Public Quality, Safety & Performance Committee

Tue 16 January 2024, 10:00 - 13:00

Microsoft Teams meeting

Agenda

1. PRESENTATIONS

1.1. Welsh Blood Service - Donor Story

To be led by Andrew Harris, Head of Donor Engagement and Alan Prosser, Director, Welsh Blood Service

1.1.0 WBS Donor Story.pdf (1 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 November 2024

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

2.4.0 DRAFT Minutes - Public Quality Safety and Performance Committee 16th November 2023 (v3).pdf (16 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 Nov-Jan.pdf (6 pages)

2.6. Matters Arising

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

2.6.1. Digital Risk Overview

To be led by Carl Taylor, Chief Digital Officer

2.6.1 20240116 Digital Services Risks QSP.pdf (10 pages)

2.6.2. Freedom of Information Act / Environmental Information Regulation Report Q1-Q3 2023/2024

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

2.6.2 QSPC FOI Report December 2023 V3.pdf (9 pages)

3. MAIN AGENDA

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

3.1. Trust Risk Register

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

3.1.0 TRUST RISK REGISTER - QSPC Jan 24- final.pdf (14 pages)
3.1.0 QSPC Risk Report - Jan 24.pdf (3 pages)

3.1.1. Trust Assurance Framework

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

3.1.1 TAF Paper -QSPC - Jan 24.pdf (8 pages)
3.1.1 Copy of V26- TAF DASHBOARD 2.0 - 12.01.2024.pdf (21 pages)

3.2. Workforce Supply & Shape and Associated Finance Risks

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

3.2.0 Supply and Shape Paper QSP Jan 2024.pdf (15 pages)

3.2.1. Speaking Up Safely Framework – Implementation Update

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

3.2.1 Speaking up Safely - QSP Update Jan 2024Final.pdf (8 pages)

3.2.2. Recruitment and Retention Audit and Action Plan

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

3.2.2 Recruitment & Retention Audit and Action plan QSP Jan 24.pdf (6 pages)
3.2.2b VT2324-04 Recruitment and Retention Final Internal Audit Report_.pdf (14 pages)

3.3. Finance Report for the Period Ended 31st November 2023 (M8)

To be led by Matthew Bunce, Executive Director of Finance

3.3.0a Month 8 Finance Report Cover Paper QSP 16.01.2024.pdf (11 pages)
3.3.0b M8 VELINDRE NHS TRUST FINANCIAL POSITION TO NOVEMBER 2023 QSP 16.01.2024.pdf (26 pages)
3.3.0c Appendix 2 - TCS Programme Board Finance Report (November 2023) - Main Report.pdf (17 pages)

3.4. Quality, Safety and Performance Reports

3.4.1. Welsh Blood Service Quality, Safety & Performance Report

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

Including:

- Summary of Incidents reported to the MHRA since January 2023

3.4.1 WBS Q+S Report August to November 2023 EMB Final.pdf (26 pages)

3.4.2. Trust Performance Management Framework Report and Supporting Analysis for November 2023/24

To be led by Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance

3.4.2 QSP Cttee 16.01.23 NOV PMF Performance Report FINAL version 018a.pdf (69 pages)

BREAK - 10 minutes

3.5. Integrated Quality & Safety Group Highlight Report

To be led by Chris Kelly, Deputy Head of Quality, Safety & Assurance and Tina Jenkins, Interim Deputy Director of Nursing & Quality

Including:

- VCS Patient Administration and Process Improvement Plan

3.5.0a IQSG Highlight report January 2024.pdf (14 pages)
3.5.0b patient information v 0.2 10012024.pdf (18 pages)

3.6. Trust Infection Prevention Management Group Highlight Report

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

3.6.0 QSP IPCMG 16th January 2024.pdf (18 pages)

3.7. Nurse Staffing Levels (Wales) Act Update

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

3.7.0 NSA QSP paper.pdf (13 pages)

3.8. Medical Devices Report

To be led by Peter Richardson, Head of Quality, Safety and Regulatory Compliance, WBS

3.8.0 QSP Medical Devices Annual Report v2.1 16.01.2024.pdf (12 pages)

4. 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. Trust Policies for Approval

4.1.1. Health and Safety Policies

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

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

4.1.1a(i) V&A Policy - QSP Committee Report Jan 24.pdf (8 pages)
4.1.1a(ii) QS15 Management of Violence and Aggression Policy_v8 QSP FOR APPROVAL.pdf (25 pages)
4.1.1b(i) DSE Policy QSP Committee Report Jan 24.pdf (8 pages)
4.1.1b(ii) Safe Use of DSE Policy.pdf (11 pages)
4.1.1c(i) MH Policy - QSP Committee Report Jan 24.pdf (8 pages)
4.1.1c(ii) QS 14 Safer Manual Handling Policy - FOR APPROVAL.pdf (12 pages)
4.1.1d(i) COSHH Policy - QSandP Committee Report Jan 24.pdf (7 pages)
4.1.1d(ii) QS33 Control of Substances Hazardous to Health (COSHH)_v5.0_Sept 23.pdf (16 pages)
4.1.1e(i) Latex Policy QSP Committee Report Jan 24.pdf (7 pages)
4.1.1e(ii) QS09 Policy for the Management of Latex and Latex Allergy_v7.0_Sept 23.pdf (16 pages)

4.1.2. Organisational Development & Workforce Policies

To be 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

4.1.2 Policy Update Paper QSP.pdf (5 pages)
4.1.2a All Wales NHS Dress Code 2020.pdf (9 pages)
4.1.2b Draft - Annual Leave Policy (Agenda for Change).pdf (16 pages)
4.1.2c Draft - Redundancy and Security of Employment.pdf (20 pages)
4.1.2d Draft - Recruitment and Selection Policy.pdf (8 pages)

5. CONSENT ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

6. CONSENT ITEMS FOR NOTING

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

To be led by Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee

6.1.0 RDI Highlight Report.pdf (4 pages)

6.2. Quarterly Information Governance Assurance Report

To be led by Matthew Bunce, Executive Director of Finance

6.2.0 20231213-QSP Quarterly IG Assurance Report -FINAL.pdf (13 pages)

6.3. Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee - 26th October 2023 and 23rd November 2023

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

6.3.0a QSP Highlight Report Public 23.11.2023.pdf (3 pages)
6.3.0b QSP Highlight Report Public 26.10.2023.pdf (5 pages)

7. 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. January 2024 Analysis of triangulated meeting themes

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

7.2. January 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?

7.3. November 2023 Committee Effectiveness: Reflective Evaluation Feedback Report

To be led by Liane Webber, Business Support Officer

7.3.0a QSP Committee Effectiveness Survey Nov 2023 Cover Report_DRAFT.pdf (5 pages)
7.3.0b MESEXP-SurveySummary-W-VUNHST (3).pdf (7 pages)

8. 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

9. ANY OTHER BUSINESS

Prior approval by the Chair required.

10. 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.

WELSH BLOOD SERVICE DONOR STORY

Please visit the link below to view the Donor Story prior to the Quality, Safety & Performance Committee meeting:

https://youtu.be/CoRIzRRIRzo

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 16th November 2023
Time: 10:00 – 13:00
Location: Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
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 Organisational Development & Workforce	SfM
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
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
Emma Stephens	Head of Corporate Governance	ES
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Matthew Lazarus	Research Radiographer	ML
Katrina Febry	Audit Lead, Audit Wales	KF
Mel Findlay	Business Support Officer (for item 3.1.0)	MF
Susan Thomas	Deputy Director of Workforce and Organisational Development	ST
Ruth Alcolado	Medical Director, Corporate Services, NWSSP	RA
Fiona Davies	Head of Safeguarding and Vulnerable Persons	FD
Harriet Ryland (observing)	Senior Strategic Planning Manager	HR

APOLOGIES:		
Steve Ham	Chief Executive Officer	SHam
Cath O'Brien	Chief Operating Officer	COB
Stephen Allen	Regional Director, Llais Cymru	SA

1.0.0	**PRESENTATIONS**	**ACTION**
1.1.0	**Velindre Cancer Service - Patient Story** Led by Matthew Lazarus, Research Radiographer The Committee received an uplifting video interview of a patient who had received the five fraction radiotherapy regime for prostate cancer This approach, has developed over the last few years and, delivers a higher, more targeted radiotherapy, sparing more organs at risk. Patients can receive their treatment five times over ten days, rather 20 times over a four-week period. This has substantial benefits for both the patient and the Trust, as with an average of 30 patients per month, this brings a LINAC saving time of 62½ hours, significantly increasing the capacity to treat further patients. Side effect profiles were also noted to be less than or at least equal to that of previous patients undergoing the more traditional four-week treatment run. The patient described a very positive experience whilst having this treatment. DM advised that she had received correspondence earlier this week from the Health Minister, advising of a letter from a radiography patient who had written to enthuse about the positive experience he had received at the Cancer Service, acknowledging the hard work of the consultants and nursing staff and highlighting how courteous and helpful the reception staff were. It was noted that this is the third such letter that had been received that specifically mentions this.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** Apologies were noted as above.	
2.2.0	**In Attendance** Attendees were noted as above.	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were received.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 14th September 2023** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from the 14th September 2023 Public Committee.	

