Report

1st October 2023 – 31st December 2023

1. EXECUTIVE SUMMARY

Quarter 3- At A Glance.

Total Number of Concerns Raised Q 3	Number managed as Early Resolution	Number managed under Putting Things Right (PTR)	Compliance with PTR timescales
55	35	20	100%

98% Donor Experience Score	93% Patient Experience Score	94 Compliments	1 Ombudsman Concern	2 New Claims Confirmed
2 Duty of Candour Incidents	0 Never Events	1 National Reportable Incident	1 Patient Safety Alert	0 External Assurance Reviews

1
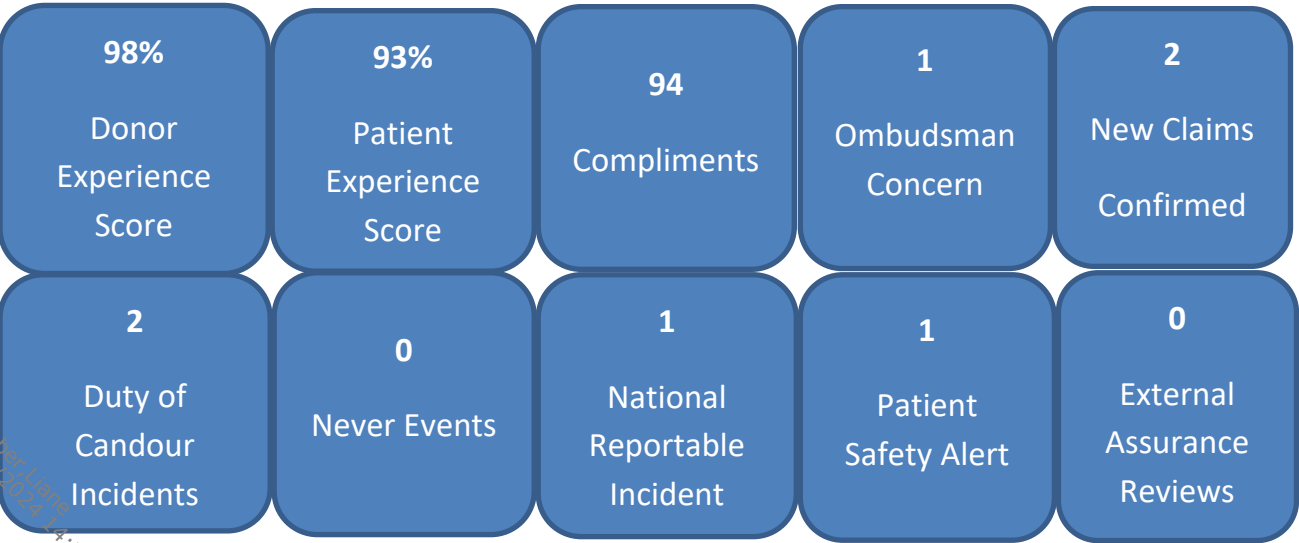
Healthcare Associated Infection Measures

C. Difficile	MRSA Bacteraemia	MSSA Bacteraemia	E.Coli Bacteraemia	Klebsiella Sp.
2	0	0	1	0

Quarter 3- Duty of Quality Progress

- **Development of Quality Metrics**
- **Continuation of 'Always on Reporting'**
- **Quality Management System Development**
- **Implementation of Duty of Candour procedures and processes**

2. INTRODUCTION

The Trust 2023/2024 Quality and Safety Quarter 3 report aims to provide an overview and analysis of Quality and Safety activity and performance during 1st October 2023- 31st December 2023, to provide assurance that the Trust is both fulfilling its legislative requirements in line with the Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintains a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person Centred Care.

3. QUARTER 3 QUALITY AND SAFETY INDICATORS OVERVIEW

(Concerns, Compliments, Claims, Incidents, Safety Alerts, Safeguarding and Infection Prevention and Control.)

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023-2024					
	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24
Compliments	*51*	*26*	*63*	*77*	*94*
CONCERNS					
Early Resolution					
(resolved within 48 hours)	*24*	*24*	*45*	*34*	*35*
Trust Putting Things Right (PTR) (Formal)					
Number Received (Trust wide)	9	11	11	*21*	*20*
% Acknowledged within 48 hours	100%	100%	100%	100%	100%
% PTR closed within 30 days	44% (4)	100% (11)	100% (11)	95 % (20)	100% (14)
%PTR closed after 30 days	55% (5)	0%	0%	5% (1)	0%
Welsh language concerns	0	1	0	0	0
Total number of Concerns	33	35	56	55	55
OMBUDSMAN					

2

New	0	1	0	0	1
Open	3	3	4	4	2
Closed	3	1	0	0	2
REDRESS					
New	1	2	1	1	1
Open	3	4	5	5	4
Closed	1	0	0	1	2
CLAIMS					
New	0	1	0	2	0
Open	6	5	5	5	6
Closed	1	2	0	0	1
INQUESTS					
New relating to Trust	1	0	1	4	4
open	5	5	4	3	6
Closed	1	1	0	2	2
INCIDENTS REPORTED					
Corporate	2	2	3	3	0
VCS	385	501	473	502	395
WBS	67	74	89	86	52
National Reportable Incidents	3	2	0	2	1
IR(ME)R reported incidents	5	7	4	2	0
Total opened during quarter	462	586	569	595	447
SAFETY ALERTS RECEIVED					
Pharmaceutical alerts	31	37	33	45	32
Patient safety alert	2	1	1	1	2
Patient Safety Notice	2	1	0	0	0
Medical Device	0	3	3	3	2
Estates and facilities	3	14	14	7	7
Field Safety Notice	0	0	0	2	1
Welsh Health Circulars	7	3	5	4	4
Total received during quarter	45	59	56	62	48
SAFEGUARDING					
Adult reports	4	2	5	4	4
Child reports	1	1	1	0	2
Allegations of Abuse involving Trust treatment or Services at VCS	0	0	0	0	1
MARRAC Referrals	0	1	0	0	0
Concerns about Trust Practitioners	2	0	3	1	1
Deprivation of Liberty Safeguards	7	1	2	3	1
HEALTHCARE ASSOCIATED INFECTIONS					
Clostridioides *difficile*	1	1	0	0	2
Gram Negative Bacteraemia	2	4	3	5	1
Staphylococcus Bacteraemia (including Meticillin Resistant)	1	1	0	0	0

3

4. QUARTER 3 TRUST CONCERNS, EXPERIENCE AND FEEDBACK.

Concerns Summary

4.1 Trust

Number of Concerns 55	Early Resolution 35	Putting Things Right 20	Reopened 0	Compliments 94

There were 55 concerns raised, equivalent to the previous quarter. There has been a significant increase (96%) in the number of PTR concerns received since quarter 3 2022/23. The increase in the number of concerns have related to the Velindre Cancer Service.

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023-2024					
	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24
Trust Putting Things Right (PTR) (Formal)					
Number Received (Trust wide)	9	11	11	*21*	*20*
% Acknowledged within 48 hours	100%	100%	100%	100%	100%
% PTR closed within 30 days	44% (4)	100% (11)	100% (11)	95 % (20)	100% (14)
%PTR closed after 30 days	55% (5)	0%	0%	5% (1)	0%
Welsh language concerns	0	1	0	0	0
Total number of Concerns	33	35	56	55	55

Concern management performance compliance remains high, with all concerns being acknowledged within 48 hours, and **100% (14)** of PTR concerns being investigated and closed within 30 working days.

It is evident through thematic reviews that concerns are rising relating to **communication** with the patient regarding **appointments** e.g. appointment time, location, or type (face-to-face vs. telephone) changing without patient being informed by phone or letter. Patient's having difficulty **contacting** VCC particularly SACT bookings and medical secretaries. Specific trends are evident with detail and learning included below:

4

Q3 Concerns Received by Division

Concerns Received over 2 Year Period by Theme (Top 5)

Q3 Concerns Received by Theme and Division

5

Q3 Concerns Closed by Division and Type

	Managed through PTR	Early Resolution
Velindre Cancer Centre	13	18
Welsh Blood Service	0	14
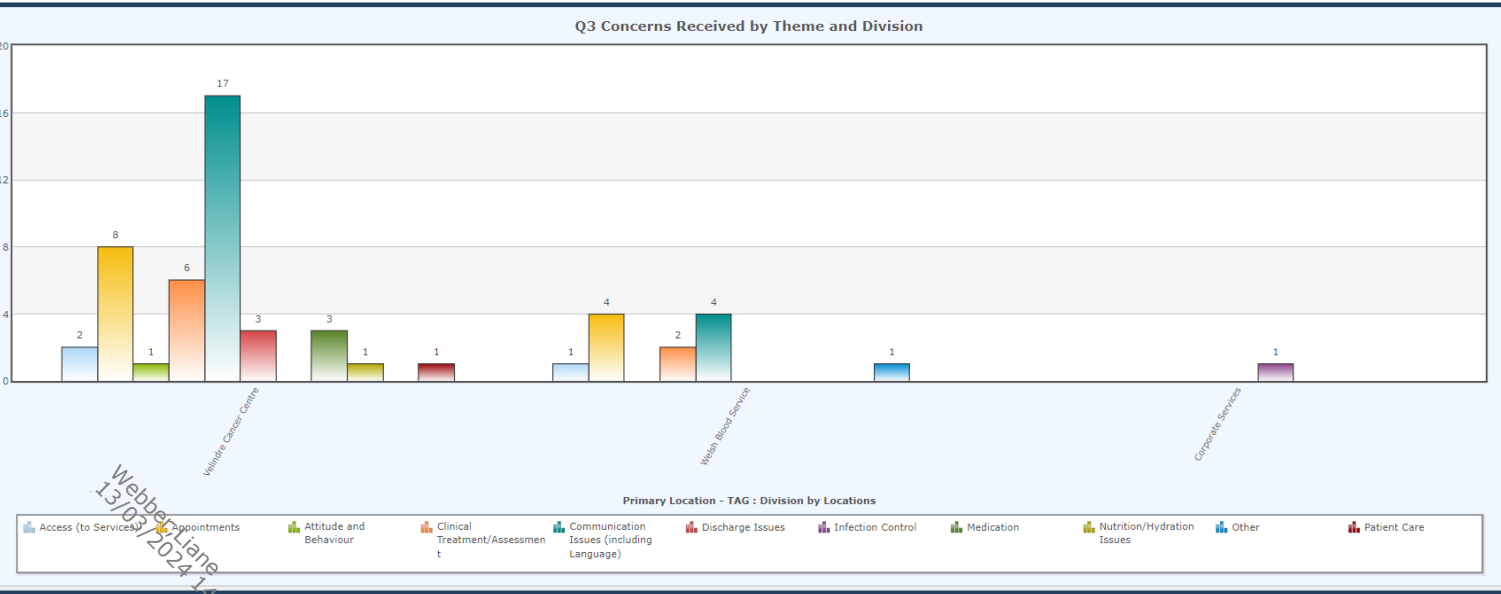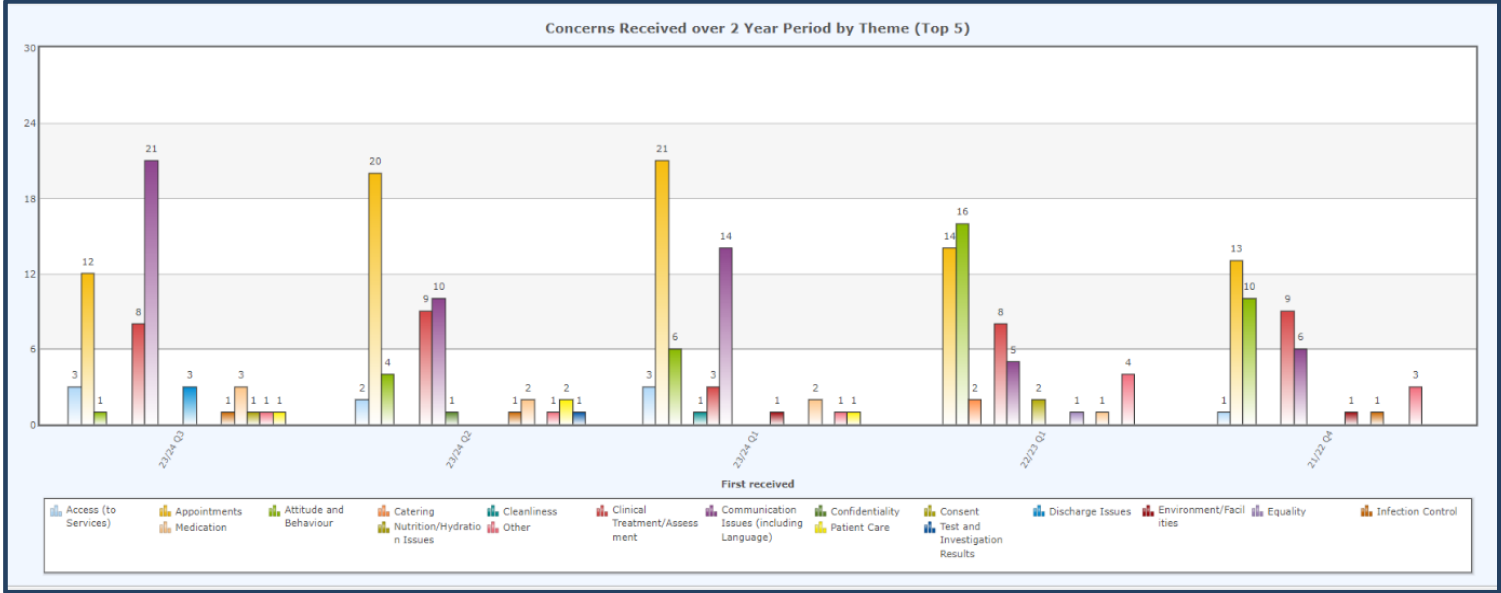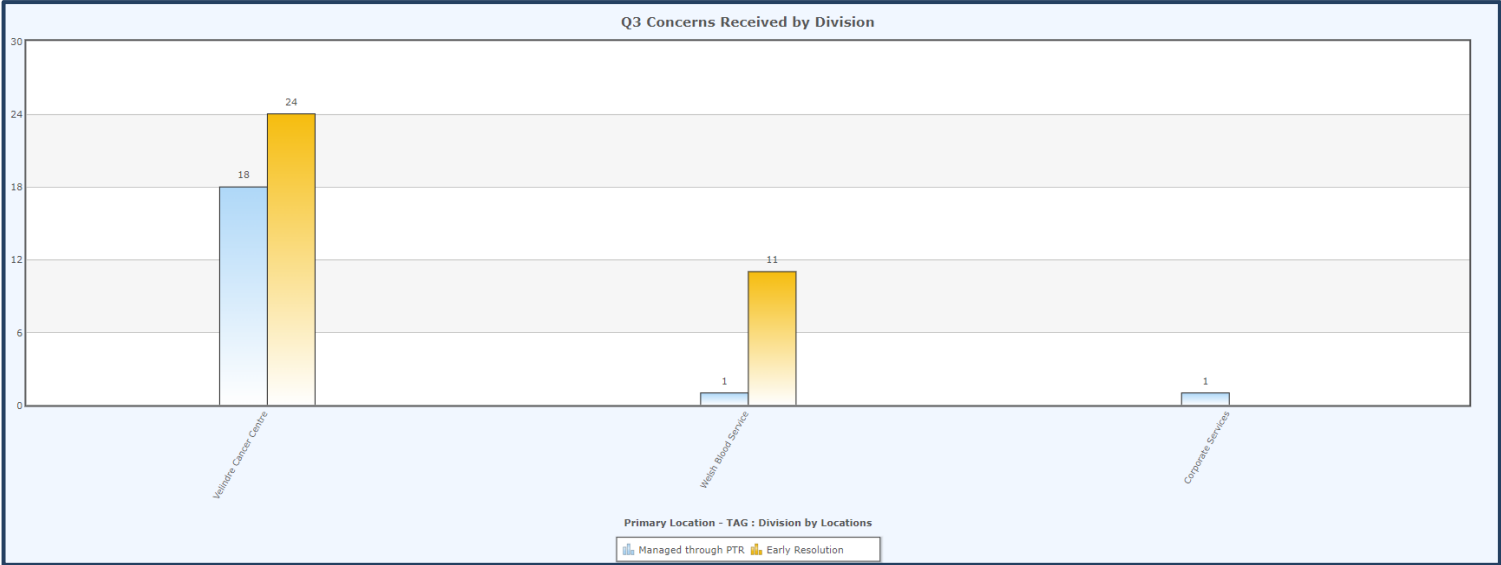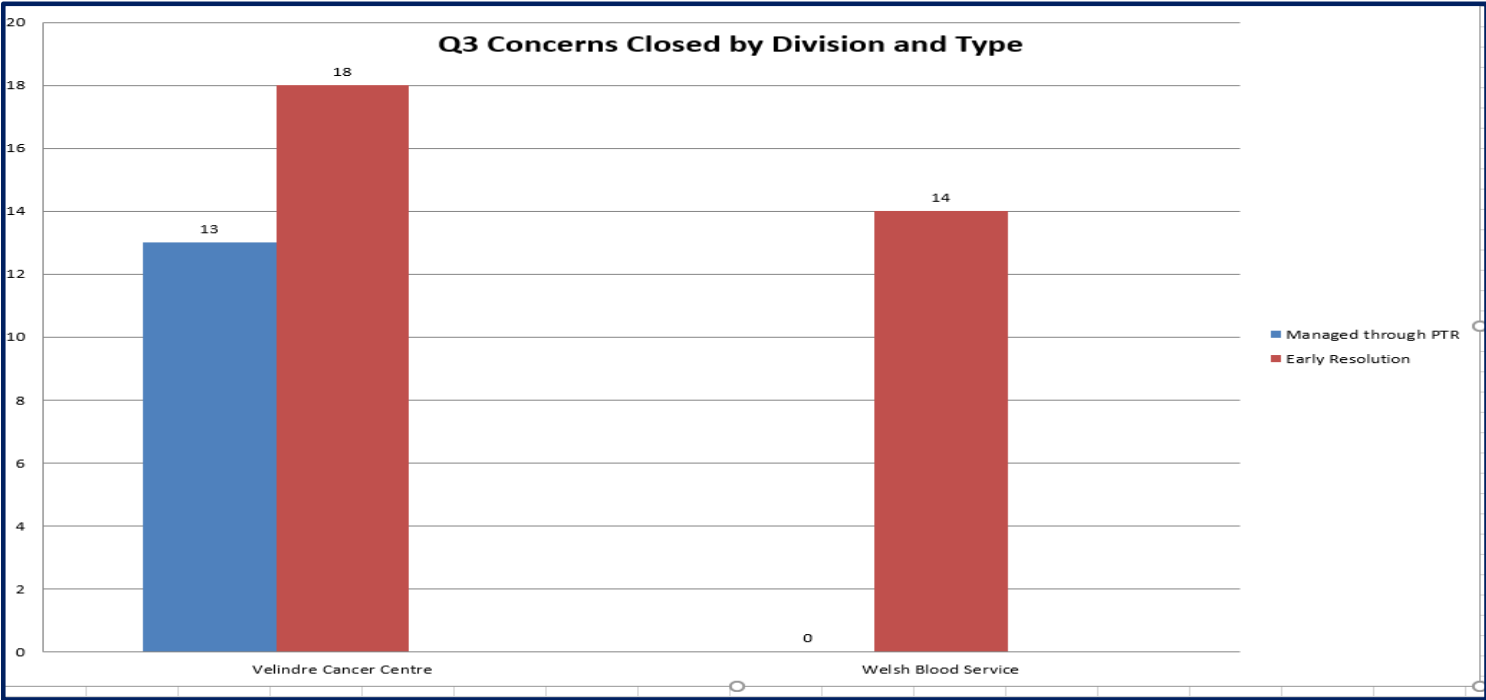
4.2 Velindre Cancer Service Concerns Summary

Total Number of Concerns	Early Resolution	Putting Things Right	Reopened	Compliments	Patient experience score
42	**24**	**18**	**0**	**94**	**93%**

4.2.1 Velindre Cancer Centre Concerns Themes and Learning

42 concerns representing 0.0007% of total patient contacts for this quarter.

Identified concern and learning themes during this period relate to **appointments**, **patient communication** and **treatment planning,** with several specific trends being evident and are highlighted below**:**

The theme around communication and appointments continues. Patients continue to report difficulty contacting departments particularly medical secretaries (phones not being answered and voicemails are not returned). A meeting has been arranged with Director of Cancer Services and Head of Medical Records/ Outpatients to discuss. Specific themes identified include:

- Appointments – patients continue to report lack of communication around SACT and outpatient appointment date, location, and time changing without appropriate communication. This will also be discussed at the meeting with the Director of the Cancer Service.
- Recurrent theme around the length of time patients are waiting. Lowest patient satisfaction related to waiting is in outpatients dept and radiotherapy.
- Medical concerns have been received regarding information given in clinic and awaiting telephone clinic consultation. The themes around concerns are unchanged from the previous report.
- The Division is focusing on learning and improvement opportunities with several service reviews being undertaken to address.

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- There is a theme emerging around Dragon taxi's that are arranged by Velindre Cancer Centre and WAST, in relation to attitude, verbal aggression, and communication. A meeting was arranged with WAST 13/10/2023 to discuss.
- A theme around blood test results not being reviewed and actioned by the team arranging the bloods. One incident has triggered duty of candour and the process has generated the below learning which will be shared across the Division.
- Feedback has been received regarding the monitoring and management of blood glucose while patients are on SACT resulting in requests for blood glucose to be added to Chemocare as a mandatory test to overcome the problem. Nursing and pharmacy keen to develop a working group to take the work forward, require medical support to progress.

4.3 Welsh Blood Service Concerns Summary

Total Number of Concerns	Early Resolution	Putting Things Right	Reopened
12	**11**	**1**	**0**

Total Number CIVICA Surveys Completed	Donor Experience Scores
3179	**98%**

11 out of 12 concerns received during quarter 3 were managed through early resolution. There was 1 Putting Things Right concern received in December 2023 relating to a Donor raising many concerns around their donation experience. The concern was formally acknowledged within 2 days and a full Investigation is being undertaken to establish if a breach of duty has occurred. 6,638 donors were registered at the donation clinics, the concern raised represents 0.01% of all donors registered.

There has been a significant reduction in the number of concerns received to that of previous month.

4.3.1 Welsh Blood Service Concerns Themes and Learning

Top concern themes and opportunities for improvement this quarter were identified and relate to **appointment & communication** issues which are shared at a divisional level for consideration and to address. Further learning and improvement areas following concerns have led to:

- an ongoing Service Improvement Project (SIP) to address the issues raised relating to the lack of signage at sessions. All signage is being reviewed so is taking some time to come to complete.
- a piece of work looking at the development of an app whereby donors can access a number of services relating to the Welsh Blood Service.
- The operational Managers are working closely to source more savoury snack/post donation care snack options. The WBS has recently introduced Mini Cheddar snacks due to feedback received.
- Each collection team has been provided with a Dyson heater/cooler so can be used to warm or cool a venue. (It is also worth noting that some venues do take some time to warm up/cool down before donors attend for their donation. There is a required temperature that must be maintained for the integrity of the blood collected, there for the temperature of each venue should be maintained where possible within this requirement).

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- In Q3 we received a number of feedback responses relating to the amount of flies at one of our collection venues. The Operational team have worked with planning departments who are working closely with the venue host to address this issue. If this issue cannot be resolved a different room will be used.

Further examples of how the Welsh Blood Service listened to their complainants and resolved as early resolution are detailed in the below, "you said, we did" table:

You Said	We Did
Donor was unhappy that staff do not introduce themselves by name.	Operation's manager working in collaboration with the Education and Development team Manager to reinforce that all staff must introduce themselves personally to donors when in contact. This will be monitored for progress.
Donor finds some of the questions on the technical questionnaire offensive and the number of questions asked bordering on the ridiculous.	Specialist Nurse in Donor Care contacted donor to discuss the issues raised, explaining the questions asked are to ensure the safety of the blood supply chain for our donors, recipients, and staff. All staff reminded of terminology used when addressing issues raised by donors.
Donor unhappy to be turned away from session for attending with a child in pram.	Operation's manager discussed with donor the constraints of accepting donors who attend session with children and how individualised risk assessments are undertaken. Donor happy with outcome of conversation had.
Donor unhappy about venue opening times.	Operational Manager spoke to donor at length regarding the availability of alternative venues, on-going work to source new donation venues and opening times.

4.4 Patient and Donor Experience Feedback

Utilising all patient and donor feedback is of great benefit to our service and assists in understanding both successes and further opportunities to improve. To both effectively capture and trend our patient and donor experience, and share feedback with patients, their families, donors and staff across the service in line with the requirements of the Duty of Quality (2023), work has been undertaken to capture and share feedback received both through our CIVICA experience surveys through the development of 'always on reporting' public facing internet page, the collection of compliments through the Datix Cymru system, and through the development of our 'Wall of Thanks'. These developments have proved beneficial in informing service developments and improvements to optimise donor and patient experience and satisfaction, as can be demonstrated through the following examples:

Welsh Blood Service

It was recognised that there were less collection team survey's being completed predominantly across the South Wales Collection teams so during the quarter the introduction of new iPads have been issued to Trailer 1 & 2, with the use of QR codes. The implementation has benefited every blood session within the donation clinic, meaning Welsh Blood Service have seen an increase in the number of survey responses collected during the quarter. On a monthly basis Operational managers are sent a survey summary report for each collection team and on review of the reports, any learning is identified and acted on accordingly. If lower response numbers are identified across each team at this point this is addressed with the Clinical Leads to ensure staff encourage and support donors to complete the survey following their experience.

The majority of feedback is positive and very complimentary towards Welsh Blood Service staff and the Service as a whole, this feedback is also shared equally with teams and staff members to boost morale.

Welsh Blood Service Wall of Thanks

East A team

"Everything I experienced while donating blood was wonderful and inviting. I will definitely be coming back again."

Bangor team

"I always feel very welcome, appreciated and safe. Thank you so much."

East B team

"It is always a pleasant experience and the staff are always very friendly, helpful and courteous. Thank you to them all."

West team

"It was great. It's always made a lovely experience when giving blood. Staff are amazing.£

Platelets team

"As always, the care and friendliness of the team was exemplary. Special thanks to Sally who really goes above and

2370 donors provided feedback:

Satisfaction score **98%**

Feedback about our staff
- Friendly and welcoming **100%**
- Helpful and knowledgeable **100%**
- Compassionate and caring **100%**

Feedback about your experience
- Quality of care **100%**
- Dignity and respect **100%**
- Hygiene and cleanliness **100%**
- Venue and facilities **99%**

Welsh Blood Service CIVICA Heat Map

Heat Map

Showing : Survey results for chosen service, broken down by ward/clinic and displayed as a heat map. For the date period specified in filters.

- Benchmark Met
- 1 - 5 points below the Benchmark
- More than 5 points below the Benchmark

Start Date: 01/10/2023 12:00:00 AM   End Date: 31/12/2023 11:59:59 PM

Location	Responses	6 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	7 - Based on today's visit did you find staff welcoming & friendly?	8 - Based on today's visit did you find staff helpful & knowledgeable?	9 - Based on today's visit did you find staff professional, compassionate & caring?	10 - Based on today's visit do you feel you were treated with dignity & respect?	11 - Based on today's visit were you provided with enough information about the donation process?	12 - Based on today's visit did you receive adequate emotional & physical support?	13 - Based on today's visit did you find a good standard of hygiene & cleanliness?	14 - Based on today's visit did you feel safe?	15 - Based on today's visit do you feel you were offered quality of care?	16 - Based on today's visit are you satisfied with the venue & facilities?	17 - Based on today's visit were you satisfied with the snacks and beverages available to you?	Overall
		Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	Compliments and Concerns. East C	
Bangor Team	270	99	100	100	100	100	100	100	100	100	100	100	100	100
Donation Clinic (TG)	28	98	100	100	100	100	100	100	100	100	100	96	100	100
East A	875	98	100	100	100	99	100	100	100	100	100	99	100	100
East B	556	97	100	100	100	100	100	100	100	100	100	99	99	99
East C	382	98	100	100	100	100	100	100	100	100	100	99	100	100
West Team	856	99	100	100	100	100	100	100	100	100	100	99	99	100
Wrexham Team	206	98	100	100	100	100	100	100	100	100	100	100	100	100
Overall		98	100	100	100	100	100	100	100	100	100	99	99	100
Benchmarks		95	95	95	95	95	95	95	95	95	95	95	95	

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Velindre Cancer Service

Velindre Cancer Service Wall of Thanks

"Thank you for your efforts in trying to save my late husband. You did all you could… bless you all."

"A huge thank you to all staff at Velindre Cancer centre for your outstanding kindness and care."

"For 10 years of extra time with our beloved father, we thank you all."

"Thank you all at Velindre Cancer Centre for all the work and support you have given me and my family and all the other patients. You are all truly remarkable people."

"You all [Café Catering Team] do a great job. Well done and thank you for all the lovely food you have supplied me with the last 11 years."

333 patients provided feedback. The patient feedback data gets shared monthly with all the Departments who have participants and is also included in the Quality safety management Group reports. Furthermore, the data will be included in the new Directorate reports that are being sent out on a bi-monthly basis.

Satisfaction score: **93%**

Feedback about your experience — Being listened to: **94%**, Speaking Welsh: **90%**, Waiting times: **77%**

Feedback about your experience — Being well cared for: **100%**, Receiving assistance when needed: **99%**, Patient understood their care: **92%**
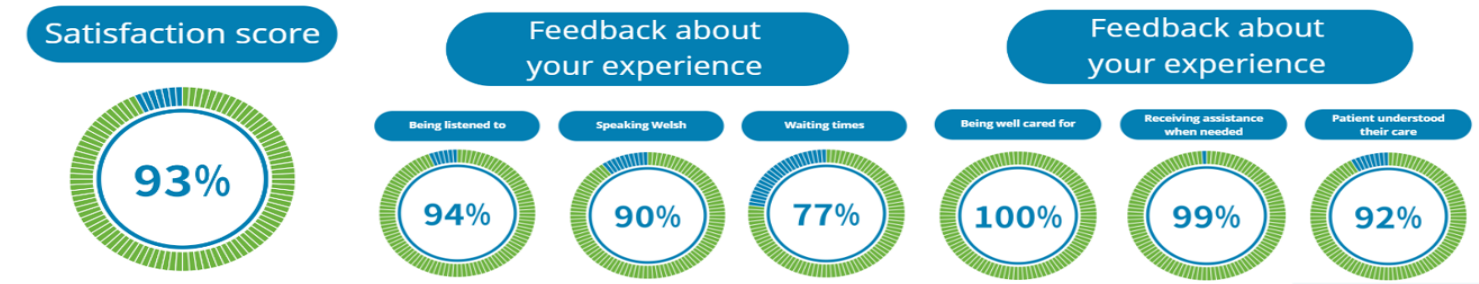
Velindre Cancer Service CIVICA HEATMAP

Service	Responses	1 - Overall, how was your experience of our service?	2 - Did you feel that you were listened to?	3 - Were you able to speak Welsh to staff if you needed to?	4 - From the time you realised you needed to use the service, was the time you waited:	5 - Did you feel well cared for?	6 - If you asked for assistance did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall e	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Catering services	1	100	-	-	-	-	-	-	-	-	-	100
Clinical Trials	25	-	99	96	79	100	100	96	98	98	98	96
Nuclear Medicine	13	100	-	-	-	-	-	-	-	-	-	100
Nursing	47	100	96	88	80	97	100	94	94	88	91	95
Outpatients	30	86	87	91	61	85	90	82	84	76	87	82
Pharmacy	6	100	-	-	-	-	-	-	-	-	-	100
Radiology	40	100	98	93	79	98	97	98	96	98	95	96
Radiotherapy	19	89	93	100	73	85	79	92	85	90	100	89
SACT	30	100	-	-	-	-	-	-	-	-	-	100
Welfare rights	1	100	-	-	-	-	-	-	-	-	-	100
Overall		98	94	94	73	93	95	92	92	90	94	92
Benchmarks		85	85	85	85	85	85	85	85	85	85	92

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4.6 COMPLIMENTS

Velindre Cancer Service

94 written compliments were recorded, which is an increase of 19% (77) from quarter 2. To support this the more effective capture on Datix of compliments, a range of staff communications have been issued and training user guides developed by the corporate Quality and Safety Team. The predominant themes identified include beyond the Duty of Care, Communication, Environment, Listening and Understanding:

Q3 Compliments in Writing by Theme

Compliment Subject	Value
Beyond duty of care	4
Communication	5
Environment	2
Listening	3
Understanding	9

Compliment Subjects
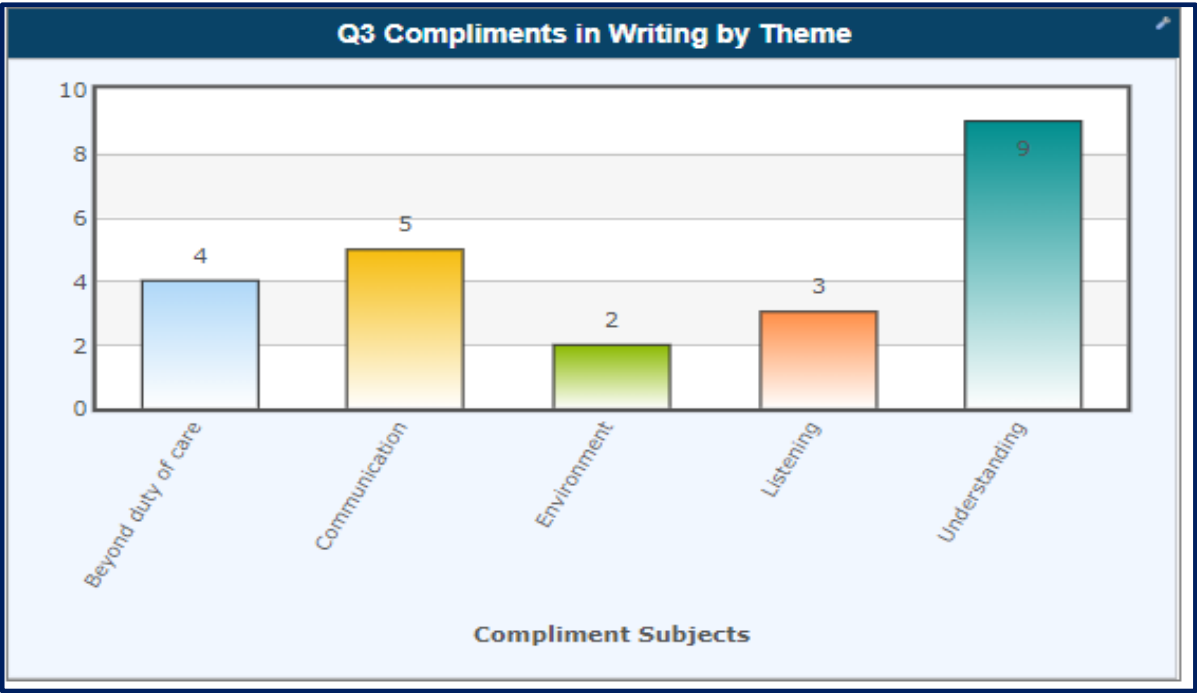
Welsh Blood Service

Welsh Blood Service have implemented the use of the Datix feedback module to capture compliments not recorded with the Donor Experience Survey and Civica system. Such compliments involve feedback received from customer hospitals which are key to service provision.

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5. PUBLIC SERVICE OMBUDSMAN OF WALES (PSOW)

The graph run below displays Ombudsman cases opened within the last 2 years:

During the reporting period:

- 1 new Ombudsman case was opened.
- 2 cases were closed.
- At the end of the reporting period, 2 Ombudsman cases remain open.

The main themes relate to poor/lack of communication, delay to treat and failures to appropriately clinical assess and diagnose.

Total number of Ombudsman Cases between Q2 2022/2023 - Q3 2023/2024
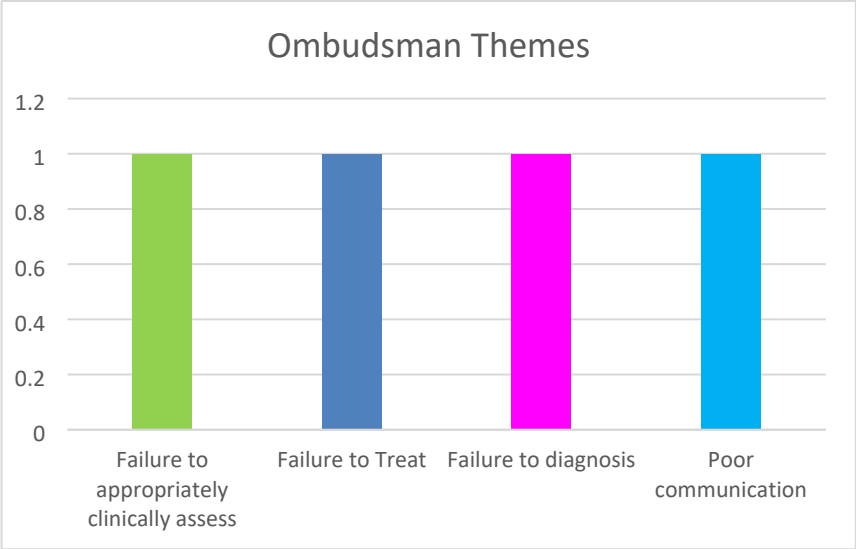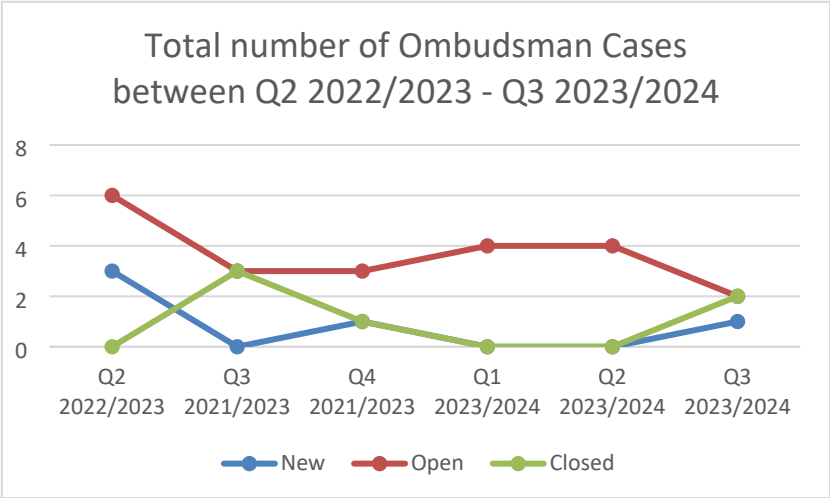
Ombudsman Themes

Please note that in some instances, the figures for themes comprise of more than one theme per complaint.

Assurance: The Ombudsman did not uphold the concerns raised against the Trust in the two cases that were closed (details of which are captured below). While no recommendations were made in relation to these cases, PSOW investigation reports serves as an opportunity to reflect on the importance of maintaining robust clinical records by detailing communication, rationale and decision-making.

Case Summary

One new Ombudsman case referred regarding a General Practitioner trainee. Initial review identified that responsibility for this lies with Swansea Bay University Health Board.

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Closed Ombudsman Case Summary	Findings
Family member raised concerns with regard to a delay in commencing lung cancer treatment. Final report issued during the quarter. The Ombudsman did not uphold the concerns against the Trust and partially upheld the concerns against Cwm Taf Morgannwg University Health Board.	Concerns were raised in relation to Velindre Cancer Centre and Cwm Taf Morgannwg University Health Board. The Ombudsman found the clinician had taken the patient's wishes into account when agreeing to delay treatment. **Conclusion/ learning:** 1. Reinforces the value of proactive engagement and communication with service users. 2. Highlights the importance of continually maintaining good clinical practice by considering the wishes and needs of service users. 3. Empower service users to make informed choices regarding their health journey. 4. Demonstrates the importance of maintaining good clinical record keeping, including discussions held, rationale and decision-making process.
Family member raised concerns in relation to lack of communication and decision-making. The Ombudsman did not uphold the concerns raised against Velindre Cancer Centre but has upheld the concerns against Cwm Taf University Health Board in relation to the poor standard of record keeping and the standard of trauma and orthopaedic involvement, which was found to be below a reasonable standard. Cwm Taf Morgannwg UHB have accepted the finding.	Concerns raised against Cwm Taf Morgannwg Health Board. The Trust was not subject to the investigation but was involved in relation to providing comments. The final report: 1. Highlights the importance of clear communication between services and NHS organisations. 2. Illustrates regular communication, as evidenced within the medical records. 3. Supports decision-making and rationale for non-treatment/treatment, recorded within the medical records.

6. REDRESS

During the Quarter:-

- 1 new Redress case was opened
- 2 Redress cases were closed
- At the end of the quarter, 4 Redress cases remain open

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Comparison of Redress Cases from Q1 2021 - Q3 2023

Percentage of Redress Themes for Q3 2023

WRP Assurance update:

3 Case Management Records and supporting financial information were submitted to the Welsh Risk Pool, seeking reimbursement in relation to 3 Redress matters. The Trust has received two Welsh Risk Pool approvals in relation to the reimbursement requests. Reimbursements were made during the quarter. These two Redress cases have now closed (details outlined below). It is anticipated that the third request for reimbursement will be approved during quarter 4.

Case Summary - Welsh Blood Service	Main Learning Points
Failure to recognise and treat arterial bleed following donor donation.	Following a qualifying liability, staff have been reminded of the importance of identifying a suspected arterial bleed. • **Training** has been implemented to improve skills and knowledge. • **Standard** operating procedures have been revised. • **Reiteration** to staff of recording accurate clinical information. • **Update** to donation training package, now includes the key criteria for identifying an arterial bleed.
Case Summary - Velindre Cancer Service	**Main Learning Points**
Failure to provide correct radiotherapy treatment i.e. vault brachytherapy instead of external beam radiotherapy, resulting in a potentially reduced dose of radiotherapy.	Although no qualifying liability was determined, the case provided an opportunity for learning. The following learning and review has been undertaken:- • **Review** of Joint Departmental Gynaecology Protocol, including review of planning scans • **Establishment** of peer review meetings • **Introduction** of version control for documents that are uploaded onto the Velindre Cancer Centre (VCC) intranet • **Snapshot audit** of compliance against version control through ISO (International Standardisation for Organisations) audit. • **Approvals** initiated for brachytherapy treatments are sought from licensed practitioners or via formal delegated approval. • **Training needs analysis** to be undertaken for staff prescribing brachytherapy.

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- **Clinical audits** have now been established to demonstrate adherence to licenced requirements.
- **Revised pathway** to prescribe and justify the dose and fractionation for vaginal vault brachytherapy.
- **Refresh** of medical induction programme.
- **Programme for transition** from senior trainee to new consultant is under development by the Assistant Medical Director for Workforce and the Medical Business Team.
- **Review and reporting** by medical business team against training compliance.
- **Support** provided to all tumour site teams to ensure compliance with the Royal College of Radiologists
- **Implementation of Action plan** following Health Inspectorate Wales (HIW) inspection in 2019, to ensure training is delivered and recorded accurately, and is accessible to relevant departmental leads. This includes the use of a Radiotherapy Passport for trainees.
- **Development of core competencies** of learning for all clinicians, particularly those undertaking locum roles.
- **Implementation** of a documented robust multidisciplinary peer review process to support the discussion of treatment planning and decision-making. This has been rolled out across all tumour sites, in line with the recommendation from the Royal College of Radiologists (RCR).
- **Engagement** with the clinical audit team to be able to demonstrate sustained change to the peer review process and compliance with the RCR peer review guidance.
- **Revision** of protocol for prescribing vaginal vault brachytherapy.
- **Introduction** of standard departmental form as part of a review exercise to scope the practice for radiographers in any extended specialist, advanced practitioner and consultant role.

New Redress Case Summary	Progress
Failure to appropriately follow up patient and have a robust discharge process in place.	Following a Putting Things Right investigation, which identified failings concerning the lack of follow up arrangements in place to monitor the patient's cancer diagnosis, the matter has been transferred for investigation under Part 6 of the Redress arrangements of Putting Things Right Regulations. This is in the early stages of review.

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7. CLAIMS

During the reporting period:-

- No new claims were opened
- At the end of the quarter, 6 claims remain under investigation
- 1 claim was closed
- 1 Learning from Events Reports was submitted to the Welsh Risk Pool for scrutiny of learning. A summary of the learning actions undertaken by the division is outlined below.

Claims Comparison from Q1 2021 - Q3 2023 incorporating both Clinical Negligence and Personal Injury Claims
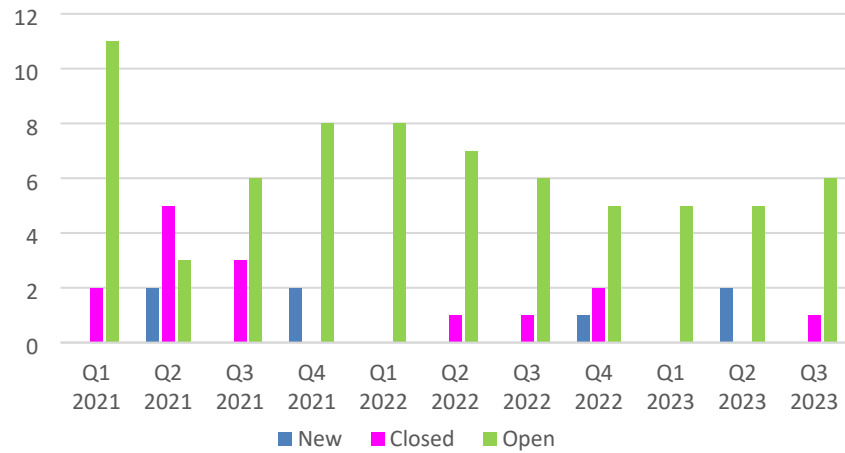
Comparison of Clinical Negligence Claims Themes Analysis from Q1 2021 - Q3 2023
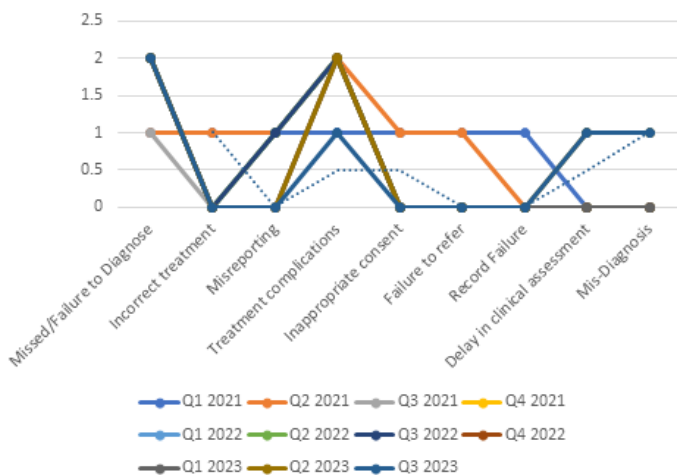
Comparison of Personal Injury Claims Themes for Q1 2021 - Q3 2023

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Percentage of Personal Injury Themes analysis comprising Q1 2021 - Q3 2023

- Slip, Trip, Fall
- Data Protection Breach
- Manual Handling
- Defective Equipment

CLINICAL NEGLIGENCE CLAIM THEMES FOR Q3 2023

- Inadequate clinical assessment/failure to treat appropriately 25%
- Delay in clinical assessment, follow up and treatment 25%
- Misdiagnosis 25%
- Failure to diagnose 25%
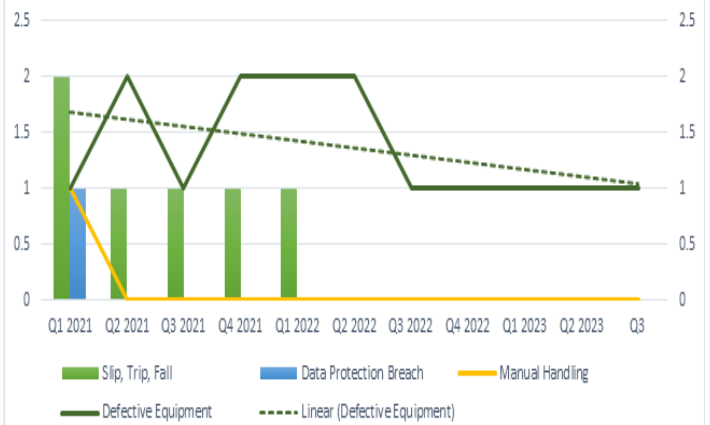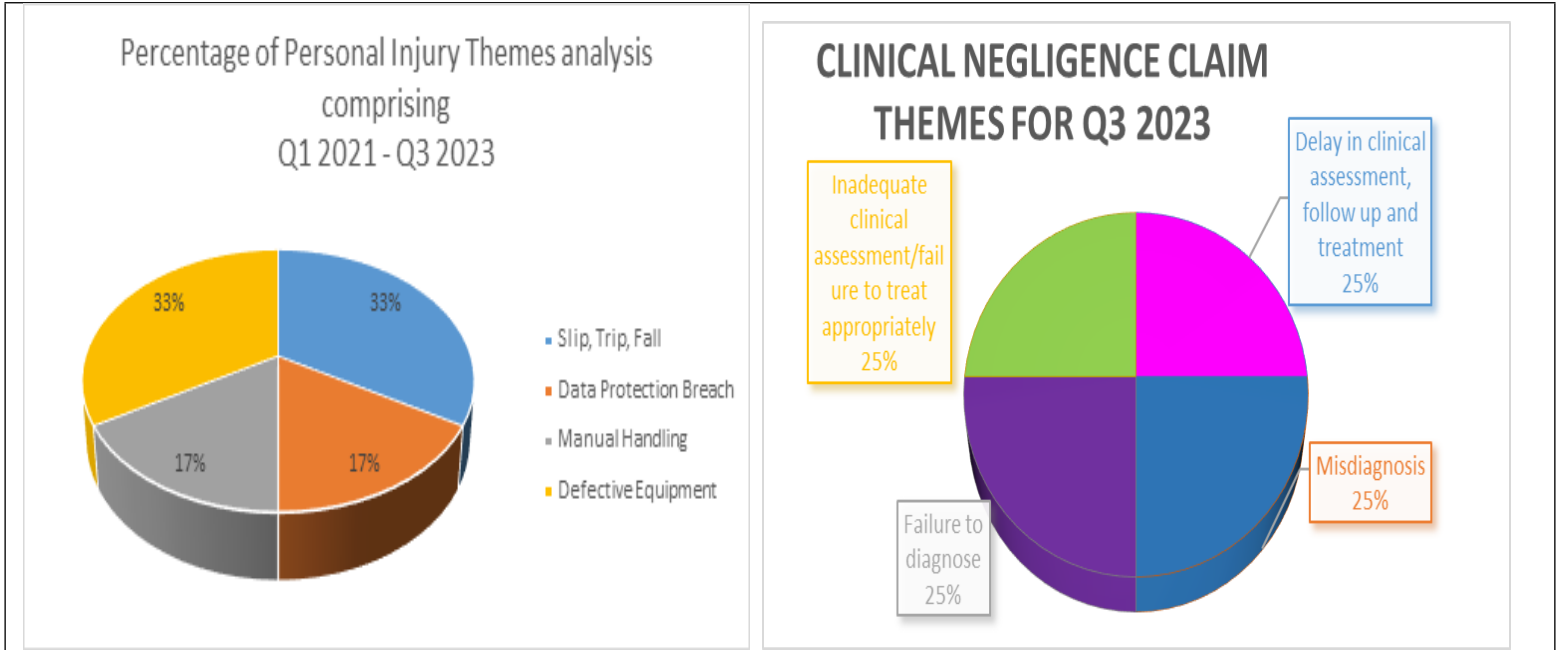
Throughout the reporting period, both clinical negligence and personal injury claims continue to remain stable.

Financial Liability: It is estimated that the Trust's financial liability for claims at quarter 3 amounts to £973,424.58. However, as the Trust is required to pay the first £25,000 of a claim and seek reimbursement from the Welsh Risk Pool for any sums incurred beyond this amount, the Trust's estimated amount to settle its current claim caseload is calculated at £159,244.00.

Learning from Events

Case Summary - Velindre Cancer Centre	Outcome	Learning from Events Report
The Claimant suffered a myocardial infarction two days after attending for a second course of chemotherapy (BEP) where he complained of shortness of breath and pain in his chest. It is contended that there was a failure to perform an Electro Cardiogram (ECG) on review.	Following investigation, a denial of liability was maintained. However, given vulnerabilities in the case, the Trust solicitor recommended settling the case on an economic basis. In September 2023, authority was provided to serve a Defence and, at the same, time, make an offer of settlement. A Learning from Events Report was submitted to the Welsh Risk Pool in December 2023, for approval of learning, the outcome of which is awaited.	**Vulnerabilities:** • Lack of record keeping. • Trust personnel, who are not factual witnesses, to refrain from make misplaced comments/admissions. **Learning:** Circulation of updated annotated clinic template Training NEWS, Sepsis and SACT rolled out to staff personnel, including monitoring and surveillance. Staff awareness BIG 4 circulation on the importance of record keeping. Update to NEWS/Sepsis Policy

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		Update to NEWS Chart in line with All Wales.
		Implementation of NEWS Cymru Audit (Observation Chart)
		Clinical supervision mandated from 2024.
		Reflective Practices undertaken by Trust personnel
		Learning Brief
		Case discussion and awareness shared at
		- Senior Medical Staffing Committee - Site Specific Team Lead meeting - Quality and Safety Management Group - VCS Resuscitation Committee

Risk: High Priority for Claims

Two high risk priorities have been identified during the reporting period, details of which are outlined below as follows:-

1. **Impact of Fixed Recoverable Costs - Changes to the claims litigation process:** This has been subject to two consultation processes, which have now closed. It is planned that the process involving fixed fee costs under the recoverable costs scheme will come into effect from April 2024. The changes are envisaged to make the litigation process quicker, simpler and cheaper. It is anticipated that there will be two new types of tracking systems introduced, one involving low value cases (claims less than £25,000) and claims involving sums over £25,000.

   The new process is designed for Claimant solicitors to undertake the initial groundwork. This will require solicitors in having to obtain copy records and liability report/s and provide details of the financial loss suffered by the Claimant when issuing their letter of claim. NHS organisations will be under an obligation to consider/agree or dispute liability much earlier on in the process.

   - Legal and Risk Services have advised that they are currently engaged with NHS Wales representative to discuss and devise processes to align with the proposed changed.
   - Updates to Datix will be made to take account of the legislative changes.
   - Enhanced learning will be rolled out across organisations.

   The Trust will need to have in place a swift claims process, to prevent claims from falling outside the proposed scheme. It is therefore proposed that discussions are facilitated with clinical leads and quality and safety leads to ensure that a process is implemented to allow for early assessment of liability and quick turnaround.

2. **Datix Claims and Redress Module Impact on payments: T**he OfWCMS Central Team and RLDatix are continuing to investigate the issue associated with rendering payments within the Datix claims and

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redress record. This is a risk to the Trust as there is an inability to record payments made in relation to claims and redress on the current Datix system. The recording of payments is an integral part of the claims and redress management function. The Trust is required to continually review and monitor potential threats regarding payments and are required to take steps to ensure that public funds are protected. It is a requirement to ensure that there is both a safe and effective system for recording, monitoring and maintaining accurate payments, aligned to the Trust's financial accounts systems, that complies with auditing and scrutiny e.g. Audit Wales and the Welsh Risk Pool.

The OFwCMS Central Team has advised that a potential workaround is currently being tested, supported by Swansea Bay University Health Board. It is proposed that during quarter 4 a potential hotfix will be rolled out across NHS Wales and that, in the meantime, all NHS organisations have been requested to refrain from adding new payments into the Datix Cymru systems while the investigations and resolution continue to be explored. The Trust already has in place systems to support the back up of payments made for recording, monitoring and auditing purposes. This includes Payment Schedules opened for each Claim and Redress matter, which records and details the payments. This is aligned to the Welsh Risk Procedures and is submitted to the Welsh Risk as part of the financial checks undertaken when requesting reimbursement of payments made. In addition to this, a spreadsheet keeps track of all payments that are made and is regularly updated and checked. These systems act as a safety net whilst Datix continues to investigate the issues causing the disruption. Both these risks are currently being risk assessed and added to the Trust Risk Register.

8. INQUESTS

During quarter 3, the Trust continues to see a rise in the number of inquests involving Trust personnel.

- 4 new inquests were opened
- 2 inquests were closed
- At the end of the Quarter, 6 inquests remain ongoing
- No inquest hearings were held during the reporting period

Comparison of Inquests from Q1 2021 - Q3 2023
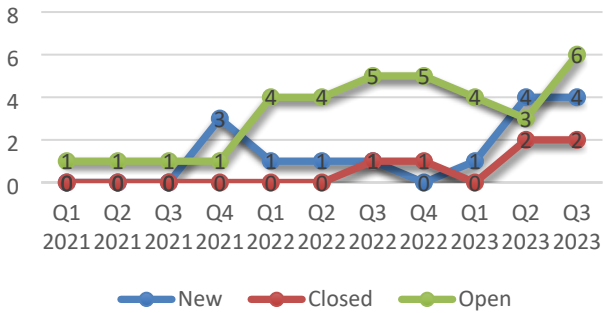
New Inquest Cases - Summaries	Progress of Inquest cases during Q3
Unexpected death at home	• Disclosure of Trust personnel Witness Statement and further addendum statement provided to HM Coroner, following queries raised in relation to the likely cause death following the issue of the Post Mortem. • Inquest date is awaited.
Patient death while acutely unwell in A&E. Investigations revealed: 1. Multiple pulmonary emboli.	• Disclosure of Trust personnel Witness Statement and addendum Witness Statement following queries raised by the

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2. Multifocal pulmonary atelectasis. 3. Arterial attenuation reflecting altered physiological status. 4. Left femoral vein embolus. 5. Gastrointestinal ileus. 6. Bilateral renal microinfarcts. 7. Left subclavian artery occlusion.	Coroner as to whether the thromboembolic disease should have been investigated prior to the patient's emergency admission. • Inquest date is awaited
Patient admitted to Marie Curie Hospice and passed away with confusion and general deterioration, following a biopsy in November 2022, indicating spindle cell mesothelioma.	• Witness Statement has been sought from Trust personnel. • There is a suggestion that the patient was suffering from industrial exposure. The Coroner is seeking help with the cause of death. • A review of the patient's care has been requested in relation to the admission, diagnosis and cause of death.
Patient was reported missing from home was found unresponsive, in water off Barry Island beach. Although taken to hospital, he sadly died.a	• Witness Statement has been sought from Trust personnel together with review of the care/treatment provided to the patient to assist coronial enquiries.

Comparision of Inquests from Q1 2021 - Q3 2023

COMPARISON OF INQUEST PERCENTAGES FROM Q1 2021 – Q3 2023
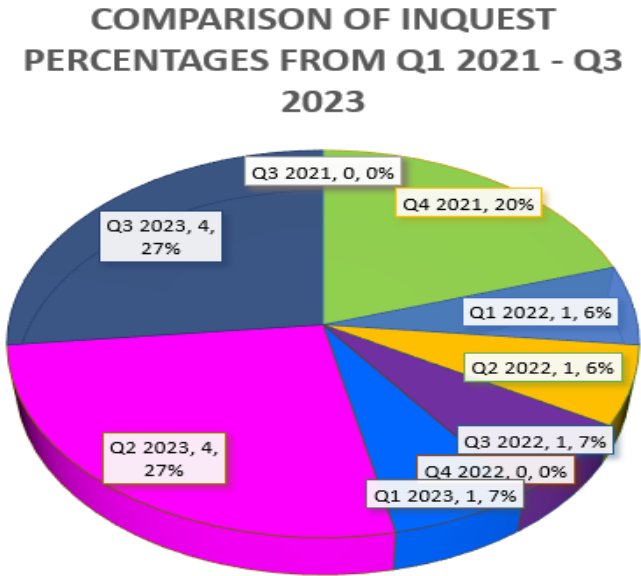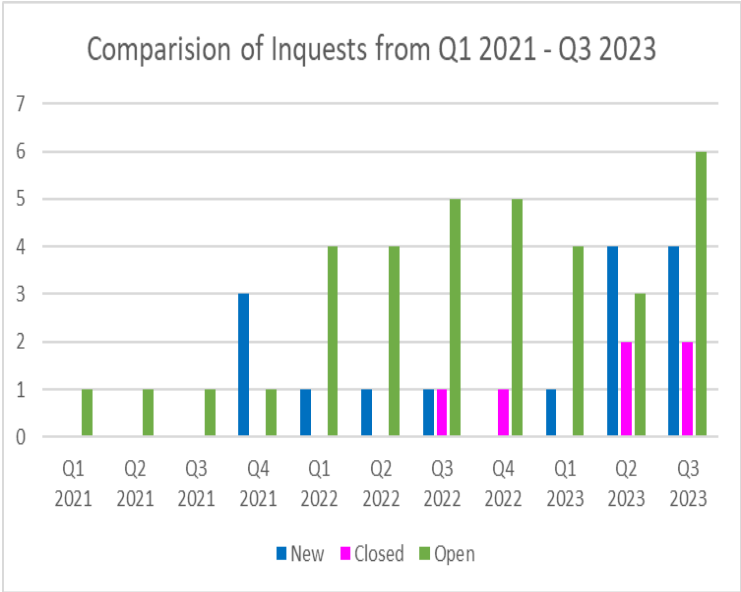
Assurance :

While HM Coroner did not identify any issues for the Trust to address, following the outcome of the below inquest hearings, the Trust, nonetheless, considers the opportunity to learn from the circumstances surrounding a death and, if so, will address any improvements needed to enhance patient safety, with the aim of improving the quality of care delivered when concerns are identified.

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Case Summary	Coroner's Conclusion	Outcome/Learning Assurance
Patient was referred for squamous cell carcinoma of mid oesophagus. Coroner sought statements from the LHB and Velindre Cancer Services as to whether there were any contributory factors that led to the death.	Natural Causes	On review, it was found that patient had undergone appropriate investigations and treatment. There was evidence of regular communication with the patient and family regarding the expected deterioration of the patient, following the diagnosis. No concerns were identified in relation to the clinical review undertaken. The Coroner was satisfied with the comprehensive Witness Statement produced in evidence, which outlined the care and treatment provided. In accordance with the Coroner's Rules he exercised his discretion not to issue a summons for the clinician's attendance at the hearing. On the evidence disclosed, the Coroner concluded the matter on the papers before him and reached a conclusion of natural causes.
Patient was diagnosed with distal oesophageal poorly differentiated adenocarcinoma. The treatment was considered to be palliative only with symptom control. Following diagnosis, the patient was found to have passed away at home from shotgun wounds.	Suicide	In recognition of the impact that a poor diagnosis can have on a patient, there has been collaboration with the Clinical Psychology Services and clinical staff to introduce measures to support patients, family and carers. The following measures have been introduced previously to help support those requiring assistance:- • Development of a "Keeping Someone Safe Checklist" document • Development of "Keeping Myself Safe" document • Implementation and update of Risk Protocol • Staff inductions are currently are under review to ensure that they are sufficiently comprehensive, to include distress and risk assessments for Trust personnel • Intranet update to include details of the mental health crisis teams. This will ensure close liaison with the mental health teams and patients presenting with complex needs and requiring access to crisis teams in an urgent situation.

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9   INCIDENTS

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patient's/ donor's receiving healthcare. Incidents are reported and managed within the Datix Cymru system, with all reported incidents being reviewed at service level, through Quality and Safety leads.
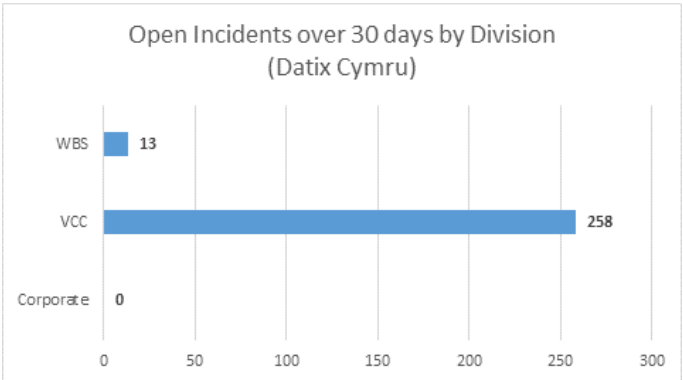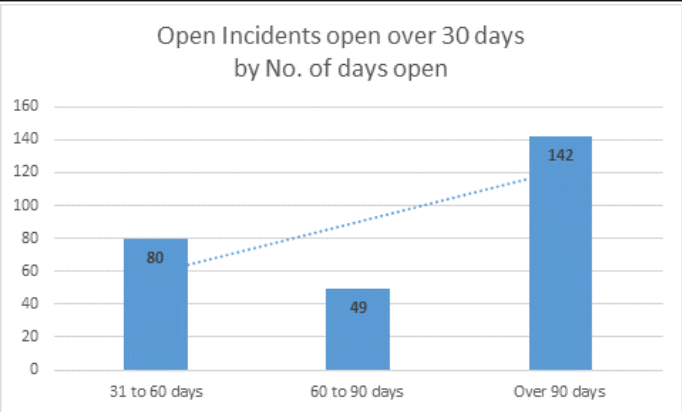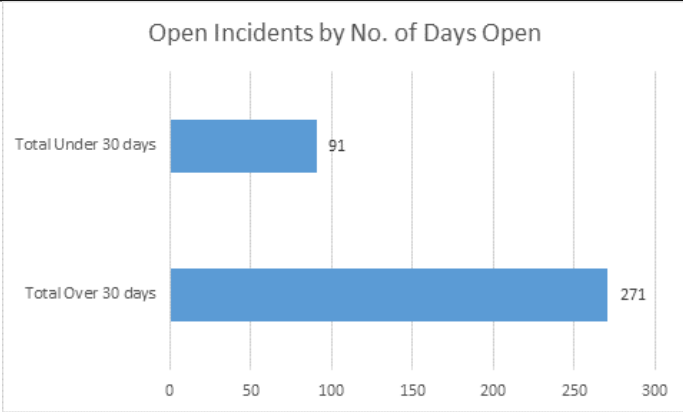
9.1   Quarter 3 Trust Incident Summary.

Incidents reported	Corporate Services	Velindre Cancer Service	Welsh Blood Service
447	0	395	52

No/ Low Harm	Moderate Harm	Severe Harm
445	1	1

Incidents reported over 2 year period by Division
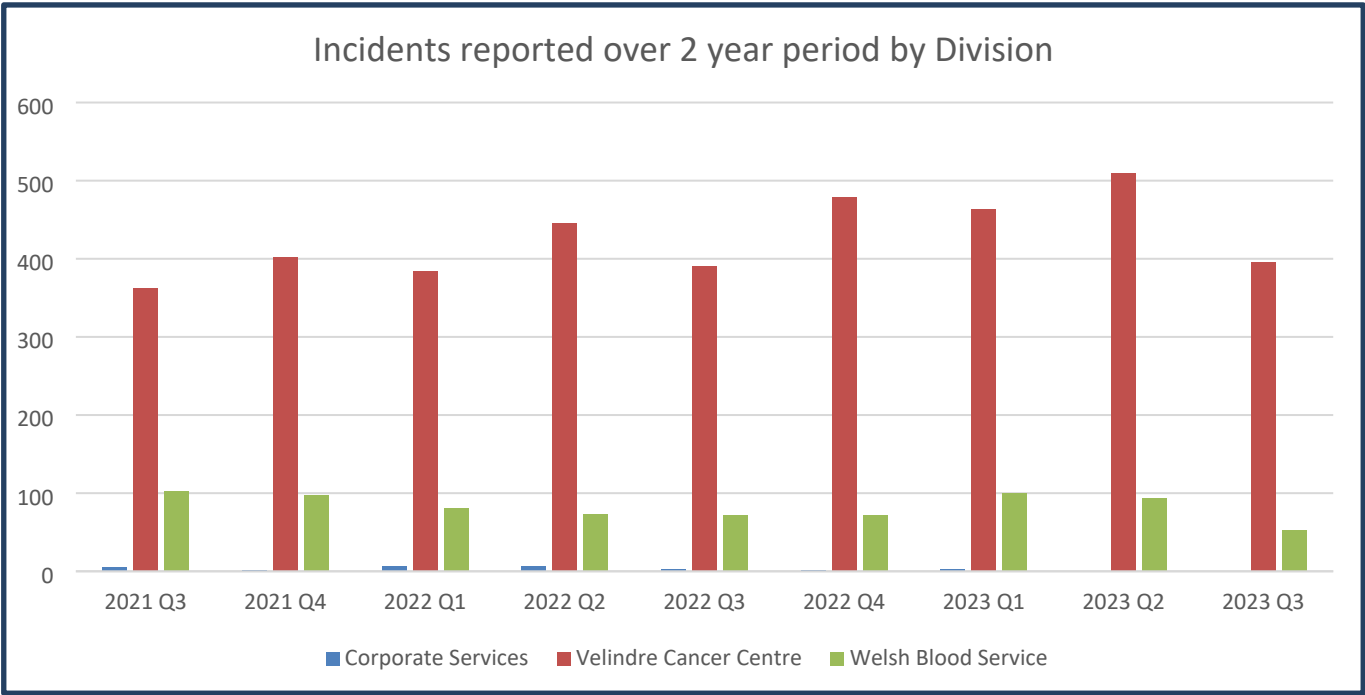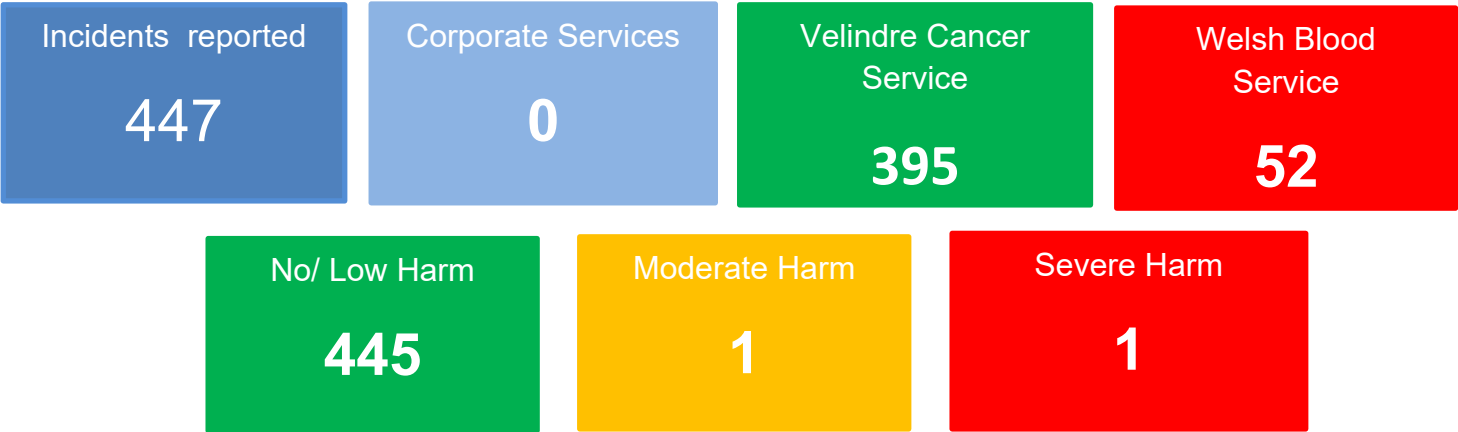
During the quarter, 631 incidents were closed because of collaborative efforts from corporate and divisional teams.

324 incidents remain open longer than 30 days.

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Open Incidents by No. of Days Open

Open Incidents open over 30 days by No. of days open

Open Incidents over 30 days by Division (Datix Cymru)

To further improve this, an opportunity has been identified within both divisions:

- Velindre Cancer Service will review their radiotherapy event report processes, that are required to be captured, but do not meet the criteria of an incident. This improvement opportunity will be undertaken by corporate and divisional quality leads in collaboration with the National Datix team.
- Welsh Blood Service will review their current processes relating to the reporting and management of health and safety incidents.
- WBS are undertaking improvement project to improve connectivity to improve real time reporting to assist with this and this is included in Divisional Priorities for 2024/25

Quarter 3 Trust wide Incident reporting trends

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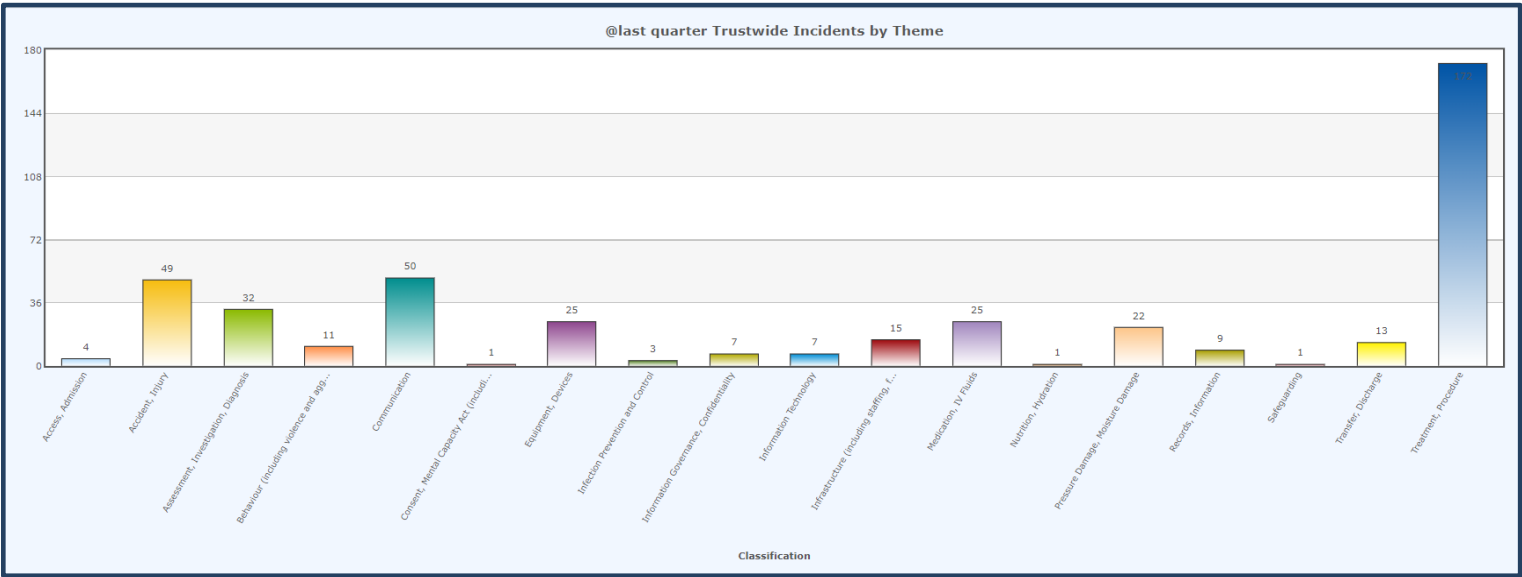
Radiotherapy has recorded the highest number of incidents, the Trust are aware that a number of these incidents are a repeated trend and are in relation to:

- A known international manufacturer fault with the radiotherapy system that at this time cannot be resolved, but methods of mitigation are being considered.
- Capture of radiotherapy event reports that do not meet the criteria of an incident, which will be reviewed within the next quarter.

9.2 Incident Themes and Learning Opportunities.

During the quarter several incident themes and trends have been identified both within Velindre Cancer and the Welsh Blood Service:

Velindre Cancer Service

- Monitoring and management of SACT patients' blood glucose work has commenced to address a theme, by considering the adaptation of the current Chemocare system to include Mandatory Blood Glucose Testing. To achieve this, a working group is being established and a medical lead identified.

- Management of unwell patients in radiotherapy, remedial action is currently being considered by the service area.

Welsh Blood Service

A trend of incidents related to screening was identified.

9.3 EXTERNALLY REPORTED INCIDENTS

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Reportable

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The Ionising Radiation (Medical Exposure) Regulations 2017 are designed to protect people while undergoing examinations and treatment. Where there is unintended or accidental exposure to ionising radiation this must be reported and investigated. IR(ME)R notifications are reported to HIW.

There were **no (IR(ME)R)** incidents reported.

9.3.2 NATIONAL REPORTABLE INCIDENTS (NRI).

A Nationally Reportable Incident is a safety incident that requires national reporting as it has been assessed or suspected that an action or inaction in the course of treatment has or could have caused or contributed to severe harm or death.

There was **1** Nationally Reportable Incident which related to Velindre Cancer Service. This was a **Medication Prescribing Error** identified through the Trusts mortality review process. It was identified that a patients chemotherapy dosage was not reviewed in line with National guidance when the patient developed neutropenic sepsis and pancytopenia. This has triggered both NRI and Duty of Candour procedures.

This incident was reported and managed in line with the All Wales Incident and Reporting Management Policy (2023) and an investigation commissioned.

Welsh Blood Service Externally Reportable Events

The table below details all WBS adverse events which were reported to MHRA via the SABRE incident reporting portal. Serious Adverse Blood Reactions and Events (SABRE) is the MHRA's online system for reporting blood safety incidents. If the WBS quality system fails to pick up an event at the time occurred and the problem is discovered later in the cold chain, especially if a unit has been issued, it is considered SABRE reportable.

The preventive action from two events, SABRE 106 and SABRE 109, have identified further instances of similar events; these instances have been reported as separate events.

An emerging theme from root cause analysis investigations for these events is the complexity of the donor eligibility assessment process. Preventive action seeks to reduce this complexity (where possible) and a concern about the complexity of the Geographical Disease Risk Index (GDRI) has been raised with the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC), via the Specialist Advisory Committee for Care and Selection of Donors (SACCSD).

SABRE Number	Incident Date	Notification Date	Event	Root cause	Corrective & Preventive Actions
SABRE 111 Datix 13996	10/10/23	02/11/23	Malaria residency potentially assessed incorrectly.	Investigation revealed that the donor did not meet the criteria for residency but had been a long-term visitor to the region. The malaria residency risk had expired by the time the donor presented at clinic.	No further action required. MHRA response: Event excluded from annual summary. *The event does not affect the quality and safety of the component as required by Serious Adverse Event reporting*

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				Therefore, there was no recipient risk and no requirement to take a MAT sample.	*requirements. The event may be a clinical event not covered by the Blood Safety & Quality Regulations.*
SABRE 112 Datix 14010	14/06/23	20/11/23	Donor was incorrectly accepted to donate at their previous attendance.	RN accepted the donor without fully exploring the implications of the medication being taken. The person involved did not recall the event as it had happened 5 months previously.	1. Donor permanently deferred from donating at this attendance (10/10/23). 2. Product recall initiated for previous attendance (14/06/23) and made safe. 3. Staff member involved completed Individual-specific Confidential Training, including the importance of reviewing donor eligibility by accessing ALL available resources to aid correct decision making. 4. Staff member completed a reflective account of the incident. MHRA response: Event excluded from annual summary. *The event does not affect the quality and safety of the component as required by Serious Adverse Event reporting requirements. The event may be a clinical event not covered by the Blood Safety & Quality Regulations.*
SABRE 113 Datix 14716	25/10/22	20/11/23	Incorrect Assessment of tetanus risk (linked to SABRE 109)	Still under investigation – report in draft, under review. CCA failed to recognise the difference between a post-exposure immunisation (need to defer donor) and a booster immunisation (accept donor). CCAs do not have regular experience of assessing this particular scenario.	Corrective and Preventative Actions to be determined and agreed.
SABRE 114 Datix 14728	06/11/23	20/11/23	Donor travel risk not reviewed correctly (linked to SABRE 109)	Still under investigation – report in draft, under review.	Corrective and Preventative Actions to be determined and agreed.

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10. DUTY OF CANDOUR

The Duty of Candour applies if the care we provide has or may have contributed to unexpected or unintended moderate or severe harm, or death.

From April 2023 the Duty of Candour has been a legal requirement for all NHS organisations in Wales. It requires them to be open and transparent with service users when they experience harm whilst receiving health care. They will be required to:

- talk to service users about incidents that have caused harm
- apologise and support them through the process of investigating the incident
- learn and improve from these incidents
- find ways to stop similar incidents from happening again

Following identification of a Duty of Candour incident, an immediate Make it Safe meeting is convened. At this meeting, any immediate actions required are identified, and responsibility is assigned to colleagues for carrying these out.   proportionate investigation is requested, with Terms of Reference drafted, and an investigation team identified. Learning from investigations informs is disseminated to colleagues at Learning Events and through other communication channels as appropriate. The recommendations from reports inform action plans, which are held at the Divisional level.

22 Patient/Service User incidents were reported as being initially graded when reported as Moderate harm or above. Following the initial management review **20** of the incidents were graded as no or low harm and rationale provided as to why the grading was changed. **2** incidents remained graded as Moderate or above to trigger the Duty of Candour procedures during October 2023

To further improve reporter harm assessments, several Datix User Masterclasses have been and continue to be delivered to staff across the Trust to guide and share information. A request has been made to the Datix Cymru team to add clear harm definitions that align with the Duty of Candour definitions within the Datix Cymru incident system, this request was welcomed and accepted as a system enhancement that will be beneficial for users across Wales.

2 Duty of Candour incidents were reported and managed in line with the Duty of Candour procedures. Details are provided below:

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Table below refers to the incidents that have triggered the act since its inception in April 2023: *Duty of Candour Incident Summary*:

Duty of Candour triggered – 6th December 2023 (detail provided above)

Duty of Candour triggered – 15th December 2023
Patient admitted with Immunotherapy induced hepatitis and has liver injury. A CT scan displayed Bowel obstruction/sigmoid perforation. The surgical team advised patient for conservative management/bowel rest, therefore TPN indicated. TPN bags are very limited at Velindre Cancer Centre and the ones available were inadequate to meet the patient's nutritional requirements. Not optimised nutrition increases patient's risk of sarcopenia, weight loss and malnutrition.

Immediate make it safe actions:
Quality & Safety Manager to inform Dep. Head of Nursing (VCS) about incident.
Dep. Head of Nursing to inform ward nurses and dietitian of patients that are nil by mouth, this will then be put on the big 4 board and be mentioned during handover.
Quality & Safety Manager to inform the dietetics team that they need to be aware of patients that are nil by mouth.

An investigation is currently underway to understand the root causes of the incident and produce recommendations to future occurrences.