2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed in detail and Committee members confirmed that they were assured that all actions identified as closed on the action log had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed and will remain open. The following was agreed: ***2.6.1 (14/09/2023) - Further detail with regards to the nature of FOI breaches, action taken and timeliness to be provided to the Committee*** - Following the recent appointment of the new Freedom of Information & Compliance Officer, work on this report will continue at pace and will be circulated to the Committee in due course. ***3.5.0 (14/09/2023) - Claim related to chairs to be reviewed to ensure robust audit process is being followed*** - CJ advised that circa £80K had been identified to carry out replacement of all chairs, commencing with Outpatients and Radiotherapy, anticipated to be completed by the end of March 2024. It was agreed that **this action can therefore be closed.** ***3.6.1 (14/09/2023) - Ensure new 20mph speed limit is taken into consideration with regards to late arrivals for appointment times*** - AP advised that to date no issues have been reported that have led to delays as a result of the new speed restrictions. It was agreed that **this action can therefore be closed.** ***6.1.0 (14/09/2023) - Equality Impact Assessments (EqIA) to be completed prior to policies being presented to the Committee for approval/endorsemen***t - NW advised that significant work has been undertaken and a comprehensive update provided to EMB on 13/11/23. Extra checks and balances are now in place to ensure continued monitoring of the EqIA process prior to presentation to the Committee. It was agreed that **this action can therefore be closed.** ***3.1.0 (13/07/2023) - IMs and Committee members to receive TAF as soon as completed in late July, with a formal return to the Committee in September*** - LF advised that six of the eight revised strategic risks were on the agenda to be received at this meeting. It was agreed that the **action is to remain open until the remaining two risks have been received by the Committee**. ***2.5.0 (14/09/2023) - Committee to receive the outcome of the Risk 2465 audit*** - RH advised that, due to the requirement for several key individuals to support the COVID inquiry, this has led to delays and the report has not yet been completed. Given the timescales this report is to be circulated to the Committee immediately following receipt at Executive Management Board. ***3.1.0 (14/09/2023) - Detailed presentation on progress of Digital risks to be presented to November Committee*** - CJ advised that,	**LF** **Secretariat** **Secretariat** **Secretariat**

	although it was acknowledged that there are currently no digital risks scoring over 15, a full overview of the digital risks given the ongoing triangulated clinical related digital risks the Committee has identified and the manual workarounds on legacy systems, would be provided at the next Committee. ***3.6.2 (14/09/2023) - Committee to have sight of final RAAC report when received*** - CJ advised that although the final RAAC report is still awaited, given the age of the construction it is not anticipated that any of the Trust's buildings will be affected. SH however queried whether there were any additional processes in place around the use of buildings outside of the NHS for blood donor sessions, etc. PR to look further into the matter. DM highlighted that Shared Services have conducted a review for the whole of Wales NHS estate and suggested obtaining a copy of the report to refer to as necessary when delivering services externally.	**CJ** **CJ** **PR**
2.6.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
3.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Risk Register report including a summary of four of the five highest scoring risks was discussed in detail (one risk was private). The risks included staffing levels within Radiotherapy Physics, staffing within Brachytherapy, work-related stress and excessive clinical email traffic. LF assured that significant work had been undertaken to further refine the Risk Register although it was identified that further updating in respect of these four risks is required. The Committee requested that the new theme of administrative processes within the Cancer Service is added into the Risk Register and agreed to receive a comprehensive analysis of the digital risks (all individually scoring under 15) at the next meeting to identify whether there is an overarching higher level digital risk. VM asked that further narrative be included to demonstrate recent actions and progress made as the current view does not provide adequate assurance that mitigating action is being taken. The Committee **NOTED** the risks reported in the Trust Risk Register and requested a number of further enhancements for future reports.	**RH/LF** **LF**

3.1.1	**Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The draft, revised, partially completed Trust Assurance Framework aligned with the Trust's strategic risks was received and discussed. Six of the eight revised strategic risks were described although further refinement is required. The Committee requested further work to align and include the current strategic objectives to enable the Committee to judge that the mitigating actions against the risks would support the delivery of the strategic objectives. The Committee was assured that the gaps in today's sections and the remaining elements of the TAF were being reviewed by the Executive Management Team and would come to the November Trust Board. The Committee highlighted issues with the readability of both the Risk Register and Trust Assurance Framework upon upload to Admincontrol and requested that for future meetings these files also be circulated by email upon publication, although it was acknowledged that the issue will remain when papers are viewed via the Trust website. The Committee: • **NOTED** the on-going developments of the Trust's risk framework. • **REVIEWED** the Strategic Risk Refresh and **NOTED** the next steps.	**LF** **Secretariat**
3.2.0	**Workforce Supply and Shape & Associated Finance Risks** Led by Susan Thomas, Deputy Director of Workforce and Organisational Development The Committee received the report which further outlined the risks to the workforce as highlighted within the Risk Register and detailed the strategic interventions and operational plans put in place to mitigate them. The report also provided an insight into the impact of these actions and the Committee noted the overall downward trend in vacancies, whilst recognising that "hot spots" remain within certain areas. SfM advised that focused work with service leads in these areas continues and further detail regarding these specific areas of concern will be highlighted within the paper at the next meeting. Whilst the benefits of the longer-term arrangements were recognised, the Committee highlighted the importance of ensuring action is taken to mitigate the risks in the short to medium term. The Committee **NOTED** the Workforce Supply and Shape updates and associated financial impacts as outlined within the contents of the report.	
3.2.1	**Anti-Racist Wales Action Plan - Progress Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce	

	An overview of compliance with the Trust's anti-racist action plan was provided. Although progress had been made it was recognised that this is a first report and that much more work is required. The Committee were advised that SfM has been invited to chair the Welsh Government Steering Group on the implementation of the Race Equality Standard, which will provide a rich data source to enable a fuller understanding of the situation across the organisation. It was agreed that the open actions would be transferred onto the Quality and Safety Tracker for ongoing high-level monitoring by the Committee. The Committee **NOTED** the progress in the report.	**SfM**
3.2.2	**Finance Report for the period ended 30th September 2023 (M6)** Led by Matthew Bunce, Executive Director of Finance The month 6 Finance Report was discussed. The report provided assurance that the revenue position remains in line with expectations, with a projected forecast outturn position of breakeven. The following points were highlighted: • Key Performance Indicators show an on-target balance year to date and year-end forecast for revenue and public sector payment. A deficit for Capital due to delays with Financial Close for the new Velindre Cancer Centre project was noted, although this is being mitigated by a request to Welsh Government for funding for the project, with the latest forecast being circa £2.9m. • Long Term Agreement contract income flows from commissioners - where a risk around whether sufficient income would be provided to cover the cost of investments made during COVID had previously been identified, it is now anticipated that, based on the latest forecasted income, these costs will be covered. • All known risks around Digital Health Care Record (DHCR) data capture issues noted within the month 6 report have since been resolved. • NHS Wales deficit - the Trust continues to look to identify further areas to support the financial system in terms of reduced costs. Details of areas already identified and submitted to Welsh Government are noted within the report. The Committee **NOTED** the contents of the September 2023 financial report and in particular the year-end financial performance which at this stage is reporting a breakeven position.	
3.3.0	**Workforce Planning Audit and Action Plan** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the 'Review of Workforce Planning Arrangements' Audit Wales report, and the action plan that had been developed to meet the identified recommendations. SfM advised that	

	a number of the identified actions had already been completed in the months since the audit was conducted. Ongoing management of the audit recommendations and action plan will be conducted through working closely with senior leadership teams with regular reporting to the Executive Management Board and will be tracked via the Audit Committee. The Committee were advised that an internal audit on recruitment and retention has recently been undertaken and higher reasonable assurance has been received. Details of this audit will also be reported to the next Committee. The Committee **NOTED** the audit and action plan in place.	**SfM**
3.4.0 **3.4.1**	**Quality, Safety & Performance Reports** **Velindre Cancer Service Quality & Safety Divisional Report** Led by Rachel Hennessy, Interim Director, Velindre Cancer Services A detailed Quality and Safety report covering the period April 2023 to September 2023 was presented to the Committee and the following key points were noted: • Positive HIW inspection of radiotherapy undertaken. • No avoidable falls reported during the period. • Challenges around service pressures and workforce vacancies remain a recurring theme throughout the report. It was noted that patient feedback via the CIVICA system had signalled patients were dissatisfied with waiting times. Work to refine the question on the CIVICA system is to be undertaken in order to be able to more clearly ascertain the detail around the specific areas of delays, although the Committee were made aware of lengthy waiting times within the Cancer Service as a result of capacity issues. RH advised that work is underway with the site-specific teams to examine the flow of patients through their clinics, as well as looking to identify opportunities to reconfigure services in order to release a number of rooms for use in a clinical capacity. Patient feedback also highlighted an issue around patient-related communications and administrative processes including telephony issues, timely response to voicemail messages, ability to reach the required department, referrals and bookings both from SACT and outpatients. RH provided assurance that some immediate remedial action has been taken to make safe and work is ongoing to address the pathway issues. A clear action plan with target dates will be provided at the next Committee. An issue had been identified where there were delays beyond 30 days with non-urgent post clinic letters being sent out. A harm review has commenced. An initial screening of all has been completed and a further review of 79 has commenced. To date no harm has been	**RH**