11.SAFETY ALERTS
During the quarter, the Trust received **48** safety alerts that consisted of: **2** patient safety alerts; **2** medical device alerts; **1** field safety notice; **7** estates alerts; **4** Welsh Health Circulars; and **32** pharmaceutical alerts. All alerts are reviewed by the Quality and Safety team on receipt, and the detail of each alert is circulated across the Trust via the Datix v14 system. Following review by Divisional leads the Quality and Safety team record and update the compliance status. The below table displays the number of different alerts the Trust has received over the past year:

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023-2024					
	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24
SAFETY ALERTS RECEIVED					
Pharmaceutical alerts	31	37	33	45	32
Patient safety alert	2	1	1	1	2
Patient Safety Notice	2	1	0	0	0
Medical Device	0	3	3	3	2
Estates and facilities	3	14	14	7	7
Field Safety Notice	0	0	0	2	1
Welsh Health Circulars	7	3	5	4	4
Total received during quarter	45	59	56	62	48

There are 2 open alerts remaining and which the actions are being worked through in readiness for update and closure. The details of the 2 open actions are below:

11.1 OPEN ALERTS – actions underway

- **National Patient Safety Alert 2023/013: Valproate - organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.** *Deadline for compliance: 31ˢᵗ January 2024.* The MHRA is asking organisations to put a plan in place to implement new regulatory measures for sodium valproate, valproic acid and valproate semi sodium (valproate) due to a significant risk of serious harm to a baby after exposure to valproate in pregnancy. The measures aim to reduce initiation of valproate to only patients for whom no other therapeutic options are suitable. Velindre Cancer Service current update:

  In response to the safety alert Velindre Cancer Service have undertaken several interventions to ensure compliance with the notice which include;

  a review of seizure guidelines to ensure alignment with the alert requirement,

  a review of previous dispensing episodes since April 2023 which identified only 1 patient had been prescribed the medication that fell under the criteria of the alert, but treatment had been initiated prior to being referred to VUNHST and the individual remains under the care of a specialist neurologist for their ongoing neurological condition.

  - Communications have been issued to neurological oncologists

- **National Patient Safety Alert 2023/010: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.** *Deadline for compliance: 1ˢᵗ March 2024*
- **Such equipment is only utilised within the cancer service, and in response** a Bed Rail risk assessment has been completed and a bed rail Procedure is being drafted and once complete will be reviewed by Health and Safety Lead and approved at Integrated Care Operational Group .

12. SAFEGUARDING

Safeguarding summary

During this reporting period the new Head of Safeguarding and Vulnerable Persons and a Practice Educator for Dementia commenced their posts, prioritising the Vulnerable Persons work within the Trust.

Types of Report

6 Duty to Reports were raised to the local authority in line with the Wales Safeguarding procedures, following disclosures or allegations of abuse. **4** adults at risk and **2** child at risk reports were submitted. The areas of concern noted on 2 of the adult at risk reports were financial abuse and self-neglect. **1** report related to care within the Trust which is also being managed through the Duty of Candour process, relating to the incident detailed above in relation to the provision of Total Parenteral Nutrition to a patient with bowel obstruction. This is an increase in safeguarding activity compared to **4 Duty to Reports** in quarter 2. It should be noted that all 6 reports were generated from VCC.

1 adult at risk and both child at risk reports relate to a mother and child. The mother had a recent cancer diagnosis, and the team involved in her care raised concerns around the mum's noncompliance with medical advice (placing baby at risk), nonattendance at appointments and concerns for domestic abuse (though no

disclosure made at the . Mum did not speak English. A child at risk report was submitted. The team linked with patient's GP and Head of Safeguarding linked with Health Visitor. Attendance at clinic improved and Mum acted on medical advice.

There was **1 new** professional concerns report made, in relation to issues that occurred in employee's personal and professional life which was managed through the multi-agency section 5 Persons in a Position of Trust process. The outcome was no further required action.

Safeguarding supervision and support has been accessed across the Trust, for concerns relating to patients and staff.
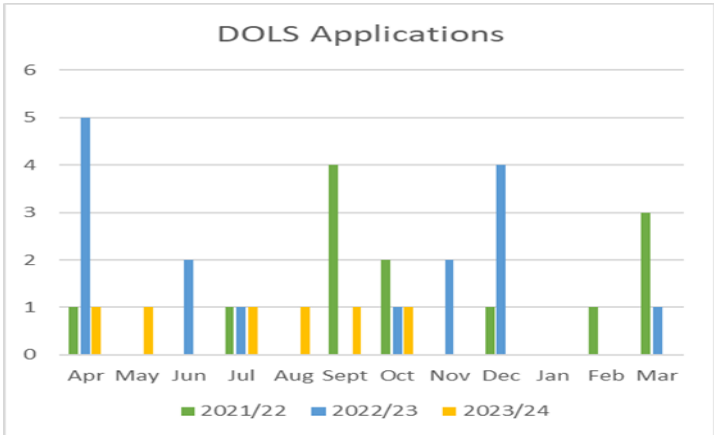
Only **1** application for Deprivation of Liberty Safeguards (DoLS) was made. This is a decrease of 33% compared with quarter 2. In order to be assured that the Trust is not unlawfully detaining anyone who should have a DoLS application the Practice Educator for Mental Capacity Act (MCA) is undertaking weekly visits to the ward to ensure that the Trust is compliant in appropriately supporting patients who lack capacity (temporarily or permanent).

There has been an excellent example of collaborative working in regard to a patient, a prisoner in HMP Cardiff, who had been recently diagnosed with cancer and was deemed to lack capacity. The Head of Safeguarding with support from the Practice Educators for MCA/DoLs and Dementia care, along with the clinical team were able to ensure that the patient had advocacy support arranged for their appointment, the Practice Educator for Dementia Care was also present to ensure that the patient was provided with resources to assist with their understanding and decision making, and all treatment planning work was arranged to take place whilst the patient attended their first clinic appointment. Reducing the stress for the patient and the need to attend multiple outpatient appointments.

Improving Safeguarding training compliance remains a priority. The Practice Educator for MCA/DoLS has already made improvements in training compliance in MCA training level 2 across the Trust. Whilst further work is required to improve the uptake on Ask & Act Group 2 training and Safeguarding Children/Adults Level 3 training, a continued improvement has been noted with a 4% increase in the figures when comparing the end of quarter 2.

13. INFECTION PREVENTION & CONTROL

Healthcare Associate Infections Quarter 3

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	C. difficile	Bacteraemia cases				
HCAI Review to end March 2024						
Month			MRSA	MSSA	E. coli	P. aeruginosa	Klebsiella species

Month	C. difficile	MRSA	MSSA	E. coli	P. aeruginosa	Klebsiella species
	2022-23 total no. of cases = 2	2022-23 total no. of cases = 0	2022-23 total no. of cases = 2	2022-23 total no. of cases = 6	2022-23 total no. of cases = 0	2022-23 total no. of cases = 1
Q1.	1	ZERO	ZERO	2	ZERO	2
Q2.	ZERO	1	ZERO	2	ZERO	3
Oct-2023	1	ZERO	ZERO	ZERO	ZERO	ZERO
Nov-2023	ZERO	ZERO	ZERO	ZERO	ZERO	ZERO
Dec-2023	1	ZERO	ZERO	1	ZERO	ZERO
Total:	3	1	0	5	0	5

Clostridioidies *difficile* - There were two cases of toxin positive Clostridioides difficile during the reporting period. The October patient has had previously had multiple admissions to VCC with chemotherapy induced colitis and proctitis and had previously tested toxin negative. Genetic testing on the specimen does not link it to any other known cases in Wales.

A Root Cause Analysis has commenced for the second case.

E.coli bacteraemia - There was one case of E.coli bacteraemia. While an RCA is still underway for this case there is no evidence of transmission, poor clinical practices, or environmental hygiene standards.

Klebsiella bacteraemia – There were five cases reported during the first two quarters of 2023/24, which was a 100% increase compared to the same period in 2022/2023. This is reflected in the rising national picture.   The cases were reviewed collectively, and the specimens were sent to the UKHSA Collindale reference laboratory for genomic typing.

The lookback exercise identified that there was no correlation of infection between the treatments that the patients received with 3 receiving chemotherapies, all different regimens, while another had chemotherapy and radiotherapy. None of the cases had received immunotherapy. In addition, the reference laboratory could not find any epidemiological or genetic typing link for the Klebsiella bacteraemia cases in Velindre. All cases have been typed differently to each, other including the two isolates for one patient which again supports the conclusion that there has been no transmission of infection linked to the Trust.

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14. INFORMATION GOVERNANCE

Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance.

Training Attainment – the minimum standard for compliance is 75%, 85% exceeds the minimum requirement and is the aim for attainment.

Information Governance Incidents – 1st October 2023 – 31st December 2023

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Corporate Services	1	0	1	0	1	0	1	1	0	1
Velindre Cancer Services*	5	0	5	0	5	0	5	4	1	5
Information Technology	1	0	1	0	1	0	1	1	0	1
WBS	1	0	1	0	1	0	1	0	1	1
Total Trust	**8**	**0**	**8**	**0**	**8**	**0**	**8**	**6**	**2**	**8**

Analysis Table for Incidents – 1st October – 31st December 2023 - VCC

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
Other	1	1	1	0	0

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Patient records/information inappropriately divulged	1	1	0	1	0
Patient records/information lost (electronic and paper)	1	1	1	0	0
Breach of patient/service user Confidentiality	1	1	1	0	0
Patient records/information sent to wrong recipient	1	0	1	0	0
Total	**5**	**4**	**4**	**1**	**0**

DATIX 14947 – Information Governance Actions complete and DATIX closed

DATIX 15154 – Information Governance Actions complete – awaiting closure by service area

DATIX 15237 – Information Governance Actions complete – HRM assessing whether SOP needed for checking of demographic data by clinical staff

DATIX 13869 – Information Governance Actions complete – awaiting closure

DATIX 14682 – Head Of Information Governance requested HRM investigate on 18/11/23

Analysis Table for Incidents – 1st October – 31st December 2023 – Corporate

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
Breach of Staff/Contractor confidentiality	1	1	1	0	0
Total	**1**	**1**	**1**	**0**	**0**

DATIX 14244 – Information Governance Actions complete

Analysis Table for Incidents – 1st October– 31st December 2023 – Information Technology

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
Documents not available	1	0	1	0	0
Total	**1**	**0**	**1**	**0**	**0**

DATIX 14738 – Head Of Information Governance /HOD requested further information from service area due to perceived delay in reporting Aug 23 to Nov 23.

Analysis Table for Incidents – 1st October – 31st December 2023 – WBS

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
Patient records/information sent to wrong recipient	1	1	0	1	0
Total	**1**	1	0	1	**0**

DATIX 14815 – IG Actions complete

Subject Access Requests – 1st October 2023– 31st December 2023

VCC

Month	Service	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
Oct-23	Med Records – SAR's	14	10	71.42%
Nov-23	Med Records – SAR's	14	10	71.42%
Dec-23	Med Records – SAR's	11	6 (5 in the process of being completed within established timeframe as of 9/1/24)	54% - incomplete month as deadline for responses not reached.

Details of non-compliance to the timeline:
October:
1 x 3 days
2 x 5 days
1 x 12 days

November:
3 x 1 day - Christmas period
1 x 3 days – Christmas period

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1 x outstanding, under restoration at Harwell's - extension for further two months in accordance with Data Protection Law (due to complexity of request), requestor made aware as soon as possible – DPO assesses compliant.
Non-compliance is as a result of the impact of resource issues in Medical Records.

Corporate

Service	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
Corporate	0	0	N/A

Training Statistics by Division for the Trust – 31st December 2023

Division	% attainment
TCS	81.82
RD&I	92.98
WBS	91.05
VCC	82.46
Corporate	84.72
Trust Overall	85.45

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2-year Trend Analysis.

VCC Trend Analysis - December 2021- December 2023

Total Incidents Reported
Confidentiality
Data Protection
Linear (Total Incidents Reported)
Linear (Confidentiality)
Linear (Data Protection)

WBS Trend Analysis - December 2021 - December 2023

IG Training and Workshops 2021 - 2023 (Including IG and Counter Fraud Induction)

Information Governance Training Attainment % by Division - December 2023

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Assurance and Analysis

Positive assurance
Training continues to be delivered by the IG function. Current non-integrated induction training appears steady at approx. 10-15 members of Staff receiving training per month (see trend figures above) estimated to increase as Induction Training backlog cleared and becomes BAU. IG/Counter-Fraud training session took place on 13th, 14th and 20th December 2023. Further sessions: 8th Jan 24 (WBS), 17 Jan 24 (HQ) and 25 Jan 24 (VCC) As of 31st December 2023, M&S Training compliance is at 85.45% for the Trust, the minimum standard is 75%. Trend analysis was provided in November 2023 and IG will provide assurance once per annum unless required more regularly so that the Group can derive assurance. TCS figures have improved from 78.26% to 81.82% during the quarter. IG Reviews in WBS continued throughout the quarter, DPIA's were identified as being required in several areas, that work is ongoing supported by IG. The DPIA for the access card system has been presented in December 2023 for final overview prior to approval by HOIG. Reporting of incidents by Staff across all divisions continues, albeit statistics for Q3 continue to be unusually low. Individuals continue to contact IG for advice/guidance. First meeting of the Records Management T&F Group took place in December 2023, the focus for Q4 2023/24 needs to be Information Asset Registers preceded by Information Asset Owner training. An IAO training package has been devised and will be delivered in Q4. SOP for use of email now in production and 40% complete, it has been agreed that it will be a joint piece of work with Digital and is to be completed by end of January 2024. DHCW delivered a Board Development Session on Cyber Security, HOIG is discussing the testing of the Trust Cyber Incident Response Plan with Digital colleagues, briefing SIRO as required. The Trust has successfully appointed a new Cyber Security Manager, who has now taken up their post. One of the early objectives of the new member of staff will be to conduct a formal test of the plan with a number of key stakeholders within the organisation. It is anticipated that this test will most likely be conducted in early 2024. HOIG chaired an EBA DPO WG Cyber discussion on 31 Oct 23 with attendance from WBS it involved the CIO/COO from MAKS delivering an update on risk/impact in respect of the recent cyber incident in order to share learning. Positive learning across all EBA Blood Establishments in relation to the incident. SAR Review Report delivered to Director VCC in October 2023 and is under consideration by SLT. Offsite Storage Incident – Contract awarded to Harwell to enable full restoration of frozen medical records to enable a decision to be taken whether to preserve or not once restored. Also restored from a VFM perspective as point now reached whereby further freezer storage exceeds cost of restoration. Maltings Review was conducted in November 2023 by HOIG/HRM through physical visit, DPIA updated and circulated to C&VUHB/PHW for comment. DPIA approved and maintained. Noted that the site has improved even further, no concerns over storage standards on site.
Analysis, themes and learning
Training statistics have continued to improve there is a real need to ensure that delivery is as localised as possible. The "offer" to support divisions across the Trust remains extant. As of 31st December 2023, 239 Staff are non-compliant against the established workforce of 1,659. This data does not include those on Maternity leave or on Long Term Sick. DATIX 15237 relates to the lack of appropriate checks for demographics which resulted in unauthorised data sharing. Service area reminded of their obligations, HRM reviewing SOP for three-point demographic checks. Induction training will be amended to reflect case study and learning ICO Case IC-237352-Q4S0 relates to an email sent to a patient in June 2023, ICO responded to the report on 28/12/23 stating no further action, case study is included in future induction packages to reflect learning. This is in line with the ICO guidance and advice. Cyber incidents still occurring (latest being a supplier from the USA which supplies consumable products to Trusts and HB's in Wales). Trust not impacted, but as hosting body for NWSSP HOIG as DPO kept a watching brief on incident and engaged with NWSSP Staff. Incident required Digital/IG/CDO involvement and Exec

overview (SIRO/Director of Strategic Transformation, Planning and Digital). National analysis remains that cyber criminals are increasingly targeting the supply chain / suppliers rather than direct attacks on individual organisations and NHS institutions.

Cyber incidents still occurring. Another Varian linked incident reported to HOIG/Head of Digital (HOD) in November 2023 showed that the risk remains high. DATIX 14738 refers. Incident required Digital/IG/CDO involvement and Exec overview (SIRO/Director of Strategic Transformation, Planning and Digital).

To provide assurance to the Trust in relation to Cyber Security, the Cyber Incident Response Plan requires testing in early 2024.

SAR compliance significantly improved above that in October 2023, this is because significant resources have been brought to bear within Medical Records to address issues. The IG offer of support was not able to be used for other reasons.

Comments

HOIG required to provide advice, guidance and support to Medical records to support the SAR action plan implementation in a timely and efficient manner.

Cyber incidents and the risk from data loss, unauthorised loss etc remains high with focus by criminals on third party supply chain.

Increased training provision is anticipated to increase awareness at the beginning of an individual's employment in Velindre, all sessions are full in WBS/HQ/VCC, some have had to be moved to Jan 24 due to site capacity. IG putting on extra sessions in conjunction with Counter Fraud.

Delivery of standard, risks to delivery and mitigation

WBS Reviews continue, further Reviews planned for 2024 as part of the normal BAU programme.

Reviews across VCC required to ensure a similar assessment of compliance can be undertaken for 2023/24.

All-Wales IG policies have emerged as a risk. Further work in November 2023 identified that can be reduced to one All Wales IG policy which is out for consultation, deadline date extended to 22/1/24 to all the All-Wales Cyber Security Group to review the policy as well as internally across Trust's and Health Boards.

SAR process will continue to require additional support during 2024

Safe	Timely	Effective	Efficient	Equitable	Person Centred
Evidence that Staff recognise their responsibilities in respect of Legislation, Codes of Practice and Trust Policy.	All incidents, reports and SAR's are submitted and/or responded to within required timescales	All IG incident reports have been completed appropriately and where feedback is received it is acted upon.	IG support is accessed at the correct point in any process (data protection by design and default) and where needed for incident management	The principles of Caldicott, Confidentiality and Data Protection are based on the European Convention on Human Rights and Article 8 of the Human Rights Act 1998	Evidence that the Caldicott and data protection principles have been adhered to in all reports made across the Trust. A fair approach has been taken in relation to allegations of any wrongdoing by members of Staff

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15. CONCLUSION

The triangulation of data this quarter has identified a theme of continued concerns and incidents relating to communication with VCS patients:

- In SACT, changes to the time, location and type of appointment (face to face vs. telephone) not being communicated to patients.
- VCS patients report difficulty in contacting departments, with calls not voicemails not being returned
- Concerns continue around information given in medical appointments

The Division is focusing on learning and improvement opportunities, with several service reviews being undertaken to address these ongoing communication issues.

Overall satisfaction scores for both Divisions remain high, with the exception of VCS waiting times (77%).

Compliance with Putting Things Right timescales for concern responses is 100%.

Compliments from patients are now being captured in Datix, providing opportunities to share positive feedback with colleagues.

Positive reporting culture – incident reporting remains high, demonstrating a willingness to raise issues and an understanding of the importance of this.

2 incidents in VCS triggered the Duty of Candour, having been assessed as having potentially caused moderate harm to patients.

1 incident concerned a missed opportunity to reduce a dose of chemotherapy.

1 incident concerned provision of Total Parenteral Nutrition to a patient.

Both incidents are currently subject to investigation, to identify learning and opportunities for improvement.

16. PRIORITIES FOR QUARTER 4, 2023-24

- Divisions to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, to successfully investigate and close any outstanding incidents.
- To further analyse incident investigation outcomes to identify further opportunities for learning
- To strengthen investigations and to effectively capture and address learning identified from concerns, incidents and patient/ donor feedback during Quarter 4 2023-24.
- To further develop collaborative working opportunities to optimise quality and safety outcomes and support learning and continuous improvement.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

The Medical Examiner Service and Velindre University NHS Trust

DATE OF MEETING	14th March 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	Sarah Owen, Quality and Safety Manager
PRESENTED BY	Zoe Gibson, Interim Corporate Head of Quality and Safety
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The report provides an update regarding the implementation of the Medical Examiner Service. VCC continues to meet the statutory requirements around the MES. There is a robust process in place for the formal reviews of VCC inpatient deaths and progress is being made in the reviewing process of death within 30 days of SACT and 30/90 days of radiotherapy by the clinical teams which is reported in the Division's QS&P Report.

RECOMMENDATION / ACTIONS	The QS&P Committee is asked to **NOTE** the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC SLT	07/03/2024
EMB RUN (Out of Committee)	07/03/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Approved by SLT	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as '**ASSURANCE**', this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full *Fully compliant with all aspects of MES legislation*

APPENDICES	

ACRONYMS	
MES	Medical Examiner Service
QS&P	Quality, Safety & Performance Committee
VCC	Velindre Cancer Centre

1. SITUATION

1.1 This report is provided as an update to the Quality, Safety and Performance (QS&P) Committee regarding the implementation of and compliance with the Medical Examiner Service requirements within Velindre University NHS Trust.

This paper is provided for the QS&P Committee to:
- Have an overview of the high-level outcomes.
- **NOTE** the progress that has been made in implementing the revised mortality review process, the progress made since the last update was provided and the priorities and plans for the next 6-month period.

2. BACKGROUND

2.1 The Medical Examiner Service (MES) was implemented in England and Wales in response to The Shipman Inquiry and Mid Staffordshire NHS Foundation Trust Public Inquiries. These require a common approach to death certification and independent scrutiny of all deaths to allow the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

UK Legislation: From April 2024 the Medical Examiner Regulations (2024) will come into force. It will be a statutory requirement for all deaths not investigated by a coroner to be scrutinised by a medical examiner as set out in the Coroners and Justice Act (2009) and recently published draft legislation applicable to both England and Wales. The regulations will put all the medical examiner system's obligations, duties, and responsibilities on to a statutory footing and ensure they are recognised by law. Once the death certification reforms come into force, all deaths in England and Wales will be independently reviewed, without exception, either by a medical examiner or a coroner. Guidance from Welsh Government states all healthcare providers including GP practices should set up processes to start referring deaths to medical examiner offices if they have not already done so. These processes are fully established within VCC, and no further action is required to ensure compliance with the Medical Examiner Regulations (2024).

2.2 Health Boards and Trusts within Wales must have in place arrangements to meet statutory requirements, which include:

a) Arrangements to provide timely notification of the death (within one working day) to the relevant Medical Examiner Office.

b) Arrangements for electronic access (within the same working day) to relevant clinical records, via "scan and send" paper records or direct access to clinical systems (data sharing agreements already exist to support this).

c) A mechanism for providing timely access to the Qualified Attending Practitioner (within three working days of notification of death). The Qualified Attending Practitioner is a doctor representing the clinical team that last treated the deceased before they died.

d) A named contact and email drop box, to receive and act upon any referrals from the Medical Examiner Service for further review or investigation.

2.3 Local Implementation

Since autumn 2021, the MES reviews the medical records for all patients who die at Velindre and consults with the treating team to determine the cause of death so that the death certificate can be completed at VCC. As part of this process, the MES completes a comprehensive mortality review and feeds back any issues they identify to VCC / relevant Health Board. The MES also contacts the Next of Kin to discuss the cause of death and allow them the opportunity to raise any issues about the care the patient may have received (at any point in their illness). This process has now become fully embedded and operational across Wales.

3. **ASSESSMENT**

3.1 MES Requirements

A presentation was given at the January 2024 Trust Integrated Quality and Safety Group surrounding the national requirements for mortality review and the current VCC position. The requirements are met through the role of the nursing administrator providing timely information to the MES, a dedicated VCC mortality email address for the MES that is manned during normal working hours, and a clear process for the review of referrals sent to VCC by the MES. Reassurance was provided that all mandated requirements of the MES are being met 100% of the time. It was recognised that the fact VCC are reviewing all VCC inpatient deaths, we are working above the national requirements which mandate that only MES referrals are reviewed. A VCC MES Standard operating procedure has been developed and approved.

3.2 The MES Case Review Panel

This panel meets when required to discuss any referrals from the MES. In the 6-month period 1st August 2023 – 29th February 2024, there were 27 deaths in VCC and 8 referrals in total from the MES. 4 of the referrals were related to patients that died elsewhere and were referred as the patient had died within 30 days of SACT, or due to next of kin feedback. There were no clinical concerns noted by the MES or on VCC further review. 4 referrals were regarding patients that died on First Floor, VCC. These were all referred to VCC due to NOK feedback or death within 30 days SACT. Again, no clinical concerns noted by the MES or on VCC further review.
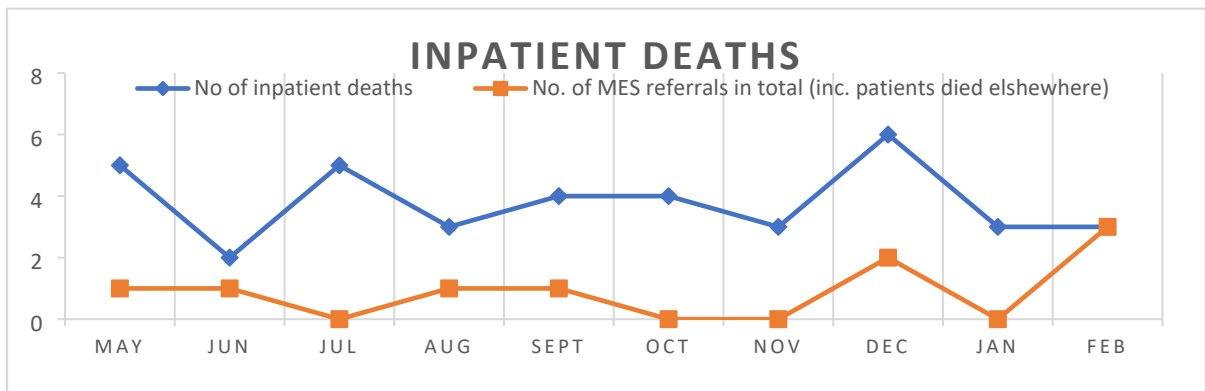
The referrals are reviewed in the MES Review meetings, the purpose of which is to highlight where improvements may be required and to identify learning. This learning is then fed back to the individual consultant or Site-Specific Teams.

3.3 MES Quarterly Reports

The MES share quarterly information with Health Boards and Trusts and since January 2024 have produced a Velindre Specific Quarterly report. The numbers are small, and we will also receive an annualised report in due course. We will align this period of reporting to the existing Trust reporting time frame moving forward so this can presented as a single set of data. The data below is combined to cover the time 1st April 2023 – 31st December 2023. The figures received from the MES do not fully correlate with the data captured manually within VCC (number of inpatient deaths, and number of referrals from MES). The Quality and Safety Team will link with the MES regarding this. There is no concern that any VCC inpatient deaths have not been reported to the MES as a MES review has been requested by VCC for each VCC death as part of our monthly inpatient mortality review process.

Medical Examiner

Quarterly Mortality Statisitics

2023/24 Quarter 2 & 3

01/07/2023 to 31/12/2023

Data for:

Velindre NHS Trust

| Number of Deaths Reported | 15 |
| Number of Paediatric Deaths | 0 |

Breakdown of deaths reported by Age group		Male	Female	Transgender Female	Transgender Male	Non-binary	Indeterminate	Not Stated
0 to 4	0	0	0	0	0	0	0	0
5 to 17	0	0	0	0	0	0	0	0
18 to 24	0	0	0	0	0	0	0	0
25 to 29	0	0	0	0	0	0	0	0
30 to 34	0	0	0	0	0	0	0	0
35 to 39	0	0	0	0	0	0	0	0
40 to 44	0	0	0	0	0	0	0	0
45 to 49	0	0	0	0	0	0	0	0
50 to 54	1	0	1	0	0	0	0	0
55 to 59	0	0	0	0	0	0	0	0
60 to 64	2	0	2	0	0	0	0	0
65 to 69	2	0	1	0	0	0	0	0
70 to 74	5	3	1	0	0	0	0	0
75 to 79	2	2	0	0	0	0	0	0
80 to 84	2	1	1	0	0	0	0	0
85 and over	1	0	1	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0
	15	6	8	0	0	0	0	0
% of deaths by Gender		40.00%	60.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Referral to Coroner

		No attending medical practitioner within a reasonable time frame	Death in custody or otherwise in state detention	Death due to an injury or disease attributable to any employment held by the person during the person's lifetime	Death due to the use of a medicinal product, controlled drug or psychoactive substance	Death due to neglect, including self-neglect	No referral required	Death due to poisoning, including by an otherwise benign substance	Death due to self-harm	Death due to exposure to or contact with a toxic substance;	Death due to trauma or injury	Death due to the person undergoing a treatment or procedure of a medical or similar nature	Unknown identity of the deceased	Death due to unnatural causes but does not fall within any of the circumstances listed in sub-paragraph (a)	Cause of death unknown	Death due to violence	Category not stated
Velindre Cancer Centre	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Referred for Moratality Review by Health Board

		Death where ME has identified need for mortality review referral?	Death where QAP or Staff have significant concerns about the care?	Death where the bereaved has significant concerns about the care?	Death where the patient was not expected to die (e.g. in elective procedures)	Death where learning will inform the provider's quality improvement work.
Velindre Cancer Centre	3		2	0	2	0	2
	3		2	0	2	0	2

3.4 VCC Inpatient Mortality Review Group

This is a monthly meeting that reviews all inpatient deaths by utilising the MES reviews, receiving feedback from the patient's consultant and the ward doctors and nurses. The review focuses on identifying areas of good practice and areas for improvement and ensure the learning is actioned. In the period 1st August 2023 – 29th February 2024, there were 27 deaths in VCC. The deaths were all anticipated and had appropriate Do Not Attempt Resuscitation orders in place and there was evidence of good communication with the patients and their families. All patients had a high level of palliative care input. There were no clinical concerns noted and 3 of the cases were referred to VCC for further review from MES due to NOK concerns and death within 30 days SACT. The learning identified from the reviews is mainly around the completion of assessment paperwork and use of PRN medication overnight (palliative care have undertaken education sessions with the nursing night staff).

4. **SUMMARY OF MATTERS FOR CONSIDERATION**

VCC continues to meet the statutory requirements around the MES. The development of Velindre Quarterly reports from the MES service will give us robust data which can be benchmarked against other health boards in Wales. No clinical concerns have been identified by MES. No cases have been referred to coroners following MES review due to clinical concerns.

5. **IMPACT ASSESSMENT**

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience.	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations.	☐
• A beacon for research, development and innovation in our stated areas of priority.	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe.	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[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-dutyoverview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**

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

6. RISKS

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

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QSP COMMITTEE

VCC DIVISIONAL QSP REPORT
(October 2023 – December 2023)

DATE OF MEETING	15.03.2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	VIV COOPER, HEAD OF NURSING, QUALITY, SAFETY AND PATIENT EXPERIENCE SARAH OWEN, QUALITY AND SAFETY MANAGER TRACEY LANGFORD, QUALITY & SAFETY OFFICER KEVIN STAYTE, PATIENT EXPERIENCE AND CONCERNS MANAGER
PRESENTED BY	RACHEL HENNESSY, DIRECTOR OF CANCER SERVICES
EXECUTIVE SPONSOR APPROVED	

REPORT PURPOSE	FOR ENDORSING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
VCC SLT	08.02.2024	Approved
EMB	12.02.2024	

ACRONYMS	
VCC	Velindre Cancer Centre
QSMG	Quality and Safety Management Group
QSP	Quality, Safety and Performance
WCP	Welsh Clinical Portal
NRI	National Reportable Incident
WG	Welsh Government
RT	Radiotherapy
SLT	Senior Leadership Team
PTR	Putting Things Right
WRP	Welsh Risk Pool
OfW	Once for Wales
DHCW	Digital Health Care Wales
HIW	Health Inspectorate Wales
MES	Medical Examiner Service
SDEC	Same Day Emergency Care

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1.   SITUATION

This purpose of this paper is to provide the Trust Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Velindre Cancer Centre for the period October 2023 – December 2023, the QSP should note that the data is retrospective by 3 months when presented to the Committee.

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

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

The format of this report is structured around the 6 domains of quality and safety.

2.   BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Velindre Cancer Centre for the period October 2023 – December 2023.

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

3.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises:

- Key performance outliers and associated actions to resolve
- Key quality and safety related indicators and remedial action identified
- Feedback from Patients and our responses to this feedbacl.
- Regulator and Audit Feedback, assurance and learning themes
- An outline of key service developments in VCC

3.1   Triangulated Analysis
The purpose of this report is to provide assurance to the Quality, Safety and Performance Committee that VCC is continuing to meet its Quality, Safety and Performance standards. To summarise for data, actions, and learning for the reporting period (October 2023 – December 2023).

All clinical services were under significant pressure during the reporting period following an increase in demand and an increase in complexity of patient clinical presentation.
- The aims and objectives of the 2 Safer Care Collaborative Projects, Malignant Spinal Cord Compression Pathway and The SACT Treatment Helpline are progressing as planned and

reporting as required through the divisional SLT and Divisional QSMG, these 2 projects have been included in the agreed Quality and Safety prioirities for 2024/2025.

- Falls and Pressure Ulcer learning panels (previously known as scrutiny panels) continue to meet monthly and examine the documentation, evidence and learning around each individual incident are reported in the Divisional monthy PMF.
- Compliance with the PTR regulations related to concerns/complaints continues at 100%An improvement is being seen in the closure of quality and safety incidents within the required 30 days
- A process has been agreed by SLT for the management of the outcomes of serious incidents, these will be formally accepted and a requirement for the appropriate department to develop an action plan which will be monitored through the Divisionslal QSMG.
- The Clinical audit team have joined the quality and safety team this will improve triangulation between quality and safety, clinical audit, and service improvement to ensure that themes and trends identified through concerns, incidents, and risks are key features in the annual clinical audit plan.
- Robust monthly review of risk register by the Divisional SLT

3.2   The top six matters arising for this period are;

- There were 0 avoidable VCC inpatient falls for the reporting period

- An improvement plan has been drafted by Outpatient and Medical Records Management Group to incorporate 4 workstreams related to themes identified from concerns and incidents including waiting time on the day in OPD and communication issues around appointments. Progress will be monitored through QSMG. High level plan has been presented at January QSP.

- 2 reportable incidents for this reporting period (1 Duty of Candour and 1 incident BOTH Duty of Candour and NRI)

- SST mortality review meetings are being rolled out across the SST's. Inpatient mortality reviews and full compliance with MES regulations continue

- Data quality continues to be a concern within the cancer centre regarding patients who have died within 30 days of receiving SACT and 30/90 days of radiotherapy – the service is unable to meet the WG reporting requirements at present.

- A joint pilot has been successfully implemented as business as usual between VUNHST and ABUHB for direct referral from VCC Treatment helpline in to ABUHB SDEC unit

3.3 Key Actions / Areas of focus during next period

Quality, safety and patient experience remains at the heart of our service during this period in all aspects of service delivery as does the well-being of our staff. The staff psychologist is working with a number of groups and individuals across the service to help/support following any incidents/concern/challenging clinical scenarios experienced due to high patient acuity.

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current quality, safety and performance reporting and monitoring system is predicated upon identifying issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and improving the overall experience of patients and
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

RECOMMENDATIONS

The SLT are asked to **APPROVE** the content of this report for onward submission to the Trust QSP.

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1.0	Introduction

INTRODUCTION

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

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

2.0	Impact Assessment

2.1 This report covers the period of October, November and December 2023 and therefore retrospectively provides VCC service, quality and safety data and narrative, the purpose of which is to provide assurance. The report is structured around the 6 domains of quality and safety.

3.0	Highlight Report from Velindre Cancer Centre Quality and Safety Management Group

3.1 There has been one VCC QSMG meeting held during this period and the following matters were escalated to SLT.

- A continuous theme from incidents and concerns around letters, telephone and responses to messages left is adversely affecting communication with patients around appointments for OPD and SACT.

4.0	**Safe Care Descriptor; avoid harm**

Incidents/near-misses/compliments/feedback are used as indicators of safe care and are captured using the Once for Wales DATIX software system. Assurance regarding the safety of the services provided at Velindre Cancer Centre is provided through various routes/reports and committees including:

- Tier 1 Reportable Indicators (reported via the Divisional monthly performance reports)
- Incidents (discussed in each Directorate and reported to the VCC SLT, QSMG and Trust QSP)
- Complaints (discussed in each Directorate and reported to the VCC SLT, QSMG and Trust QSP)
- Claims (reported to the Trust QSP)

Compliments are discussed in each Directorate and reported to the VCC QSMG and Trust QSP, knowing 'how we are' doing boards have been placed in each service area as part of the implementation of Civica with a governance structure in place to ensure they are regularly updated. This section will provide assurance that safe care is being delivered in Velindre Cancer Centre and that where there are lessons learned and actions to improve service there is a monitoring system in place.

4.1 Incidents

Severity (degree of harm) code descriptors in relation to the Once for Wales System are as follows:

No harm	No harm (impact not prevented) - Any incident that ran to completion, but no harm occurred to people receiving NHS funded care
Low	Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care
Moderate	Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care
Severe	Any unexpected or unintended incident that directly resulted in permanent harm to one or more persons
Death	Any unexpected or unintended incident that directly resulted in the death of one or more persons

NUMBER OF INCIDENTS REPORTED EACH MONTH

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
172	172	169	146	153	186	167	167	196	143	141	97

Incidents by classification

Classification	Value
Treatment, Procedure	~162
Transfer, Discharge	~13
Safeguarding	~1
Records, Information	~6
Pressure Damage, Moisture Damage	~21
Nutrition, Hydration	~1
Medication, IV Fluids	~23
Infrastructure (including staffing, facilities, environment)	~11
Information Technology	~7
Information Governance, Confidentiality	~6
Infection Prevention and Control	~2
Equipment, Devices	~22
Consent, Mental Capacity Act (including DoLS)	~1
Communication	~45
Behaviour (including violence and aggression)	~7
Assessment, Investigation, Diagnosis	~11
Accident, Injury	~38
Access, Admission	~4

The majority of new incidents are categroised under "treatment" – the majority of these are related to radiotherapy as all radiotherapy errors require reporting **for notification purposes** to UK Health and Safety Authority (UKHSA) only as per national guidelines. The majority of these incidents are "near misses".

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Themes of Radiotherapy Errors (RTE) by Towasrds Safer Radiotherapy (TSRT) Pathway code
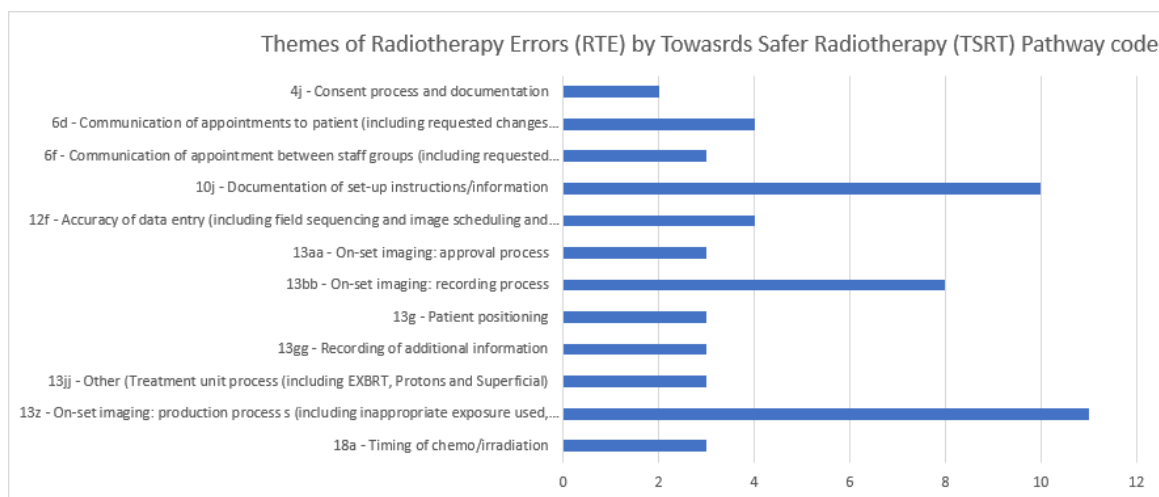
Themes and learning from incidents

- Communication with patients regarding appointments e.g. change in appointment time, location, or type (f2f v telephone) without patient being informed by phone or letter. OPD and Medical Records improvement group finalising an improvement plan incorporating 4 workstreams related to the ongoing themes around appointment and communication
  1. referral pathways in to VCC from Health Boards
  2. demand and capacity in OPD (including waiting times and room)
  3. time from referral to treatment (SACT and Radiotherapy)
  4. DHCR review of ways of working, processes, etc.
- Increased diligence surrounding take home medication from ward – ensure all medication prescribed on one prescription and delivered to the ward at the same time
- Notes a theme around a small number of patients who are not at risk of falls falling when standing out of bed – lying and standing blood pressure now being undertaken on all patients on admission to identify patients who may have a postural blood pressure drop when standing that can contribute to a fall, and notices being placed around the bed areas for patients to be mindful of footwear when getting out of bed.
- Increased security around the car park following a false notice left on a patients car that a charge would be applied due to the length of time they had been in the car park. No further reports of this since
- Increase collaboration between WAST and VCC to improve timely transport for patients requiring urgent treatment for Metastatic Spinal Cord Compression – WAST staff spending time in VCC to understand the importance of prompt treatment and the challenges in delivering.

4.1.3 Reportable Incidents and Duty of Candour

There were 2 reportable incidents during this reporting period, with 1 incidents triggering the Duty of Candour only, and 1 incident meeting the criteria for both Duty of Candour and Nationally Reportable Incident.

Duty of Candour – missed opportunity to start TPN (Total Parenteral Nutrition) earlier and the failure to provide the required dose of TPN due to the patients high nutritional requirements. Immediate learning and actions identified the need for robust processes for identifying and referring patients to the dieticians, and also need a review of the TPN service that is provided in Velindre Cancer Centre including the referral process for TPN and the different doses of TPN that are available at the cancer centre.

Duty of candour and NRI – Missed opportunity to reduce the dose of chemotherapy in line with guidelines which resulted in potentially prolonged period of pancytopenia (low red, white and platelet blood cells) and development of pneumonia which may have contributed to the patients death. Initial review identified human error to be the cause and further work is being undertaken to identify which processes can be out in place to prevent this happening again.

2 Duty of Candour incidents and 1 NRI have been closed during this period. An action plan is being developed for all 3 which will be signed off by SLT and monitored via QSMG. The key findings and improvements from these investigation are:

- Process within the Treatment Helpline including use of the UKONS triage tool and escalation of patients of concern.
- Review of the process around correspondance writing, sign off, and communication with patients.
- Develop a clear and robust process regarding blood sample requesting and reviewing of blood test results, particularly for patients on weekly SACT

4.1.2   Open Incidents

VCC Incidents Open Over 30 Days

Incidents by Classification

Classification	Value
Treatment, Procedure	~176
Transfer, Discharge	~13
Safeguarding	~1
Records, Information	~5
Pressure Damage, Moisture Damage	~22
Nutrition, Hydration	~1
Medication, IV Fluids	~26
Infrastructure (including staffing, facilities, environment)	~14
Information Technology	~7
Information Governance, Confidentiality	~6
Infection Prevention and Control	~3
Equipment, Devices	~17
Consent, Mental Capacity Act (including DoLS)	~1
Communication	~49
Behaviour (including violence and aggression)	~7
Assessment, Investigation, Diagnosis	~14
Accident, Injury	~38
Access, Admission	~4

Following the development of the action plan as a result of the VUNHST WRP audit there has been a consistent decrease in the number of incidents open over 30 days. The actions put in place to improve compliance with the KPI - re-establishing regular departmental Incident Lead Review Meeting, strengthening of the monthly SLT and directorate reports produced by the Quality and Safety Team, and regular Datix Masterclass sessions for all VUNHST staff continue to be successful and will be monitored via QSMG.

4.2 Falls Learning Panel

There have been 0 avoidable falls on First Floor Ward during this reporting period.

4.2.1 Pressure Ulcer Learning Panel

There was 1 potentially avoidable VCC acquired pressure ulcer during this reporting period. Learning actioned related to use of appropriate pressure relief equipment, and prompt intervention where any changes to skin condition are identified. This case is being presented to the wider First Floor team as a case review by the Lead Tissue Viability Nurse.

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4.2.2 IR(ME)R HIW Reportable Incidents

The Ionising Radiation (Medical Exposure) Regulations 2017 are designed to protect people while undergoing examinations and treatment. Where there is unintended or accidental exposure to ionising radiation this must be reported and investigated. IR(ME)R notifications are reported to HIW. During the period There were 0 Significant accidental or unintended exposures under IR(ME)R (SAUE) incidents reported to Health Inspectorate Wales (HIW) during the period. The significant reduction is due to the change in the guidance for the reporting of IR(ME)R incidents, which was changed in April 2023. A significant number of the incidents reported previously were due to the intermittent equipment failure of radiotherapy cone beam CT (on-treatment imaging systems used to verify the position of the patient during their radiotherapy treatment). This was a known national / worldwide issue but was not clinically significant. As a result of these issues the guidance was updated in April 2023.

4.2.3 Early Warning Notifications

There are no Early Warning Notifications for this reporting period.

4.3. IRMER Compliance/ Issues/ Incidents

Between 1st October 2023 and 31st December 2023, 93 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 93 incidents reported, 79 were classed as radiotherapy errors / radiation incidents. 74 of which have been or are under investigation by the radiotherapy department and have been coded in line with Towards Safer (TSRT) pathway coding and 5 have been referred to Radiotherapy Physics for investigation. No incidents have caused harm to patients.

0% of radiation incidents were classed as Level 1 and were reportable to HIW as per Significant Accidental Unintended Exposures (SAUE) under IR(ME)R guidance.

100% of radiation incidents were classed as minor radiation incidents (Level 3, 39.2%), near misses (Level 4, 27.0%), or other and non-conformances (Level 5, 33.8%) for the 3-month period 1/10/2023 to 31/12/2023 which benchmarks well with the National report of 97.0.%, reported in the UK Health Security Agency Safer Radiotherapy e-Bulletin #11 September 2023 (**Appendix A)**.

All staff involved in these (and all) incidents have been spoken to regarding these errors and asked to reflect on their current practice and what they can do to reduce the risk of then occurring again.

Incidents associated with the location of Radiotherapy Department from 1/10/2023 to 31/12/2023

- Level 1 - Reportable RI
- Level 2 - Non -Reportable RI
- Level 3 - Minor RI
- Level 4-Near Miss
- Level 5-Other Non Conformance
- Non radiation incident
- Referred to Physics for Investigation
- Rejected
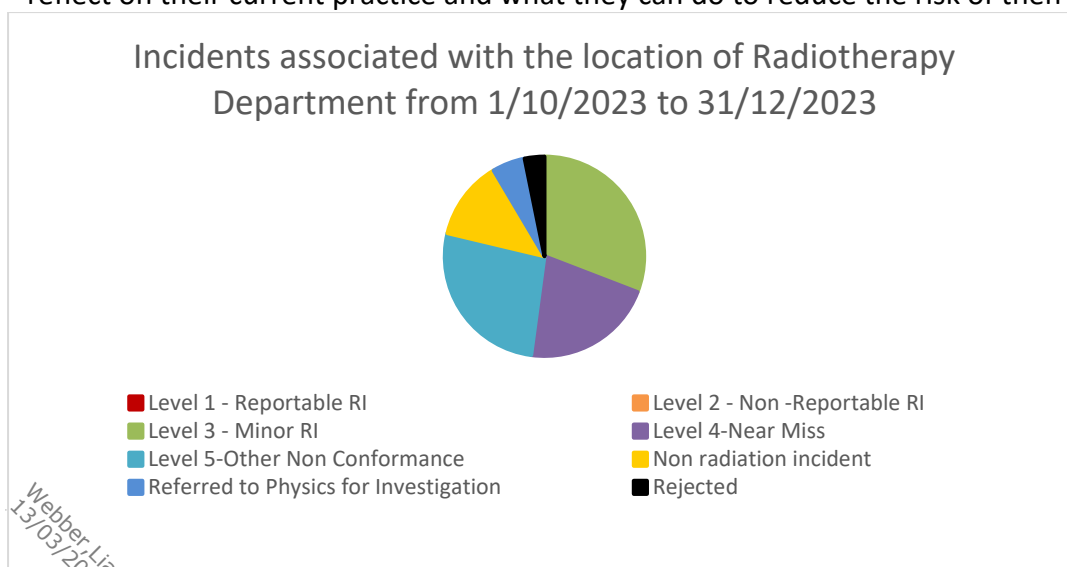
4.4 Mortality

The Inpatient Mortality Review Group continues to review all VCC inpatient deaths and all referrals for review from the MES. Each death was anticipated and had appropriate Do Not Attempt Resuscitation orders in place. There was evidence of good communication with the patients and their families. All patients had a high level of palliative care input. No clinical concerns have been identified by the MES or VCC Mortality Group from VCC inpatient deaths. Learning has been identified around the information provided on the Trust website about First Floor ward and the need to audit VCC infection rate in patients having paracentesis. Improvement has been noted in the completion of Treatment Escalation Plans and Venous Thromboembolism Risk Assessments as a result of action taken by the mortality group.

For cases referred to VCC by MES where the patient did not die at VCC, 2 cases require further investigation. 1 case has been reported as a NRI and the Duty of Candour applied (see 4.1.3). 1 case is being managed under PTR due to the concerns raised by the family around outpatient assessment of the patients clinical condition.
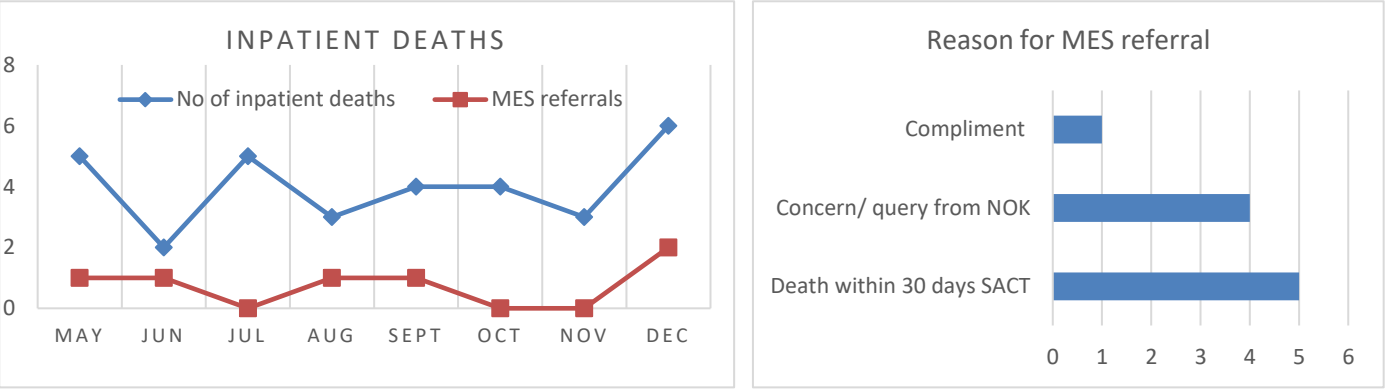
The MES share quarterly information wit Health Boards and Trusts, the first we have received is for the reporting period 1st October 2023 – 31st December 2023.

| Number of Deaths Reported | 7 |
| Number of Paediatric Deaths | 0 |

Breakdown of deaths reported by Age Group

Age Group		Male	Female	Transgender Female	Transgender Male	Non -binary	Indeterminate	Not Stated
0 to 4	0	0	0	0	0	0	0	0
5 to 17	0	0	0	0	0	0	0	0
18 to 24	0	0	0	0	0	0	0	0
25 to 29	0	0	0	0	0	0	0	0
30 to 34	0	0	0	0	0	0	0	0
35 to 39	0	0	0	0	0	0	0	0
40 to 44	0	0	0	0	0	0	0	0
45 to 49	0	0	0	0	0	0	0	0
50 to 54	0	0	0	0	0	0	0	0
55 to 59	0	0	0	0	0	0	0	0
60 to 64	1	0	1	0	0	0	0	0
65 to 69	1	0	1	0	0	0	0	0
70 to 74	3	2	1	0	0	0	0	0
75 to 79	1	1	0	0	0	0	0	0
80 to 84	1	0	1	0	0	0	0	0
85 and over	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0
	7	3	4	0	0	0	0	0
% of deaths by gende		42.86%	57.14%	0.00%	0.00%	0.00%	0.00%	0.00%

	No attending medical practitioner within a reasonable time frame	Death in custody or otherwise in state detention	Death due to an injury or disease attributable to any employment held by the person during the person's lifetime	Death due to the use of a medicinal product, controlled drug or psychoactive substance	Death due to neglect, including self-neglect	No referral required	Death due to poisoning, including by an otherwise benign substance	Death due to self-harm	Death due to exposure to or contact with a toxic substance;	Death due to trauma or injury	Death due to the person undergoing a treatment or procedure of a medical or similar nature	Unknown identity of the deceased	Death due to unnatural causes but does not fall within any of the circumstances listed in sub-paragraph (a)	Cause of death unknown	Death due to violence	Category not stated
Velindre Cancer Centre	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Referred for Moratality Review by Health Board

	Death where ME has identified need for mortality review referral?	Death where QAP or Staff have significant concerns about the care?	Death where the bereaved has significant concerns about the care?	Death where the patient was not expected to die (e.g. in elective procedures)	Death where learning will inform the provider's quality improvement work.
Velindre Cancer Centre	0	0	0	0	0
	0	0	0	0	0

A presentation was given at the January 2024 Trust Integrated Quality and Safety Group surrounding the national requirements for mortality review and the current VCC position. Reassurance was provided that all mandated requirements of the MES are being met. It was recognised that VCC, by reviewing all VCC inpatient deaths are working above the national requirements which mandate that only MES referrals are reviewed.

Work is ongoing to develop a robust process for reviewing all patients that have died within 30 days SACT and 30/90 days radiotherapy. This is recognised nationally as best practice but does not have any mandated requirement. A plan is in place for all SST's (Site Specific Teams) to have a Mortality and Morbidity meetings in place by August 2024. Reassurance is provided the MES discuss the use of SACT with the oncologist in all cases where patients die within 30 days of SACT in a hospital setting.

A governance route is being strengthened for mortality through the development of a quarterly overarching mortality meeting that will pull together all strands of mortality (VCC inpatient mortality, MES referrals, and SST mortality meetings) and feed in to QSMG.

A Welsh Government requirement to report death within 30 days SACT and 30/90 days radiotherapy mortality data was put in place in April 2023. Data quality continues to be a concern within the cancer centre. Initial data validity issue has been rectified around where those deaths occurred outside the Trust – e.g. in another Health Board following the implementation of DH&CR in November 2022. Further data validation has highlighted further issues. When calculating death within 30 days of SACT BI look to "formal" SACT attendances, which are a combination of activity in Chemocare and in WPAS. However gaps were discovered between what was in Chemocare and the formal SACT attendances, which results in under reporting death within 30 days of SACT. The cause is as follows:

A) The BI Team identified Chemocare activity marked as given, that doesn't have a corresponding WPAS appointment. Which is created as a way of working in the SACT service.

B) It also seems there are issues around the completeness of the Chemocare "given" indicator, which prevents us being able to identify cases such as A and its possible solution.

C) There are around 2-3 patients that are incorrectly flagged as death within 30 days of oral SACT and SACT, we are investigating this and anticipate it being an issue with reference data.

Solutions/fixes
- The BI Team have created a Data Quality Task List (DQTL) that goes to the SACT service alerting them to these discrepancies, so that they can be corrected at source.
- BI have written in revised logic to the mortality reporting, so that we can "soft" match SACT activity based on it marked as given in chemocare (in lieu of the record being corrected as per B).
- Integrated Care are establishing a process to ensure all patients have the correct activity completed in Chemocare and WPAS – this is estimated to be in place 1st April 2024.

4.5 Divisional Risks

The risk register currently holds 187 records, 27 of which have been scored 12 and above. During the reporting period October 2023 to December 2023, there were 10 (12 and above) accepted risks opened and 0 (12 and above) risks closed during the reporting period.

The departments with open risks for that period are Integrated Care, Medical, Operational Services, Radiation Services and SACT services and are mainly related to DHCR, workforce challenges, and funding. The need to ensure the risks are updated and managed regularly has been escalated to SLT. Work is ongoing with SLT to review and close tolerated risks.

5.0	Effective Care Descriptor: evidence based and appropriate

5.1. Complaints

Number of concerns per month

A line chart showing the number of concerns per month:
- Jan: 6
- Feb: 6
- March: 7
- April: 8
- May: 13
- June: 16
- July: 19
- August: 13
- Sept: 9
- October: 12
- November: 20
- December: 7

Concerns by Classification

A horizontal bar chart showing concerns by classification:
- Patient Care
- Medication
- Communication Issues (including…)
- Attitude and Behaviour
- Access (to Services)

A summary of the key themes is highlighted below. Improvement plans and lessons learnt are being captured and shared where appropriate to demonstrate the learning undertaken.

There were 44 concerns raised for the time period October to December 2023, with 26 of these being managed through the Early Resolution pathway of Putting Things Right.
There have been no concerns raised in the time period that relate to breach of duty and none have been transferred over to redress.

Themes for this time period can be summarised as:
- Challenges with incorrect, changed or not received appointments – both Outpatient and SACT bookings
- Communication issues due to poor telephone contact (calls not being answered or returned) which also account for the access to service concern
- Access to Portacath's for small number of patients that require that intravenous access from the Cardiff and Vale UHB area and are not able to be managed by the VCC PICC service.
- Patients not receiving a copy of their clinic letters

- Clinical communication around treatment plans

Improvements and learning identified:
- OPD improvement group finalizing an improvement plan incorporating 4 workstreams that have been identified through concerns and incidents
    - referral pathways in to VCC from Health Boards
    - demand and capacity in OPD (including waiting times and room)
    - time from referral to treatment (SACT and Radiotherapy)
    - DHCR review of ways of working, processes, etc.
- An SLA is being developed with Cardiff and Vale UHB to support the placement of Portacath's for patients from the Cardiff and Vale area
- A review of who will contact patients when chemotherapy is deferred on medical grounds (blood results).

5.1.1 Ombudsman
VCC has received 1 referral from the Ombudsman during this time period. The report from the Ombudsman is still in draft and recomendations related to SACT treatment decision at the start of the Covid-19 pandeminc. An extension was requested and granted due to complexity around decision making at the start of the pandemic and advice has been sought from Legal and Risk to ensure the Trust response is appropriate. The response will be submitted on 30th January 2024.

5.1.1   Claims

- 0 new claims received.
- 5 Clinical Negligence Claims and 1 personal injury claim remain open.
- 1 claim closed.

5.1.2 Welsh Risk Pool
1 Learning from Events Reports was submitted to the Welsh Risk Pool for scrutiny of learning and approved.

Case Summary	Outcome	Learning from Events Report
The Claimant suffered a myocardial infarction two days after attending for a second course of chemotherapy (BEP) where he complained of shortness of breath and pain in his chest. It is contended that there was a failure to perform an Electro Cardiogram (ECG) on review.	Following investigation, a denial of liability was maintained. However, given vulnerabilities in the case, the Trust solicitor recommended settling the case on an economic basis. In September 2023, authority was provided to serve a Defence and, at the same, time, make an offer of settlement. A Learning from Events Report was submitted to the Welsh Risk Pool in December	**Vulnerabilities:** • Lack of compliance with the NEWS observation chart. • Trust personnel, who are not factual witnesses, to refrain from make misplaced comments/admissions. **Learning:** Circulation of updated annotated clinic template Training NEWS, Sepsis and SACT rolled out to staff personnel, including monitoring and surveillance.

Directorate: Velindre Cancer Centre	2023, for approval of learning, the outcome of which is awaited.	Staff awareness BIG 4 circulation on the importance of record keeping. Update to NEWS/Sepsis Policy Update to NEWS Chart in line with All Wales. Implementation of NEWS Cymru Audit (Observation Chart) Clinical supervision mandated from 2024. Reflective Practices undertaken by Trust personnel. Learning Brief Case discussion and awareness shared at • Senior Medical Staffing Committee • Site Specific Team Lead meeting • Quality and Safety Management Group • VCS Resuscitation Committee

6.0	Efficient Care Descriptor; avoid waste

6.1. Clinical audit Update:

All clinical audit activity is captured via AMaT, projects have been added retrospectively and now all new proposals are registered via the system. The table below provide an overview of the project status this is work in progress as the implementation process is ongoing.

Total number of projects	64	100%
Total number of open projects	59	92%
Number of open projects with no results	34	58%
Number of open projects with results	25	42%
Number of open overdue projects (no action plans)	6	10%
Total number of open projects (with action plans)	11	19%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	5	8%
Number of abandoned projects	0	N/A

Actions

- Overdue
- Partially complete (Overdue)
- Partially complete
- Complete
- New
- Unable to complete

85.0% 2.5% 12.5%
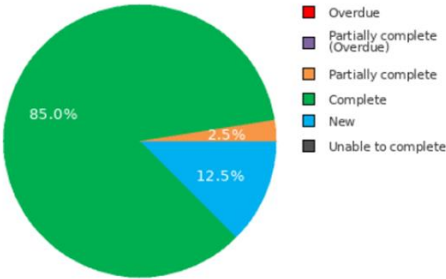
Clinical audit team is now a part of the the Quality and Safety department. This will further improve triangulation between quality and safety, clinical audit, and service improvement to ensure that themes and trends identified through concerns, incidents, and risks are key features in the annual clinical audit plan.

7.1   CIVICA has now been implemented throughout VCC. There is a choice for patients of completing 2 surveys – the quick 7 question "VCC Friends and Family Test", and the longer 28 question "Your Velindre Experience".

Departments have a 'You said, we did' board to allow patient, visitors and staff to see how each department is utilising the feedback they are receiving. Whilst updating these boards is the departments responsibility, it has recently been noticed that some departments are not regularly updating the boards to reflect up to date feedback. The Q&S Team are working with Department Leads to ensure these boards are updated monthly, in line with the Civica reporting and this monthly update is reported back in to QSMG.

Whilst waiting times have been consistently an issue within VCC, the majority of patients have rated them as about right or shorter than expected.

Waiting times in Outpatients – whilst a consistent theme throughout the reporting period – are being addressed by the Department within their Improvement Plan (see 4.1). There have been more responses in this reporting period and the acceptable waiting time has slightly improved. Managers continue to review the use of clinical rooms to ensure all are maximised but volume of patient visits and the needs of the service continue to be a challenge in relation to available space.

Service	Responses	1 - Overall, how was your experience of our service?	2 - Did you feel that you were listened to?	3 - Were you able to speak Welsh to staff if you needed to?	4 - During your most recent visit to Velindre Cancer Centre, how have you did you find the waiting time?	5 - Did you feel well cared for?	6 - If you asked for assistance did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall e	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Catering services	1	100	-	-	-	-	-	-	-	-	-	100
Clinical Psychology	1	100	-	-	-	-	-	-	-	-	-	100
Clinical Trials	84	-	96	84	78	99	99	93	97	94	95	93
Nuclear Medicine	10	100	-	-	-	-	-	-	-	-	-	100
Nursing	47	96	92	88	83	99	96	92	98	95	95	93
Outpatients	132	97	85	96	58	85	83	85	88	90	84	87
Palliative care	1	0	-	-	-	-	-	-	-	-	-	0
Pharmacy	15	100	-	-	-	-	-	-	-	-	-	100
Radiology	3	-	100	100	82	100	100	92	92	100	97	95
Radiotherapy	33	94	96	100	84	100	100	98	100	100	98	97
SACT	2	-	100	100	73	100	100	75	75	100	100	90
Overall		96	94	89	75	96	97	92	95	94	93	92
Benchmarks		85	85	85	85	85	85	85	85	85	85	92

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Breakdown of waiting times across the cancer centre:

Question 4: During your most recent visit to Velindre Cancer Centre, how have you did you find the waiting time?

Survey: Your Velindre Experience

Create_new action

Available Answers	Responses	Score (%)
Shorter than expected	49	30.43%
About right	96	59.63%
A bit too long	10	6.21%
Much too long	6	3.73%
Total	161	100%

Score: 75%

Shorter than expected (30.43%)   A bit too long (6.21%)   Much too long (3.73%)
About right (59.63%)
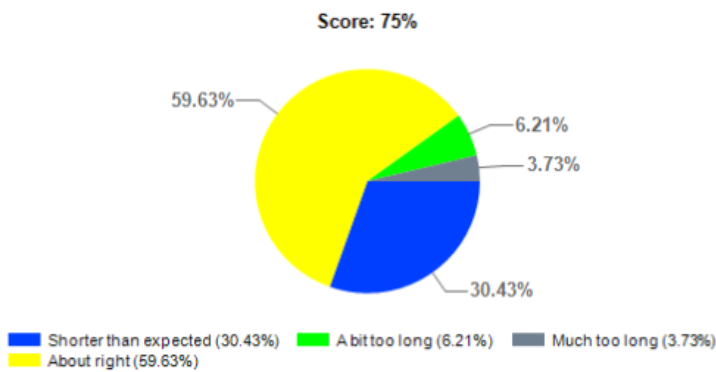
Breakdown of waiting times in OPD:

Question 4: During your most recent visit to Velindre Cancer Centre, how have you did you find the waiting time?

Survey: Your Velindre Experience

Create_new action

Available Answers	Responses	Score (%)
Shorter than expected	5	15.15%
About right	18	54.55%
A bit too long	5	15.15%
Much too long	5	15.15%
Total	33	100%

Score: 58%

Shorter than expected (15.15%)   A bit too long (15.15%)   Much too long (15.15%)
About right (54.55%)
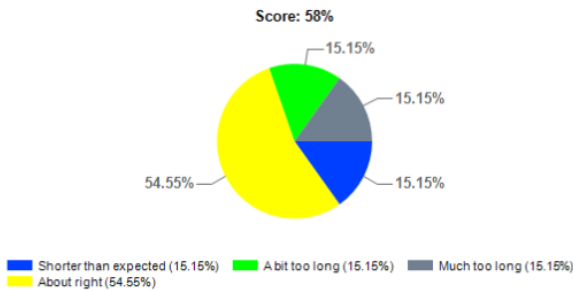
Waiting time responses over time by Directorate:

Patient Feedback about Waiting Times on the Day
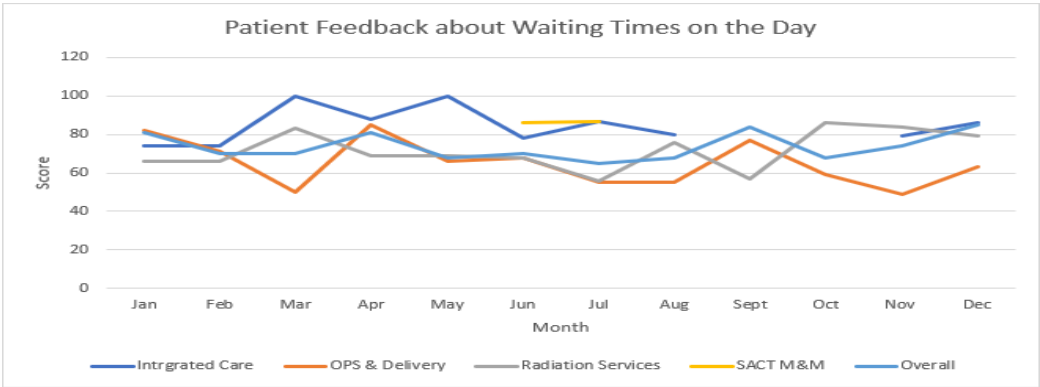
Overall, the feedback about Staff at VCC is incredibly encouraging and positive.

All Used Categories Pos/Neg Count
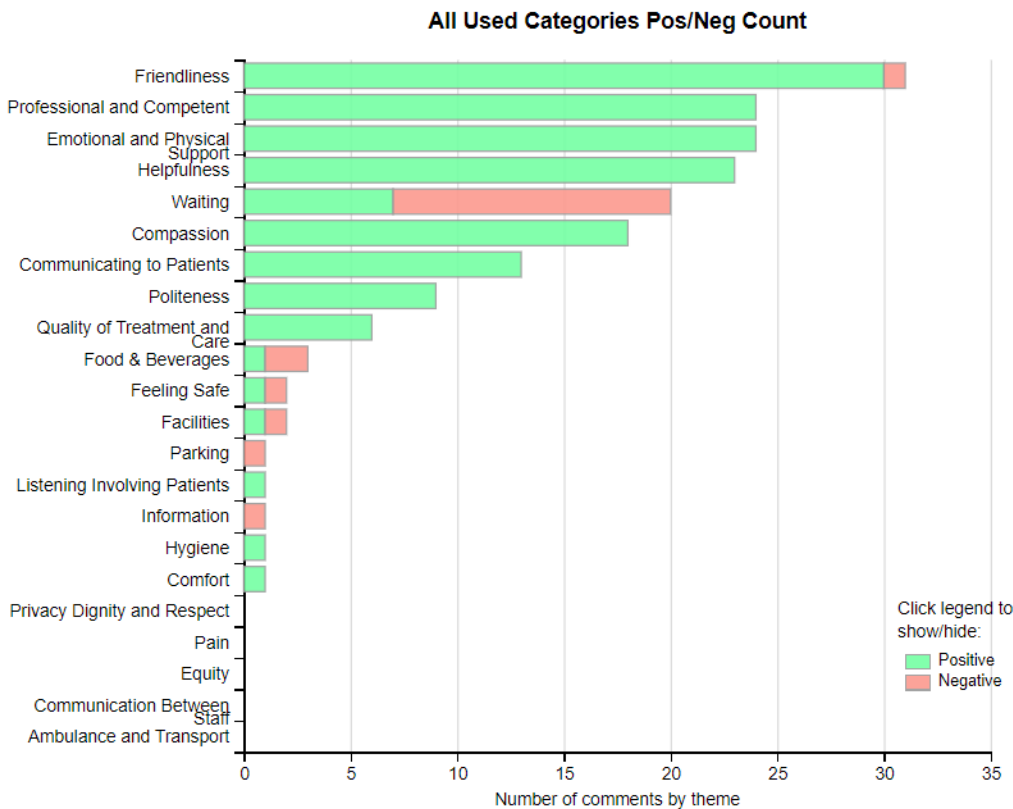
7.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

ISO 9001 External Audit Radiotherapy Treatment by BSI 12th & 13th October 2023 via MS Teams.
The overall assessment and recommendation of the assessment was that audit objectives have been achieved and the certificate scope remains appropriate and that the audited organization can be recommended for continued certification.

Treatment Helpline Peer Review 12th and 13th December 2023
Following themes identified through concerns and incidents, and as part of the Safe Care Collaborative, an external peer review was commissioned with findings expected to the Trust in February 2024.

| 8.0 | **Timely Care** | 24 | P a g e |

ABUHB SDEC

A joint pilot was commissioned between VUNHST and ABUHB for direct referral from VCC Treatment helpline in to ABUHB SDEC unit and ran from 20th November to 15th December 2023. A triage tool, working between Acute Oncology Services in ABUHB and the treatment help line at VCC was developed. It is recognised through development of Same Day Emergency Care (SDEC) at VCC that same day review is appropriate for many cancer patients however current triage services are set up to send patents directly to the front door of local hospitals. This would enable specialist needs to be addressed more quickly in an appropriate setting, providing care closer to home, and reduce time spent in acute care, thus improving patient outcome and experience. The pilot was successful and has now been adopted as business as usual.

Email Audit

SLT received the audit in December. This is being worked through and a paper including the findings of the audit is on agenda for EMB February. Work will now take place to established a T&F group across the Division and a supporting delivery plan.

| 9.0 | **Equitable Care**
Descriptor; an equal chance of the same outcome regardless of geography,
socioeconomic status |

8.1.1. Safe Care Collaborative

Malignant Spinal Cord Compression Pathway –
- Aim: The project will aim to improve the Metastatic Cord Compression Pathway and prevent delays in treatment and improve patient experience.

Barriers
- Revised NEPTS (Non-Emergency Patient Transport Service) booking process is more demanding of time and resource and is negatively affecting ability to transport patients in a timely fashion.
- Financial cost of any revised ambulance transport service likely to be significant.
- Limited radiotherapy treatment capacity available at weekends (Sunday provision is particularly challenging).
- Inability to register patients unknown to the Centre over weekends – an IR(ME)R cannot be generated, and patients cannot be scanned nor treated.
- Radiology capacity to support decision making earlier during the day.
- Variation in use of terminology in health board radiology reporting resulting in some lack of clarity with respect to diagnosis.

- Timely access to health board patient level data (for example, NICE guidance requires that treatment begin within 24-hours of positive diagnosis. Needs to be determined whether this information can be routinely obtained in a timely fashion and is accurate).

Breakthrough
- Project team have identified range of change options that have not previously been considered.
- Regular bi-weekly meetings established for the team.
- Improved inter departmental relationships
- Patient process mapp for VCC completed highlighting bottlenecks and potential solutions - Cardiff and Vale UHB AOS team to cooperate on whole pathway work to be supported by Improvement Cymru.
- Engagement with palliative care team at Cardiff and Vale UHB.
- Engagement with WAST

Contact with clinical audit to regarding post-radiotherapy **Next Steps**
- SOP for lunchtime MDT meeting drafted and circulted to the regional AOS teams for comment.
- Develop communications package on transport booking, escalation, etc. for use at Velindre and in health boards.
- Consider options for routinely registering patients unknown to Velindre at weekends

SACT Telephone Helpline
- Aim: To improve the treatment helpline and ensure that there are clear pathways for escalation of deteriorating patients and eliminate helpline related patient harm.

Barriers
- Planned annual leave and clinical pressures resulting in less time available and hampered ability to attend national event.
- Awaiting implementation of interim telephony system changes from Operational Services.

Breakthroughs
- Revised (and approved) triage tool is now in use.
- Presentation to Exec Team at National Learning Event
- Time in Motion study agreed, and data collection sheet developed with support from IC
- Peer Review undertaken 12th and 13th December 2023. Findings expected to the Trust in February 2024.
- Met with Head of Patient Experience to discuss patient survey to capture the 'lived experience' of using the STH.

Next Steps
- Review KPIs
- Draft Patient Survey Questions
- Escalate Telephony System Phase1 changes (if unresolved)
- Consider Peer Review recommendations once available.

Learning Infographics

The learning infographics below show the themes from incidents, claims and are where Directorate leads are being asked to focus their efforts on learning, retraining and intervention. There are many improvement plans in place in all of the Directorates to address some of the themes. These

improvement plans are monitored through the Velindre Futures Board and through the IMTP for each Directorate.

Velindre Cancer Centre themes from incidents and feedback

Appointments	Staff Attitude / Behaviour	Clinical Services/Assessments
Communications issues (Including Language)	Infection Control	Monitoring and Observations
Access to Services and Resources	Test and Investigation	Patient Care

10.0	Performance

10.1 VCC Performance Summary

(**Appendix B**) to follow

11.0	Celebration and Exception

11.1 Celebrations

The VCC Immunotherapy Toxicity Service won the prestigious Macmilan Professionals Excellence Award for Innovation for their streamlined support to patients with toxicities from ear;y recognition to resolution and discharge. Its initiatives include same day emergency care, robust guidelines and pathways to standardise patient care, and collaborative multi-disciplinary team (MDTs).

To share their knowledge with clinical colleagues across the UK, the team have helped establish and co-ordinate a monthly National Immunotherapy Education Forum and have also co-created a weekly podcast called 'The Immunobuddies'.

The annual UK Oncology Nursing Society (UKONS) Conference 2023 was held at Newport this year and the work of some of our nurses, along with other colleagues, was recognised. We had a record 11 posters accepted and showcased at the conference. We were very proud that the cancer service had such great representation at the conference and was able to showcase all the fantastic projects that have been undertaken by some of our nurses, alongside other members of the MDT and neighbouring UHBs. We were also thrilled that Hannah Churchill (pictured left) was selected to present her work on the UKONS Digital Passport and Rhianydd Jones facilitated a lively discussion on the evolution of SACT from IV to SC. As a UKONS board member, Dr. Rosie Roberts chaired breakout sessions but also represented Velindre by also having a poster accepted. All posters and presentation were very well received by other delegates at the conference and we were very proudly waving the flag for Velindre.

Along with nine other employers from across Wales, the Trust was recognised for the outstanding support it gives to the Armed Forces Community at a special awards ceremony held at Hensol Castle.

12.0	Conclusions

There is evidence that incidents/concerns/compliments continue to be consistently managed appropriately and compliant with the PTR regulations, the VCC team have worked hard to achieve 100% compliance with the national KPIs. Lessons learned and actions are implemented and monitored by Directorate leads and their teams. Improvement continues in the identification on themes and trends amongst incident, concerns, and patient feedback with the Q&S Team working proactively with directorates to develop improvement plans and ensuring themes and trends are reflected in the clinical audit plan.

There is increased pressure and demand within SACT services which has resulted in business continuity being triggered, however it was not within this reporting period and a separate paper will be provided to QSP on this.

Compliance and engagement with the Duty of Candour is high throughout the cancer centre, and consideration given to the level of harm is evident.

Quality Safety and Performance Committee

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

Date of meeting	14/03/24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	**THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO JANUARY 2023/24 ARE:** **Velindre Cancer Service** **SACT Services:** - SACT non-emergency performance dropped to 65% compliance, from previous performance ranging between 90 and 95% over the last 12 months, against our target of 98%. This is due to constrained pharmacy capacity against an increase in demand during January 2024. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group established that has developed plans to increase capacity across the service. It is anticipated that these plans will positively affect performance by July 2024. - A demand forecast for SACT services, up to 2028/2029, has been completed. The outcome of this exercise is an assumption that SACT demand will increase by 8%-12% over the next five years. A demand focus response programme for 2024/25 has been established and the associated recovery plans will ensure that this anticipated level of demand can be met in line with requirements. - A weekly Gold command group has also been established to ensure Executive oversight and support in respect of SACT performance. A Gold Command addendum is attached. **Radiotherapy Services:** - Radiotherapy performance for January was reported as 79% in relation to patient treated within 21 days. This was due to an increase of treatments due to commence in January 2024 following the Christmas period. However, recovery to required delivery levels has been achieved in February 2024 (Note: not this current reporting period). **Welsh Blood Service:** - Despite being another challenging month, all clinical demand was met. The blue alert, issued in December 2023 to support increasing the stock position, was lifted on the 25th January. This has been assisted in part by the establishment of a Task & Finish Group that is examining workforce related pressures in the collection clinic model. **Financial Performance:** - 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 revised planned savings targets are achieved, and that any new financial risks that may emerge before the end of the financial year are mitigated for in 2023-24.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to: • NOTE and DISCUSS the January 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 February 2024
VCS SLT / Performance Review	20 February 2024
Executive Management Board – Run	29 February 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 NOT APPLICABLE

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

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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

1. **SITUATION AND BACKGROUND**
   VELINDRE NHST PERFORMANCE REPORT FOR JANUARY 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 January 2024 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance.

   1.1 **Cancer Centre Services Overview**
   Radiotherapy
   79% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in January, a drop in performance from 87% in December 2023 against a target of 100%. It is, however, expected that February performance will recover to the average compliance being reported towards the end of last calendar year. Plans are in development to compensate the planned spring bank holidays and the linac replacement programme, but this is expected to be challenging for the service.

Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment improved from 88% in December 2023 to 95% in January 2024 against a target of 100%.

95% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%). One patient breached, due to a compliance issue with the referral processes. The process has now been reviewed and safeguards put in place to prevent any further breaches occurring of this nature.

SACT
All patients (100%) received emergency SACT within the required timescales.

160 patients did not receive their non-emergency SACT within the required 21 days (65% compliance). This is due to constrained pharmacy capacity against an increase in demand during January 2024. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group has been established that has developed plans to increase capacity across the service. It is anticipated that these plans will positively impact performance by July 2024. A demand forecast analysis for SACT up to 2028/2029 has been completed. This has identified a forecast increase in demand between 8%-12% over this period. In response a demand focus plan for 2024/25 has been initiated and the recovery plans will ensure that this anticipated demand can be met. Weekly Gold command meetings have also been established to ensure Executive oversight and support in respect of SACT performance. A Gold Command addendum is attached

The greatest area of risk to achieving our required level of performance relates to SACT Pharmacy provision. However, we have identified a number of mitigating actions. These include buying in pre-prepared SACT, additional third party support and increasing VCC pharmacy capacity to manufacture and dispense treatment agents. This is all anticipated to have a positive impact on performance by July 2024.

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

Falls
There was an increase in the number of falls during January 2024. There were 8 patients who fell against an average of 4 falls per month. However, no patient experienced any harm from their fall. Each patient fall has been investigated and reviewed by the falls scrutiny panel. From these investigations it was deemed that each fall was unavoidable.

Welsh Blood Service Overview

Despite being another challenging month, all clinical demand was met. The blue alert, issued in December 2023 to support increasing the stock position, was lifted on the 25th January. This has been assisted in part by the establishment of a Task & Finish Group that is examining workforce related pressures in the collection clinic model.

There is an increase in Quality incident investigations closed within 30 days, which remains above target (90%) once again at 93% in January. This performance reflects the improvement in timely closure of Datix reports in the past month. No adverse event reports were submitted to the Medicines and Healthcare Regulatory Agency (MHRA) or the Human Tissue Authority (HTA) and no serious hazards of Transfusion (SHOT) incidents were reported this month.

Donor satisfaction continues to perform strongly in January and was above target at 96% (95% target). 7,906 donors were registered at donation clinics and 9 informal concerns was raised (0.11% of all donors registered). All the concerns were managed as early resolutions and responded to, to the donor's satisfaction within 48 hours. No formal concerns were raised in January 2024.

All clinical demand for platelets was met representing a strong performance against this metric. At 9%, platelet wastage met target (10%) again for January. There has been significantly improved performance against the platelet wastage target since April 2023.

The total cell provision for the service in January 2024 was 7 (7 stem cell collections from Welsh donors and 1 cell product imported for Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 45-50 at year end. The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures. Bespoke swab only recruitment sessions were introduced towards the end of January and an increase in new bone marrow volunteers is expected from February onwards.

1.2   Workforce and Wellbeing
Sickness
Overall sickness remains high with the current rolling absence of 5.35% to January 2024, above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%.

PDAR's (staff appraisals)
Trust wide PADRs this month is 74% (target 85%). This is an improved performance over the last three months.

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

1.3   Patient and Donor Experience
Velindre Cancer Centre uses two patient satisfaction surveys. In January performance against 'Would you recommend us?' was 89% and 'Your Velindre experience?' was 98% both set against the 85% target.

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

1.4   Digital Services

Performance largely stable – largely unchanged from December 2024.

Planning for implementation of a new IT Service Management tool has commenced, with work to deploy anticipated to start in late-February 2024. Deployment should improve performance across a range of service areas, as well as improve various regulatory and administrative activities – e.g. asset management.