	identified. Given the volume this has been reported as a nationally reportable incident. An incident investigation had highlighted the lack of a single electronic referral processes into the Cancer Service. The Committee were advised that a link has been established with Digital Health Care Wales (DHCW) in relation to the national electronic referral system, with opportunities for a system to be in place anticipated for early next year, although an interim solution with the Cancer Network is currently being sought. The Committee **NOTED**: • Performance against the six domains of Quality • Issues, corrective actions and monitoring arrangements in place • Service developments within VCC The Committee **REQUESTED** to see the high-level improvement plan at the next meeting.	**RH**
3.4.2	**Trust Performance Management Framework Report and Supporting Analysis for September 2023/24** Led by Peter Richardson, Head of Quality, Safety & Regulatory Compliance, Deputy Director WBS and Rachel Hennessy, Interim Director, Velindre Cancer Services The Committee received the Trust-wide September 2023 Performance Management Framework report. The following was highlighted: • Blood supply chain remains challenging with a further blue alert experienced at the end of the month. No imports were required although a number of recovery actions were necessary. National trends around blood shortages have been identified and are being further investigated. • Fluctuating performance in serology was noted, this was understood to be largely due to the increasing complexity of cases. However issues around turnaround time for deceased donor matching has highlighted a communication issue with specialist nurses in organ donation and engagement work has commenced to look at providing a much more fluid process. • One reportable event had been submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) around an error in screening for malaria. This was noted to be a widely experienced issue across blood services due to increasing complexities around the geographical Donor Risk Index and work is ongoing at a service and national level to look at potential changes to the donor questionnaire. • Progress in terms of radiotherapy performance was evident. Depressed demand for radiotherapy in August and September was noted, although this was understood to be as a result of the annual leave period, with draft figures for October suggesting further improvement.	

	• A review of the PADR process is to be undertaken to look at creating a more engaging process to meet the Welsh Government target of 85% rather than the current reported 74%. • One MRSA bacteraemia case had been identified. Following a full Root Cause Analysis it was established that the bacteraemia was community acquired and so not contributed to Velindre, although some opportunities for learning had been noted. The Committee received a comprehensive Trust-wide report covering the July 2023 period that highlighted some of the current challenges. Fragility of the workforce was noted as a common theme, although it was understood that this had been exacerbated due to the high number of annual leave days taken during the summer period. 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.	
3.5.0	**Integrated Medium Term Plan 2023-2024**	
3.5.1	**Trust Integrated Medium Term Plan – Progress Against Quarterly Actions for 2023/2024 (Quarter 2)** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital An overall positive report covering the period July-September 2023 was received by the Committee and generally good progress over the last six months for both the Velindre Cancer Service and Welsh Blood Service was noted. The Committee's attention was brought to the two actions with an amber rating: • Implementation of the national Transforming Access to Medicines (TrAMs) Model • Implementation of the approved Full Business Case for the development of the new Velindre Cancer Centre Both of these risks feature highly in the Trust Risk Register given their potential impact. Assurance was sought regarding the delivery of the high number of actions with a yellow progress rating (18 with remedial action plans). The Committee was advised that, with the systems in place and using past performance as an indicator of future performance, reasonable assurance can be given, although a more informed position will be demonstrated to the Committee in the next quarterly report.	

	The Committee **NOTED** the progress made in the delivery of the agreed IMTP (2023-2026) actions as at Quarter 2 for both the Velindre Cancer Service and the Welsh Blood Service.	
3.5.2	**Integrated Medium Term Plan - Accountability Conditions** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital The Committee were advised that the Trust's 2023-2026 IMTP was approved on the 14th September 2023 and the accountability conditions letter was received on the 2nd October 2023. The report set out the key accountability conditions and accountable officer for each condition. The Committee: • **NOTED** the Welsh Government accountability conditions • **APPROVED** the approach for reporting against the Welsh Government conditions	
3.6.0	**Integrated Quality & Safety Group Highlight Report** Led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The comprehensive Integrated Quality and Safety Group Highlight report from the meeting held on the 18th October 2023 was discussed. The focus of discussions included: • Good progress being made in relation to the five Safe Care Collaborative projects. • Work has commenced to determine the 2024/25 Trust Quality priorities within both Divisions. • The new AMaT Quality and Safety Action tracker - The actions had all been transferred over to the AMaT Inspection Module significantly enhancing governance, reporting and transparency. However, assurance could not yet be gained from the tracker that was presented as further work is being undertaken to ensure all action owners can use the system and keep the action status live. In particular, the Brachytherapy improvement actions had not been updated on the system. The Committee noted that although full assurance could not yet be gained from the report, significant strides have been made towards development and implementation of processes and a fuller, clearer picture is anticipated to be presented at the next Committee. The Committee **NOTED** the discussions held at the Integrated Quality & Safety Group in particular: • Integrated Quality & Safety Group Workplan • Safe Care Collaborative Governance Structure • the approach to development of Quality and Safety Action tracker • the approach for revision of Information Governance policies.	

3.7.0	**Quality & Safety Framework & Quality Priorities Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Quality & Safety Framework & Quality Priorities report was discussed. The following was highlighted: • 14 out of the 26 (54%) of the quality framework implementation actions have been delivered. • 2 (8%) will meet agreed timescales • 10 (38%) have needed revised timescales as there have been extended quality and safety team staffing gaps (detailed in the report). The Corporate Quality & Safety Team is now fully resourced. • The key exception was identified as being in relation to the development of the quality and harm measures which required dedicated Business Intelligence support and there had been no trajectory for completion of this work. The Committee **NOTED** the status of the Quality Framework Implementation, the plans to have a peer review undertaken by Hywel Dda University Health Board followed by a refresh of the framework and the plans to develop the 2024/2025 quality priorities.	
3.8.0	**2023-24 Quarter 2 Quality & Safety Report** Led by Tina Jenkins, Deputy Director of Nursing and Patient Experience A comprehensive report covering the period 1st July 2023 to 30th September 2023 was discussed. The triangulation of data this quarter has identified a theme of increasing concerns and incidents relating to patient administrative processes at Velindre Cancer Service. The areas identified where wholescale changes are required relate to: • Referral processes – there needs to be a single electronic referral mechanism into VCS, • Clinical letter approval processes – need to ensure that patients' GPs and patients receive a letter following an appointment within a reasonable timescale (30 days is proposed), and • Booking and appointment processes – a central automated booking process is required. • Patient Communication methods A summary of the findings of a generally positive Welsh Risk Pool audit of compliance with the operationalisation of the Putting Things Right procedures covering current policies, procedures, and practice was provided. There were four areas of substantial assurance: claims, redress, learning from events and reimbursement, one of reasonable assurance: concerns and one of limited assurance: incidents. The Committee were provided with assurance that positive action has been completed to address the areas of deficit in relation mainly to the utilisation of the Datix system.	

	The Committee **NOTED** the Quarter 2 Quality & Safety report and its findings, in particular the emerging trends relating to administrative processes at Velindre Cancer Service.	
3.9.0	**Private Patient Service Improvement Group Highlight Report & Improvement Plan Update** Led by Rachel Hennessy, Interim Director, Velindre Cancer Service and Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The Committee received an update in relation to the Private Patient Improvement Plan and highlights from the Private Patient Improvement Group held on the 30th October 2023. The continuing prevalence of business intelligence support issues was highlighted to alert/escalate to the Committee. Ongoing discussions are taking place with Digital and an interim solution is being sought to facilitate timely and robust billing. The Committee **NOTED** the Private Patient Service Improvement Group Highlight Report & Improvement Plan Update.	
4.0.0	**NHS WALES SHARED SERVICES PARTNERSHIP**	
4.1.0	**Transforming Access to Medicine/Clinical Pharmacy Technical Services Update** Led by Ruth Alcolado, Medical Director, Corporate Services NWSSP A comprehensive report was presented to the Committee. Further detail around the high levels of environmental contamination was sought. The Committee were informed that no further issues had been identified and full assurance had been received from the Infection Control team for Public Health Wales and the Infection Prevention and Control team in relation to actions that were taken and risk reduction mitigations that were implemented. The Committee **NOTED** the contents of the report.	
4.2.0	**Duty of Quality NWSSP Update** Led by Ruth Alcolado, Medical Director, Corporate Services NWSSP A comprehensive report detailing progress of the work undertaken by NWSSP around implementation of the Duty of Quality was presented to the Committee. The report was positively received and significant advancements in always on reporting were noted. The Committee **NOTED** the progress made in implementation of the Duty of Quality.	
5.0.0	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	