Rolling 12-month position for the number of significant IT business continuity incidents continues to steadily improve, down slightly again in January 2024 to 10 incidents in the last 12 months. Significant improvement in performance anticipated from February 2024, due to overall improvement in stability through 2023. Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. There was on significant incident in January 2024 – a telephony failure that affected external (inbound and outbound) call across all Trust sites for approx. 2 hours on the evening of 30th January 2024. The root cause has already been identified and remediated to prevent risk of re-occurrence.

Reporting arrangements for two remaining (2) indicators are still being developed, delayed due to recruitment challenges and capacity:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role, this role has now been filled – new starter due to commence in post early December 2023.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

A number of new metrics have been drafted, to demonstrate Trust performance against the various objectives set out in the recently-published Digital Strategy. Internal discussions on their inclusion on the PMF are ongoing; however, the aim is to commence reporting of these indicators from February 2024. The 5 measures are as follows:

- % of outpatient consultations performed virtually

- % of donors booking online
- % compliance with cyber security statutory & mandatory training
- % of Trust expenditure in digital
- Hours saved through digitisation / automation of paper-based manual processes

1.5   Estates Infrastructure and Sustainability

The period through to January has seen consolidation of levels of compliance for Planned Preventive Maintenance (PPM) and reactive tasks which are currently listed as green for the North Wales' sites and Trust HQ. VCC is slightly under benchmark standard of 95% benchmark due to newly appointed staff obtaining site familiarity and training courses attended by technicians. There has also been a number of staff off sick during this period. Recruitment completed within the Estates Team. Successfully appointed VUNHST Trust Health and Safety manger with a planned start date 11th March.

The Trust have appointed a bureau (Team Sigma) to manage the validation of utility bills which will improve the management position. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data. This is becoming a month-on-month issue. There have been some teething issues with the new NHS Wales gas & electricity suppliers. These are being worked through by the Trust and some of the utilities graphs contained in this document may be subject to change as a result of this.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation. Fire Safety Manager has continued to work with departments to improve training compliance through bespoke in person scheduling to suit departmental requirements.
Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward.

1.6   Finance

The overall position against the profiled revenue budget to the end of January 2024 is underspent by £0.015m and is currently expecting to achieve an outturn forecast of **Breakeven.**

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 revised planned savings targets are achieved, and that any new financial risks that may emerge before the end of the financial year are mitigated for in 2023-24.

The latest approved Capital Expenditure Limit (CEL) as of January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to January'24 of £22.987m and is currently forecast to remain within the overall CEL. The Trust has now received the funding award letter towards the nVCC project costs and once signed and returned will officially form part of the CEL.

During January '24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

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

In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. In addition, the reserves position continues to be under review with the option that if the emergency reserve is not fully required during the remainder of 2023-24 then it will be offered to support the NHS Wales position on a non-recurrent basis.

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

2.1   The Performance Management Framework (PMF) Scorecards, in this Section, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.
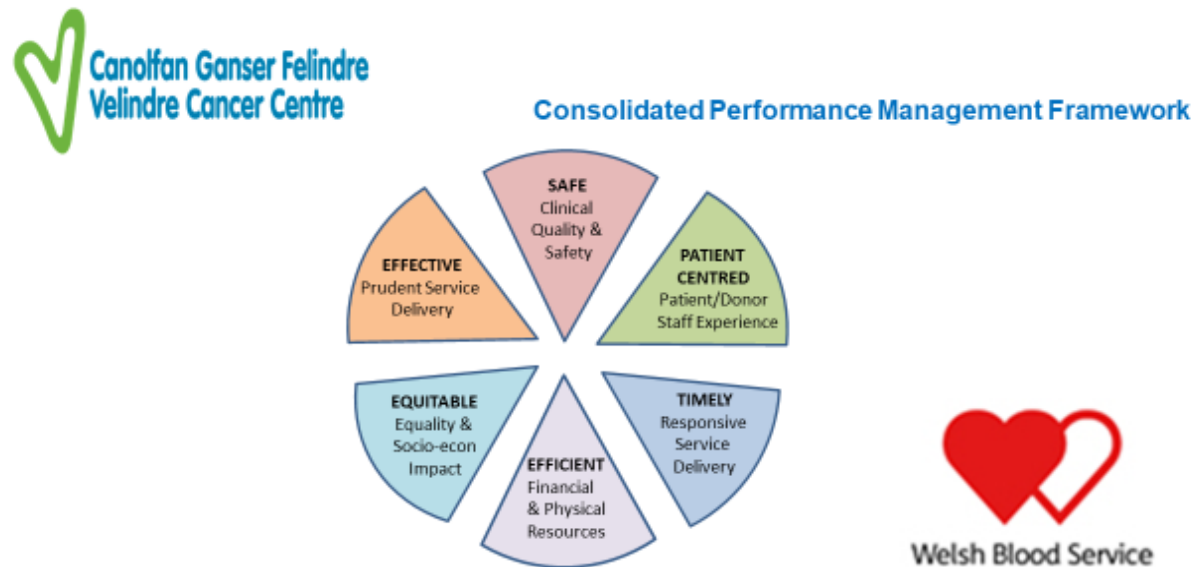
2.2   Navigating our PMF Performance Report

The following PMF Scorecards incorporate hyperlinks to supporting Key Performance Indicator (KPI) data and analysis, enabling switching between the high-level positions to detailed analysis provided in **Appendices 1 to 3**

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

Quality Safety & Performance (QSP) Committee Scorecard as at January (Month 10) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	86%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA Bacteraemia	National	Monthly	0	0	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	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99%	✓	→	KPV.08
	Number of National VCS Reportable Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	0	✓	↑	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	10	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓	→	EST.06

PMF Performance Report January 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 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	3	✗	⬇	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	109%	✓	⬆	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.01%	✓	➡	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	115%	✓	⬇	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	9%	✓	⬆	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	7	✓	⬆	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.35%	✗	⬆	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%	95%	89% 98%	✓	➡	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	96%	✓	⬆	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	➡	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A	✓	➡	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	18% 79%	✗	⬇	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	8% 95%	✗	➡	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	95% 95%	✗	⬇	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 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%	85% 89%	✗	⬇	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	65%	✗	⬇	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	➡	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%	✓	⬆	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	100%	✓	⬆	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.015 m	✓	➡	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£22.987m	£22.9872	✓	➡	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.543 m	£0.890 m	✗	⬇	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.456 m	£1.456 m	✓	➡	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	➡	FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	TBA	TBA	✓	➡	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.62%	✓	➡	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	5.33%	✓	➡	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	9.41%	✓	➡	WOD.81

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

PMF Performance Report January 2023/24

3. IMPACT ASSESSMENT

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

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

4. **RISKS**

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Number of VCC Inpatient Falls per month	
Target: 0 Avoidable	**SLT Lead: Head of Nursing**

| Current Performance against Target or Standard | Performance |

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul2 3	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual Number	4	5	2	0	4	2	0	3	5	5	3	5	3	6	8
Avoidable Falls	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

No avoidable falls in January 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

SPC Chart Inpatient Falls per month Target NIL (avoidable)

SPC Chart Analysis

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

Number of VCC Acquired Pressure Ulcers per month (Inpatients)														
Target: 0 Avoidable														
Current Performance against Target or Standard														

VCC	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**	**Jul 23**	**Aug 23**	**Sep 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**
Actual Number	1	1	0	0	1	0	0	0	2	2	3	0	2	2	1
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SLT Lead: Head of Nursing

Performance

There was 1 unavoidable pressure ulcer in January 2024.

SPC Chart Acquired Pressure Ulcers per month Target NIL

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

Service Improvement Actions – Immediate (0 to 3 months)		
Identified members of the nursing team to receive individual teaching/updates. Updated communications in the daily Big 4	**Timescale:** End of January 2024	**Lead: Ward Manager**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

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PMF Performance Report January 2023/24

Statutory and Mandatory (S and M) Training Compliance	
Target: 85%	**SLT Lead: WOD Business Partner**
Current Performance against Target or Standard	**Performance**

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	87	87	88	87	87	87	87	88	88	88	87	86	86	86	86
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

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.

SPC Chart Statutory & Mandatory Training Target 85%

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

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

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

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Hospital Acquired Thromboses	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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KPI Indicator KPV.04

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

Incidence of Healthcare Acquired Infections for the period Oct 2022 to Dec 2023

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
C.diff	0	1	1	0	0	1	0	0	0	0	0	1	0	1	0
MRSA bacteraemia	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
MSSA bacteraemia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteraemia	0	1	3	1	0	1	0	1	1	0	1	0	0	0	0
Klebsiella bacteraemia	0	0	1	0	0	1	1	0	1	1	0	0	0	0	0
Pseudo Aerugi bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg bacteraemia	0	1	4	1	0	3	1	1	3	1	1	1	0	0	0

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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PMF Performance Report January 2023/24

KPI Indicator KPV.08

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

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
VCS Hand Hygiene								100%	100%	99%	99.6%	100%	99%	100%	97.5%
WBS Hand Hygiene								100%	99.2%	99%					99.8%
Trust Hand Hygiene								100%	100%	99%					98.6%
IPC Validation								100%	100%	100%	99.4%	100%	96%		100%
Target 100%	0	0	0	0	0	0	0	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: IPC
- Weekly validation audit by IPCT		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

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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)															
Current Performance against Target or Standard															

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

[Currently under development]

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

SLT Lead:

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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		Performance

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual	0	2	0	2	0	0	2	0	1	2	1	0	4	1	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assessment of current performance, set out key points:
There were no adverse events submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in January.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead: Peter Richardson
The completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Operational Managers are exploring opportunities to share learning through formal staff engagement sessions, to promote discussion	**Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Incidents Reported to Regulator/Licensing

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

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
VCC	7	9	5	2	9	4	3	4	6	9	6	4	7	4	5
WBS	11	2	3	3	6	2	10	1	9	6	8	7	4	2	5
Corporate	0	0	0	0	0	2	0	1	0	2	0	0	0	0	0

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

Target: 0

Current Performance against Target or Standard - Level

SLT Lead: Carl James

Performance - remains stable

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

Actions: As above	Timescale:

Expected Performance gain

Risks to future performance
 Incomplete incident investigation – ongoing monitoring

Total Number of Incidents by Division

% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline	
Target: -16% by 2025	**SLT Lead: Asst. Director of Estates**
Current Performance against Target or Standard	**Performance**

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual Number	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33	86.37	85.36	105.00	117.56	137.40	
Target (-3% from previous years emissions)	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858	95.86	102.66	132.22	187.67	205.74	

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
-

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

EFFECTIVENESS

KPI Indicator KPV.05

Number of Pathway of Care Delays		
Target: NIL		**SLT Lead: Head of Nursing**
Current Performance against Target or Standard		**Performance**

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual PoCDs Number	1	0	0	1	1	1	4	3	8	3	3	3	3	2	3
Days Delayed									32	19	43	73		5	
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:

There were 2 Pathway of Care delays reported in January 2024

Patient 1: Delayed Transfer of Care with a delay of 4 days due to lack of capacity within HB.

Patient 2: Delayed Transfer of Care with a delay of 3 days due to lack of capacity within HB.

There was 1 Repatriation delay reported in January 2024

Patient 1: Awaiting repatriation to local hospital with a delay of 1 day.

Number of Pathways of Care Delays Target NIL

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	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 Llais Cymru to discuss/address delays affected by social services and how Llais may be able to support improvement work in this aspect.		Matthew Walters Operational Senior Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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	% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE														

Target: 100%								**SLT Lead: Jayne Davey / Georgia Stephens**							

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

	Nov 22	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**June 23**	**July 23**	**Aug 23**	**Sep 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**
Actual %	115	94	106	103	104	104	97	110	105	102	95	101	107	97	109
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Performance

Performance on this metric has met target in January.

The average weekly demand in January was 1398 compared to December at an average of 1350 units per week.

Overall, the stock position improved throughout January, with the Blue alert removed on 25th January.

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

% Red Cell Demand Met

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term N/A

Risks to future performance

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

SPC Chart Red Blood Cell Demand Target 100%

SPC Chart Analysis

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

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

SLT Lead: Georgia Stephens

| Current Performance against Target or Standard |

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	0.33	0.36	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0	0	0	0	0.01
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

Performance

Assessment of current performance, set out key points:
Performance of this metric has met target in January 2024, with minimal Red Cell expiry recorded.

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

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

SPC Chart Time Expired Red Blood Cells Target 1%
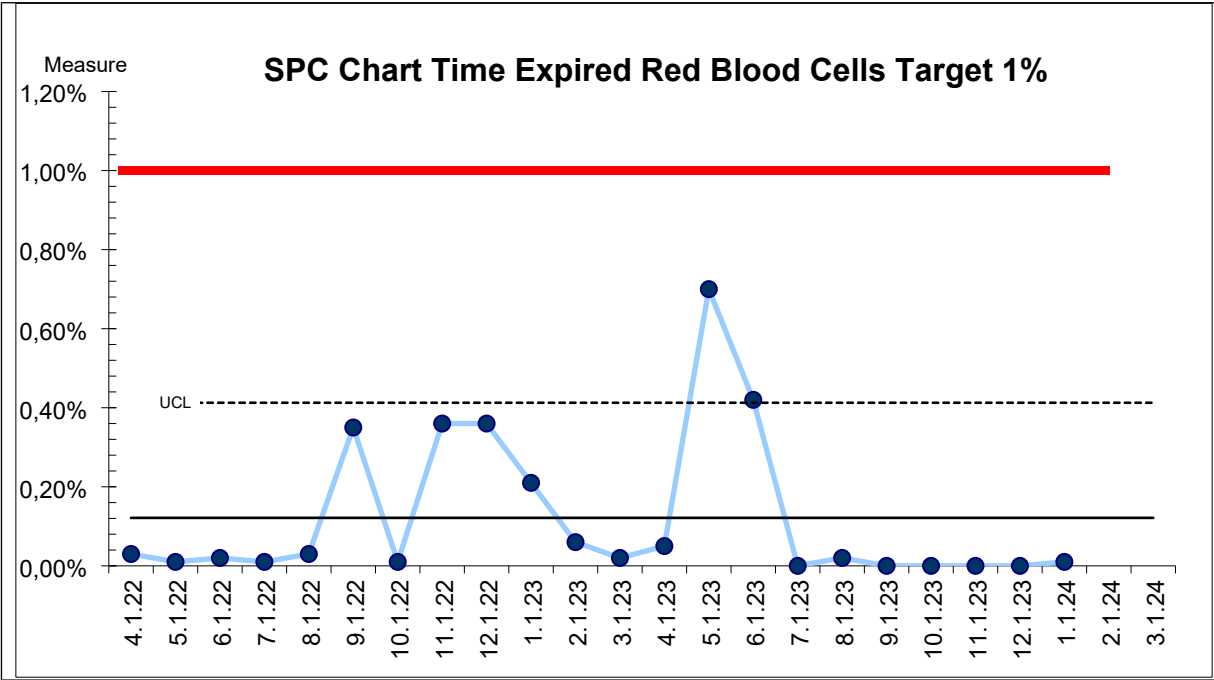
SPC Chart Analysis

The SPC chart shows common cause variation over the last 6-month period, with one 'special cause variation' in the month of May. However, the average performance of 0.15% remains well within the maximum 1%

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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	**Performance**

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	139	145	141	168	133	127	117	114	120	125	121	122	115	125	115
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Assessment of current performance, set out key points:

All clinical demand for platelets was met in January, representing a continued strong performance against this metric.

% Platelet Demand Met

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

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 work stream 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 work stream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q1 2024/25	**Timescale:** Q1 2024/25 **Lead:** Georgia Stephens

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

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

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SPC Chart Platelet Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 135% consistently exceeding the 100% target.
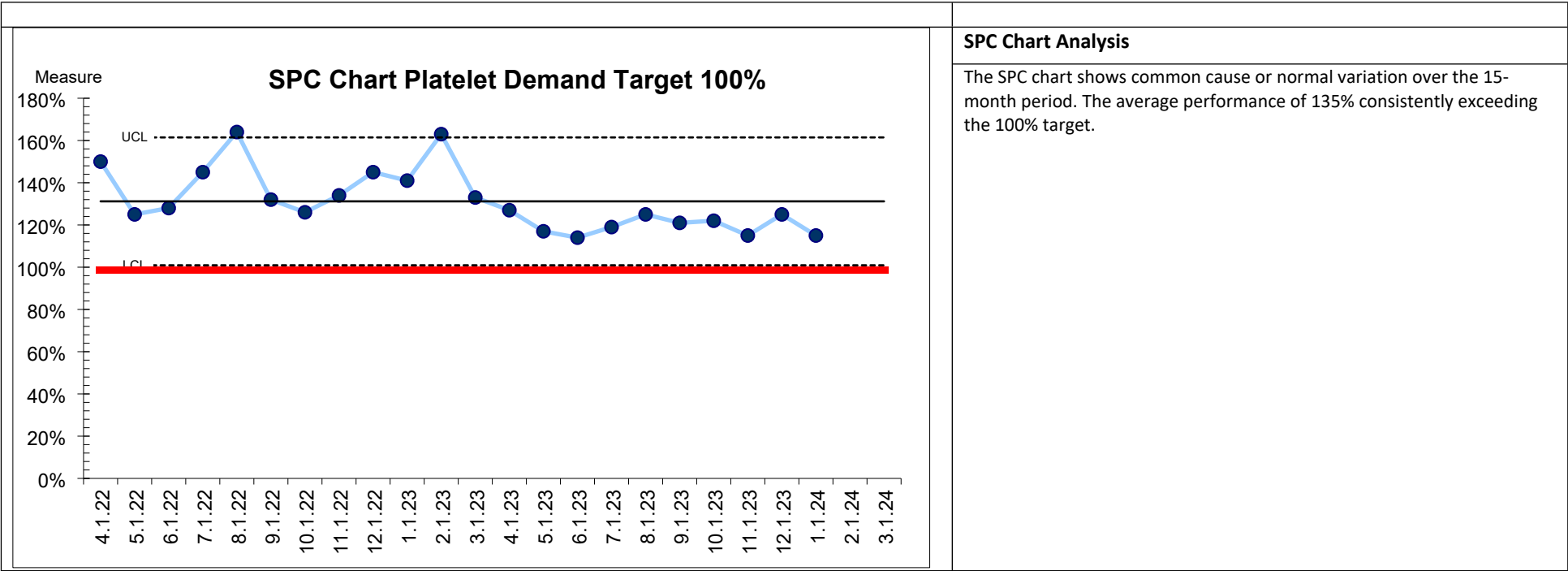
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13/03/2024 14:14:09

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

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	15	27	23	25	20	10	8	9	12	12	11	11	10	10	9
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Time Expired Platelets

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.

Performance

Assessment of current performance, set out key points:
At 9%, performance met target for January.

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
A work stream 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 work stream meetings have been initiated, work is underway on the scope and prioritisation	Q1 2024/25 **Lead:** Jayne Davey/ Georgia Stephens

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

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

Risks to future performance

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

SPC Chart Analysis

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

SPC Chart Time Expired Platelets Target Max Wasteage 10%

Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum	SLT Lead: Deborah Pritchard

Current Performance against Target or Standard	Performance

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Cumulative Actual	15	19	23	26	32	3	6	12	18	21	26	33	35	38	44
Cumulative Target p/a	56	63	70	77	84	7	14	21	28	35	42	49	56	63	70

Performance

At 7 total stem cell provision for January the service met target. January performance compiled of 6 Peripheral Blood Stem Cell (PBSC) collections and 1 import for a Welsh patient.

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

The service is seeing a gradual increase in activity for this year with a current projected outturn of 45-50 at year end (against a target of 80).

NB: The Projected Forecast detail does not include stem cells collection sourced globally for patients in Wales.

Stem Cell Collections

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

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Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being developed to support the ongoing development of the WBMDR. This is part of WBS Futures programme. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	**Timescale:** Q4 **Lead:** Deborah Pritchard

Expected Performance gain - immediate. As above

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

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

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

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	6.19	6.19	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75	5.70	5.63	5.50	5.35
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Assessment of current performance, set out key points:
There is a continued decline in sickness stats as the People and Relationship Team continue to support managers in the application of the MAWW policy.

Short-term absence remains relatively low across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken • ICT (closed) • RD&I(closed • Private Patients (Closed) Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken	Ongoing	Head of Workforce 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 • 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	30/04/2024 Ongoing	Head of OD Head of OD and Trust Board

SPC Staff Sicknesss National Target 3.54% Local 4.7%

SPC Chart Analysis

PMF Performance Report January 2023/24

The SPC chart shows an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target	Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance - Not having enough staff available due to sickness absence could impact on delivery of services across the Trust - Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

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Performance and Development Reviews (PADR) % Compliance															

Target: 85%													SLT Lead: WOD Director		

Current Performance against Target or Standard													Performance		

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	76	77	77	74	73	73	72	73	74	74	74	71	72	74	74
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

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

SPC Chart PADR Target 85%

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

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Would you recommend us? %	nda	nda	93	96	95	95	98	96	97	97	95	95	94	95	89
Your Velindre Experience? %	nda	nda	84	86	82	82	68	71	91	94	63	83	87	95	98
Target CIVICA 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

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

Very Good 78.57% = Good 10.71% = 89.28%

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

Excellent (10/10) 82.76 + Very good (9/10) 8.62% + Good (8/10) 6.9% = 98.28 %

Reset Target to CIVICA 85%

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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	66	78.57%
Good	9	10.71%
Neither good nor poor	2	2.38%
Poor	5	5.95%
Very poor	2	2.38%
Don't know	0	0.00%
Total	84	100%

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

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
10	48	82.76%
9	5	8.62%
8	4	6.90%
7	0	0.00%
6	0	0.00%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	1	1.72%
0	0	0.00%
Total	58	100%

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

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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 — **Performance**

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	95	97	97	95	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Assessment of current performance, set out key points:
At 96.3%, donor satisfaction is above target for January. In total there were 1,341 respondents to the donor survey, 281 from North Wales (scoring satisfaction at 97.7%), and 831 from South or West Wales (scoring satisfaction at 95.0%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve
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.

Timescale: Business as usual, reviewed monthly
Lead: Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Timescale: Q4 2023/24
Lead: Andrew Harris

Expected Performance gain – longer-term.
N/A

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

Donor Satisfaction chart

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KPI Indicator KPV.12

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

Performance

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:
- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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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		**Performance**

WBS	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/a
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Assessment of current performance, set out key points:
No formal concerns were due to be reported in January 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.

% Responses to Concerns closed within 30 Working Days

(Chart: Oct-23 = 100%, Nov-23 = 100%; Jun-23 = 0%, Jul-23 = 0%; Apr-23, May-23, Aug-23, Sep-23, Dec-23, Jan-24 = NA)

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

TIMELINESS

KPI Indicator KPV.14

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

Scheduled Elective RT COSC within 14 & 21 days

21% of RT patients (Jan) (43) breached the 100% referral to treatment within 21 days target

79% of RT patients (Jan) 37 + 125=162) met the 100% referral to treatment within 21 days target

Only 18% of RT patients (Jan) (37) met the 80% referral to treatment within 14 days target

Legend: Patients <14 days (green); Patients <21 days (yellow); Patients >21 days (red)

SPC Chart Analysis

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

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	205	
treated within 14 days of referral (80% target)	36	18%
treated within 21 days of referral (100% target)	162	79%

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

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

Sickness absence levels in radiotherapy workforce

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

Current Performance against Target or Standard section:

Scheduled Urgent RT COSC within 2 & 7 days

5% of RT patients (Jan) (2) breached the 100% referral to treatment

95% of RT patients (Jan) (3 + 35 = 38) met the 100% referral to treatment within 7 days target

8% of RT patients (Jan) (3) met the 80% referral to treatment within 2 days target

Legend: ■ Patients <2 days   ■ Patients <7 days   ■ Patients >7 days

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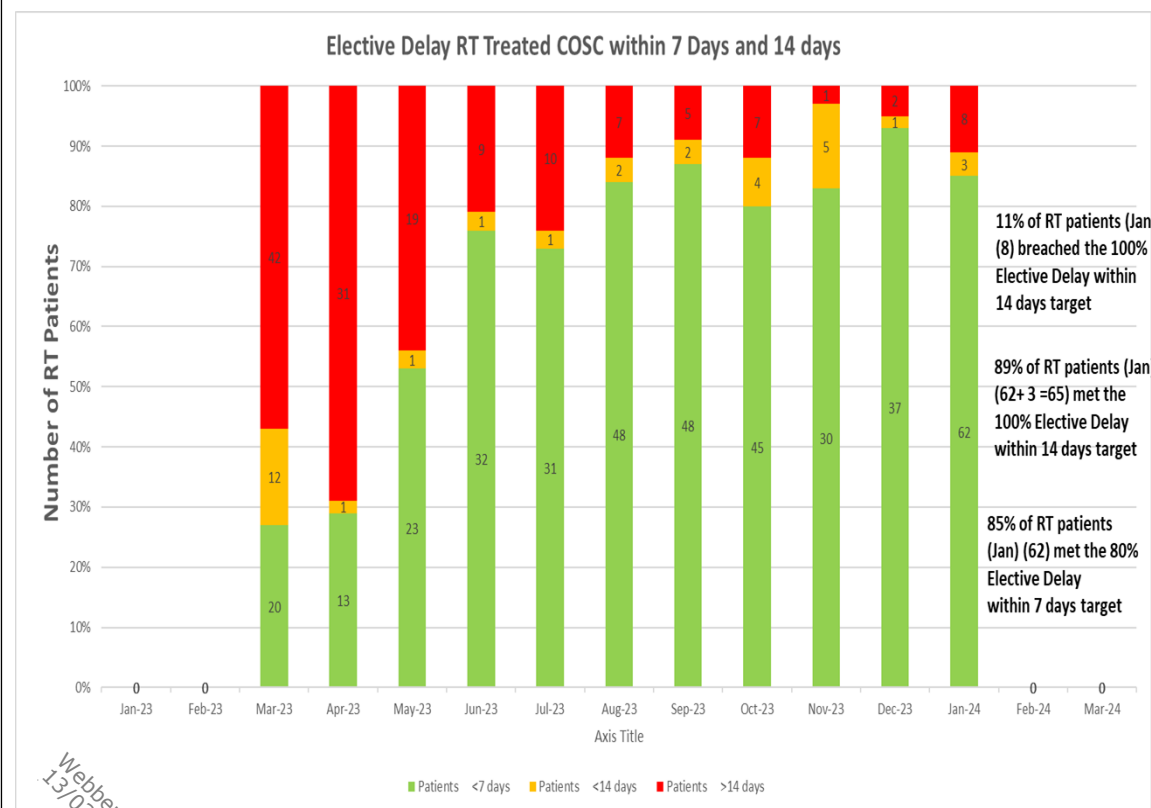
Performance section:

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

Number of referrals	40
treated within 2 days of referral (80% target)	3	8%
treated within 7 days of referral (100% target)	38	95%

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	Helen Payne/ Thomas Rackley	April 2024

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
  •
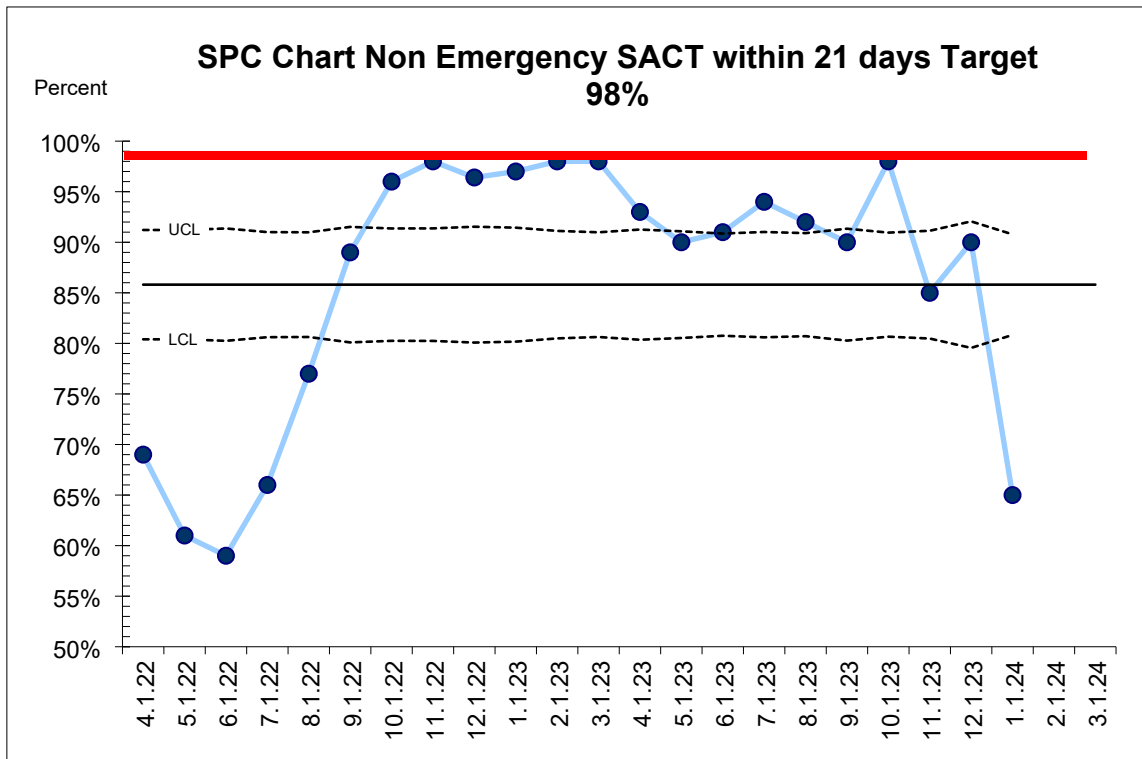
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Emergency Radiotherapy Patients Treated Within 1 Day	
Target: 80% within 1 Day and 100% within 2 Days	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

<table>
<tr><td rowspan="2">

Emergency RT COSC within 1 day

5% (1) RT patient (Jan) treated over 48 hours

95% of RT patients (Jan) (17) met the 100% referral to treatment within 1 day target

</td><td colspan="3">**Assessment of current performance, set out key points:**
Target Achieved</td></tr>
<tr><td>Number of referrals</td><td colspan="2" align="center">18</td></tr>
</table>

80% treated within 1 day of referral	17	95%
100% treated within 2 days of referral	17	95%

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	

SPC Chart Analysis

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

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

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.

Elective Delay RT Treated COSC within 7 Days and 14 days

11% of RT patients (Jan) (8) breached the 100% Elective Delay within 14 days target

89% of RT patients (Jan) (62+ 3 =65) met the 100% Elective Delay within 14 days target

85% of RT patients (Jan) (62) met the 80% Elective Delay within 7 days target

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

Performance

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

Number of referrals	73	
treated within 7 days of referral (80% target)	62	85%
treated within 14 days of referral (100% target)	65	89%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	•

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

Non-Emergency SACT Patients Treated Within 21-Days		
Target: 98%		**SLT Lead: Head of Medicines Management and SACT**
Current Performance against Target or Standard		**Performance**

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	98	96	97	98	98	93	90	90	94	92	90	98	85	90	65
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	6	12	9	9	8	26	40	40	25	32	35	10	57	29	160
Within 21 days	354	322	336	388	409	343	354	378	370	380	323	414	329	251	283

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	2,811	2,414	2661		

Performance

January 24:

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	65	33	30	32

The longest wait was 56 days.
Demand continues in excess of predicted levels.
Pharmacy capacity remains the main challenge to delivering required activity levels to meet demand.

All patients within a Trial are booked within Trial timeframes.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	Timescale	Lead
Increased pharmacy production capacity through: 1) Reconfiguration of accommodation to deliver increased aseptic capacity following capital approval received December 2023. Build completion expected March 2024. Capacity increase expected June/July 2024.	31/06/2024	BT
2) Agreed increase on mobile unit from 14 to 20 patients daily x 2 days weekly.	31/06/2024	BT
3) provide cleaning provision from operations to allow for potential release pharmacy staff on weekends to produce additional regimens	31/06/2024	MD/MRM

Expected Performance gain – immediate

Not until June 2024

SPC Chart Non Emergency SACT within 21 days Target 98%

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Nursing: international nurse recruitment and preceptorship recruitment	01/05/24	AB
• Develop outsource model in advance of TrAMS implementation	TBC	BT
• Realign working patterns at outpatient clinics to maximise daily throughput.	01/05/24	NH/CM

Expected Performance gain – longer-term

Risks to future performance

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

SPC Chart Analysis

The SPC chart shows a reduced performance in January 2024.

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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	Performance

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	83	100	75	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	1	0	1	0	0	0	0	0	2	0	0		1	0
Within 5 days	6	5	8	3		5	0	12	10	5	8	4		7	9

Performance

Target achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

SPC Chart Emergenct SACT within 5 days Target 100%

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

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														

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	87	97	96	96	96	95	98	97	96	96	96	92	95	97
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Antenatal Turnaround Times

Performance

Assessment of current performance, set out key points:
At 97% the turnaround time performance for routine Antenatal tests continued to exceed target in January 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 Antenatal Turnround Time 3 days Target 90%

SPC Chart Analysis

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

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KPI Indicator KPI.17

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	97	96	60	92	97	98	97	98	99	100	99	100	98	100
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

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

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

Performance

There was excellent performance during Quarter 3 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 100% in January 2024 & performance averaged 99% in quarter 3, meeting target and showing consistent high performance.

Service Improvement Actions – Immediate (0 to 3 months)

N/A | Timescale: | Lead:

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

Anti D & -c Quantitation — 84%, 97%, 99%, 98%

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Anti D & C Results within 5 days Target 90%
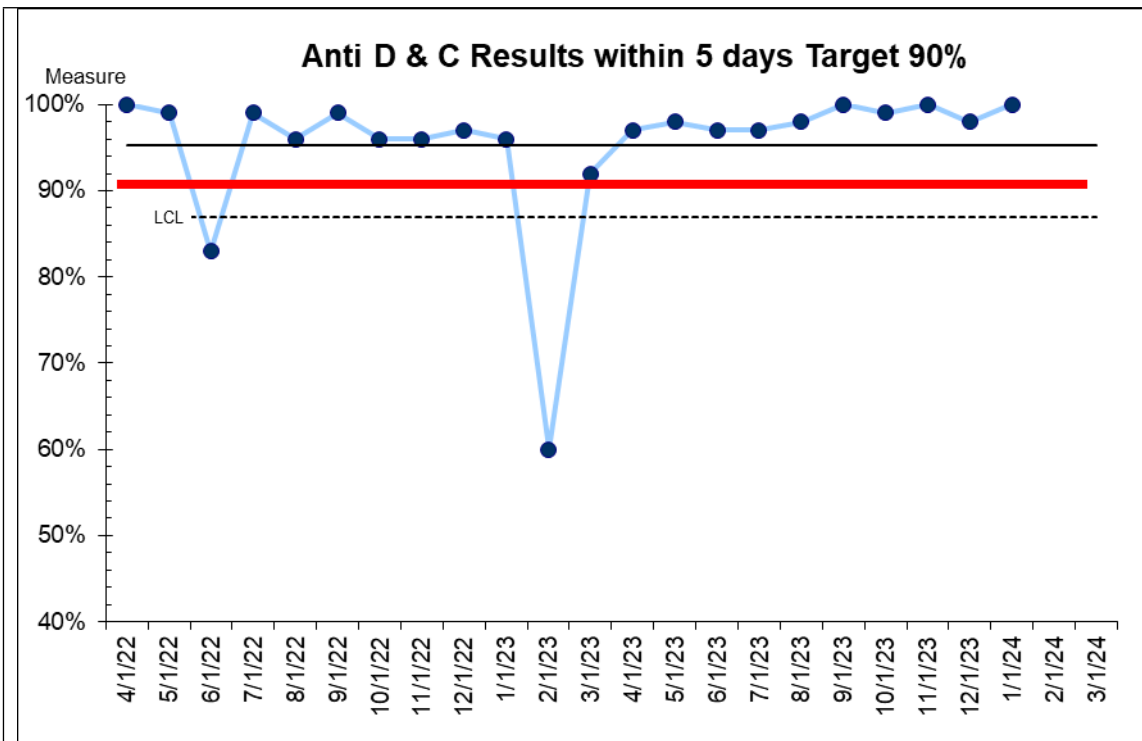
SPC Chart Analysis

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

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EFFICIENT

<mark>**KPI Indicator FIN.71**</mark>

Financial Balance – Revenue Position		
Target: Net Zero Trajectory		**SLT Lead: Director of Finance**
Current Performance against Target or Standard		**Performance**

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

Trust-wide Revenue Position as at January 24

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(34.733)	(34.733)	(0.000)	(41.347)	(41.347)	(0.000)
RD&I	(0.281)	(0.280)	0.001	0.091	0.091	0.000
WBS	(18.356)	(18.354)	0.001	(21.703)	(21.703)	0.000
Sub-Total Divisions	**(53.369)**	**(53.367)**	**0.000**	**(62.959)**	**(62.959)**	**(0.000)**
Corporate Services Directorates	(11.052)	(11.050)	0.002	(13.204)	(13.203)	0.000
Delegated Budget Position	**(64.422)**	**(64.417)**	**0.005**	**(76.163)**	**(76.163)**	**0.000**
TCS	(0.605)	(0.594)	0.010	(0.744)	(0.744)	0.000
Health Technology Wales	(0.109)	(0.109)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	65.136	65.136	0.000	77.024	77.024	0.000
Trust Position	**0.000**	**0.015**	**0.015**	**(0.000)**	**0.000**	**(0.000)**

Performance

The overall position against the profiled revenue budget to the end of January 2024 is underspent by £0.015m and is currently expecting to achieve an outturn forecast of Breakeven.

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 revised planned savings targets are achieved, and that any new emerging financial risks are mitigated during 2023-24.

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

In response to the letter the options were considered to contribute c£2m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:** M Bunce
Actions addressed through Divisional Action Plans		

NHS Wales Financial Pressures Contribution

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

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.73

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

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual (Cum)	27.8	1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m		
Target £26.4075 CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m		

Capital Position as at December 2024

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	9.579	0.000	1.317	10.896	0.000
nVCC - Project costs	0.000	2.818	0.000	(2.818)	3.243	(3.243)
nVCC - Advanced Design Works	3.882	3.863	0.000	0.019	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000	0.000	0.898	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	0.000	(0.014)	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	5.211	0.000	2.615	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.073	0.000	0.074	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.113	0.000	0.055	0.168	0.000
Digital Cyber Security	0.051	0.000	0.000	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.000	0.000	0.085	0.085	0.000
Digital DPIF - EPMA	0.100	0.000	0.000	0.100	0.100	0.000
Digital WHAIS	0.250	0.000	0.000	0.250	0.250	0.000
Capital Year End Spend	0.257	0.000	0.000	0.257	0.257	0.000
Total All Wales Capital Programme	24.724	22.569	0.000	2.155	27.981	(3.257)
Discretionary Capital	1.683	0.418	0.000	1.265	1.683	0.000
Total	26.407	22.987	0.000	3.420	29.664	(3.257)

The approved Capital Expenditure Limit (CEL) as at January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.**

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

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

In January the Trust was awarded a further £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ring-fenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January. The allocation has provided funding to support the following prioritised schemes.

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG during this September, with the caveat that the funding will be re-provided in future years.

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities. In addition, a further £0.250m was ring-fenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the

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14th February. The £0.250m will now be released and considered for redistribution against prioritised schemes at the next Capital planning group meeting.

NHS – All Wales Capital Prioritization

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 31st March 2024 which coincides with the IMTP submission. The prioritisation from must be completed for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received. The forms will be presented to EMB Shape on the 18th March before being submitted to WG.

Performance to date

The actual expenditure to January 2024 on the All-Wales Capital Programme schemes was £22.569m, this is broken down between spend on the nVCC enabling works £9.579m, nVCC Project Costs £2.5818, nVCC Advanced design works £3.863m, nVCC Advanced works £0.898m Whitchurch Hospital Site £0.014m, IRS £5.211m, IRS RSC £0.073m and Digital RISP £0.113m.

Spend to date on Discretionary Capital is currently £0.418m.

Year-end Forecast Spend

The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL.

All schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.

The CEL was fixed by WG at the end of October (for all capital programmes apart from the nVCC Project as highlighted above), after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.

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		Service Improvement Actions – Immediate (0 to 3 months)		
		Actions: what we are doing to improve •	Timescale: XX/XX/XX	Lead: AN Other
		Expected Performance gain - immediate		
		Service Improvement Actions – tactical (12 months +)		
		Actions: what we are doing to improve •	Timescale: XX/XX/XX	Lead: AN Other
		Expected Performance gain – longer-term		
		Risks to future performance		

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Trust Position	**22/23**	**Apr 23**	**May 23**	**Jun 23**	**Jul 23**	**Aug 23**	**Sep 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**	**Mar 24**
Actual	1.323	88	77	86	**75**	109	117	83	95	68	90		
Target (per IMTP) £0.543M Forecast	**543**	115	115	115	58	50	50	16	16	8	0	0	0

Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

The spend on agency for Jan'24 was **£0.090m** (Dec £0.068m), which gives a cumulative year to date spend of £0.890m and a current forecast outturn spend of circa **£1.035m** (£1.323m 2022/23).

Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: Matthew Bunce
• Actions addressed via Divisional action plans		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

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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

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	**0.132m**	0.137m	0.137m	0.254m	0.167m	0.167m	0.172m		
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.1727m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

Cummulative monthly savings achieved compared to target

■ Cumulative Achieved Savings   ■ Cumulative Target Savings

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The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the £0.391m of underlying surplus which had been carried forward from 2022/23.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness
The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days														
Target: 95%													**SLT Lead: Finance Director**	

Current Performance against Target or Standard

	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98	96	98	97	98	98	98		
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During January '24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.	31/03/2024	M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

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EQUITABLE

% of Workforce not declared Welsh Language Listening/Speaking capability														

Target: TBA%														

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	11.63	-	-	10.30	-	-	9.81	-		9.41	
Target %	-	-	-	-	0%	-	-	0%	-	-	0%	-			

Performance

Assessment of current performance, set out key points:
- Welsh Language declaration 'not stated' recorded quarterly
- Target agreed as 0% non-declaration

Trust
Welsh Language (Listening/Speaking)
31st Dec 2023

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1077	1689	63.77%
1 - Entry/ Mynediad	236	1689	13.97%
2 - Foundation / Sylfaen	64	1689	3.79%
3 - Intermediate / Canolradd	41	1689	2.43%
4 - Higher / Uwch	50	1689	2.96%
5 - Proficiency / Hyfedredd	62	1689	3.67%
Not Stated	159	1689	9.41%
Grand Total	**1689**	**1689**	**100%**

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
- insert text

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Mean Gender Pay Gap – Annual	
Target: TBA%	SLT Lead: Director of Workforce and OD
Current Performance against Target or Standard	Performance

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	13.45	-	-	-	-	-	-	-			
Target TBA%	-	-	-	-	TBA	-	-	-	-	-	-				

Assessment of current performance, set out key points:
- Gender pay gap position recorded as at March 2023
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Trust
Gender Pay Gap
31st Mar 2023

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£22.25	£17.94
Female	£19.26	£16.84
Difference	£2.99	£1.09
Pay Gap %	13.45%	6.10%

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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Diversity of Workforce – % Black, Asian and Minority Ethnic people														
Target: TBA%														

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard														

Performance

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	5.18	-	-	4.56	-	-	5.45	-		5.62	
Target TBA%	-	-		–	TBA	-	-	TBA	-	-	TBA	–			

Assessment of current performance, set out key points:
- Staff ethnic origin recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

Trust		
Ethnic Origin		
31st Dec 2023		

Ethnic Origin	Headcount	%	BAME %
Asian	52	3.08%	**5.62%**
Black	17	1.01%	
Chinese	11	0.65%	
Mixed	15	0.89%	
Not Stated or Unspecified	86	5.09%	
Other	10	0.59%	
White	1498	88.69%	
Grand Total	**1689**	**100%**	

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

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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	**Performance**

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	4.63	-	-	4.9	-	-	4.9	-		5.33	
Target TBA%	-	-	-	-	TBA	-	-	TBA	-	-	TBA	-			

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

Trust

Disability

31st Dec 2023

Disability	Headcount	%
No	1396	82.65%
Not Declared	48	2.84%
Prefer Not To Answer	12	0.71%
Unspecified	143	8.47%
Yes	90	5.33%
Grand Total	**1689**	**100%**

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
- insert text	XX/XX/XX	AN Other
-	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

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<table>
<tr><td colspan="2" align="center">QUALITY, SAFETY AND PERFORMANCE COMMITTEE</td></tr>
<tr><td colspan="2" align="center">Performance Management Report Addendum: SACT Gold Command</td></tr>
<tr><td>DATE OF MEETING</td><td>14th March 2024</td></tr>
<tr><td>PUBLIC OR PRIVATE REPORT</td><td>Public</td></tr>
<tr><td>IF PRIVATE PLEASE INDICATE REASON</td><td>NOT APPLICABLE - PUBLIC REPORT</td></tr>
<tr><td>REPORT PURPOSE</td><td>ASSURANCE</td></tr>
<tr><td>IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?</td><td>NO</td></tr>
</table>

PREPARED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Science, Dr Jacinta Abraham, Executive Medical Director & Steve Ham, Chief Executive Officer
PRESENTED BY	Steve Ham, Chief Executive Officer
APPROVED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Science, Dr Jacinta Abraham, Executive Medical Director & Steve Ham, Chief Executive Officer

EXECUTIVE SUMMARY	Gold escalation procedures have been instigated in respect of SACT delivery due to SACT pharmaceutical availability. VCS has developed a recovery plan and a number of actions have been agreed by Gold that are detailed in the report.

RECOMMENDATION / ACTIONS	To **NOTE** the establishment of SACT Gold Command and the key deliberations that have taken place.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
SACT Gold Command	2/02/24-1/03/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Deliberations summarised in the paper.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 1 - Actions for symptomatic issues, no defined outcomes

1. SITUATION

This addendum is to provide Quality, Safety & Performance Committee with a summary of the key deliberations and outcomes from SACT Gold Command meetings held between 2nd February 2024 and the 1st March 2024.

2. BACKGROUND

SACT Gold Command was established on the 2nd February 2024 following business continuity being declared at Velindre Cancer Service due to the increasing inability to provide patients with their SACT treatment within the required timescales mainly due to the inability to provide the require volume of SACT pharmaceuticals.

SACT business continuity arrangements were instigated at Velindre Cancer Service week commencing the 19th January 2024 due to increasing demand for SACT treatments and the inability of pharmacy to provide the required level of SACT pharmaceuticals so that patients can receive their treatments within the required timescales.

The current risk score is 20.

3. SACT GOLD COMMAND

Four weekly SACT Gold Command meetings have been held since the 1st February 2024 and these will continue weekly until there is sufficient assurance that there is a robust SACT recovery delivery plan that has milestones and that the plan is having the desired outcome. At such a time the frequency of meetings will reduce and be under constant review until monitoring and oversight can revert to business-as-usual arrangements through Executive Management Board. This is chaired by a Clinical Executive Director or Chief Executive.

The problem is described by Velindre Cancer Service as being increased SACT treatment demand and treatment complexity and having insufficient pharmacy capacity to meet this demand. VCS has advised of a 12% growth in demand.

Gold Demand Decisions

1. *Robust SACT data intelligence* – Although there is SACT performance information available, there are currently significant validation requirements and

there is a requirement for enhanced data intelligence work which would facilitate enhanced analysis and oversight.

At the first meeting Gold Command identified this as a key priority action. The new Assistant Director of Data and Insights has been asked given resolution of this matter as her number one priority. There are a number of workstreams underway, all of which should be completed within the next month. These include reviewing bookings data, creating a single patient list, enhancing the pharmacy treatment list, and supporting enhancing SACT capacity management.

2. *Funding for outsourced dispensary room* - financial commitment has been given to provide additional storage space and infrastructure within Pharmacy to facilitate buying in additional SACT pharmaceuticals is anticipated to be ready by 31st March. Staff are currently being recruited.

3. *Robust SLA discussions with Health Board Commissioners* regarding SACT pharmaceutical provision within outreach – Executive support agreed to assist in Health Board level negotiations regarding Health Board provision of SACT availability

4. *Increasing Third Party SACT provision and Delivery* – Commitment given to support additional third party SACT delivery and provision.

5. *SACT Recovery Plan* – A detailed SACT recovery plan was received on the 1st March 2024 that included trajectory delivery dates. This will be monitored through Gold Command weekly.

6. *Patient prioritisation* – Gold Command have been assured by VCS that daily patient prioritisation is undertaken to ensure that available treatments are prioritised for those patients with the greatest clinical need.

7. *Patient Communications / harm Review* – Processes have been put in place within VCS to have telephone discussions with all patients not receiving treatment by the time they were advised they would receive it, to offer sincere apologies, be provided with an explanation and be given details (if date not possible) as to when treatment may commence.

   A patient tracker has been established by VCS to track all patients not receiving treatment within required timescale. A clinical review is being undertaken for any patient not receiving treatment within required timescale to identify any possible harm. Any such incidence will be recorded as an incident on Datix.

8. *Staff Communication* – Weekly staff communication is being provided to Velindre Cancer Centre Staff within 48 hours of Gold Command being held. The aim of the communication is to keep everyone informed of the situation and resolution actions and advise of escalation and support processes.

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).	
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		

FINANCIAL IMPLICATIONS / IMPACT	Yes – there are financial implications of increasing SACT & SACT Pharmacy capacity. Some financial decisions have been made and others are being 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 is a highlight report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There are legal implications aligned to Duty of Quality, Duty of Candour and in possible future litigation in the event of the Trust not providing treatment within the required timeframe if there is adverse impact on patient outcomes

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*SACT Treatment cannot be provided to patients within the required timescale due to insufficient provision of SACT pharmaceuticals – current risk score of 20*
WHAT IS THE CURRENT RISK SCORE	Risks assessments currently being added to individual entries on the Risk Register
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*Recommended remedial actions if implemented fully should reduce the risks*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	July 2024
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	*D*elays with national Trams programme
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	14th March 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Susan Thomas, Deputy Director of W&OD Chris Moreton, Deputy Director of Finance
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Matthew Bunce, Executive Director of Finance
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The workforce issues in delivering the correct Supply and Shape of the Workforce is the ability to (1) recruit and retain the workforce (2) ensure a work environment that supports staff's wellbeing (3) develop effective service and workforce plans. The emerging risk is the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness. The paper provides a summary of the workforce strategic objectives, risk identified in delivery, actions being taken to mitigate the risk and the

	resulting improvement performance trajectories for 23/24 due to actions successfully implemented.

RECOMMENDATION / ACTIONS	The 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	**29/2/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
	No Appendices

1.   SITUATION/BACKGROUND

Effective workforce supply and shape will be delivered by ensuring we plan, recruit, retain, upskill and develop our workforce.   Management of our people's health and engagement will ensure we are the employer of choice, meeting the commitments laid

out in our people strategy. Our IMTP objectives (specifically aligned to our risk) are clear, they are to ensure:

- **Our staff will feel valued and supported**
- **We are an Employer of Choice**
- **Our Services will have the right people in the right place at the right time**

This report concentrates on delivery against those key strategic objectives, noting the risks in delivering, the actions being taken and the resulting performance improvements trajectories delivered in 23/24. The paper also references the financial implications of the workforce risk.

2.   ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

Each objective is discussed noting the risk, actions taken and improvement trajectories delivered for 23/24.

2.1   Our staff will feel valued and supported
2.1.1. Strategic Direction and Operational actions

IMTP Objectives 23/24
Wellbeing of Future Generation **Objective - Our staff will feel valued and supported** This will be achieved by: • Development of a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement
Risk 23/24
• Risk 3001 • 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
Actions 23/24
• Implemented recommendations of Managing Attendance at Work Policy Audit • Improving attendance at Managing Attendance at Work Policy training • Working with managers to improve accuracy in complying with policy

- Implementation of the Health and Wellbeing plan shows a downwards sickness trend, remedial actions being undertaken as follows:
- Targeted interventions for sickness - Menopause cafes established/ Cancer support network for staff
- Employee Assistance Programme in place and being re-commissioned
- Staff Psychologist working closely with WOD
- NHS Charities Together funding secured for furnishing Wellbeing Centre and employing a Project Coordinator (Nov 2023)
- Welling Co-Ordinator taking up post from … as additional support
- Wellbeing areas established for staff in both Divisions
- Complementary Therapies Lead in post and re-launching the service for staff
- Regular pulse survey with staff to gain feedback to the Healthy and Engaged Steering Group; 34% response rate for NHS Staff Survey (up from 25% in 2020)
- Listening events ongoing in Trust – competed in Jan 2024
- Themes have been triangulated and assessed and were discussed by Divisional Senior Leadership Teams in February before being presented to EMB in March 2024.
- Working Together Sessions in place and continuing through 2024
- Speaking Up Safely Action Plan agreed and
- Fatigue and Facilities Charter for Medical Staff has been adopted and all arrangements put in place to meet the criteria.
- Health shield payment plan introduced to support staff with health costs
- Financial wellbeing workshops regularly run
- Hybrid Working arrangements and toolkit in place to support flexible working
- Implementing our respect and resolution policies, promoting a culture of proactive management via our Inspire management development Programme has reduced our Employee relation cases
- Reviewed our values – new values now agreed and implementation Programme to commence in February 2024. Development of a Behaviours Framework to support the values being developed.
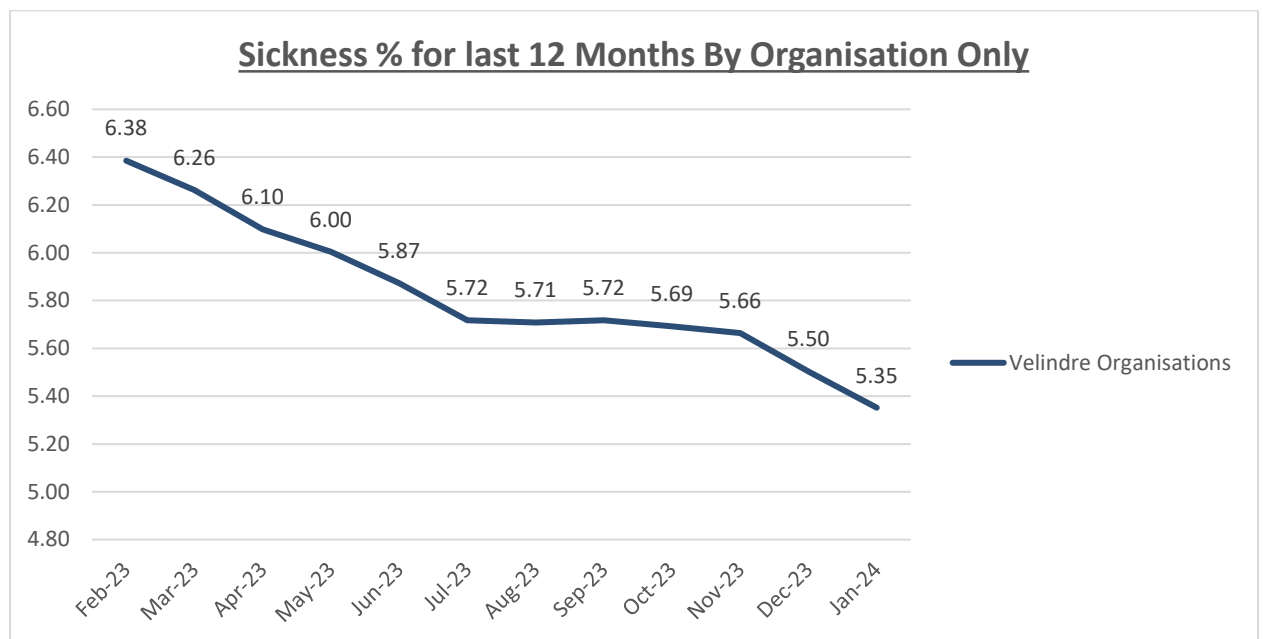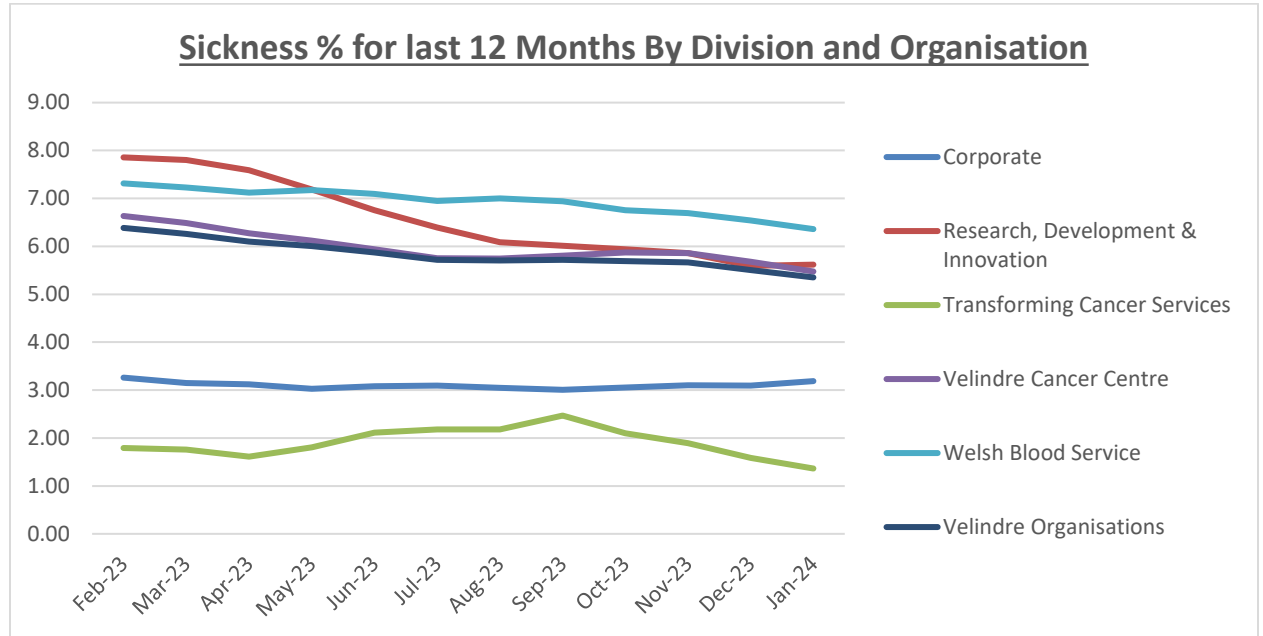
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2.1.2 Resulting Performance Improvement Trajectories
Wellbeing – Sickness Management

Further to the work described above in mitigating the risk to staff wellbeing there has been a downwards trend in sickness absence over the last 12 months:

Sickness % for last 12 Months By Division and Organisation

Sickness % for last 12 Months By Organisation Only

2.2 We are an Employer of Choice
2.2.1. Strategic Direction and Operational actions

IMTP Objectives 23/24
Attraction and Retention **Objective - Employer of Choice** This will be achieved by: • Creating new approaches to recruitment marketing, targeting specific areas of shortage and using a range of communication channels to engage prospective staff • Focus on bi-lingual recruitment to grow our Welsh speaking workforce • Promote the Trust as a local employer of choice • Ensure our recruitment processes are agile assessing our time to hire regularly • Maintain a dialogue with our staff with effective engagement mechanisms to retain and maintain our workforce and its wellbeing • Always ensuring our staff are recognised for achievements
Risk 23/24
TAF 04 - 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
Actions 23/24

Recruitment and retention Audit recommendations have been implemented. In addition engagement with NHS Wales Shared Services Partnership (NWSSP)recruitment modernisation programme and our own internal recruitment and retention task and finish group has delivered the following, to improve, attract and retain staff and move toward our vision of being an Employer of Choice
 	
• Participated in International Recruitment – 13 new recruits from overseas
• Working with NWSSP to implement a recruitment modernisation process to improve time to hire rates thus reducing agency spend and improving vacancy rates (see improvement trajectories)
• To promote Velindre as an employer of choice, a recruitment and retention task and finish group has implemented the following:
    • VCC careers page
    • Targeted job videos
    • Implemented a recruitment policy
    • Links with Centre for Learning and School of Oncology to promote Velindre as Employer of Choice

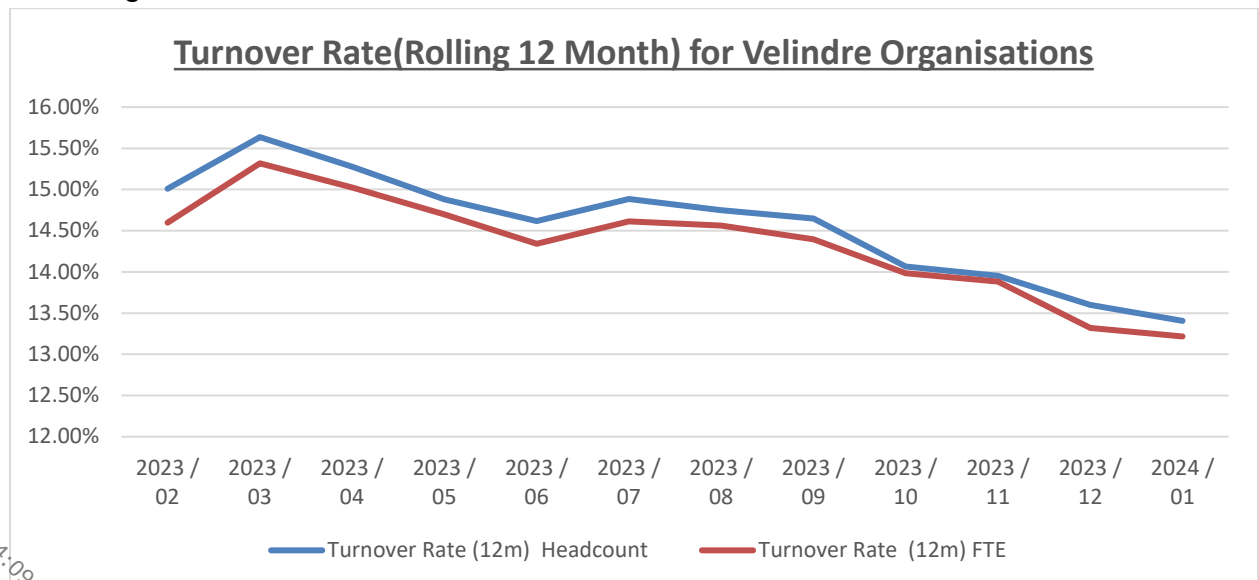- Understand the retention issues though exit process analysis
- Implemented our 'pre-exit' interview process
- Retention toolkit being utilised
- Working Together sessions in place – themes being assessed
- Croeso Induction Programme in place with bi-lingual focus, supporting the implementation of our Welsh Culture plan

- Encouraged widening access routes:
  - Engagement with local schools/collages on career options, promoting us an a bi-lingual employer to support welsh speakers into the workplace
  - Disability Confident Level 2 renewed to set benchmark for how to support people with disabilities to join our workforce
  - Agreement to support Army veterans and Nursing Cadets into the workplace signed
- Staff awards ceremony in September 2023 to recognize staff achievement

2.2.2 Resulting Performance Improvement Trajectories

Further to the efforts described above in mitigating the risk there has been a downwards trend in vacancy rates, time to hire rates, agency spend and turnover rates to support our employer offer as noted below:
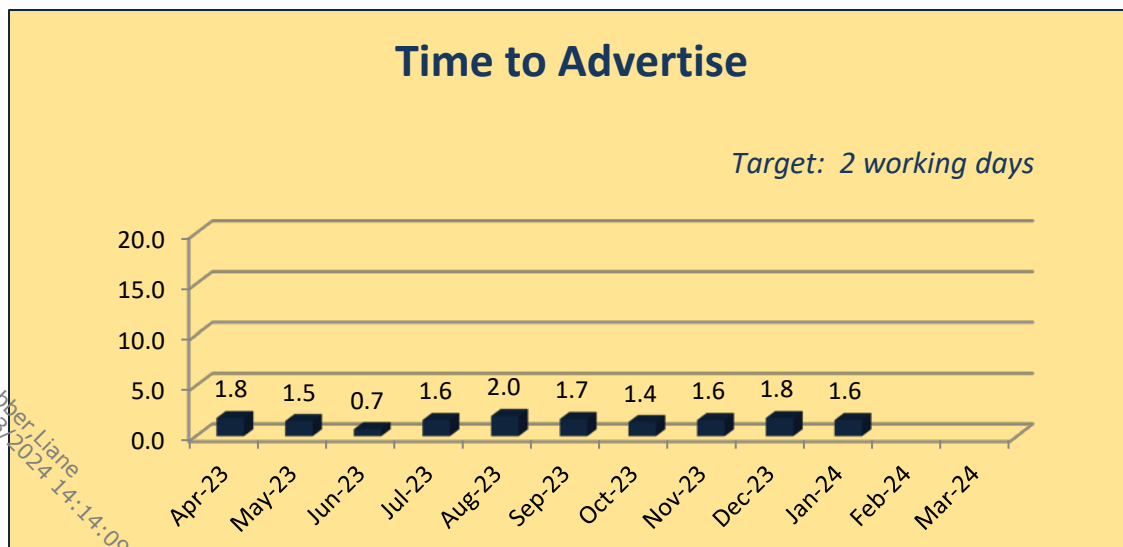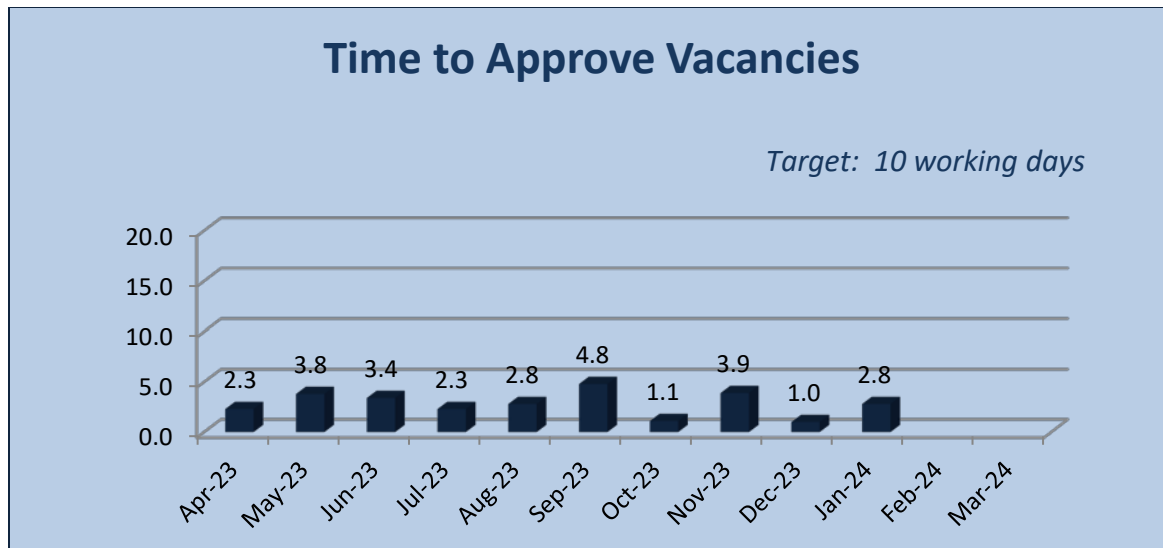
Turnover
Declining turnover rate achieved.

Turnover Rate(Rolling 12 Month) for Velindre Organisations

Legend: Turnover Rate (12m) Headcount — Turnover Rate (12m) FTE

Time to Hire

The time taken to manage vacancies when approved has remained within KPIs and is managed well to ensure an effective and efficient recruitment process with minimal delays, as noted below in the time to approve vacancies and time to advertise roles. Time to hire rates are taken from the point of Vacancy Creation to Ready for Start Date the NHS Wales target is 71 days, Velindre's average if 61 days.

Time to Approve Vacancies

Target: 10 working days

Apr-23: 2.3, May-23: 3.8, Jun-23: 3.4, Jul-23: 2.3, Aug-23: 2.8, Sep-23: 4.8, Oct-23: 1.1, Nov-23: 3.9, Dec-23: 1.0, Jan-24: 2.8

Time to Advertise

Target: 2 working days

Apr-23: 1.8, May-23: 1.5, Jun-23: 0.7, Jul-23: 1.6, Aug-23: 2.0, Sep-23: 1.7, Oct-23: 1.4, Nov-23: 1.6, Dec-23: 1.8, Jan-24: 1.6

Vacancies

Vacancies throughout the Trust are reducing. As at January 2024, the current staff in post is 1,1560 WTE. The number of vacancies for the core Trust including HTW is 79 WTE, which represents a vacancy rate of 4.8%. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to January 2024:

*Changes in Vacancy rate (%) 2022-23 to 2023-24*
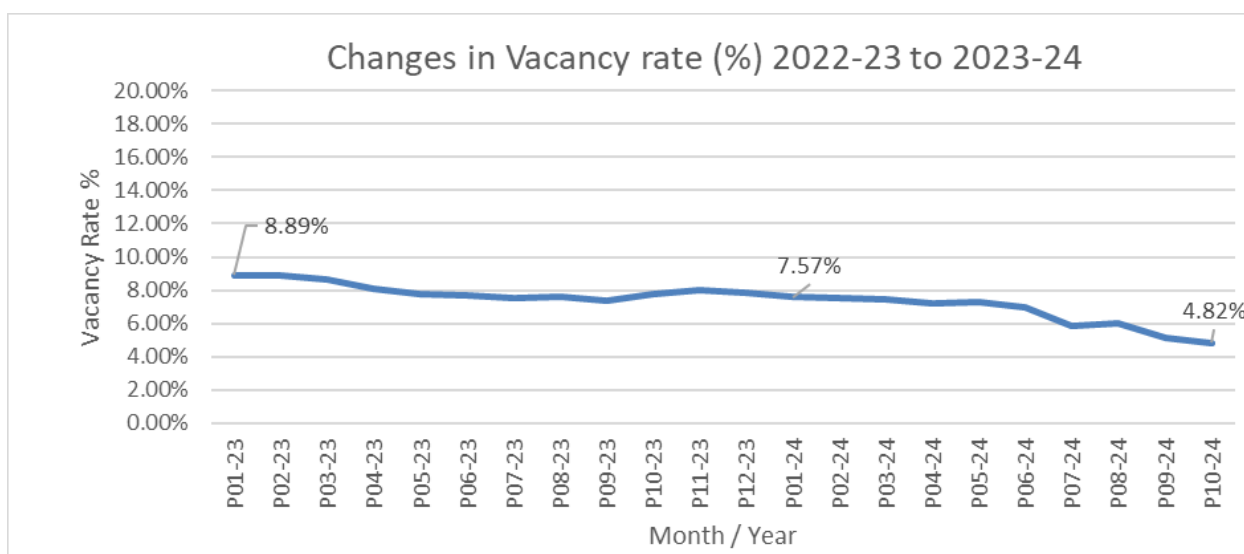
Agency

The spend on agency for Jan'24 was **£0.090m** (Dec £0.068m), which gives a cumulative year to date spend of £0.890m and a current forecast outturn spend of circa **£1.035m** (£1.323m 2022/23).   Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and plans are in place to recruit substantive and establish a more a administration bank.

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22
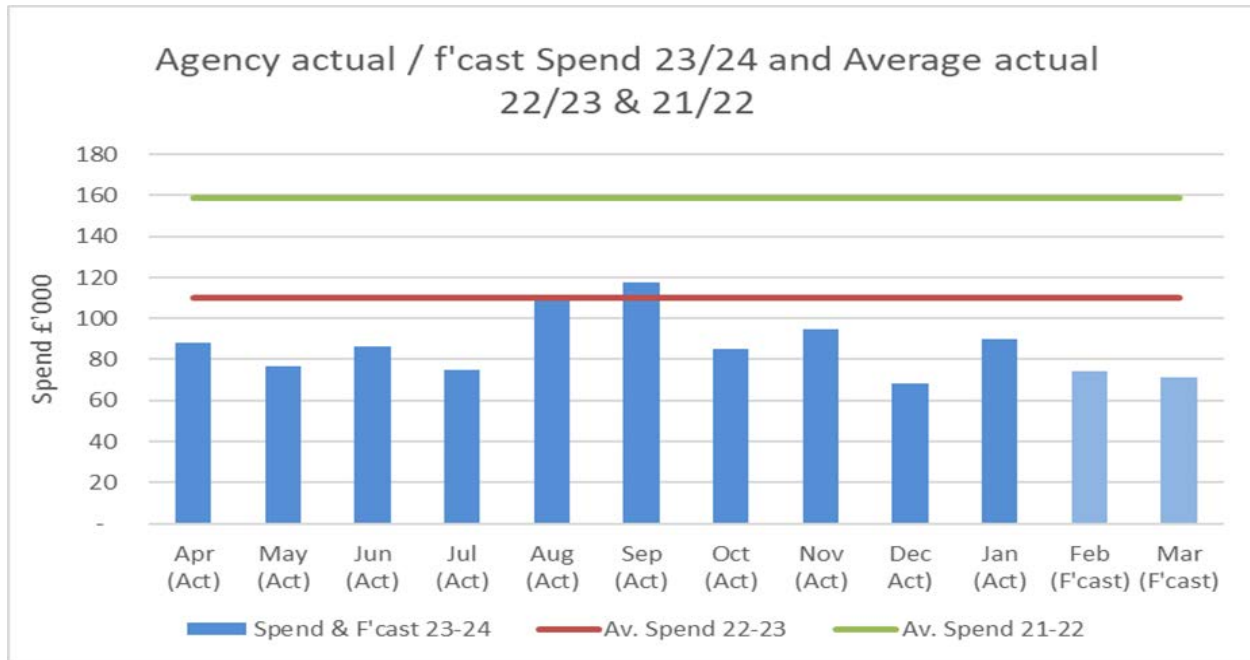
2.3 **Our Services will have the right people in the right place at the right time**

2.3.1. Strategic Direction and Operational actions

IMTP Objectives 23/24
Supply and Shape **Our Services will have the right people in the right place at the right time** This will be achieved by: • Aligning to our Education Strategy, developing a Talent management process that supports career pathways so staff have opportunities to grow professionally and internal and external pathways are visible to current and new staff • Reviewing our work plans to have the right skill mix of staff, maximising opportunities for new roles. • Maximise opportunities for all entry pathways including Apprenticeship, Graduate entry as well as Supported Recruitment to ensure an inclusivity in our supply routes

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• Further embed our workforce planning process and develop our workforce information to maximise the opportunities for new ways of working

Risk 23/24
TAF 04 –   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.

Actions 23/24
Following the Workforce Planning Audit an Implementation Plan for the People Strategy has been agreed. This sset the organisational direction on Supply and Shape, a focus on Workforce planning, education and training and reviewing the governance mechanisms for monitoring workforce plans. The following has been delivered: • Implementation plan for the People Strategy • Regular reporting and monitoring of work plans by Senior Leadership Teams, Executive Management Board and the Quality Safety and Performance Committee via monthly workforce dashboards and this paper quarterly respectively • Ongoing infrastructure of workforce planning training embedded via the Trust management and leadership Inspire Programme   Review of workforce plans and education commissioning monitoring via the Trust People and OD Steering group

### 2.3.2 Operational Plans in Place – Right People, Right Place

A planned and sustained workforce is key to delivering services for our patients and donors. An overview of the operational and strategic interventions to ensure we have the right people in place in both divisions is highlighted below. The diagrams highlight the Programmes of work being taken forward in the Divisions to ensure an effective workforce and notes the outputs and timelines to the projects. The focus of work strategically will be the clear articulation of service models to support the variety of work ongoing operationally. The production of a clinical and scientific strategy and strategic workforce plan will help shape workforce plans from April 2024 onwards.

The service is exploring workforce and service redesign with the intention to take forward some fundemental changes that will enable a more efficient and productive service.

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. This investment was committed without certainty around the source of funding either through the LTA income from additional activity or Full Business Case funding approval by WG and Commissioners. The latest position within VCS is that the contract performance income has recovered however, work will continue in VCS to understand the likely cancer activity demand / associated income and identify further sources of funding to support these posts. VCS are also assessing options to migrate staff into vacancies should it be required to help mitigate the financial risk exposure.
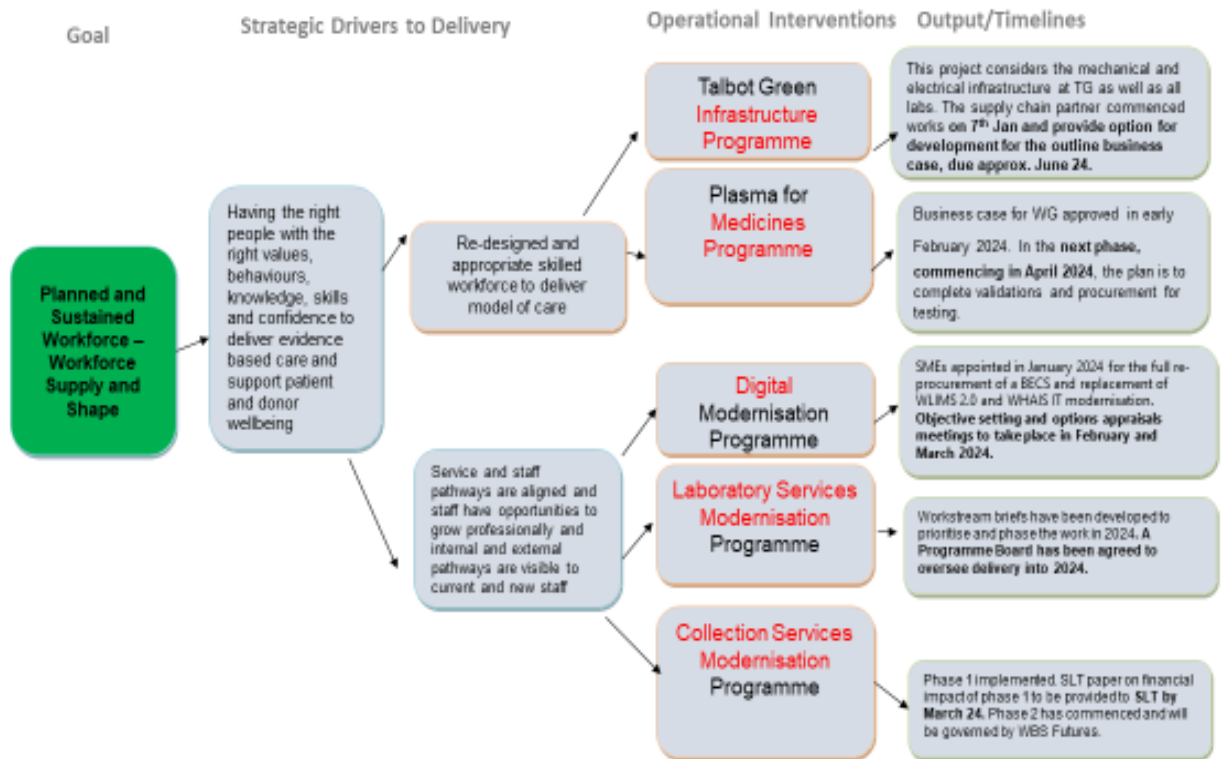
Velindre Cancer Service

Planned and Sustained Workforce – Overview of the Strategic and Operational Interventions to Boost the Workforce – VCC – November to March 2024

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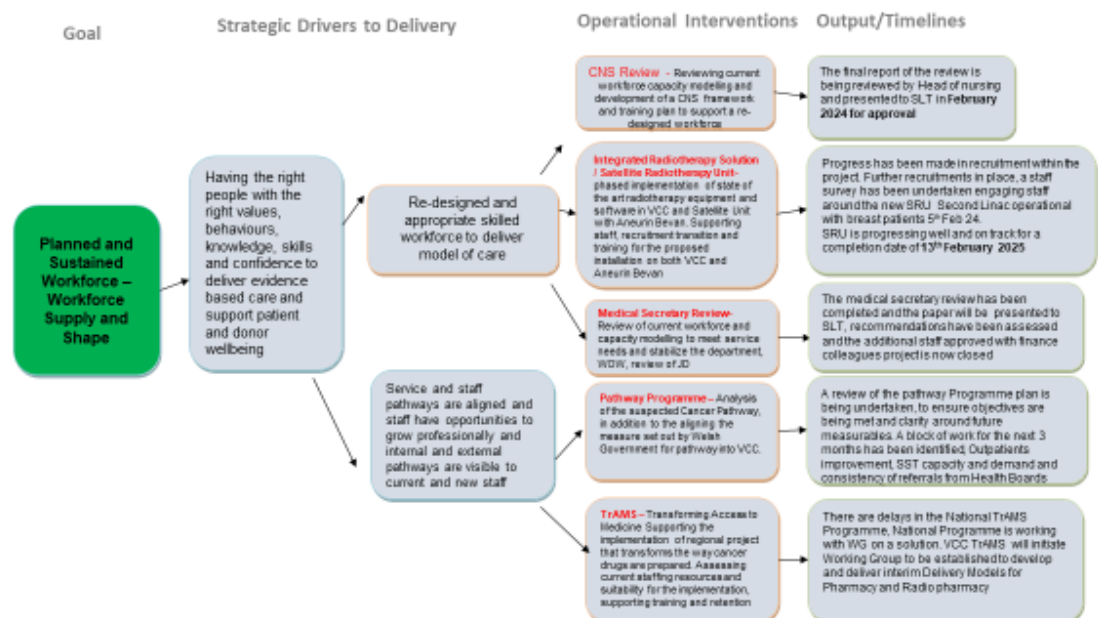
Welsh Blood Service

Planned and Sustained Workforce – Overview of the Strategic and Operational Interventions to Boost the Workforce – **WBS** – November to March 2024

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.

Pay Budget 2023/24

The full year pay budget as at end of January 2024 is £85.2766m based on 1,639 WTE. The Trust has reported cumulative year to date spend of £70.935m on pay against a

budget of £71.457m resulting in an underspend of £0.521m as at January 2024. The pay costs include the costs of agency staff, on-call and overtime.

Pay Award

The Trust has now received £4.835m (90%) of the funding towards the 1.5% and 5% recurrent pay award for both A4C and Medical staff groups, and is still expecting at this stage to receive the full allocation of £5.372m.

The Trust has previously received full funding for the one off recovery pay award which was paid in June.