5.1.0 **5.1.1**	**Trust Policies and Procedures for Approval** **National Policy on Patient Safety Incident Reporting and Management** Led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The Committee **APPROVED** the implementation of the NHS Wales National Policy on Patient Safety Incident Reporting and Management across Velindre University NHS Trust in replacement of current Trust policy QS01: Incident reporting and investigation.	
5.1.2	**Freedom of Information/Environmental Information Regulations Standard Operating Procedure** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Committee: • **NOTED** the Equality Impact Assessment undertaken for the Freedom of Information Act Policy. • **APPROVED** the revisions to the Freedom of Information Act and Environmental Information Regulations Standard Operating Procedure.	
5.2.0	**Revised Committee Cycle of Business** Led by Emma Stephens, Head of Corporate Governance The Committee **APPROVED** the proposed revisions to the Quality, Safety & Performance Committee Cycle of Business.	
6.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
6.1.0	**Trust Policies for Endorsement**	
6.1.1	**Trust Claims Policy** Led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The Committee **ENDORSED** the revised Claims Management Policy (Clinical Negligence and Personal Injury Litigation): QS04a for onward Trust Board approval.	
6.1.2	**Handling Concerns Policy** Led by Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance The Committee **ENDORSED** the revised version of the Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour):QS03 for onward Trust Board approval.	
6.2.0	**NHS Wales Red Cell Shortage Plan** Led by Alan Prosser, Director, Welsh Blood Service	

	The Committee **ENDORSED** the NHS Wales Red Cell Shortage Plan for onward Trust Board approval.	
7.0.0	**CONSENT ITEMS FOR NOTING**	
7.1.0	**Policy Management Review and Compliance Status: October 2023** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff ***This item was moved from the consent agenda for further discussion*** The Policy Compliance paper identified that 50% of policies were currently past their review date. Assurance was provided by LF that targeted action is being taken to address this. A new Compliance Officer has commenced who will be working with Trust officers to prioritise policy governance, this will also be enhanced through the implementation of the new Trust-wide document management system. Timescales for addressing the work is required for the next meeting. NW highlighted discussions at a previous meeting and queried progress of implementing a robust Trust wide document management system for all Trust and divisional policies, procedures etc. to provide better automated processes and flagging mechanisms. PR advised that the procurement has been signed off and procurement paperwork is awaited. A project team is currently being established to manage implementation. The Committee: • **NOTED** 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. • **NOTED** the Quality, Safety and Performance Committee Policies Extract Compliance Report. • Received **ASSURANCE** that progress is being managed via the Executive Management Board.	
7.2.0	**Patient Nosocomial COVID-19 Update** Led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The Committee **NOTED** the position in relation to patient nosocomial COVID-19 reviews and next steps of the national programme.	
7.3.0	**Safeguarding & Vulnerable Adults Management Group Highlight Report** Led by Fiona Davies, Head of Safeguarding & Vulnerable Persons The Committee **NOTED** the deliberations at the Safeguarding & Vulnerable Adult Group meetings held in July & October 2023.	

7.4.0	**Highlight Report from the Radiation Protection and Medical Exposures Strategic Committee (RPMESC)** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 21st September 2023.	
7.5.0	**Internal Audit Report: Digital Strategy & Transformation Programme** The Committee **NOTED** the contents of the Internal Audit Report.	
7.6.0	**Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee - 21st September 2023** Led by Stephen Harries, Vice Chair & Chair of the Transforming Cancer Services Programme Scrutiny Sub Committee The Committee **NOTED** the Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report - 19th June 2023.	
8.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks).	
8.1.0	**November 2023 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members The Risk Register and Trust Assurance Framework were noted as widely recurring themes, with risks around workforce issues continuing to be highlighted as particular points of concern. Staff sickness continues to contribute to fatigue and burnout amongst many areas of the workforce, and recruitment challenges for core staff vacancies present many operational constraints, particularly in terms of business intelligence capacity. The results of the current staff survey are awaited to give a better understanding of culture and staff feedback and will be discussed in due course. The increasing service pressures at the Cancer Service and the associated impact on all areas of delivery were also identified as an emerging theme. The theme in relation to communication and patient administrative processes at the Cancer Service was highlighted. It was highlighted through a number of papers that further refinement is required in respect of how the seven levels of assurance framework is reflected in the paper templates. It was recognised that further training in respect of this is planned.	

8.2.0	**November 2023 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members The Committee were urged to respond to the CIVICA survey which is circulated to all attendees following the meeting.	
9.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members to identify items to include in the Highlight Report to the Trust Board: • For Escalation • For Assurance • For Advising • For Information	
10.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
11.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **16th January 2024 from 10:00-13:00**	
CLOSE		

QUALITY, SAFETY & PERFORMANCE COMMITTEE - PART A

Minute ref	Action	Action Owner	Progress to Date	Target Date	Status (Open/Closed)
Actions agreed at the 13th July 2023 Committee					
3.1.0	IM's and Committee members to receive TAF as soon as completed in late July, with a formal return to the Committee in September.	Lauren Fear	**Update 09/01/24:** the two remaining risks are being progressed. Update 16/11/23 - 6 of the 8 revised strategic risks presented to Committee - action to remain open until remaining two are received by the Committee. Update on agenda for meeting 14/09/23	31/07/23	OPEN
3.1.0	Risk 3001 - impact of actions and interventions taken towards staff wellbeing to be provided to the Committee	Sarah Morley	**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	OPEN
9.1.0	Trust Annual report template to be developed and Trust style determined to facilitate consistency for future annual reports	Emma Stephens	**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	OPEN
Actions agreed at the 14th September 2023 Committee					

2.5.0	Committee to receive the outcome of the Risk 2465 audit	Rachel Hennessy	**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	14/03/24	OPEN
2.6.1	Further detail with regards to the nature of FOI breaches, action taken and timeliness to be provided to the Committee	Lauren Fear	**Update 08/01/24:** Report on agenda for January meeting. Update 16/11/23 - FOI & Compliance Officer now in place, work to be completed and provided at next meeting.	16/01/24	CLOSED
2.6.2	Outcome of CCTV system audit to be circulated to the Committee	Rachel Hennessy	**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	OPEN

			Update: 23/10/23 - CCTV audit and action plan to be considered by SLT 9/11/23		
2.6.2	Fuller Inquiry report to be reviewed to ensure compliance with proposed nVCC facilities	Carl James	The mortuary area plans have been reviewed. If the below is actioned through stage 4/RDD then the Trust will be compliant: • Room 01.CM.014-3 Lift Lobby 3 and Room 01.CM.014-5 Lift Lobby 5 both need static CCTV • Room 01.MO.001 need a door and Secure access system to secure the waiting area to prevent access to waiting area and viewing rooms / prevents accidental wandering into sensitive area • Room 01.MO006 move CCTV from this room for dignity reasons to Bier Room 01.MO005 Room 01.MO.006 move PTZ to 01.MO.004 above desk and change to static camera In addition to the above the car park area is needed to be redesigned to allow privacy when undertakers arrive, again this needs to be actioned at stage 4/RDD	16/11/23	CLOSED

3.1.0	Detailed presentation on progress of Digital risks to be presented to November Committee	Carl James	Digital risks analysis will be presented during the January Quality Safety and Performance Committee.	~~16/11/23~~ 16/01/23	CLOSED
3.5.0	Review - Health & Safety Risk Register risks over 15 not currently included within Trust Risk Register	Carl James	All Health & Safety Risks have been reviewed.	16/11/23	CLOSED
3.6.2	Committee to have sight of final RAAC report when received	Carl James	**Update 09/01/24:** Arup will conduct the final three visits week commencing: 11th December. Once these have been completed all inspections have been undertaken. The final report will be produced to complete the full RAAC review. Once CJ has received the report this will be circulated to the Quality, Safety and Performance Committee.	16/01/24	OPEN
3.10.0	Validation of mortality data to be completed	Dr Jacinta Abraham	**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	01/02/24	OPEN

			of mortality data is planned for 24/11/23		
Actions agreed at the 16th November 2023 Committee					
2.5.0	Presence of RAAC in 3rd party buildings used for blood collection - WBS to confirm that 1) all 3rd party venues have been assessed for the presence of RAAC, 2) where the presence of RAAC is established, that an appropriate risk assessment has been documented before any further donation clinics are arranged.	Peter Richardson	The Head of Planning and performance has confirmed that WBS have requested this information from all venues currently used for collection and now include these checks to all new venue Risk Assessments Completed assessments: 35 (1 location does contain RAAC and has been suspended as a collection venue). Progressing the remaining 45 venues, plus a further 57 potential new venues, with expert support from the WBS Health, Safety & Environmental Compliance Manager. A project plan has been developed and it is anticipated that work with the existing venues will continue throughout Qtr 4 2023/24 at which point a further progress update will be provided.	21/12/23	CLOSED
2.5.0	CJ to obtain a copy of the RAAC report conducted by NWSSP on the Welsh NHS estate	Carl James	RAAC report was undertaken through Arup architects following recommendations from Stuart Douglas, NWSSP. Report findings no RAAC present in any Trust buildings in VUNHST.	16/01/24	CLOSED
3.5.1	CJ to confirm that amber risks within the IMTP are sufficiently set out within the	Carl James	**Update 09/01/24:** The Trust is currently updating its IMTP. As part of	31/03/24	OPEN

	TAF		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.		