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

5. RISKS

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

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

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QUALITY, SAFETY AND PEFORMANCE COMITTEE

**FINANCE REPORT FOR THE PERIOD ENDED
31ST JANUARY (M10)**

DATE OF MEETING	14/03/2024

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 January 2024. The three main issues are highlighted below: 1. **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 to meet the PSPP target of paying

	95% of Non-NHS invoices within 30 days for 2023-24.
	• At this stage the Trust is expecting to achieve the Capital CEL, a funding letter has now been provided by WG for the nVCC projects costs, and so this risk has been removed.
	2. LTA Income & Covid Recovery / Planned Care Capacity
	• The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Dec'23 is that income will cover the cost of the additional capacity.
	3. NHS Wales Financial Pressures
	• In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.
	• In addition, the reserves position continues to be under review with the option that if the emergency reserve us not fully required during the remainder of 2023-24 then it could be offered to support the NHS Wales position on a non-recurrent basis.

| | The Quality, Safety and Performance Committee is asked to: |
| **RECOMMENDATION / ACTIONS** | **NOTE** the contents of the January 2024 financial report and in particular the expectation that the Trust will deliver against its 3 statutory Financial Targets at year end. |

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/02/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The report was received and noted at the Executive Management board on the 29th February 2024.	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
Appendix 1	Trust Finance Report – January 2024
Appendix 2	TCS Finance Report – January 2024
Appendix 3	Velindre Monthly Monitoring Return Commentary

1. SITUATION/ BACKGROUND

1.1   The attached report outlines the financial position and performance for the period to the end of January 2024 and forecast year end performance.

1.2   The key financial targets information included within this report relates to the Core Trust (Including Health Technology Wales (HTW)). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to Welsh Government (WG) for its financial performance. The Balance Sheet / Statement of Financial Position (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	6	15	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2,315	22,987	29,664
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.8%	97.8%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of January'24 is an underspend of **£0.015m**, with an outturn forecast of **Breakeven** expected.

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.
Long Term Agreement (LTA) Contract Performance

Velindre Cancer Service (VCS) Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a small risk that the income growth for the remaining months of the year may not transpire at the projected levels.

NHS Wales Financial Pressures
On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested

by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the following options were considered to contribute c£2m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

The Trust continues to report a year end forecast breakeven position, however this is based on the assumption 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 the remainder of 2023-24.

2.3 Savings

At this stage the Trust is currently planning to fully achieve the revised savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.
Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service leads to implement changes.

The procurement supply chain saving schemes have again been affected by procurement team personnel changes and capacity constraints and current market conditions during 2023-24.

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2.4   PSPP Performance

PSPP performance for the whole Trust is currently 97.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 97.8% as at the end of Janaury'24.

2.5   Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023-24 reduced to £0.053m.

Covid Recovery and Planned Care Capacity

Funding for Covid recovery and planned care capacity investment flows through the LTA marginal contract income from commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Dec'23 which has been shared with commissioners is that income will cover the cost of the additional capacity.

The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.

2.6   Reserves

The financial strategy for 2023-24 enabled the establishment of recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25. In addition, the Trust holds an emergency reserve of £0.522m which has been unused.

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs

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which may arise over the remainder of the year, however, given that none of the emergency reserve has thus far been utilised it is expected that the Trust should be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

2.7 Financial Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the Trust the risks the majority of these risk have been managed or mitigated for 2023/24.

A new risk had emerged in terms of the Trust receiving full funding for the 2023/24 pay award. Indicative figures suggested that the gap could have been up to c£0.300m, however latest intelligence suggests that this could be a lot less or even removed completely.

There are still several risks that may impact from 2024/25 with the material risks being uncertainty around the Whitchurch site security costs and operational cost pressures as highlighted within the main finance report which are being considered as part of the IMTP.

2.8 Capital

All Wales Programme

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) Projects the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG in September, with the caveat that the funding will be re-provided in future years.
The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL.

The all Wales schemes are at this stage expected to deliver to budget for 2023/24.

Other Major Schemes in development that are detailed in the main finance report will be considered as a part of the IMTP process in conjunction with WG.

Discretionary Programme

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022-23.

The allocation of the discretionary programme for 2023-24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB in August.

At this stage the discretionary programme is expected to deliver to budget.

The Capital Expenditure Limit (CEL) was fixed by WG at the end of October, after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.

2.9 Cash

In order to support a cash flow pressure during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG.
The Trust has also received an interim payment of c£10m from WG to support the cash position whilst the final pay award settlement figure is agreed.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ⊠ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☐ for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk

Page 8 of 9

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	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream	
	The Trust reported a revenue financial position of **£0.015m** for January'24 which is in line with the IMTP financial plan. The capital position is forecast overspend as the Trust is awaiting for the nVCC Project cost to officially form part of the CEL.	
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required	
	There is no requirement for this report.	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.	
	N/A	

4. RISKS

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

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 JANUARY 2024

QUALITY, SAFETY & PREFORMANCE COMMITTEE
14/03/2024

Webber Liane
13/03/2024 14:14:09

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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 2023-24.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2023-2026 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- For 2023-24 the Plan included;
  - an underlying **Surplus of £0.684m** brought forward from 2022-23,
  - FYE **of new cost pressures / Investment** of -**£17.514m,**
  - offset by **new recurring Income** of **£16.221m,**
  - and Recurring FYE **savings schemes** of **£1.000m,**
  - Allowing **a £0.391m surplus position** to be carried into 2023-24.

- The Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 discretionary uplift funding that was held due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period. IMTP planning assumptions assumed that a £0.391m underlying surplus will be c/fwd into 2024-25.

- **In order to achieve the c/fwd underlying surplus of £0.391m the savings target set for 2023-24 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**

2
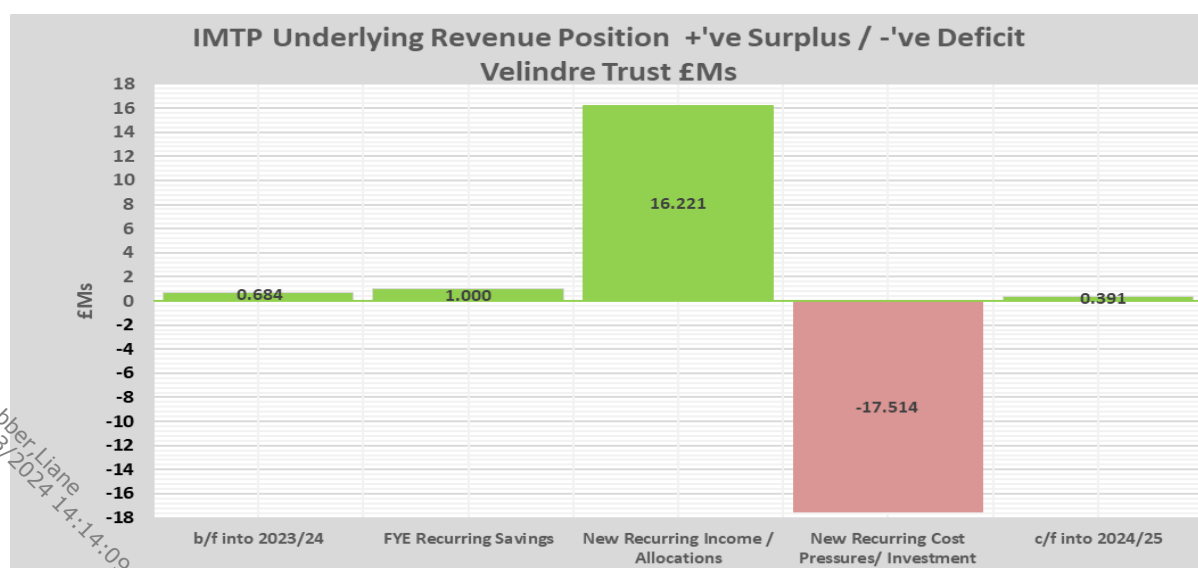
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1000	16.221	-17.514	0.391

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	6	15	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2,315	22,987	29,664
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.8%	97.8%	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 Trust has reported a **£0.006m** underspend on the in-month position for January '24, which gives a year to date cumulative underspend of **£0.015m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to January'24 of £22.987m and is currently forecast to remain within the overall CEL. The Trust has now received the funding award letter towards the nVCC project costs and once signed and returned will officially form part of the CEL.

The Trust's current CEL and in year movement is provided below:

	£m Opening	£m Movement	£m Current
Discretionary Capital	**1.683**	**-**	**1.683**
All Wales Capital:			
nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Design Works		3.882	3.882
IRS	10.326	(2.500)	7.826
Digital Priority Investment	0.164	-	0.164
RSC Satellite Centre	1.347	(1.200)	0.147
Digital DPIF Cyber Security		0.051	0.051
nVCC - Advanced Works		0.898	0.898
Digital DPIF RISP		0.168	0.168
Digital DPIF Cyber Security (2)		0.085	0.085
Digital DPIF EPMA		0.100	0.100
Digital WHAIS		0.250	0.250
Priority Year end Spend		0.257	0.257
Total All Wales Capital	**22.733**	**1.991**	**24.724**
Total CEL	**24.416**		**26.407**

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during September, with the caveat that the funding will be re-provided in future years.

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

Further funding has since been awarded to the following schemes £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP and £0.051m & £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS, and £0.257m towards the year end prioritised Capital Scheme list.

PSPP

During January '24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

Revenue Position

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Cumulative				Forecast			
£0.015m Underspent				Breakeven			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(162.885)	(165.184)	2.299	(200.004)	(202.272)	2.268
Pay	71.457	70.936	0.522	85.767	85.249	0.518
Non Pay	91.428	94.234	(2.806)	114.238	117.023	(2.785)
Total	(0.000)	(0.015)	0.015	0.000	(0.000)	0.000

The overall position against the profiled revenue budget to the end of January 2024 is an underspend of **£0.015m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust continues to report a year end forecast breakeven position, however this is based on the assumption 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 the remainder of 2023-24.

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

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

In response to the letter the Trust has reviewed its cost control mechanisms and implemented Enhanced Monitoring arrangements which are intended to ensure savings delivery to meet the Trust's financial plan, oversee cost control mechanisms and assess choices / options and impacts of further cost saving opportunities. Following a review of the financial plan and savings position, an extraordinary Board meeting on the 09th August considered the further options for Velindre to contribute towards reducing the financial pressures in the system. The following financial improvement options were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

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Underlying Position

As highlighted above in the IMTP Financial plan the Trust brought forward a surplus of £0.684m from 2022-23 and is forecast to reduce year-on-year as additional cost pressures arise over the 3-year planning period.

The expected underlying surplus to be carried into 2024-25 had reduced from £0.391m to £0.086m following the inability to enact several savings schemes, which resulted in the underlying recurrent cost pressures forecast exceeding the recurrent savings schemes. Further recent assessment of savings and cost pressures has meant that there is now no underlying surplus to carry forward into 2024-25

Income Highlights / Key Issues

Other Income

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises.

VCS and WBS overachievement from Private Patient, Drug Rebate, SACT Homecare, and Plasma sales.

VCS Long Term Agreement (LTA) Contract Performance

The Trust's Medium-Term Financial Plan assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24, however there was a risk that activity levels may have been high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position (Dec'23 M9) is that the contract performance has recovered to a level that sufficiently funds the capacity investments made to date.

The tables below set out the projected year-end LTA Income performance based on data to December '23 by Commissioner and main service delivery areas:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Hywel Dda (7A2)	0.283	-0.025	0.258	-9%
Swansea Bay (7A3)	0.294	-0.001	0.293	0%
Cardiff & Vale (7A4)	15.036	1.256	16.292	8%
Cwm Taf Morgannwg (7A5)	13.221	0.918	14.140	7%
Aneurin Bevan (7A6)	17.344	1.191	18.535	7%
Powys (7A7)	0.758	0.154	0.912	20%
WHSSC	2.633	0.255	2.888	10%
Total	**49.569**	**3.748**	**53.317**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Radiotherapy	17.929	-0.294	17.634	-2%
Nuclear Medicine	0.923	-0.049	0.874	-5%
Radiology Imaging	2.840	0.536	3.376	19%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.161	2.755	6%
Delivery of Systemic Anti-Cancer Therapy	5.935	0.969	6.904	16%
Ambulatory Care Services	1.235	0.246	1.482	20%
Outpatient Services		2.255	11.484	24%
Inpatient Admitted Care	9.229	-0.076	8.808	-1%
Total	**49.569**	**3.748**	**53.317**	**8%**

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date (£3.5m).

Pay Highlights / Key Issue

At this stage the Trust is still expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award which was processed in October (c£0.7m). WG have now made an interim payment which equates to 90% of the pay award and are aiming to resolve the final pay allocation as soon as possible. Indicative figures suggested that the gap in pay award funding against actual costs could be c£0.300m, however recent correspondence suggests that the gap could now be a lot less or removed completely. If the Trust does not receive the full funding, then the shortfall can be managed on a non-recurrent basis during 2023-24, however could lead to a recurrent shortfall being carried into next financial year. Pay award budget has been allocated to Divisions on assumption of WG matched funding.

The Trust has received full funding for the one off recovery non-consolidated pay award which was paid in June.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in VCS and with Health Board partners through the operational groups 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 (£0.600m), WBS (£0.450m) and Corporate (£0.150m) hold a vacancy factor target, which will need to be achieved each year in order to balance the overall Trust financial position.

Non-Pay Key Issues

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

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As part of the IMTP the Trust included £1.191m for the anticipated increase in energy prices during 2023-24. Latest projection from NWSSP suggests that the stepped increase will be c£0.622m. As noted above this potentially releases c£0.569m (£0.661m m9) back into the system to support the NHS Wales Financial Pressures.

The Trust emergency reserve remains uncommitted at this stage and should it not be required may be released to support the overall NHS Wales Position. The budget for the reserves is held in month 12 and is released into the position to match agreed spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

As of January 2024, the current staff in post is 1,560 WTE. The number of vacancies is 79 WTE, which represents a vacancy rate of 4.82% (5.2% December) against the budget of 1639 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

Vacancies throughout continues to reduce, however remains relatively high particularly in Nursing, last year significant improvement was made through targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. Ongoing recruitment interventions are being assessed for SACT nursing with the Trust utlising the international recuritment scheme, with 17wte posts expected to be recruited in Quarter 4 of 2023/24. During October'23 VCS filled 10 vacancies across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to January 2024:
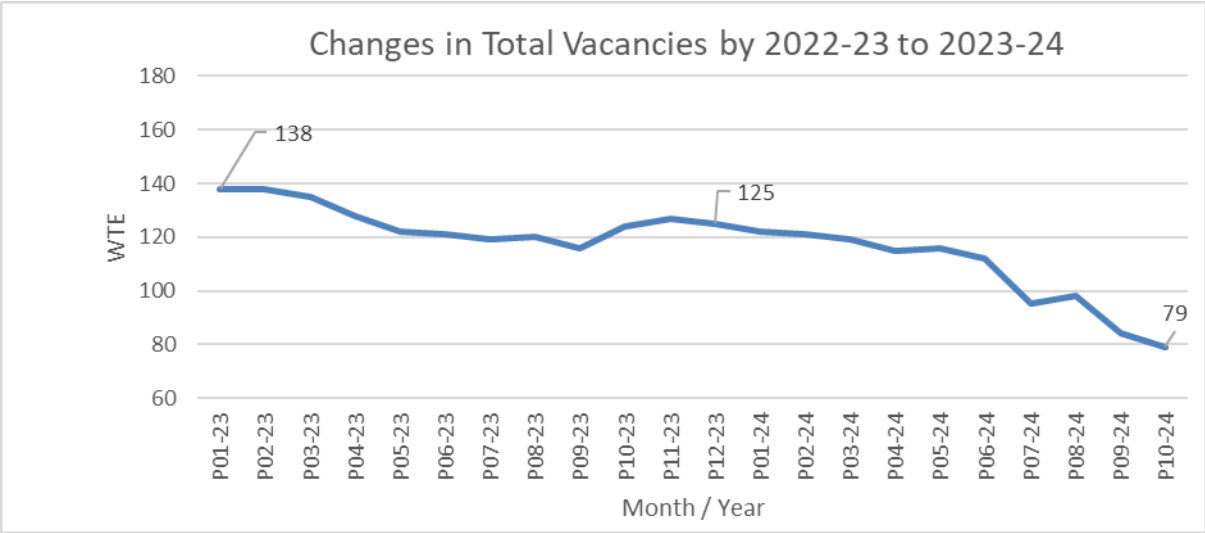
The total Trust vacancies as of January 2024 is 79wte (December 84wte), VCC (47wte), WBS (17wte), Corporate (6wte), R&D (5wte), TCS (2wte) and HTW (2wte).

Changes in Vacancy rate (%) 2022-23 to 2023-24

8.89%
7.57%
4.82%
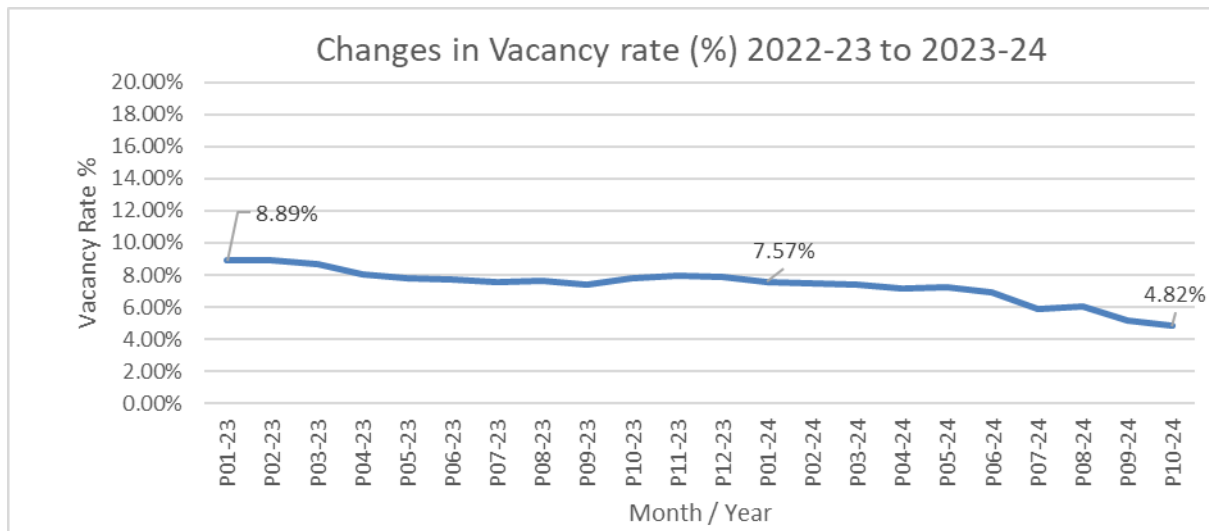
Per the IMTP the Trust is still aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

Actual / F'cast Pay Spend 23/24 and Average actual 22/23 & 21/22

Spend & F'cast 23-24   Av. Spend 22-23   Av. Spend 21-22
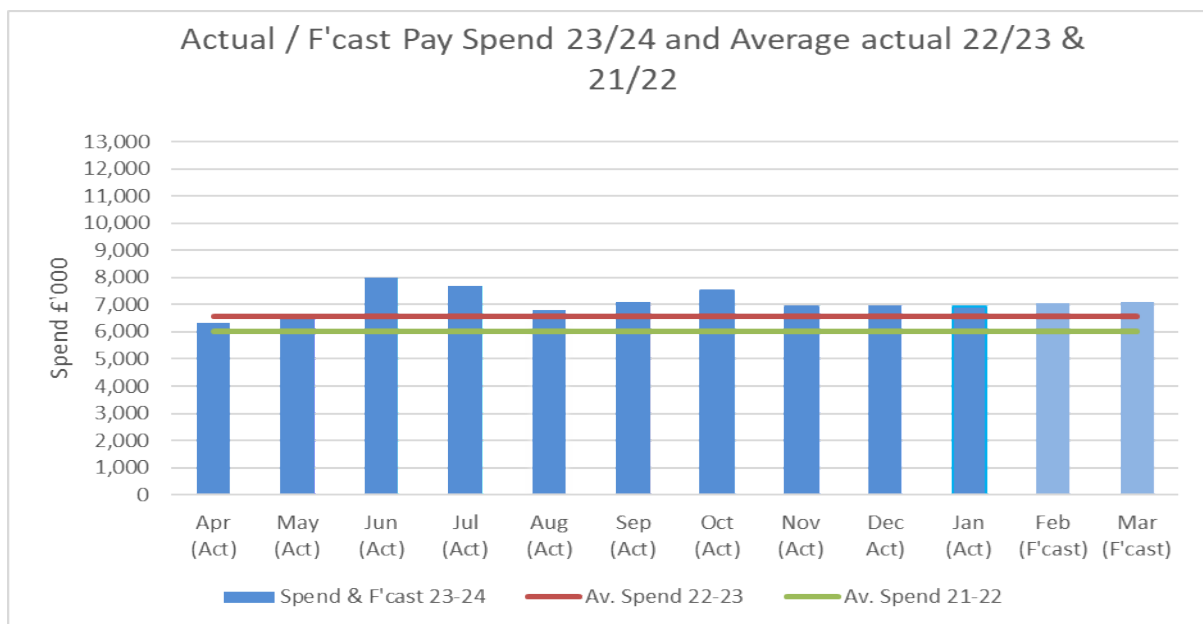
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.
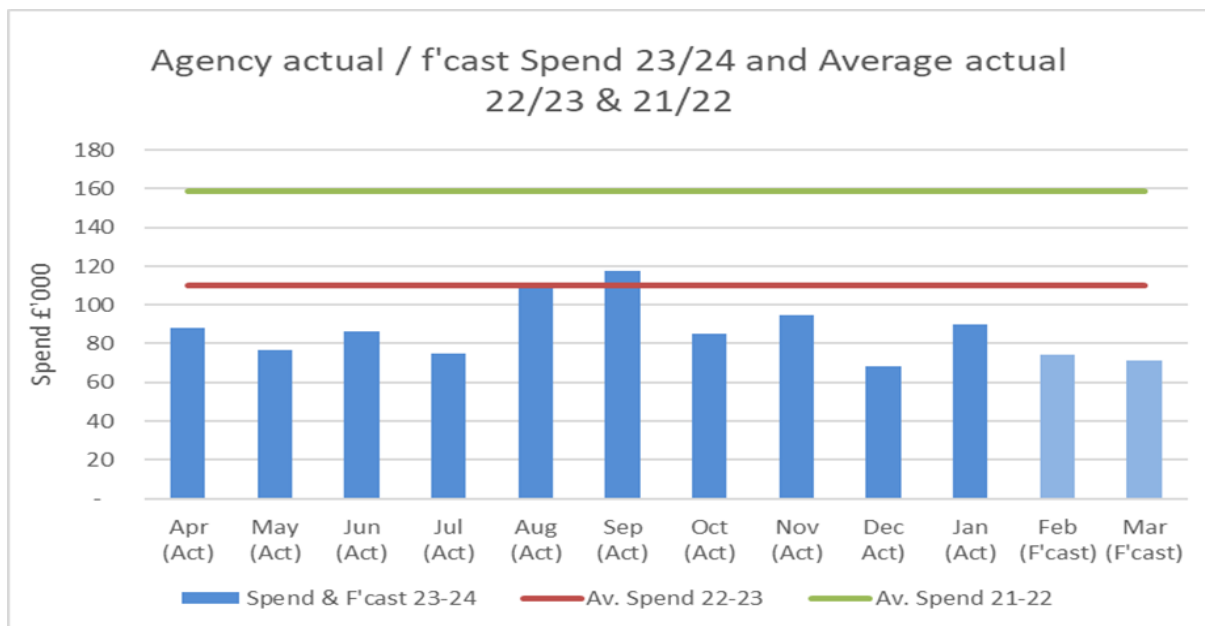
9

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

The spend on agency for Jan'24 was **£0.090m** (Dec £0.068m), which gives a cumulative year to date spend of £0.890m and a current forecast outturn spend of circa **£1.035m** (£1.323m 2022/23).

Changes in Total WTE 2022-23 to 2023-24

Changes in Actual WTE 2022-23 to 2023-24 By Division
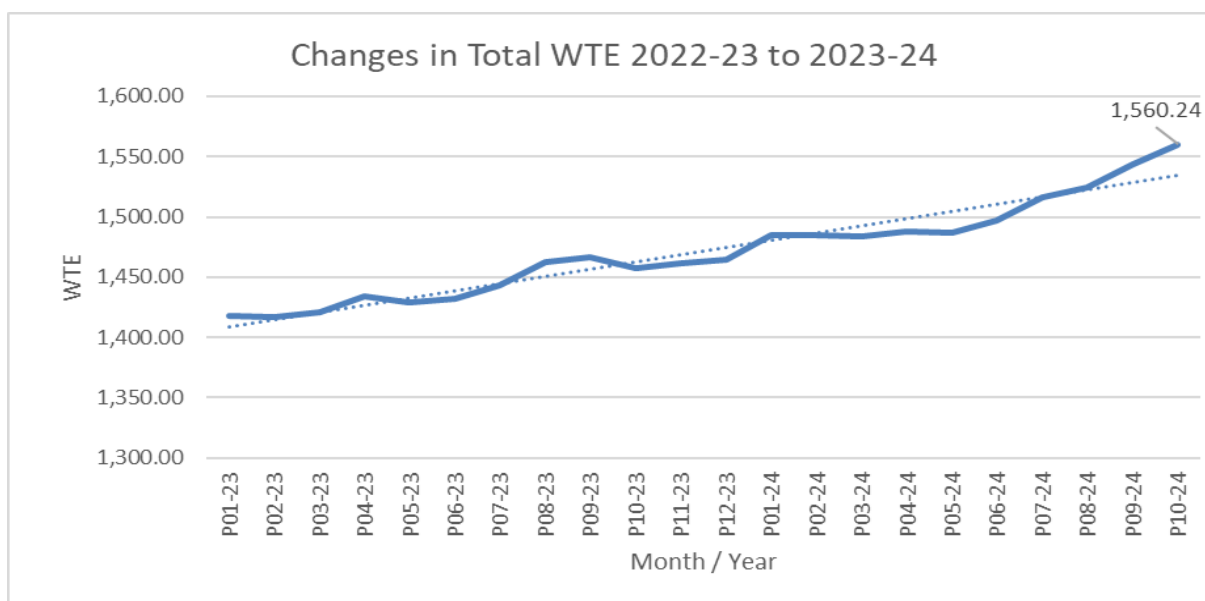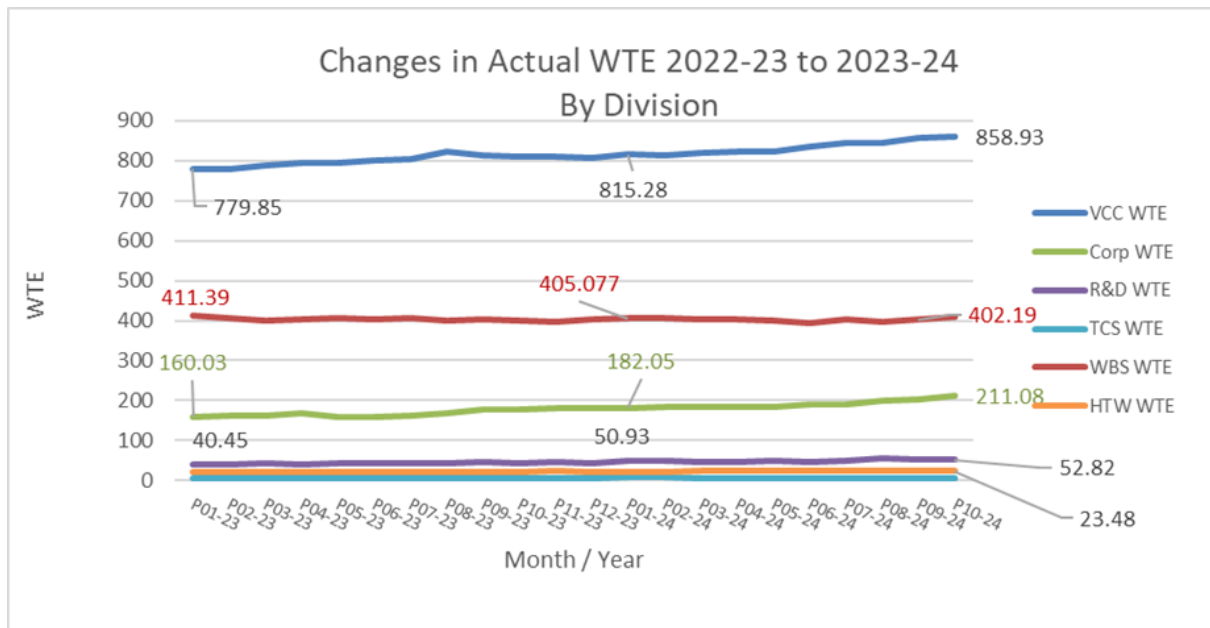
4.3 Non-Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £9.3m per month which is a £0.7m increase from the previous whole year average. Largest movement is in drug spend which has increased by £8m ytd, or £0.8m average per month when compared with the previous year's spend for the same period.
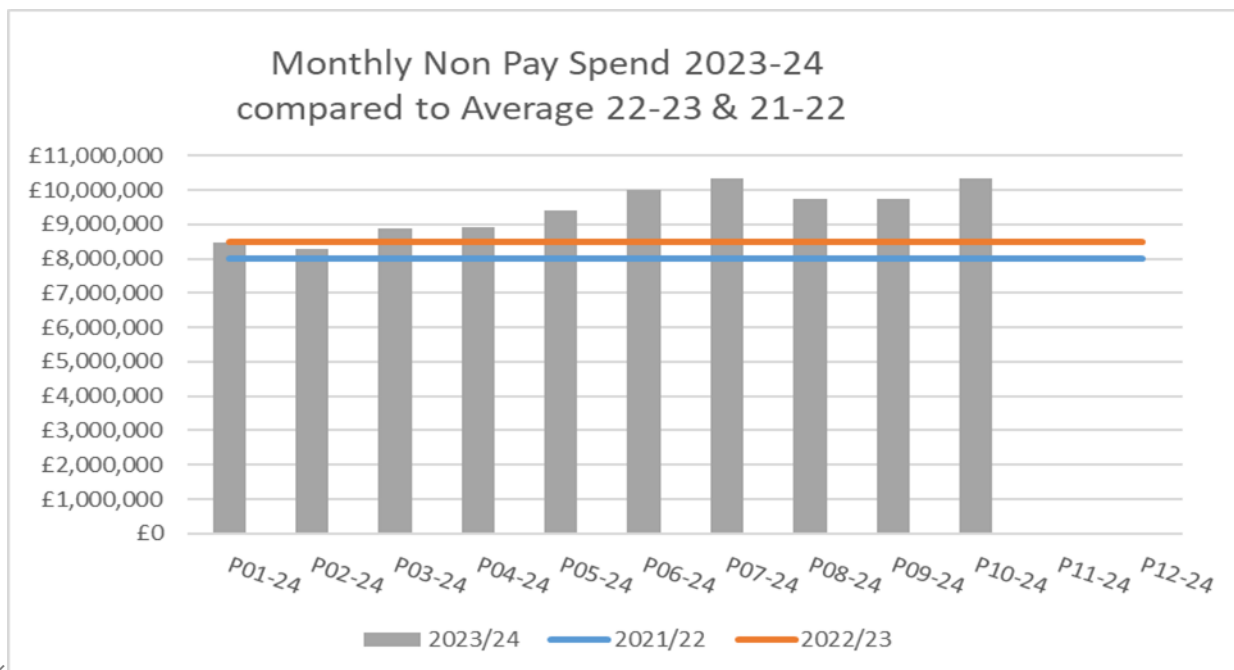
4.4 Covid-19

Covid Programme Costs

Last year there was clear expectation from WG that following issue of their Covid de-escalation letter that organisations would be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of certain ongoing Covid response and national programme costs as set out in the Director General of Health & Social Services letter dated 22nd December 2022. These programme costs will include support towards mass vaccination, and the provision of PPE which will be funded to the Trust based on actual spend during 2023/24.

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at January 23 being £0.053m, which is a reduction of £0.187m from the £0.240m requested as part of the IMTP. However, whilst unlikely if the Trust is required to support the HBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m for 2022-23. The income funding for this additional capacity flows via performance related LTA contracting income from Commissioners and is dependent upon activity levels. The LTAs approved by LHBs in June 2023 included a level of income protection for the Trust. Recognising the financial pressures faced by the system in NHS Wales, the Trust Board made a decision in August to concede the income protection arrangements in order to contribute to the reduction of the NHS Wales planned deficit. This was formally communicated with Commissioners and transacted following updated LTAs in September.

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.

Whilst the year to date gap in funding has recovered since the IMTP planning stage work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing or repurposing these costs.

The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the underlying surplus of £0.391m position that had been carried forward from 2022-23.

Service redesign and support service structures continue to be a key area for the Trust where it is focusing on to find efficiencies in the ways we are working, ensuring the appropriate staff are undertaking each activity. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of activity growth and sickness limiting the capacity of service leads to implement changes.

The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met each year.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	950	765	765	0	950	0
			100%		100%	
WBS TOTAL SAVINGS	700	565	565	0	700	0
			100%		100%	
CORPORATE TOTAL SAVINGS	150	125	125	0	150	0
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	1,800	1,456	1,456	0	1,800	0
			100%		100%	

Scheme Type	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes						
Establishment Control (N/R) (Corporate)	75	63	63	0	75	0
Procurement Supply Chain (R) (WBS)	100	78	0	(78)	0	(100)
Collection Team Costs Reduction (R) (WBS)	10	8	8	0	10	0
Collection Team Costs Reduction (NR) (WBS)	8	7	7	0	8	0
Establishment Control (R) (WBS)	60	50	50	0	60	0
Reduced use of Nitrogen (R) (WBS)	55	43	0	(43)	0	(55)
Reduced Research Investment (R) (WBS)	25	21	8	(13)	25	0
Stock Management (NR) (WBS)	125	104	125	21	125	0
Reduced Transport Maintenance (NR) (WBS)	30	23	18	(5)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	137	107	91	(15)	137	0
Service Workforce Re-design (R) (VCS)	50	39	0	(39)	0	(50)
Establishment Control (NR) (VCS)	175	136	136	0	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	150	117	117	0	150	0
Reduction in use of Agency - Radiation Services (R) (V	125	104	104	0	125	0
Reduction in use of Agency - Radiation Services (NR) (	50	42	42	0	50	0
Procurement Supply Chain (R) (VCS)	100	78	0	(78)	0	(100)
Total Saving Schemes	1,275	1,018	769	(249)	970	(305)
Income Generation						
Bank Interest (R) (Corporate)	75	63	63	0	75	0
Sale of Plasma (R) (WBS)	150	125	125	0	150	0
Expand SACT Delivery (R) (VCS)	200	167	167	0	200	0
Private Patient Income (R) (VCS)	50	42	42	0	50	0
Private Patient Income (N/R) (VCS)	50	42	42	0	50	0
NEW Medicines at Home (N/R) (VCS)		0	117	117	150	150
NEW Sale of Plasma (NR) (WBS)		0	132	132	155	155
Total Income Generation	525	438	686	249	830	305
TRUST TOTAL SAVINGS	1,800	1,456	1,456	0	1,800	0
			100%		100%	

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Cummulative monthly savings achieved compared to target

Legend: Cumulative Achieved Savings (blue), Cumulative Target Savings (orange)
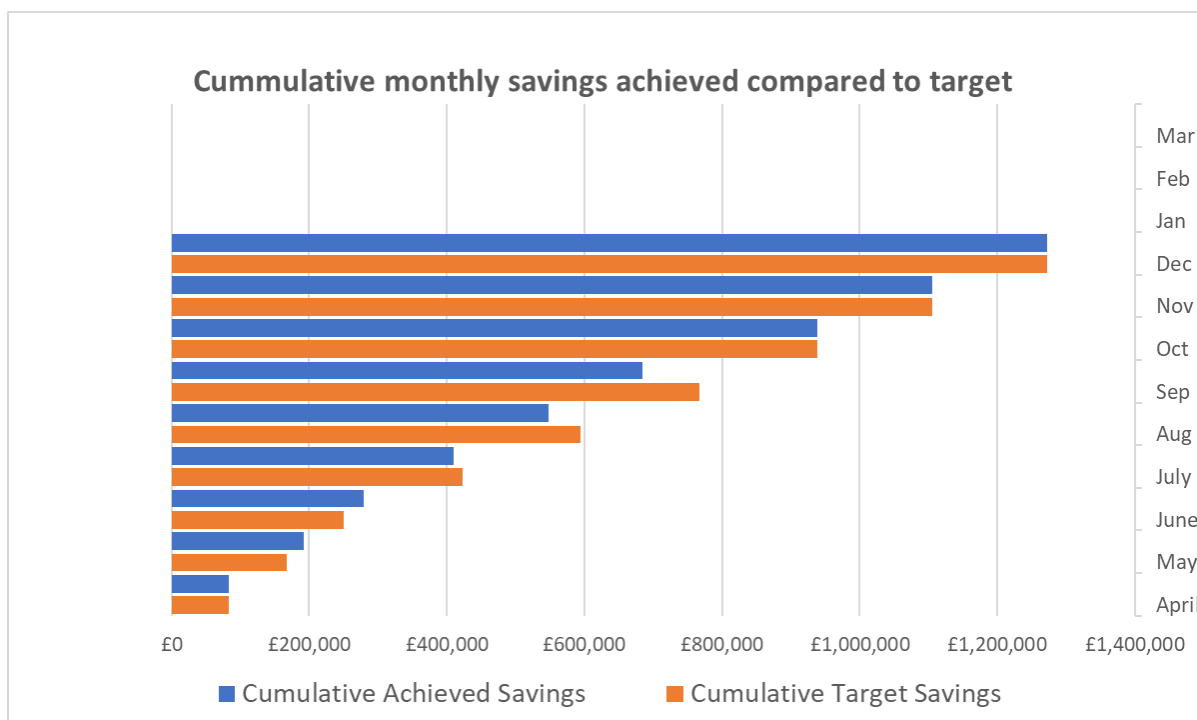
5. Reserves

The financial strategy for 2023-24 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25.

As well as the planned reserves further, un-planned non-recurrent reserves have arisen during the year as financial pressures built into the IMTP financial plan have reduced (e.g. energy costs) or been mitigated and income levels improved above the plan, including Bank Interest, cancer services activity recovery above plan, balance sheet provisions not required, Plasma Sale income (commercial) and Private Patient Income (Commercial) above plan.

In addition to the above reserves, the Trust holds an emergency reserve of £0.522m which it has not had to utilise to date.

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs which may arise over the remainder of the year, however, given that none of the emergency reserve has thus far been utilised it is expected that the Trust should be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

6. End of Year Forecast / Risk & Opportunities Assessment

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the Trust the majority of the risks have now either been managed or mitigated for 2023/24.

The remaining key financial risks & opportunities as highlighted to Welsh Government are provided below:

Risks

2023/24 Pay Award – c£0.300m

At this stage the Trust is still expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award which was processed in October (c£0.7m). WG have now made an interim payment which equates to 90% of the pay award and are aiming to resolve the final pay allocation as soon as possible. Indicative figures suggested that the gap in pay award funding against actual costs could be c£0.300m, however recent correspondence suggests that the gap could now be a lot less or removed completely. If the Trust does not receive the full funding, then the shortfall can be managed on a non-recurrent basis during 2023-24, however could lead to a recurrent shortfall being carried into next financial year. Pay award budget has been allocated to Divisions on assumption of WG matched funding.

Trust wide - Management of Operational Cost Pressures – *Risk mitigated for 2023/24 / Risk 2024/25.*

Whilst there are several cost pressures that are already within the service divisions, expectation is that these will be managed from within normal budgetary control procedures or through utilisation of the Trust reserve during 2023/24. The recurrent impact of these cost pressures for future years will be considered as part of the IMTP process.

VCS - NEW RISK - Whitchurch Site Security – *Risk mitigated for 2023/24 / Risk 2024/25.*

The annual cost of maintaining security on the Whitchurch hospital site based on information provided by C&VUHB is expected to be £0.600m.The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs, The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer will be dependent on completion of all due diligence work regarding the land and the Whitchurch Hospital building and the WG formal process for transfer which is currently anticipated to take place towards the end of the financial year, however this could be delayed into 2024-25. Once the land is transferred to the Trust, the cost pressure would remain on a recurrent basis, if WG does not fund, until the residual Whitchurch estate can be disposed of. This £0.600m cost pressure together with other revenue cost pressures relating to the nVCC over the next 4 years could lead to the Trust failing to meet its Financial breakeven requirement.

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7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *And to ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	9.579	0.000	1.317	10.896	0.000
nVCC - Project costs	0.000	2.818	0.000	(2.818)	3.243	(3.243)
nVCC - Advanced Design Works	3.882	3.863	0.000	0.019	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000	0.000	0.898	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	0.000	(0.014)	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	5.211	0.000	2.615	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.073	0.000	0.074	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.113	0.000	0.055	0.168	0.000
Digital Cyber Security	0.051	0.000	0.000	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.000	0.000	0.085	0.085	0.000
Digital DPIF - EPMA	0.100	0.000	0.000	0.100	0.100	0.000
Digital WHAIS	0.250	0.000	0.000	0.250	0.250	0.000
Capital Year End Spend	0.257	0.000	0.000	0.257	0.257	0.000
Total All Wales Capital Programme	24.724	22.569	0.000	2.155	27.981	(3.257)
Discretionary Capital	1.683	0.418	0.000	1.265	1.683	0.000
Total	26.407	22.987	0.000	3.420	29.664	(3.257)

The approved Capital Expenditure Limit (CEL) as at January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.**

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

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

In January the Trust was awarded a further £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ringfenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January. The allocation has provided funding to support the following prioritised schemes.

Scheme	Amount £'000s
Abdominal Compression	35
Centrifuge Sorvall	7
Hand and Foot Monitor	25
Microplate Reader	6
Phase Contrast Material for Transport of Frozen Products	40
PRRT	35
QPCR Machine (PC-DCR Machine)	75
Radiological Equipment Test Instrument	16
Replacement Blood Gas Analyser	18
Total	**257**

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG during this September, with the caveat that the funding will be re-provided in future years.

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities. In addition, a further £0.250m was ringfenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the 14th February. The £0.250m will now be released and considered for redistribution against prioritised schemes at the next Capital planning group meeting.

NHS – All Wales Capital Prioritisation

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 31st March 2024 which coincides with the IMTP submission. The prioritisation from must be completed for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received. The forms will be presented to EMB Shape on the 18th March before being submitted to WG.

Performance to date

The actual expenditure to January 2024 on the All-Wales Capital Programme schemes was £22.569m, this is broken down between spend on the nVCC enabling works £9.579m, nVCC Project Costs £2.5818, nVCC Advanced design works £3.863m, nVCC Advanced works £0.898m Whitchurch Hospital Site £0.014m, IRS £5.211m, IRS RSC £0.073m and Digital RISP £0.113m.

Spend to date on Discretionary Capital is currently £0.418m.

Year-end Forecast Spend

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The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL.

All schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.

The CEL was fixed by WG at the end of October (for all capital programmes apart from the nVCC Project as highlighted above), after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The latest draft position of schemes that will be included in the IMTP for 2024-25 is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2024-25 £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	7.653	6.952	52.429	1.801		68.835
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.060	0.583	0.586	0.500		2.729
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	2.253	0.050	0.050	0.159		2.512
Talbot Green - Infrastructure	0.369	1.346	10.633	10.640	19.708	42.696
WBS Fleet Replacement		0.330	1.205	1.225		2.760
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
Total Unapproved Capital Schemes	**16.269**	**10.047**	**65.774**	**14.325**	**21.268**	**127.683**
Total All Wales Capital Plans	**32.698**	**13.634**	**81.574**	**15.164**	**21.268**	**164.338**

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8. BALANCE SHEET / Statement of Financial Position (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

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	Opening Balance Beginning of Apr 23	Closing Balance End of Jan-24	Movement from 1st April Jan-24	Forecast Closing Balance End of Mar 24
Non-Current Assets	£'m	£'m	£'m	£'m
Property, plant and equipment	170.418	186.662	16.244	186.662
Intangible assets	11.194	9.335	(1.859)	9.335
Trade and other receivables	1,107.047	1,111.853	4.806	1,111.853
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,288.659	1,307.850	19.191	1,307.850
Current Assets				
Inventories	34.070	31.769	(2.301)	31.769
Trade and other receivables	565.742	548.019	(17.723)	578.107
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	40.488	9.352	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.948	620.276	(10.672)	620.276
TOTAL ASSETS	1,919.607	1,928.126	8.519	1,928.126
Current Liabilities				
Trade and other payables	(226.254)	(230.258)	(4.004)	(230.258)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(430.662)	(38.137)	(430.662)
Current Liabilities sub total	(619.902)	(660.920)	(41.018)	(660.920)
NET ASSETS LESS CURRENT LIABILITIES	1,299.705	1,267.206	(32.499)	1,267.206
Non-Current Liabilities				
Trade and other payables	(3.092)	(3.092)	0.000	(3.092)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,108.919)	(1,069.028)	39.891	(1,069.028)
Non-Current Liabilities sub total	(1,114.432)	(1,072.120)	42.31	(1,072.120)
TOTAL ASSETS EMPLOYED	185.273	195.086	9.813	195.086
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	36.039	1.33	36.039
PDC	131.461	139.928	8.467	139.928
Retained earnings	19.104	19.119	0.015	19.119
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.273	195.086	9.813	195.086

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

In order to support cash flow pressures during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG. In addition, whilst the Trust is yet to receive confirmation of the 2023-24 Pay award allocation, WG have provided an interim payment of c£10m which equates to 90% of the pay award for the whole Trust whilst the final allocation is agreed and settled.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		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**	37.581	38.378	41.097	40.905	41.581	41.028	45.508	50.729	40.780	49.819	44.217	45.167	516.790
2	**WG Income**	14.460	18.799	9.707	42.966	22.143	2.138	9.901	40.339	38.269	45.454	26.944	26.144	297.263
3	**Short Term Loans**													0.000
4	**PDC**							8.881					13.145	22.026
5	**Interest Receivable**	0.149	0.162	0.143	0.126	0.106	0.117	0.140	0.107	0.147	0.124	0.100	0.100	1.521
6	**Sale of Assets**													0.000
7	**Other**	6.156	3.753	2.953	5.651	5.886	12.689	4.605	9.557	10.364	4.299	6.250	6.525	78.687
8	**TOTAL RECEIPTS**	**58.346**	**61.092**	**53.900**	**89.648**	**69.716**	**55.971**	**69.035**	**100.732**	**89.560**	**99.696**	**77.510**	**91.080**	**916.287**
	PAYMENTS													
9	**Salaries and Wages**	31.801	34.720	38.993	34.802	34.922	34.500	37.556	39.292	35.915	35.533	35.911	35.971	429.917
10	**Non pay items**	28.883	34.362	26.186	46.813	35.820	9.253	33.404	49.863	71.353	25.586	64.746	50.502	476.772
11	**Short Term Loan Repayment**													0.000
12	**PDC Repayment**		0.000											0.000
14	**Capital Payment**	1.122	0.394	2.160	1.949	0.824	1.094	2.297	5.077	1.955	1.915	3.071	8.476	30.334
15	**Other items**													0.000
16	**TOTAL PAYMENTS**	**61.807**	**69.477**	**67.339**	**83.564**	**71.566**	**44.847**	**73.257**	**94.232**	**109.223**	**63.034**	**103.728**	**94.949**	**937.022**
17	**Net cash inflow/outflow**	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(4.222)	6.500	(19.663)	36.662	(26.218)	(3.869)	
18	**Balance b/f**	31.136	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	3.826	40.488	14.270	
19	**Balance c/f**	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	3.826	40.488	14.270	10.400	

Monthly Cash Flow Forecast

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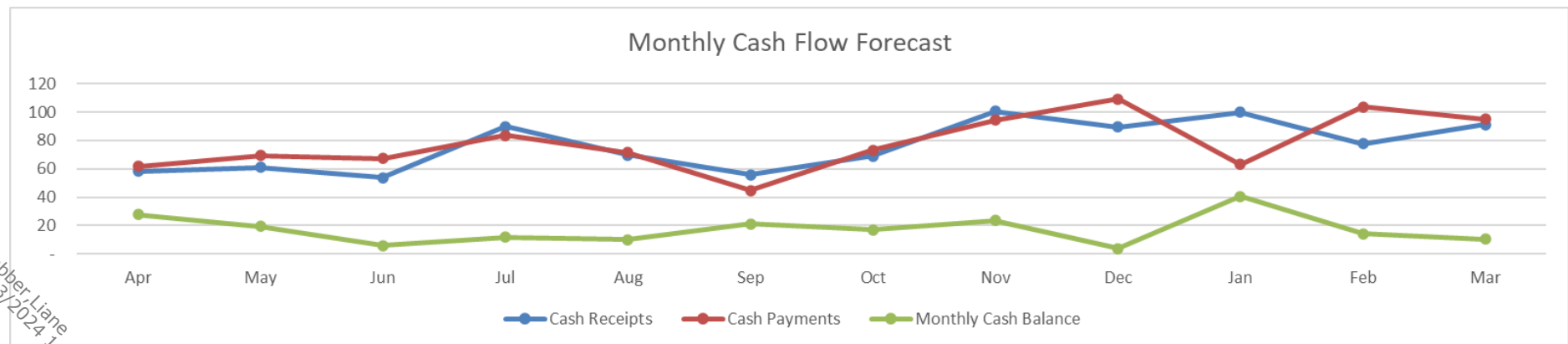
(Figures in parenthesis signify an adverse variance against plan)

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	(34.733)	(34.733)	(0.000)	(41.347)	(41.347)	(0.000)
RD&I	(0.281)	(0.280)	0.001	0.091	0.091	0.000
WBS	(18.356)	(18.354)	0.001	(21.703)	(21.703)	0.000
Sub-Total Divisions	**(53.369)**	**(53.367)**	**0.000**	**(62.959)**	**(62.959)**	**(0.000)**
Corporate Services Directorates	(11.052)	(11.050)	0.002	(13.204)	(13.203)	0.000
Delegated Budget Position	**(64.422)**	**(64.417)**	**0.005**	**(76.163)**	**(76.163)**	**0.000**
TCS	(0.605)	(0.594)	0.010	(0.744)	(0.744)	0.000
Health Technology Wales	(0.109)	(0.109)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	65.136	65.136	0.000	77.024	77.024	0.000
Trust Position	0.000	0.015	0.015	(0.000)	0.000	(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	**62.110**	**63.379**	**1.269**	**76.174**	**77.443**	**1.269**
Expenditure						
Staff	41.420	41.498	(0.079)	49.729	49.808	(0.079)
Non Staff	55.423	56.614	(1.191)	67.792	68.983	(1.191)
Sub Total	**96.843**	**98.112**	**(1.269)**	**117.522**	**118.791**	**(1.269)**
Total	**(34.733)**	**(34.733)**	0.000	**(41.347)**	**(41.347)**	**(0.000)**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of January 2024 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 10 represents a surplus of **£1.005m**. Considerable overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare. This is offsetting and providing a significant surplus above the divisional management savings target. Other income overachievements are in areas such as Catering and project income which are offset with non-pay costs.

VCS have reported a year to date overspend of **£(0.79)m** against staff. Vacancies with the division continue to reduce with VCS filing 10 vacancies in October across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy.

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Vacancies levels do however remain high in Nursing budgets, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme has been used to help fill current vacancies in Nursing with 17wte expected to be recruited during Quarter 4.

Non-Staff Expenditure at Month 10 was **£(0.191)m** overspent which is a result of the divisional management savings target, along with increased activity pressures which can be linked to activity contract performance in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**23.783**	**24.306**	**0.523**	**28.957**	**29.480**	**0.523**
Expenditure						
Staff	15.239	15.224	0.015	18.442	18.428	0.015
Non Staff	26.899	27.436	(0.537)	32.218	32.755	(0.538)
Sub Total	**42.138**	**42.660**	**(0.522)**	**50.660**	**51.183**	**(0.523)**
Total	**(18.356)**	**(18.354)**	**0.001**	**(21.703)**	**(21.703)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of January 2024 was a small **£0.001m underspend** with an outturn forecast position of **Breakeven**.

Income overachievement of **£0.523m** to month 10. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities to support divisional investment. Plasma sale income is being partly offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is still yet to see signs of recovery. WBS are continuing to run campaigns in order to try and grow the panel in sites such as schools and universities, and also raise awareness through advertising on platforms such as social media, however the year to date target continues to underachieve by c39% as at the end of January.

Staff reported a **£0.015m** underspend to January. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured.

Discussions ongoing within WBS SMT to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff reported an overspend of **£(0.537)m** to January. YTD energy price rises have been funded centrally by the Trust as agreed at the IMTP planning stage along with venue hire costs

pressures c£10-£15k per month previously funded by WHSSC, are being partly offset by reduced spend from lower activity releasing non-recurrent benefits linked to reduced production volumes. Trust and Divisional savings plans are phased into the position and contributing to the overspend.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**2.497**	**2.948**	**0.451**	**2.963**	**3.415**	**0.451**
Expenditure						
Staff	10.521	9.968	0.553	12.601	12.048	0.553
Non Staff	3.028	4.030	(1.002)	3.566	4.570	(1.004)
Sub Total	**13.549**	**13.998**	**(0.449)**	**16.167**	**16.618**	**(0.451)**
Total	**(11.052)**	**(11.050)**	0.002	**(13.204)**	**(13.203)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of January 2024 was a small underspend of **£0.002m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to significantly benefit from receiving greater returns on cash being held in the bank due to the rise in interest rates.

For staff several vacancies have been carried throughout the year across the division particularly within finance which is offsetting the cost of agency and the divisional savings target within non pay and reflecting and underspend of £0.553m as at month 10.

Non pay overspend largely relates to the divisional savings target and the increased running costs associated with the ageing hospital estate.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**2.329**	**2.353**	**0.024**	**3.384**	**3.408**	**0.024**
Expenditure						
Staff	2.426	2.398	0.028	3.006	2.978	0.028
Non Staff	0.184	0.235	(0.051)	0.287	0.339	(0.052)
Sub Total	**2.610**	**2.633**	**(0.023)**	**3.292**	**3.316**	**(0.024)**
Total	**(0.281)**	**(0.280)**	0.001	**0.091**	**0.091**	**(0.000)**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of January 2024 was a **£0.001m** underspend with a current forecast outturn position of **breakeven**.

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Trials Income fluctuations expected throughout the year.

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	**0.000**	**0.032**	**0.032**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.523**	**0.523**	**(0.000)**	**0.693**	**0.693**	**0.000**
Non Staff	**0.011**	**0.043**	**(0.032)**	**0.051**	**0.051**	**0.000**
Sub Total	**0.534**	**0.566**	**(0.032)**	**0.744**	**0.744**	**0.000**
Total	**(0.534)**	**(0.534)**	(0.000)	**(0.744)**	**(0.744)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of January 2024 is **Breakeven** overspent with a forecasted outturn position of **Breakeven.**

Revenue funding of £0.041m will be provided to the nVCC Project for Project Delivery and Judicial Review cost from interest incurred from the Escrow Account.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.154**	**1.151**	**(0.004)**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**1.151**	**1.146**	**0.004**	**1.545**	**1.545**	**0.000**
Non Staff	**0.107**	**0.107**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**1.257**	**1.253**	**0.004**	**1.794**	**1.794**	**0.000**
Total	**(0.103)**	**(0.103)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of January 2024 was **breakeven,** with a forecasted outturn position of **breakeven.**
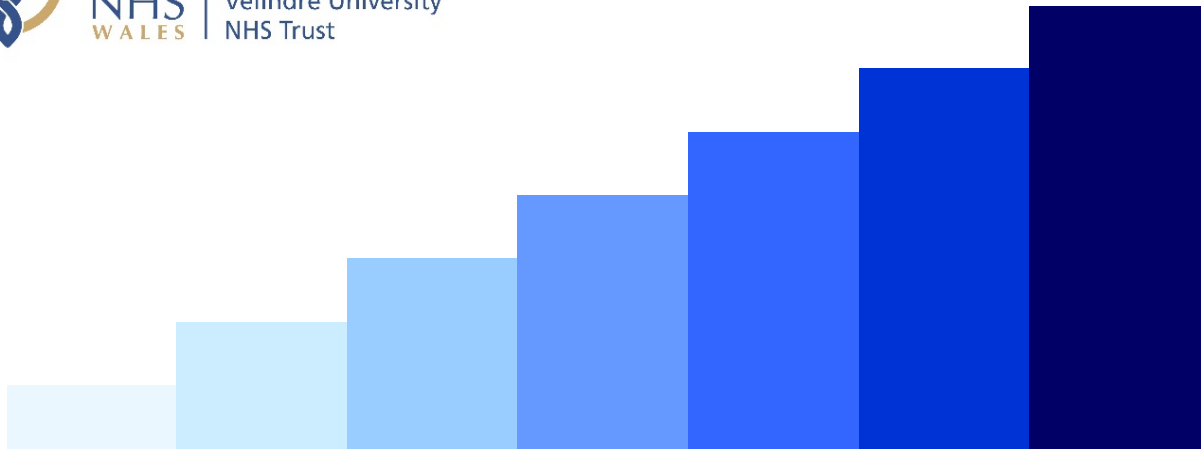
HTW programme costs are funded directly by WG.

TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 31st January 2024

**Presented to EMB Shape on
19th February 2024**

Contents   Page

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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 2023-24, outlining spend against budget as at 31st January 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 2023-24 as at 31st January 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	2023-24 Full Year		
		Budget	Forecast	Variance
Capital	£17.174m	£18.934m	£18.942m	-£0.008m
Revenue	£0.629m	£0.785m	£0.785m	£0
Total	**£17.803m**	**£19.719m**	**£19.727m**	**-£0.008m**

2.2 The overall forecast outturn for the Programme is an overspend of £0.008m for the financial year 2023-24 against a budget of £19.719m.

2.3 Capital funding of £3.257m was allocated by WG to the nVCC Project for this financial year on 26th January 2024.

2.4 Capital funding of £0.898m for the Advanced Works Agreement for the nVCC Project was allocated by WG on 9th January 2024.

2.5 Revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year from the interest incurred by the Escrow account. This supersedes the proposed funding request of £0.041m which was to be made to the Trust.

2.6 The current financial risks associated with the TCS Programme are:

- There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding.

    There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG as part of the Enabling Works FBC Addendum.

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.

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3.2 By 31st March 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2.293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018-19, increased to £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2023-24 is £10.896m capital and £0.785m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding
Initial Allocation (as at 1st April 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
ADDA	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£10.896m**	**£10.896m**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£3.257m	£3.257m
ADDA	£4.780m	£4.780m
Whitchurch Hospital Site	£0	£0
Total	**£8.037m**	**£8.037m**

Current Allocation (as at 31st January 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£3.257m	£3.257m
ADDA	£4.780m	£4.780m
Whitchurch Hospital Site	£0	£0
Total	**£18.934m**	**£18.934m**

Sources of Revenue Funding
Initial Allocation (as at 1st April 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0	£0	£0.300m
nVCC	£0	£0	£0	£0	£0
SDT	£0.180m	£0.131m	£0	£0	£0.311m
Total	**£0.420m**	**£0.191m**	**£0**	**£0**	**£0.611m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0	£0	£0.028m	£0	£0.028m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0	£0	£0.009m	£0	£0.009m
Total	**£0**	**£0**	**£0.133m**	**£0.041m**	**£0.174m**

Current Allocation (as at 31st January 2024)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0.028m	£0	£0.328m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0.180m	£0.131m	£0.009m	£0	£0.320m
Total	**£0.420m**	**£0.191m**	**£0.133m**	**£0.041m**	**£0.785m**

4. CAPITAL POSITION

4.1 The current capital funding for 2023-24 is outlined below:

- Enabling Works Project   £10.896m
- nVCC Project   £3.257m
- ADDA   £4.780m
- Whitchurch Hospital Site   £0
  - **Total**   **£18.934m**

4.2 The capital position as at 31st January 2024 is outlined below, with a forecast spend of £18.942m for 2023-24 against a budget of £18.934m.

Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£9.580m	£10.896m	£10.905m	-£0.009m
nVCC Project	£2.818m	£3.257m	£3.243m	£0.014m
ADDA	£4.762m	£4.780m	£4.780m	£0
Whitchurch Hospital Site	£0.014m	£0	£0.014m	-£0.014m
Total	**£17.174m**	**£18.934m**	**£18.942m**	**-£0.008m**

4.3 Capital funding of £3.257m was allocated to the nVCC Project from WG for 2023-24 on 26th January 2024.

4.4 There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval.

5. REVENUE POSITION

5.1 The revenue funding for 2023-24 is outlined below:

- PMO £0.328m
- nVCC Project £0.137m
- SDT Project £0.320m
  Total **£0.785m**

5.2 The revenue position as at 31st January 2024 is outlined below, with a forecast breakeven position for the financial year for 2023-24 against a budget of £0.785m.

Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
PMO	£0.263m	£0.328m	£0.328m	£0
nVCC Project	£0.118m	£0.137m	£0.137m	£0
SDT Project	£0.248m	£0.320m	£0.320m	£0
Total	**£0.629m**	**£0.785m**	**£0.785m**	**£0**

5.3 Revenue funding of £0.041m will be provided to the nVCC Project for Project Delivery and Judicial Review cost from interest incurred from the Escrow Account.

5.4 The 2022-23 one-off pay recovery payment was paid out in June 2023, with funding provided by WG in June 2023 via the Trust. Funding has also been provided by WG to cover the recurrent pay award for 2023-24 paid out in August 2023.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that the majority of costs will have been incurred within the first half of the financial year.

EW Project Cash Flow 2023-24
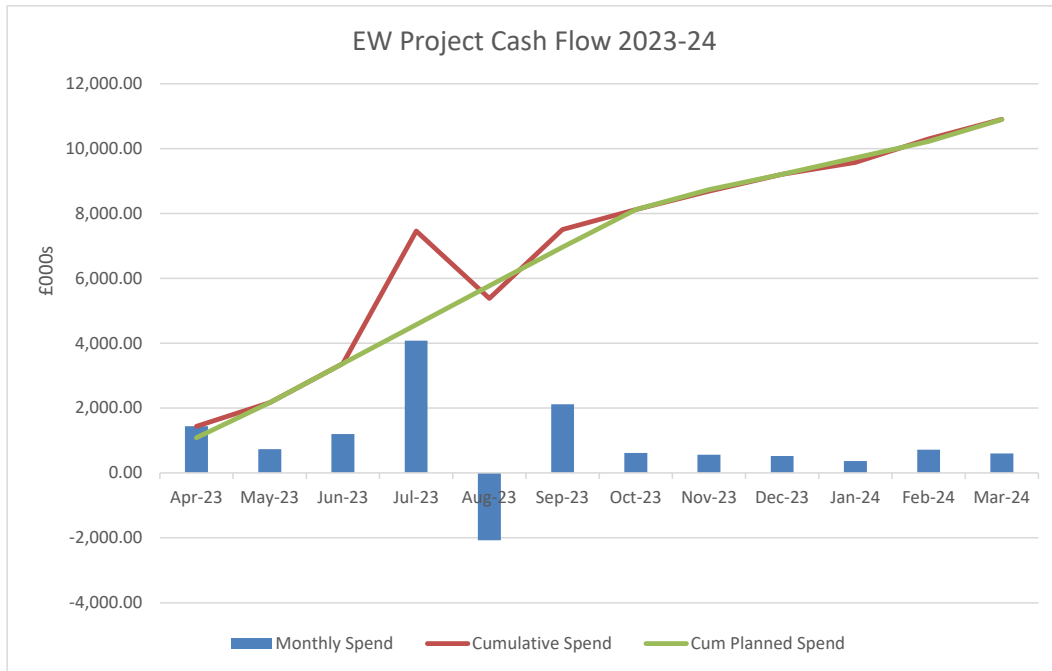
6.2   The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher than planned spend due to the increased costs associated with the delay in financial close.

nVCC Project Cash Flow 2023-24
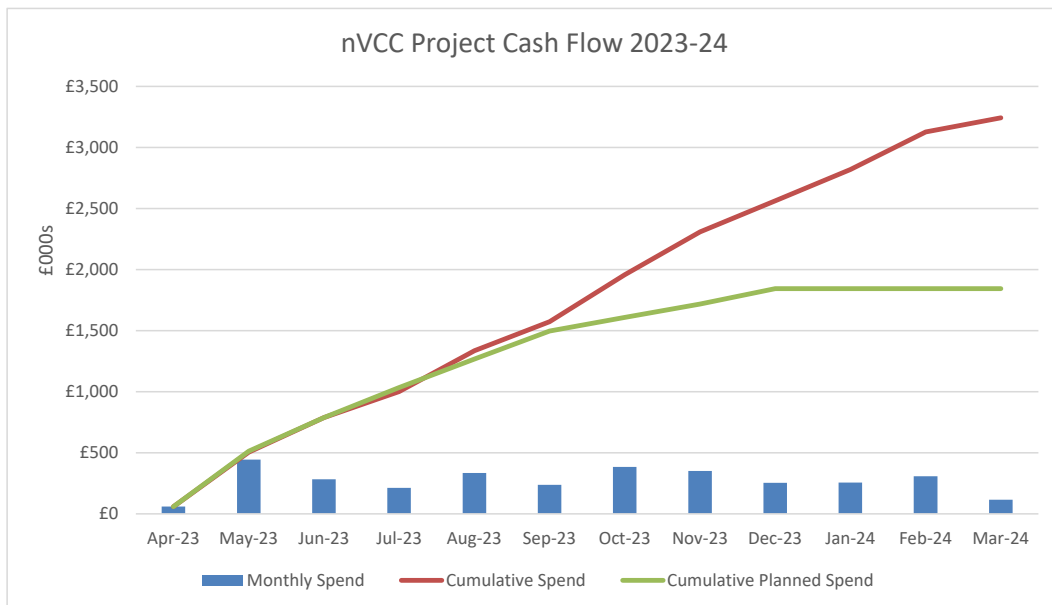
6.3   The capital cash flow for the ADDA Project will be provided in the next report. The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

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 2023-24 is £0.328m. £0.240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.028m from WG 2022-23 for pay awards.

7.3 There has been no capital funding requirement for the PMO in 2023-24.

7.4 The revenue position for the PMO as at 31st January 2024 is shown below, showing a forecast breakeven positon for the year against a budget of £0.328m.

| PMO Expenditure | Year to Date Spend | 2023-24 Full Year | | |
		Budget	Forecast	Variance
Pay	£0.259m	£0.316m	£0.316m	£0
Non Pay	£0.003m	£0.013m	£0.013m	£0
Total	**£0.263m**	**£0.328m**	**£0.328m**	£0

7.5 There are currently no financial risks associated with the PMO for 2023-24.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC. This has provided capital funding of £28.089m in total, with £10.896m provided in 2023-24.

7.7 The Project's financial position for 31st January 2024 is shown below. The forecast position reflects an overspend of £0.009m against a budget of £10.896m for this financial year. This overspend will be managed within the Project.

| Enabling Works Capital Expenditure | Year to Date Spend | 2023-24 Full Year | | |
		Budget	Forecast	Variance
Pay	£0.256m	£0.230m	£0.293m	-£0.064m
Non-Pay	£9.324m	£10.667m	£10.612m	£0.055m
Total	**£9.580m**	**£10.896m**	**£10.905m**	**-£0.009m**

7.8 There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval. The elements are:

- Water Main Diversion   £0.850m inc VAT
- S278 Works – Longwood Drive   £1.200m inc VAT
- Off Site Habitat Creation   £0.400m inc VAT
- HV Intake Room   £0.450m inc VAT
  Total   **£2.900m inc VAT**

7.9 The Project spend relates to the following activities:

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Enabling Works FBC Project Capital Budget & Spend Summary 2023-24

Description		Budget Jan-24 £	Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Annual Forecast £	Annual Variance £
		Year to Date			**Financial Year**		
PAY							
Project 1b - Enabling Works FBC		200,534	256,251	-55,717	229,841	293,393	-63,552
Pay Capital Total		**200,534**	**256,251**	**-55,717**	**229,841**	**293,393**	**-63,552**
NON-PAY							
EF02	Utility Costs	2,472,139	1,891,385	580,754	2,873,927	2,391,385	482,542
EF03	Supply Chain Fees	291,667	376,613	-84,946	375,000	443,113	-68,113
EF04	Non Works Costs	260,421	129,164	131,257	312,505	329,364	-16,858
EF05	ASDA Works	3,451,946	2,539,500	912,446	3,813,893	2,745,686	1,068,207
EF06	Walters D&B	3,033,982	4,452,603	-1,418,621	3,033,982	4,852,603	-1,818,621
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	0	0	0
EF08	Section 278	0	0	0	0	250,000	-250,000
EFQR	Quantified Risk	6,247	512	5,735	257,245	512	256,733
EFQS	QRA - SCP	0	-65,439	65,439	0	-65,439	65,439
EFRS	Enabling Works FBC Reserves	0	-549	549	0	-335,549	335,549
Enabling Works FBC Project Capital Total		**9,516,402**	**9,323,789**	**192,613**	**10,666,552**	**10,611,674**	**54,877**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**9,716,936**	**9,580,040**	**136,896**	**10,896,393**	**10,905,068**	**-8,675**

7.10 There is currently one financial risk associated with the Enabling Works Project:

- The three new elements to the Enabling Works Project require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding.

New Velindre Cancer Centre Project
Capital

7.11 The nVCC Project has now been allocated capital funding of £3.257m for

7.12 The capital financial position for the nVCC Project for 31st January 2024 is shown below, with a forecast underspend of £0.014m. This underspend will be managed within the Project.

nVCC Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	**Forecast**	**Variance**
Pay	£0.957m	£1.164m	£1.168m	-£0.004m
Non-Pay	£1.861m	£2.093m	£2.075m	£0.018m
Total	**£2.818m**	**£3.257m**	**£3.243m**	**£0.014m**

7.13   The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Budget Jan-24 £	Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Annual Forecast £	Annual Variance £
PAY						
Project Leadership nVCC OBC	178,076	183,970	-5,895	213,691	225,596	-11,905
Project 2a - New Velindre Cancer Centre OBC	791,975	772,925	19,050	950,370	942,152	8,218
Pay Capital Total	**970,051**	**956,895**	**13,156**	**1,164,061**	**1,167,748**	**-3,687**
NON-PAY						
nVCC OBC Project Delivery	42,209	42,209	0	63,963	62,963	1,000
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	0	1,586,454	-1,586,454	1,828,788	1,735,454	93,334
VC10 Legal Advice	0	9,398	-9,398	32,398	9,398	23,000
VC11 S73 Planning	0	14,437	-14,437	14,437	14,437	0
VC12 nVCC FBC	0	187,634	-187,634	153,216	231,634	-78,418
VCRS nVCC OBC Reserves	0	20,945	-20,945	0	20,945	-20,945
nVCC Project Capital Total	**0**	**1,818,868**	**-1,818,868**	**2,028,839**	**2,011,868**	**16,971**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**1,012,260**	**2,817,972**	**-1,805,712**	**3,256,863**	**3,242,579**	**14,284**

7.14   There are currently no capital financial risks to the Project.

Revenue

7.15   The current revenue funding for the nVCC Project for 2023-24 is £0.137m, provided from WG for pay awards and interest incurred from the Escrow account. The latter has superseded the proposed request for revenue funding of £0.030m for nVCC Project Delivery and £0.011m for the Judicial Review.

7.16   The revenue financial position for the nVCC Project for 31st January 2024 is shown below, reflecting a forecast break even position for the year against budget of £0.137m.

nVCC Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	**Forecast**	**Variance**
Pay	£0.083m	£0.096m	£0.096m	£0
Project Delivery	£0.024m	£0.030m	£0.030m	£0
Judicial Review	£0.011m	£0.011m	£0.011m	£0
Total	**£0.118m**	**£0.137m**	**£0.137m**	**£0**

7.17   The Judicial Review matter is now closed, with the final costs being submitted in July 2023. The final cost in 2023-24 is £0.011m, with a total cost for this matter of £0.138m.

7.18   There are no revenue financial risk associated with the nVCC Project at present.

Advanced Design Delivery Agreement (ADDA)

7.19   The ADDA Project reflects the commercial agreement between the Trust and SACYR for advance design services that covers RIBA stage 4 design / design not falling under the nVCC MIM Project bid deliverables and including masterplan amendments. In addition, it covers design costs associated with the Value Engineering exercise. The RIBA Stage 4 direct costs have been incurred, (including management team) up to a value of £3.882m (excl. VAT).

7.20 The Project includes the Advanced Works Agreement, which received funding of £0.898m from WG in early January 2024.

7.21 The capital financial position for this Project for 31st January 2024 is shown below, with a forecast spend of £4.780m against a current budget of the same for the year.

| ADDA Expenditure | Year to Date Spend | 2023-24 Full Year | | |
		Budget	Forecast	Variance
Non-Pay	£4.762m	£4.780m	£4.780m	£0
Total	**£4.762m**	**£4.780m**	**£4.780m**	**£0**

7.22 The spend relates to the following activities:

ADDA Capital Budget & Spend Summary 2023-24						
		Year to Date			Financial Year		
Description		Budget Jan-24 £	Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Annual Forecast £	Annual Variance £
PAY							
Project 2b - Advanced Design Development Agreement		0	0	0	0	0	0
Pay Capital Total		**0**	**0**	**0**	**0**	**0**	**0**
NON-PAY							
Work Packages							
AD01 Advanced Design Development Agreement		3,881,995	3,863,528	18,467	3,881,995	3,881,994	1
AD02 Advanced Works Agreement		898,457	898,458	-1	898,457	898,458	-1
nVCC Project Capital Total		**4,780,452**	**4,761,986**	**18,466**	**4,780,452**	**4,780,452**	**0**
TOTAL nVCC OBC CAPITAL EXPENDITURE		**4,780,452**	**4,761,986**	**18,466**	**4,780,452**	**4,780,452**	**0**

7.23 There are currently no financial risks for this project.

Whitchurch Hospital Site

7.24 The achievement of the EPSL from NRW required the granting of a habitat Licence on elements of the residual Whitchurch Hospital estate by Cardiff and Vale University Health Board. In order for the Trust to receive the habitat Licence from Cardiff and Vale University Health Board (C&VUHB), it agreed in principle to accept the formal transfer of the residual estate. The Trust is currently undertaking the required legal and technical diligence. With regards technical diligence, asbestos and condition surveys are being commissioned by the Trust to meet its obligations. The cost of the surveys is funded by securing additional funding from WG as part of the Enabling Works FBC Addendum.

7.25 The capital financial position for the nVCC Project for 31st January 2024 is shown below, with a forecast overspend of £0.014m.

| Whitchurch Hospital Site Expenditure | Year to Date Spend | 2023-24 Full Year | | |
		Budget	Forecast	Variance
Non-Pay	£0.014m	£0	£0.014m	-£0.014m
Total	**£0.014m**	**£0**	**£0.014m**	**-£0.014m**

7.26   The spend relates to the following activities:

Whitchurch Hospital Site Capital Budget & Spend Summary 2023-24

Description	Budget Jan-24 £	Year to Date Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project 2c - Whitchurch Hospital Site	0	0	0	0	0	0
Pay Capital Total	**0**	**0**	**0**	**0**	**0**	**0**
NON-PAY						
Work Packages						
WS01 Advisory Services	0	7,040	-7,040	0	7,040	-7,040
WS02 Prelimiary Works	0	6,495	-6,495	0	6,495	-6,495
WSRS Whitchurch Hospital Site Reserves	0	0	0	0	0	0
nVCC Project Capital Total	**0**	**13,535**	**-13,535**	**0**	**13,535**	**-13,535**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**13,535**	**-13,535**	**0**	**13,535**	**-13,535**

7.27   There is a risk of a lack of funding for these costs, which is being mitigated by securing additional funding from WG as part of the Enabling Works FBC Addendum.

Service Delivery and Transformation Project

7.28   The revenue funding for the Project for 2022-23 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.009m from the WG 2022-23 one-off recovery payment funding. The resulting budget is £0.320m for this financial year.

7.29   There is no capital funding requirement for the Project in 2023-24.

7.30   The SDT Project revenue position for 31st January 2024 is shown below, showing a forecast breakeven positon for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.231m	£0.281m	£0.281m	£0
Non-Pay	£0.018m	£0.038m	£0.038m	£0
Total	**£0.248m**	**£0.320m**	**£0.320m**	**£0**

7.31   There are currently no financial risks associated with the Project for 2023-24.

8.   KEY RISKS AND MITIGATING ACTIONS

8.1   The current three financial risks associated with the TCS Programme are outlined below:

- There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding.

- There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG as part of the Enabling Works 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.

9.2 Appendix 3 provides cumulative report to 31st March 2022. The report for the financial year 2022-23 is currently being produced.

9.3 The cumulative report shows a total spend for the TCS Programme of £30.352m (£26.481m Capital, £3.871m Revenue). The total pay costs for this period were £11.303m.

9.4 The spend to 31st March 2022 for each Project within the Programme is summarised below.

Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC...£13.234m
Project 3a Integrated Radiotherapy Solution.............£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning £0m

9.5 The five deliverables with the highest spend during this period are:

Project Control..£4.390m
Feasibility Studies..£2.734m
Planning and Design £2.669m
Outline Business Case (inc revision and approval)......£2.456m
Project Agreement..£1.838m

APPENDIX 1: TCS Programme Budget and Spend as at 31st January 2024

TCS Programme Budget & Spend 2023-24

CAPITAL	Budget Jan-24 £	Year to Date Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project Leadership nVCC OBC	178,076	183,970	-5,895	213,691	225,596	-11,905
Project 1b - Enabling Works FBC	200,534	256,251	-55,717	229,841	293,393	-63,552
Project 2a - New Velindre Cancer Centre OBC	791,975	772,925	19,050	950,370	942,152	8,218
Capital Pay Total	**1,170,585**	**1,213,146**	**-42,561**	**1,393,902**	**1,461,142**	**-67,240**
NON-PAY						
nVCC OBC Project Delivery	42,209	42,209	0	63,963	62,963	1,000
Project 1b - Enabling Works FBC	9,516,402	9,323,789	192,613	10,666,552	10,611,674	54,877
Project 2a - New Velindre Cancer Centre OBC	0	1,818,868	-1,818,868	2,028,839	2,011,868	16,971
Project 2b - Advanced Design Development Agreement	4,780,452	4,761,986	18,466	4,780,452	4,780,452	0
Project 2c - Whitchurch Hospital Site	0	13,535	-13,535	0	13,535	-13,535
Capital Non-Pay Total	**14,339,062**	**15,960,386**	**-1,621,324**	**17,539,805**	**17,480,492**	**59,313**
CAPITAL TOTAL	**15,509,647**	**17,173,533**	**-1,663,886**	**18,933,707**	**18,941,634**	**-7,927**

REVENUE	Budget Jan-24 £	Year to Date Spend Jan-24 £	Variance Jan-24 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
nVCC Pay Award	83,413	83,413	0	96,408	96,408	0
Programme Management Office	259,366	259,354	12	315,656	315,644	12
Project 6 - Service Change Team	230,927	230,927	1	281,219	281,219	1
Revenue Pay Total	**573,707**	**573,694**	**13**	**693,283**	**693,271**	**13**
NON-PAY						
nVCC OBC Project Delivery	25,390	23,987	1,403	30,000	30,000	0
nVCC OBC Judicial Review	11,000	11,000	0	11,000	11,000	0
Programme Management Office	6,324	3,174	3,150	12,644	12,656	-12
Project 6 - Service Change Team	24,542	17,542	7,000	38,411	38,412	-1
Revenue Non-Pay Total	**67,257**	**55,703**	**11,553**	**92,055**	**92,068**	**-13**
REVENUE TOTAL	**640,963**	**629,397**	**11,566**	**785,339**	**785,339**	**0**

APPENDIX 2: TCS Programme Funding for 2023-24

Description	Funding Type	
	Capital	**Revenue**
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2023-24 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£3.257m**	**£0.137m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Escrow Interest		£0.041m
2023-24 CEL from Welsh Government funding for nVCC Project approved in January 2024	£3.257m	
Advanced Design Development Agreement	**£4.780m**	**£0**
2023-24 CEL from Welsh Government funding for ADDA approved October 2023	£3.882m	
2023-24 CEL from Welsh Government funding for AWA approved January 2024	£0.898m	
Whitchurch Hospital Site	**£0**	**£0**
Funding for Whitchurch Hospital Site to be provided by WG	£0	
Radiotherapy Satellite Centre	**£0**	**£0**
No funding requested or provided for this project to date		
SACT and Outreach	**£0**	**£0**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0**	**£0.320m**
Commissioner's Funding		£0.180m
Trust Revenue Funding		£0.131m
WG One Off Pay Award 2022/23 Funding		£0.002m
WG Recurrent Pay Award Funding		£0.007m
VCC Decommissioning	**£0**	**£0**
No funding requested or provided for this project to date		
Total	**£18.934m**	**£0.785m**

APPENDIX 3:   TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

SPEND PER PROJECT PER YEAR

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH PROJECT ACROSS ALL YEARS

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

£328,459 £2,398,448
£6,428,671
£6,167,590
£3,924,181
£3,909,063
£2,928,426
£4,267,262

Legend:
- 2014-15
- 2015-16
- 2016-17
- 2017-18
- 2018-19
- 2019-20
- 2020-21
- 2021-22
- 2022-23
- 2023-24
- 2024-25
- 2025-26

TOTAL SPEND BY PROJECT TO DATE   £30,352,092

Project	Amount
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Integrarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,266,123
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

	Supplier	Amount
1	Payroll	£11,048,740
2	Mott MacDonald	£5,614,021
3	DLA Piper	£3,398,669
4	Non Pay Costs	£1,043,962
5	Price Waterhouse Coopers	£848,084

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

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Fax: 01443 843259
 e-mail:Matthew.Bunce@wales.nhs.uk

13th February 2024

Matthew Denham-Jones
Deputy Director of Finance
Health & Social Services Group
Welsh Government

Dear Matt,

Velindre Month 10 (January 2024) Monitoring Return

In line with the guidance issued, please find attached the tables required for Month 10.

1. **Table A – Movement of Opening Financial Plan to Forecast Outturn**

   The Velindre core table has been completed in line with the Trust draft IMTP, NWSSP has then been combined to give the overall Trust Position.

   As included in the 2023-24 IMTP the Core Trust had a carry forward underlying surplus of £0.684m, which relates to the 2022-23 1.5% core discretionary uplift funding that was not committed due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

   The non-recurrent component of the energy cost increase in 2022-23 resulted in an underlying surplus being carried forward into 2023-24 which was to act as contingency for further anticipated volatility in energy prices. The balance of the underlying surplus was forecast to reduce year-on-year to fund new cost pressures over the 3-year planning period. However, due to non-achievement of some recurrent saving schemes and emerging cost pressures the underlying surplus has been fully used to cover this funding shortfall in the plan.

   The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income. All LTA/ SLA documents were issued and signed by the 30th June in line with the

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funding flows mechanism agreed at Directors of Finance Forum. The final funding flows agreement included income protection measures for Velindre Cancer Services, which were not included within the Trust's Medium Term Financial Plan as the agreement was reached after the IMTP was approved. This resulted in c£1.25m of additional income in excess of the plan which the Trust has foregone as a contribution to supporting the NHS financial deficit.