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Digital Risks Overview

DATE OF MEETING	16/01/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	David Mason-Hawes | Head of Digital Delivery
PRESENTED BY	Carl Taylor | Chief Digital Officer
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Digital Services team are responsible for the management of a range of strategic, operational and project/programme risks. This paper sets out the key themes and challenges associated with those risks and work being undertaken within the Digital Services team to ensure their effective management. The current risk management approach in respect of those risks follows the Trust wide risk management processes with assurance through regular review and audit work.

	Digital Risk is one of the key risks in the Trust Assurance Framework (Risk 05), with overall risk rating 12 (significant – likelihood 3 x impact 4) with effectiveness rated as 'partial effectiveness'. Of the controls in place for the 14 individual risks captured within the risk assessment, 5 are rated as 'effective'; the remaining 9 risks are rated as 'partial effectiveness'. There are 21 digital operational risks with 15 rated at significant. There are currently 37 digital risks across the various change programmes being led or supported by the Digital Services team. 3 of those have a current risk rating of 'critical' (in the ePMA, BECS and WHAIS IT projects). A further 14 are scored as 'significant'. However, there remain several areas where further investment and more effective organisational prioritisation, governance etc. is required to ensure current risks are effectively mitigated. These will form part of an implementation plan for the Digital Strategy published in Dec '23. The report is presented to QSP to provide **assurance** in respect of the management of this portfolio of digital risks.

RECOMMENDATION / ACTIONS	Following its publication in Dec '23, an agreed plan that supports implementation and addresses the risks in this paper needs to be created which can then also feed into the Integrated Medium Term Plan (IMTP). This is intended to be reviewed by EMB in Feb '24 and can then return to the Board sub-committees for further assurance.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (Run)	**02/01/2024**

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The risks presented were reviewed for assurance and it was agreed to create an implementation plan for the Digital Strategy that also covered work to mitigate the thematic digital risks.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended

APPENDICES	

1. SITUATION

The Digital Services team are responsible for the management of a range of strategic, operational and project/programme risks. This paper sets out the key themes and challenges associated with those risks and work being undertaken within the Digital Services team to ensure their effective management.

The report is presented to QSP to provide **assurance** in respect of the management of this portfolio of digital risks.

2. BACKGROUND

2.1 Strategic Risks - TAF 05

The Trust Assurance Framework (TAF – risk 5) sets out a range of risks relating to the failure to deliver the aims and objectives of the Digital Strategy, published in December 2023.

The overall risk rating for TAF05 is '12' (significant – likelihood 3 x impact 4). The overall level of effectiveness is rated as 'partial effectiveness'.

Of the controls in place for the 14 individual risks captured within the risk assessment, 5 are rated as 'effective'; the remaining 9 risks are rated as 'partial effectiveness'.

Open actions are captured within the assessment, relating to the intention to: continue the establishment of the Digital Programme; creating the Trust Digital Reference Architecture; approving the digital inclusion plan; continuing to embed cyber security; and identifying benchmarks for digital services.

2.2 Operational (Delivery) Risks

The Digital Delivery team manage a range of operational risks pertaining to the day-to-day operations and the use of Trust digital systems. These are managed by the Digital Delivery team.

There are currently 21 active (open) risks on the operational digital services risk register.

The current breakdown of risks based on 'current' risk rating/score is:

Risk Rating	***No. of Risks***
Significant	15
Moderate	3
Low	3
Grand Total	**21**

The highest scored risks (#2651 and #92) are currently scored as '12' (significant) – all risks are up to date in terms of risk reviews. Where risks have

actions associated with them as part of the risk 'treatment', these are captured within the detail of each risk. The highest scored risks relate to commercial arrangements for the Blood Establishment Computer System (BECS) in WBS (#2651) and procurement/supply chain challenges (#92).

2.3 Project / Programme Risks

The Digital Programmes team are currently accountable for the delivery and/or management of digital risks within the following major digital transformation projects:

- Welsh Blood Service (WBS) – Futures – Digital Modernisation
    - Blood Establishment Computer System (BECS)
    - Welsh Histocompatibility & Immunogenetics Service IT (WHAIS IT) system
    - Laboratory Information Management System 2.0 (LIMS2.0)
- Velindre Cancer Service (VCS) - Futures
    - Radiology Information System Programme (RISP)
    - Electronic Prescribing and Medicines Administration (ePMA)
    - Integrated Radiotherapy Solution (IRS)
    - Radiotherapy Satellite Centre (RSC)

There are currently 37 digital risks across the various change programmes being led or supported by the Digital Services team. 3 of those have a current risk rating of 'critical' (in the ePMA, BECS and WHAIS IT projects). A further 14 are scored as 'significant'.

Work to formally close Phase 1 of the Digital Health & Care Record (DHCR) project in VCC is almost complete. Any risks that will remain open following the closure of the project have been handed over to the operational service to manage via the DHCR Operational Group. Where required, the Digital Services and Data & Insight team support their management – e.g. resolution of data quality issues, revision to ways of working / data entry, staff training etc.

3. ASSESSMENT

3.1 Strategic Risks - TAF 05

The areas where effectiveness is rated as 'partial' cover areas such as:

- Trust funding for digital (target 4%)
- Digital prioritisation and governance
- Workforce capability (training, digital literacy)
- Digital Inclusion
- Legacy applications and digital infrastructure
- Cyber security assurance

Governance for the Digital Programme is in the process of being established. The Digital Programme Board is now operational and has met twice, with plans

to establish a Digital Design Authority in early 2024. In combination, this will ensure more effective oversight of the prioritisation and delivery of the range of projects that underpin the delivery of the Digital Strategy.

Work to address the operational challenges above are set out below (section 3.2). Work is ongoing to improve workforce capability and embed digital inclusion into project and service delivery, with a view to establishing achievable plans in early 2024.

Whilst there have been marked improvements in Trust funding for digital services capability and capacity over recent years – for example, investment has been made to ensure a number of previously fixed term roles could be established permanently within the team to ensure service continuity and resilience – current investment falls below the target 4% of Trust expenditure regarded as a benchmark for high-performing, digitally capable organisations. Further investment will be identified through an implementation plan for the Digital Strategy. It is noted that a number of major change programmes, such as nVCC, RSC, IRS etc., are providing a mixture of fixed-term and permanent funding, to help mitigate this risk.

Looking ahead, it is anticipated that the risk landscape over coming years is likely to become more challenging. There is significant uncertainty in respect of the national financial position and the challenges posed by the transition of digital services from a capital to revenue funding model. Capacity constraints within the service are also likely to create a challenge in delivering the Trust's digital ambitions.

3.2 Operational (Delivery) Risks

Of the 21 risks, 9 relate to the risk of a cyber security breach due to the ongoing use of legacy IT infrastructure and services. The risk impact score of all these risks is '5', to reflect the potential impact on operational services and patient/donor care should a breach occur. However, the likelihood of those risks occurring is rated as 'unlikely' due to a range of mitigations and cyber security that the team have put in place. These are supported by national 'boundary' protections that are in managed by Digital Health & Care Wales (DHCW).

From July 2022 to December 2023, the Trust was without any dedicated cyber security lead following the departure of the previous Cyber Security Officer. This role has now been filled; however, the challenge in recruiting to this role in a hyper-competitive market, coupled with the fact that the team currently only has 1 dedicated, full-time cyber security role, highlights a resilience challenge that is still to be addressed. Following the successful recruitment of the Cyber Security Manager in December 2023, the team are confident that in the short term, further improvements will be made in respect of the delivery of the Cyber Security Strategic Plan – progress on this is assured by the Quality, Safety & Performance Committee.

The ongoing use of legacy / end of life IT infrastructure remains a challenge. As well as being a contributory factor to the Trust's cyber security posture, this also

increases costs and constrains to develop a more modern digital architecture to underpin service delivery. The cost and complexity of addressing these issues remains a challenge and, in some cases, the ability of the Trust to permanently resolve such issues is dependent on 3rd party suppliers.

Capacity & capability within the Digital Services team and the wider workforce remains a factor across a number of risks, impacting on the ability of the Trust to meet the demand for digital change across the Trust. It is anticipated that this challenge will exacerbate over coming years. Investment into both the Digital Services team and the operational service is required to ensure the digital transformation agenda can be delivered and will form part of the implementation plan for the digital strategy.

Supply chain management – supplier management, contract management etc. – is ineffective, in part due to capacity within the team to effectively execute this aspect of the service. Furthermore, inconsistent procurement advice is creating an environment where the delivery of the required internal governance (e.g. Trust Board review/sign-off) for new procurements is compromised.

Although recognised as a 'tolerated' risk, it is noted that there remains a developing challenge around the trend for the migration of charging for digital services from a capital to revenue model with the move to cloud-based services. This is an all-Wales challenge, as services previously funded as one-off capital payments now move to a subscription-based revenue model. We have developed a draft Trust Infrastructure Strategy to set out our principles and plans in this area which is under review by the Digital Programme Board.

3.3 Project / Programme Risks

For digital risks across the major digital change programmes being overseen or supported by the Digital Services team, of the higher-scoring risks (i.e. 12 and above) a common theme can be observed in terms of the challenges faced across those project – i.e.

- Workforce (both digital and service-side) capacity.
- Insufficient or unconfirmed funding routes.
- The need to address known (non business-critical) 'gaps' in system functionality in respect of new 3rd party digital systems being procured and implemented.

All risks have project controls and actions in place to address those risks. However, confidence in the ability of the service to fully mitigate those risks is yet to be fully realised. As an example, the funding route to ensure delivery of the BECS programme is yet to be identified.

The highest scoring risk relates to the availability of dedicated 'digital pharmacist' resource to support the delivery of electronic prescribing and medicines management (ePMA) – the appointment into a full-time post was successful week commencing 18th December 2023, so it is anticipated that this risk will be reduced when it is next reviewed.

Although not yet established as a formal project, formative discussions are underway to ensure the delivery of a new **SACT e-Prescribing** service into VCC. The current contract runs until October 2024 and a national position on future contract options is being established by Shared Services.

4. SUMMARY OF MATTERS FOR CONSIDERATION

This report is presented to QSP to provide assurance that current mechanisms for managing digital risks are in line with Trust wide approaches and that digital risks are well understood across the Trust.

The Board are asked to consider:

- Whether the current iteration of the Trust Assurance Framework (risk 05 – digital) correctly reflects the breadth of strategic, operational and project/programme risks outlined in this paper.

- The risk landscape for digital in relation to the assessment provided in this paper and emerging themes.

- The development of an implementation plan for the digital strategy that will seek to further address the risks and identify further investment opportunities for Trust Digital Services.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	07 - Digital Transformation - Failure to Embrace New Technology

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risks summarised in this report cover all quality & safety domains.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Report is an update on current active digital risks – a socio economic assessment does not apply in the context of this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The Trust faces a range of funding challenges across the various digital projects and

	programmes, as well as operational digital service delivery. Local and national funding is required to ensure effective delivery of the digital transformation programme – in some cases, this funding is already in place; however, a number of essential works identified within current IMTP discussions remain unfunded. **Type of Funding:** Revenue and Capital Funding
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
	Report is an update on current active digital risks – an equality impact assessment does not apply in the context of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Various – see body of report
WHAT IS THE CURRENT RISK SCORE	Various – see body of report
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	See body of report
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Various – see body of report
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	See body of report
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FREEDOM OF INFORMATION ACT / ENVIRONMENTAL INFORMATION REGULATION REPORT Q1-Q3 2023/2024

DATE OF MEETING	16th January 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 assurance on the compliance with the Freedom of Information Act and Environmental Information Regulations for Q1-Q3 2023 and the improvement in compliance since the appointment of a permanent Freedom of Information and Compliance Officer. The percentage of compliance has risen by **3.26%** Q2 to Q3, which is a **3.47%** increase on Q1. We finish Q3 with a compliant response rate of **73.75%** which, whilst below target of 80%, has been achieved despite capacity challenges up to November 2023.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **REVIEW** the level of compliance from Q1-Q3 and the improvement in compliance since the appointment of a new, permanent Freedom of Information Officer • **NOTE** the level of **ASSURANCE** in relation to the Trust's compliance with the Freedom of Information Act and Environmental Information Regulations.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	02/01/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board:

- **REVIEWED** the level of compliance from Q1-Q3 and the improvement in compliance since the appointment of a new, permanent Freedom of Information Officer
- **NOTED** the level of **ASSURANCE** in relation to the Trust's compliance with the Freedom of Information Act and Environmental Information Regulations.
- **ENDORSED** the **Freedom of Information Act / Environmental Information Regulation Report** for submission to the January 2024 Quality, Safety and Performance Committee.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

ACRONYMS	
EIR	Environmental Information Regulations 2005
FCO	Freedom of Information and Compliance Officer
FOIA	Freedom of Information Act 2000
GDPR	General Data Protection Regulation
HOIG	Head of Information Governance

1. SITUATION

1.1 The purpose of this report is to provide **ASSURANCE** about the way Velindre University NHS Trust (Trust) manages requests made to it under the Freedom of Information Act (FOIA) and Environmental Information Regulations (EIR), and the continuing progress that has been made in regard to compliance with the Act and Regulations.

1.2 A permanent Freedom of Information and Compliance Officer (FCO) was appointed at the end of September 2023, with the handover from Information Governance back to Corporate Governance being completed at the end of October 2023.

1.3 The Quality, Safety and Performance Committee is asked to:

- **REVIEW** the level of compliance from Q1-Q3 and the improvement in compliance since the appointment of a new, permanent Freedom of Information Officer
- **NOTE** the level of **ASSURANCE** in relation to the Trust's compliance with the Freedom of Information Act and Environmental Information Regulations.

2. BACKGROUND

2.1 All NHS Bodies in Wales must ensure organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (2018), General Data Protection Regulation (GDPR), Freedom of Information Act (2000) and Environmental Information Regulations (2004).

2.2 Velindre University NHS Trust is committed to ensuring that it meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

2.3 A Freedom of Information Stewards' Network has been established within the Trust which comprises key members of staff who are able to identify within divisions or directorates information to support FOI responses.

3. ASSESSMENT

3.1 FOI Responses

The Trust has received **158** FOIA requests and **2** EIR requests in this period, of which **118** (73.75%) were responded to compliantly (or not yet responded to but are within the FOIA timescales) and **42** (26.25%) were in breach of FOIA timescales.

In relation to the provision of **ASSURANCE**, the FOIA/EIR data and analysis from 1st April 2023 to 31st December 2023 is shown in full below:

Month	Total	Compliant	Breached	% Compliant
April	14	12	2	85.71%
May	19	11	8	57.89%
June	14	11	3	78.57%
July	23	19	4	82.61%
August	15	13	2	86.67%
September	13	5	8	38.46%
October	20	9	11	45.00%
November	21	17	4	80.95%
December	21	21	0	100%

3.2 Source of Requests

Between 1st April 2023 and 31st December 2023, **158** FOIA requests and **2** EIR requests have been received. The source of these requests is as follows:

Individual/Unknown	51
Campaigner	47
Group, Association, Chartered Society	13
Recruitment	6
Education	5
Marketing	28
Media	5
MP	1
Other NHS Organisation	1
Pharmaceutical Company	1
Plaid Cymru	2

3.3 Subjects of Requests

Request Not Applicable to the Trust	34
Request Not Applicable to the Trust – transfer/refer	4
IT & Digital	24
Corporate	17
Finance	11
Review	5
VCC - Medical/Drugs/Stats	41
WIBSS	4
WBS	2
Workforce	18

3.4 **Exemptions Applied**

The Freedom of Information Act contains a number of exemptions that allow organisations to withhold information from a requester. In some cases, these will also allow the Trust to refuse to confirm or deny whether the information is held by the organisation.

52 exemptions were applied to the **118** responses closed during this reporting period, with some responses having more than one exemption applied.

Exemption	**Number of times applied**
Section 1 (not recorded)	5
Section 8 (request not formulated correctly)	2
Section 12 (exceeds cost limit)	19
Section 14 (vexatious or repeated request)	4
Section 21 (information accessible by other means)	3
Section 31 (prevention/detection of crime)	3
Section 40 (personal information)	21
Section 43 (protection of commercial interests)	1

3.5 **Reason for Breach**

It is the Trust's policy to respond to all FOI/EIR requests, regardless of their complexity, even where this may mean that the information is delayed. Where there is likely to be a delay in providing a response to requests, FCO liaises with the requester to ensure they are aware of the possibility of a delay and to agree a revised timescale for response. Where there are complex requests, and where the information is required from multiple disciplines, it is not always possible to provide the information within the 20-day timescale.

There are currently two requests that are in breach. These are complex EIR requests. The division responded on 22nd December 2023 noting the information is likely to be commercially sensitive. The FOC has taken advice from HOIG and will undertake a balancing exercise in line with the public interest test within the EIR. It is anticipated the response will be sent in the first half of January 2024.

As will be confirmed in the Information Governance Report, the periods where FOIA compliance were the lowest, coincide with imminent deadlines for the COVID Inquiry, which took precedent. This in turn has impacted the quarterly compliance percentage however, it is worth noting that there is a marked increase in the individual months of November and December 2023 where the FCO has been in place.

The dedicated resource for FOI in the Trust will also ensure that the Publication Scheme can be a 'live document'. In the future the FCO will play an active role in training and awareness raising of FOI across the organisation. Linked to this work is liaison with the Communications Team to expand and promote the routine publication of appropriate information across the Trust. The Trust also maintains a Disclosure Log of all previous FOI requests which also assists in directing requesters to previously published information.

3.6 **Requests for Review**

There have been **5** requests for review since April 2023. The status of each is provided below:

1) The open request for review is in response to a S12 exemption (cost of compliance exceeds the limit). The HOIG is liaising with other Health Boards for a unified response.

2) A review was requested as other public bodies were providing the information. Whilst the request for review was outside of the deadline, the Trust did investigate and respond, upholding the majority of its original response; S.31(1) (prevention and detection of crime), S.14(2) (repeated request), S.40(2) (personal data). However, the Trust did provide some data, which was the same as a previous response now over 12 months prior.