At this stage of the year the emergency reserve still remains available and whilst it is really important to keep a contingency for unforeseen cost pressures, we are fairly confident on the basis that if no costs arise before the end of the financial year that the Trust should be in a position to release the emergency reserve on a non-recurrent basis to support the All-Wales position.

We will of course continue to review the financial position over the final months of the year to see whether any further contribution may be possible. **(Action Point 9.1)**

2. Table A1 – Underlying Position

As planned in the IMTP the Trust brought forward a surplus of £0.684m from 2022-23 and as highlighted above this surplus was forecast to reduce year-on-year as additional cost pressures arose over the 3-year planning period.

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

3. Table A2 – Risks & Opportunities

Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the management of the Trust the risks have now either been managed or mitigated for 2023/24.

2

Pay Award funding - £(300)k

We appreciate that WG colleagues are looking to resolve the pay allocations as soon as possible, but until settled there is a risk that the allocation may not match the funding requirement. Indicative figures suggests that the gap could be c£300k which can be managed on a non-recurrent basis during 2023-24, however will lead to a recurrent shortfall to be carried into next financial year. This potential cost pressure hasn't currently been included in the 2024-25 IMTP financial plan.

Management of Operational Cost Pressures – (Removed from table for 2023/24)

Whilst there are several cost pressures within the service Divisions, expectation is that these will be manged from within normal budgetary control procedures or through utilisation of the Trust non-recurrent reserve during remainder of 2023/24. The recurrent impact of these cost pressures for future years has removed any underlying surplus but is under consideration as part of the 2024-25 to 2026-27 IMTP process.

Whitchurch Site Security – (removed from table for 2023/24)

The annual cost of maintaining security on the Whitchurch hospital site based on information provided by C&VUHB is expected to be £0.600m.The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will fund these costs, The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer will be dependent on completion of the WG formal process for transfer which is currently anticipated to take place towards the end of the financial year, however this could be delayed into 2024-25. Once the land is transferred to the Trust, the cost pressure would remain on a recurrent basis, if WG does provide funding, until the residual Whitchurch estate can be disposed of. This £0.600m cost pressure together with other revenue cost pressures relating to the nVCC over the next 4 years could lead to the Trust failing to meet its Financial breakeven requirement. Welsh Government Officers have asked the Trust to submit a paper to the WG Health Service Board setting out the costs associated with the Whitchurch site transfer and funding requirement.

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Response to Financial Pressures: Financial Improvement Options

Following the letter received from Judith Paget on the 31st July which provided a view on the overall financial position of Welsh NHS organisations for 2023/24, and a request for those organisations with balanced plans to support the delivery of a reduction in the overall NHS Wales deficit, the Trust has delivered the following financial improvement options which were endorsed by the Trust Board on the 9th August and were submitted to WG on the 11th August.

Velindre Cancer Services (VCS) Contract Protection - c£1.250m

The Trust has confirmed to its Commissioners that it will relinquish the Nationally agreed LTA income protection included in the signed 2023/24 LTA/ SLA's with them. This reduces the cost of Velindre Cancer Services (VCS) for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across South Wales LHBs, with the majority of the benefit in C&VUHB, ABUHB and CTMUHB.

Energy - c£0.569m

The latest energy forecast shared by NWSSP during February suggests that as at month 10 there is a reduction of c£0.569m (month 9 c£0.661m) from the figures presented at the IMTP planning stage. The actual savings that will be available will be dependent on forecast wholesale prices provided by the supplier and the energy procurement options available through the Crown Commercial Service Framework which is led by NWSSP as part of the all-Wales Energy Group. However, expectation is that if further cost reduction opportunity arises in 2023-24 it can be released to support the NHS deficit.

Review Utilisation of Reserves and Planned Expenditure Commitments (Inc Emergency Reserve) (£0.500m)

As highlighted above the Trust should be in a position to release the emergency reserve on a non-recurrent basis during 2023/24, on the basis that any unforeseen costs that may materialise before the financial year will need to be mitigated / managed at Divisional level.

Medicines Management (c£0.250m 6 months & £0.500m recurrently)

The Trust agreed with NWSSP Medicines Unit to use two generic / biosimilar Immunotherapy medicines which commenced from mid-September '23 delivering cost savings to our Commissioners. The savings passed through to

4

Commissioners as part of the NICE/HCD cost recharge are net of any internal resource costs required to deliver the change. The Trust will continue to work with NWSSP on the opportunity for scalability to include other medicines as this will require a system approach and any change to the current scope of two products will need to be agreed in advance of supply agreement.

Opportunities

The reserves position is described above as part of a potential contribution to the system to support the NHS Financial pressures.

Table B – Monthly Positions

The Trust position for the period ended January 2024 as reported in table B is a £0.015m underspend and a forecasted outturn position of breakeven.

The combined table is produced by adding NWSSP to the Trust Core return.

Non pay costs is a result of increase in Blood Wholesale costs (c£500k), which is offset with an increase in Health Board income.

Pay & Agency (Table B2)

Of the £1.761m agency spend reported in the table as at the end of January, £0.890m 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.

As previously described the Trust has been transitioning the Radiotherapy, Medical Physics and some of the Estates staff into substantive positions within the Trust following investment decisions in these areas, with expectation that some agency costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical is largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

4. Covid-19 (Table B3)

Covid Programme Costs

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Per the allocation letter funding for ongoing national Covid responses, including mass vaccination, and the provision of PPE will be held centrally and allocated on actual costs incurred during 2023-24. It is recognised that any other Covid related programme costs will need to be funded by the Trust.

The Trust is still only expecting to draw funding from WG towards PPE costs for 2023-24. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity:

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m made in 2021-22 and 2022-23 using WG Covid funding which ceased from 1st April 2023. The income to fund this additional capacity flows from Commissioners via performance related LTA contracting income which is dependent on activity levels being delivered above baseline contract. The LTAs approved by LHBs in June 2023 included a level of income protection for the Trust. Recognising the financial pressures faced by the system in NHS Wales, the Trust Board made a decision in August to relinquish the income protection arrangements in order to contribute to the reduction of the NHS Wales planned deficit. This was formally communicated with Commissioners and transacted following updated LTAs in September.

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners. The Trust's Medium-Term Financial Plan assumed that activity levels may not be sufficient to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position is that the contract performance has recovered to cover the £3.5m investment during 2023/24.

Whilst the year to date gap in funding has recovered since the IMTP planning stage, work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing or repurposing these costs.

The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.

5. **Savings (Table C – C4)**

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As highlighted last month replacement saving schemes have been identified to replace those that are RAG rated red. At this stage of the year the Trust is expected to deliver the revised savings plan.

The RAG rating status for NWSSP has been reviewed and should be accurately reflected this month **(Action Point 9.2)**

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 10.

7. Invoiced Income (Table E1)

The Total income for the year is shown within Table E.

8. SoFP (Table F)

The latest Velindre Trust SoFP has been included for month 10.

9. Cash Flow (Table G)

In line with the guidance the cash flow has been completed for month 10.

10. PSPP (Table H)

We are pleased to report that the Trust continues to achieve the 95% target of Non-NHS invoices being paid within 30 days.

Regular meetings of the PSPP group have been reinstated with an area of focus being to review NHS performance, especially in light of improved Non-NHS performance. High levels of sickness and significant capacity issues throughout the Trust have had an impact on performance, however with the recent re-appointment of the Invoices on Hold (IOH) officer in Shared Services we are working with NWSSP colleagues to shape the role to support the core Trust which will provide additional capacity, with a sole focus on processing invoices and resolving issues. **(Action Point 9.3)**

The Trust will continue to work with NWSSP colleagues with the aim of improving the 95% NHS invoice target.

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The PSPP forecast has been reviewed and updated for this return**. (Action Point 9.4)**

11. Capital Tables (Table I-K)

The Capital tables have been completed for month 10.

Per the recent CEL we recognise that £3.257m of funding has been allocated below the line to support the nVCC project costs.

12. EFL (Table L)

In line with the guidance the EFL has been completed for month 10.

The IFRS 16 calculations have been reviewed and agreed for month 10, which should align with the figures provided in table E. **(Action Point 9.5).**

13. Aged Debtors (Table M)

There are currently no invoices that are older than 11 weeks for Velindre Core Trust.

14. Ringfenced (Table P)

In line with the allocation letter the latest forecast funding requirement in relation to Value Based Healthcare (VBHC) has been presented in table P.

15. Other

This letter and relevant tables from the MMR will be going to the Trust Quality, Safety and Performance Committee in March 2024.

The supplementary IFRS16 template has been completed and is attached with this return. **(Action Point 9.6)**

The financial accounting team have reviewed the guidance provided on IFRS 16 accounting principles and can confirm that there is no impact **(Action Point 9.7).**

Conclusion

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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
Director of Finance
Velindre UNHS Trust

Nicola Williams
Acting Chief Executive
Velindre UNHS Trust

Quality, Safety and Performance Committee

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (QUARTER 3).

Date of meeting	14/03/24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

Prepared by	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	1. VELINDRE NHST IMTP PROGRESS 2023/24 1.1 This report provides an update (position as of 25th December 2023) of progress against the actions (October – December 2023) which were included within the IMTP for 2023/24 as at Quarter 3. 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 3.

RECOMMENDATION / ACTIONS	The Quality Safety & Performance Committee is asked to**:** • **NOTE** the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 3 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide initiatives.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	**19 December 2023**
VCS SLT / Performance Review	**20 December 2023**
Executive Management Board	**29 February 2024**
Summary and outcome of previous governance discussions: The report has been considered and endorsed at the VCS and WBS Performance Review and EMB Run meetings and is presented to the QSP Committee for information and noting.	

7 LEVELS OF ASSURANCE N/A

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/12/2023.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/12/2023.**
3	**Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 25/12/2023.**

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2023/24-2025/26 was submitted to the Welsh Government on 31st March 2023. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 3 (October to December 2023), has given only a short time for a detailed assessment of progress against IMTP actions during early January for EMB consideration.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q3 for WBS, VCS and Trust-wide.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2023/24 Actions	Velindre Cancer Services IMTP 2023/24 Actions	Trust-wide Initiatives IMTP 2023/24 Actions
BLUE	Action successfully completed with benefits being realized			
GREEN	Satisfactory progress being made against action in line with agreed timescale	10 Q actions	10 Q actions	6 Q actions
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	5 Q actions	10 Q actions	6 Q actions
AMBER	Delays in implementation / action paused due to external issues beyond our control		2 Q actions	
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2023/23 Quarterly Actions		15 Q actions	22 Q actions	32 Full Year Actions

3.3 WBS are making satisfactory progress, categorised as '*green or yellow*', against all 15 of their actions as at Q3.

3.4 VCS are making satisfactory progress, categorised as '*green or yellow*', against 20 of their 22 actions.

3.5 However, two actions that remain assessed as 'amber'. This is defined as '*Delays in implementation / action paused due to external issues beyond our control*'. These two actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.22)
- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025) (pg. 30)

3.6 There are 32 Trust-wide actions or 'themes' (Digital 6; workforce 6; Estates 4; Sustainability 10 and finance 6), all of which are making good progress as at Q3.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ⊠ • An internationally renowned provider of exceptional clinical services ⊠ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ⊠ areas of priority • An established 'University' Trust which provides highly valued ⊠ knowledge for learning for all. • A sustainable organization that plays its part in creating a better future ⊠ for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarized here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
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

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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
6.

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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Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 15/01/2024.

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2032 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2025/26.	• Personalised donor experience • Wider communication choice for donors • Increased donor retention • Improved information (for sharing/decision-making) • Increased levels of efficiency/ productivity	Prepare donor data recovery map for incorrect donor details.	Begin implementation of donor data recovery plan.	Finalise implementation of donor data recovery plan. Re-platform appointment system portal for booking blood donations.	Scope requirements of integrated communication platform for Donor Contact Centre.	Donor Data Recovery Plan - semi-automated process introduced. Appointment system portal launch planned for Summer 2024. Scoping completed for an integrated communication platform for Donor Contact Centre.	
	Develop and implement strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2023/24.	• Increased stem cell donor panel • Increase in stem cells supply. • Improved resilience in stem cell supplies	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved. Develop implementation plan.	Launch and implement strategy.	Post implementation review.	Development of Strategy has been transferred to WBS Futures portfolio and work is underway. Timelines are being reappraised.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved clinical outcomes in Wales/globally • Increased income levels						
SP2: To provide a world class donor experience **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement our new donor strategy by 2025/26.	• Right size/shape donor panel • Increased resilience for supply of blood/products across Wales • Improved levels of efficiency/productivity Reduced importation and costs • Increased brand awareness and reach • Wider population/donor education • Development of rich data to	Sign off strategy.	Review existing systems and processes in line with strategy.	Identify opportunities for further improvement.	Commence implementation. Review and Identify opportunities. Review current establishment.	Final draft strategy developed, awaiting sign off prior to initiating a review of systems and processes. Implementation will form part of the WBS Futures portfolio.	

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IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		improved insights and focus efforts in right areas						(yellow)
SP3: Drive the prudent use of blood across Wales (Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively • Reduced length of stay post-surgery • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance.	Advertise and recruit Anaemia Team Review baseline Digital Health Care Wales (DHCW) data.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Implement relevant plan as agreed. Recruit Health Board nurses to manage Anaemia clinics. Raise profile with primary care leads, and the internal review of the Pathway with users (January 2024).	Stakeholder engagement underway. Resource Toolkit for patients and healthcare professionals developed. Stakeholder and nursing data dashboard training sessions staged in October and December 2023. A pilot of patient related experience survey (PREMS) is taking place with BCUHB and ABUHB.	(green)

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IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved efficiency • Cost efficiencies.						
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2024/25.	• Increased /Sustainable collection model • Improved access for service users • Improved collection efficiency • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry	Continue reintroduction of Mobile Donation Collections.	Introduce 'tours' to remote areas of North West Wales.	Establish project group to progress identified fixed site options.	Continue to progress fixed site model.	Tours for North Wales have been scoped and stakeholder engagement commenced. Continued exploration of potential fixed venues/sites is underway.	

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	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Continue phased implementation of OCP (2019) outcomes. Complete new job descriptions.	Continue phased implementation of OCP (2019) outcomes. Complete review of existing service model.	Complete implementation of OCP (2019) outcomes. Develop workforce plan. Provide and promote leadership learning opportunities.	Prepare OCP 2 process in relation to clinically led service model. Complete OCP 2 consultation. Implement new clinically led collection team model.	Work continues with the Organisational Change Process (OCP) to review the impact on north and west Wales collection teams. Work continues in preparation for go live of OCP recommendations in South Wales in January 2024. OCP2 will form part of the WBS Futures portfolio.
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste • Reduce wastage.	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of platelet planning tool.	Planning tool developed and in routine use. Review the clinic collection plan for Apheresis to ensure the clinic times are optimised.	Clinical and Scientific roadmap established to predict future trends e.g., cold platelets. Begin development of platelet strategy.	Continue development of the platelet strategy.	The Platelet Strategy development has been transferred to WBS Futures portfolio and work is underway. First workshop took place in October 2023 and second planned for January 2024 to finalise scope and prioritisation of work. Timelines are being reappraised.
	Implement a new Laboratory Information Management	• Improved availability of information	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Procurement has been completed and supplier identified.

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	System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste					Implementation commenced January 2024 after contract award. Implementation will form part of the WBS Futures portfolio.	🟩
	Procure new Blood Establishment Computer System (BECS) contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	Commence Supplier engagement for new BECS contract.	Supplier Engagement.	Contract award.	Confirm supplier & commence implementation	Schedule for procurement approved. User Requirements Specification is approximately 90% complete. Consultants supporting Outline Business case. Funding position remains unconfirmed.	🟨
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO	Implemented testing strategy in 2022/23. Ongoing look back exercises as required.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	The project is running to plan, in compliance with SaBTO recommendations. Data is being collated as our contribution to the SaBTO review.	🟩

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	donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	recommendations.	Input data into SaBTO review.				SaBTO have not confirmed a report date for this review.	
	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 2023/24.	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create the Divisional Quality Hub. Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to support Continuous Improvement culture.	6 month review of Quality Hub delivery. Implementation of eQMS. Review amended Change Management process.	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and functionality.	Divisional Quality Hub meets monthly and is delivering on its objectives. The e-Quality Management System procurement (eQMS) has concluded. A Project group established to validate the new system. A continuous improvement approach to review changes and identify further improvements to the change management system has been adopted.	

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		update processes.					
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety • Improved patient experience • Reduction in avoidable waste/costs	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free Foetal DNA testing.	Procurement of commercial kit completed November 2023. Validation of test and development of software in progress. The 'Go live' date has been agreed by Programme Board as 13th May 2024.	
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secure the supply chain for Immunoglobulins in Wales • Reduces need for importation. • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate / renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and	A business case for Welsh Government (WG) has been drafted. Financial modeling is under review and endorsed by Strategic Development Committee (January 24). If approved by Trust Board this will be circulated to WG and WHSCC in February 2024. A MOU has been signed allowing WBS and WG	

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				(subject to WG policy decision).		recovered plasma.	to join the UK Plasma Board and participate in the national program. WG advice on program governance at Wales level to be agreed.	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2032 – 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	• Improved donor satisfaction • Improved staff well-being • Increased service resilience • Reduction in energy consumption and utilisation • Reduction in carbon emissions • Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Refresh of Programme Business Case (PBC). Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Decision to integrate phase 1 (sustainability elements) & phase 2 (laboratory space utilisation) into one OBC. Funding secured to update OBC. Project re-baselined. Anticipated submission Qtr 2 2024.	
SP7 Develop great people and a	Develop a sustainable workforce model	• Enhanced workforce capacity &	Consult on new Senior Leadership	Permanently recruit to remaining SLT	Permanently recruit to remaining SLT	Review of newly implemented	WBS Senior Leadership Team (SLT) recruitment complete.	

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great place to work **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	which provides 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.	Team (SLT) workforce model and recruit to roles where there are substantive job holders.	roles where there are currently only seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	roles where there are currently only seconded post holders. Plan and deliver training / team development sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	SLT workforce model. Phased implementation of new Clinical Services workforce model. Phased implementation of new Laboratory Services workforce model.	The Clinical Services delivery model scoping has concluded with a new model recommended. Existing roles are being reviewed/introduced via a phased approach as opposed to an OCP. The Laboratory Services Modernisation Programme is on schedule to be delivered via the WBS Futures portfolio.	

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 25/12/2023

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction	Complete recruitment to any additional posts identified in workforce plan. Review SLAs. Review operational model	Undertake staff training. Deploy communications plan. Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25 Installation of 2 standard linear accelerators and a CT Sim at the centre.	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan .	• Working group established in conjunction with ABUHB to design service specification and SLA.	(yellow)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care	Clinical commissioning of first replacement linear accelerator at the existing VCS	Realise initial pathway improvements. Initiate digital implementation and develop	Decommissioning and removal of second linear accelerator. Bunker refurbishment commenced in	Installation and commissioning of second replacement linear accelerator at VCS	• All aspects of phase 1 (year 1) delivered on-time and on-budget.	(green)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• 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	First patient treatment (June 2023)	benefits realisation plan.	advance of installation of second replacement linear accelerator.		• Planning for phase 1 (year 2) in development.	
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy services by Q1 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Brachy therapy service improvement group. Identify actions requiring divisional/Trust support.	Optional appraisal to be completed to identify and agree service model required to address capacity gap.	Business case to be completed (if required) to address additional resource requirement.	Continue to implement local actions.	• Work on the peer review action plan has been paused following the resignation of a Brachytherapy MPE. Now single handed MPE focused	

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| Link to Trust Destination 2032 | Objective | Expected Benefits | Key Specific Quarterly Actions for 2023/24 | | | | Quarterly Progress Update for Q3 | Progress Rating |
			Q1	Q2	Q3	Q4		
		• Improved productivity and efficiency levels • Improved patient satisfaction	Gather and review baseline data set for theatre utilisation and determine capacity gap Work with Cardiff and Vale University Health Board to review anaesthetic provision and associated SLA	Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		activity on Clinical Commissioning and training additional MPE to maintain operational service.	(yellow)
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP - Radiology Informatics System Procurement.**	• Improved diagnostics information • Better information sharing and enhanced clinical decision-making	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support National implementation	Development of a local implementation plan to support National implementation	• Local deployment order approved by Executive Management Board and the Trust Board (September 2023).	(green)

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Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
		• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction					• Full implementation plan in development.	
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		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding			• Year 3 work plan to be completed during quarter 4. • All year 2 objectives to be completed during quarter 4.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Reduction in avoidable admissions • Improved patient satisfaction						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Quality Management System (Hub) within Velindre Cancer Services by Q2 2023/24**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Task and Finish group. Agree scope of Quality Management System.	Identify resource within VCS to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	• Hub at VCS to be fully implemented by end of quarter 4.	
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist Review by Q3 2023/24**	• Improved patient outcomes • Improved quality of care • Improved patient safety	Identify possible funding requirements and develop business case to support change of service model / finance	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts Completion of review	Review and evaluate impact of implementation	• CNS competency framework formally approved. • Capacity and demand review	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
		• Improved patient • Satisfaction • Reduction in avoidable admissions					complete in the case of all tumour sites. • Feedback to CNS teams and wider SSTs complete.	🟩 (green)
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Progress Pilot 3 - BOPA Centralised (Separated) Clinical Verification Process	Clinical and technical elements of Clinical Verification separated Undertake local compounding of materials	Define local financial impact of model. Further review / Development of SACT processes to ensure service sustainability	Confirm Pay Tech Service resource that must remain @nVCC	• Agreed model for VCC dispensary. • Secured capital funding to support expansion of VCC dispensary capacity. • Continued engagement with national programme.	🟧 (amber)
Trust Strategic Goals 1, 2 and 5	**Expansion of VAP services by Q4 2023/24**	• Provision of care at home/close to home		Develop service model for expansion of service (to	Develop workforce plan. Develop	Realise service expansion subject to any	• Business case to support VAP expansion completed and	🟩 (green)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduced patient needs to travel • Increased patient experience / satisfaction		include opportunities for service transformation).	financial plan and supporting business case.	resource requirement being secured. Evaluation of service change.	submitted to VCS Senior Leadership Team for scrutiny and approval.	(green)
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with national timeframes**	• Improved quality • Improved patient safety • Improved information (access to and sharing of) • Improved levels of efficiency and productivity • Reduction in carbon emissions	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier Map business processes and consider the effects ePMA will have on ways of working	Develop local procurement specification Identify resource required for implementation team Develop business case to support recruitment of implementation team Develop project plan for implementation	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• Engagement with health board partners focused on identifying potential collaboration opportunities.	(yellow)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
Trust Strategic Goals 1, 2, 4 and 5	Implementation of SACT improvement programme by Q1 2024/25	• Improved quality • Improved patient safety • Reduced waiting times • Improved levels of efficiency and productivity • Reduced costs • Improved patient experience	Commence implementation of changes in response to findings of capacity reviews in nursing, treatment booking and pharmacy Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs.	Implementation of findings from capacity reviews in nursing and booking NHH interim service model in place Best practice service model in place ready to transition to nVCC	Progress continues: • Nursing – 5 outstanding recommendations. Anticipated that all will be complete by the end of quarter 4. • Bookings – 4 of 6 recommendations complete. • Pharmacy - 4 outstanding recommendations. Anticipated that all will be complete by the end of quarter 4.	(green)
Trust Strategic Goals 1 and 2	Enhance the Velindre Cancer Services SACT telephone	• Improved quality • Improved patient safety	Establish working group as part of the Safe Care Collaborative	Develop guidelines for audit.	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage	• Improvements to processes implemented supported by	(yellow)

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Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
	helpline to provide 24hr advice, triage service and achieve required standards by Q3 2023/24	• Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Technical capability to record all telephone calls is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.	Conduct audit process		line is achieving agreed VCS standards in accordance with the VCS Generic Patient Enquiry implementation action plan	the Safe Care Collaborative. • Further digital telephony improvement work identified.	(yellow)
Trust Strategic Goals 1, 2 and 4	Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a focus on supporting improved system-wide Suspected	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation of pathway improvements where possible Review ways of	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere Continued engagement in Safe Care Collaborative	• Scoping work on development of interim process to rationalize referral processes ahead of introduction of Hospital 2 Hospital referral solution undertaken.	(green)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24							
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			Cancer Pathway compliance. Improving compliance against new radiotherapy time-to-treatment (previously COSC) targets and improved flow and performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to map sessions and agree key processes and treatment specific pathways for focus Identify service	improvement Establish project teams to take forward Safe care Collaborative project and ensure clear scope of work Develop and Implement new service and delivery model for Attend Anywhere.	working and identify opportunities for workforce reconfiguration Continued engagement in Safe Care Collaborative programme, including review of existing pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere	Programme Identify new ways of working and opportunities for workforce reconfiguration	• Safe Care Collaborative project teams have identified and implemented various pathway improvements and areas for further focused improvement work.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
			improvements / opportunities for change aligned to best practice / national standards Gather and review baseline data sets Establish Task and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries Initiate service improvement projects in conjunction with the Safe Care					

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			Collaborative within MSSC pathway and SACT telephone helpline Review lessons learned/benefits from previous Attend Anywhere pilot, identify tumour site group to initiate work, secure approval to proceed Establish project group					
Trust Strategic Goals 1, 2 and 5	**Digitisation of Medical Records programme by Q4 2024/25**	• Improved patient safety • Improved access to information (for sharing /	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal	Develop supporting business case(s) Initiate phased delivery of the Project	• Project group yet to be established.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions			Explore off-site storage options as part of a phased transition			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of national prehabilitation to rehabilitation deliverables by 2025/26**	• Improved quality • Improved patient safety • Reduction in cancelled treatments • Improved patient health and well-being • Improved clinical outcomes • Improved patient experience	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define timelines Review funding streams and commissioning models to	Establish task and finish group to develop prehabilitation website for VCS patients	Introduce prehabilitation (self-management) website for VCS patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	• Working group now meeting on a monthly basis. • Continued engagement with national prehabilitation meetings. • Staff engagement and awareness survey in development. • First project communication	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
			facilitate prehabilitation service development.				newsletter in development.	(green)
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025)	• Improved quality • Improved patient safety • Improved patient dignity and experience • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Reduction in carbon emissions • Reduced staff sickness	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works Continued engagement between nVCC project team and VCS.	Achieve financial close Ground clearance works Continued engagement between nVCC project team and VCS.	Commence nVCC construction Continued engagement between nVCC project team and VCS.	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCS to the nVCC Finalise clinical models to be implemented to support nVCC.	• Full Business Case remains under development and awaits Welsh Government approval.	(orange)
Link to Trust Destination	Implementation of Outreach	• Increase care close to home	Project board re-established in	Service model developed and agreed in	Identify and agree additional workforce	Service model developed and agreed with	• Strategic planning assumptions	(yellow)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Programme by 2025/26**	• Improved access • Improved equity • Improved patient experience • Reduction in carbon emissions	conjunction with HBs	partnership with ABUHB Development of service model in partnership with CTMUHB	requirements and funding streams Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB Ongoing discussions with CTMUHB to determine model and next steps.	both CTMUHB and C&VUHB	and baseline data reviewed. • Engagement with Aneurin Bevan UHB, in the first instance, on delivery model scheduled to take place in January 2024.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes	Establish an acute care programme board Agree scope and develop a statement of intent	Undertake review of service model at VCS and identification of required next steps	Develop communication strategy Develop AOS framework for VCS and service model	Undertake engagement on service model for nVCC	• New operational manager recruited to support regional work.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduction in avoidable admissions • Improved patient experience • Reduction in carbon footprint					• Velindre specific acute oncology project progressing with particular focus on pathways, processes and patient transport issues.	
Trust Strategic Goals 1, 2 and 4	**Implementation of national programme for palliative care and end of life in line with national timeframes**	• Improved quality of care • Reduction in avoidable admissions • Improved patient experience	Review baseline data and outcome from pilot work to date. Identify scope of palliative radiotherapy within VCS and as part of a regional model.	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan Identify possible funding options	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Develop business case to support palliative radiotherapy model if required	• Meetings to focus on the development of an agreed, sustainable model for palliative radiotherapy scheduled for early 2024.	

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
					redesign and develop associated workforce plan			
Trust Strategic Goals 1, 2, and 4	**Implementation of new services / delivery models by 2025/26.**	• Improved quality • Improved patient safety • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Enhanced organisational reputation for quality of service	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments Establish working group to develop service model to support delivery of internal mammary lymph node (IMN) radiotherapy for eligible patients	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and where appropriate commence business case developments for agreed treatments in phased approach according to priority and	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer Develop strategy and service model to support adoption of motion management	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional	• Working group established to plan introduction of IMN and other novel breast cancer treatments. Group will identify treatment solution and any resource implications which will inform the development of a business case to support introduction of new techniques.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q3**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			with breast cancer Continue to engage with WHSSC service appraisal process in relation to proposed PRRT service Develop service model to support implementation of PRRT service for eligible patients with neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients	timetable agreed Identify additional resource required to implement IMN and develop business case if required for consideration by commissioners. Develop service models to support delivery of extreme hypofractionated radiotherapy for eligible patients with prostate cancer if required Identify additional resource required to implement extreme hypofractionated		resource required to support the expansion of the SRS service and develop business case, if required	• Working group established to plan implementation of hypofraction for the treatment of eligible prostate cancer patients (aka SABR for prostate).	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			with prostate cancer. Develop business case for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery of new indications for Stereotactic Ablative Radiotherapy (SABR)	radiotherapy for eligible patients with prostate cancer and develop business case for consideration by commissioners Develop business case to support implementation of PRRT service to WHSSC and funding stream for additional revenue resource if required Train Medical Physics Expert to support implementation of PRRT service				

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
Trust Strategic Goals 1, 2 and 5	**Implement DHCR phase 2 by 2024/25**		Review learning from phase 1 to support implementation of further phases continue implementation of training plan Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of phase 1b (VCS specific) agree scope and prioritisation of phase 2	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• Phase 1 closure report and benefits realisation review developed. Lessons learned exercise undertaken.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q3	Progress Rating
			Q1	Q2	Q3	Q4		
								(yellow)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation by Q4 2024/25**	• Creation and sharing of knowledge across Wales/wider to improved cancer care • Development of network of partners to tackle key issues • Creation of knowledge economy and innovation across Wales • Physical space to support innovation and development working across the region/Wales/wider	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	Workshop to be held to scope CfCL and ways of working	Review potential projects aligned to CfCL, e.g. school for oncology, ARC, etc.	Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	• CCfLI collaborative workshop undertaken and next steps agreed.	(green)

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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Trust-wide Initiatives - IMTP Progress Report 2023/24 for Quarter 3 as at 25/12/2023.

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		**Progress Rating**
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	
Digital Initiatives	**Theme 1: Ensuring our Foundations** **Theme 2: Digital Inclusion** **Theme 3: Insight Driven** **Theme 4: Safe and Secure Systems** **Theme 5: A Digital Organization** **Theme 6: Working in Partnership**	• Provide resilient digital services which support excellent care • Seamlessly digitally connect patients, donors, staff and partners with our services and equally value non-digital channels • Become a data driven, insight led organisation where staff take care of and have the right information, at the right time, all of the time • Secure our data, information and services through an effective approach to Cyber Security • Create a digital culture across the Trust of innovation and knowledge sharing that supports the delivery of world class services	• Implementing our digital strategy • Constantly evolving our IT infrastructure and Cyber Security arrangements to meet good practice with a hybrid of cloud and on premise deployment • Implementing a digital transformation programme to drive benefits and create digital services that our patients, donors and staff value and can be accessed close to home • Increasing the speed of development, deployment and functioning of new technologies to increase our productivity • Working in partnership to implement a range of national systems, to support a once for Wales approach • Working with the public and Centre for Digital Public Services and Digital Communities Wales to champion and accelerate digital inclusion • Developing our partnership role with the Digital Intensive Learning Academy and Health Education and Improvement Wales to increase the digital literacy, skills and knowledge of our staff • Identifying opportunities to join digital accelerator programmes and initiatives	• Digital Strategy Published • Digital Programme established – group met for first time in Q3 2023/24. Digital Design Authority to be established in Q4. • Cyber Security Manager in post – implementation activities against Cyber Security Strategic Plan re-commenced. • Ongoing progress in respect of major digital change programmes – i.e. BECS, WHAIS, RISP, ePMA. • Further development of	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
			• Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols • Transforming our information capability to provide data, information and knowledge to the right person at the right time and introduce new analytical capabilities • Building digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being	relationships with Academia – e.g. Digital Degree Apprenticeships Roadshow planned for Q4 2023/24. • Digital Infrastructure Strategy and Supplier Management Framework drafted – for approval in Q4 2024/25. • New Assistant Director of Data & Insight due to commence in post January 2024. Piloting of 'Agile' delivery model for digital transformation activities due to commence in Q4 2024/25.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		
			Our Objectives will be achieved by Delivering	Quarterly Progress Update for Q3	Progress Rating
Workforce and Organizational Development	**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-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	• Clinical agreed short and long-term MDT workforce plans • Improved alignment of our education and training functions to the needs of our services • Services delivered at a location and time which best suits our patients and donors • All staff to be proud to, and able to, promote our core values and principles • Improved health and well-being of our workforce.	A Health and Wellbeing Plan has been in place for 22/23 overseen by the Healthy and Engages Steering Group. A highlight report is sent to EMB quarterly A training plan is in place for 22/23 overseen by the Education and Training Steering group. A highlight report is sent to EMB quarterly A Strategic Equality plan has been agreed. An implementation plan for 22/23 is being delivered An Agile working Programme has been delivered to support hybrid working across the Trust A Programme to increase Welsh Essential roles is ongoing in the Trust. A Programme of welsh	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Growing the Trust Inspire Leadership and Management Programme		education is also in place The Trust has undertaken Staff Awards in 2023 and has a programme of Long Service Awards in place The Trust Inspire Management and Leadership programme is in its 4th Cohort, intermediate evaluation is in train	

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Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		
			Our Objectives will be achieved by Delivering	Quarterly Progress Update for Q3	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**	• Provide an estate which enables the delivery of high quality clinical services • Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience • Provide healthy buildings which support and enhance individual well-being • Minimise the impact of our estate on the environment • Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve	• Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs • Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces • Investing additional resources in the maintenance of the existing estate to maintain a Category B • Implementing our estates, digital, workforce and sustainability strategies • Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles • Identifying innovative ways to adopt renewable energy sources to service our requirements • Identifying facilities we can share the use of with other public bodies and wider partners • Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets • Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services • Delivering a number of transformative capital programmes which have sustainability at their centre of design:		

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IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
			o Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 o Refurbishment / development of new outreach facilities by 2024/2025 o Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 o Opening of the new Velindre Cancer Centre by 2025		
Sustainability	**Theme 1: Creating Wider Value** **Theme 2: Sustainable Care Models** **Theme 3: Carbon Net Zero** **Theme 4: Sustainable Infrastructure** **Theme 5: Transition to a Renewable Future** **Theme 6: Sustainable Use of Resources** **Theme 7: Connecting with Nature**	• Be recognised as a leading NHS Trust for sustainability nationally • Be a carbon 'Net Zero' NHS organisation by 2030. • Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being • Support the transformation from ill-health to well-being across Wales •	• Developing clinical service models which support sustainability • Implementing our sustainability strategy • Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle. • Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities. • Investing in a range of refurbishments and new buildings which will support our carbon		

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	Theme 8: Greening our Travel and Transport **Theme 9: Adapting to Climate Change** **Theme 10: Our people as Agents for Change**		reduction and healthier buildings and healthier people approach. These include: ○ Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025 ○ Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024 ○ Construction of a new Velindre Cancer Centre by 2025 • Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities • Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices. • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy		

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		
			Our Objectives will be achieved by Delivering	Quarterly Progress Update for Q3	Progress Rating
The Financial Plan	We have had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.	Our Integrated Medium Term Plan (IMTP) for 2023-2026 sets out our Financial Strategy from 1st April 2023 to 31st March 2026. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated demand for services whilst still in recovery, ensuring that we return to pre-pandemic activity levels and address the backlog. Recovery from the pandemic continues to be further compounded by significant financial challenges due to the system wide exceptional cost pressures, which include energy & fuel cost increases and extraordinary levels of cost inflation, each of which will need to be met by the Trust in 2023-24.	The financial plan for 2023-24 consists of a number of distinct parts: 1. Core Revenue Plan: Balanced 2. COVID-19 Recovery 3. Financial Plan – demand & capacity 4. Income & Cost Assumptions 5. Planned Savings 6. Capital Plans Financial reports and returns		

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KEY:

BLUE	Action successfully completed with benefits being realized
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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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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS.

DATE OF MEETING	14th March 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

| EXECUTIVE SUMMARY | Following the approval of the IMTP 2023/24 to 2025/26 the Trust received an Accountability Conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive, **see Appendix 1**.

A stated requirement within the Accountability Conditions letter was for the Trust to report progress against the conditions on a quarterly basis from quarter 3 (2023/24). |
|---|---|

RECOMMENDATION / ACTIONS	The Quality Safety & Performance Committee is asked to: • **NOTE** the progress update against the Welsh Government accountabilities conditions in **Appendix 1 and 2**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	**30/10/23**
Executive Management Board – Run	**1/02/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board.	

7 LEVELS OF ASSURANCE – NOT APPLICABLE

APPENDICES	
1	Velindre University NHS Trust IMTP Accountability Conditions Letter from the Welsh Government
2	Accountability Conditions Progress Quarter 3 Update

1.   SITUATION

1.1   The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023/24 to 2025/26 had been approved.

1.2   Following the approval of the IMTP, the Trust received an Accountability Conditions letter dated 2nd October 2023, from the NHS Wales Chief Executive **(see Appendix 1)** which laid down the following key accountabilities:

a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risk.

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b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

2. BACKGROUND

2.1 The Welsh Government Accountability Conditions letter stated there was an expectation that:
"*The Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year*".

3. ASSESSMENT

3.1 To ensure robust delivery of IMTP objectives and actions, and to discharge the Welsh Government IMTP accountability conditions, the November QSP Committee recommended that quarterly progress reports are submitted to:
- The Executive Management Board (Run)
- The Quality, Safety and Performance Committee
- The Velindre University NHS Trust Board

Note: we currently report progress against the actions included within the Trust IMTP on a quarterly basis. This proposal is specific to the four Welsh Government accountability conditions.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Quality, Safety and Performance Committee is asked to:

- **NOTE** the progress made against the Welsh Government accountability Conditions for 2023/24 a) to d) in **Appendix 2**

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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:		
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*	Not applicable
	Not Applicable
	The purpose of this paper is to outline the approach for reporting against the Welsh Government IMTP accountability conditions.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the approach outlined within the paper or attached appendices.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A - There are no Trust Well-Being goal implications or impact linked directly to the approach outlined within the paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The purpose of this paper is to initiate a discussion in relation reporting requirements against the Trust IMTP accountability conditions. However, there will be a requirement to undertake an IMTP Equality Impact Assessment I support of the development of the Trust IMTP for 2024/25 – 2026/27.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

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

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Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Mr Steve Ham
Chief Executive
Velindre University NHS Trust
Trust Headquarters
Unit 2, Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ
Steve.Ham2@wales.nhs.uk

2 October 2023

Dear Steve

Integrated Medium-Term Plan 2023-2026

I am pleased to confirm that the Minister for Health and Social Services has approved the Trust's Integrated Medium-Term Plan (IMTP) which you submitted on the 31 March 2023, together with Ministerial priority templates. This approval recognises the development of integrated planning within Velindre, whilst recognising the current challenges and management of risks**.**

Whilst the financial position is extremely challenging for the system, I expect organisations to deliver the commitments set out within their plans, particularly in relation to the Ministerial priorities. You will be aware of parallel discussions with NHS Trusts to proactively explore if there are opportunities to deliver financial improvement beyond the current forecast.

The organisation should continue to progress improvements of a clear triangulated financial position and key trajectories. This is fundamental to the successful delivery of your Board supported IMTP. The organisation will need to:

a)   Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.

b)   Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c)   Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

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Gwefan ● website: www.gov.wales

d)   Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

This will be monitored by the NHS Executive, Financial Planning and Delivery Team on a quarterly basis.

There is an ongoing expectation that the organisation will continue preparing robust financial plans for future years, that considers all choices and options to meet the requirements of the Finance Wales Act 2014.

I expect the Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year, in particular against the Ministerial priority templates you submitted. A copy of your Board reports should be forwarded on a quarterly basis to HSS-PlanningTeam@gov.wales. Organisations should refresh their Minimum Data Set (MDS) on a quarterly basis for as part of their internal review of plans. Please submit your quarter two MDS returns to HSS-PlanningTeam@gov.wales by 27th October 2023.

The Minister is clear that progress in delivering key priorities will form part of the ongoing discussions with Chairs. The delivery of plans will also form the agenda for our Joint Executive Team (JET) meetings going forward. The Welsh Government Planning team will continue to engage and support local planning teams and track progress. Performance and delivery discussions on areas of priority and risk will continue to be scrutinised via the regular Integrated Quality Planning and Delivery (IQPD) meetings.

Risks or challenges that develop during the year will need to be discussed and agreed at your Board and communicated to Welsh Government via the governance arrangements (e.g. IPQD meetings). Where this necessitates any material changes to the plan in year, you will be required to advise me of these changes through an 'Accountable Officer' letter.
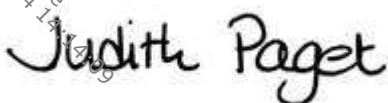
As articulated in the Ministerial letter, approval of the Integrated Medium-Term Plan does not equate to agreement to the detailed service changes, business case proposals or capital assumptions indicated within it. Nor does the plan approval confirm any validity in funding assumptions around additional revenue or capital funding other than that specified below. All service change and business case proposals will still be subject to:

- compliance with extant requirements set out in guidance or in legislation, and
- business cases and bids being subject to the normal business case approval process, including capital, and Invest to Save bid approval processes.

You will be aware that I wrote to you separately on 11th September confirming there will be no change in your escalation status, which remains at "routine arrangements".

The organisation has not requested financial flexibility as part of the IMTP, and none has been granted. I trust that this letter provides clarity on our expectations, but should you have any queries then please do not hesitate to contact me.

Yours sincerely

Judith Paget

Judith Paget CBE

cc: Nick Wood, Deputy Chief Executive NHS Wales
        Samia Edmonds, Planning Director
        Jeremy Griffiths, Director of Operations
        Hywel Jones, Director of Finance

Integrated Medium Term Plan 2023/24 – 2025/26 Accountability Letter 2 October 2023

Quarterly Actions Monitoring Document 2023/24 – New Conditions 2023/24

Accountability Conditions (Judith Paget Letter dated 2/10/23)	Quarterly Actions Progress to comply with IMTP Accountability Conditions			
	Q1	Q2	Q3	Q4
a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Savings** The Trust is currently planning to fully achieve the revised savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status. Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service	

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			leads to implement changes. The procurement supply chain saving schemes have again been affected by procurement team personnel changes and capacity constraints and current market conditions during 2023-24.	
b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	The Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures in response to national financial pressures. As set out to EMB Shape in September, the purpose of the Finance and Investment Enhanced Monitoring agenda item is to strengthen the control environment by	

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			ensuring accountability at an Executive level in relation to:	
			1. Savings delivery 2. Cost control 3. Choices and Options which could contribute towards wider system financial pressures 4. Impacts of spending decisions considering quality, safety, experience and value This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust. In response to the financial pressures faced by NHS Wales, the Trust identified costs savings	

| | | | proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.

Additionally, the non-recurrent reserves position continues to be monitored against financial risks. If it is not required, it can be utilised to support the NHS Wales position on a non-recurrent basis. | |
|---|---|---|---|---|
| c)
Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID. | Accountability Letter not received until October 2023
Progress monitored from Q3 | Accountability Letter not received until October 2023
Progress monitored from Q3 | **Covid Programme Costs**

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast | |

			for 2023-24 reduced to £0.053m. **Covid Recovery and Planned Care Capacity** Funding for Covid recovery and planned care capacity investment flows through the LTA marginal contract income from commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.	

			The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.	
d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Value Based Healthcare Programme** The scope of the Value Based Healthcare programme at Velindre includes the Value Intelligence Centre, Preoperative Anaemia Pathway Project and the Velindre Food Mission. The Value Based Healthcare Programme received funding from Welsh Government to progress two key Value Based Healthcare initiatives across the Trust as follows:	

| | | | Preoperative Anaemia Pathway Project with the Welsh Blood Service (WBS) Value Intelligence Centre across the Trust A VBH Programme update and governance proposal was provided to EMB Shape in October 2023. The governance, terms of reference and implementation plan was approved.

Pre-op Anaemia Pathway (WBS)

This project addresses the variation in the diagnosis and management of patients prior to major surgery. It is funded as a 2 year project to implement an All- | |

			Wales Pre-operative Anaemia Pathway (up to December 2024). **Value Intelligence Centre** A detailed programme plan was approved by the VBH Steering group in November 2023 and is set out in the table below. This includes specific, prioritised work packages and resource requirements taking into account the following interdependencies: • other Velindre programmes (e.g. Data and Insights Data Warehouse, Workforce changes, Quality and Safety, Digital etc.)	

			• National PROMs procurement • Organisational dashboard development workplan • Varian's Noona implementation (as part of the Integrated Radiotherapy Solution) **Food Mission** This workstream focuses on improving the health and wellbeing of patients, donors and staff whilst contributing to the local economy and environmental sustainability of food production through increasing access to healthy food across the Trust.	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Estates Assurance Group – Highlight Report

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Jonathan Fear, Interim Assistant Director of Estates, Environment and Capital Development
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	DISCUSS AND REVIEW

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NWIS	NHS Wales Informatics Service
CSTF	Core Skills Training Framework
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
HSE	Health and Safety Executive
RIDDOR	Reporting of Diseases and Dangerous Occurrences Regulations
nVCC	New Velindre Cancer Centre

1. PURPOSE

1.1 This paper had been prepared to provide the Quality, Safety and Performance Committee with a summary of the key issues considered, and actions taken, by the Trust Estates Assurance Group during quarter 3 (2023 /2024)

1.2 The Trust Estates Assurance Group considered reports from the Trust services in relation to Health and Safety, Fire Safety, Environment and Statutory Compliance as of quarter 3 (2023 / 2024).

1.3 Key highlights from the meeting are reported in section 2.

1.4 The Quality, Safety and Performance Committee is asked to **NOTE** the contents of the report and the actions which are being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Health and Safety** Training compliance figure have improved but still below benchmark of 85% in some areas of the Trust. This is being raised with divisions to ensure benchmark will be reached.

	Oct-23	Nov-23	Nov-23
Corporate Division	81%	81%	81%
RD&I	86%	88%	88%
TCS	81%	82%	82%
VCC	75%	74%	74%
WBS	89%	91%	91%
Trust Compliance	82%	80%	80%
Target	85%	85%	85%

Bespoke training has been arranged in some areas where it is possible to deliver outside of the normal delivery model.

Violence and aggression module C training competency was added in February 2023. 120 staff were identified in the training needs analysis. 108 spaces have been made available. Compliance stands at 20.4%.

Estates Health and Safety RAAC Welsh Blood Service Blood Collection Venues

WBS are currently assessing the risks of RAAC within the blood collection venues that they visit. 144 venues are regularly visited by WBS Collections teams. These venues have been contacted to determine whether RAAC is an issue for them. 67 venues have responded to confirm that RAAC is not an issue for them. The remaining venues are being followed up as a priority. Interim Assistant Director Estates to engage with NWSSP obtain advice on next steps to ensure assurance can be obtained. Update to be provided.

Fire Safety

Statutory and Mandatory Training levels continue to be below required levels across

[RED]	the whole organisation. An action plan has been developed in order to improve compliance and this has resulted in improved training compliance in quarters 2 and 3 (2023 / 2024). Ongoing compliance will be monitored during the coming quarter and a follow-up report will be submitted to the Trust Executive Management Board. **Environmental / Sustainability** Utility costs remain at an inflated level; this provides a cost pressure to the Trust. However, Trust utility costs are being closely monitored and reported and we are also working closely with NWSSP and Health Board colleagues to reduce costs if/where possible. This topic is currently an agenda item for the All-Wales Financial Managers Forum.
ADVISE	**Health and Safety** There have been two incidents relating to chairs within waiting areas at VCC. The Trust Estates department have recently asset tagged and maintained all chairs across the site, VCC division is currently looking to procure new chairs in Quarter 4. A number of incidents relating to chairs involving staff at WBS also have occurred in the last 6 months. New chairs are on the end of year plan awaiting funding. **Scalding Risk Assessment Actions** Hot surfaces risk assessment has been reviewed and has resulted in a number of recommendations for action. A framework request has been raised to rectify the actions from the audit, this will be completed this financial year. **Patient Manual Handling Trianing** From April 2024 training will only be available through the Cardiff & Vale. Discussions are being held to re-instate in house training, however; this may take a few months to implement, and 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, to date 12 staff have completed the IOSH training. There will be a focus in the next 6 months to complete the remaining licenses. **Health and Safety Risk Register** **Estates Safety Risks Impact of 5 (<12)** 2262 – Evacuating persons from passenger lift, manual release **(10)** 2336 – Risk of Injury or ill Health to Estates staff in a lone working environment **(5)** 2338 – Risk to staff working in confined space **(5)** 2339 – Risk to staff whilst using single and double extension ladders and steps **(5)** 2342 – Risk to patients using curtain track as ligature point **(5)** There have been no new H&S risks that are over 12 for WBS 1 RIDDOR reported in VCC (Q3) – Staff slip, trip & fall – Specified Injury

There has been no Health and Safety risks that are over 12 for WBS.

Fire Safety

A Programme of works to validate the cause-and-effect arrangements at the Velindre Cancer center fire alarm system is underway and is due for completion by the end of March 2024.

Environmental

The Welsh Government is introducing new regulations that will require all workplaces to separate recyclable materials in the same way that most domestic householders are currently required do undertake. In response, the Trust Waste Management Policy has been reviewed, updated.

The workplace recycling legislation comes into force on the 6th April 2024 however VCC are classified as a NHS hospital setting and therefore have two years to comply.

WBS are not included in this classification therefore are required to comply by the 6th April. WBS are working towards compliance by installing additional bins, working with the waste contractor and carrying out staff awareness campaigns in readiness for the April deadline.

Sustainability

A key enabling action within the Trust Sustainability Delivery Plan which has progressed in Quarter 3 in preparation for the end of quarter 4 in order to submit to Welsh Government April 2024.

Estates and Statutory Compliance

Staffing

Staffing levels have improved since the last update provided to the Executive Management Board with a majority of the Estates team now in post.

Trust Discretionary Capital Programme

The capital programme for 2023/2024 has been approved. A summary of progress against each Estates scheme is provided below.

Linear Accelerator (LA) 5 Replacement

LA5 replacement, and associated bunker refurbishment works, has been completed and is now in clinical use.

Boiler Replacement at VCC

Boiler replacement works have now been completed and the site has also seen an improvement in hot water temperatures and improved sampling results.

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	First Floor Ward Ventilation First Floor Ward Ventilation works due to start in February 2024 with a 10-week program of works to complete the installation of two Air Handling Units to the inpatient facility at Velindre Cancer Centre.
ASSURE	**Health and Safety** . - Successful recruitment for the Trust Head of Health and Safety post – Expected start date 11th March 2024 - Radon Exposure - The most recent radon measurements, undertaken in the workshop at VCC post remediation works, indicate that the remediation work was successful in reducing the radon concentration within area to below the annual action level. Radon monitoring is currently being carried out in areas where monitors were lost or not returned in the 2022 survey. Due to be collected Feb 2024. The Radon policy is under development and consultation. Due for ratification in 2024/25 (Q1) - WBS received a visit from the HSE last year to look at their blood irradiator and associated controls. Although work had taken place on improving the emergency contingency plans it was highlighted, during the visit, that further work is needed. Work took place to meet the requirements of the HSE and legislation over the summer period of 2023. The HSE were provided with the relevant evidence of the completion of the works and have signed off as satisfied with the work that was completed. - A DSEAR Assessment was undertaken at both VCC and WBS in the last month. Waiting for the report to be issued. - There has been no RAAC identified in VUNHST Buildings VCC and WBS. Hosted organisations NWSSP have 2 leased buildings that have identified RAAC and have adopted a risk based approach. **Fire Safety** A programme of works to validate the cause-and-effect arrangements at the Velindre Cancer center fire alarm system is underway and is due for completion by the end of March 2024. **Environmental / Sustainability** **Trust Well-Being Objectives** The Trust is working to refresh its Well-Being Objectives as required under the Well-Being of Future Generations (Wales) Act 2015. The Sustainability Team has been engaging with a number of internal and external stakeholders – including the Local Partnership Forum, patients & donors and the public. The Trust will now work to evaluate the feedback of this engagement and assess the Trust's current Well-Being Objectives.

	Estates and Statutory Compliance Current performance / compliance, as of quarter 3 (2023/2024), is summarised below: • VCC Compliance – 91% • WBS Compliance - 95% • Trust HQ Compliance - 97% • Dafen WBS Compliance 100% • Pembroke House WBS Compliance 97% • Bangor WBS Compliance – 100%
INFORM	**Fire Safety** Trust priorities in relation to fire and safety (quarter 2 - 2023 / 2024) are summarised below: • Undertake validation of the VCC fire alarm system • Commence annual fire audit • Regain traction around fire safety action plans with divisional groups. • Focus on review of FRAs and existing fire safety policies, procedures and strategies [with input from dedicated fire safety professional]. **Environmental / Sustainability** Trust priorities in relation to environmental and sustainability are summarised below: • Development of the Sustainability Implementation Plan (site-based) • Hosting several Jambori and other engagement events over the forthcoming school holidays • Implementation of the Trust-wide decarbonisation plan implementation • Commencement of Velindre Cancer Centre's new walking aids recycling initiative **Estates and Statutory Compliance** Trust priorities in relation to estates and statutory compliance (quarter 4 - 2023 / 2024) are summarised below: • Recruitment of key positions to support estates and statutory compliance • Delivery of linac 3 to VCC • Delivery of FF Ward Ventilation Sytstem • Key Appointments of AP & CP Roles • Implementation of Synbiotix • Undertake Trust Condition Survey exercise VCC & WBS • Support Divisions in Capital Operational improvements works
APPENDICES	**NOT APPLICABLE**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

POLICY MANAGEMENT REVIEW AND COMPLIANCE STATUS: OCTOBER 2023 TO FEBRUARY 2024

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to provide the Quality, Safety and Performance Committee with an update on the policy compliance work undertaken from October 2023 to February 2024 and provide assurance on the continuing progress that has been made. As at February 2024, of the 113 policies under review **62 (54.87%)** are in date and **51 (45.13%)** have passed their review date. Of the 51 policies that have passed their review date, **10 (19.61%)** are classified as All Wales Policies.

	There have been **2** new policies implemented since the previous report and **1** policy has been archived. The percentage of compliance has risen by **5.37%** since October 2023.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: a) **NOTE** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. b) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***N/A***	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

ACRONYMS	
FCO	Freedom of Information and Compliance Officer
WOD	Workforce and Organisational Development

1. SITUATION

1.1 The purpose of this report is to provide **ASSURANCE** to the Quality, Safety and Performance Committee on the continuing progress that has been made on the current policy compliance status between October 2023 and February 2024.

1.2 A permanent Freedom of Information and Compliance Officer (FCO) was appointed at the end of September 2023 and collaborations with the divisions to increase compliance is ongoing.

The Quality, Safety and Performance Committee is asked to:

a) **NOTE** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b) Receive A**SSURANCE** that progress is being managed via the Executive Management Board.

2. BACKROUND

2.1 The Document Control Register is regularly reviewed with collaborative engagement undertaken with each of the respective policy leads on a regular basis. The purpose of the ongoing collaborative engagement exercise is to confirm and validate the following:
- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

3.2 The importance of planning the review of the policy *in advance* of its review date to ensure it remains in date has been highlighted to each of the policy leads during the audit review. The Document Control Register has been updated to incorporate a trigger point to help facilitate this. As part of the continuous life cycle of a policy, there will never be a fixed static point as a result, during the last 4 months further policies fell outside of their review date.

3. ASSESSMENT

3.1 In relation to the provision of **ASSURANCE**, as at February 2024, of the **113** policies under review **62 (54.87%)** are in date and **51 (45.13%)** have passed their review date. Of the **51** policies that have passed their review date, **10 (19.61%)** are classified as All Wales Policies.

3.2 Table 1 highlights the progress made by each Division in reviewing their policy position between October 2023 - February 2024 and shows the current position of policies outside of their review date, split between Trust policies and All Wales policies.

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Table 1: Progress as at February 2024

Directorate/Department	Policies outside review date October 2023	Policies approved October 2023 - February 2024	Policies outside review date February 2024	
			Trust	All Wales
Workforce & Organisational Development	25	4	20	3
Planning, Performance and Estates	9	0	9	0
Infection Prevention and Control	1	0	2	1
Health and Safety	8	5	4	0
Quality and Safety	5	2	4	1
Digital Services	3	0	1	2
Information Governance	3	1	0	2
Corporate Communications	2	0	1	1
TOTAL	56	12	41	10

3.3 Since the last reported position to the Quality, Safety and Performance Committee in November 2023, there have been **2** new policies approved and implemented within Workforce & Organisational Development and **1** policy archived within Quality and Safety. These are shown in Table 2:

Table 2: New and Archived policies between October 2023 – February 2024

Directorate/Department	Policy Title	Status
Workforce & Organisational Development	WF04b Disclosure and Barring Service Checks Procedure	Approved January 2024
Workforce & Organisational Development	WF04 Recruitment and Selection Policy	Approved January 2024
Quality and Safety	QS07 Medical Gas Cylinders Policy	Archived – to be managed locally by VCS Senior Leadership Team as not Trust-wide.

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4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1   Policy compliance has risen over **5%** since October 2023, with Workforce & Organisational Development remaining the division with the largest number of policies that have passed their review date.

4.2   Workforce & Organisational Development (WOD) account for **42.5%** of <u>all</u> Trust policies, and **49%** of the policies outside of their review date (excluding All Wales policies). As such, a meeting between WOD and the FCO has been scheduled for 28th February 2024 to create an action plan with agreed timescales to improve policy compliance.

4.3   Table 3 highlights the number of policies within each division and the number of policies both within and outside of their review dates.

Table 3: Policy Breakdown by Department

Directorate/Department	Policies outside of review date (inc. All Wales)	Policies within review date (inc. All Wales)	Total policies within the division
Workforce & Organisational Development	23	25	**48**
Planning, Performance & Estates	9*	5	**14**
Infection Prevention & Control	3	9	**12**
Health & Safety	4	7	**11**
Quality & Safety	5	6	**11**
Digital	3	5	**8**
Information Governance	2	5	**7**
Corporate Communications	2	0	**2**
TOTAL	**51**	**62**	**113**

4.4   *Five of the Planning, Performance & Estate policies that are outside of their review date are included as separate items on the agenda for this meeting of the Quality, Safety and Performance Committee for approval.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☐ for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.

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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*	Not required - please outline why this is not required
	GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents has an associated EIA. The EIA will be refreshed when GC01 is due for review.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

6.1 The appointment of a permanent FCO will ensure a continual review cycle of the policies and ensure compliance with GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents.

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

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Transforming Access to Medicines / Clinical Pharmacy Technical Services Update

DATE OF MEETING	March 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?	YES

PREPARED BY	GARETH TYRRELL
PRESENTED BY	GARETH TYRRELL
APPROVED BY	Choose an item

EXECUTIVE SUMMARY	The Pharmacy Technical Services continues to provide ready-to-administer products to organisations across NHS Wales under the MHRA "Specials" licence, whilst also maximising the resource utilisation opportunities through the Wholesale Dealer License. The TrAMS programme is currently not operational however progress is reported through the NWSSP Partnership Committee

RECOMMENDATION / ACTIONS	The committee are asked to note the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Managing Director / Director of Pharmacy / Clinical Director	07/03/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

DETAILS WITHIN THIS REPORT HAVE BEEN PRESENTED AT THE NWSSP PHARMACY DIVISION SERVICE BOARD WHERE SERVICE PERFORMANCE AND SAFETY IS PRESENTED. THERE ARE CURRENTLY NO OUTSTANDING GOVERNANCE ISSUES TO REPORT.

7 LEVELS OF ASSURANCE
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

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

APPENDICES

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1. SITUATION

1.1 The aim of this report is to provide assurance on the current performance of the Pharmacy Division within NHS Wales Shared Services Partnership, and report to the board any matters of exception that increase the risks of service delivery.

2. BACKGROUND

2.1 The Pharmacy Division provided several Pharmacy Technical Services to partners across NHS Wales under agreed Service Level and Technical agreements. These services are heavily regulated under Medicines and Healthcare products Regulatory Agency (MHRA), Home Office and General Pharmaceutical Council (GPhC) licences. These services include:

- Manufacture and supply of ready-to-administer injectable medicines under an MHRA "Specials" Licence.

- Purchase, storage, and supply of licenced and unlicenced products, including vaccines, under an MHRA Wholesale Dealer Authorisation.

- Purchase, storage, and distribution of controlled drugs under Home Office Licence.

2.2 Staff within NWSSP who are named on the licences are legally responsible for implementing the regulatory requirements under The Human Medicines Regulations 2012.

2.3 All services adhere to European and UK Good Manufacturing and Distribution practices as set out within the licences and are subject to risk-based compliance inspections by the regulator intervals determined by service risk.

2.4 The service is currently deemed "low risk" and has a 24-month inspection interval.

2.5 Monthly performance reports are presented to the NWSSP Service Board for governance.

2.6 Products supplied from the NWSSP Pharmacy Division are detailed below

- Potassium Chloride 50mmol in 50mL syringe

- Rituximab 600mg in 250mL 0.9% Sodium Chloride

- Rituximab 700mg in 250mL 0.9% Sodium Chloride

- Rituximab 800mg in 250mL 0.9% Sodium Chloride

- Nivolumab 480mg in 100mL 0.9% Sodium Chloride

3. ASSESSMENT

3.1 NWSSP aim to comply fully with the licencing requirements for MHRA Specials Manufacturing and Wholesaler Dealing, and the regulatory standards of Good Manufacturing Practice.

3.2 The service is currently undergoing a full gap analysis and implementation programme for compliance with the updated Annex 1 – Manufacture of Sterile Products.

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4. **SUMMARY OF MATTERS FOR CONSIDERATION**

The purpose of this paper is to highlight current exceptions to service adherence of Good Manufacturing and Distribution Practice.

4.1 There are no service deviations or exceptions to report across the Specials and Wholesale Dealer services.

4.2 Current collaboration is ongoing between NWSSP and Velndre NHS Trust Pharmacy to implement the Wellsky Pharmacy System to replace the legacy pharmacy system used at IP5. This work is scheduled for completion 31st March 2024.

4.3 The availability of Atezolizumab Subcutaneous Injection for use has resulted in a discontinuation of the Atezolizumab 1200mg Infusion product. Other doses via IV infusion are available.

4.4 The service is currently engaging with the Home Office in relation to the controlled drugs licence inspection at Picketston.

4.5 Medicines Unit are working with other NWSSP divisions and Welsh Government policy leads on the National Influenza Programme

4.6 Ongoing work is being undertaken to fill current service vacancies.

5. **IMPACT ASSESSMENT**

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Working / Stakeholder Engagement
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐
	Timely ☐
	Effective ☒
	Equitable ☐
	Efficient ☒
	Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The implications outlined in this report as exceptions risk the ability of the service to prepare medicines within a times and efficient manner
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: https://www.gov.wales/socio-economic-duty-overview	**Click or tap here to enter text**

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13/03/2024 14:14:09

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

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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

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
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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QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
Trust Infection Prevention and Control Management Group - Policies	

DATE OF MEETING	14th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	Two Infection Prevention and Control policies have been reviewed in line with the planned review process and the latest national guidance and evidence base. These are: • IPC 00 – Framework Policy for Infection Prevention and Control • IPC 11 – Transport of Specimens Policy

RECOMMENDATION / ACTIONS	To **APPROVE** the following policies: • IPC 00 – Framework Policy for Infection Prevention and Control • IPC 11 – Transport of Specimens Policy.

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) Executive Management Board	6th December 2023 29th of February 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ENDORSED for APPROVAL	

7 LEVELS OF ASSURANCE
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/A as policies for endorsement

APPENDICES	
1.	IPC 00 Infection Prevention and Control Framework – The Accountabilities and Responsibilities
2	IPC 11 – Transport of Specimens

1. BACKGROUND

The purpose of Infection Prevention and Control policy is to outline the overarching standards process of management for the prevention and control of infection in patients and to prevent the occupational exposure of Healthcare Workers. They cover all Divisions within the Trust and where specified, for hosted organisations and to ensure compliance with national guidelines.

Both policies were shared for a consultation period to members of both the divisional Infection Prevention and Control Group and the Infection Prevention and Control Management Group.

2. ASSESSMENT

2.1 IPC00 - Infection Prevention and Control Framework – The Accountabilities and Responsibilities

The following changes were made:

- The terms of reference in the Policy were approved through the Infection Prevention and Control Management Group, and no amendments were made
- Equality Impact Assessments for the policy undertaken (Appendix 2) – no potential negative impact has been identified.

2.2 IPC11 - Transport of Specimens Policy

The following changes were made:
- Page 4: inclusion of WBS SOP 022/BCT – Accounting for blood and other items for return from clinics
- Page 7: updated Health and Safety Executive guidance - The Approved List of Biological Agent Advisory Committee on Dangerous Pathogens, HSE, 4th Edition 2021
- Equality Impact Assessments for the policy undertaken (Appendix 4) – no potential negative impact has been identified.

All other Infection Prevention & Control Policies are in date.

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
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*	Yes - please outline what, if any, actions were taken as a result
	Click or tap here to enter text. No impact on people with protected characteristics. No issues raised during the equality impact process.
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	Yes - please complete sections below
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	Risks assessments currently being added to individual entries on the Risk Register
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*Recommended remedial actions if implemented fully should reduce the risks*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Low risk
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

Appendix 1: IPC 00

FRAMEWORK POLICY FOR INFECTION PREVENTION AND CONTROL

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	25.01.2024
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	December 2023
Next Review Date	December 2024
Version:	6

CONTENTS

ABBREVIATIONS

AMR	Antimicrobial Resistance
ANTT	Aseptic Non-touch Technique
HCAI	Healthcare Associated Infection
HCW's	Healthcare Workers
ICD	Infection Control Doctor
IPC	Infection prevention and control
IPCMG	Infection Prevention and Control Management Group
IPCT	Infection Prevention and Control Team
RCA	Root cause analysis
KPI	Key Performance Indicator
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1 POLICY STATEMENT

1.1 This policy outlines the overarching framework for the management and organisation of infection prevention and control (IPC).

Oncology patients are largely susceptible to infections. While all Healthcare Associated Infection (HCAI) are preventable, a consistent 'zero tolerance' approach to hospital acquired infection is required to adhere to a national strategy, best practice guidance and requirements of Healthcare standards for Wales.

HCAI refers to an infection that occurs as a result of contact with the healthcare system in its widest sense – from care provided in the home, to general practice, nursing home care, care in acute hospitals and interaction with supportive services. This broad description potentially could cover all patients who attend Velindre Cancer Centre and donors that attend a Welsh Blood Service donation clinic. A consistent approach and effective leadership within the organisation is required to prevent Trust acquired HCAI.

There are a wide range of effects of a HCAI which can range from short term discomfort to significant harm and can even lead to permanent disability or death. It can lead to an extended hospital stay, which not only can have consequences for the patient/family, but can disrupt the effective use of patient facilities. A HCAI can also be detrimental to the Trust, not only in terms of money but as a loss of reputation for the organisation.

The Infection Prevention and Control Team (IPCT) provides expert advice and support to all services of Velindre University NHS Trust, especially clinical and front facing services. It is important that the IPCT have clear lines of accountability for the effective management of the service to ensure integrated working practices across the Trust.

Please note:
COVID-19 may have an impact on Infection Prevention and Control (IPC) policy documents. Policies should be read in conjunction with the IPC organism specific policy, May 22.

[IPC measures for Management of SarsCoV-2 in Healthcare Setting](#)

2 SCOPE OF POLICY

2.1 This policy provides a framework and principles of best practice to ensure all Healthcare Workers (HCW's) are familiar with the structures in place for infection prevention and control management.

2.2 The responsibilities and programmes of work outlined aim to reduce risk and prevent HCAI and comply with National guidance and strategy.

2.3 This policy covers Welsh Blood Service, Velindre Cancer Centre and Corporate Services and applies to all staff and contactors working within these areas.

3 AIMS AND OBJECTIVES

3.1 The policy objectives are to outline:
- Clear lines of accountability and responsibility in relation to Infection Prevention & Control
- Key processes and programme for infection prevention and control
- Reporting mechanisms for Infection Prevention & Control to the Trust Executive Management Board
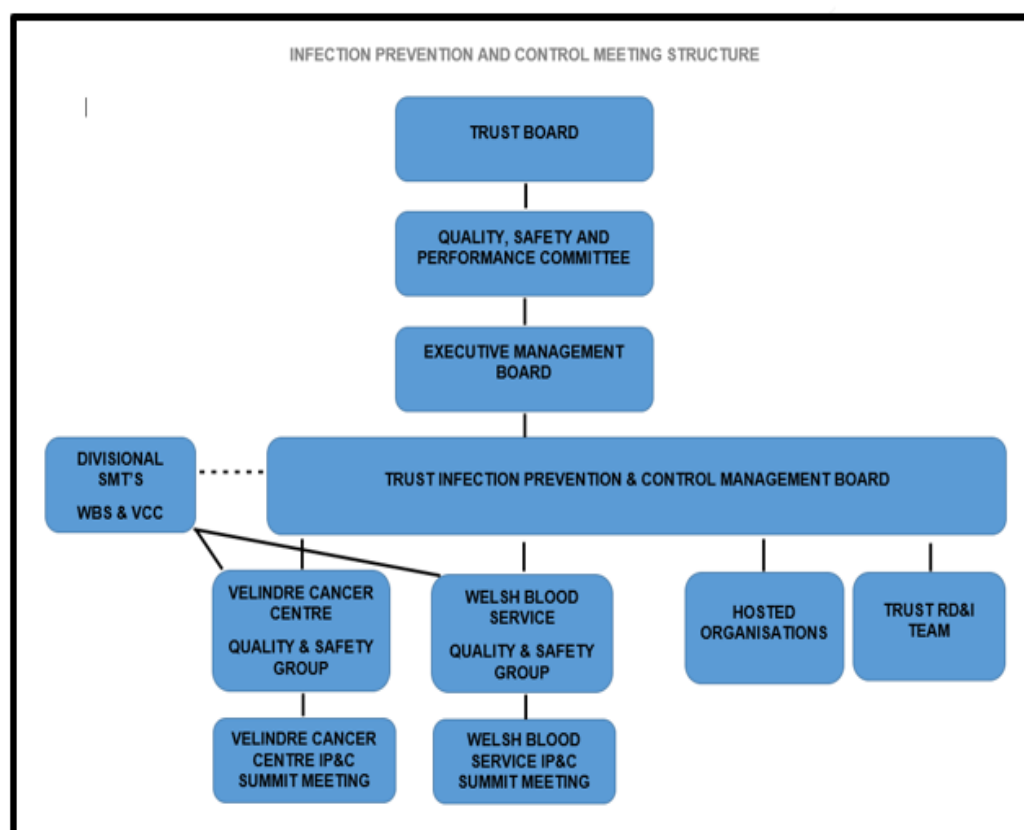- Key messages:

- o Infection Prevention and Control is **everybody's** responsibility
- o Departmental Leads/Managers are responsible for ensuring infection prevention and control training requirements, standards and practices are followed by all staff within their designated areas
- o Programmes for audit, training, surveillance and policy provision are managed as key strategies for infection prevention and control.

4 RESPONSIBILITIES

This framework has been developed to provide clarity throughout the Trust in relation to accountabilities and responsibilities for Infection Prevention and Control and related duties as part of the Trust governance and assurance processes. It focusses on accountabilities and responsibilities of both the Trust Infection Prevention & Control Team and those of local, Divisional and Senior Management Teams.

4.1 Infection Prevention & Control Reporting Mechanisms

INFECTION PREVENTION AND CONTROL MEETING STRUCTURE

MEETING	CORE IPC ACCOUNTABILITIES
Trust Board	To receive assurance and exceptions via the Quality, Safety & Performance Committee in relation to the Trust meeting its core IPC & decontamination accountabilities/responsibilities against national standards & legislative requirements. To ensure adequate resource and funding is directed to support the agenda for Trust wide IPC activities and performance.
Quality, Safety & Performance Committee	To receive clear evidence and timely advice from the Executive Management Board in order to be able to provide the Trust Board with accurate information to assist it in discharging its functions in meeting its responsibility with regard to IPC & Decontamination for quality and safety. This includes assurance against the Trust's stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales. To rapidly escalate any significant concerns and risks for patient harm or reputational risk for the organisation.

Executive Management Board	To receive highlight reports, performance reports and exceptions from divisions & the Infection Prevention & Control Management Group and agree any required Trust wide action / prioritisation. Receive any external Infection Prevention & Control / decontamination relation inspections / reviews. Monitor delivery of high level mitigation actions. Oversee any high level Infection Prevention & Control risks.
Trust Infection Prevention and Control Management Group	To have oversight of achievements, deficits and actions across all divisions for the Trust Infection Prevention & Control programme of work. Measure progress and performance so that Velindre University NHS Trust can provide evidence it is adequately executing its responsibilities in relation to the preventing and controlling infections & decontamination. Report and advise divisions of any new or emerging risks, policies or innovations and the associated actions required. Share learning so that all actions can be taken to prevent infection related avoidable harm to patients. Identify key risks to performance. Communicate and engage with independent member of the Board
Divisional Senior Management Team Meetings	Receive assurance that all Infection Prevention & Control / Decontamination standards are being adhered to across the Division. Receive and agreed definitive action to address any exceptions. Escalate any areas of high risk, patient / donor / staff risks or where division need support to progress.
Divisional Quality & Safety Groups	Receive the highlight / exception report – triangulate with additional Quality & Safety outcomes. Agree mitigation actions and identify areas good practice. Provide assurance / exceptions to the Senior Management Team Meeting.
Monthly Divisional Infection Prevention & Control Summit meetings	To monitor compliance with Trust and national Infection Prevention & Control policies, standards and the achievement of objectives against the Healthcare Associated Infection code of practice and national requirements for reduction expectations. To assess performance against the agreed work plan of each service/department within division in achieving its objectives and timescales. To support areas in meeting and maintaining the required standards. In particular: • Environmental standards • All relevant training & competency standards • Audit processes, outcomes & actions • Relevant Clinical practice standards (bundles) • Management of incidents or outbreak • Timely contribution to Root cause analysis (RCA) and Investigations of key Healthcare Associated Infections Provide assurance / escalation highlight report for Divisional Quality, Safety and Performance group & Trust Executive Management Board.

4.2 The accountability & responsibility of the Individual/team

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
Executive Director of Nursing, AHP, Health Scientists & Deputy Director of Nursing, Quality & Patient Experience	• To ensure the Trust has in place all the required governance arrangements, monitoring processes, policies, procedures, strategies, assurance systems and resources to effectively discharge its responsibility for IPC and decontamination. • Act as the Trust's named Executive lead for Decontamination in accordance with statutory requirements. • Represent the Board on HCAI at Welsh Government Meetings • Executive Lead for the Trust's multi-disciplinary Infection Prevention and Control programme	• Operational delivery of Infection Prevention & Control / decontamination practices

Project Name	2024 Proposed date survey
CT Scanner X Ray	We are available to visit anytime to suit Trust, please confirm.
MRI	**19/01/2024**
Fluoroscopy	We are available to visit anytime to suit Trust, please confirm.
LA6	**26/06/2024**
LA7	**17/05/2024**
LA3	We are available to visit anytime to suit Trust, please confirm.
LA4	**24/07/2024**
Operating Theatre	**19/01/2024**
LA8	**09/08/2024**
LA5	**23/02/2024**
LA2	**18/10/2024**
CT Scanner 1	Please confirm when in December we are able to visit
CT Scanner 2	Please confirm when in November we are able to visit
LA1	Please confirm when in November we are able to visit

	• To assign a nominated deputy to act in their absence in accordance with Trust objectives • To represent the Board in national decision making via Nurse Directors/executive forum	
Infection Prevention and Control Team	• Provide both a proactive and a reactive IPC service to the Trust operating Monday to Friday based on priorities • Develop and deliver a work programme for the team that addresses the Trust objectives and National agenda • Support divisions in the development of annual IPC work plans • Provide assurance to the Board on progress against the IPC work programme • Lead IPC through a coordinated multi-professional, evidence-based approach to the prevention and control of infection including HCAIs • Operational management of the Infection Prevention and Control Team • Provide specialist advice, support guidance in relation to all IPC systems & processes including water safety, decontamination, evidence based clinical practice, environmental cleanliness, ventilation, • Support the development of the Trusts' Vaccination programme • Development of Trust wide up to date IPC / decontamination related policy, procedure, guidance – supporting the implementation of national policy, best practice, requirements into practice • Trust wide oversight of urgent response and pandemic planning • Provide expert advice and leadership in the recognition and management of increased incidents/outbreaks across all areas of Velindre University NHS Trust in accordance with national and local guidance. • Provide expert advice in relation to IPC and emergency planning including planning for pandemics and new or re-emerging pathogens. • Monitoring and Trust oversight of Trust compliance of the IPC elements of National Decontamination Standards • Specialist advice and oversight into Trust environmental and clinical cleaning & decontamination standards • To develop and deliver relevant, robust IPC related training & development programme. To monitor compliance with IPC training requirements • Establishing robust 'service delivery level to board assurance monitoring & reporting arrangements • Develop and regularly review a robust Trust wide ward to board infection control & decontamination audit infrastructure • Oversee and support the co-ordination of internal & external IPC/Decontamination related inspections and reviews e.g. Healthcare Inspectorate Wales, Environmental Health Officer, NHS Wales Shared Services • Initiate and manage a comprehensive alert organism surveillance system for key pathogens including HCAI infection reduction expectations organism.	• Owner of all identified healthcare associated associate infections • Responsible for individual staff performance in relation to flu vaccinations / hand hygiene/ PPE donning & doffing / IPC Level 2 training/ Fit Testing • Keeping staff training or flu vaccination records • Sole owner of FFP3 Fit testing records • Ensuring staff attend training • Operational delivery of IPC & decontamination standards • Management of non IPC clinical staff in relation to IPC practices

		• Provide comprehensive surveillance data reports and detailed analysis of that data for scrutiny to the Board. • Support departments and teams in the co-ordination and reporting of investigations into Velindre HCAI cases in accordance with the national and local requirements e.g. Serious Untoward Incidents, Putting Things Right. • Utilise Quality Improvements methodology in the systematic investigation of HCAI, IPC or decontamination incidents e.g. Route cause analysis • Provide expert advice and active involvement on all matters relating to infection prevention and control / decontamination for any new builds / refurbishment programme / introduction of new services. • Utilise existing incident reporting mechanisms e.g. Datix to document IPC related adverse incidents or near misses • Critically review Trust IPC Datix data to identify themes/trends/lessons learnt • Develop and lead on medical device decontamination work streams • Monitor and evaluate progress against performance measures / KPIs and report outcomes hierarchy structure for Trust Governance & assurance as stated above • Work collaboratively with the Infection Control Doctor (ICD) and Antimicrobial Pharmacist to promote antimicrobial stewardship • Organise and facilitate the Infection prevention & Control Management Group and required reporting / escalation / assurance to Trust • Oversee and monitor strategic and operational delivery of IPC / decontamination Health & Care Standards • Oversee and review/revise all Trust IPC / decontamination related risks / risk register entries • Utilise quality improvement methods and risk assessment skills to support the identification of risk and risk and reducing actions • Work collaboratively and participate in national work streams and delivery groups.	
	Infection Prevention & Control Doctor (Microbiology Consultant)	• Provide timely and expert advice to support the Trust in meeting its IPC/ decontamination responsibilities • Provide strategic leadership working as part of the Trust IPC Team to ensure operational delivery of required standards and translation of national policy into local context and delivery action • Actively engages in the development and production of Trust IPC policies/ procedures/ strategies /guidance through critical review and monitoring of effectiveness. • Provide specialist advice in supporting the strategic co-ordination of IPC activities within the IPC team and the divisions • Uses leadership and specialist knowledge of antimicrobials to support the Trust and the Antimicrobial Stewardship Meeting in setting the direction for antimicrobial prescribing goals, actions and standards	• Delivery of the Infection Prevention & Control Programme

		• Provide guidance to clinical colleagues on appropriate antimicrobial prescribing by conducting regular antimicrobial ward rounds and via telephone consultation • To provide expert ICD advice on all aspects of HCAI & IPC including reactive responses to outbreak/incidents, emerging threats including pandemic Management • To work with the IPC team to critically evaluate and prioritise responses to local issues identified. • Interpret, translate and & contextualise national and local data to support decision making and prioritisation • Provide local training for all disciplines of staff including medical staff • Provide expert advice in relation to Safe Water management Systems/ Ventilation & Decontamination • Support IPC team in implementing risk reduction and quality improvement measures. • Participate and give expert advice where necessary on HCAI investigations e.g. RCA	
	Associate Medical Director Role for Infection Prevention & Control & Antimicrobial Prescribing / Sepsis	• To provide medical leadership at Velindre Cancer Centre in relation to IPC / decontamination and antimicrobial stewardship • Support the IPCT / Microbiology Consultant to drive the IPC / Antimicrobial Resistance (AMR)/ Sepsis agenda forward within the Trust • Role model for IPC campaign and initiatives e.g. World Health Organization 5 moments HH, vaccination programme etc. • Provide medical leadership at relevant IPC / antimicrobial Meetings e.g. Infection Prevention & Control Management group • Review IPC policies to ensure they can be operationally implemented / support develop of new / revised IPC / decontamination / antimicrobial related Policies / procedures / strategies & guidelines • Champion IPC – increase engagement with junior doctors to ensure support for RCAs for all HCAIs • Promotion and participation in national IPC events, such as HCAI/ AMR collaborative, Aseptic Non-touch Technique (ANTT) steering group as required and act as a role model and champion of Trust work • Share HCAI and IPC best practice with established networks e.g. medical directors forum, cancer network to highlight challenges • Ensure all required Infection Prevention & Control audits feature on the Trusts annual audit plan, oversee the outcomes and actions – ensuring completion of the cycle for improvement • Senior leadership to the Trusts sepsis improvement programme • Champion & Drive IPC practices within VCC & support IPC Outbreaks meetings • Actively promote a 'zero tolerance' approach to HCAI	• Lead the Infection Prevention & Control Agenda • Operational delivery of IPC
	Pharmacy	• Strategic direction, oversight and management of the Trusts antimicrobial improvement programme • Provides expert advice to support strategic initiatives related to antimicrobial guidelines and prescribing and	• Be responsible for inappropriate prescribing within the Trust

	provide assurance to the IPCMG and Medicines Management Group on antimicrobial prescribing metrics. • Support the ICD in discharging responsibilities for antimicrobial ward rounds/stewardship • Actively contribute antimicrobial knowledge to HCAI investigations e.g. RCA • Monitor progress against antimicrobial prescribing key performance indicators (KPI's) and champion antimicrobial prescribing across the Trust. • Collect Point Prevalence Survey data monthly and promote Start Smart the Focus & disseminate data to Public Health Wales. • Participate in national work streams to share best practice and knowledge gained to shape Trust policy • Ordering, delivery and co-ordination of influenza and COVID staff vaccinations	

Divisional Directors / SMTs	• Responsible for Divisional delivery against all national & trust agreed IPC / Decontamination and antimicrobial standards – Monthly monitoring & reporting against all IPC / decontamination outcomes and process performance measures (including Senior Leadership Team oversight of infection rates, cleaning & decontamination standards, staff IPC related training, flu vaccinations, IPC audit compliance, fit testing etc.) – ensuring robust Data collection and validation mechanisms – service level-board reporting
	• Ensure Division is meeting its IPC/Decontamination audit requirements and escalation of any areas on non / low compliance
	• Ensure all service developments / changes / redesign meets required IPC / decontamination standards
	• Having in place system & processes for identification & monitoring of IPC related risk and for taking appropriate action within Division for IPC risk reduction
	• Provide assurance to Trust Quality & Safety on Divisional progress against KPI's
	• Identify an Infection Prevention & Control SMT Lead & a champion from within each service area
	• Ensure Departmental engagement and ensure appropriate reporting on all aspects of Infection Prevention & Control
	• Ensure that every ward/clinical department has a designated infection control link nurse (or other registered practitioner).
	• Systems & processes for management of all outbreaks
	• Ensure all agreed IPC / decontamination actions are fully implemented
	• Ensure that RCA's of Healthcare associated infections are discussed at the relevant Governance meetings and the minutes of these forwarded to the DIPC's
	• Ensure that Infection control is a standing agenda item for Divisional meetings and, that as a minimum, the following are included:
	   o Review of infection prevention and control key performance indicators (KPI's)
	   o Outbreak reports/action plans
		• Lead the Infection Prevention & Control Agenda

14/64   439/660

		o Infection Prevention and Control audits where any element of the audit is less than 85%	

Departmental / Ward / Team Managers	• Manage staff in line with HSE requirements – ensuring staff deliver in line with agreed IPC standards and work place is safe
	• Early identification of any patient / donor infection risk, seek advice and guidance as indicated & manage in line with standards / advice
	• Minimise risk of infection to both staff and patients / donors
	• Maintain robust staff IPC related records and manage any areas of non-compliance
	• Provide assurance, audits & monitoring in relation to key performance indicators;
	    o Fit Testing
	    o Hand hygiene compliance
	    o Hand Hygiene training compliance
	    o Staff influenza Vaccination uptake
	    o ANTT Training compliance (E-learning & competency assessments)
	    o Level 2 IPC Training compliance
	    o Environmental audits
	    o Decontamination audits
	• Ensure departmental representation to support staff influenza vaccination campaign, fit testing & hand hygiene training
	• Ensure departmental collaboration with IPCT on all RCA investigations
	• Ensure vaccination status of new starters is reported an held at local level	

Estates Department	Responsible for delivery of: • Leading the Trust and divisional water safety groups • Responsible person for the management of Water systems and water quality • Analysis of results and lead actions to correct water results that are out of acceptable parameters in collaboration with the IPC team • Compliance with national guidance for safe water management systems • Compliance assurance of in-house services & contractors • Induction of contactors on IPC, including: dust management and water safety • Assessing and reporting compliance against Health Technical Memorandum –in relation to Safe Water Management, Ventilation & Building/ refurbishment etc., (Regularly liaise with infection prevention & control team to ensure safe processes) • Maintaining good building / estate repair though programme of repair/refurbishment and reactively through IPC environmental audit results. • Timely escalation of any issues or concerns arising on sites that would create a patient / donor or staff IPC risk • Consult IPC on planned or emergency work • Engage and consult IPCT for any new build or refurb at early stage in accordance with Infection Control in the Built environment	• Individually responsible for poor water management

	• Ensure estates staff are compliant with IPC training and adhere to policy when working in clinical areas/dept.	
Operational Services Department	Responsible for delivery of: • Delivering the required level of cleaning to the require standards using the products relevant to the situation at the time • High standards of food safety for all aspects of in-house catering facilities • Compliance assurance & audit of in-house services and contractors. • Innovation and new technologies • Reactive services and proactive responses to managing environmental cleanliness e.g. during incident/outbreaks where there are infected cases on wards • Provides reports on standards of cleanliness and waste management. • Development and review of non-clinical polices such as Laundry, Waste Management and Cleaning. • Management of all staff in line with HSE requirements, ensuring staff received relevant training and monitoring of compliance as per training needs analysis for the role	
All staff	All employees are responsible for: • Complying with Trust Infection Prevention and Control policies, procedures & guidelines and escalating any situation that prevents this occurring. • Maintaining their legal duty to take reasonable care of their health, safety and security and that of other persons who may be affected by their actions and for reporting untoward incidents and areas of concern. • Keep up to date with all IPC training requirements according to role • Identifying infectious conditions and circumstances that may lead to transmission of / outbreaks of infection that require specific controls to protect themselves, their patients or others, informing the IPCT of any such circumstances. • Ensuring safe working practices are implemented as outlined in Infection Prevention and Control policies.	