3) A review was requested following a Section 43 exemption being applied (protecting commercial interests), however it was found that the information was already publicly available in a report and therefore the information was disclosed.

4) The request was originally refused as the requestor did not formulate the request correctly (under Section 8). The review was undertaken despite being out of the time limit, and upheld this decision as well as applying Section 14 (vexatious request)

5) A requestor was advised in the original response that the Trust would not be responding as this was being reviewed by Welsh Government. The request to review was withdrawn 7 days later.

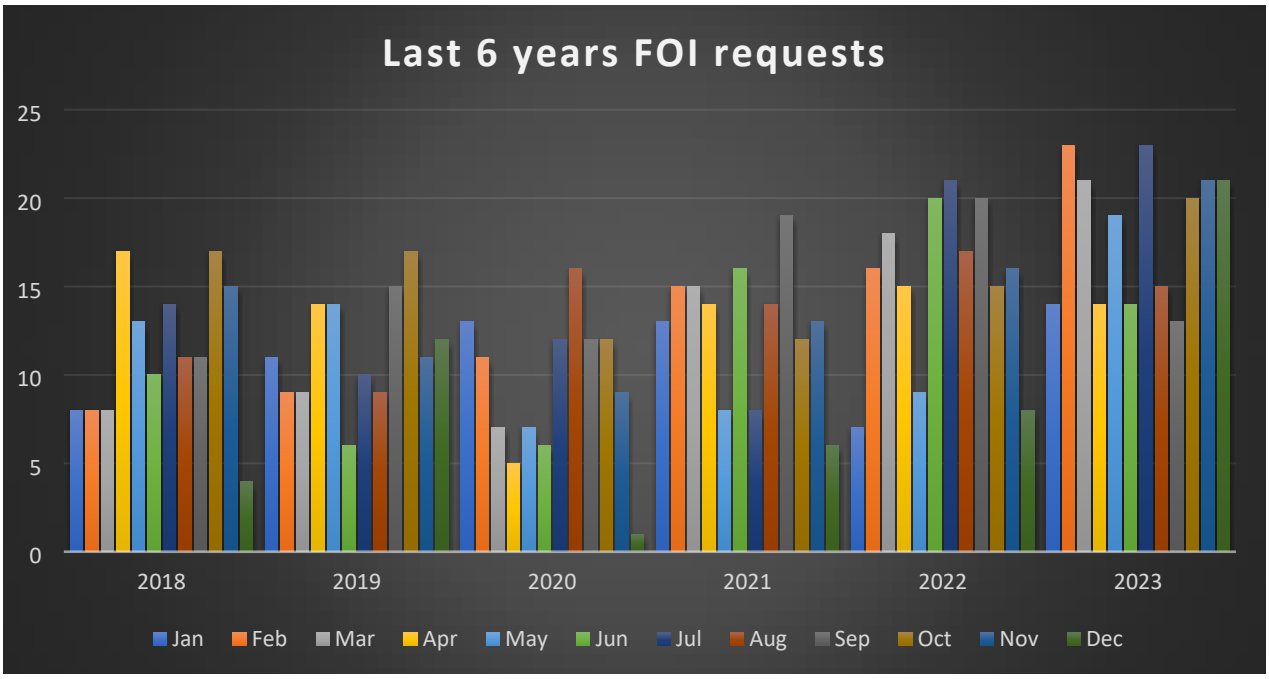
4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Following the departure of the Trust's FOI Officer in Mid-December 2022, the FOI/EIR requests were temporarily undertaken by the Trust's Archivist alongside their other work with the COVID-19 Inquiry. This was overseen by the Head of Information Governance (HOIG).

4.2 A permanent FOI Officer came into post at the end of September 2023, with the handover of FOI/EIR requests from Information Governance to Corporate Governance completing at the end of October 2023.

4.3 The volume of FOI/EIR requests to the Trust is rising. In the 2023 calendar year, **218** requests have been received, compared to **182** in 2022 and **153** in 2021. This coupled with not having a dedicated FOI Officer throughout the majority of 2023, has resulted in not meeting the target of 80% compliant response rate.

4.4 The table below highlights the requests received month on month, per calendar year from 2018 to 2023.



4.5 The percentage of compliance has risen by **3.26%** Q2 to Q3, which is a **3.47%** increase on Q1. We finish Q3 with a compliant response rate of **73.75%** which, whilst below target of 80%, has been achieved despite capacity challenges up to November 2023.

4.6 A Freedom of Information Stewards' Network has been established which comprises key members of staff who are able to identify within divisions or directorates information to support FOI responses. The Wales-wide Community of Practice network also provides invaluable support and advice to ensure that requests received by all Trusts/Health Boards are responded to in a similar manner.

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 thorough and clear framework for the management of FOIA and EIR requests is essential to ensuring Trust wide compliance. The Trust has recently revised and strengthened the FOI/EIR Standard Operating Procedure (SOP).
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	IG08 Freedom of Information Act Policy has an associated EIA
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

6.1 Now that a permanent FOI Officer is in post, a continual review cycle will be undertaken to ensure compliance with the FOIA/EIR timescales.

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	16.1.2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	LAUREN FEAR, DIRECTOR OF GOVERNANCE AND CHIEF OF STAFF
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Note the on-going development activity and status of these actions. • The structure of the report has been developed further since the last Quality Safety and Performance Committee and

	responds to feedback from this and other governance fora, as explained in section 4.

RECOMMENDATION / ACTIONS	The Committee is asked to: • **NOTE** 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. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board	2.1.2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

1. The **Quality Safety and Performance Committee** and **Trust Board** in November considered the October version of the Risk Register. The Trust Board also noted the development activities listed in section 4.

2. Executive Management Board reviewed the November version in meeting 4th December, and following further scrutiny with VCS Senior Leadership Team, the updates were made and included in the December 19th **Audit Committee**.

3. This extract is from December and has been considered by Executive Management Board for reporting to **Quality Safety and Performance Committee and Trust Board** in January.

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR			2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.				

APPENDICES	
1	Current risk register data.

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 7 risks to report to Board and Committee on Datix 14, this includes 4 risks with a current score over 15 and 3 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes since December reporting:

3.2 Risks which were proposed to be closed/ no longer at Board risk appetite reporting levels - and outcome of Executive Management Board consideration

- **3184 – Risk closed - Executive Management Board confirmed agreement with proposal to close:**

  "There is a risk to Velindre Cancer Centre as a result of no Lead Digital Pharmacist in post, resulting in multiple risks for Velindre Cancer Centre and the Trust."

  January reporting update: *Appointment made and in post.*

- **3222 – Risk closed - Executive Management Board confirmed agreement with proposal to close:**

  "There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of the Trust."

  January reporting update: *Appointment made and in post.*

- **3215 – Risk was proposed to be closed, however Executive Management Board requested further assurance of compliance with all required standards before it could be closed. Therefore remaining open until this assurance is received.**

  "There is a risk that clinical instruction or information may not be received or acted on by primary or secondary care medical colleagues for patient management due to clinical correspondence not being signed off via the Document Management System (DMS)."

  December reporting update: Review of letters complete. Escalation process in place. Harm review completed and no harm identified.

  In addition, at the December 19th Audit Committee, it was requested by the Chair of Quality, Safety & Performance Committee that the action plan from the incident be brought to Quality, Safety & Performance Committee, to include clear assurance that this would not be repeated.

  Propose to include on March Quality, Safety & Performance Committee agenda and to March Executive Management Board in advance.

3.3. <u>Risks which Executive Management Board accepted as appropriate that score not changed during this reporting period:</u>

- **3001 – Risk score remains at 12, as a result of action being taken and external environment continuing to be challenging**

  "There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust

sickness absence figures show mental health issues and stress to be the highest cause of absence from work."

Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12.

- **3230 – Risk score remains at 12, expected reduction in January as a result of actions taken**

  "There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care."

  December reporting update: New short-term central management of new patient referrals agreed and will be implemented by end January 2024.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12 until new process implemented by end January as documented. Executive Management Board also requested that the process would need to be fully evaluated, with assurance being presented to Executive Management Board, before the risk could be proposed to close.

- **2465 – Good progress made and risk score will start to reduce as actions implemented during 2024**

  "There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information."

  December reporting update: Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft Integrated Medium Term Plan 2046-27.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12 until new actions implemented during 2024 and begin to

have an impact on risk score and this will be considered each reporting period in line with progress.

- **3227 – Risk expected to decrease in line with progress to Financial Close**

  "new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs."

  December reporting update: This risk is expected to decrease in score in next reporting period due to good progress made to Financial Close requirements.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 16 until publically reportable (as appropriate with live procurement) governance leading up to Financial Close.

- **3153 – Risk score currently remains at 15, expected reduction in January reporting cycle as a result of actions taken**

  "There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm."

  December reporting update: Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised. Confirmed on 7/1/24 that exclusions to real time scanning have been applied in line with requirements from the manufacturer of the medical device. This is now therefore expected to go through January Senior Leadership governance and propose to be closed/ score reduced for February Executive Management Board consideration (and onwards reporting to Quality, Safety & Performance Committee in March).