4.3 Governance and Quality Assurance

The key forum for management and governance for the infection control service within the Trust is the Infection Prevention, Control and Management Group (IPCMG). The IPCMG receive the highlight reports from the VCC and WBS monthly IPC summit meetings. Each department should have a designated lead for IPC who is reports and is answerable to the divisional IPC lead. Please see *appendix 1* for the IPCMG Terms of reference

The IPCT has primary responsibility for advising on aspects of audit and surveillance pertaining to the prevention and control of infection at Trust level. The IPCT produces an Annual Report and an Annual Programme which are ratified by the Trust IPCMG and received by the Trust via the Quality and Governance Committees.

4.4 Distribution

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The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 IMPLEMENTATION / POLICY COMPLIANCE

5.1 Infection Prevention and Control Programme

The main aim of the Infection Prevention & Control programme is to plan, manage, co-ordinate and deliver a proactive infection prevention service for the Trust while being reactive to incidents and outbreaks as they arise. The main components of an effective programme include:

- Providing infection prevention and control of infection advice to all divisions and departments of the Trust
- Incorporating divisional infection control needs within the Trust infection control programme
- Providing education and training on the prevention and control of HCAI to all levels of HCW's
- Providing bespoke education on the management of infections as they arise
- Undertaking surveillance of infections, facilitating and validating data received
- Producing, implementing, and auditing compliance with infection prevention policies
- Liaising, communicating and advising with staff on matters relating to infection prevention and control during working hours, with advice available on a 24-hour basis from Public Health Wales microbiology service
- Developing infection prevention and control policies for the Trust in accordance with Legislation, National guidance, strategy, Quality frameworks and evidence based medicine
- Advising Divisions and hosted organisations on guidelines and procedures with relation to infection control.
- Implementing Welsh Government directives with regard to surveillance and strategic direction
- Implementing and developing the Health Care Associated Infection Strategy for Wales

5.1.1 Education

Education of all Trust staff is undertaken either by using nationally agreed e-learning programmes, delivered by members of the Infection Prevention & Control Team or using materials developed or advised by the Infection Prevention & Control Team. Where possible blended learning, including classroom teaching, e-learning and opportunistic workplace methods will be utilised. The level of training is determined by a Training Needs Analysis of the role being undertaken. As a minimum *all healthcare workers, regardless of their role undertake Infection Prevention and Control Level 1 training within 4 weeks of starting employment.*

- *Level 1 training* focuses on precautions and procedures undertaken by those providing direct patient / service user care or working within a clinical environment.
- *Level 2 training* is update training undertaken every 2 years to ensure clinical healthcare workers are kept up to date with current research, guidelines, policies and projects.
- *Level 3 training –* Massive Open Online Course (MOOC) which is targeted at registered practitioners and senior staff in supervisory roles who are responsible for ensuring compliance with good IP&C practices e.g., ward and Departmental clinical managers.

5.1.2 Training availability

- Both Level 1 and 2 training are available as e-learning if classroom session not available
- Junior and locum doctor induction is provided per intake
- The ICD updates consultant colleagues at Consultant meetings while the Antimicrobial Pharmacist will input into the doctor training programme.
- Additional targeted training will be provided as required for specific groups including porters, domestics, volunteers etc. and as required to respond to a new infection prevention problem or to meet a particular need.

5.1.3 Surveillance

Surveillance is a key component of the infection control programme. The aim of surveillance is to collect continuous timely data on organisms and patient information to identify infection rates and trends. It assists the early detection of outbreaks or increased incidence of infection, informs changes in clinical practice and assists the targeting of preventative methods. Types of surveillance undertaken include:

- Daily surveillance - Identification, monitoring, advising on and recording of 'alert' organisms as provided by the laboratory reports received daily.
- Routine surveillance – collection, analysis, dissemination and feedback of data on condition/infections among patients and staff, to allow the appropriate action to be taken.
- Targeted and enhanced surveillance - undertaken following risk assessment, which may identify high-risk areas of practice, to enable the monitoring of procedures and processes to identify potential problems and areas for improvement.
- Mandatory Surveillance - as identified by the Welsh Government and managed by HARP.
- National projects – voluntary participation in 'all Wales' surveillance 'projects of targeted areas/organisms.

Surveillance data may be used within a framework of performance management in an attempt to assess the effectiveness of the Infection prevention and Control standards being deployed.

5.2 Audit and monitoring

The Infection Prevention & Control Team's annual programme framework has been updated and there is now one audit programme covering both division.

Both nationally recognised and locally developed tools (to address targeted areas) are used to audit policy, standards and guidelines for the environment and clinical practices. Results are reported to the departmental and local managers and summarised in the quarterly team report and annual reports submitted to Divisional Senior Leadership Teams, Trust Executive Management Board and Quality, Safety & Performance Committee.

6 GETTING HELP

Further information and support

IPCT: 02920 196129 or bleep 205.

Microbiology at UHW on 02920 744825.

18/64   443/660

7 RELATED POLICIES

The national related Infection Prevention & Control policies can be found here:

http://howis.wales.nhs.uk/sitesplus/972/page/51445

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

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP

Terms of Reference & Operating Arrangements

Version: 8
Date Reviewed: October 2023
Review Date: October 2024
Agreed by: Infection Prevention and Control Management Group
Approved by: Executive Management Board **02/01/2024**
Approved by Quality, Safety & Performance Committee **16/01/2024**

1. INTRODUCTION

1.1 These Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Quality Standards (2023) for Infection Prevention and Control and Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.

2. PURPOSE

The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to preventing and controlling infections and therefore taking all actions to prevent infection-related avoidable harm to patients. This includes:

2.1 Ensure systems for assessing, reducing, reporting, and monitoring infection risks across the Divisions / Trust are robust.

2.2 Ensure robust governance structures for monitoring decontamination services within Divisions / the Trust, including arrangements for decontamination of reusable medical devices.

2.3 Agree Trust-wide Infection Prevention and Control (IPC), decontamination and infection / antimicrobial surveillance, audit programs, and assurance and monitor compliance in respect of these.

2.4 Oversee the development and regular review of all Trust IPC, decontamination, antimicrobial & and surveillance policies, guidelines and procedures. This will include receiving and endorsing adoption of relevant national IPC related policies, procedures and guidelines.

2.5 Ensure there is a robust implementation plan in place corporately and across Divisions for all local and national IPC policies, procedures and guidelines and monitor through audit the implementation across the Trust.

2.6 Receive all IPC, Decontamination, antimicrobial related external / internal audits / reports / peer reviews and be responsible for ensuring the development of robust improvement actions and overseeing through to completion all such action plans. Reporting any exceptions through to Executive Management Board / Trust Quality, Safety and Performance Committee.

2.7 Ensure appropriate Outbreak Management mechanisms in place and ensuring national outbreak standards are met, robust reporting in place and oversee completion of all post outbreak recommendations / actions to completion.

2.8 Endorse and monitor all IPC, decontamination and antimicrobial related risks as logged on Trust / Divisional Risk Registers, ensuring that all such risks are being appropriately managed / escalated.

2.9 **Oversee the regular review and oversight of Health and Care Standard** and Decontamination. Including endorsing annual self-assessment, agreeing actions and overseeing completion of related action plan.

2.10 Develop and monitor robust Trust wide and Divisional IPC assurance framework with Key Performance Indicators that are monitored and reviewed at least annually.

2.11 Ensure there is a robust IPC training programme in place that meets national and local standards and requirements, oversee compliance with this.

2.12 Review progress against the annual Staff Influenza Vaccination Campaign /

COVID vaccine programme.

2.13 Ensure appropriate processes and procedures in place to respond to pandemics such as influenza / COVID.

2.14 Receive outcomes of all Root Cause Analysis investigations from all healthcare associate infections ensuring appropriate remedial actions have been taken

2.15 Oversee processes for the identification and dissemination of good practice / lessons learnt both from internal events and external to the Trust.

2.16 Oversee compliance with all PPE standards across the Trust.

2.17 Agree the IPC Annual Work Programme.

2.18 Oversee compliance with Water quality standards including compliance with national guidance and the Trust's Legionella Policy.

2.19 Oversee adherence to national cleanliness standards.

2.20 Oversee compliance with all Decontamination standards.

2.21 Oversee and ensure appropriate action taken from all IPC HCAI Surveillance Data and monitor compliance against all nationally agreed Infection reduction / improvement goals.

2.22 Oversee Divisional compliance with all IPC, Decontamination, water safety and antimicrobial standards ensuring that appropriate divisional action is being taken to mitigate risks.

2.23 Oversee the implementation of a robust antimicrobial resistance action plan.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Infection Prevention & Control Management group formally reports into the Trusts Executive Management Board, following which to the Trusts Quality, Safety and Performance Committee. A highlight report will be provided following each meeting that will be supplemented by any papers identified as being required at the meeting. All such reports will be approved by the meeting chair prior to submission.

4.   MEMBERSHIP

4.1   The core membership of the Committee, is set out below:

Chair: Executive Director of Nursing, AHPs and Health Science

Vice Chair: Deputy Director of Nursing, Quality and Patient Experience

Co-Option: Additional members maybe co-opted onto a meeting as relevant to the agenda with prior agreement of the Chair / Vice Chair.

Secretariat: Administrator for Infection Prevention and Control Team

Membership
All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

Table 1

TITLE	ROLE & RESPONSIBILITES	REPORTING REQUIREMENTS
Executive Director of Nursing, AHPs and Health Scientists	Chair of Meeting. Leadership and strategic focus in meeting compliance. Overall Executive responsibility for infection prevention and control. Provide assurance / escalation to Trust Board members.	National information / requirements Feedback from Quality and Safety / Board. Proposed strategy / direction.
Deputy Director of Nursing, Quality and Patient Experience	Vice Chair of Meeting. Leadership and strategic focus in meeting compliance. Provides report to Quality and Safety Group Board.	As above.
Senior Nurse for Infection Prevention and Control	Organisation, oversight and management of meeting Identify any areas of concern re non-compliance with Code of Practice/ Health & Care Standards 2.4 / work plan and inform members of risks/ hot spots. Drafting all post meeting reports Quality checking all divisional reports / documents Develop and ensure delivery against IPCMG work plan	Provision of IPCT reports, to include KPIs/ surveillance, audit and training activity, staff influenza campaign and preparedness, incidents and complaints, policy/ procedure review, risk register and produce annual report.

Infection Prevention and Control Nurses/ Respiratory Trainer	To present on specific elements of the IPCT report, including surveillance of infectious conditions and incidents, issues arising on the management of incidents and outbreaks, audit, Department of Health guidance, policy/procedure review and link champion training activity.	Datix Report-Incidents and Outbreaks. Influenza Report. Service Improvement.
Consultant Microbiologist	Expert resource from Public Health Wales and to provide infection control advice to the group and inform on national and local initiatives in driving policy and management of infectious conditions.	Reports to be provided on an adhoc basis e.g. Updates on: Antimicrobial Prescribing Alerts/ outbreaks across Wales.
Principal Pharmacist	Expert advice to support strategic initiatives e.g. Anti-microbial guidelines.	Antimicrobial compliance report at each meeting.
Divisional Representatives / chair of Divisional IPC related meetings / R,D and I Lead	To provide assurance reports from division against all required standards / KPIs at each meeting. Escalate areas of risk, concern, where support required Identify and highlight areas of good practice / lessons learnt Provide feedback from the IPCMG to the division ensuring robust two way information / feedback flows.	Provide highlight / assurance report at each meeting that includes compliance with agreed KPIs, decontamination and water standards, summary of audit findings and RCA, Outbreak reports.
Senior Estates Manager	Chair of the water management meeting which is a sub meeting of IPC. To provide formal water management reports quarterly on water management and issues arising regarding meeting compliance with L8 and safe water management systems. Details external reviews / reports from estate. Ventilation compliance. Provides compliance assurance of in-house services and contractors.	To provide quarterly reports on water management legislative requirements, audit outcomes, assurance, highlights and exceptions.
Operational Services Manager VCC and WBS	Provides compliance assurance of in-house services and contractors. Provides reports on standards of cleanliness and waste management. Development and review of non-clinical polices such as laundry, waste management and cleaning.	Compliance and assurance report that covers: in-house services, contractors, policies and procedures, National standards of Cleanliness, waste management, laundry, and cleaning.

Appointed Authorised Engineers (Decontamination)	Expert advice to support strategic initiatives (decontamination).	Provide highlight report on decontamination updates.
Consultant Nurse (HARP Team)	Expert advice to support strategic national initiatives.	As required.
Assistant Medical Director, IPC	To provide medical leadership in respect of IPC/antimicrobial stewardship agenda.	As required.
Trust Health and Safety Manager	To act as an advisory from a Health and Safety perspective across the Trust in relation to infection prevention and control.	To provide bi-annual reports on Health and Safety Issues relating to Infection Prevention & Control.
Workforce Development Manager	Support development of IPC associated training and workforce requirements in accordance with national standards	

5. IPCMG MEETINGS

5.1 Quorum
The Chair / Vice Chair, Microbiologist, Anti-microbial Pharmacist, Infection Prevention and Control Nurse and a senior decision maker from each Division must be represented in order for a meeting to proceed.

5.2 Frequency of meetings
Meetings shall be held at least quarterly and otherwise as the IPCMG Chair deems necessary.

5.3 Papers
- Draft meeting notes and action log MUST be circulated to all members.
- No verbal or tabled reports will be accepted. If an event occurs that requires reporting to the IPCMG after papers have been circulated a late paper is to be submitted after agreement with the meeting chair.
- All papers are to be provided to the meeting secretariat at least 8 days prior to the meeting.
- The agenda and papers will be circulated at least 7 days in advance of the meeting.
- All papers should be submitted to the Head of Infection Prevention and Control and Secretariat. The agenda will be approved by the Chair prior to issue.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The IPCMG reports to the Trust's Executive Management Board and in turn to the Trusts Quality, Safety & Performance Committee by means of a highlight report after each meeting. Additional reports /papers will be provided as appendices as determined by the Group.

6.2 The IPCMG shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 There will be formal reporting mechanisms to and from Divisions into IPCMG. This will be achieved via the Divisional representative. A formal Divisional assurance paper will be provided to the IPCMG for each meeting. The reporting organogram is detailed below:

INFECTION PREVENTION AND CONTROL MEETING STRUCTURE

8.   REVIEW

8.1   These terms of reference and operating arrangements shall be reviewed in 12 months.

Appendix 2

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	IPC 00: Framework Policy for Infection Prevention and Control. Terms of Reference & Operating Arrangements.
Manager	Hayley Harrison Jeffreys
Date of meeting with OD Manager – ED&I	N/A
Date of submission	**January 2024**
Date of next review	**January 2025**

These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	IPC 00: Framework Policy for Infection Prevention and Control. Terms of Reference & Operating Arrangements
1.2	Who owns it?	Infection Prevention & Control Management Group
1.3	What is the aim of the change(s)?	No change. Annual review of terms of reference only.
1.4	Who is affected most by the change?	N/A
1.5	How does this topic fit into the wider context of the organisation?	This document outlines the overarching framework for the management and organisation of Infection Prevention and Control (IPC). The Responsibilities and programmes of work outlined aim to reduce risk and prevent Healthcare Associated Infection (HCAI) and comply with National guidance and strategy. This policy has been developed in line with current guidance and strategy and is intended for All Trust Healthcare workers (HCWs).
1.6	Who is undertaking the EQIA?	Infection Prevention and Control. Head of Infection Prevention & Control; Hayley Harrison Jeffreys & Senior Infection Prevention & Control Nurse; Julianne Golding-Sherman.

1.7	When will you start and end the EQIA?	24/01/2024
2.1	What data is available to help inform the EQIA?	Previous EQIA submitted 2023
2.2	What information is still needed?	N/A
2.3	How will missing data be collected?	N/A
2.4	What is considered relevant information and data?	The Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Quality Standards (2023) for Infection Prevention and Control and Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.

The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to preventing and controlling infections and therefore taking all actions to prevent infection-related avoidable harm to patients.

This policy sets out the roles and responsibilities of all staff to ensure infection prevention and control.

Working closely with the VCC dignity group to ensure that patient dignity is maintained whilst also ensuring infection risk is reduced.

Patient-centered care, to ensure that health and mental well-being is not compromised, whilst minimising risk.

Signage to be accessible and bilingual. Where possible visual images/icons to be used. Which would support those with learning disabilities, English no their first language etc.

Compliance with national strategy guidance and improvement methodologies.

A Healthier Wales
Working to Infection Prevention and Control guidance will ensure that patients are well cared for and there is early identification of, correct |

| | | treatment of and reduced transmission of infection whenever possible. Infection prevention and control is at the heart of everything we do.

A More Equal Wales
Recognising the need to look at the impact Infection Prevention and Control.

National Institute for Health and Clinical Excellence (2012) *Infection Control: Prevention of healthcare associated infection in primary and community care.* CG 139. *NICE, London.*
https://www.nice.org.uk/guidance/cg139 (Accessed December 2016)

Loveday, H. P. Wilson, J. A. Pratt, R. J. Golsorkhi, M. Tingle, A. Bak, A. Browne, J. Prieto, J. Wilcox, M. (2014) EPIC 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.
http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf (Accessed December 2016)
Department of Health. (2015). The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance (Updated 2010).
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-ofpractice-on-the-prevention-and-control-of-infections-and-related-guidance. |

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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…*			√		
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			√		
Gender re-assignment *Would this affect those in/post-transition differently?*			√		
Marriage or civil partnership *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…*			√		
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			√		
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			√		
Sex/Gender *Does it only apply to men / women?* *Could this affect one group more than the other?*			√ √		
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			√		
Socio Economic Duty			√		

Low income / no income groups? *Rural locations affected differently?* *Those with caring responsibilities?*			√ √		
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?*			√		Patient information leaflets/publications will be available in Welsh and English. Staff are available to provide the care recommended in the guidelines via the medium of Welsh and English. Signage to be bilingual.

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	Continue the policy. Evidence as above.
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	N/A
4.3	Could be policy be implemented in a different way to avoid negative impact?	N/A
4.4	How will this change promote equality of access and equality of opportunity?	N/A
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	N/A
5.1	What do you have so far?	The policy sets out the roles and responsibilities for all staff to ensure infection prevention and control.
5.2	Have any themes emerged?	N/A

IPC11 V5

5.3	What do people have to say about our work?	N/A
5.4	How will you consult widely on your topic?	The policy has been shared with the IPC Management group for consultation and approval.
5.5	Who will you consult with?	Infection Prevention & Management Group.
5.6	How long will the consultation stage last?	As there was no recommended change 2 week review period was followed.
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	3. Continue the policy.
6.2	What will you do with the comments or information you have gathered from your consultations?	N/A
6.3	How did the consultation help guide new policy?	N/A
6.4	Will you make any changes to the draft report you produced?	N/A
7.1	Confirm actions	No changes required. To renew annual policy.

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8.1	Establish timetable for reviewing actions and refreshing the assessment	Annual policy review required.

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
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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Equality & Diversity Manager

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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

Last updated: mars 7, 2024

Appendix 3

Ref: IPC 11

Specimen Collection, Handling and Transport Policy

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professionals and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	Infection Prevention and Control Management Group
Approval Date:	xx-xx-xx
Date of Equality Impact Assessment:	26.01.2024
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	Three years
Version:	5

CONTENTS

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ABBREVIATIONS

COSHH	Control of Substances Hazardous to Health
HCW's	Health Care Worker
IPCT	Infection Prevention and Control Team
NIPCM	National Infection Prevention and Control Manual
PPE	Personal Protective Equipment
NWSSP	NHS Wales Shared Services Partnership
AHP's	Allied Healthcare Professionals

1   POLICY STATEMENT

A clinical specimen can be defined as any bodily substance, solid or liquid, that is obtained for the purpose of analysis and examples include blood, sputum, pus, urine, faeces, and skin tissue.

All specimens are potentially infectious, and all staff involved in collecting, handling, and transporting specimens must follow infection control precautions to reduce the risk of transmission of infection and be aware of related infection prevention and control policies i.e. IPC10 – Hand Hygiene Policy and Procedure and IPC05 – National Infection Prevention and Control Manual.

Prompt, accurate laboratory reports are possible only if the specimen is properly collected with accompanied request form detailing patient information, stored and transported safely.

Staff handling specimens are responsible and have a duty to safely collect, handle and transport specimens outlined under the Health and Safety at Work Act (1974) and Control of substances hazardous to health (COSHH) Regulations (2002). If specimens are not stored and transported safely, they pose a risk of infection to staff, patients and the wider public. Containers used for carrying and transporting specimens to pathology laboratories must be secure and conform to the relevant regulations set out in the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011.

The technical issues in appendix A apply mainly to Velindre Cancer Centre, though the principles are universal in accordance with national guidance. They are applicable where pathological specimens are collected and transported. The following divisions/departments will hold systems of work or procedures at local level:

- Cancer Research Wales
- Biochemistry laboratory
- Haematology laboratory
- Pharmacy
- Phlebotomy
- Clinical Research Trials Unit

At Welsh Blood Service this policy should be read (where relevant) in conjunction with the following divisional document that outlines procedures:

WBS – **SOP 022/BCT** – ACCOUNTING FOR BLOOD AND OTHER ITEMS FOR RETURN FROM CLINICS

2   SCOPE OF POLICY

This policy applies to all Velindre University NHST Trust (VUNHST) staff members who are directly involved in the collection, handling and transportation of biological specimens and blood products.

3   AIMS AND OBJECTIVES

The aim of the policy is to inform Trust staff on how to collect, handle and transport specimens in accordance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011, COSHH 2002, The Health and Safety at Work Act (1974) along with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (2015).

4   RESPONSIBILITIES

4.1 Chief Executive
The chief executive has overall responsibility to ensure this policy is adhered to while the operational authority for appropriate practice lies with the individual user.

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science
The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and Control training and monitoring is in place. This includes the transportation of specimens.

4.3 Departmental Managers/ Clinical Directors / Clinical Managers

Ensuring systems are in place to monitor staff attendance at mandatory training and to act on non-attendance at training with teams/ departments. They must also ensure adequate resources are available for staff to comply with this policy. Managers need to support and promote the principles outlined in this policy and ensure implementation of the IPC audit programme with the support of the IPC link nurses/healthcare workers (HCWs). They should also identify and take initial action around areas of non-compliance.

All line managers are responsible for monitoring individual attendance at mandatory training and following up non-attendees / non-compliance; for ensuring clinical staff have access to the handling and transportation of specimens' policy. Line managers should promote the principles, ensure monthly audits are performed and act upon and document non-compliance in an action plan.

4.4 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will advise clinical staff and will incorporate training on the safe collection and transportation of specimens and samples as part of mandatory and statutory training. The infection prevention and control committee are responsible for final ratification and dissemination of the collection handling and transportation of specimens' policy.

4.5 Healthcare Workers

Under the Health and Safety at Work Act 1974 (as amended) and the Control of Substances Hazardous to Health Regulations 2002 (as amended). Staff have a responsibility to raise awareness of correct practice and principles with colleagues, services users, carers, and visitors. VUNHST staff must report any near-miss, accidents, or incidents via the Trust incident reporting system.

5   DEFINITIONS

Potentially infectious micro-organisms have been classified into one of four hazard groups by the Government Advisory Committee on Dangerous Pathogens as shown in figure 1. The approved list of biological agents can be found on Health and Safety Executive website.

5.1 Hazard Group Definitions

When classifying a biological agent, it should be assigned to one of the following groups according to its level of risk of infection to humans.

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Figure 1

Group 1	Group 2	Group 3	Group 4
Unlikely to cause human disease	Can cause human disease and may be a hazard to employees; it is unlikely to spread to the community and there is usually effective prophylaxis or treatment avialable	Can cause severe human disease and may be a serious hazard to employee(s); it may spread to the community, but there is usually effective prophylaxix or treatment available.	Causes severe human disease and is a serious hazard to employees; it may spread to the community, but there is usually effective prophylaxis or treatment available.

6. Implementation and Distribution

This policy will be implemented and maintained by the IPCT. The policy will be available via the Trust Intranet site and from IPC pages. Where staff do not have access to the intranet their line manager will ensure that they have access to a copy of the policy.

7. Equality Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. References

- Department of Health: The Health and Social Care Act 2008; Code of Practice on Prevention and Control of Infections and related guidance (updated 2015).
- Loveday HP, Wilson JA, Pratt RJ, Golsorkhi, A Bak JB, Prieto J and Wilcox M (2014) epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection, supplement S1-S70.
- Control of Substances Hazardous to Health Regulations 2002 (as amended in 2004) (COSHH) Carriage of Dangerous Goods (Classification, Packaging, and Labelling) and Use of Transportable Pressure Equipment Regulations 2009 SI 2009/1348.
- **www.HSE.gov.uk/coshh/index.htm**

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendments) Regulations 2011.
- Health and Safety at Work Act, 1974.
- The Approved List of Biological Agent Advisory Committee on Dangerous Pathogens, HSE, 4th Edition 2021.

9. Getting Help

For further information and support please contact the Trust Infection Prevention and Control Team

Telephone: 02920 196129
Email: VCCInfectionPreventionControl@wales.nhs.uk

10. Related Policies

This policy should be read in conjunction with:

2023 Model Policy Aseptic Non-Touch Technique (ANTT)
IPC10 - Hand Hygiene Policy and Procedure
IPC 05 - National Infection Prevention & Control Manual (NICPM)
IPC 09 - Sharps Safety Policy

11. INFORMATION, INSTRUCTION AND TRAINING

All healthcare staff working in clinical areas are required to be trained in sharps safety and the correct use of Personal Protective Equipment.

Mandatory Infection Prevention and control training is required annually.

Further development-based training as identified by training needs analysis.

12   MAIN RELEVANT LEGISLATION
The policy is led by:

- Control of Substances Hazardous to Health COSHH (2002) – Control of Substances Hazardous to Health Regulations.
- Health and Safety (1974) - Health and Safety at Work Act.
- United Nations Economic Commission for Europe (UNECE) (2017) European Agreement concerning the International Carriage of Dangerous Goods by Road.

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (amendment) Regulations 2011. Advisory Committee on Dangerous Pathogens (2013) Approved List of Biological Agents. Health and Safety Executive: London.

Any HCW responsible for handling specimens has a responsibility and duty for the safe collection, handling and transporting of specimens under the Health and Safety at Work Act (1974) and the Control of Substances Hazardous to Health (COSHH) Regulations (2002).

Specimens from Velindre Cancer Centre travel by road and by post to local laboratories. Therefore measures to ensure that all specimens are transported in accordance with the European Agreement Concerning the International Carriage of Dangerous Goods by Road (2007) (ADR) and the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (2007) is essential.

Appendix 1: Collection of Specimen

The need for a specimen should be assessed before collection. Policies such as the VCC Diarrhoea Policy, the Neutropenic Sepsis policy, and the MRSA policy IPC07 include guidance for clinicians as to when clinical specimens should be taken. Further information in **Appendix 2**.

Specimens should be collected using:
- Standard infection control precautions (hand washing and the use of personal protective equipment (PPE)).
- The correct containers. (Appendix 1).
- Ensure the container lid is secure (specimens which have leaked will not be processed).

Labelling
The specimen form must be labelled correctly with:

- Patients name, sex, and address (in full not initials)
- Date of birth
- Hospital number
- Date and time sample was taken
- Specimen type e.g., Catheter specimen of urine, midstream specimen of urine, venous blood, wound swab
- Clinical information e.g., pyrexia, description and site of wound, persistent diarrhoea, MRSA screen
- Investigation(s) required
- Relevant medical history e.g., antibiotic history, symptom history
- Consultant name and signature of clinician requesting the specimen

- Hazardous group 3 organisms e.g., blood borne virus, Tuberculosis (TB) Creutzfeldt-Jakob disease (CJD) must have the specimen and the form identified as a 'High Risk" specimens (see Fig 1)
- Outbreak number if appropriate

The specimen container must be labelled correctly with:

- Patients name, sex, and address (in full not initials)
- Date of birth
- Hospital number
- Date and time sample was taken

Specimen bags and containers

There are several types of form used for investigation:

- Bacteriology
- Virology
- Biochemistry
- Haematology
- Cytology

Specimens must be placed in the approved specimen bag and sealed using the integral sealing strip. Bags must not be sealed using staples, or paper clips etc.

High risk specimens taken from individuals with known or suspected hepatitis, TB, CJD or Human Immunodeficiency Virus for example, should be deposited into the approved packages marked with the biohazard symbol. (Figure 1). The specimen container should be:

- Labelled and marked with the round yellow sticker indicating biohazard risk.
- Deposited into the sealed plastic pocket of a standard specimen form.
- The sealed pocket should be detached from the form and put into the sealable pocket of the biohazard bag (effectively double wrapping the specimen)
- The detached form should be labelled and placed in the unsealed pocket of the biohazard bag
- The paper form should be folded to protect patient confidentiality.

The biochemical laboratory at Velindre Cancer Centre is not equipped to process high risk specimens so they are sent to the laboratory in Cardiff and Vale NHS Trust (CAVUHB). The haematology laboratory will process high risk samples which have been appropriately bagged for a full blood count.
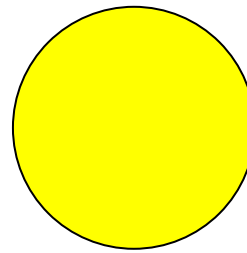
Figure 1: High Risk Specimen Bags

Storage

Storing specimens for collection (ward)

Each ward or Department should have a designated collection point. The receptacle should be an approved robust, secure container sited away from public areas. Containers should be kept closed between collections. The containers must be cleaned and disinfected weekly and after any visible spillage.

VCC ward collection times
10:00 hrs
12:00 hrs
15:30 hrs

All specimens must be transferred from the clinical environment to the storage area via a closable, leak proof, portable container storage container. The containers must be identified by the biohazard label and UN3373 code (Figure 2). The containers must be cleaned and disinfected weekly and after any visible spillage.

Figure 2: Biohazard Labels

If the specimen cannot be transported immediately to the laboratory, some can be refrigerated for a limited amount of time, in a designated fridge, for a maximum of 24hours at 2-8 degrees centigrade. This will help prevent bacteria and contaminates from multiplying and giving misleading results.

Storage of specimens

Specimens and samples should be sent to the relevant laboratory as soon as possible. In VCC specimens are collected at regular intervals from the inpatient wards and outpatient departments by portering staff and delivered to the phlebotomy department where they are sorted and stored according to specimen type, either at room temperature or refrigerated.

Samples for biochemical rather than microbiological investigation do not need to be refrigerated, however, bloods for culture must not be refrigerated and must be transported to the laboratory as soon as possible.

The fridge should have a minimum/maximum thermometer and cleaned as directed in the cleaning schedule for the relevant department. The fridge must also be cleaned weekly. Fridges must be visibly clean with no blood or body substances, dust, dirt, debris, spillages, food debris or build-up of ice. Freezers must be defrosted and cleaned monthly (NPSA, 2010).

Storing samples overnight

Samples stored at room temperature	Samples for refrigeration
Blood cultures Wound swabs Sputum Wet slides Biopsy Urine samples in red topped containers (containing boric acid)	Faeces Dry slides Cross match Full blood count Tumour markers (ca-125, ca-153, ca-199, CEA, PSA CYFRA -211, AFP & HCG) FSH, LH, TFT, TSH, T4, Thyroglobulin, Methotrexate levels
Renal, liver and bone profile and coagulation samples should be sent to switchboard for transportation to UHW.	

Leaking Specimens

Any container containing a specimen that will be sent to the laboratory must be robust, must not leak during normal use and must be suitable for its purpose. An incident form must be completed if any of these containers leak or break during a normal use to facilitate investigation of consumables.

Any HCW collecting, transporting or receiving specimen(s) that discovers a spillage or leak is responsible for managing the spillage. The HCW should don appropriate PPE before cleaning up the spillage. Absorbent material, from a spill kit, should be used to absorb the spillage and the container or surface should be cleaned and disinfected. The sample should be discarded into the appropriate waste stream and the sender notified that the specimen has been damaged. After removal of PPE hand hygiene should be performed.

Transporting specimens

Under the Health and Safety at Work Act 1974, all staff have a responsibility to protect themselves and others, including patients and the wider public, from inadvertent contamination from hazardous substances. All specimens must be placed in a designated secure collection area until ready for collection. All specimens must be placed in a specimen bag with the required form in a separate pocket or attached to the adhesive strip of the bag and folded. If sample is of 'high risk' status, ensure specimen is placed in biohazard bag. Appropriate transportation packaging should be used in line with the Carriage of Dangerous Goods and use of Transportable Pressure Equipment (amendments) Regulations (2011). Specimens must be transported to the laboratory in transport containers, which comply with UN3373 regulations. (United Nations Economic Commission for Europe, 2017) requirements

Velindre University NHS Trust has a contract with NWSSP to collect specimens for transport to the local laboratory. Whilst CAVUHB are responsible for the outer container and the cleaning thereof, the Health Courier Service is responsible for the Temperature Control Units in the vehicles.

Collection times are every hour from 08.20 until 16.20.

To arrange transport of specimens outside of working hours, clinical staff should contact the hospital switchboard.

Appendix 2: Collection and storage of specimens for microbiological investigation

The following is guidance only on the procedures required for managing specimens. Detailed information can be obtained from the Royal Marsden Manual of Clinical nursing procedures 9th Ed (2015) available via the Velindre University NHS Trust website.

Wherever possible specimens should be obtained at a time when it can be transported to the laboratory (lab) in a timely manner. Specimens that are stored overnight in a refrigerator must be placed in a designated specimen refrigerator.

Specimen	Container	Refrigeration	Transport to laboratory	Collection
Wound swab	Cotton tipped charcoal swabs (black top)	No. Refrigeration can kill some fastidious organisms and the charcoal transport medium allows cultures to be maintained for at least 24 hours.	As soon as possible within 24 hrs	Moisten the swab with sterile saline before taking sample. Use a zigzag motion whilst simultaneously rotating between fingers.

Sputum	White universal container	No – refrigeration will kill Strep Pneumoniae, one of the target organisms. Room temperature storage for up to 24 hrs is the best option.	As soon as possible within 24 hours	In suspected cases of pulmonary TB three samples should be taken on consecutive days preferably on waking. The request form should be marked 'acid-fast bacilli (AFB) and a high risk label attached to the form and container and inserted into a bio bag.
Catheter specimen of urine (CSU)	Red topped universal container containing Boric acid.	No - the Boric acid will prevent the bacteria multiplying. **NB If plain universal containers are used specimens should be refrigerated. Refrigerate within two hrs of taking specimen. Bacteria multiply at room temperature giving false positive results.**	As soon as possible within 24 hrs	10mls is required using a non-touch aseptic technique. The port should be swabbed with 70% isopropyl. Equipment used to take the specimen must be sterile. Specimen must not be taken from the catheter bag.
Midstream specimen of urine (MSU)	Red topped universal container containing Boric acid	No - the Boric acid will prevent the bacteria multiplying. **NB If plain universal containers are used specimens should be refrigerated. Refrigerate within two hrs of taking specimen. Bacteria multiply at room temperature giving false positive results.**	As soon as possible within 24 hrs	10mls is required. The first few mls of urine should be discarded and the mid-stream specimen collected into a sterile foil bowl.

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Faeces	Blue topped stool specimen container	Yes – must be refrigerated within 2 hrs of taking the specimen.	As soon as possible within 24 hrs	15mls of liquid or approximately the size of a walnut is sufficient. NB No-diarrhoea specimens will not be processed for bacterial or viral infections.
Blood cultures	Specific bottles (Beckton Dickinson)	No – store at room temperature until sent to the laboratory.	As soon as possible within 24 hrs	Non touch technique and swabbing the bottle tops and skin with 70% isopropyl alcohol.
Tissue/pus	Universal container	No – send directly to the lab.	Immediate transportation	Aspirate with needle and syringe into a sterile container using an aseptic technique.
High Vaginal Swabs	High vaginal swabs	No – send directly to the lab.	must reach lab within 4 hrs	
Throat	Red topped cotton swab in virus transport medium	Yes – refrigerate within 4 hrs.	Send directly to the laboratory	The patient should stick out their tongue whilst the swab is guided down the side of the throat to make contact with the tonsil, a tongue depressor may be required.
MRSA Screen Nose and Groin (include throat swab for ENT patients) Swab all wounds and	Cotton tipped black topped swabs with transport medium	Yes – refrigerate within 4 hrs.	Within 24 hours	Prior to taking swabs moisten swabs with sterile saline.

invasive devices for C &S				
Virology e.g flu	Red topped cotton swab in virus transport medium	**Yes**	Send directly to the laboratory.	The patient should stick out their tongue whilst the swab is guided down the side of the throat to make contact with the tonsil, a tongue depressor may be required.
Legionella antigen	Plain universal container	**No**	Send directly to the laboratory	

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Appendix 4

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	Transport of Specimens		
Manager	Hayley Harrison-Jeffreys		
Date of meeting with OD Manager – ED&I	N/A		
Date of submission	**January 2024**		
Date of next review	**January 2027**		
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	**IPC 11 - Transport of Specimens**
1.2	Who owns it?	Infection Prevention & Control Management Group
1.3	What is the aim of the change(s)?	No change to policy. Addition of divisional standard operating procedures for how to take a specimen.
1.4	Who is affected most by the change?	N/A
1.5	How does this topic fit into the wider context of the organisation?	Staff handling specimens are responsible and have a duty to safely collect, handle and transport specimens outlined under the Health and Safety at Work Act (1974) and Control of substances hazardous to health (COSHH) Regulations (2002), and conform to the relevant regulations set out in the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011.
1.6	Who is undertaking the EQIA	Hayley Harrison Jeffreys – Head of Infection Control

1.7	When will you start and end the EQIA?	24/01/2024
2.1	What data is available to help inform the EQIA? Note to self ** query to include said changes amendments new regulations etc from old policy	Previous EQIA submitted January 2019.
2.2	What information is still needed?	N/A
2.3	How will missing data be collected?	N/A
2.4	What is considered relevant information and data?	To inform Trust staff on how to collect, handle and transport specimens in accordance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011, COSHH 2002, The Health and Safety at Work Act (1974) along with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (2015). United Nations Economic Commission for Europe (UNECE) (2017) European Agreement concerning the International Carriage of Dangerous Goods by Road. European Agreement Concerning the International Carriage of Dangerous Goods by Road (2007) (ADR) and the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (2007) is essential. All specimens are potentially infectious, and all staff involved in collecting, handling, and transporting specimens must follow infection control precautions to reduce the risk of transmission of infection and be aware of related infection prevention and control policies i.e. IPC10 – Hand Hygiene Policy and Procedure and IPC05 – National Infection Prevention and Control Manual. Therefore, there is a need to ensure that the sample is handled safely and securely and is

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		contained in a closable box. This is to ensure the dignity and respect of the patient any potential breach of data security that could impact on the patient. The box also provides protection for the staff member transporting the sample should there be an incident or breakage.

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…*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Gender re-assignment *Would this affect those in/post-transition differently?*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.**	

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				Encourage participation in public life.	
Marriage or civil partnership *Are single people affected differently?* *Are married people or civil partners treated differently?*			√	To eliminate discrimination and harassment. Promote equality of opportunity. Promote good relations and positive attitudes. Encourage participation in public life.	
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			√	To eliminate discrimination and harassment. Promote equality of opportunity. Promote good relations and positive attitudes. Encourage participation in public life.	
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			√	To eliminate discrimination and harassment. Promote equality of opportunity. Promote good relations and positive attitudes. Encourage participation in public life.	
Religion *Affects one religious group more?* *Clashes with religious holidays?*			√	To eliminate discrimination and harassment. Promote equality of opportunity. Promote good relations and positive attitudes.	

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What about groups with no religion?				**Encourage participation in public life.**	
Sex/Gender *Does it only apply to men / women?* *Could this affect one group more than the other?*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*			√		

Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	

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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	Continue the policy. Evidence as above.
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	N/A
4.3	Could be policy be implemented in a different way to avoid negative impact?	N/A
4.4	How will this change promote equality of access and equality of opportunity?	N/A
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	n/a
5.1	What do you have so far?	This policy sets out the safe management of clinical specimens across both divisions of the Trust.

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5.2	Have any themes emerged?	N/A
5.3	What do people have to say about our work?	N/A
5.4	How will you consult widely on your topic?	The policy has been shared with the IPC Management group for consultation and approval.
5.5	Who will you consult with?	Infection Prevention & Management Group.
5.6	How long will the consultation stage last?	As there was no recommended change 2 week review period was followed.
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	3. Continue the policy
6.2	What will you do with the comments or information you have gathered from your consultations?	N/A
6.3	How did the consultation help guide new policy?	N/A
6.4	Will you make any changes to the draft report you produced?	N/A

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7.1	Confirm actions	No changes are Policy required. To renew policy
8.1	Establish timetable for reviewing actions and refreshing the assessment	Policy review every 3 years.

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
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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	Double-click to add signature below:
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Attachments

5. The policy concerned
6. Data used in completing the assessment
7. Details of consultation undertaken
8. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

Last updated: mars 7, 2024

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST Medical Gas Policy PP10

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	FINAL VERSION WILL BE PUBLISHED IN PUBLIC DOMIAN

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	This policy addresses the provision of a piped medical gas pipeline system (MGPS) at Velindre University NHS Trust.

RECOMMENDATION / ACTIONS	The Quality and Safety Performance Committee is requested to **APPROVE** the latest version of the Medical Gas Policy PP10.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Medical Gas Meeting (circulation to group members)	**19/09/2023**
Executive Management Board RUN	**29/02/2024**
	(DD/MM/YYYY)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Minor amendments have been made to policy to reflect 2 manifolds that are now in use at VCC for resilience. The section on medical gas cylinders has been removed as we have a separate medical gas cylinder policy.

7 LEVELS OF ASSURANCE	
n/a	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
1	PP10 VUNHST Medical Gas Policy

1. SITUATION

1.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

1.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety		
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**		
	Safe	☒	
	Timely	☐	
	Effective	☐	
	Equitable	☐	
	Efficient	☐	
	Patient Centred	☐	
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). a) The policy fulfils statutory and mandatory duties. b) The policy provides a framework for the Trust to comply with its statutory, mandatory and moral duties with regard to keeping people safety. c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].		
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required		
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.		
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.		
	If more than one Well-being Goal applies please list below:		
	The policy also supports: • A Prosperous Wales • A More Equal Wales		
	If more than one wellbeing goal applies please list below:		

	As noted above, the objects of the policy are to protect: • Life • Assets • Provision of services • The environment • Trust and Reputation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance/replacement of outdated/damaged equipment; investment in time for training etc. Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	As noted above, fire does not discriminate but the
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

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

Ref: PP 10

Medical Gas Piped Systems Policy

Executive Sponsor & Function:	Chief Executive
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	
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1.0 The Importance of a Managed Approach to Medical Gases

This policy is compliant with Health Technical Memorandum (HTM 02-01) and looks at the issues of operational management. The policy covers such issues as statutory requirements, functional responsibilities, operational procedures, training and communications, cylinder management, general safety, maintenance and risk assessment, control of exposure to anaesthetic agents, giving definitions and working practices throughout. This policy is intended for use by Operational Managers, Engineers, Quality Controllers, Technicians, Finance Officers and all Medical and Portering staff involved in the day to day running of a medical gas pipeline system. The primary objective of this policy is to ensure the provision of safe and reliable medical gas pipeline systems and their efficient operation and use. This objective will only be achieved if the medical and nursing users and Estates staff participate in the introduction of this operational policy designed to minimise the hazards likely to arise from misuse of the system.

It is not intended that this policy covers the use of small, manually portable gas cylinders.

At least 60% of patients are administered medical gases during their stay in hospital.

Not having safe and reliable gas supplies can be as life-threatening as not having electricity, yet responsibility for medical gases does not fit precisely into any one person's role.

According to Health Technical Memorandum (HTM) 02-01/EN737 and the National Minimum Care Standards & Regulations for Independent Health Care (NMCSR) 2002, all hospitals should at least have:

Effective system designs covering the capacity and capability of piped medical gases, including alarm systems and the siting of back-up systems.

Defined functional responsibilities requiring the nomination of an Authorised Person; Competent Person, Quality Controller and Designated Medical/Nursing Officer.

A hospital-wide medical gases operational policy based on comprehensive risk assessment and training carried out for clinical and non-clinical staff.

A demonstrable cylinder management programme in place.

1.1 Risk Assessments

Compliance by the Trust is essential to manage the risks to patients, visitors and staff.

Site based risk assessments have been carried out by British Oxygen Company (B.O.C.). These are held by the Works and Estate department and are available for inspection upon request to the relevant Authorised Person for Medical Gas Pipeline Systems.

2.0 General Policy Statements

This policy addresses the provision of a piped medical gas pipeline system (MGPS) at Velindre University NHS Trust.

The (MGPS) provides a safe, convenient and cost-effective supply of medical gases to points where these gases can be used by clinical and nursing staff for patient care.

Velindre University NHS Trust recognises its commitment to maintaining the MGPS to required standards and the training of all personnel associated with its operation.

It is the Trust policy that before work on the MGPS can commence a Permit to Work Form, signed by an Authorised Person (MGPS) MUST be completed.

3.0 Scope of Policy

This policy is intended for use by all staff involved with MGPS at Velindre University NHS Trust.

It applies throughout at Velindre University NHS Trust to all fixed medical gas pipeline systems and to the use and management of cylinders associated with the MGPS. It does not apply to the use of small portable cylinders used, for example, during the transportation of patients.

Compressed gas and vacuum supplies to general engineering workshops and Pathology Department equipment are separate from the general MGPS and are NOT included in this policy, although the general principles in this document should be followed for these departments.

MGPS terminal units define the limits of Estates' responsibility in this policy.

Equipment connected to the terminal units is NOT covered by this policy, other than where its mode of use may affect system operation or safety.

Medical equipment is the responsibility of the Electro Biomedical Engineering Department.

Medical gases should not be used for non-medical purposes, other than as a test gas for medical equipment.

Medical air should be used as the power source for ventilators; the routine use of oxygen as a driving gas is to be avoided.

The operational management responsibility for MGPS on Health Boards sites resides with the Estates Department and each site specific Estates Authorised Person is responsible for the completion of the site specific information to be detailed in Appendices A – D.

4.0 Responsibilities

The responsibilities detailed by job title or role in this section (section 4) are to be made specific to each site by the Authorised Person for that site. This will involve the separate completion of Appendices A – D for every location at which this policy applies.

4.1 Chief Executive

Ultimate management responsibility for MGPS rests with the Health Board's Chief Executive.

The Velindre University NHS Trust's Chief Executive is responsible for ensuring that an Authorising Engineer (AE) is appointed for MPGS. This function will be fulfilled by Welsh Health Estates.

4.2 Authorising Engineer

The duties and responsibilities of the Authorising Engineer are:

4.2.1 To recommend to the Estates Manager those persons who, through individual assessment, are suitable to be Authorised Persons (MGPS);

4.2.2 To ensure that all Authorised Persons (MGPS) have satisfactorily completed an appropriate training course;

4.2.3 To ensure that all Authorised Persons (MGPS) are re-assessed every three years and have attended a refresher or other training course prior to such re-assessment;

4.2.4 To review the management systems of the MGPS, including the Permit to Work System;

4.2.5 To monitor the implementation of the operational policy and procedures.

4.3 Authorised Person (MGPS)

The Authorised Person(s) (MGPS) are listed in Appendix C. The Authorised Persons (MGPS) assume effective responsibility for the day-to-day management and maintenance of the MGPS.

The Duties and Responsibilities of Authorised Persons (MGPS) are:

4.3.1 To ensure that the MGPS is operated safely and efficiently in accordance with the statutory requirements and guidelines;

4.3.2 To manage the Permit to Work System, including the issue of Permits to Competent Persons (MGPS) for all servicing, repair, alteration and extension work carried out on the existing MGPS;

4.3.3 To supervise the work carried out by Competent Persons (MGPS) and for the standard of that work (A Register of Competent Persons (MGPS) must be kept);

4.3.4 To ensure that the Health Board MGPS maintenance specification and schedule of equipment (including all plant, manifolds, pipe work, valves, terminal units and alarm systems) are kept up to date;

4.3.5 To liaise closely with Designated Nursing/Medical Officers, the Quality Controller (MGPS) and others, who need to be informed of any interruption, alteration and testing of the MGPS;

4.3.6 To provide technical advice to those responsible for the purchase of any medical equipment which will be connected to the MGPS, in order to avoid insufficient capacity and inadequate flow rates;

4.3.7 In accordance with the Velindre University NHS Trust's *policy* on provision of services, provide advice on the provision and or replacement of MGPS central plant and associated systems. The Estates Department will hold overall responsibility for the provision and maintenance of MGPS services within the Health Board;

4.3.8 To organise such training of Estates staff and/or transfer of MGPS information, as is needed for the efficient and safe operation of the MGPS.

4.3.9 To advise the Trust on any other training requirements, outside the Works and Estate department.

4.4   Competent Person (MGPS)

Competent Persons (MGPS) are Craft Persons, employed by Velindre University NHS Trust and are listed in Appendix C.

All Competent Persons (MGPS) shall be registered to BS EN ISO 9001 / BS EN ISO 13458, with clearly defined registration criteria.

Where sub contract labour is required to carry out the Competent Person duties then the same registration must be adhered to.

The Duties and Responsibilities of Competent Persons (MGPS) are:

4.4.1 To carry out work on the MGPS in accordance with the Health Board maintenance specification;

4.4.2 To carry out repair, alteration or extension work, as directed by an Authorised Person (MGPS) in accordance with the Permit to Work System and HTM 02-01 (2005);

4.4.3 To perform engineering tests appropriate to all work carried out and inform the Authorised Person (MGPS) of all test results.

4.4.4 To carry out system integrity tests under direct supervision of the Appointed Person;

4.4.5 To carry out all work in accordance with the Velindre University NHS Trust & Safety Policy.

4.5 Quality Controller (MGPS)

It is the responsibility of the Chief Executive or the designated Executive Director to appoint, in writing, on the recommendation of the Chief Pharmacist, a Quality Control Pharmacist with MGPS responsibilities.

The Authorised Person (MGPS) will be responsible for liaising with the QC (MGPS) and organising attendance as required.

The Duties and Responsibilities of the QC (MGPS) are:

4.5.1 To assume responsibility for the quality control of the medical gases at the terminal units, i.e. the wall or pendant medical gas outlets;

4.5.2 To liaise with the Authorised Person (MGPS) in carrying out specific quality and identity tests on the MGPS in accordance with the Permit to Work System and relevant Pharmacopoeia Standards;

4.5.3 To organise MGPS training of Pharmacy staff who may deputise for the QC (MGPS);

4.5.4 They should have received training on the verification and validation of MGPS and be familiar with the requirements of this MGPS Operational Policy.

Pharmacy at Velindre University NHS Trust will;

Receive delivery notes for compressed gas cylinders, check against invoices received and pass invoices for payment;

Order and supply cylinders of medical gases and special gas mixtures for the hospital;

Maintain a record of cylinder rental charges and pass rental invoices for payment;

Ensure that cylinder gases comply with Ph Eur requirements;

Ensure that other gases and gas mixtures comply with manufacturers' product licences.

4.6 Designated Medical / Nursing Officer (DMO)

The Designated Medical / Nursing Officer in charge is the person, on each site, with whom the Authorised Person MGPS liaises on any matters, affecting the MGPS and who should give permission for a planned interruption to supply. These persons should have received training on MGPS relevant to their departments and on the action to be taken in the event of an emergency.

The Duties and Responsibilities of the Designated Medical / Nursing Officer (DMO) are:

    4.6.1 To give permission for any interruption to the MGPS and should sign the appropriate part of the permit. However, in certain circumstances such permission may be given by the Senior Clinician in charge;

    4.6.3 To ensure that all relevant staff are aware of the interruption to the MGPS and which terminal units cannot be used.

4.7 Designated Persons

The Designated Persons are the Portering staff. They will have undergone specialist training in the identification and safe handling and storage of medical gas cylinders, associated with MGPS, including relevant manual handling training. The Portering Manager will arrange this training.

The Duties and Responsibilities of the Designated Persons in Velindre University NHS Trust.

    4.7.1 To assist with the delivery of gas cylinders by BOC Medical or designated gas supplier;

    4.7.2 To transfer gas delivery notes from the delivery driver to the Pharmacy Department;

    4.7.3 To attach to and remove from cylinders, medical equipment regulators (or regulator / flow meter combinations) and manifold tailpipes;

    4.7.4 To identify and remove from service faulty (e.g. leaking) cylinders and subsequently notify Pharmacy of the location of such cylinders;

    4.7.5 To perform a monthly check on cylinder stocks and report any deficiencies to the Pharmacy Department;

    4.7.6 To ensure that all cylinder contents are used within the 3-year fill / refill timescale specified by the gas supplier;

The Designated Person must work safely at all times, using the appropriate Personal Protective and Manual Handling Equipment, damage to which m u s t be reported immediately to the Operational Services Manager.

4.8   Medical Gases Committee

A Medical Gases Committee shall consist of the Chief Pharmacist and a Senior Authorised Person (MGPS), for the Health Board, a nominated designated Nursing / Medical Officer, the Portering Manager and the QC (MGPS).

MGPS Operational Policy Review

The MGPS Operational Policy should be reviewed annually. The Authorised Person (MGPS) shall convene the review meeting and be responsible for writing and distributing the minutes of the meeting. The Committee shall report to the Works and Estate Statutory Compliance Group, which in turn reports to the Health Board Health and Safety Committee.

MGPS Record Drawings and Documentation

The Authorised Person (MGPS) will maintain copies of the following:-

* Up-to-date and accurate 'as fitted' record drawings (including valve / key numbers/ TU identification) for all MGPS;
* Any necessary MGPS insurance / statutory documentation;
* MGPS safety valve replacement schedule (on a 5-yearly basis);
* New and completed Permit to Work books for work on the systems (for 10 years);
* Plant history / maintenance records;
* Manufacturer's technical data sheets / manuals for all MGPS components;
* Health Technical Memorandum 02-01, any associated supplements and NHS Model Engineering Specifications C11, all latest editions;
* MGPS contractors' service contracts and ISO 9001(or equivalent) certificates, staff training records, equipment calibration certificates (copies);
* A list of all personnel associated with the MGPS, especially the Permit to Work System;
* Emergency and other useful telephone numbers;
* MGPS staff training records;
* Calibration certificates of the hospital test equipment;
* The MGPS Operational Policy

Pharmacy will maintain copies of the following:

* Delivery notes – invoices V.I.E.
* Delivery notes for medical gas cylinders;
* Sales invoices for medical gas cylinders;
* Delivery Summary Form (tracks cylinder stock information);
* Cylinder rental invoices;
* Cylinder Rental Reconciliation Form (Monitors trends in cylinder use over 6 months);
* Delivery notes for special gas and industrial gas cylinders;
* Sales invoices for special gas and industrial gas cylinders;
* Rental invoices for special gas and industrial gas cylinders;
* Calibration records of QC test equipment and records of all QC tests performed;

5.0 Training

It is essential for the safety of patients that NO PERSON should operate, or work on, any part of an MGPS unless adequately trained or supervised.

MGPS Training at Velindre University NHS Trust's for all Estates staff is administered by the Works and Estates Department.

A record of those trained is kept in the Estates Department.

It is the duty of Departmental Managers to ensure that all staff using MGPS are appropriately trained and records kept.

The Authorised Person (MGPS) may request training records of contractors' staff.

Training on MGPS will be provided as follows:

Title	Training	Frequency
Authorised person	Specialist training	Refresher 3 years
Competent person	Specialist training	Refresher 3 years
Quality controller	Specialist training	Refresher 3 years
Designated Nursing/Medical Officer	On site knowledge	Annually
Portering staff	Specialist training	Refresher 3 years

6.0 The MGPS structure

The site specific locations and structure of MGPS can be found in Appendix D and is to be completed by the site Authorised Person for every site at which this policy applies, i.e. Oxygen, Medical Air 4 Bar, Surgical Air 7 Bar, Medical Vacuum, Nitrous Oxide and Entonox.

7.0 Signage

Appropriate identification and safety warnings should be displayed in accordance with current requirements.

A notice should state the location of the keys and be fixed to the Plant Room door.

8.0 Cylinder Storage

Accommodation for medical gas cylinders should comply with the following guidelines:-

8.0.1 Ventilation All cylinder stores should be well ventilated

8.0.2 Labelling All cylinder stores should be clearly labelled as appropriate with the type of cylinders contained

8.0.3 Emergency action Details of emergency action procedures and location of keys together with no smoking signs should be clearly posted on the front of the cylinder store

8.0.4 Access Clear access to all cylinder stores is required including adequate space for vehicular access and cylinder loading and unloading

8.0.5 Fire protection All cylinder stores should be free from naked flames and all sources of ignition appropriate fire extinguishers should be readily available

8.0.6 Cylinder stores for medical gasses should only contain medical gas cylinders

8.0.7 Industrial and pathology gasses cylinders should be stored in a separate designated area

8.0.8 Cylinders in use in wards or departments should be secured to ensure they cannot fall, topple or be pushed over, causing subsequent potential for personal injury and damage.

9.0 Area Valve Service Units (AVSUs)

Locked boxes, with breakable glass fronts and containing area valve service units (AVSUs), are provided at the entrance to wards and departments.

These valves provide facilities for both routine and emergency isolation of gas supplies.

These valve boxes contain an emergency inlet port (Non Interchangeable Service Terminal, or NIST)), which is gas specific. This may be used to supply gas to a ward when the main supply fails or is shut down for essential engineering work.

General Rules and Conditions for Control of Line Valve Assemblies LVAs

Pipeline valves (called lockable line valves assemblies LVAs) in ducts, risers ceiling spaces etc. shall be locked in the normal operating position.

Pipeline valves will normally be left unlocked if they are sited in a locked Plant Room. Estates will hold keys for these valves.

10.0 Access

Under normal events, only the Authorised Persons (MGPS) using the appropriate key from the Estates medical gases key cabinet, should access AVSUs and any other locked line valves, under control of a Permit to Work.

The key cabinet contains a list identifying all AVSUs and locked line valves, with corresponding key numbers.

11.0   Key Holders:

Any of the Authorised Persons listed in the site specific information in Appendix C will be key holders for that site.

In the event of an emergency, access to the valve boxes and AVSUs may be gained by smashing the breakable glass fronts.

A senior member of the medical or nursing staff will perform this action, after steps have been taken to ensure that no patient is compromised by isolation of the gas supply.

12.0   Routine and Planned Procedures (The MGPS Permit to Work System)

The aim of the MGPS Permit to Work System is to safeguard the integrity of the medical gas system, and therefore the safety of the patients.

It is the policy of Velindre University NHS Trust that, with the knowledge and permission of the Authorised Person (MGPS), a Permit must be raised before any work, except changing of manifold cylinders or emergency isolation by a member of the nursing staff, can be undertaken at any part of the hospital's medical gas system.

Granting of a Permit to Work and the way in which the work is carried out must follow the directions of HTM02-01, unless otherwise defined in this Policy.

Responsibilities for signing a Permit to Work is detailed in sections 13.1 and 13.2 of this policy.

Designated Medical / Nursing Officers, or exceptionally the Senior Clinician on duty, should ensure that colleagues are advised of the interruption to the gas supply, and its estimated duration. They should also ensure via the Estates Department that all affected terminal units are appropriately labelled.

13.0   Planned or Routine Interruption

A planned interruption will be needed for repair, extension or modification to the existing MGPS. An Authorised Person (MGPS) shall supervise any planned interruption in strict accordance with the Permit to Work System in HTM 02-01:2005. The QC (MGPS) Pharmacist shall be involved in any planned interruption from the initial planning stage.

The Authorised Person (MGPS) shall assess the hazard level of the work to be carried out in accordance with the definitions that are given in the following sections for High and Low Hazard work.

13.1   HIGH Hazard Work

Any work on the MGPS, such as cutting or brazing, that will introduce hazards of cross-connection and pollution, will be classified as HIGH HAZARD.

Cross-connection, performance, identity and quality tests shall be required before the MGPS is taken back into use.

High hazard work may require at least a planned interruption to a single ward or department, or, at worst, a major shutdown of a system to a whole site.

In such events, an Authorised Person (MGPS) must ensure that key personnel for each and every ward or department are informed; if necessary, holding a site meeting.

The QC (MGPS) Pharmacist should be included in any discussions that may lead to an interruption of the MGPS.

Two weeks prior to the planned interruption, the Authorised Person (MGPS) shall liaise in person with the Designated Nursing / Medical Officer(s) of the ward(s) or department(s) concerned.

At the same time, the Authorised Person (MGPS) will complete Part 1 of the Permit to Work Form.

The Designated Medical / Nursing Officer(s) for the ward(s) or department(s) involved will be made aware that their signatures will be required on the date on which the work is due to take place.

The requirement for portable cylinders or vacuum units will be determined and confirmed, with details of the interruption, by a notification rom Estates AP to the Designated Medical / Nursing Officer(s).

A copy of this memorandum will be sent to the ward(s) or departments(s) concerned. A further memorandum, requesting the services of a Quality Controller (MGPS) and detailing the requirements for portable cylinders shall be sent to Pharmacy.

It is the responsibility of the Authorised Person (MGPS) to arrange, through the Pharmacy Department, or an appropriate hire firm if necessary for portable cylinders and regulators (Stocks of regulators are held by Estates).

Any additional portable vacuum units to be supplied are the responsibilities of the Estates Department.

The Authorised Person (MGPS) will provide all details of the work to be carried out in Part 2 of the Permit to Work Form, including any other Permits, e.g. for hot works or for entry into confined spaces.

Work shall only commence when the Designated Medical / Nursing Officer or Senior Clinician(s) for the ward(s) or department(s) is / are satisfied that no patients will be put at risk by the shutdown of the MGPS and has / have signed Part 1 of the Permit to Work Form.

The Authorised Person (MGPS) will then supervise isolation of the AVSU(s). Isolation to be carried out by the Designated Medical / Nursing Officer.

Once the system(s) has / have been isolated and de-pressurised, the Competent Person (MGPS) will sign Part 2 of the Permit to Work Form and commence work.

The Competent Person (MGPS) will sign Part 3 of the Permit to certify that work has been completed, and contact the Authorised Person (MGPS), so that the installation may be examined and tested.

For all High Hazard work, the Authorised Person (MGPS) will determine and carry out, with the assistance of the Competent Person (MGPS), the necessary tests and examination of the system(s) in accordance with HTM 02-01 'Validation and Verification'.

When these tests have been completed satisfactorily, the Authorised Person (MGPS) will initial the relevant spaces and sign Part 4 of the Permit.

The Quality Controller Pharmacist (MGPS), with the assistance of the Authorised Person (MGPS) will carry out identity and quality tests on the system(s) in accordance with HTM 02-01 'Validation and Verification'.

When these tests have been completed with satisfactory results, both will initial the relevant spaces and sign Part 5 of the Permit.

The Quality Controller (MGPS), with receive the pink copy of the Permit to Work Form from the Authorised Person (MGPS).

Note: It should be the normal practice of Estates to retain the white copy along with the original (yellow) copy in the Permit to Work Book. Photocopies (signed and dated by the AP (MGPS) and the CP (MGPS)) of the white copy may be issued to the Competent Person (MGPS) on request.

The Designated Nursing / Medical Officer(s) will accept the system(s) back into service by signing Part 6 of the Permit and will undertake to notify his / her colleagues that the system is fit for use.

13.2   LOW Hazard Work

Any work on the MGPS which will not introduce any hazard of cross-connection or pollution.

A performance test will be required before the MGPS is taken back into use.

If there is any doubt as to the hazard level classification of a particular Permit to Work, advice should be sought from the Senior Authorised Person (MGPS), detailed in Appendix A.

Low hazard work on terminal units is normally the result of a leak on an individual terminal unit due to a faulty valve or seal but may also include work on plant, which does not interrupt gas supplies.

This type of work is usually carried out at short notice because of the need for minimum disruption in patient care. In such events, the Authorised Person

(MGPS) may have to arrange a portable cylinder or vacuum unit, so that the terminal unit can be taken out of service.

The Authorised Person (MGPS) will fill out the relevant section of Part 1 of the Permit to Work Form. The Authorised Person (MGPS) will liaise with, and fully brief, the Senior Clinician on duty within the ward / department who will then sign Part 1, if required.

The Authorised Person (MGPS) will provide all details of the work to be carried out in Part 1 of the Permit to Work Form

When satisfied with the extent of the work, the Competent Person (MGPS) will sign Part 2 and begin the work.

The Competent Person (MGPS) will sign Part 3 of the Permit to certify that the work has been completed and contact the Authorised Person (MGPS) for the installation to be examined and tested.

The Competent Person (MGPS), with the assistance of The Authorised Person (MGPS), if necessary, will carry out flow, pressure drop, mechanical function and gas specificity tests on the serviced terminal unit(s).

Other equipment function tests, e.g. on plant, will be made to the satisfaction of the Authorised Person (MGPS).

The Authorised Person (MGPS) Competent Person (MGPS) will initial the relevant spaces, and sign Part 4 of the Permit.

When satisfied with the test results, the Authorised Person (MGPS) will sign Part 5 of the Permit.

The Designated Medical / Nursing Officer or Senior Clinician on duty within the ward or department will accept the MGPS back into service by signing Part 6 of the Permit and will undertake to notify his / her colleagues that the system is fit for use.

14.0   Actions in the Event of a Medical Gas Alarm

The diagram on page 18 (Diagram 1) shows a typical medical gas panel and the actions that should be taken at each level of alarm.

On detection of a local alarm indication e.g. in a ward area, the Senior Clinician on duty, or deputy, should contact the Switchboard to confirm that a fault has been signalled and that Estates has been informed.

In the event of an alarm condition on the central alarm panel, it is the responsibility of the Security control room to inform the appropriate staff.

Disabling the alarm system, other than when due authorisation has been obtained from an Authorised Person (MGPS), is absolutely forbidden as this may compromise patient safety.

There should always be a 'normal' light. If there is no 'normal' light, then there is a fault of some kind, possibly just with the alarm panel. However, Estates should investigate this fault.

Alarms should be tested weekly by a Competent Person (MGPS). Operation of the TEST button will confirm operation of all audible / visual indicators.

Nursing / Medical staff should be advised of this test.

The results of these tests should be recorded and stored by the Authorised Person.

14.1   Example – Oxygen

NWH   =   Normal Working Hours
ONWH   =   Outside Normal Working Hours

ALARM INDICATION	Action (Security to inform)
NORMAL	No action to be taken
PLANT FAULT	NWH - Estates ONWH - Estates (On-call rota)
PLANT EMERGENCY	NWH - Estates ONWH - Estates (On-call rota)
RESERVE LOW	NWH - Estates ONWH - Estates
PRESSURE FAULT	NWH - Estates ONWH - Estates (On-call rota)

Panel Indication (all alarm panels)	
Alarm Indication	ACTION (SECURITY TO INFORM)
Power On	No action to be taken
System Fault	NWH - Estates ONWH - Estates (On-call rota)

Diagram No. 1 Typical Medical Gas Alarm Panel

It is the responsibility of the AP (MGPS), to ensure that a procedure for each alarm indication is displayed next to the respective central alarm panel.

In the event of an Authorised Person not being available refer to M&M Medical 24hr Contact Details.

M&M Medical - Paul Sayer – 01443 227600 Mobile -07899997128

BOC – 0800 222888

15.0   Cylinder Management

15.1   Connecting Cylinders to the Manifold System (by Designated Persons)

15.1.1 Connect the cylinder to the equipment or manifold tail pipe and tighten   firmly with the recommended key.

15.1.2 Ensure that no leaks are present at the junction between the cylinder valve and equipment and also between the valve spindle and gland nut.

15.1.3 The connection between the cylinder valve and equipment should be checked for leaks using an approved leak detector.

15.1.4 Regulators/manifolds or other equipment should only be used with the gas for which they are designed.

15.1.5 Prior to opening the cylinder valve, ensure the equipment flow control valves are closed.

15.1.6 When the cylinder is not being used the cylinder valve should be closed and the gas trapped within the regulator should be safely vented to atmosphere by opening the flow control valve and then closing it again.

16.0   Shutdown of the MGPS for Maintenance, Extension etc.

Pre-planned work on the MGPS requiring isolation of a plant, or part of the system, will be covered by the MGPS Permit to Work System.

No isolation should take place without full liaison between the Authorised Person (MGPS) and all other relevant disciplines.

All necessary emergency / additional gas supplies should be in place before the work starts. This may involve the provision of portable emergency supply systems and / or additional provision of cylinder regulators from the Estates Department.

Attempts should be made to reduce gas consumption during the work.

17.0 Generator Operation on Mains Failure

During changeover from electrical mains to emergency generator supplies, there is always a possibility that spurious MGPS alarms or changes in plant indications may be generated.

Consideration should be given to the statutory/planned generator tests that are planned to run every four weeks.

THESE ALARMS MUST BE INVESTIGATED IMMEDIATELY, as they could represent real, rather than false conditions The status of equipment such as compressors should also be checked, to ensure they are operating as selected: on / on stand-by / on duty mode / off.

Additionally, it must be remembered that:

Failure of generator and mains supplies simultaneously will results in failure of the central medical vacuum system.

It is important that medical / nursing staff are aware of this risk to the vacuum system and any patients using it.

All relevant staff must undertake training in the use of emergency vacuum equipment.
In areas where vacuum supply is considered critical, locally generated vacuum will have to be provided. However, with a failed electricity supply this will not be possible using the normal electrically driven portable suction units.

An alternative would be a BATTERY DRIVEN suction unit, but it is important that, with this type of unit the battery is maintained in a FULLY CHARGED condition.

Medical Vacuum Units are located on every department.

Failure of both mains and electricity supplies will also mean that the medical air compressors will not function.

Estates staff must ensure that all plant equipment and alarms have reset to full operating conditions on restoration of power.

18.0 Emergency Procedures

Use of Emergency reserve manifolds.

Emergency supply manifolds are attached to all medical gas systems.

18.1 Oxygen System

In the event of failure of the primary VIE (Vacuum Insulated Evaporator) oxygen supply on applicable sites, back up VIE will automatically supply the hospital with gas through 2 x back up manifolds.   In the event of such a failure, the Estates Department are to be
contacted via the numbers in Appendix C.

Where manifold provides the secondary supply.

Important: Cylinder manifolds have limited capacity in relation to the normal hospital demand supplied from a VIE, so additional manpower may be required in an emergency situation of this kind, both to change the cylinders on the manifold and to bring the replacement cylinders to the manifold.

Measures to reduce gas consumption may also need to be taken.

It is the duty of the Portering/pharmaceutical staff to ensure that sufficient J size cylinders are available to maintain the gas supply and that there is an emergency procedure in place for handling these cylinders with support of the site Authorised Person.

Note that the medical vacuum system has no emergency reserve manifold system. Failure of the plant for any reason will result in total failure of the vacuum service.

18.2   Emergency Cylinder Ordering Procedure

See Medical Gas Cylinder Policy

18.3   Failure of Mains Electricity Supply

In the event of an electricity failure, medical gas supplies should be maintained by the emergency generator system (The 'Essential' supply).

The surgical compressed air plant, vacuum plant, oxygen system, all manifolds and medical gas alarm systems are connected to the 'essential' electricity supply and will continue to provide and monitor gas supplies as normal.

18.4   In the Event of Failure of Both Mains and Generator Supplies:

The oxygen system will continue to supply gas from it's VIE or secondary supply manifold system.

The vacuum plant will not operate and central vacuum service will be lost.

Alarm panels will display a 'System Failure' red warning light and give an audible alarm.

If the electricity supply to an alarm panel only is interrupted, the panel will display a 'System Failure' red warning light and emit an audible alarm; gas supplies will not be affected.

In any of these events:

The Authorised Person (MGPS) will be informed of the situation, via the Designated Medical / Nursing Officer / Nursing staff / Telephonist.

Portering and Estates will arrange for staff to monitor manifold gas consumption, replacing empty cylinders as necessary, until the electricity supply is restored.

The Authorised Person will arrange emergency cylinder / regulator supplies as necessary.

The Authorised Person (MGPS) will monitor the situation and confirm re-setting of compressor and vacuum plant and system alarms following restoration of supply.

18.5 A Serious Leak of Medical Gases

In these events:

The Duty Porter and the Authorised Person (MGPS) will be contacted by the Telephonist / Duty Nurse.

Details of the leak should be confirmed: i.e. the floor level, department, room number, the gas or gases involved and if patient ventilators are in use.

Outside normal working hours the On-call Engineer will notify the Authorised Person (MGPS) Estates Manager On call.

It is the responsibility of the Senior Clinician to carry out isolation of medical gases to the area, after ascertaining that no patients will be put at risk in any area(s) affected by the isolation.

The Senior Clinician will issue appropriate instructions to make the situation safe, such as to open windows in the affected area and close doors, in accordance with the hospital Fire Policy.

The Duty Porter will remain on standby to provide extra gas cylinders as required.

The Authorised Person (MGPS) will arrange for repairs to the system(s) affected to be carried out under the Permit to Work system.

18.6 Total or Partial failure of a Medical Gas Supply

In these events:

The person discovering the failure will inform the Telephonist and Duty Nurse immediately.

The Telephonist will inform the Duty Senior Manager, the Duty Porter and the Duty Authorised Person (MGPS) of the leak.

Details of the failure should be confirmed: i.e. floor level, department, room number(s), the gas or gases involved and if patient ventilators are in use.

As a precaution measure, the Telephonist will also notify critical areas e.g. First Floor Ward Inpatients that a failure has occurred on part of the system, so that they are prepared in the event of the fault extending to their departments.

It is the responsibility of the Senior Clinician to check which patients may have been put at risk by the failure and, if necessary, to arrange immediate emergency medical action.

Depending on the reason for the failure and its possible duration, the Authorised Person (MGPS) will decide the most appropriate method of long-term emergency gas provision.

This may involve establishing locally regulated cylinder supplies at ward / department entrances.

Nursing and medical staff should attempt to reduce gas consumption to a minimum during the emergency.

Portering staff will be required to monitor / replenish cylinders at any emergency stations and at Plant Room emergency supply manifolds.

Pharmacy will arrange emergency cylinder deliveries as necessary.

The Authorised Person (MGPS) will liaise with the Competent Person (MGPS) to complete emergency repairs needed to re-instate the gas supply, using the Permit to Work system.

When the supply is fully restored, the Authorised Person (MGPS) will complete a Critical Incident Form and produce a full report, which will be given to the General Manager within 24 hours of the incident.

In situations where it is envisaged that there will be long term loss of oxygen, vacuum or medical air services, the Duty Senior Manager will liaise with clinical colleagues, including the Designated Medical / Nursing Officer, the Clinical Director and the Authorised Person (MGPS) on the need for transfer of critically ill patients to (premises), as department closure may be warranted in extreme events.

18.7   Contamination of a Medical Gas Supply:

It is not unusual for a smell to be noticed when using 'plastic' equipment hoses to deliver gas to a patient. This smell usually disappears rapidly after first use of the hose and will generally be familiar to operatives.

However, if either operatives or patients complain of any unusual or strong smells from equipment, the situation MUST be treated seriously and IMMEDIATE action taken to ascertain the cause.

Where it is obvious that the smell is coming from the pipeline rather than a piece of connected equipment, the GAS SUPPLY MUST NOT BE USED.

In such an event the fault should be treated as a complete gas failure to that area and the actions described above taken IMMEDIATELY.

It is very important that if such an incident occurs the Telephonist advises ALL departments of the problem, especially those involved with critical care.

18.8   Contamination of Medical Vacuum System

Contamination of the medical vacuum system will usually be detected during routine maintenance inspection and evidenced by the presence of liquid in the on-line bacteria filter drain flask. The Consultant Microbiologist should be informed immediately and should advise on any additional precautions to effect filter change safely.

Portable suction units may be used in areas where there is a possibility of the vacuum system being contaminated. (The need for portable suction units should be discussed with the Consultant Microbiologist).

It is the responsibility of the Competent Person (MGPS) to change the filter in accordance with the procedure described in HTM 02-01 and any additional advice from the Consultant Microbiologist.

If the contamination is due to system misuse, the Authorised Person (MGPS) must complete an Incident Report Form. The form is to be sent to the General Manager so that the appropriate Clinical Manager can be informed, and remedial action taken.

Decontamination of pipework (if necessary) should be carried out in accordance with the procedure described in HTM 02-01 BEFORE filters are changed.

18.9   Failure of an Anaesthetic Gas Scavenging System (AGSS)

Failure of an anaesthetic gas scavenging system results in spillage of gaseous/ vaporised anaesthetic agents into the area of use of the system.

In Theatres it is likely that staff exposed to the spilled gases will exceed the COSHH recommendations for exposure when working in the area for extended periods, even though ventilation rates are high.

A local alarm 'System fail' warning and failure of the air receiver flow indicator will indicate failure of the system. Both should be inspected by Operating Department staff on a regular basis.

The Authorised Person (MGPS) and the Theatre Manager will be informed of the failure by the Theatre Technician and all attempts should be made to reduce staff exposure, if operations continue with a failed system.

When repairs have been completed (under a Permit to Work signed by the Theatre Nurse Manager, or their nominated deputy) Theatre staff should be made aware (by the person signing off the Permit to Work) that the system is back in use.

18.10   Over or Under Pressurisation of One or More Gas Systems

Local alarms are designed to indicate when system pressure is more than 20% above or below its norm.

Excessively high or low pressures may cause medical equipment to malfunction.

The Senior Clinician should report all instances of local alarm operation to the Telephonist. The Telephonist will then inform the Duty Senior Manager, the Duty Porter and the Authorised Person (MGPS).

18.11 Fire

Procedures in accordance with the hospital Fire Policy should be followed in the event of a fire involving, or likely to involve the MGPS.

During a fire the Senior Brigade Officer will assume full control of the area(s) affected.

Under no circumstance should medical gas supplies be isolates until the senior clinician has confirmed that all patients likely to be affected have been evacuated and/or have alternative gas provision.

Appendix A

19.0   Policy Signatories

This policy has been prepared and will be implemented and monitored by:

Name: Signature: Date:

This policy will be monitored and reviewed on a bi-annual basis.

Training needs associated with the policy will be co-ordinated by**.**

The Senior Authorised Person (MGPS) for medical gas systems within the Health Board is**.**

This policy is accepted by:

Chief Executive
Name: Signature: Date:

Authorised Person (MGPS)
Name: Signature: Date:

Name: Signature: Date:

Name: Signature: Date:

QC Pharmacist
Name: Signature: Date:

                             Signature: Date:

Senior Designated Nursing / Medical Officer
Name: Signature: Date:

Security and Portering Manager
Name: Signature: Date:

Infection Control Officer
Name: Signature: Date:

                             Signature: Date:

Fire / Safety Officer
Name: Signature: Date:

Assistance with the interpretation of this policy, or additional copies, can be obtained by contacting (Works and Estates Manager ******** Hospital).

Appendix B

20.0   Policy Circulation List for Velindre Cancer Centre.

Title	Name	MGPS Role	Contact number (Ward)
Head of Maintenance and Operations		N/A	
Estates Manager for the site		Authorised Person	
Estates Technician		Authorised Person	
Chief Pharmacist		Chief Pharmacist	
Head of Nursing		Designated Nursing Officer	
Pharmacist		QC Pharmacist	
Portering Manager		Designated Person	
On Call M+M Medical		On call Authorised Person	

Appendix C

Contacts for Velindre Cancer Centre.

21.0   Authorised Persons (MGPS)

Name	Contact number

21.1   Competent Persons (MGPS)

Name	Contact number

21.2   Designated Medical / Nursing Officers

Name	Title	Contact Number

21.3   Other Important Telephone Numbers

Name	Contact number	Out of hours contact number
Portering	Switchboard	
Pharmacy	Switchboard	
Gas Supplier (Emergency number)	BOC	

Appendix D

22.0   Site Specific Information for Velindre Cancer Centre.

22.1   Location of Oxygen supply for the Hospital

Main supply VIE. Located opposite Cancer Research Wales entrance
Back up supply located in manifold room opposite Cancer Research
Wales.

22.2   Location of Medical Vacuum for the Hospital.

Located in plant room bunker 7+8.

Appendix E

23.0   Statutory Requirements Relevant to Medical Gas Pipeline Systems

Medical Gas Pipeline Systems are regulated by the Health and Safety at Work etc. Act, 1974 and all the relevant delegated legislation, such as regulations and statutory instruments enabled by the Act.

23.1   Other Guidance Applicable to Medical Gas Pipeline Systems

- Health Technical Memorandum (HTM) 02-01 'Medical Gas Pipeline Systems', 2005
- Volume 1, Design, Installation, Validation and Verification
- Volume 2, Operational Management
- Supplement No 1 'Dental Compressed Air and Vacuum Systems' 2003
- Supplement No 2 'Piped Medical Gases in Ambulance Vehicles' 1997
- National Health Service Model Engineering Specification, C11, 'Medical Gases', 1999
- European Pharmacopoeia Standards for medical gases, including medical compressed air
- Premises Health and Safety Policy
- Premises Fire Policy
- Any other relevant local guidance

<table>
<tr><td colspan="2" align="center">QUALITY, SAFETY & PERFORMANCE COMMITTEE</td></tr>
</table>

<table>
<tr><td colspan="2" align="center">VUNHST High Voltage Operational System Policy PP11</td></tr>
</table>

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	FINAL VERSION WILL BE PUBLISHED IN PUBLIC DOMAIN

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	JONATHAN FEAR, INTERIM ASSISTANT DIRECTOR ESTATES CAPITAL & ENVIRONMENT
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Velindre University NHS Trust has a statutory responsibility to manage the electricity supply systems in each of its health premises in accordance with the *Health and Safety at Work etc Act 1974* and in particular *The Electricity at Work Regulations 1989.*

RECOMMENDATION / ACTIONS	THE QUALITY SAFETY PERFORMANCE COMMITTEE is requested to **approve** the latest version of the HV policy [PP12].

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Electrical Safety Group Members Circulation	**12/07/2023**
Executive Management Board RUN	**29/02/2024**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

As there have been no changes to the policy [no changes to legislation / guidance or any significant incidents] since its last version [v.1], the policy has been submitted directly for

approval by this Board.

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	

APPENDICES	
1	

1. SITUATION

1.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

1.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

5. IMPACT ASSESSMENT

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

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)

For more information: STRATEGIC RISK DESCRIPTIONS	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). a) The policy fulfils statutory and mandatory duties. b) The policy provides a framework for the Trust to comply with its statutory, mandatory and moral duties with regard to keeping people safety. c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The policy also supports: • A Prosperous Wales • A More Equal Wales
	If more than one wellbeing goal applies please list below: As noted above, the objects of the policy are to protect: • Life • Assets • Provision of services • The environment • Trust and Reputation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance/replacement of outdated/damaged equipment; investment in time for training etc. Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	As noted above, HV does not discriminate but the
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	NO
WHAT IS THE RISK?	
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?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Webber Liane
13/03/2024 14:14:09

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

Ref: PP 11

Operational Policy for
High Voltage Electricity Supply Systems
using a contractor as the
Authorised Person (HV)

Executive Sponsor & Function	Director of Transformation, Planning and Digital
Document Author: Capital Development	Assistant Director of Estates, Environment &
Approved by:	Executive Management Board
Approval Date: 2024	**29th FEBRUARY**
Date of Equality Impact Assessment: 2024	**9TH FEBRUARY**
Equality Impact Assessment Outcome:	Approved
Review Date: 2027	**29TH FEBRUARY**
Version:	2

Contents

1.0 POLICY STATEMENT

Velindre University NHS Trust has issued a Policy for Management of High Voltage (HV) Electricity Supply Systems (Trust HV Policy) as part of the Corporate Health and Safety Policy.

This High Voltage Electricity Operational Policy (HV Operational Policy), using a Contractor as the Authorised Person (HV), is the practical implementation of the Trust HV Policy from which it derives its authority, it meets the requirements of *paragraph 3.2a, Health Technical Memorandum (HTM) 06-03: Electrical safety guidance for high voltage systems* and is required due to the inherent dangers.

2.0 DOCUMENT SCOPE AND PURPOSE

2.1 The HV systems serving the Trust healthcare properties shall be managed and operated in accordance with this document and *HTM 06-03* which should be followed as Best Practice. Adherence to these two documents should normally be sufficient to comply with the legislation relevant to HV systems (*Electricity at Work Regulations 1989*).

2.2 The arrangements contained in this document must be agreed in writing by the Authorising Engineer (HV).

2.3 The Policy applies to the HV systems in the following hospitals/buildings:

Velindre Cancer Centre
Welsh Blood Service

Summary details of the equipment at each site are detailed in Appendix 5.

3.0 ROLES AND RESPONSIBILITIES

3.1 The roles involved in the management and operation of HV electrical systems are defined in *HTM 00: Best practice guidance for healthcare engineering, HTM 06-03* and below. Additional roles or duties are defined below.

Appendix 1 names the individuals in the various roles.

3.2 **The Chief Executive** has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's HV electrical supply systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

3.3 **Director of Transformation, Planning and Digital** (*Executive Director*) will be charged with being the Designated Person (*as referred to in HTM 06-03*). He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the HV electrical supply systems within

Velindre University NHS Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's
He/she should:
- Set out the standards and quality of service to be provided
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for High Voltage Electricity (AE(HV)).

3.4   HV Manager (This is a local arrangement not referred to in *HTM 06-03*.)
The HV Manager is appointed by the Trust and has the responsibility and authority to manage the HV systems to ensure they are operated and maintained safely.

In general, for the day-to-day operations, these powers will be delegated to the Trust HV Officers, see below.

The HV Manager shall manage:
- the work of the AP Contractor and may refer operational HV decisions by the AP Contractor to the Authorising Engineer (HV).
- the maintenance of non-HV work such as building work and related building services in high voltage areas.

3.5   HV Officer (This is a local arrangement not referred to in *HTM 06-03*)
The HV Officer (s) is an Operational Engineer with delegated authority from the HV Manager to manage the day-to-day operation of the HV system on a particular site.

The HV Manager and HV Officers:
- Shall be trained to recognise the danger of HV systems by the AP Contractor (see Paragraph 10)
- using the form in Appendix 6 shall transfer control of the HV systems to the AP Contractor following the guidance in Appendix 3
- shall control the keys giving entry to the HV areas.
- may issue *Limitation of Access (L.o.A.)* safety documents for non-HV work but only after consultation with the AP Contractor.

The HV Manager and HV Officers are NOT authorised to operate or maintain the HV system.

3.6   Authorising Engineer HV
The duties of the Authorising Engineer (AE) HV in *chapter 4, HTM 06-03*, shall apply in general to the AP Contractor, not the individual staff employed by the AP Contractor.

Audit Reports shall be sent to the Designated Person and copied to the HV Manager.

The AE (HV) may recommend the suspension of the AP Contractor or any employee to the HV Manager.

3.7 AP Contractor (This is a local arrangement not referred to in *HTM 06-03*)

The AP Contractor is a specialist contractor appointed by the Trust to receive Transfer and Control Certificates (TOCC), operate and maintain the HV systems, and train the HV Manager and Officers all in accordance with this policy.

The AP Contractor shall have the authority to stop any work on or around the HV systems serving the hospital which could damage the HV system or endanger lives.

The AP Contractor shall employ suitably qualified and experienced staff (Authorised and Competent Persons as defined in *HTM 06-03*).

Except in an emergency, the AP Contractor shall only undertake the duties following signed acceptance of a TOCC issued by the HV Officer.

The AP Contractor shall be fully conversant with:
- The HV distribution for the site
- *HTM 06-03, Electrical Safety Guidance for HV installations*
- This HV Operational Policy
- *The Electricity at Work Regulations 1989*
- *Health and Safety at Work etc Act 1974*
- *Report of Injuries Diseases and Dangerous Occurrences Regulations 1985 (RIDDOR)*

Any incident reports will also be copied to the HV Manager. When the incident involves high voltage then the Authorising Engineer (HV) shall also be advised and will carry out an investigation.

The AP Contractor shall give advice to an HV Officer on the issue of a *LoA*.
If the AP Contractor considers the work to be beyond the scope of the HV Officer, then the AP Contractor shall issue the *LoA*. See also Appendix 4.
If required by the HV Manager or the AE (HV), the AP Contractor shall remove an employee from the site and if necessary provide a replacement. Such actions would be subject to a review between the Trust and the AP Contractor.

4.0 DESIGN, OPERATION AND MAINTENANCE OF HV ELECTRICAL SYSTEMS – GENERAL PRINCIPLES AND REQUIREMENTS

4.1 The Trust HV Policy specifies the requirements for Design, Operation and maintenance of HV electrical systems.

4.2 Maintenance shall also include the buildings/enclosures and associated building engineering services but this work will normally be carried out by Trust staff or contractors working under an *L.o.A.* document.

5.0 ACCESS CONTROL TO DANGEROUS AREAS

5.1 HV switchrooms and other areas containing HV equipment shall be kept locked with access restricted to the HV Officer. Visitors must be accompanied by the HV Officer. See also 5.3 below.

The HV Officer can authorise access to the following people by issuing safety documents or a TOCC but has absolute authority and can deny or withdraw access at any time:
- Employees of the AP Contractor
- Those working under an L.o.A. safety document
- Anyone working with one of the above and under their direct supervision

5.2 Keys giving access to HV areas and equipment shall be controlled in accordance with *paragraphs 6.1-6.6, General Precautions, of HTM 06-03* except that for Authorised Person (HV) in the HTM, the text should be read as HV Officer

The *Site Logbook* shall be completed by the HV Officer on issue and receipt of keys.

5.3 Where HV areas contain equipment belonging to the DNO (*electricity infrastructure provider*) their staff have a legal right to enter at any time which is usually arranged by some form of joint key arrangement.

5.4 The HV Officer and the AP Contractor (*under the contract*) have the power to immediately exclude any person from the high voltage areas if they are considered to be acting in a manner likely to cause danger to themselves or others.

6.0 **LIMITATION OF ACCESS SAFETY DOCUMENTS, *L.o.A.***

6.1 A *Limitation of Access* document and its use are defined in *Chapter 8 of HTM 06-03*. It is used for specific **non-HV** work to be undertaken in a HV area under the supervision of the HV Officer or AP (HV). An example would be the painting of a door.

6.2 A HV Officer can issue/cancel a *L.o.A.* as follows:
- A *L.o.A.* for simple work will normally be issued by the HV Officer **in consultation** with the AP Contractor. Refer to Appendix 4
- If the work to be carried out is in close proximity to HV equipment, then, for safety reasons, the AP Contractor will issue the *L.o.A.* documents. The division of responsibility will form part of the training of the HV Officer.

6.3 Since a craftsman is unlikely to be familiar with *HTM 06-03*, the meaning of paragraphs 4.23 to 4.29 must be explained and understood.

A printed copy of paragraphs 4.23-4.29, as well as a statement that "The CP (HV) and any assistants must NOT touch or interfere with the HV system" should be encapsulated and issued with the L.o.A., the issue being recorded on the L.o.A.

7.0 MONITORING/REVIEW PROCEDURE

Since the HV Operational Policy has differences from *HTM 06-03*, additional audit checks will be undertaken by the AE (HV) on the following:

- Emergency procedures
- Training, certification and appointment of the HV Officers
- The use and issue of Safety Documents and Transfer Control Certificates
- A check on the work carried out by the HV Officers
- The replacement, refurbishment and maintenance programme

8.0 OPERATING DOCUMENTS

8.1 Records for the operation and maintenance of HV electrical systems shall be available together with back-up copies, as detailed in *paragraph 1.16 of HTM 06-03*.
   a. Suitable documents matching those in *HTM 06-03* shall be purchased from TSO.

8.2 The following manuals and documentation must be available for the operation and maintenance of HV systems and are held in the Estates Managers Office

8.3 Operational Procedure Manual (HTM document)
This holds the information listed in *paragraphs 8.12-8.17 of HTM 06-03*, and:
- Records of Appointments/Acceptances and Certificates for HV Officers
- Copy of Trust contract with AP Contractor
- HV Operational Policy
- Policy for SF6 equipment gas escape (if applicable)
- Copies of Transfer of Control Certificates (TOCC)

8.4 Operating and Maintenance Manual (HTM document)
This holds the information listed in *paragraphs 8.18-8.20* of *HTM 06-03* and:
- Site drawings showing HV system and standby generators
- Switchgear and transformer schedule for the system
- Protection grading charts for the system
- Maintenance and Inspection reports, see*, paragraphs 8.21-8.23, HTM 06-03*
- AP Contractor schedules of maintenance

8.5 Record Documentation Control
The HV Officer named in Appendix 1, has responsibility for the control and upkeep of all Operating Records as above and those in *Chapter 8 of HTM 06-03*.

9.0 SAFETY DOCUMENTS

9.1 The AP Contractor shall prepare a *Safety Programme* and issue/cancel *Safety Documents* as defined in *HTM 06-03*.

9.2 Subject to written agreement, the AP Contractor can use his own safety documentation in place of the *HTM Safety Programme and Safety Documents.*

9.3 The AP Contractor shall send either the original or a copy of the *Safety Programme and Documents* to the HV Officer identified in Appendix 1.

9.4 If only copies of safety documents are retained on the NHS site, then the AP Contractor must demonstrate to the AE (HV) that the originals are available for inspection at any reasonable time and stored as required by *HTM 06-03,* e.g. retained for 3 years.

10.0 TRAINING OF PERSONNEL

10.1 Training of AP Contractor staff
The AP Contractor must ensure its employees are adequately trained and that a register of training is maintained.

This should include Cardio-pulmonary resuscitation.

The Trust may request at any time to view the training records and reserves the right to refuse access to employees of the AP Contractor whom the Trust considers are not adequately trained.

10.2 Training of HV Officers
The AP Contractor will provide safety training for the HV Officers who will then be assessed by the AE (HV). HV Officers will be appointed in writing by the Trust. Refer to Appendix 4.
HV Officers shall be trained in cardio pulmonary resuscitation by the Trust.

11.0 PROGRAMME FOR MAINTENANCE OF HV SYSTEMS

11.1 The work shall be carried out as required in the contract between the Trust and the AP Contractor and the schedule of maintenance included in the Operational Procedure Manual. Any additional work specified by the manufacturer must also be undertaken and details recorded.

11.2 The Schedule of Maintenance should include as a minimum:
- Inspection and cleaning of the HV equipment and associated protection relays
- Partial discharge testing of the equipment
- Maintenance and testing of the switchgear and arc control/insulating medium (as applicable) as well as protection relays, including secondary injection

- Maintenance and testing of all transformers, including any necessary testing of and replacement of insulating medium (as applicable) and cleaning
- Maintenance and testing of battery tripping units (as applicable)

12.0 OPERATIONAL EQUIPMENT

All equipment required for switching, testing, earthing and safety padlocks shall be provided by the AP Contractor who shall be responsible for maintaining such equipment in good order. This shall include specialist equipment provided as part of the HV system by the Trust.

APPENDIX 1: LIST OF NAMED INDIVIDUALS

Designated Person: _____

HV Manager: _____

HV Officer with responsibility for document control: _____

Authorising Engineer (HV):
NHS Wales Shared Services Partnership – Specialist Estates Services

AP Contractor: _____

APPENDIX 2: DEFINITIONS

Health Technical Memorandum (HTM)
A suite of documents issued by the Department of Health which provides guidance on technical issues with particular relevance to NHS healthcare facilities.

Due to differences in NHS policy between England and the devolved administration in Wales, the Welsh Assembly Government may modify these documents for use in Wales.

HTM 06-03, Electrical safety guidance for high voltage systems. A Trust which follows this guidance should normally be doing sufficient to satisfy the requirements of the *Health and Safety at Work etc Act 1974* and the *Electricity at Work Regulations 1989.*

Users with access to the HOWIS intranet can find and download these documents on the Shared Services Partnership website at http://howis.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=10859

Users who do not have access to HOWIS intranet can access the full list of HTMs and associated Status Notes on the Shared Services Partnership internet website at http://www.nwssp.wales.nhs.uk/publications-and-information. but not download the HTM documents.

Transfer of Control Certificate
The transfer document (see Appendix 6) allows the Trust to pass control of the HV electrical systems to the AP Contractor for switching or maintenance whilst ensuring that the effects on the hospital are fully understood and that any necessary precautions are in place to minimise effects on patient care.

APPENDIX 3: HIGH VOLTAGE PROCEDURES

PROCEDURES TO BE FOLLOWED TO ISSUE A TRANSFER OF CONTROL CERTIFICATE

Either the HV Officer will contact the AP Contractor if there is a problem with the electricity supply to the hospital. During working hours the telephone contact number is ████████████████. At any other time a Help Desk can be reached on ████████████████.

Or, the HV Officer and the AP Contractor will have previously made arrangements to carry out maintenance to the HV system.

1. The HV Officer will check that the AP Contractor employee attending is suitably authorised (this requirement will be part of the contract).

2. The HV Officer will issue access keys and accompany the AP Contractor to the sub-stations to ensure the AP Contractor is familiar with their geographical location. Logbook entries are required.

3. The AP Contractor will create a Safety Programme. NOTE that this should include details of any LV switching required.

4. **The AP Contractor should identify with the HV Officer which parts of the LV system (if any) will be affected by the programme.**

5. The HV Officer will decide whether a *Permission for disconnection or interruption of electrical services* form (Copy only in *HTM 06-02*) is required and make any arrangements necessary such as back up generation. It should be cross-referenced with the Transfer of Control Certificate, Appendix 6 (TOCC), and the copy stored in the Operational Procedure Manual.

6. When arrangements are complete, parts 1 and 2 of the TOCC should be completed to pass control of the HV system to the AP Contractor.

7. **The HV Officer is not trained or authorised to approve the HV work to be carried out by the AP Contractor.**

   The issue of the TOCC means only that the Trust has completed arrangements to protect the operation of the hospital (so far as possible), and the AP Contractor can start the HV work.

8. All LV switching required will be carried out by NHS staff but only when directed by the AP Contractor who will also fit any safety locks and signs.

9. On completion of the work to, the HV system, parts 3 and 4 of the TOCC will be signed off by the APContractor and the HV Officer. The Mimic Panel must now be adjusted by the AP Contractor to represent any changes.

10. The HV Officer shall ensure the Site Logbook for HV Systems is completed and paperwork filed.

APPENDIX 4: SAFETY TRAINING FOR Trust HV OFFICERS

1.   As part of the contract, the AP Contractor shall conduct training so the HV Manager and nominated HV Officers at each site can understand the dangers of a HV installation and are considered competent to enter the HV sub-station/compounds alone without putting themselves at risk.

2.   Training should also ensure each candidate:

  - Is considered competent to supervise visitors to the sub-stations/compounds and, if required, issue to (in consultation with the AP Contractor) and supervise a person working on a **L.o.A.** document for minor building works, such as painting, re-lamping, checking fire alarms. Note that all work on L.o.A. documents will require direct supervision by the HV Officer or AP Contractor.

  - Understands that neither the HV Officer nor any visitors nor persons on L.o.A. documents can under ANY circumstances touch or interfere in any way with the HV equipment (this will also be emphasised on HV Officer appointment letters from the Trust).

  - Is competent to decide when work located close to the HV systems should be risk assessed with the AP Contractor to issue the L.o.A. instead of the HV Officer.

3.   If satisfied, the AP Contractor should certify competence in writing to the HV Manager for each nominated staff member to be appointed as a HV Officer using the draft form attached.

4.   Each nominated HV Officer will then be interviewed by the AE (HV) who will recommend (or not) that they be appointed.

        The HV Manager will then arrange for them to be appointed by the Trust using the draft forms and certificate attached.

4.   **If the AP Contractor is unwilling to certify that a particular Trust employee put forward for training is competent to act as an HV Officer they should make their concerns known to the HV Manager at the time.**

5.   The training and certification process should be repeated every three years and will form part of the audit procedure conducted by the Authorising Engineer (HV).

6.   Cardio-Pulmonary Resuscitation training will be provided by the Trust to staff members.

7.   The AE (HV) will also provide training in the use and completion of *Limitation of Access* documents.

APPENDIX 5: SUMMARY OF HV ELECTRICAL SYSTEMS

_____Hospital, Velindre University NHS Trust

(Insert details of switchgear etc. Note that these details are provided to give an overview of each site but should not be relied upon as a definitive statement)

APPENDIX 6: TRANSFER OF CONTROL CERTIFICATE FOR HIGH VOLTAGE SUPPLY SYSTEMS

Velindre University NHS Trust   **Serial Number…………………**

ESTATES DEPARTMENT:
TRANSFER OF CONTROL CERTIFICATE FOR HIGH VOLTAGE SUPPLY SYSTEMS

Part 1

I, ………………………the representative of the AP Contractor…………………………………..wish to carry out the following high voltage works or switching at
……………………………………………………………………… Hospital.
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..
…………………………………………………………………………………………..
Safety Document No (s): …………………………… will be issued for this work.
Your agreement to proceed is required taking full account of any local hospital restrictions relating to the HV/LV installation.

Signed:………………………………… Print Name: …………………………………………

Designation: …………………………………...Date:……………………… Time: ………………

Part 2

AGREEMENT by HV Officer
Agreement to the above works is made on behalf of the HB/Trust and note should be taken of the following circumstances (if none write NONE). Any arrangements necessary to protect hospital services have been completed.
Permission for disconnection form No………………………………………………………………
…………………………………………………………………………………………………..
…………………………………………………………………………………………………..

Signed:………………………………… Print Name: …………………………………………

Designation: HV Officer   .Date:……………………… Time: ………………

CLEARANCE

Part 3
As the Authorised Person I hereby declare that the work for which this certificate was listed is now suspended/completed (delete as necessary) and that the system is safe and operational.

Signed:………………………………… Print Name: …………………………………………

Designation: …………………………….Date:……………………… Time: ……………….

Part 4
Clearance is noted and the HV system accepted back on behalf of …………………………… Hospital

Signed:………………………………… Print Name: …………………………………………

Designation: HV Officer   Date:……………………… Time: ………………

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST High Voltage Operational System Policy PP12

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	FINAL VERSION WILL BE PUBLISHED IN PUBLIC DOMIAN

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Velindre University NHS Trust has a statutory responsibility to manage the electricity supply systems in each of its health premises in accordance with the Health and Safety at Work etc. Act 1974 and in particular The Electricity at Work Regulations 1989.

RECOMMENDATION / ACTIONS	The Quality and Safety Performance Committee is requested to **APPROVE** the latest version of the HV policy [PP12].

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Electrical Safety Group Members Circulation	**12/07/2023**
Executive Management Board RUN	**29/02/2024**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
As there have been no changes to the policy [no changes to legislation / guidance or any significant incidents] since its last version [v.1], the policy has been submitted directly for approval by this Board.	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
1	PP12 VUNHST High Voltage Operational System Policy

1. SITUATION

1.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

1.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)

For more information: STRATEGIC RISK DESCRIPTIONS	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ⊠ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). a) The policy fulfils statutory and mandatory duties. b) The policy provides a framework for the Trust to comply with its statutory, mandatory and moral duties with regard to keeping people safety. c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The policy also supports: • A Prosperous Wales • A More Equal Wales
	If more than one wellbeing goal applies please list below: As noted above, the objects of the policy are to protect: • Life

	- Assets - Provision of services - The environment - Trust and Reputation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance / replacement of outdated/damaged equipment; investment in time for training etc. Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	As noted above, HV does not discriminate but the
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

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

Operational Policy for
High Voltage Electricity Supply Systems

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment Capital Development
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	Approved
Review Date:	3 years
Version:	2

Contents

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13/03/2024 14:14:09

1.0 POLICY STATEMENT

Velindre University NHS Trust has a statutory responsibility to manage the electricity supply systems in each of its health premises in accordance with the *Health and Safety at Work etc Act 1974* and in particular *The Electricity at Work Regulations 1989.*

In recognition of these responsibilities the Trust has issued this High Voltage (HV) Electricity Operational Policy. It meets the requirements of *paragraph 3.*2a, *Health Technical Memorandum (HTM) 06-03: Electrical safety guidance for high voltage systems* and is required due to the inherent dangers.

2.0 DOCUMENT SCOPE AND PURPOSE

2.1 The HV systems serving the Trust healthcare properties shall be managed and operated in accordance with this document and *HTM 06-03* which should be followed as Best Practice. Adherence to these two documents should normally be sufficient to comply with the legislation relevant to HV systems (*Electricity at Work Regulations 1989*).

2.2 The Policy must be read in conjunction with *The Electricity at Work Regulations 1989, Health Technical Memorandum (HTM) 00: Best practice guidance for healthcare engineering* and *HTM 06-03: Electrical safety guidance for high voltage systems*.

2.3 *HTM 06-03* must be followed as best practice, not guidance, since following it should normally be sufficient to meet the requirements of the relevant legislation. In the event of any queries or conflicts with other documents the Authorising Engineer (HV) should be consulted.

3.0 ROLES AND RESPONSIBILITIES

3.1 The roles involved in the management and operation of HV electrical systems are defined in *HTM 00: Best practice guidance for healthcare engineering, HTM 06-03* and below.

3.2 **The Chief Executive** has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's HV electrical supply systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

3.3 **Director of Transformation, Planning and Digital** (*Executive Director*) will be charged with being the Designated Person (*as referred to in HTM 06-03)*. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the HV electrical supply systems within Velindre University NHS Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's
He/she should:
- Set out the standards and quality of service to be provided
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for High Voltage Electricity (AE(HV)).

3.4 Authorising Engineer (HV)

The duties of the Authorising Engineer (AE (HV)) is defined in *chapter 4, HTM 06-03, paras, 4.7-4.13*.

Audit reports shall be sent to the Designated Person and copied to the Authorised Person.

3.5 Authorised Person (HV)

The duties of the Authorised Person (HV), is defined in *chapter 4. HTM 06-03, paras, 4.14-4.22.*

He/she should be solely responsible for:

- The practical implementation and operation of *HTM 06-03, and*
- The systems and installations for which management is in control of danger and for which the Authorised Person (HV) has been appointed.

3.6 Competent Person (HV) (normally an appointed contractor)

Is a person with adequate knowledge and training to undertake work on systems as designed by engineering managers, In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on High Voltage systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.0 DESIGN, OPERATION AND MAINTENANCE OF HV ELECTRICAL SYSTEMS – GENERAL PRINCIPLES AND REQUIREMENTS

4.1 The Trust HV Policy specifies the requirements for Design, Operation and maintenance of HV electrical systems.

4.2 HV systems owned by the Trust shall be:

- designed, installed and tested in accordance with current standards prior to being commissioned so they are safe for use.
- operated within their safe design capacity and in accordance with the HV Operational Policy.
- protected against adverse or hazardous environmental conditions

4.3 Due to the very specialist nature of the equipment, the Trust shall employ an external specialist as the Maintenance Contractor.

5.0 ACCESS CONTROL TO DANGEROUS AREAS

5.1 HV switchrooms and other areas containing HV equipment shall be kept locked with access restricted to the Authorised Person (HV). Visitors must be accompanied by the Authorised Person (HV). See also 5.3 below.

The Authorised Person (HV) can authorise access to the following people by issuing safety documents or a TOCC but has absolute authority and can deny or withdraw access at any time:

- Employees of the HV Contractor
- Those working under an L.o.A. safety document
- Anyone working with one of the above and under their direct supervision

5.2 Keys giving access to HV areas and equipment shall be controlled in accordance with *paragraphs 6.1-6.6, General Precautions, of HTM 06-03*.
The *Site Logbook* shall be completed by the Authorised Person (HV) on issue and receipt of keys.

5.3 Where HV areas contain equipment belonging to the DNO (*electricity infrastructure provider*) their staff have a legal right to enter at any time which is usually arranged by some form of joint key arrangement.

5.4 The Authorised Person (HV) and the HV Contractor (*under the contract*) have the power to immediately exclude any person from the high voltage areas if they are considered to be acting in a manner likely to cause danger to themselves or others.

6.0 LIMITATION OF ACCESS SAFETY DOCUMENTS, *L.o.A.*

6.1 A *Limitation of Access* document and its use are defined in *Chapter 8 of HTM 06-03*. It is used for specific **non-HV** work to be undertaken in a HV area under the supervision of the Authorised Person (HV). An example would be the painting of a door.

6.2 Since a craftsman is unlikely to be familiar with *HTM 06-03*, the meaning of paragraphs 4.23 to 4.29 must be explained and understood.
A printed copy of paragraphs 4.23-4.29, as well as a statement that "The CP (HV) and any assistants must NOT touch or interfere with the HV system" should be encapsulated and issued with the L.o.A., the issue being recorded on the L.o.A.

7.0 MONITORING/REVIEW PROCEDURE

Auditing the safe operation and maintenance of the HV electrical system is detailed in Appendix 3 of *HTM 06-03* and, generally, is the responsibility of the Authorising Engineer (HV).

8.0 OPERATING DOCUMENTS

8.1 Records for the operation and maintenance of HV electrical systems shall be available together with back-up copies, as detailed in *paragraph 1.16 of HTM 06-03*.
  a. Suitable documents matching those in *HTM 06-03* shall be purchased from TSO.

8.2 The following manuals and documentation must be available for the operation and maintenance of HV systems and are held in the Estates Managers Office.

8.3 Operational Procedure Manual (HTM document)
This holds the information listed in *paragraphs 8.12-8.17 of HTM 06-03*, and:
- Records of Appointments/Acceptances and Certificates for Authorised Persons
- Copy of Trust contract with AP Contractor
- HV Operational Policy
- Policy for SF6 equipment gas escape (if applicable)

- Copies of Transfer of Control Certificates (TOCC)

8.4   Operating and Maintenance Manual (HTM document)
This holds the information listed in *paragraphs 8.18-8.20* of *HTM 06-03* and:
- Site drawings showing HV system and standby generators
- Switchgear and transformer schedule for the system
- Protection grading charts for the system
- Maintenance and Inspection reports, see*, paragraphs 8.21-8.23, HTM 06-03*
- AP Contractor schedules of maintenance

8.5   Record Documentation Control
The Authorised Person named in Appendix 1, has responsibility for the control and upkeep of all Operating Records as above and those in *Chapter 8 of HTM 06-03*.

9.0 SAFETY DOCUMENTS

9.1   The Authorised Person (HV) shall prepare a *Safety Programme* and   issue/cancel *Safety Documents* as defined in *HTM 06-03*, table 1-2.

10.0   TRAINING OF PERSONNEL

10.1   Training of AP Contractor staff
The AP Contractor must ensure its employees are adequately trained and that a register of training is maintained.
This should include Cardio-pulmonary resuscitation.
The Trust may request at any time to view the training records and reserves the right to refuse access to employees of the AP Contractor whom the Trust considers are not adequately trained.

11.0   PROGRAMME FOR MAINTENANCE OF HV SYSTEMS

11.1   The work shall be carried out as required in the contract between the Trust and the AP Contractor and the schedule of maintenance included in the Operational Procedure Manual. Any additional work specified by the manufacturer must also be undertaken and details recorded.

11.2   The Schedule of Maintenance should include as a minimum:
- Inspection and cleaning of the HV equipment and associated protection relays
- Partial discharge testing of the equipment
- Maintenance and testing of the switchgear and arc control/insulating medium (as applicable) as well as protection relays, including secondary injection
- Maintenance and testing of all transformers, including any necessary testing of and replacement of insulating medium (as applicable) and cleaning
- Maintenance and testing of battery tripping units (as applicable)

12.0   OPERATIONAL EQUIPMENT

All equipment required for switching, testing, earthing and safety padlocks shall be provided by the AP Contractor who shall be responsible for maintaining such equipment in good order. This shall include specialist equipment provided as part of the HV system by the Trust.

APPENDIX 1: DEFINITIONS

Health Technical Memorandum (HTM)
A suite of documents issued by the Department of Health which provides guidance on technical issues with particular relevance to NHS healthcare facilities.

Due to differences in NHS policy between England and the devolved administration in Wales, the Welsh Assembly Government may modify these documents for use in Wales.

HTM 06-03, Electrical safety guidance for high voltage systems. A Trust which follows this guidance should normally be doing sufficient to satisfy the requirements of the *Health and Safety at Work etc Act 1974* and the *Electricity at Work Regulations 1989.*

Users with access to the HOWIS intranet can find and download these documents on the Shared Services Partnership website at
http://howis.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=10859

Users who do not have access to HOWIS intranet can access the full list of HTMs and associated Status Notes on the Shared Services Partnership internet website at http://www.nwssp.wales.nhs.uk/publications-and-information. but not download the HTM documents.

Transfer of Control Certificate
The transfer document (see Appendix 6) allows the Trust to pass control of the HV electrical systems to the AP Contractor for switching or maintenance whilst ensuring that the effects on the hospital are fully understood and that any necessary precautions are in place to minimise effects on patient care.

QUALITY, SAFETY & PERFORMANCE COMMITTEE	

VUNHST Low Voltage Operational System Policy PP13	

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	FINAL VERSION WILL BE PUBLISHED IN PUBLIC DOMIAN

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Velindre University NHS Trust has a statutory responsibility to manage the electricity supply systems in each of its health premises in accordance with the *Health and Safety at Work etc Act 1974* and in particular *The Electricity at Work Regulations 1989.*

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is requested to **APPROVE** the latest version of the HV policy [PP13]. Policy amendments have been inserted by the Trust Authorising engineer NWSSP and are in the policy under track changes.

Webber Liane
13/03/2024 14:14:09

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Electrical Safety Group Members Circulation	**12/07/2023**
Executive Management Board RUN	**29/02/2024**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Additional items are identified in policy under track changes to support process – comments received by the Authorising Engineer NWSSP.	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
1	PP13 VUNHST Low Voltage Operational System Policy

1. SITUATION
1.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

1.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

2. BACKGROUND
2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

3. ASSESSMENT
3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

4. SUMMARY OF MATTERS FOR CONSIDERATION
4.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

Webber Liane
13/03/2024 14:14:09

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 　　　　　YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☐ ☐ ☐ ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**

QUALITY AND SAFETY IMPLICATIONS / IMPACT (cont.)		
	Safe	☒
	Timely	☐
	Effective	☐
	Equitable	☐
	Efficient	☐
	Patient Centred	☐

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

a) The policy fulfils statutory and mandatory duties.
b) The policy provides a framework for the Trust to comply with its statutory, mandatory

	and moral duties with regard to keeping people safety. c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The policy also supports: • A Prosperous Wales • A More Equal Wales
	If more than one wellbeing goal applies please list below: As noted above, the objects of the policy are to protect: • Life • Assets • Provision of services • The environment • Trust and Reputation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance/replacement of outdated/damaged equipment; investment in time for training etc.

	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
	Type of Funding:
	Revenue and Capital Funding
	Scale of Change
	Please detail the value of revenue and/or capital impact:
	Click or tap here to enter text
	Type of Change
	Business as Usual Improvement
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Yes - please outline what, if any, actions were taken as a result
	As noted above, fire does not discriminate but the
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

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

Webber Liane
13/03/2024 14:14:09

Ref: PP 13

ELECTRICAL LOW VOLTAGE POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Environmental Officer
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	**APPROVED**
Review Date:	**3 years**
Version:	2

Webber Liane
13/03/2024 14:14:09

Contents

Webber Liane
13/03/2024 14:14:09

1.   Policy Statement

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of electrical systems.

Velindre University NHS Trust, will ensure that all electrical systems, are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2.   Scope of Policy

This policy applies to all persons (staff, contractors, patients and members of the public)
who may be affected by any electrical activity arising from works (including use or contact with equipment) carried out on Trust premises or leased property. It also applies to all electrical activities undertaken by employees and/or contractors when working at other locations.

3.   Aims and Objectives

This document will detail the Trust's policy to achieve safety in all its electrical activities in compliance with its legal and statutory obligations and to ensure that all electrical equipment and systems are maintained in a safe condition and that only competent persons are permitted to work with, repair or maintain electrical systems or apparatus.

4.   Responsibilities

The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

4.1   The Chief Executive

The Chief Executive has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's electrical

systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

4.2 Director of Strategic Transformation, Planning and Digital

The Executive Director will be charged with being the Designated Person, under HTM 06-02. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the low voltage systems within the Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's.
He/she should:
- Set out the standards and quality of service to be provided.
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for Low Voltage Electricity (AE(LV)).

4.3 Estates Manager

The Estates Manager is responsible for ensuring that all electrical systems are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.
The Estates Manager shall ensure that:
- All systems are identified and subjected to testing by an Authorised person.
- Maintain a register of Authorised Persons.
- Ensure that appropriate reactive and planned preventative maintenance arrangements are put in place to deliver to the aims of this policy.
- Have in place a procedure for assessing Competent Persons.
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. i.e. it is the individual not the contractor that needs to be assessed.
- Ensure that competent persons undertake regular maintenance on electrical systems and equipment.
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services.
- Audit the effectiveness of the arrangements and arrange corrective action.
- Report any deficiencies which cannot be addressed within delegated limits of resource and authority.
- Ensure that electrical systems are independently verified annually in accordance with H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems.
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.

4.4 Project Managers

Have the responsibilities to ensure that:
- All new installations meet the latest legal and technical standards.
- A suitably qualified person is involved in the design of all new installations and that commissioning and performance checks are undertaken and documented.
- All new installations are accessible and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure.
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes.
- That appropriate training and familiarisation is provided to in house and contract teams.
- That all new designs or major modification to existing systems are checked by the Authorising Engineer prior to the commencement of work.
- That all new installations are independently validated prior to contract completion.
- That all variations from the standards set out within H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems, are listed and agreed in writing by the Authorising Engineer / Estates Manager, prior to implementation.

4.5 Authorising Engineer (Low Voltage) (AE(LV))

Is defined as a person designated by management to provide independent auditing and advice on Low Voltage electrical systems and to review and witness documentation on validation/verification.
He/she shall:
- Provide a service in accordance with H.T.M 00 Policies and Principles of Healthcare Engineering.
- Advise on technical compliance with H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Advise on interpretation of H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Assess and make recommendations for the appointment of Authorised Persons.
- Monitor the performance of the service and undertake an annual audit.
- To investigate any adverse incident and report on any findings.
- Advise on the consequences of any proposed variation from the standards given within H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.

4.6   Authorised Person (Low Voltage) (AP(LV))

Will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing (following advice from the AE (LV)), who is responsible for the implementation and operation of Management's safety policy and procedures relating to the engineering aspects of Low Voltage Electrical systems in accordance with current HTMG guidance

4.7   Competent Person (Low Voltage) (CP(LV)

Is a person with adequate knowledge and training and practical skills to undertake work on systems as designed by engineering managers. In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on individual Low Voltage Electrical systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

 4.7b Skilled Person (Low Voltage)A person who possesses, as appropriate to the electrical work to be undertaken, adequate education, training and practical skills, and who is able to prevent danger, or where appropriate, injury, and has been assessed to be competent by the Authorised Person (LV) for a specific electrical task and is aware of specific requirements from HTM06-02 with regard to the task but has not been formally appointed in writing as a Competent Person (LV).

4.8   Accompanying Safety Person

An accompanying Safety Person is a person not directly involved with the work or test, who has received training in emergency first aid for electric shock and who has adequate knowledge, experience and the ability to avoid danger, keep watch, prevent interruption, apply first-aid and summon help. The person should be familiar with the system or installation being worked on or testes and should have been instructed on the action to be taken to safely rescue a person in the event of an accident.

4.9   User

The person responsible for the management of the unit in which the electrical system is installed, for example, head of department, operating theatre manager, head of laboratory, production pharmacist, head of research or any other responsible person.

Definitions

4.10   Limitation-of-access

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a person in charge of work to be carried out

in an area or location which is under the control of an Authorised Person (LV) and for which a permit-to-work, LW1,LW2 or certificate of authorization for live working areisnot appropriate.

4.11   Permit-to-work (electrical LV)

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a Competent Person (LV) or skilled person (LV) in charge of work to be carried out. It defines the scope of the work to be undertaken and makes known exactly what equipment is dead, isolated from all live circuit conductors and safe to work on.

4.12   Safety signs

- **Caution sign** is a temporary, non-metallic sign bearing the words "caution – persons working on equipment" and "do not touch" which is to be used at a point-of-isolation.
- **Danger sign** is a temporary, non-metallic sign bearing the words "danger live equipment" and "do not touch" which is to be used where there is adjacent live equipment at the place of work.
- **Switchroom sign** is a permanent, no-metallic sign bearing the words, "electrical Switchroom" and "no unauthorised access"

4.13   Voltage range

- **Extra low voltage,** a potential not exceeding 50V ac or 120 V ripple-free dc whether between conductors or to earth.
- **Low voltage (LV),** a potential not exceeding 1000V ac or 1500 V dc between conductors, or 600V ac or 900V dc between a conductor and earth.
- **High voltage (HV),** a potential normally exceeding low voltage.

5.   Training and other resource implications for this policy

Training should be of an appropriate level, depending on roles and responsibilities, and outlined in the Divisions/Hosted Organisations local procedures. Managers have the responsibility to inform relevant employees and contractors of any hazards that may exist when carrying out maintenance work, operation, testing or other repairs to equipment within their department. All staff, whether working for the Trust or as partners who have duties under this policy should receive appropriate training. Tradespersons are to be made aware of the dangers from electrical shock, injury or burns. The information given should include: -

- The nature and type of risks to health where applicable
- Control measures employed
- Working procedures/policies

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All records of training are to be maintained by the Estates Directorate.

Arrangements shall be made by the appropriate manager to ensure: -
 i. That all employees concerned with particular work activities are adequately informed as to the systems, plant and apparatus that are affected, and instructed in all safety procedures.
 ii. So far as is reasonably practicable, that other persons who are not employees but may be affected by the work activities also receive adequate information and/or instruction.

6. Implementation/Policy Compliance

The Trust Board expects those tasked with managing aspects of electrical safety to:

- diligently discharge their responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of electrical works;
- have in place a programme for the assessment and review of electrical risks
- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate electrical risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment, in regard to working on and using electrical equipment;
- develop and implement a programme of appropriate electrical safety training for all relevant staff;
- develop and implement monitoring and reporting mechanisms appropriate to the management of electrical safety.

7. Equality Impact Assessment Statement

A summary of the outcome of the EIA must be present on the front cover of the document.:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

8. **Main Relevant Legislation and References**

   Statutory

   - Confined Spaces Regulations 1997.
   - Construction Design and Management Regulations 2015.
   - Electricity at Work Regulations 1989.
   - Electricity Safety, Quality and Continuity Regulations 2002.
   - Health and Safety (Safety Signs and Signals) Regulations 1996.
   - Health and Safety at Work etc. Act 1974.
   - Management of Health and Safety at Work Regulations 1999.
   - Manual Handling Operations Regulations 1992 (as amended 2002).
   - Personal Protective Equipment at Work Regulations 1992 (as amended 2002).
   - Provision and Use of Work Equipment Regulations 1998.
   - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
   - Workplace (Health, Safety and Welfare) Regulations 1992.
   - Dangerous Substances and Explosive Atmosphere Regulations 2002.

   Guidance

   - The Department of Health:

       a. Health Technical Memorandum 00 – Policies and Principles.
       b. Health Technical Memorandum 06-02 – Electrical safety guidance for low voltage systems.
       c. Health Technical Memorandum 06-03 – Electrical safety code for high voltage systems.

   - The Institution of Electrical Engineers:

       d. Code of practice for in-service inspection and testing of electrical equipment.
       e. Guidance Note 3 – Inspection and testing.

   - The Health & Safety Executive's:

       f. Avoidance of danger from overhead electric lines GS6.
       g. Avoiding danger from underground services HSG47.

h. Electrical safety on construction sites HSG141.
i. Electrical test equipment for use by electricians GS38.
j. Electricity at work: safe working practices HSG85.
k. Health and Safety (First Aid) Regulations 1981, Approved Code of Practice and Guidance.
l. Keeping electrical switchgear safe HSG230.
m. Maintaining portable and transportable electrical equipment HSG107.
n. Memorandum of guidance on the Electricity at Work Regulations 1989 HSR25.
o. Safety in electrical testing at work INDG354.

9. **Audit and Monitoring**

- The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

10. **Policy Conformance / Non Compliance**

- If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's 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.

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QUALITY, SAFETY & PERFORMANCE COMMITTEE	

VUNHST Ventilation Policy PP14	

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	FINAL VERSION WILL BE PUBLISHED IN PUBLIC DOMIAN

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of ventilation systems. Velindre University NHS Trust, will ensure that all ventilation/air conditioning units (AHU's), are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose

	a health or operational risk to either, staff, patients or members of the public.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to **APPROVE** the latest version of the Ventilation Policy PP14

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Ventilation Group Meeting (circulation to group members)	**26/04/2023**
Executive Management Board RUN	**29/02/2024**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Minor amendments have been made to the policy to aims and objectives 3.0 in track changes 5.4 additional line has been inserted to cover critical systems in the trust.	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
1	PP14 VUNHST Ventilation Policy

1. SITUATION

1.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

1.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties with regard to fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy, there has been no significant changes to Version 5.

5. IMPACT ASSESSMENT

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

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13/03/2024 14:14:09

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). a) The policy fulfils statutory and mandatory duties. b) The policy provides a framework for the Trust to comply with its statutory, mandatory and moral duties with regard to keeping people safety. c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The policy also supports: • A Prosperous Wales • A More Equal Wales
	If more than one wellbeing goal applies please list below: As noted above, the objects of the policy are to protect: • Life • Assets • Provision of services • The environment • Trust and Reputation

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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: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance/replacement of outdated/damaged equipment; investment in time for training etc. Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	As noted above, fire does not discriminate but the
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

6. RISKS

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

Ref: PP 14

VENTILATION POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	Approved
Review Date:	3 years
Version:	2

Contents

1.   Policy Statement

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of ventilation systems.

Velindre University NHS Trust, will ensure that all ventilation/air conditioning units (AHU's), are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2.   Scope of Policy

This policy applies to all properties owned and maintained by the Trust, including properties leased, rented or occupied under lease or any other occupancy agreement.

The policy covers the maintenance of all ventilation/air handling equipment within Velindre University NHS Trust, to ensure a safe environment for both patients, staff and the public.

3.   Aims and Objectives

The Policy has been developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The Policy will not only ensure the organisation complies with the law, it also fosters confidence amongst both public and staff that the organisation takes its responsibilities regarding maintenance of these systems seriously.
Implementation of the policy will:

- Ensure ventilation/air handling equipment is suitable for its intended use and is maintained to satisfactory performance levels.
- Contribute to the overall control of infection agenda within the Trust.
- Comply with Health and Safety legislation requirements.
- Maintain the health, comfort and environment for all patients, staff and public, by ensuring adequate heating and ventilation exists and it is fully functional.

4. Responsibilities

The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

4.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's ventilation systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

4.2 Director of Strategic Transformation, Planning and Digital

The Executive Director will be charged with being the Designated Person, under HTM 03-01, Part B. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the ventilation systems within the Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's.
He/she should:
- Set out the standards and quality of service to be provided.
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for Ventilation (AE(V)).

4.3 Estates Maintenance Manager

The Estates Maintenance Manager is responsible for ensuring that all ventilation/air conditioning systems are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.

The Estates Maintenance Manager shall ensure that:
- All systems are identified and subjected to testing by an Authorised person.
- Maintain a register of Authorised Persons.
- Ensure that appropriate reactive and planned preventative maintenance arrangements are put in place to deliver to the aims of this policy.
- Have in place a procedure for assessing Competent Persons.
- Maintain a register of Competent Persons.
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. i.e. it is the individual not the contractor that needs to be assessed.

- Ensure that competent persons undertake regular maintenance on ventilation systems and equipment.
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services.
- Audit the effectiveness of the arrangements and arrange corrective action.
- Report any deficiencies which cannot be addressed within delegated limits of resource and authority.
- Ensure that ventilation systems are independently verified annually in accordance with H.T.M 03-01, part B Specialised ventilation for healthcare premises, Operation management performance verification.
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.
- Maintaining critical ventilation & LEV system inventory and log books.

4.4   Project Managers

Have the responsibilities to ensure that:
- All new installations meet the latest legal and technical standards.
- A suitably qualified person is involved in the design of all new installations and that commissioning and performance checks are undertaken and documented.
- All new installations are accessible and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure.
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes.
- That appropriate training and familiarisation is provided to in house and contract teams.
- That all new designs or major modification to existing systems are checked by the Authorising Engineer prior to the commencement of work.
- That all new installations are independently validated prior to contract completion.
- That all variations from the standards set out within H.T.M 03-01, Specialised ventilation for healthcare premises Part A: Design, installation and commissioning. Systems, are listed and agreed in writing by the Authorising Engineer / Estates Manager, prior to implementation.

4.5   Authorising Engineer (Ventilation) (AE(V))

Is defined as a person designated by management to provide independent auditing and advice on ventilation systems and to review and witness documentation on validation/verification.

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He/she shall:

- Provide a service in accordance with H.T.M 00 Policies and Principles of Healthcare Engineering.
- Advise on technical compliance with H.T.M 03-01 Specialised Ventilation in Healthcare Premises, Part A and B.
- Advise on interpretation of H.T.M 03-01, Specialised Ventilation in Healthcare Premises, Part A and B.
- Assess and make recommendations for the appointment of Authorised Persons.
- Monitor the performance of the service and undertake an annual audit.
- To investigate any adverse incident and report on any findings.
- Advise on the consequences of any proposed variation from the standards given within H.T.M 03-01, Specialised Ventilation in Healthcare Premises.

4.6 Authorised Person (Ventilation) (AP(V))

Will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing (following advice from the AE (V)), who is responsible for the implementation and operation of Management's safety policy and procedures relating to the engineering aspects of Ventilation systems.

4.7 Competent Person (Ventilation) (CP(V))

Is a person with adequate knowledge and training to undertake work on systems as designed by engineering managers. In particular:
- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on individual Ventilation systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.8 Infection and Prevention Control Team (IPCT

The IPCT will provide input into Estates on Capital projects and schemes, on infection control matters. They will ensure appropriate action is taken internally and externally by Consultants and Contractors commissioned and controlled by the organisation, to thereby reduce any risk of cross infection.

The IPCT will:
- Advise on monitoring infection control and microbiological performance of systems.
- Carry out or authorise the carrying out by an accredited laboratory, any microbiological tests as required.
- Provide infection control support to Estates staff as required in relation to infection control issues related to ventilation systems.

4.9   User

The person responsible for the management of the unit in which the ventilation system is installed, for example, head of department, operating theatre manager, head of laboratory, production pharmacist, head of research or any other responsible person.

5.   Definitions

For the purpose of this document the following definitions apply:

5.1   Environment

Relates to the total space of an occupier's surroundings when in a healthcare premises, whether they are a patient, member of staff or a visitor. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies.

5.2   Ventilation

Is a means of removing and replacing the air in a space. This can be achieved simply, by opening windows and doors etc. Mechanical ventilation systems provide a more controllable method. Basic systems consist of a fan attached to distribution ductwork; more complex systems may include the ability to heat and filter the air passing through them. Ventilation equipment is used to remove smells, dilute contaminants and ensure that a supply of "fresh" air enters a space.

5.3   Air Conditioning Systems(AHU's)

Have the ability to heat, cool, humidify, dehumidify and filter air. AHU's allow the climate within a space to be controlled at a specific level, regardless of changes in the outside air conditions or the activities within the space. Within the healthcare environment there are two classes of Air Conditioning system, Critical systems and Non-critical systems. Examples are given below.

5.4   Critical Systems

These are ventilation systems which if taken out of service would seriously degrade the ability of the premises to deliver optimal healthcare.
These include:
- Operating Theatres of any type, including rooms for interventional investigations (for example catheter labs).
- Patient isolation facility of any type.
- Critical care, intensive treatment, or high dependency unit.
- Neonatal unit.
- Category 3 or 4 Laboratory or room.
- Linear Accelerators.
- Pharmacy aseptic suite.
- Inspection and packing room (IAP), in a sterile services department.
- MRI, CAT and other types of imaging technologies that require stable environmental conditions, to remain in calibration.
- Any other system that clearly meets the definition that "a loss of service from such a system would seriously degrade the ability of the premises to deliver optimal healthcare".

5.5   Non Critical Systems

Non critical systems are general ventilation and extract systems in buildings.

6.   Training and other resource implications for this policy

Training should be of an appropriate level, depending on roles and responsibilities, and outlined in the Divisions/Hosted Organisations local procedures. Managers have the responsibility to inform relevant employees and contractors of any hazards that may exist when carrying out maintenance work, operation, testing or other repairs to equipment within their department. All staff, whether working for the Trust or as partners who have duties under this policy should receive appropriate training. Tradespersons are to be made aware of the dangers. The information given should include:

- The nature and type of risks to health where applicable
- Control measures employed
- Working procedures/policies

All records of training are to be maintained by the Estates Directorate.
Arrangements shall be made by the appropriate manager to ensure:

i.   That all employees concerned with particular work activities are adequately informed as to the systems, plant and apparatus that are affected, and instructed in all safety procedures.

ii.   So far as is reasonably practicable, that other persons who are not employees but may be affected by the work activities also receive adequate informationand/or instruction.

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7. **Implementation/Policy Compliance**

The Trust Board expects those tasked with managing aspects of ventilation safety to:

- diligently discharge their responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of ventilation works;
- have in place a programme for the assessment and review of electrical risks
- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate ventilation risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment, in regard to working on and using ventilation equipment.

8. **Equality Impact Assessment Statement**

A summary of the outcome of the EIA must be present on the front cover of the document.:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or
This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

9. **Main Relevant Legislation and References**

Statutory

- Confined Spaces Regulations 1997.
- Construction Design and Management Regulations 2015.
- The Control of Substance Hazardous to Health (COSHH) 1998.
- Health and Safety (Safety Signs and Signals) Regulations 1996.
- Health and Safety at Work etc. Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended 2002).

- Personal Protective Equipment at Work Regulations 1992 (as amended 2002).
- Provision and Use of Work Equipment Regulations 1998.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Approved Code of Practice on the Prevention and Control of Legionella (L8) and associated documents (HSG 274 parts 1, 2 & 3)

Guidance

The Department of Health:

a. Health Technical Memorandum 00 – Policies and Principles.
b. Health Technical Memorandum 03-01 – Specialised Ventilation in Healthcare Premises Parts A and B
c. Health Technical Memorandum 04-01 – The Control of Legionella, Hygiene, safe hot water, cold water and drinking water systems (Parts A, B & C).

10. <u>Audit and Monitoring</u>

The Director for Transformation, Planning and Digital, will maintain an audit cycle for monitoring and review of compliance of this and other Estates policies within the Trust.

An independent annual audit will be undertaken by NWSSP, on all critical ventilation systems and a report issued to the Director for Transformation, Planning and Digital.

The Report will contain key performance indicators to confirm:
- Any Critical systems are clearly identified.
- Where the exist, that appropriate validation checks have been undertaken.
- That any non-conformance on systems is clearly documented and deemed satisfactory.
- That required plant investments are designed, installed and commissioned in line with current legislation.

11. <u>Policy Conformance / Non Compliance</u>

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's 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.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PROFESSIONAL NURSING FORUM UPDATE

DATE OF MEETING	14th March 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	Anna Harries, Head of Nursing Professional Standards and Digital
PRESENTED BY	Anna Harries, Head of Nursing Professional Standards and Digital & Tina Jenkins, Interim Deputy Director Nursing, AHP & Healthcare Scientists
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The following are the key highlights from the report: • Progress being made with the implementation of The Framework for Enhanced, Advanced and Consultant Clinical Practice. • Interim framework for clinical supervision implementation and training plan with consideration of professional nurse advocate roles and A-Equip supervision model. • Trust is compliant with the all Wales policy for independent authorisation of blood component transfusion (IABT)

RECOMMENDATION / ACTIONS	To **NOTE** the Professional Nursing update for the period December 2023 and February 2024.

GOVERNANCE ROUTE	
Professional Nurse Forum (PNF)	07.12.2023, 04.01.2024 & 01.02.2024
Executive Management Board	29.02.24

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

PNF: During each meeting it agreed which items are reported through this paper to accurately reflect each workstream and nursing updates. It may be that a particular agenda required a standalone paper submission to highlight the significance or for specific consideration or approval.

Executive Management Board
- **DISCUSSED** the paper
- **APPROVED** the approach to use All Wales, Independent Authorisation of Blood Component Transfusion as a standalone policy.
- Requested that the ***Ockenden Review and East Kent Maternity Services*** overview is considered in a future board development session. This will be facilitated by the Head of Quality and Assurance as part of the formal launch of the Trust incident framework.

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

APPENDICES
Appendix 1 - Ockenden Report Overview

1. BACKGROUND

The Professional Nursing Forum Meets monthly and it is the forum at which all strategic professional nursing issues and standards are discussed, strategic direction agreed, and priorities determined. Reporting to Executive Management board is quarterly based on content of meetings held during the period.

It has a core attendance of senior nursing leaders across the Trust, there are regular agenda headings covering - good news stories, action log, feedback from National meetings, Items for discussion/approval, workforce, education and development, digital, Nursing workforce, senior nursing priorities, consultations, shared learning with

also items for noting and there is often an opportunity to welcome guest speakers to support the nursing agenda.

2. PROFESSIONAL NURSING FORUM HIGHLIGHTS: December 2023 - February 2024

The following is a summary of the key outcomes from the Professional Nursing forums held from December 2023 to February 2024:

2.1 Nursing Successes

The following good news stories were shared:

- The Immunotherapy Team at Velindre Cancer Service won a Macmillan Professionals Excellence Award at the UKONS Conference held in October 2023. The award was for the establishment on the Immunotherapy service.

- The newly qualified nurses are approximately halfway through the induction process. All feedback received so far has been positive and the nurses are well engaged.

- Three members of staff are up and running with their Velindre Cancer Research Fellowship Awards. The group were also advised that Ceri Stubbs has now registered as a PhD student at Cardiff University.

- Internal and external funding has been agreed for two posts until the end of March 2024, one focused on a Listening & Learning Framework for the Trust, the second to look at an Incident Management Framework and current investigation processes.

- Velindre Communications are finalising an article around the development of the nurses within the Palliative Care team in the area of Advanced Practice.

2.2 Multi-professional Advanced Practice

The National Multi-Professional Advanced Practice Framework was launched on the 9th June 2023. PNF is overseeing how this framework is being implemented and receiving an update at each meeting. Main progress includes:

- *Nationally approved Job Descriptions* - All nationally approved advance practice JDs approved from WBS and VCS PNF and to executive management board (7, 8a and 8b) Through Part 1 of the Panel, these are now with workforce to ensure use within TRACs system, business case discussion and Job Matching. These will also be used as part of Ratification Panel in Part 2.

- *Enhanced Advanced and Consultant (EAC) Panel* - Advanced practice panel held on 22nd January 2024, this was the first panel that held a Part 2 based on two example cases. These presentations were from a current advanced Nurse Practioner and a Radiotherapist. The purpose of the presentation was as a pilot for example cases and resulted in credentialling agreement in these example cases.

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- The ***Trust-wide Advanced Practice peer group*** is now well established, is chaired by advanced practitioners and meets monthly. Key outcomes to date are basing agenda around hot topics for the peer group members and updates from National and process for implementing the Framework.

2.3 *Independent Authorisation of Blood Component Transfusion (IABT)*

PNF commissioned a gap analysis against the Welsh Health Circular, a need was identified with in the Trust around six years ago to train non-medical staff to authorise Blood and blood products within the cancer centre.

Staff were trained following the IABT qualification (PG Cert) out of Swansea University (run by Dr Anne Benton as clinical lead) –This is a level 7 with 60 credits. The Trust has been following the Policy "Blood and component Transfusion Policy (VUNHST) V4" this clearly meets the circulars main concern with disparity of training.

However, the Welsh Health Circular (WHC) presents recommendations for practice which have been reviewed in line with current practice.

- All 5 staff in roles that Independently Authorise Blood Component Transfusion (IABT) met the criteria set in the Welsh Health Circular.

- The gap analysis allowed staff to comment where challenges or recommendations can be made while still meeting the criteria, it was highlighted that links to a Consultant Haematologist / SpR after qualification would be beneficial and clear process for sign off as this can be a challenge to chase.

- Any future applicant for the Independent Authorisation of Blood Component Transfusion (IABT) would complete the assessment to establish a need and ensure continuity.

- Any existing roles in post to remain compliant with Policy and competence as there may be a risk that competence could reduce with infrequent use.

- Following a gap analysis of the proposed All Wales Policy "Independent Authorisation of Blood Component Transfusion (IABT)" and the existing Velindre University NHS Trust Blood component policy is now complete. The Existing Velindre University NHS Trust Policy is already very large and covers many aspects of blood components not just IABT, therefore it is suggested to implement the All Wales suggested Policy as a standalone Policy.

2.4 *Clinical Supervision*

Following the approval of the Interim framework for Clinical supervision, scoping and collaborative work across Wales has commenced with sharing of current practice from Midwifery and England with the role of the Professional Midwifery Advocate (PMA) and Professional Nurse Advocate (PNA). This approach uses a model called A-Equip which is based on Restorative Clinical Supervision. Two Registered Nurses from the Cancer Network have offered supervision to VUNHST staff while the complete their

PNA training. This has been gratefully received by the group with suggested focus on newly qualified nurses and the Velindre Cancer Service treatment helpline nurses.

Scoping has already identified a number of staff within the Trust, that have previously been supervisors or who are interested in the role. There are 25 staff that require update or full training. This will be undertaken and agreed time scales to be discussed and agreed in March Professional Nurse Forum.

The core module descriptor has been shared with divisions from University of Cumbria for PNA training. This provides 20 Credits at Level 7 to become a Professional Nurse Advocate as part of their current role. The cost per person is £850 and is 200 hours in total. The ratio expectation for England is 1 PNA to 20 qualified staff. The Trust is therefore proposing based on a figure of 360 qualified nurses across the Trust 18 Advocates are required to be trained. This totals £15,300 for training excluding Study release.

2.5 NMC Registered Nursing Associate (RNA) Band 4 role

The Chief Nursing Officer for Wales has provided formal notification of the Welsh Government's intent to introduce a regulated band 4 nursing role in Wales and that of the NMC Registered Nursing Associate (RNA), which are subject to the required legislative amendments.

2.6 Ockenden Review and East Kent Maternity Services

The Interim Deputy Director of Nursing, Quality & Patient Experience has formally reviewed both the Ockenden and East Kent Maternity Services reviews (attached in **Appendix 1**). Despite Velindre University NHS Trust not providing Maternity care there are a number of generic lessons to learn from both. Key learning for the Trust are:

- **Monitoring safe performance** – key outcome and quality indicators.
  Shared Learning: measure meaningful outcomes and try and pick out important safety "signals" from "noise".

- **Standards of clinical behaviour** – technical care is not enough; kindness, compassion and professional behaviour is required. Trust failure to address grossly unprofessional consultant behaviour such as refusing to attend labour ward when on call. Importance of senior role models.

  Shared Learning: Embed professional behaviour and compassionate care – every interaction with patients and families should be with kindness and respect; listen to patients.

- **Flawed team working -** In almost all failed maternity services, flawed team working has been a significant finding, usually at the heart of the problem. Dys-functional team working within and across professional groups, lack of trust and respect posed a significant threat to mothers and babies. Poor morale amongst trainees, pressurised and unsupported.

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Shared Learning: common purpose, objectives and training for teams, re-evaluate patterns of working and training for junior doctors.

- **Organisational behaviour** – first instinct is to protect reputation. Denial, de-flection, concealment, aggressive responses to challenge.
  Shared Learning: need for openness, honesty, disclosure and learning must outweigh everything. Duty of candour is not enough, legislate for organisations to have open and honest dealings with families and official bodies ("Hillsborough Law"). Response to harm must be kind and compassionate. Lasting duty of care to those who suffer harm.

2.7   Divisional Nursing Audit Outcomes

Since March 2023, the two Divisions have been presenting their Tendable nursing assurance audit outcome reports on alternate months. These reports are highlighting compliance with audit, areas to improve, areas to celebrate and provide vital data on suitability of audit questions to further improve suitability and value from data. Key improvements we have seen in recent months as reflected in these audits are:

- WBS- improved compliance with uniform policy & appearance
- General compliance with completing Audits have increased across both divisions
- Identification of required standard and ordering of single use Blood pressure cuffs and posters required in clinical areas.

2.8   Nursing Conference 2024 – Monday 13th May 2024

The Conference planning team has been reinstated and currently finalising Conference plans, these are based on feedback from 2023 conference and the theme of the International Nurses Day 2024 "*Our Nurses. Our Future. The economic power of care*".

2.9   Digitalisation

Digitalisation of nursing documentation has slowed recently and has been raised as a risk to Digital Healthcare Wales (DHCW) as a development team collectively, many nursing assessments remain on paper with a new version release expected in March. This has also been escalated by the director of Nursing to Welsh Government.

Procurement process is underway for the Electronic Prescribing system. There are two bids for consideration and significant engagement in the process from both Technical and Clinical teams. This will be reported in the next update paper.

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:*	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). *PNF covers all aspects of Quality and Safety domains from a nursing 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
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	

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<u>Summary of some areas for consideration and discussion at VUNHST from the Ockenden Review and East Kent Maternity Services</u>

The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019

The review was commissioned by the then Secretary of State for Health, Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. This timeline shows the failure of the Trust's maternity services to listen to families and to learn from critical incidents spanning the entire period of the review.

Missed Opportunities

In summary, this was a trust that had a number of problems, but the perception was that, until 2017, the maternity service was not a major risk.

The consistent message coming from both senior maternity staff and from trust board members was that external reports into the maternity service were generally favourable, and that there were more pressing problems in other services at the trust. The management of the maternity service was perceived to be competent and able, and governance concerns seem to have been managed within the service and not escalated.

The review team believes that the trust board and the CCGs were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures, this message was lost in a wider healthcare system that was struggling with other significant concerns.

1. Patterns of repeated poor care

Evidence that lessons not learned as similar themes continue.

2. Workforce and Safe Staffing

The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.

All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings

3. Multidisciplinary training and learning

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.

Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.

All trusts must mandate annual human factor training for all staff working in a maternity setting. This should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.

There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies, including haemorrhage, hypertension and cardiac arrest, and the deteriorating patient.

There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well-supported staff teams are better able to consistently deliver kind and compassionate care.

4. Escalation and accountability

Staff must be able to escalate concerns if necessary

There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.

All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.

5. Clinical governance – leadership

Trust boards must have oversight of the quality and performance of their maternity services.

In all maternity services, the director of midwifery and clinical director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

Trust boards must work together with maternity departments to develop regular progress and exception reports and assurance reviews, and regularly review the progress of any maternity improvement and transformation plans.

Every trust must ensure they have a patient safety specialist who is specifically dedicated to maternity services.

All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.

6. Clinical governance – incident investigation and complaints

Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner

All maternity governance teams must ensure the language used in investigation reports is easy to understand for families – for example, ensuring any medical terms are explained in lay terms.

Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

Actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred.

Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred.

All trusts must ensure that complaints that meet the serious incident threshold must be investigated as such.

All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent.

Complaint's themes and trends must be monitored by the maternity governance team.

Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation October 202

This was covered in the national news, relating to an investigation of East Kent maternity services between 2009 and 2020; it makes for salutary reading.

4 KEY ACTION AREAS

1. **Monitoring safe performance** – key outcome and quality indicators.
   ACTION: measure meaningful outcomes and try and pick out important safety "signals" from "noise".

2. **Standards of clinical behaviour** – technical care is not enough; kindness, compassion and professional behaviour is required. Trust failure to address grossly unprofessional consultant behaviour such as refusing to attend labour ward when on call. Importance of senior role models.
   ACTION: Embed professional behaviour and compassionate care – every interaction with patients and families should be with kindness and respect; listen to patients.

3. **Flawed team working**. In almost all failed maternity services, flawed team working has been a significant finding, usually at the heart of the problem. Dysfunctional team working within and across professional groups, lack of trust and respect posed a significant threat to mothers and babies. Poor morale amongst trainees, pressurised and unsupported.
   ACTION: common purpose, objectives and training for teams, re-evaluate patterns of working and training for junior doctors.

4. **Organisational behaviour** – first instinct is to protect reputation. Denial, deflection, concealment, aggressive responses to challenge.
   ACTION: need for openness, honesty, disclosure and learning must outweigh everything. Duty of candour is not enough, legislate for organisations to have open and honest dealings with families and official bodies ("Hillsborough Law"). Response to harm must be kind and compassionate. Lasting duty of care to those who suffer harm.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	14/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
HCRW	Health and Care Research Wales
RDI	Research, Development and Innovation
QSPC	Quality, Safety and Performance Committee
VCS	Velindre Cancer Services
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service
WG	Welsh Government

1. PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the Public Meeting of the Research, Development and Innovation Sub-Committee on the 06/02/2024. Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	There were no items identified for **ADVISE** to the Quality, Safety & Performance Committee.
ASSURE	**TRUST RD&I RISK REGISTER EXTRACT** It was reported that there were no open risks recorded on Datix for escalation to the February 2024 Research, Development & Innovation Sub-Committee, in-line with the Trust Board Risk Appetite. As requested, a Summary of the RD&I Risk Profile was presented, which shows that since the 1st April 2023 there are five risks recorded, three of which have been closed and two remain open. These risks are currently being adequately controlled with appropriate action plans and have not met the threshold for escalation. Risks are reviewed through the RD&I governance route as appropriate and only escalated to a higher level where the Controls / Action Plan are unable to reduce the risk to an acceptable level. The Committee were informed that the Radiotherapy resource issues as discussed at the last Committee Meeting, were being addressed through a Task and Finish Group and the risk register would be updated accordingly. **TRUST RD&I INTEGRATED PERFORMANCE REPORT FOR QUARTER 3, FINANICAL YEAR 2023/24** The report provided an update on activities of the Trust's Research, Development and Innovation service during Quarter 3, Financial Year 2023/24. The newly revised report provides an update of activities against the Trust's Research, Development, and Innovation service's strategic priorities. It was of particular note, that study recruitment at the end of Quarter 3, FY 2023/24 was 120 more than for the whole of the previous financial year. Key highlights were reported by the respective leads as follows: ● Velindre Cancer Research & Development Strategic Ambitions ● Nursing, Allied Health Professionals & Health Science

	- Performance Indicators - Welsh Blood Service - Innovation - Financial Report
INFORM	**PRESENTATION** The RD&I Sub-Committee received a presentation by Sian James, Head of Research, Development and Innovation Services, Welsh Blood Service & Sophie Harker, Senior Epidemiological Scientist, Public Health Wales. The presentation was regarding the establishment of a surveillance system as Wales experienced some of the highest rates of confirmed COVID-19 cases in Europe. The presentation was very well received from the Research, Development & Innovation Sub-Committee and conveyed their sincere thanks to both Sian James and Sophie Harker for the informative presentation. **EXECUTIVE SUMMARY HIGHLIGHTS** The Executive Summary Briefing reported high-level activities relating to Research, Development and Innovation during Quarter 3, Financial Year 2023/24 along with noteworthy items from the RD&I environment since the last meeting of the RD&I Sub-Committee. Key highlights included: - Welsh Government / Health and Care Research Wales Annual Performance Review with Velindre University NHS Trust - Policy on the Use of Small Animals in Research - Moorhouse Consulting Workshops - Trust Board Development Session – RD&I - Welsh Blood Service – Improving Outcomes for Kidney Transplant Patients - Innovation Update **WBS RD&I STRATEGY PROJECT UPDATE** The Committee requested an update on progress to date with timelines for the WBS RD&I Strategy. The project has been delayed somewhat due to capacity issues and is now likely that the final document will be ready for consideration in early Spring 2024. **H&CRW / VUNHST ANNUAL REVIEW MEETING** Formal feedback from Health and Care Research Wales was received by the Trust on the 2nd January 2024, describing the meeting as constructive, outlining the discussions, their feedback and proposed next steps. A SMART action plan will now be developed to address the points raised as appropriate with timelines to be determined following further discussion within the RD&I Senior Core Team. The Trust will respond to HCRW feedback in due course as requested.

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3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Public Meeting of the Research, Development & Innovation Sub-Committee held on the 06/02/2024.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

15 STEP VISIT UPDATE REPORT

DATE OF MEETING	14/03/2024

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	Kyle Page, Business Support Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This report is to provide an update to the Quality, Safety & Performance Committee on progress against recommendations and identified actions following a programme of 15 step visits undertaken across both divisions to date. • **Visits to date:** A total of 14 visits have been undertaken since June 2021, 6 within Velindre

	Cancer Service and 8 within the Welsh Blood Service
	
	• **Emerging Themes:** The following emerging themes were identified over the course of the programme:
	
	    o Display of current / relevant information on notice boards
	    o Welsh Language representation
	    o Information in relation to staff on duty / providing care
	    o Patient feedback / complaint opportunities
	    o Hygiene / Infection Prevention Control improvements
	
	Further information in relation to resolutions implemented is detailed in section 3.3

RECOMMENDATION / ACTIONS	**RECOMMENDATION** • The Quality, Safety & Performance Committee is asked to **NOTE** the contents of the report and the assurance it provides regarding the activities undertaken to address recommendations identified following 15 step visits.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	**29/02/2024**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix 1	Schedule of visits to date since launch of programme
Appendix 2	Updated action plan – **WBS Collections Team (Port Talbot)** *(previously received at July 2021 Quality, Safety & Performance Committee)*
Appendix 3	Updated action plan – **VCC Outpatients Department** *(previously received at September 2021 Quality, Safety & Performance Committee)*
Appendix 4	Updated action plan – **WBS Apheresis Clinic** *(previously received at November 2021 Quality, Safety & Performance Committee)*
Appendix 5	Updated action plan – **VCC SACT Outreach Clinic** *(previously received at January 2022 Quality, Safety & Performance Committee)*
Appendix 6	Updated action plan – **WBS Laboratories** *(previously received at November 2022 Quality, Safety & Performance Committee)*
Appendix 7	Updated action plan – **VCC Radiotherapy Department** *(previously received at November 2022 Quality, Safety & Performance Committee)*
Appendix 8	Updated action plan – **WBS Collections Team (Wrexham)** *(previously received at November 2022 Quality, Safety & Performance Committee)*
Appendix 9	Updated action plan – **VCC First Floor Ward** *(previously received at November 2022 Quality, Safety & Performance Committee)*
Appendix 10	Updated action plan – **WBS Collections Team (Cardiff)** *(previously reported on at March 2023 Quality, Safety & Performance Committee)*
Appendix 11	Updated action plan – **VCC Therapies** *(previously received at January 2023 Quality, Safety & Performance Committee)*
Appendix 12	Updated action plan – **WBS Donor Contact Centre** *(not previously received at Quality, Safety & Performance Committee)*
Appendix 13	Updated action plan – **WBS Bone Marrow Collection Team (@VCC)** *(not previously received at Quality, Safety & Performance Committee)*

1. SITUATION

The purpose of this report is to provide an update to the Quality, Safety & Performance Committee regarding progress against recommendations and identified actions following 15 step visits undertaken across both divisions to date (since the launch of the programme in June 2021).

2. BACKGROUND

Velindre University NHS Trust has been undertaking 15 step visits (previously called 15 step challenge) since June 2021. The "15 step'' programme is a process based on NHS England's "Fifteen step challenge; Quality from a Patient's Perspective." This was designed during 2017 for outpatient and clinical settings and it was the intention to adopt this within Welsh Blood Collection Teams and Velindre Cancer Centre Outpatient settings, to gain a better understanding of patients' and donors' first impressions when they initially arrive in a healthcare setting, through to their subsequent experience of the care they receive.

The Trust was due to commence piloting the process during March 2020; however, this was paused as a result of the COVID-19 pandemic. The draft process and documentation was agreed at the Executive Management Board Shape meeting held on the 21st June 2021 and was followed by the inaugural visit which was undertaken within a Welsh Blood Service Collection Team during July 2021 and subsequently reported to the July 2021 Executive Management Board and Quality, Safety & Performance Committee, as per the agreed governance route.

Due to COVID-19 pandemic restrictions, visits were initially conducted by the Executive Director of Nursing, one Independent Member and a Business Support Officer (to undertake the administration, general oversight and subsequent drafting of the report). Visits entailed a walk around of the department in addition to informal conversations with staff (and patients and donors if visiting a clinical environment). This in turn enabled identification of improvements that could be made to enhance the patient / donor experience. It was agreed that this 'pilot' period would be followed by a review of documentation and that the visits would eventually be extended to be facilitated by all Executive Directors and attended by all Independent Members and patient representatives. Although visits were initially predominantly undertaken by the Executive Director of Nursing, one / two Independent Members and Business Support only, the easing of COVID-19 restrictions enabled visits to be shadowed by an additional Executive Director, with the intention that further quarterly visits would be facilitated independently with their Business Support and other Independent Members as appropriate. A schedule of visits was mapped out to include at least one visit per Division per month.

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3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Current Visit infrastructure

It is agreed that the visits should involve all members of the Board with at least one Executive and one independent member on each visit. 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.

3.2 Current status / outcomes on actions

The programme of visits undertaken to date, recommendations identified and resulting actions are attached within Appendices 1-13 (representing the current up to date position as at the time of writing this report). Areas visited are listed in the appendices reference section above.

3.3 Analysis of emerging themes (and resolutions)

A number of emerging themes were identified across both Divisions and appropriate resolutions implemented, predominantly:

- **Current / relevant information displayed on notice boards -** Information Boards across the Trust displaying significantly out of date information; recommendations were addressed where appropriate and up to date information added, including insurance certificates and removal of outdated COVID-19 information.

- **Welsh Language representation**
  - No Welsh speaking staff were on duty during some blood collection sessions due to low numbers of Welsh speaking staff available in some areas. Welsh Speaking identification badges have subsequently been issued to all Welsh speakers to provide more visibility on session and Welsh language proficiency will be considered when recruiting into Collections staff. Current staff are to be offered the opportunity to apply through ETP funding for Welsh Courses.
  - All signs within a number of areas are displayed in English only. Welsh translation as a minimum has since been provided.

- **Information regarding staff on duty / providing care**
  - No information was present in some areas to identify staff on duty (including Welsh language proficiency) / meaning of uniforms. **WBS Collection Teams** have since provided laminated cards to enable donors to identify staff on session by the colour of their uniforms, as limited capacity in collection vehicles precludes storage of an

additional information board for this purpose. This information is also included in donor information packs.

- o **Velindre Cancer Service** (First Floor Ward and Outpatients Department) Managers are aware that boards are to be updated ahead of each shift, to include information regarding who is in charge and definition of uniforms to be present in appropriate patient waiting areas / ward corridor and this is currently being prioritised at the time of writing. Posters are currently displayed explaining All Wales uniforms in some areas, with a view to move to electronic (display screens permitting).

- **Patient feedback / complaint opportunities / you said...we did…(action taken)**
  - o No available information in relation to action taken by WBS in response to previous feedback from donors. An SMS is now sent to relevant donors if a change is made as a consequence of their feedback.
  - o COVID restrictions previously limited display of posters, replaced by 'business cards' at various WBS locations detailing how feedback / complaints / suggestions may be provided. It is the intention to physically display actions that have been taken as a direct result of feedback via the new CIVICA system via a 'you said, we did…..board'.
  - o Introduction of the new CIVICA patient / donor feedback system requires a signposted feedback zone and visible information in patient areas regarding how to make complaints, suggestions, encouraging feedback etc. It is intended that the main reception at Velindre Cancer Service (VCS) will introduce a signposted CIVICA electronic feedback point.
  - o Visible / well located information regarding how to make a suggestion, complaint or compliment to be available across all departments and divisions, in addition to actions taken as a result. Some progress to date has been evidenced in a number of areas (in the form of 'you said, we did' boards), with further improvement anticipated.

- **Hygiene / Infection Prevention Control (IPC) improvements**
  - o A deep cleaning regime is required throughout a number of departments. A weekly deep cleaning rota has been agreed with Operational Services and implemented, monitored and signed off as appropriate (VCS).
  - o Use of "I am clean" tape, to indicate patient items such as commodes / beds etc are clean and when they were last cleaned has been introduced (VCS).
  - o Review of white coat laundering and replacement processes undertaken, including assurance mechanisms that dirty coats have been regularly washed / replaced. The associated Trust policy has been updated to include specific requirements to change coats on a weekly basis and a laundering process / adequate provision is in place, in addition to regular reporting to the associated services operational group (WBS).

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- o Wipe down process introduced for dusty computer equipment and appropriate cleaning tools supplied by IT department utilised for regular cleaning of PCs (WBS).
- o Cleaning checklists established across a number of departments, detailing designated responsibility, frequency and signoff process. All dirty or damaged furniture (predominantly chairs) to be condemned and removed and replacements procured (VCS).
- o All staff to be provided with ID badge pull cords in place of lanyards given IPC risk.
- o Daily inspection of medication fridge when checking temperature.

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.*
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 – Schedule of 15 step visits

Date	Venue	Action plan / recommendations
17/06/2021	WBS Collections Team, Princess Royal Theatre, Port Talbot	Attached (Appendix 2)
27/08/2021	VCC Outpatients Department,	Attached (Appendix 3)
05/10/2021	WBS Apheresis Clinic	Attached (Appendix 4)
07/12/2021	VCC SACT Outreach, Prince Charles Hospital, Merthyr Tydfil	Attached (Appendix 5)
19/05/2022	WBS Laboratories	Attached (Appendix 6)
26/07/2022	VCC Radiotherapy Department	Attached (Appendix 7)
23/08/2022	WBS Collections Team, Wrexham and HQ	Attached (Appendix 8)
08/09/2022	VCC First Floor Ward	Attached (Appendix 9)
24/10/2022	WBS Collections Team, UHW Cardiff	Attached (Appendix 10)
28/11/2022	VCC Therapies	Attached (Appendix 11)
08/02/2023	WBS Donor Contact Centre	Attached (Appendix 12)
27/09/2023	WBS Bone Marrow Collection Team (@ VCC)	Attached (Appendix 13)
29/11/2023	WBS Patient Diagnostics, Automated Testing, Hospital Services	No action required
07/12/2023	WBS Quality Assurance	No action required

APPENDIX 2 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited: Welsh Blood Collection Team - Princess Royal Theatre
Completed by: Nicola Williams, Executive Director Nursing, AHP & Health Science & Hilary Jones, Independent Member
Date: 17th June 2021

WELCOMING AND CARING

Recommendations	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
There was no external signage into the clinic	correspondence sent to all RN'S and Supervisors to ensure notice boards are clearly displayed. Disucssion with the team supervior to ensure signs are displayed		Operations Manager	completed	Collections Services Operational Service Group/QSP
Overall fully confident in team and service being provided and delivered. Only point to note was we were asked if we had anything in mouth on arrival at triage which does not appear to be part of WBS screening process rationale given when requested	The question is asked on the day as donors wear masks so its not clear if the donor has anything in their mouth. The reason for asking donors on the day if they have anything inb their mouth is to ensure that donors do not choke on chewing gum or sweets.		on session	completed	Collections Services Operational Service Group/QSP
Pay and display car park. Should donors pay to park to donate blood? Not sure if any arrangements have been made / communicated to donors re any free parking options (there was a tesco with 2 hours parking across road)	Where possible venues are not booked where paid parking is required. On the occasional time a venue is used where donors pay for parking the donor is notified on booking		Donor Contact Centre	completed	Collections Services Operational Service Group/QSP

Recommendations	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Staff reported WBS collections staff requiring a different way of organising mandatory & statutory training as currently they are required to complete during clinics and they advised there is insufficient time to do this and their compliance is reducing	Collections teams staffing levels are being monitored on a weekly basis to identify areas where staff can be stood down from duty to compete PADRs, mandatory & Statutory training. PADR and Stat & Man compliance is >80% advanced recruitment with an additional 5 WTE CCA's to support with collections plan including training.		Collections Operational Managers & Supervisors	completed	Collections Services Operational Service Group/QSP
Staff were unclear of the uniform requirements in relation to wearing to work and unloading. They felt they had received conflicting advise and noted lack of changing facilities at venues - fully clarity in line with NHS Wales standards.	Correspondence from Operational Managers to all staff to reiterate staff can wear uniform to work but will need to wear an outer layer to cover their uniform when travelling.		Collections Operational Managers & Supervisors	completed	Collections Services Operational Service Group/QSP
Registered Nurses reported being unable to participate in professional or management meetings as have no mobile access and had requested previously lap tops and headsets so could participate more	Laptops have been issued to all teams to ensure all staff are able to join meetings when required.		I.T	completed	Collections Services Operational Service Group/QSP
Review clinic venues to ensure that all possible space is being utilised to maximise chair capacity whilst maintaining COVID social distancing restrictions	Each venue has a risk assessment prior to booking venues to ensure adequate space for social distancing and storage of equipment on venue.		Collections Operational Managers & Supervisors	completed	Collections Services Operational Service Group/QSP

Feedback from a donor regarding challenges he has each time he books his daughter into a session as she has a learning disability and on arrival at venue resulting in lengthy and repetitive conversations. Opportunities to review pathways - donor & daughter happy to support the redesign of this.	donor contacted and a bespoke process was put in place. There is ongoing monitoring to ensure it is adequate for the donor.		Donor Contact Centre	completed	Collections Services Operational Service Group/QSP

INFORMATIVE

Recommendations	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Nothing evident relating language or cognitive needs. No welsh language staff on duty. Advised there are limited welsh language staff available in collections team.	Welsh Speaking identification badges issued to all Welsh Speakers to wear on session. Welsh Language to be considered when recruiting into Collections staff offered the opportunity to apply through ETP funding for Welsh Courses		Collections Operational Managers	completed	Collections Services Operational Service Group/QSP
There were no notice Boards evident - some ad hoc information on the screening booths- too small to be read from seats or located behind donors in booths. Appeared to have used medical tape to attach and looked old and worn. Missed opportunities regarding information	Due to capacity on equipment vehicle there is no capacity to store additional baords Information in line with how to report concerns are displayed in leaflet form in English &Welsh in all venues.		Collections Operational Managers	completed	Collections Services Operational Service Group/QSP
There was no information in relation to who staff were, what different uniforms meant - there was no information identifying any welsh language staff- subsequently advised that there were no Welsh Language staff on team that day and this is a usual occurrence due to a very low number of welsh speaking staff	Welsh language as above (line 23) Laminated cards are now on session to enable donors to identify to who staff are by the colour of their uniform		Communications Manager & Operational Managers	completed	Collections Services Operational Service Group/QSP
There was no information regarding who was in charge	refer to line 25		Communications Manager & Operational Managers	completed	Collections Services Operational Service Group/QSP
There was no information available regarding what WBS has done to act on previous feedback given to donors	Leaflets are available on sessions for donors to provide feedback. Through the donor monthly satisfaction survey a SMS is sent to relevant donors if a change is made as a consequence of donor feedback. QR codes now accessible on PDC for donors to access to provide feedback and you said we did.		Donor Contact Centre	completed	Collections Services Operational Service Group/QSP

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APPENDIX 3 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited: Velindre Cancer Centre Outpatients Department
Completed by: Nicola Williams, Executive Director Nursing, AHP & Health Science & Kyle Page, Business Support Officer
Date: 27th August 2021
Position Against Actions Up-Dated by Ann Marie Stockdale 23rd February 2022

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status	Additional Comments
Implement a system of nurse rounding		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private P	Complete	Rounding in place as best practice to routinely meet patient care needs and proactively address problems before they occur.
Display board with names of nurses working in clinics and who is in charge. Identifying Welsh speakers		OPD nurse manager	~~17/09/2021~~ ~~31.03.2022~~ 30.09.2022	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Staff photographs scheduled for March 2022 to co-incide with the completion of the refurbishment of OPD (31.03.22). Delays in the refurb of OPD due to funding limitations. Redecoration scheduled for 8th August 2022. Funding stream to be confirmed for the display screens. Delivery date amended - to be approved.
Waiting times display kept up to date. Clinic nurses to ensure it regualy updated.		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Display boards in place and maintained providing patients with clinic waiting time information.
Cost to be optained for new flooring in OPD		Head of Outpatients	~~15/10/2021~~ 22/02/2022	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Funding identified and secured, specification finalised and tender awarded 22.02.22. Timeline for work to be completed by 31.03.22.
Pursue the relocation of phlebotomy to alternative location		Head of Outpatients	~~15/10/2021~~ 30/11/2022	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Three options identified for the relocation of phlebotomy and plans developed. Recommendation approved by SLT. Funding stream to be identified, this is being progressed by Finance Partner. Note:- there is a three month lead time for the ground works to be completed prior to the siting of the modular unit. The date provided is only indicative due to funding issues. Four chairs now operational. Phlebotomy review required prior to any decision to relocate required. Review complete. Funding not available. Suggest closing this action and management requirements through the Outpatient Improvement Plan.
A regime of deep cleaning throughout the Department		Operational Services	04/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group Infection Prevention and Control Group	Complete	Deep cleaning rota agreed with Operational Services, implemented and on-going (takes place every weekend)

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status	Additional Comments
Radio to be removed from main OPD waiting area		OPD nurse manager	04/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Radio no longer present or in use in the Outpatient Department.
All displayed information to be up-dated and laminated. Out of date information to be removed.		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Minimal laminted information displayed only in line with Infection Prevention and Control guidance.
Daily cleaning checks/audit		OPD manager	04/09/2021	Patients Operational Management Group Infection Prevention and Control Group	Complete	Cleaning checks in place.

Promote use of current survey Monkey until alternative solution (Civica) is implemented		OPD manager	04/10/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Civica solution in place, audits completed in line with the audit cycles (regular interaction with Anna Harries)
Consideration of relocation of reception desk to create more privacy		Head of Outpatients/Medical Records Manager	31/12/2022 31/07/2023	Outpatient, Medical Records and Private Patients Operational Management Group	In Progress On hold	Location has been identified for the relocation of the Reception Desk. Work has been scoped with the Estates Department. Portacabin in place for the WAST Liaison Officer and transport patients to enable the Reception Desk to be increased to 3 staff members. Capital monies identified however the indicative cost of the scheme was higher than anticipated. Discussions with Estates underway to consider amendments to plans to ascertain whether a reduction in cost is possible to determine the feasibility of the scheme.

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status	Additional Comments
Information on how to make a complaint/suggestion or provide feedback to be displayed in OPD		OPD Nurse Manager	30/09/2021 30/09/2022	Outpatient, Medical Records and Private Patients Operational Management Group Quality and Safety Management Group	Complete	Due to Covid restrictions, there is a limitation on the display of posters, therefore 'business cards' have been made available located throughout the department detailing how feedback can be provided (including complaints, suggestions etc). In addition to this, when feedback is received from Civica our plan is to display actions that have been taken as a direct consequence of feedback ie f 'you said, we did' . We have not received feedback that we can display as yet.
Review appointment letters going out to patients. New WPAS will have abilities to be more specific and have locally configerable letter templates associated to each clinic.		Medical Records Manager	30/05/2022 30/11/2022	Outpatient, Medical Records and Private Patients Operational Management Group Digital Health and Care Record Project	Complete	Clinic set up configured in WPAS in readiness for go live. Each clinic location has been reviewed and confirmed. The location and address will be included in the clinic appointment letter as an automated process. Implementation delayed in line with the amended WPAS go live date.
Display a poster explaining all Wales uniforms		OPD Nurse Manager	30/10/2021 01/03/2022	Outpatient, Medical Records and Private Patients Operational Management Group	Complete	Poster displayed (this will move to electronic when display screens in place)

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APPENDIX 4 - 15 STEP CHALLENGE ACTION PLAN TEMPLATE

Area visited: Apheresis

Completed by: Date:…………………..

WELCOMING AND CARING

Recommendation	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
As many donors do not drive, the cost of public transport can become onerous due to regular appointments. As transport was previously provided by the service (COVID restrictions may currently not allow this), consider the offer of reimbursment for travel expenses. Some donors also travel long distances to donate frequently.	An exercise has been undertaken to review other travel expense payments for donors across the UK. No other serivce pays donors for travel eexpenses. The Apherisis panel is meeting target and sustaining hospital demand.		Communications Manager	complete	Collections Services Operational Service Group/QSP
Possibly offer headphones to donors to enable them to listen with sound, particularly if watching a music channel.	The TVs in the clinic are not accesible to bluetooth. Prices to replace the current TV's with bluetooth headphones is being reviewed. Due to prohibitive costs and IPC process for headphones, this was not undertaken. Additionally, donors generally use their own devices.		Operational Manager RN - Apherisis	complete	Collections Services Operational Service Group/QSP
Consideration to be given regarding the meet n greet standards at main reception within Talbot Green.	Recommendations escalated to Facilities Manager for review		Estates Manager	complete	Collections Services Operational Service Group/QSP
As all donors require weighing, seated scales and any other additional assistance required for wheelchair bound patients / non-weight bearing patients.	Wheelchair specific weighing scales are on order		Operational Manager RN - Apherisis	complete	Collections Services Operational Service Group/QSP

WELL ORGANISED AND CALM

Action required	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Very few chairs. Fabric chairs turned against the wall due to COVID regulations could be temporarily removed to free up space needed by potential wheelchair users.	Chairs have been removed from the area		Operational Manager	complete	Collections Services Operational Service Group/QSP
The infrastructure to be able to support donors who had hearing / visual impairments and whose preferred language was not english or welsh was not evident i.e. availablity of translated / use of language line, braille, talk text etc. The service needs to ensure these are available routinely and that all staff are aware of what is available and how to access / use them.	There are significant resource issues to cater for all languages on the SAHH and in cases where the donor needs follow up for a positive microbiology marker or a DAER, appropriate counselling and follow up becomes resource intense. Work has been competed with a donor who is deaf and also with a donor who has special needs. Unless donors have the capacity to fully understand and complete the SAHHS and questions in screening they will not be able to donate.		Consideration for WBS to establish a working group to review resource needs	complete	Collections Services Operational Service Group/QSP

INFORMATIVE

Action required	Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
The standard regarding who was in charge of the clinic and which staff were on duty were not met. This needs to be standard practice across collections and updated each day at the start of the clinic.	Template designed and laminated to be displayed on session to idenity who is in charge. This has been implemented across all of Collections.		Communications Manager & Operational Managers.	complete	Collections Services Operational Service Group/QSP
Although donors may provide verbal feedback or suggestions as they become familiar with staff, a feedback / suggestion facility is still required, as donors may think of suggestions outside of their clinic or feel unable to verbally communicate this during their appointment. Also include evidence of acting on donor feedback e.g. "you said, we did..."	Introduction of CIVICA has facilitated this.		Communications Manager Operational Managers.	complete	Collections Services Operational Service Group/QSP
All signs within the clinic are English only. Welsh translation needs to be provided as a minimum. There needs to be information displayed in all clinics regarding how to raise a concern, make a compliment or suggestion.	All leaflets on how to raise concerns or make a compliment are now displayed in clinic.		Operational Manager RN - Apherisis	complete	Collections Services Operational Service Group/QSP

APPENDIX 5 - 15 STEP VISIT ACTION PLAN TEMPLATE

Area visited: Prince Charles SACT

Completed by: Rhianydd Jones & Rebecca Membury   Date: 13/10/22

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Clinic was difficult to locate from both externally and internally. This was echoed by Patients. Enhanced maps and clearer directions required. All signage refers only to Macmillan Unit and no reference to Unit being a Velindre @ service (apart from unit immediate door sign). Signage to include that it is a Velindre service. Possibility of Trust having a google maps pin to locate unit to be considered.	Currently engaging with CTM Capital Planning Managers to enlarge and increase the number and visibility of signs throughoout the PCH site - internally and externally. Signage with incorporate both the MacMillan and VCC logo.	SACT & MM DSM with oversight from SACT Clinical Leads	ongoing	VCC Quality and Safety. SMOGG
Patients reported that they were not advised of this dedicated parking prior to arrival for their first visit. To be included on the appointment letters sent to patients.Patients are now triaged via telephone the day before treatment and offered information on directions and parking	Patients are now triaged via telephone the day before treatment and offered information on directions and parking. Additionally, in order to enhance the patient experience, appointment letters will be amended to contain further information regarding location of MacMillan Unit.	SACT & MM DSM with oversight from SACT Clinical Leads	ongoing	VCC Quality and Safety. SMOGG
The clinic is no longer serviced by the Prince Charles hospital catering team. Staff have to collect sandwiches and milk and patients donate biscuits as these are not provided.	Currently being discussed with finance. Investigating the logistics of transporting tea/coffee/biscuiits to VCC on a monthly basis to mirror the beverages/snacks offered in VCC	SACT & MM DSM with oversight from SACT Clinical Leads	Beverages and snacks are now transported from VCC. Sandwiches and milk collected from PCH kitchens daily.	VCC Quality and Safety. SMOGG
Develop a plan for all band 6/7 SACT nurses in first instance to be prescribers - increasing to all SACT nurses in time as a competence for an 'expert SACT' Nurse.	For discussion with wider VCC as needs executive oversight and input	Head of SACT and Medicines Mangement. SACT Lead Nurse. Head of Nursing and SLT.	Pending further discussion	To be raised in SMOGG for further escalation
Review staffing model to ensure there is sufficient HCSW cover across all clinics so that registrants can focus on SACT delivery.	Capacity and Demand Modelling currently being undertaken within the SACT Service	Head of SACT and Medicines Mangement. SACT Lead Nurse. Head of Nursing and SLT.	Increased HCSW numbers has resulted in HCSW cover for the clinic most days.	SLT. SMOGG. EMB.
Details of which staff are on clinic and who is in charge to be made available upon entrance of unit for patients arriving to see.	Daily Staffing documented on whiteboard at entrance	Completed daily by staff on duty	completed	SMOGG

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Patients found the time whilst having treatment long, exacerbated by being unable to have someone with them due to the pandemic. Ceiling mounted or trolley TVs for use for patients with headphones to be considered.	Portable DVD players available. 2 Wall mounted TV's currently on the unit. As replicated in VCC.	N/A	Currently in discussions with finance regarding purchasing IPAD's using MacMillan Unit funds	SMOGG
Ornament in OPD Consultation room to be removed as this is a clinical space - possibly relocate to waiting area behind glass.	Removed and showcased in the garden.	Completed	Completed	SMOGG
Consider re-allocated phlebotomy room for clinical space e.g. SACT storage to prevent storage in main SACT delivery area.	Clinics have now recommenced and phlebotomy room is in use. Surplus equipment has been transported to VCC and used within the SACT units	completed	completed	SMOGG
Given the VCC OPD capacity issues and need to socially distance, plans should be formulated to fully utilise the PCH OPD space.	PCH OPD now in use 3 days a week but could be utilised further. Discussions with OPD Nurse Manager are ongoing.	OPD Manager & SACT Lead Nurse	Increased use by Cwm Taf specialist nurses and psychology (all oncology) but no increase from VCC	SMOGG

A locked location to be identified for the days SACT to be stored safely and securely that is not in the direct clinical area that patient care is being provided - consideration to be given for repurposing another space ? Phlebotomy room.	SACT is now stored in the treatment area behind a locked door. Refrigerated items are stored in the fride, room temperature items are stored in ambient boxes or a locked cupboard overnight.	Completed	completed	SACT Task and Finish Group
The use of ' I am clean tape' to indicate patient items such as commodes are clean and when they were last cleaned to be considered.	Green clean Stickers are now in use	Completed	Completed	IPC Audits
Sluice room should always have a supply of gloves.	Stock provided	Completed	Completed	Completed
There were two days when resuscitation checks not undertaken - if when unit was closed this needs to be documented on check list as Unit closed against said dates. If unit was open on these dates process to ensure daily checks are undertaken should be reviewed.	Communicated to staff	Completed	Completed	Completed
ECG machine to be repaired as showing as broken since 26/11/2021.	Repaired	Completed	Completed	Completed

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Clocks in two of the OPD clinic rooms to be set to the correct time as all stopped or displaying wrong time.	Batteries changed and checked regularly	Nurses utilising the areas	Completed	N/A
There needs to be a CIVICA Feedback Zone and information up in patient areas regarding how they can made a complaint, suggestion or compliment.	Signposted Complaint/suggestion box on wall in the waiting area. Ongoing work regarding digital capture of patient experience which would include information regarding complaints etc.	SACT and MM DSM	Suggestion/complaint box present, and CIVICA now in place with a board signposting comments and changes made as a result.	SMOGG. Quality and Safety.

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Consider Purchase of ceiling or trolley monuted TVs or mobile IPDA devices (that can be decontaminated) that could be used by patients with ear phones to help patients be distracted whilst receiving treatment.	Please see above for information - line 16			
Review closer to home access and explanations being provided to patients when treatment venues change.	At the start of treatment, patients should be informed in clinic that treatment close to home will be offered where possible but this may not always be available. There are currently 5 areas for SACT administration and patients should be advised of this on their first appointment/chemo education.	Patient education and SACT Bookings	Ongoing	Themes and trands identified would be shared via Quality and Safety, and SMOGG, and discussed with Service Leads.
Signage of Unit to be reviewed so that it is explicit that services are provided by Velindre. Signposting to Unit on site to be enhanced. Directions to Unit and map on letters to be revised and letters to include reference to dedicated parking. Consideration given to use of Google Pin as a locator.	Please see above for information - line 7			
Consider recommencing on site PIC service to reduce pressure and risks on VCC site.	PICC Service managed under Integrated Care. No plans to recommence this service at the MacMillan Unit at the present time.	Head of Nursing. Lead Nurse for integrated Care.	Unable to comment.	N/A
Review PHC catering arrangements - including delivery and provision of biscuits for patients.	Please see above for information - line 9			
Further SACT workforce review to be undertaken to include minimal HCSW cover (to facilitate top of licence working) and trajectory of nurse prescribing.	Please see above for information - line 11			
Name and signposting of the Unit to be reviewed to recognise that the service is delivered by Velindre University NHS Trust.	Please see above for information - line 7			
Consider a review so that the PCH Facility could be fully optimised to reduce pressure on VCC and reduce footfall at VCC to include optimisation of the OPD facility and consideration to recommence the PIC service.	Please see above for information - line 19			

APPENDIX 6 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited - Laboratory Suite (Logging In Room, Manufacturing Laboratory, Platelet Laboratory)
Completed by: Stephen Pearce   Date:07/07/22

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Improved warmth and professionalism of main (WBS) reception staff required, treating all visitors as though it is their first visit. Review staffing present and reinforce best practise and importance of the welcome all visitors receive. Explore options for customer service training for reception staff		Sarah Richards	Complete - 28/10/2022	Audit and actions will be reported in to the General Services Operational Group (Governance route for Reception). Updates will also be provided to 15 step challenge co-ordinator.
Review white coat laundering & replacement processes that include assurance mechanisms that coats have been regularly washed / replaced as a number of coats hanging outside Manufacturing Laboratory were dirty. POL(S)-009 Laboratory Safety Procedures - this doesn't have a specific requirement to change laboratory coats every week - update Policy to include this requirement. Reinforce requirement to change laboratory coats with staff at Laboratory Meetings. Process for laundering laboratory coats is in place and staff have sufficient laboratory coats. Additional coats can be ordered if more are required by individual staff members.		Stephen Pearce	29/07/2022 On review POL(S)-009 has a requirement to change laboratory coats at least once per week - Complete Lab coat changes discussed at monthly laboratory meeting - Complete	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Ensure all laboratory staff (whilst working within laboratory settings) adhere to clinical staff all wales uniform policy requirements and hand hygiene standards including no nail varnish, acrylic nails and stoned rings and have long hair tied back. Specific health and safety requirements for Laboratory staff to be reviewed in line with clinical staff all Wales uniform policy requirements to ensure high standards of health and safety (including IP&C) are met.		Georgia Stephens	Ensure compliance with Health and Safety Legislation and consistent implementation of Trust H&S Policies throughout laboratories in the Welsh Blood Service.- Laboratory Specific Health and Safety Group.	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Relocation of storage racks / cabinets within Logging In Room from floor level required to allow for cleaning of whole floor. Low level racking may be required. Storage requirement for trays reduced by utilising trolleys to store trays. Liase with estates department to install low level racking (if possible)		Stephen Pearce	Metal racking on floor removed to allow cleaning of floor. Racking not purchased - alternative storage for trays used (movable trolleys with shelving) 29/10/2022	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Sink in Booking in Room needs replacing as cracked. This was identified in April 2021 prior to MHRA audit and a request for repair raised. It had not been followed up so it has be re raised with facilities/estates.		Stephen Pearce	Update 13-10-22 - This action is with Estates to replace the sink - expected date has been requested 29/10/2022 (Dependant upon rapair/replacement time)	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept).
Wipe down process required for dusty computer equipment in Laboratories and Logging In Room and removal of sticky residue left on surface from prior use of sellotape. Work surfaces cleaned of residue. Request to IT to discuss and agree cleaning method for desktop PC's with buildup of dust.		Stephen Pearce	29/07/2022 IT supplied a vacuum cleaner which was used to clean all the PCs in M&D - this is scheduled for repeating on a 6 monthly basis (Complete)	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Review of cleaning standards / frequencies within Booking in Room as as floor had rubbish on it computers very dusty and there were cobwebs on light fittings. Request to IT to discuss and agree cleaning method for desktop PC's with buildup of dust. Review frequency and extent of cleaning for laboratory areas with facilities / cleaning staff.		Stephen Pearce	29/07/2022 IT provided vacuum to clean pcs. - complete Head of M&D to attend monthly cleaning audit with cleaning company and facilities -due AL this will take place in September 2022. 13-10-22 discussion with facilties/cleaners around some specific issues did not resolve some specific issues due to difficulties in cleaning high up delicate electrical items (lighting) - resolution may be acheved by moving to different lighting (sealed units) - this to be taken to estates group. Laboratories are swept daily and cleaned weekly by the cleaners. Work surfaces cleaned daily by laboratory staff.	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

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Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Review of cleaning schedule processes as the schedule on the notice board in laboratory had not been completed for the month of April. Cleaning record updated. Cleaning and recording is specified in SOP PRO-084 which defines daily and weekly cleaning tasks by room.		Stephen Pearce	Complete 06/07/22	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Consider a potential move to partial or complete paperless record storage for additional security. MHRA advice from audit at Wrexham was to keep (paper) primary records on site from at least the last audit. Method for electronic archiving of paper records in place. Move towards more electronic records would be welcome. WBS QA Systems are currently investigating use of electronic signatures compliant with regulatory requirements. Take suggestion into developments of the organisation.		Stephen Pearce	Raise with iHub for consideration as Service Improvement Use of electronic signatures is a longer term project so unable to give a by when date. No unaccompanied visitors allowed into the department. Access into laboratory is controlled by swipe access	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator. **This is an organisational goal which will be achieved incrementally.**

APPENDIX 7 - 15 STEP VISIT ACTION PLAN TEMPLATE

Area visited: Radiotherapy Department VCC ……..
Completed by:Nicola Williams & Vicky Morris …………………

	in progress	(yellow)
	completed	(green)
	NA	(grey)

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Tasks	Stage
Cleaning checklists required across all areas of the department - the detail which staff group are responsible for cleaning what & how often & a sign off process in place.	Welcoming and Caring	Sue Sheppard-Murphy and Sam Allen	30.9.2022 and procedure reviewed	Any concerns will be discussed directly with Sue Sheppard- Murphy when needed	Checkiists for clinical areas to be revised.- Domestics Cleaning checklist to be emailed to radiotherapy superintendents/DRSM and allow any issues to be addressed. Windows cleaned regularly. **Action complete**	
A full de-clutter is required.	Welcoming and Caring	Radiotherapy staff	30.09.2022	Radiotherapy operational meeting as required	general. La6 refurbshment due 2022-2023 which will address la6 declutter. La5 addressed in the same way. La3 will be addresed in Feburary 2024. In progess throughout department **Initial Action Complete- Maintenance is ongoing**	
Radiotherapy walk arounds to be undertaken to assess against IPC Standards (using agreed IPC Tool), facilitated and attended by Radiotherapy manager until all standards / IPC standards addressed. Frequency should then be reduced to monthly. Walkaround team to consistently include: estates manager, facilities manager, radiotherapy manager & IPC.	Welcoming and Caring	Sue Sheppard-Murphy, Hayley Jeffreys, Nigel Hill, Sam Allen,Milburn Mounter, Rhidian Richard	ongoing		First walkaround on 23.8.2022. Second booked for 20.9.22 to discuss outstanding issues. Monthly walkarounds have continued- now walkarounds are every 3months	
Floor extremely uneven outside entrance to L5 - trip hazard - requires evening out to ensure it is safe until move to the new build.	Welcoming and Caring	Nigel Hill	31.10.22	Discussed at walkaround on 23.8.22	Estates team to link with contractors re timing frame and costs .Costs sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October. 15.1.23 New flooring for areas that pose a trip hazard have been actioned . **Action Complete**	
Flooring in toilet areas by la5 uneven	Welcoming and Caring	Nigel Hill- Estates team	13/10/2022	On action plan	**Action Complete**	
The no visiting signage to be removed and replaced with the agreed support arrangements (1 person can support)					All 'no visitors signs' have been removed. No new signs have been added as there are no current visitor restrictions in the Trust. **Action Complete**	
The whole of radiotherapy department - in particular corridors and waiting areas requires painting as walls in some areas in a bad state of repair (breach IPC environmental standards).	Welcoming and Caring	Nigel Hill	31.10.22	Discussed at walkaround on 23.8.22	Estates team to link with contractors re timing frame and costs. .Costs sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October. Patient areas and corridors have been painted.**Action Complete**	

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments	
Cracked electric point (zone15/d11) to be r	Well Organised and Calm	Estates	17.08.2022		Raised by Sam Allen on the 16/8/2022.Rhidian responded and Estates will replace cover to make safe . Completed on the 17/8/2022 . **Action Complete**	
A risk assessment in relation to the carpet in the main waiting room should be undertaken.	Well Organised and Calm	H+S department rep	31.08.2022	Quality meeting	Carried out on the 19/9/2022 **Action Complete**	
Clean linen cupboards to be installed within the Linac areas for gowns and 'green sheets' and appropriate locations for solied linen skips to be determined.	Well Organised and Calm	Sam Allen	30.09.2022		Sub waiting areas are where soiled linen bags are kept.Plastic boxes with lids to be procured for each changing room to store clean gowns. Clean Green sheets are stored inside the linac rooms **Action Complete**	
Around main reception area details should be published bilingually regarding who is in charge that day.	Well Organised and Calm	Helen Payne	16.08.2022		Situated on the wall at radiotherapy reception **Action Complete**	
A full review of all store cupboards to be undertaken using 'perfect ward' principles.	Well Organised and Calm	radiotherapy	1.01.23		Review undertaken abd all essential equipment or items are locataed in the correct area nitial **Action Complete- Maintenance is ongoing due to ongoing linac replacements/refurbishment**	
An urgent review of storeroom in L6 needed and a review off all storage in line with 'productive ward principles.	Well Organised and Calm	la6 Refurbishment business case	2023		La6 refurbishment started on the 11/10/22 which will adress la6 declutter and IPC issues..	
All fans to be removed from throughout radiotherapy.	Well Organised and Calm	Sam Allen			Radiation Services use of fans Risk Assessment for non-clinical areas has been undertaken which premits the use of fans.**Not applicable currently**	
Blinds in reception to be removed	Well Organised and Calm	Nigel Hill	30.9.22		Highlighted an IPC risk. Estates to cost scallfoldng to remove the blinds. Removed 11.10.22 ction **Action Complete**	

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments
A review of all chairs in the department required - all dirty, damaged, tacky chairs to be condemned.	Well Organised and Calm	Sam Allen	31.10.22		6 chairs condemned and removed. Costs for additional chairs to be discussed. Procurement of 40 Chairs cost sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October. Regular chair review is undertaken. **Action Completed**

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments
Full review of signage throughout the department required. To ensure that only essential signage is in place, that they are bilingual and all laminated.	Informative	Radiotherapy Department	ongoing		Initial signs removed. All future signage is bilingual and laminted.**Complete-Maintenance is ongoing due to ongoing linac replacements/refurbishment**
A full review of patient information to be undertaken across the dept. Including what is provided, how it is themed (e.g possibly by SST) and how made visible.	Informative	Radiotherapy Department	23.8.22		The department has all leaflets avialble for patients. General Macmillian booklets ie benefits, tiredness, stopping smoking are avaialble for patients.Patient information booklet/leaflet is stored under plastic sheeting – no change due to covid . No leaflets on display in sub-weight areas . Any leaflet that is needed is found by reception/radiographers. Site sepcific leaftets are given in consent cinic appointmets
A review of drinks provision should be undertaken - plan in respect of café or moving vending machine to an area visible to all patients.	Informative	Sue Sheppard-Murphy.	31.9.22		Impact assessment on where the vending machine can go. No action taken- no area to put the vending machine in that isnt more appropraite than current area. **Action Completed**
Clear signage required in public and visible area regarding how to raise a concern, compliment or suggestion. Including availabilty of CHC for support.	Informative	Claire Davies	31.10.22		Discussed at QSMG in regarsd to civica and haviung feedback from patients is Trust wide issue. New civica screen and signage in radiotherapy. **Action Completed**

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments/Action
A review of staff uniform wearing required to ensure that full uniforms are worn for all clinical staff and uniform standards are fully adhered to.	Feedback from patients/donors/staff	Sam Allen	31.12.22	Email Weekly update	staff reminded in the radiotherapy email weekly update on the 19.8.22 to adhere to uniform policy including jewellery. Review Uniforms in department and to change to black scrubs in line with radioghraphers uniform policy. 6.5.23 All radiographers and clinical staff adhere to the All Wales Uniform policy through the implementatation of Scrubs. **Action Completed**
Positive feedback mechanisms to staff required in relation to the extent to which their views have been taken into consideration in relation to the new build and if all views have not been adopted the rationale made available. In the event of patient pathway issues these need to be formally escalated through to the programme board.	Feedback from patients /donors/ staff	Andrea Hague /Jacqui Couch /Kate Hammond	14.9.22	Email Weekly update	Email sent to AH and JC to send an update for staff 18.8.22. Meeting on 24.8.22 between JC and SA. AH, JC and KH to develop communication to be sent to staff in radiotherapy via weekly update on the 16.9.22.Completed and add to weekly update 14.9.22 **Action Completed**
IM requested understanding of the plan around utilisation of L6 given the current capacity / demand challenges and that it has been out of use for some considerable time.	Feedback from patients/donors/staff	Helen Payne	15.8.22	EMB Shape	Paper submitted and discussed on 15.8.22 at EMB Shape. **Action Completed**
Patient feedback Zone in main reception & mini zones in Linac areas required - main reception to include CIVICA electronic Feedback point with large 'your feedback is important to us' type signage. Within area a Know how we are Doing Board is required with a 'You Said .. We did…' feedback	Feedback from patients/donors/staff	Sam Allen/Claire Davies	1.12.22	Civia meeting	Purchase –noticeboard in department in reception for patient feedback - 1.9.22

Admin roles : Laminated and putting it up in treatment/pre-treatment.

CRD/SA Responsibility to update every other month. **Action Completed** |
| Relative had approval on support grounds to support relative on all visits to VCC. This had not been positively received within SACT and was regularly challenged in a non friendly manner. | Feedback from patients/donors/staff | Emma cunningham/Anna Burgess | 18.8.22 | Nursing staff meeting | Email sent to inform -vivien Cooper, Emma Cunnigham and Anna Burgess in SACT nursing 18.8.22 **Action Completed** |

APPENDIX 8 - 15 STEP VISIT ACTION PLAN TEMPLATE

Area visited: Wrexham (WBS Collections Team)

Completed by: Sally Gronow   Date: 12.10.2022

Action required	Strategic theme	Who will do this?	By when?	Where will it be
Although information is included within pre-donation reading material, a visible board detailing who is in charge of the clinic, what uniforms mean and Welsh speaking staff would be beneficial in case donors do not read the material provided.	language laminate cards distributed to all teams with RN / Supervisor name and displayed on entry point. Due to capacity on WBS vehicles there is no capacity to store an additional display board.	Sally Gronow	Complete	
Clinical grids / staff numbers to be reviewed to ensure efficient use of staff time. Increase in donor numbers could also be considered to support blood supply required.	Daily 10:00 conference with operations and resource planning and logistics to review clinic plans to ensure clinics and staffing are maximised	Aiysha Tufail - RPL Manager	Complete	performance discussed in daily resilience

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be
Review clinic venues to ensure that all possible space is being utilised to maximise chair capacity whilst maintaining COVID social distancing restrictions	All venue master risk assessments have been reviewed post covid to ensure full clinic utilisation Supervisor feedback venue form updated daily to identify if venue changes occur	Mark Jenkins	complete	
Staff to be provided with ID badge pull cords and asked not to wear lanyards given the IPC risks.	Lanyards ordered and distributed to all staff	Mark Jenkins	complete	

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be
Information to be available and easy to read at all clinics regarding how to make a suggestion, complaint and compliment. Additionally, inclusion of a 'You said….we did...' board detailing changes WBS has made following feedback from donors is required.	QR code now accessible on PDC for donors to access to provide feedback and you said we did updates	Sally Gronow / Simon Cambell Davies	complete	
More visibility of Welsh speaking staff required, via appropriate uniforms / more visible badges.	all Welsh speaking staff have been issued with WBS Welsh speaking badges email to all Supervisors to check if any new badges need to be distributed	Brooke Winsper - Parry	complete	

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be

Staff reported WBS collections staff requiring an alternative way of organising mandatory & statutory training as currently they are required to complete during clinics and they advised there is insufficient time to do this, resulting in reduced compliance.	advacned recruitement with an additional 5 WTE CCA's to support with collections plan including training.	Sally Gronow	complete	
Registered Nurses reported being unable to participate in professional or management meetings due to lack of appropriate devices/internet access. This has been requested previously to allow more active participation. iPADs made available to staff would make connection easier (fewer connection issues) and ensure they have an ability to dial into meetings at clinics as often there is no available computer or connection cannot be obtained and staff have to use their own phones.	RNs in North Wales have been issued with individual laptops. Connectivity issues raised with IT Collections Modernisation Programme incorporates live connectivity on session as part of a deliverable	Sally Gronow	As per Collections Modernisation Programme	
Registered staff also concerned re the travel to clinic requirement on bus as this is usually the time when professional meetings are held - there will therefore need to be variations to this rule to allow registered staff to attend required professional meetings.	Staff who attend formal meetings at base who are then required to travel to clinic will be provided with transport if they do not wish to use own transport and claim mileage.	Collections Managers	complete	

APPENDIX 9 - 15 STEP VISIT ACTION PLAN TEMPLATE					
Completed by: Matthew Walters			Date: 19/10/22		
WELCOMING AND CARING					
Action required	**Action taken (including additional context)**	**Strategic theme**	**Who will do this?**	**By when?**	**Where will it be reported?**
Ward paper signs are required to be laminated.	Ward manager made aware and this will be completed by November 22		Ward manager	Nov-22	Complete
Ward relative's room flooring in bad repair	Estates team contacted for consideration of repair or renew, a capital request will be made based on the outcome of estates review		Estates	Nov-22	In progress
All information Boards contained information that was significantly out of date.	Ward manager made aware, this has been addressed, and new information will be added to display boards		Ward manager	Nov-22	Complete
Facilities for patients and relatives were not accessible to them on the day of the visit. The only Relatives' room was being used by staff as breakout room and sink contained lots of dirty dishes etc.	Ward manager made aware, and will request support from operational services staff to ensure that the Relative's room is clean and maintained appropriately.		Ward manager	Nov-22	Complete
A Patient TV room was stacked full of storage.	Operational services have been contacted to arrange alternative storage of the air conditioning units and this now complete.		Operational Services	Oct-22	Complete
The Ward Manager (fairly new in post) advised that she was unclear of the full scope of her role and had not received induction, but learnt from the previous Ward Manager.	This situation arose due to the immediate need to move the previous ward manager to a role as senior nurse in outpatients. Full support is being given to the Ward Manager. Coaching has been arranged from a peer ward manager in a Health Board. Objectives have been set, regular 1-1s in place.		Senior Nurse	Oct-22	Complete
Staff advised that if there were some staff absent from duty then patients would not be admitted, rather sent to their Health Board. Staff could not describe an escalation process through to Divisional Director to put preventative mitigation in place.	The beds are now fully open to 32 and patients are admitted in line with the VCC Admission Criteria. The ward manager has implemented a Big 4 discussion every morning and the escalation process through to the divisional director is being discussed regularly. The ward staff are aware and where required escalate issues concerns to the ward manager and senior nurse.		Ward Manager Senior Nurse	Oct-22	Complete
No welcome signs observed. No other languages outside of English and Welsh.	Ward manager made aware and has asked the band 6 clinical sister/charge nurses to lead on this as a team as one of their joint objectives.		Ward team	Nov-22	Complete
The 'thank you messages' noticeboard outside the main doors to the ward could be replaced with a board specifying managers, titles, contact details and feedback station.	Ward manager made aware to create a board regarding the ward team and management structure with contact details.		Ward team Anna Harries	Nov-23	Complete
Information about who the staff team is and who the ward manager is.	Ward manager aware that board is to be updated on each shift.		Ward Team	Nov-22	Complete
The macerators both require attention.	Escalated to Estates team		Estates	Oct-22	Complete
Daily resuscitation trolley checks	Ward manager aware to monitor in partnership with Resus audits that are undertaken by the resus officer.		Ward Team	Oct-22	Complete
The medication fridge was extremely dirty with sticky residue and hairs.	Ward manager is ensuring that staff perform daily inspection and cleaning of fridge when checking temperature		Ward Team	Nov-22	Complete
Confirmation that bed mattresses / bars and area surrounding beds thoroughly cleaned between patients.	Ward manager aware that we should have a laminated cleaning checklist in each bed area		Ward Team	Nov-22	Complete
No visible evidence of 'you said, we did...' or a patient feedback area. Process on how to complain and compliment.	Ward manager made aware that a patient feedback board should be updated to reflect our response to feedback. The process on how to complain or compliment is now visible in the ward area.		Ward Team	Nov-22	Complete
Resuscitation trolley requires cleaning as part of daily checking process.	Ward Manager aware that cleaning of the resuscitation trolley is part of the daily checks and this has been added to the daily checklists.		Ward Team	Nov-22	Complete
Cleaning schedules to evidence cleaning	Ward manager aware		Ward Team, Estates and Operational Services	Dec-22	Complete
WELL ORGANISED AND CALM					
Action required		**Strategic theme**	**Who will do this?**	**By when?**	**Where will it be reported?**

Action required		Strategic theme	Who will do this?	By when?	Where will it be reported?
PSAG (Patient Status at a Glance Boards) not fully completed - very few had EDD, no NEWS, falls risks etc. There were no symbols in use to indicate if patents had a cognitive impairment in PSAG board or bedside.	Ward manager aware that the PSAG board should be completed in full and has since implemented a system where the board is updated as a minimum in the morning handover and then throughout the shift if there are changes made. An electronic system would further support updating this information and this has been raised as part of the Digital requirements.		Ward Team	Dec-22	Partially Complete- Velindre Dementia Nurse to support FF ward with development of a cognitive impairement symbol
There is equipment stored in the patients' TV room and also in corridors.	Ward manager aware. Will attempt to rationalise amount of equipment stored in rooms and corridors however space constraint is an ongoing issue and there is no designated storage area available in close proximity to the ward. This has been raised with operational services.		Ward Team	Dec-22	Complete
Staff kitchen also contained staff personal possessions / clothing / bags / wallets. Not a secure area. Lockers available elsewhere. The cleaners' room door was jammed open (this had just a few weeks before been identified on an HIW inspection).	Ward manager aware. Staff to ensure that they store their possessions in the lockers in changing rooms. The cleaner's room door has been escalated via Operational services.		Ward Team Operational Services	Nov-22	Complete
Clear signage to rooms, toilets etc. Dementia / cognitive impairment signage not in place.	Ward Manager will be working Supportive Care lead nurse to take forward dementia friendly signage and additional environmental changes that would benefit patients with cognitive impairment.		Ward Team Supportive Care Lead Nurse	Dec-22	In progress- Working with the Velindre Dementia nurse.
Fabric slatted blinds in place in some areas of ward - wipable blinds required.	Ward Manager aware and escalated to operational services.		Ward Team OP Services	Dec-22	In progress- escalated to OP services
Feedback from patients/donors/staff					
Action required		Strategic theme	Who will do this?	By when?	Where will it be reported?
Staff morale appeared generally low	The senior nurse and ward manager would welcome some further discussion around the concerns/evidence in relation to this statement. Work around staff morale is already being actioned, there is now a staff morale champion, the employee of the month has been reinstated, team away days have been organised. VCC offers staff psychology, Bobath staff wellbeing centre.		Ward Team Senior Management	Nov-22	Complete
There was a significant number of newly recruited staff requiring support has presented challenges, particularly now that bed numbers on the ward have increased (back to pre-pandemic level) from 22 to 32.	Recruitment is nationally a challenge. Staff are being supported with the reopening of a full ward and recruitment to support this model is currently being undertaken. The Band 4 Assistant Practitioner role is being considered for the inpatient ward.		Ward Team Senior Management	Jan-23	Complete
Reports of newer staff struggling with multiple elements of the role unfamiliar to them. We were advised that new registered staff commencing on the ward did not have the required skills: ECG, Catheterisation, bloods, discharge etc.	Staff are being supported to learn the required clinical skills supported by the clinical educators. The ward manager is working with the clinical trainer to ensure that where staff arrive with skills from previous roles there are being encouraged to be signed off as competent without repeating training programmes. The Band 4 Assistant Practitioner role is being considered for the inpatient ward.		Ward Team Senior Management	Jan-23	Complete
Staff felt that: dedicated discharge support to manage the POC, repatriation and complex discharge would help.	This has been in place previously resulting in a single point of failure and burnout for the individual in post. Consideration is being given to an agreement with HB for a rotational post from HB to VCC. The Band 4 Assistant Practitioner role is being considered to further support registered nurses for the inpatient ward.		Ward Team Senior Management	Jan-23	In progress
More support and leadership required.	The current structure is robust and feels appropriate further information on this statement would be helpful to the senior nurse and ward manager. The inpatient ward leadership structure is formed of 1 Band 8a Senior Nurse, 1 Ward manager, 3 Night managers and 8 Band 6 Coordinators. Coaching is being organised for the ward manager to support further development.		Ward Team Senior Management	Nov-22	Complete
Possible weekly remuneration for bank staff would facilitate current staff working extra shifts on ward on bank rather than agency shifts elsewhere.	This work was being taken forward with NHS Shared Services		Ward Team Senior Management	Dec-23	In progress

APPENDIX 10 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited: WBS Cardiff Collections Team, University Hospital Wales, Cardiff
Completed by:…………………   Date:…………………..

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?
Although information is included within pre-donation reading material, a visible board detailing who is in charge of the clinic, what uniforms mean and Welsh speaking staff would be beneficial in case donors do not read the material provided.	all staff who speak Welsh have to wear identification badges so donors know who to address for Welsh language laminate cards distributed to all teams with RN / Supervisor name and displayed on entry point. Due to capacity on WBS vehicles there is no capacity to store an additional display board.	Deputy Head of Collections Operational Managers	complete

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?
Additional screen for unwell donor/s required, in particular if donor cannot be moved from main donation area to separate chair.	There are spare sceens on each team for this purpose.	Sally Gronow - Deputy Head Collections	complete
Monitor volume of background music to ensure this does not become intrusive for donors.	Radio's are positioned in the clinic for backround sound to support donor privacy	Whole Blood Teams	complete
A little delay at screening, staff could have been reallocated to support as there were a good number of staff present.	staff are encouraged to flex where appropriate across all donor areas to support donor flow	Supervior / Deputy Supervisor	complete

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?
Inclusion of a 'You said….we did...' board detailing changes WBS has made following feedback from donors is required.	QR code now accessible on PDC for donors to access to provide feedback and you said we did updates	Andrew Harris - Communications Manager	complete
More visibility of Welsh speaking staff required, as per Welsh Language requirments.	all staff made aware of ETP panel to apply for Welsh language courses. All Welsh speaking staff given identitication badges so donors are aware.	Sally Gronow	complete
Full welsh language active offer review required.	Supervisors and RN's reminded to offer Welsh speaking staff where available on meet and greet All staff have been asked to updated their individaul skills in ESR	Sally Gronow	complete

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?
Possiblity of further sessions at UHW as hospital / clinical staff advised that the appointments filled up quickly and they frequently could not get an appointment.	data from BI is used to ensure donor sessions are planned appropriately in rotation with donor panel cycles	Aiysha Bailee	complete

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APPENDIX 11 - 15 STEP VISIT ACTION PLAN TEMPLATE

Area visited……..
Completed by:…………………   Date:…………………..

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Designated patient waiting area required as patients are currently collected from the Outpatients Department which is a long walk away for patients and staff (wasted clinical time) does not allow for maximum use of appointment time.	Patient wellbeing / efficiency	Jon Fear / Kate Baker	End of March 2023 // complet	ICOG
Implementation of a room in new hospital for patients unable to eat by mouth to receive nutrition in a private environment / patients to receive 'self accessible' nutrition by way of locker system to ensure they are able to receive this wherever they are being treated within the Cancer Centre.	Patient experience	Jacquie Couch / Siobhan Pearce	End of December 2022 // com	TCS squad

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Alternative storage of larger patient equipment required. Walking aids, commodes, zimmer frames currently inappropriately stored in area also used as staff kitchen. Although some racks / hooks are present, a large amount of equipment is stored at floor level, preventing cleaning of the floor space and presenting a health and safety hazard.	Health and safety	Jon fear / kate Baker	End of June 2024	ICOG
Remove unused wheelchairs / trolleys from corridors.	Health and safety	Siobhan Pearce	End of December 2023	
Repair to kitchen (fire) door required as this does not close completely, presenting a fire hazard. Ensure kitchen is only a kitchen and not used for any other purpose	Health and safety	Jon Fear / Kate Baker	End of March 2023 / comp	ICOG
Repair to door to outside garden space in corridor between Therapies and Pharmacy required, as visible splits currently allow ingress of cold air from outside.	Health and safety	Jon Fear / Kate Baker	End of January 2023 // co	ICOG
Agree use of Rehabilitation Suite (currently used for patient rehabilitation treatment and as meeting room). Set timetable to be agreed or move meeting equipment to alternative location.	Quality	Kate Baker & Siobhan Pearce	End of December 2023	ICOG
Agree cleaning schedule required with regular monitoring and sign off.	Health and safety	Sue SM & Kate Baker	End of March 2023	ICOG
Corridor between Therapies and Pharmacy and whole area around therapies to be repainted.	Patient experience	Jon Fear and Kate Baker	End of April 2023	ICOG
A full walk through with estates and facilities to agree an environmental update plan that includes cleaning of windows	Quality & Helath and safety	Jon Fear, Stuart Buswell, Kate Baker	End of December 2023	ICOG

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Visible information required to encourage patient feedback and allow raising of complaints and concerns to be present in corridors and treatment rooms.	Patient experience	Siobhan Pearce	End of February 2023	ICOG
Patient feedback zone required	Patient experience	Siobhan Pearce	End of February 2023	ICOG
Information regarding who is in charge and what uniforms mean to be present within corridor (or new patient waiting area).	Patient experience	Kate Baker	awaiting printing Jan2024	ICOG

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Attraction / Recruitment drive. Training and development plan.	Workforce	Kate Baker	End of March 2023 // ongo	ICOG
Interim solutions to be explored until moving into the new Velindre Cancer Centre.	staff experience	Kate Baker	End of March 2023 // ongo	ICOG

APPENDIX 12 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited: Donor Contact Centre, Welsh Blood Service

Completed by: Nicola Williams, Executive Director of Nursing, Kyle Page, Business
Support Officer, Steve Ham, Chief Executive Officer

Date: 8th February 2023

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update Jan 2024
No Action required					

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update Jan 2024
Development of contact centre systems to allow future options of remote working This option would only be possible on the delivery of the below actions (Row 15 & 19). Becuase of the paper based and administration processes that exist within the department, the option for the department as a whole to work remotely isnt really an option, however it would be helpful, should certain people need to be at home at particular points we can utilise their time productivley.	Deliver the best possible experience for our donors Modernise our operations to improve safety, productivity and value	Simon Davies/Digital	2025	To be discussed with Digital	Specification for Omni-Channel contact centre software has been created and shared with Digital Services. Procurement have also been engaged in terms of going out with a PIN (Prior Information Notice) to understand potential solutions and costs attached to these prior to a business case being created to seek funding. The Digital Services team are seeking to coordinate a Trust-wide procurement, since similar requirements exists across other service areas, in particular Velindre Fundraising and the WBMDR. A combined solution that can deliver a platform for the various service areas is deemed financially prudent and the right approach. The Digital Services team have undertaken a scopin workshop with Velindre Fundraising - the Digital Services team will link in with relevant staff in Jan/Feb 2024 to consider how to progress this initiative.

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update Jan 2024
Implementation of more robust digital answer machine solution, which allows multiple messages to be captured at one time Currently exploring different options with current provider and different providers, to identify best fit for the future of the Donor Contact centre. Currently have 2 demo sessions booked in to review different options to outline the art of the possible. This will give us some ideas of how we might progress and also ideas of likely costs etc.	Deliver the best possible experience for our donors Modernise our operations to improve safety, productivity and value	Simon Davies/Team Leaders/Digital	2024/2025	To be discussed with Digital	Specification for Omni-Channel contact centre software has been created and shared with Digital Services. Procurement have also been engaged in terms of going out with a PIN (Prior Information Notice) to understand potential solutions and costs attached to these prior to a business case being created to seek funding. The Digital Services team are seeking to coordinate a Trust-wide procurement, since similar requirements exists across other service areas, in particular Velindre Fundraising and the WBMDR. A combined solution that can deliver a platform for the various service areas is deemed financially prudent and the right approach. The Digital Services team have undertaken a scopin workshop with Velindre Fundraising - the Digital Services team will link in with relevant staff in Jan/Feb 2024 to consider how to progress this initiative.

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update Jan 2024
Wish list and proposals to be added to IMTP for an Omni Channel contact centre solution, including timescales & costings Currently exploring different options with current provider and different providers, to identify best fit for the future of the Donor Contact centre. Currently have 2 demo sessions booked in to review different options to outline the art of the possible. This will give us some ideas of how we might progress and also ideas of likely costs etc.	Deliver the best possible experience for our donors Modernise our operations to improve safety, productivity and value	Simon Davies/Team Leaders/Digital	2024/2025	IMTP Action Complete	Specification has been created, currently this project is sat as part of WBS Futures project plan. The Digital Services team have undertaken a scopin workshop with Velindre Fundraising - the Digital Services team will link in with relevant staff in Jan/Feb 2024 to consider how to progress this initiative.

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APPENDIX 13 - 15 STEP VISIT ACTION PLAN TEMPLATE
Area visited: Welsh Bone Marrow Donor Registry Collection
Team, Velindre Cancer Centre, Velindre Cancer Services.

Completed by: Donna Mead, Trust Chair and Independent
Member, Matthew Bunce, Executive Director of Finance and
Chris Moreton, Deputy Director of Finance

Date: 27/09/2023

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update
Contact FM team (Mark David) about the need for signage from the hospital entrance to the Welsh Bone Marrow Donor Collection Rooms.	Welcoming and caring	Matthew Bunce	30.11.23	To be completed by WBMDR Team	Update 15/11/2023: Matthew Bunce has contacted Mark David, who has agreed to pick up the signage issue. Update 28/11/2023: Sinage order is being processed through Paul Murphy. Update 03/01/2024: The order for the sinage has been put on oracle and is being processed (712182609)
Donna Mead to speak to Head of Catering (Sue Sheppard), who has agreed if Christopher Harvey makes contact an arrangement can be put in place so that a hot meal is available after 2:30pm.	Welcoming and caring	Donna Mead & Christopher Harvey	DM action Completed	To be completed by WBMDR Team **COMPLETE**	Update 28/11/2023: Christopher Harvey informed that one of the WBMDR Nurses would be in touch with Sue Sheppard-Murphy, Update 03/01/2024: This has successfully been implemented with VCC operations teams being extremly helpful and accomodating.
Suggested it could be an idea to log the preferred language of each donor on the WBMDR system when a donor is signed-up to make sure translators can be booked in advance if they are asked to donate - WBMR team to explore this.	Welcoming and caring	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2023: We are still assessing the current software (not very flexible and outdated platform and language). However are also investigating replacement software for stem cell collection/import and we have put a PIN out and spoken to a number of suppliers. Any new software would be fully functional in this respect.
Matthew Bunce to liaise with Digital Team as to whether there are plans for improving the Wi-Fi at the VCC.	Welcoming and caring	Matthew Bunce	30.11.23	To be completed by WBMDR Team	Update 15/11/2023: Matthew Bunce has liasised with the David Mason-Hawes in the Digital Team. Some tests have been performed of the Wi-Fi in the Bone Marrow donation rooms - these checked out all fine and tallied with a recent Wi-Fi survey undertaken by an independent contractor. The Team also ran some tests running "high data" services such as Netflix etc and these were all fine. Legacy issues with Wi-Fi were experienced in that area, now fixed with the deployment of some new Wi-Fi kit - which was undertaken earlier this year. David Mason-Hawes has asked Christopher Harvey to check in with the nursing staff to ensure visitors and patients are
Team to look at the options for clinical chairs suitable for donations and if after evaluation think this would be better could apply to the charity for funds. Team to engage with procurement to identify if smaller comfy chairs are available that would fit the space if a bed was continued to be used.	Welcoming and caring	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2023: We have not yet looked at this. I will speak to the nursing team and advise in the next update.

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update
No Actions identified					

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update
Speak to Corporate Nursing team around communications to training nurses on all services that Velindre provides and how they gain experience in those services.	Informative	Matthew Bunce	30.11.23	To be completed by WBMDR Team	Update 10/01/2024: MB emailed Tina Jenkins to clarify when nurses come for training what options are given around the services and Welsh Bone Marrow Donor Registry, and if there is a list of services that they get experience in.

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update
Engage with Trust Communications Team to assess if they could help make people aware and understand what's involved when registering as a donor WBMDR team to make contact.	Informative	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: We are working with WBS communications department to increase the recruitment rate of donors across Wales. This includes increasing the age that ethnic minorty donor can join the panel to 45 to improve the diversity of the stemcell volunteer donor panel. This has all now moved under the 'Futures' pathway for the WBMDR and recruitment has been moved to the responsibility of the WBS communications and engagement department. However I will provide updates from the 'Futures' recruitment arm once under way. The WBMDR has also explored using VCC screens and have sent proposed screen across to VCC operations in an attempt to inform and possibly recruit VCC staff emmebers and patient family members.
The Welsh Bone Marrow Donor Registry Team have discussed whether the brand should be changed from Welsh Bone Marrow Donor Registry to Welsh Stem Cell Donor Registry - to be fed into WBS SLT discussions on this matter.	Informative	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: As line 21 and I will update the group with the Futures Actions/Successes as they happen.
Explore options for raising awareness; such as there being a screen with an information video to view explaining the options and what is involved in Bone Marrow donation whilst people are giving blood - Team to explore if this is a possibility and at which collection sites / mobile units?	Informative	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: As line 21 and I will update the group with the Futures Actions/Successes as they happen.
There is an option to register as a donor via the WBS website by providing a DNA cheek swab, but people aren't aware of this service. - Team to liaise with WBS & Trust communication teams on how they might help with ideas around raising awareness.	Informative	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: As line 21 and I will update the group with the Futures Actions/Successes as they happen.
Contact the Wales Council of Deans Group to get a slot to explain to the council about the WBMDR and seek clarification on Christopher Harvey's point about WBMDR being able to establish students groups in Universities.	Informative	Donna Mead	30.11.23	To be completed by WBMDR Team	NOTE: WBMDR would be very interested and ready to perform this action as soon as we can.

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Update
Follow-up with Estates team (Jason Hoskins) the request that has been made for the Nurses Room which needs to have an air conditioning system installed.	Feedback from patients/donors/staff	Matthew Bunce	30.11.23	To be completed by WBMDR Team	Update 14/11/2023: Christopher Harvey advised that Jonathan Fear has proposed the idea of putting a fridge in the room for the drugs. He is concerned about energy usage for 24/7 aircon (the collection rooms as only on when required but the drug room would nee to be on constantly) so this option is being explored and Matthew Bunce will be kept updated. Update 15/11/2023: A solution has been agreed with Jonathan Fear for Nurses Room to have a Fridge installed for the safe storage of medicine relation to temperature. Jonathan Fear has engaged woth Pharamcy leads to advise annd will link with Christopher Harvey until complete. Update 03/01/2024: I am looking to purchase a medium to large temperature controlled incubator and smaller fridge for ACD-A and G-CSF drug storage respectively (self administration G-CSF requires refigeration). However, I am having some trouble identifying a suitable incubator and this is still ongoing. Any help would be greatly appreciated. Update 10/01/2024: MB emailed Gemma Roscrow to seek help in sourcing a suitable incubator.

Speak to Alan Prosser, Director of Welsh Blood Service to ensure an invite is sent Bone Marrow Donor Registry Team for future Donor Award Ceremonies.	Feedback from patients/donors/staff	~~Matthew Bunce~~ Alan Prosser	30.11.23	To be completed by WBMDR Team **COMPLETE**	Update 24/10/2023: MB spoke to Director of Welsh Blood Service for him and his team to take forward action, 24 October 2023. Note: WBMDR Excited about this prospect. Update 11/01/2024: WBMDR staff have been advised of future awards evenings and will timetable attendance in due course - CLOSED.
Contact NWSSP Procurement team to enquire if it would be possible to piggy back off the NHSBT G-SCF contract? Christopher Harvey wasn't sure if this would be possible - Initial query sent to procurement team who are investigating options.	Feedback from patients/donors/staff	Matthew Bunce	30.11.23	To be completed by WBMDR Team	opportunity to piggy back on the NHSBTS, Scottish or Northern Irish Blood Services G-SCF contracts if they have better terms and more flexible service model? Wyn Owens replied to say he would make some enquires and ask colleagues to look into this. Update 03/01/2024: I have spoken to NHSBT (BBMR) and unfortunately their self administration contract is not part of a framework. Therefore, we may be forced to implement the service from scratch and we have a meeting with a possible service provider on the 4th January 2024. Note: Sciensus have given notice to end thier G-CSF administration service in Mat 2024 so we need to move at some haste.
Inform Rachel Hennessy so she can ensure WBMDR are also involved in hospital design and service access discussions.	Feedback from patients/donors/staff	Matthew Bunce	30.11.23	To be completed by WBMDR Team	Update 03/01/2024: Not yet been involved in these meetings.
Confirm with the Alan Prosser that the WBMDR Donors are invited to the Donor award ceremonies and recognised by WBS.	Feedback from patients/donors/staff	~~Matthew Bunce~~ Alan Prosser	30.11.23	To be completed by WBMDR Team **COMPLETE**	Update 24/10/2023: MB spoke to Director of Welsh Blood Service for him and his team to take forward action, 24 October 2023. Update 11/01/2024: Alan Prosser has confirmed all WBMDR Stem cell donors are invited to donors awards evenings even if they do a secondary top up donation to the same donor) - CLOSED.
Team in process of applying Joint Accreditation Committee ISCT-Europe & EBMT (JACIE) accreditation and will keep the Trust Board informed of progress.	Feedback from patients/donors/staff	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: We have implemented the required full face ISBT128 labelling of the product and we have uploaded all required documents for assessment. The next step is the full initial inspection dat and I will update here when that is arranged. Good news so far :)
Team to consider including information regarding the Nurse Uniform colours in Donor Information packs.	Feedback from patients/donors/staff	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: Not yet progressed. Will priortise in February.
There could be an option to potentially raise the age for Donors from ethnic minority groups. Team to consider this.	Feedback from patients/donors/staff	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: This cange for 'Cheek Swab Donors' will be validated and implemented in January 2024 (progressing).
Review the Velindre Cancer Service Website to see what is identifiable about the WBMDR service and feedback to WBMDR team.	Feedback from patients/donors/staff	Alison Hedges	To be completed by WBMDR Team	To be completed by WBMDR Team **COMPLETE**	Update 13/12/2023: Review of Velindre Cancer Service Website completed and information sent to Christopher Harvey. Update 03/01/2024: This has been collated by Alison (thank you) and will form part of the 'Futures' for WBMDR rectuiment actions - will keep this group informed.
Date for WBMDR team to meet the Board to be arranged in the New Year	Feedback from patients/donors/staff	Donna Mead	30.11.23	To be completed by WBMDR Team	Note: WBMDR Excited about this prospect.
Suggested Bone Marrow Donation pins would be a nice form of recognition to be given to the donors. Team to consider if this is possible and also consider increasing the donor credit given the time required to donate for either PBSC or bone marrow.	Feedback from patients/donors/staff	Christopher Harvey	To be completed by WBMDR Team	To be completed by WBMDR Team	Update 03/01/2024: Not yet progressed. Will priortise in February.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Bi-annual Value-Based Healthcare Programme Update

DATE OF MEETING	14/03/2024

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 the Value Intelligence Centre was formed in September 2023.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the continued development of the Value Based Healthcare Programme including:

	o Positive impact of the Pre-op anaemia programme and proposal to extend scope to cover Anaemia for more clinical areas o Achievements of the Value Intelligence Centre to date and objectives for 2024/2025 o The development of a Velindre Food Mission with Welsh Government support.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE

N/A

APPENDICES

N/A	

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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 to date including the objectives for the coming year.

2. BACKGROUND

The Value Based Healthcare Programme includes three workstreams as follows:
- Preoperative Anaemia Pathway Project with the Welsh Blood Service
- Value Intelligence Centre at the Trust
- Food Mission

VBH Programme updates are provided to the QSP Committee on a bi-annual basis and the previous update was provided in September 2023.

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.

3. ASSESSMENT

3.1 Value Intelligence Centre
The VIC was formally established in September 2023 by the new Head of Value Based Healthcare. 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. This is 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 staff across the organisation to access tools with confidence to apply the principles of VBHC.

The workstreams and objectives within the programme are as follows:

Workstream	Objective for 2024/25
PROMS platform	Assess options, build business case for, secure funding for and procure a digital PROMs platform by September 2024
PROMS Questionnaires	Agreement of PROMS tools for site specific teams
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.
Data Driven Sense Making	Publish case studies to promote existing and new Value in Action projects and opportunities.
Data Maturity Group	Mobilise the Data Quality Management Group with particular focus on resolving data quality issues which have an impact on service delivery
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)

The above work takes the phase 1 activity (presented in September 2023) as a foundation and builds on the work undertaken to date. All the above objectives are on track to be delivered.

Benefits: *Focussed resource within the organisation to establish enablers for VBH, bringing together information on Clinical and Patient Reported Outcomes (Quality) and the cost of the resources used to deliver care.*

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.

The programme can demonstrate significant progress in improving the consistency of management of anaemic patients pre-operatively, therefore reducing unwarranted variation in care.

Key deliverables have included the following:
- Individualised Health Board action plans developed for the implementation/optimisation of the pre-operative pathway.
- Co-ordination of an All Wales strategy for pre-operative pathway, to include sharing best practice and benchmarking
- Training content and pathway documentation created on an All Wales basis.
- The National Major Patient Surgery Dashboard has been created, which shows the frequency of pre-operative iron tests and the effects of anaemia for a suite of 10 major procedures.

The progress of the work has gained interest across the UK and internationally.

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, cancer pathways.

The next steps for the programme are:

- To ratify a pre-operative anaemia pathway
- Facilitate a Conference on Anaemia with Blood Health National Oversight Group
- Data stream development to integrate data on use of iron treatment, and on blood transfusions with existing clinical information.

3.3 Velindre Food Mission

The Food Mission intends to 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.

The mission will be presented in March 2024 at the Strategic Development Committee and subsequently the Trust Board. It was developed through a process of workshops with staff across the Trust, a Trust wide staff survey and broader collaboration and feedback from external partners.

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).

By taking a mission-based innovation approach, Velindre can 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 suggested 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

The mission statement is designed to recognise that it may not be possible to source 70% of food within Wales, but that wherever food is being sourced from it is important to consider the impact of how that food was produced, in line with Welsh legislation.

The concept of the Food Mission and its process for development has been presented by the Deputy Director of Finance at a Welsh Government Foundational Economy workshop in January 2024, and to senior executives across the public sector in Wales at Academi Wales' Winter School "Forward Looking Leadership in a Complex World" in February 2024.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to **NOTE** the 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
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
	n/a
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
	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*	Not required - please outline why this is not required
	Not applicable for this report

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

6. RISKS

Not Applicable for this report

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

EDUCATION STRATEGY AUDIT

DATE OF MEETING	14th March 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	Susan Thomas, Deputy Director of W&OD
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	

RECOMMENDATION / ACTIONS	The Committee is asked to **NOTE** the plan to implement the recommendations of the Audit

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

Audit Committee	12/3/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted	

7 LEVELS OF ASSURANCE
N/A
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR

APPENDICES	
Separate attachment	Education Strategy Audit Full report – separate attachment

1. SITUATION/BACKGROUND

An audit to provide assurance over the effective implementation of the Trust's Education Strategy was completed in February 2024.

The Education Strategy was launched in 2019, before becoming fully incorporated into the People Strategy launched during 2022. The People Strategy focuses on maintaining a planned and sustained workforce, with staff training a key element of this.

The audit issued reasonable assurance in line with the recent progress made towards implementing the education aspects of the People Strategy. Whilst the audit noted the numerous deliverables to complete, it recognised that the establishment of the People Development and Education Steering Group has begun to ensure partial reporting is underway and the implementation of some key actions. A follow-up audit was recommended in approximately six months' time

The matters requiring management attention include:
- Robust work plans setting out timescales and responsible officers.
- An evaluation exercise completed by the People Development and Education Steering Group to evaluate the Trust's Strategy implementation and assess whether objectives have been achieved.

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2.   ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

A management action plan has been developed as follows:

An Implementation Plan for the Education Strategy will be developed to reflect actions, timescales and responsible officers. This will be signed off by **Executive Management Board in April.** Monitoring of the plan will be managed by the People Development and Education Steering Group April 2024

An evaluation framework noting key performance indicators (KPI) to assess and monitor the successful implementation of the Education Strategy Plan will be presented to the **People and Development Steering group in June**. On agreement the plan will be monitored by the group. Following each Steering group a highlight report is presented to Executive Management Board, any issues to escalate will be noted there. June 2024

An evaluation exercise, using the agreed evaluation framework, will be undertaken from June to September 2024 and presented to the **People and Development Steering group in September for discussion and next steps. This will be reported back to EMB via the Steering group highlight report Sept 2024**

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*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	
	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 Prosporous 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*	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.

4. 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?	
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	

Education Strategy

Final Internal Audit Report

February 2024

Velindre University NHS Trust

Contents

Review reference:	VT-2324-05
Report status:	Draft
Fieldwork commencement:	23rd November 2023
Fieldwork completion:	20th December 2023
Debrief meeting:	17th January 2024
Draft report issued:	8th February 2024
Management response received:	15th February 2024
Final report issued:	20th February 2024
Auditors:	Simon Cookson, Director of Audit & Assurance
	Emma Rees, Interim Deputy Head of Internal Audit
	Rhian Gard, Audit Manager
Executive sign-off:	Sarah Morley, Executive Director of Workforce & OD
Distribution:	Susan Thomas, Deputy Director of Workforce &OD
Committee:	Audit Committee

Executive Summary

Purpose

To provide assurance over the implementation of the Trust's Education Strategy.

Overview

The Education Strategy was launched in 2019, before becoming fully incorporated into the People Strategy launched during 2022. The People Strategy focuses on maintaining a planned and sustained workforce, with staff training a key element of this.

Whilst we have issued reasonable assurance on this area this is primarily attributed to the recent progress towards implementing the education aspects of the People Strategy. There are still numerous deliverables to complete, particularly with national partnership work. However, we recognise that the establishment of the People Development and Education Steering Group has begun to ensure partial reporting is underway and the implementation of some key actions. In spite of this, concern remains over how the remaining actions will be completed, together with timeframes and responsible officers.

Consequently, we recommend a follow-up audit in approximately six months' time to provide a further assessment over the assurance levels and progress.

The matters requiring management attention include:

- The lack of robust workplans setting out timescales and responsible officers. Whilst work is underway, this is still required for the remaining actions.
- There has been no evaluation exercise completed by the People Development and Education Steering Group to evaluate where the Trust's Strategy implementation is at or whether

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives	Assurance
1 Workplans	Limited
2 Roles and Responsibilities	Reasonable
3 Assurance	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

the objectives have been achieved.

- There is partial reporting taking place, but there is a limited escalation of the position of the deliverables.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Workplans	1	Operation	High
2	Roles and responsibilities	2	Design	Medium
2	Assurance	3	Design	Medium

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1. Introduction

1.1   The review of the Education Strategy was completed in line with the 2023/24 Velindre University NHS Trust (the 'Trust') Internal Audit Plan.

1.2   The Education Strategy was launched in 2019 and just like the People Strategy it is one of a suite of enabling strategies underpinning the Trust's corporate strategy: Destination 2033. The main aim of the Education Strategy is to *"create and maintain an agile workforce in possession of the skills and competencies required to deliver excellence".* The audit reviewed the different components of the strategy and whether they are implemented and embedded throughout the trust.

1.3   The key risks considered in this review were:

- the Trust is not focusing on the right things to support the delivery of the Education Strategy;

- insufficient focus to deliver the strategy appropriately; and

- processes, systems, and procedures do not enable staff to achieve their set roles and the implementation of the strategy.

2. Detailed Audit Findings

Management of the implementation of the organisation's development priorities including;

Objective 1: Workplans with achievable deliverables in place

2.1   The Education Strategy (the 'Strategy') was approved in May 2019 and there was a pause in implementation because of the pandemic. The Strategy does not appear to have been communicated across the Trust but has since been superseded. Following this, the People Strategy as part of the enabling strategies underpinning the Trust Strategy: Destination 2033, was launched in May 2022. Our testing shows key components of the Education Strategy are also included in the People Strategy, and overall, there is a strong linkage between the two.

2.2   From our testing we can see that as part of the approval process in 2018/19 the Executive Management Board (EMB) recommended the need for action plans with timescales of implementation and a mapping exercise on resource requirement to be completed. The Education Strategy refers to deliverables and states *"A detailed action plan to support the delivery of the aspirations set out in this strategy will be developed."* We confirmed these are not yet in place, but there is a draft Education Strategy action plan, which is in the process of being completed. However, this has not yet been finalised. There are no timeframes or responsible officers detailed within the draft action plan. As there are no work plans in place, we are unable to see if the deliverables are on track for delivery.

2.3   The draft action plan details the four components from the Strategy, six actions, seventeen objectives and twenty outputs. From the twenty outputs only eight actions are classed as complete, eight are not completed, one is in progress and

three are on hold. We tested the eight outputs classed as complete and found evidence of five of them being complete. Three of the eight we viewed as still work in progress, rather than complete, contrary to what was stated in the draft action plan. The three outputs refer to Performance Appraisal Development Review (PADR) compliance, review of the policy, and the development of the training plan. However, we did confirm that work has taken place and is still underway, but we did not feel that the actions have yet been fully completed.

2.4   The training plan, dated September 2023, is still an evolving document. Once complete it is intended to provide information on all training, education and development opportunities, both internal and external to the organisation. Currently, it captures a wealth of training available, but does not detail responsible officers or timeframes and a lot of the fields are filled in with "tbc".

The above points are included within **matter arising one.**

Conclusion:

2.5   We confirmed that the Education Strategy has been incorporated into the People Strategy. Furthermore, we identified the recent progress of work to compile a draft action plan and training plan, but there are significant gaps to be completed and updated for them to be specific, measurable, achievable, relevant and timely (SMART). The output and actions of these plans are not yet fully implemented. Therefore, we have provided **limited assurance** for this objective.

Objective 2: Management of the implementation of the organisation's development priorities including roles and responsibilities are clearly defined

2.6   According to the Education Strategy *"its implementation will be overseen by the Education and Training Steering Group which reports to the Executive Management Board".* The Education and Training Steering Group has recently been changed to the People Development and Education Steering Group (the 'Group'). We understand that the Group paused during 2022, when the terms of reference were reviewed. However, since 2023 the Group meets quarterly to discuss education, training, and the implementation of the Strategy.

2.7   Highlight reports are completed and discussed on a quarterly basis, which are also provided to the Executive Management Board (EMB). Action and risk logs are also reviewed at each of the meetings and closed out when they are completed. However, these do not detail any risks concerning the Strategy deliverables not being achieved.

2.8   High level metrics such as statutory and mandatory and PADR compliance are discussed at the meetings as part of the implementation of the Strategy. This information is captured from the Electronic Staff Record (ESR) and shared with the respective divisions when necessary.

2.9   The Medical Education Board provides updates into the Group and representatives from both forums attend respective meetings to ensure there is a joined-up approach across the Trust.

2.10 From a review of the minutes in 2023 and from observing the December 2023 meeting we observed high attendance, from across many different specialities and key workforce staff. Key roles are identified to ensure progress is made. We confirmed discussion on the implementation of the components of the Strategy took place, but not in terms of outstanding actions to ensure the deliverables are implemented.

The above points are included within **matter arising two.**

Conclusion:

2.11 We confirmed key roles and responsibilities are defined in terms of the Group. We also observed discussion on the implementation of components of the Strategy together with the actions and risk logs. However, there is no record of the risks, regarding the Strategy implementation delay. Highlight reports and updates are fed into the EMB for noting and discussion. As there are clear roles and responsibilities and these are working to implement the Strategy, we have therefore provided **reasonable assurance** for this objective.

Objective 3: Management of the implementation of the organisation's development priorities including assurance process is in place to escalate any risks or issues when required

2.12 Assurance is provided through to the Group and then onwards to the EMB. Risks and high-risk areas are discussed at the Group along with the necessary actions to resolve them. When necessary, they are then escalated to the EMB.

2.13 Through the assurance route we can see evidence of highlight reports and updates taken to the EMB. Within these reports the high-risk areas are documented, but we are unable to see if any assurance is provided on the Strategy.

2.14 The highlight reports document the high-level metrics; compliance for statutory and mandatory training, PADR compliance and any competencies with low compliance, along with the internal and external training being delivered across the Trust. For November 2023, PADR compliance stands at 72.21% and statutory and mandatory training is 86.24%. The compliance target is 85%. However, as referenced within audit objective one, there are no other metrics or deliverables currently reported.

The above points are included within **matter arising two.**

Conclusion:

2.15 There is a route of assurance and escalation in place, and we have seen evidence of risks and issues being escalated and discussed at the People Development and Education Steering Group with escalation to the EMB if required. We can see highlight reports being reported detailing compliance on high level metrics, but no escalation on the lack of implementation of the Strategy deliverables. Overall, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Implementation (Operational)	Impact
Whilst we confirmed that elements of the Education Strategy were being implemented, we did not identify any finalised implementation / action plans to ensure all objectives were completed in a timely manner. We found that a recent, high level draft Education Strategy Action Plan (the 'Plan') has been compiled by the Organisational Development Team and is in the process of being implemented, but these actions do not detail timeframes or responsible officers. Within this Plan we tested eight objectives marked as complete but found that three were still in progress. Overall, we were unable to determine if and when the Plan will be fully completed and the objectives of the Strategy embedded.	Potential risk of: • The Strategy is not embedded in a timely manner. • Staff are not developed or trained within their roles.

Recommendations		Priority
1.1	An Implementation Plan will be developed to track the remaining actions to be completed to embed the Strategy. This should also detail all remaining actions, with responsible owners and appropriate timescales. The progress should be closely monitored via the People Development and Education Steering Group.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1	An Implementation Plan for the Education Strategy will be developed to reflect actions, timescales and responsible officers. This will be signed off by Executive Management Board in April. Monitoring of the plan will be managed by the People Development and Education Steering Group	15th April 2024	Susan Thomas Deputy Director of Organisational Development & Workforce

Matter Arising 2: Monitoring and Assurance (Design)	Impact
Roles and responsibilities: The People Development and Education Steering Group formerly known as the Education and Training Steering Group is responsible for the implementation of the Strategy. We observed detailed discussion taking place, however, there is a lack of oversight over remaining deliverables and actions required to embed the Strategy. Furthermore, there has been no evaluation exercise completed to confirm what the Trust has achieved, regarding the Strategy. Assurance: There is partial reporting to the Executive Management Board (EMB) in the form of highlight reports, but there is a lack of escalation over the lack of implementation of the Education Strategy. Whilst we confirmed that progress is underway, status reporting for the remaining actions has not been fully completed since 2019. The lack of progress should be escalated to an appropriate forum / the EMB.	Potential risk of: • The Strategy is not implemented in a timely manner. • Progress is not being tracked and results in delayed action. • A lack of visibility / oversight of current progress.

Recommendations		Priority
2.1	An evaluation exercise should be completed to confirm at what stage the implementation of the Strategy is at and whether the objectives are being achieved. In addition, there should be regular oversight of progress made against the Implementation Plan (once introduced). Where progress is slow, this should be escalated to the Executive Management Board or other appropriate forum.	**Medium**
2.2	The reporting should incorporate key metrics and deliverables and be regularly presented to the People Development and Education Steering Group / the EMB. This should be utilised to assist in determining the stage of progress.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	An evaluation framework noting key performance indicators (KPI) to assess and monitor the successful implementation of the Education Strategy Plan and objectives will be presented to the People and Development Steering group in June. An evaluation exercise, using the agreed evaluation framework, will be undertaken from June to September 2024 and presented to the People and Development Steering group in September for discussion and next steps. On agreement the plan will be monitored by the group. Following each Steering group a highlight report is presented to Executive Management Board, any issues to escalate will be noted there.	September 2024	Susan Thomas

Deputy Director of Organisational Development & Workforce

and

Claire Budgen

Head of Organisational Development |
| 2.2 | The quarterly meetings of the People and Development Steering Group will include progress updates against the plan and will include key metrics and deliverables. This will begin at the September meeting of the Steering Group and reported to EMB via the Steering group highlight report. | September 2024 | Susan Thomas

Deputy Director of Organisational Development & Workforce

and

Claire Budgen

Head of Organisational Development |

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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