3.5 Risks which Executive Management Board requested further review

- **Risks 2187 and 2515 – both at score 15 – Executive Management Board in December requested further review at February Executive Management Board**

  2187 – *"There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks."*

  2515 – *"There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service."*

  Velindre Cancer Services team will ensure Datix updated to ensure clear update to evidence risk being actively managed. The Team advised that the Velindre Cancer Services Senior Leadership Team discuss regularly and currently there has not been sufficient progress which would reduce risk scores.

4. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

Matters 1 – 7 were reported to the Trust Board on 30th November.

Matters 8 and 9 were recommended from the Trust Risk Group and supported by Executive Management Board in December.

Matter 10 was raised at December Audit Committee.

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status to report in January reporting cycle
1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team work, a number of scores were	December- January reporting cycle	**Propose to Close** – updated in December Audit Committee and in this paper for January reporting cycle

		challenged and are being reassessed through the December-January cycle		
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee	**Propose to Close** – On January Quality, Safety & Performance Committee agenda
3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	December- January reporting cycle	**Propose to close:** No further risks proposed by SLT following consideration
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December- January reporting cycle	**Propose to close** – addressed in TAF 03
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper	**Propose to close** – cover paper style re-vamped and positive feedback in December Audit Committee
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety & Performance Committee	Addressed in this paper	**Propose to close**
7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores being reduced however not yet	December- January reporting cycle	**Propose to close** – Audit Committee confirmed that due to progress made in

		evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.		December reporting cycle that Assurance Level could remain at 2
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	Current risks have been reviewed against the previous report. There are no risks which have reduced to a level below that reportable to Trust Board.	**Propose to close** – now included in re-vamped style of cover paper
Recommendations from Trust Risk Group				
8	Review of risk domains – particular concern with respect to Clinical safety being clearly part of Quality domain on Datix	Review of Policy by Trust Risk Team, including this. Data pull for Quality and Safety domains during December – (to report on in January) – to review categorisation	March (for Trust Board approval) March	Deep dive work underway for March cycle reporting.

9	When risks first loaded onto Datix, inherent risks reported above risk appetite levels – for assurance on effectiveness of controls	To action for March reporting cycle	March reporting cycle	Process discussed with Risk Group to be implemented for March Board cycle reporting
Requested by December Audit Committee				
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	March reporting cycle	

Next Steps in Engagement and Embedding

As of 21st December 2023 an Introduction to Risk training has a completion rate of 77% across VCS, WBS and Corporate.

As we approach the six month initial completion deadline (end November) work is being undertaken with managers to ensure completion of level one training, as well as sharing the training through Trust wide communications.

Row Labels	Completed	Not Completed	Grand Total	%
120 Corporate Division				
NHS|MAND|Risk Awareness - 2 Years|	**169**	**46**	**215**	**79%**
120 Research, Development and Innovation Division				
NHS|MAND|Risk Awareness - 2 Years|	**50**	**7**	**57**	**88%**
120 Transforming Cancer Services Division				
NHS|MAND|Risk Awareness - 2 Years|	**13**	**9**	**22**	**59%**
120 Velindre Cancer Centre				
NHS|MAND|Risk Awareness - 2 Years|	**641**	**260**	**901**	**71%**
120 Welsh Blood Service				
NHS|MAND|Risk Awareness - 2 Years|	**386**	**62**	**448**	**86%**
Grand Total	**1259**	**384**	**1643**	**77%**

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item.

	Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text.

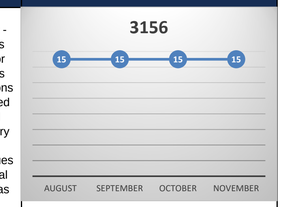
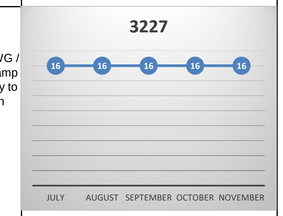
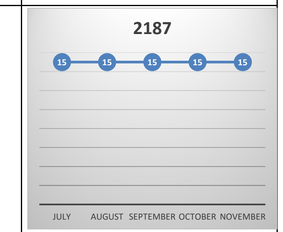
6. RISKS

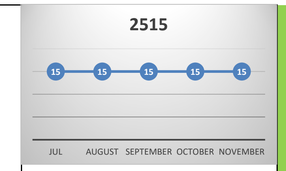
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require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

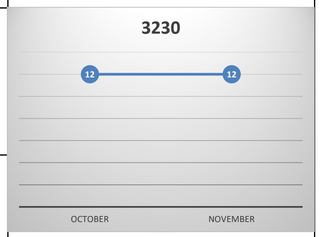
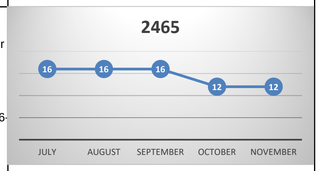
APPENDIX 1

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

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

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update	Risk Type	Opened	Division	Likelihood (Initial)	Impact (Initial)	Rating (Initial)	Likelihood (Current)	Impact (Current)	Rating (Current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3153	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm.	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm. We use a package called ProSoma (which is a Medical Device) for creating target volumes and treatment plans as part of the Radiotherapy pre-treatment process. The manufacturer has supplied lists of folders to exclude from real time anti-virus scanning to avoid interfering with the correct operation of the software. Digital have implemented real time scanning of these folders contrary to the advice of the manufacturers and Medical Physics Experts in Radiotherapy.	- Advised Digital of the manufacturer requirements and the radiation risks to patients from realtime scanning. -Regular 'liaison' meetings between RT Physics and digital are in place to ensure any future system upgrades are planned in line with manufacturer recommendations and ensure the risk to immediate patient safety / the radiation risks are considered in addition to the risk of cyber attack. There is still significant risk from Prosoma radiation incidents.	Confirmed on 7/1/24 that exclusions to real time scanning have been applied in line with requirements from the manufacturer of the medical device. This is now therefore expected to go through January Senior Leadership governance and propose to be closed/ score reduced for February Executive Management Board consideration (and onwards reporting to Quality, Safety & Performance Committee in March). 18/10 Update: Kept risk at 15 until Digital confirm that realtime antivirus scanning of these folders has ceased. Will update risk as soon as have confirmation. It is Physics understanding that realtime scanning of these folders is still happening, risk to remain at 15. Some incidents have been reported whereby saving of patient scans and delineated tumour volumes has not been possible, thus impacting the patient pathway. The full detail of these incidents are to be submitted as Datix incidents to enable appropriate investigation.	Safety	12/07/2023	Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen	1- Negligible	1	30/11/2023		Actions being taken as per progress column. 6/12 update - Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised.	
3227	new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	changes during the design development process lead to a design which costs more overall, increasing project costs.	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial boot camp is scheduled for w/c 09/10/23 to try to finalise commercial position on various issues Ongoing 2. See comments against Action 1. Ongoing	Risk increase is due to Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury.	Financial Sustainability	16/10/2023	Transforming Cancer Services	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	14/12/2023	Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial boot camp is scheduled for 10/10/23 to try to finalise commercial position on various issues Ongoing	
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service.	A comprehensive 5 year workforce plan is underway to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. This includes recruiting to the 13.5 posts within the satellite centre business case and additional posts for the IRS commissioning schedule at nVCC. Financial support of the workforce plan will be required to enable the target risk rating to be achieved. A process of continual prioritisation of business critical tasks is in place and it is ensured that detailed project and resource plans are kept up to date. Every occurrence when developmental / IRS work is put on hold to meet urgent radiotherapy treatment planning demand is being logged.	Safety	14/09/2020	Velindre Cancer Centre	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	29/12/2023	31/10/2023 30/11/2023	5 year workforce plan Readvertise post that did not recruit	

2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team. A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due September 2023	Options appraisal to be delayed due high current service demand. The current on resources to support the shift to a paperless radiotherapy service required for the satellite centre (due for completion by May 2024) and ongoing IRS demands. Options appraisal review delayed until early 2024.	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Probable - Will probably occur/reoccur but will not be a persistent issue.	5 - Critical	20	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	30/12/2023	30/09/2023 31/07/2023	Brachy Workforce Insufficient brachy MPE	

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update Since Last Governance Cycle	Risk Type	Opened	Division	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	Meeting took place to review the risk with the senior WOD SLT and Exec Director. Confirmation was received that the Healthy and Engaged Workforce Steering Group is the meeting to oversee this risk and to review on a quarterly basis	Safety	09/12/2022	Corporate Services	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/12/2023	31/03/2024	Healthy and Engaged Steering Group to agree arrangements to monitor and evaluate wellbeing interventions	
																		22/12/2023	The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio.	
																		31/04/2024	Divisions/Departments should have proactive stress risk assessments	
3230	There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Standard referral form in draft. Links with the Digital Team established to look at e-form solutions. Central e-mail box set up in readiness. Meeting with DHCW to be scheduled to review the e-referral solution (Hospital to Hospital). Demonstration Recording shared for background/further information to support discussion.	Safety	19/10/2023	Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very	4 - Major	4	45260	31/01/2024	Short term central management of new patient referrals	
																		31/12/2024	Electronic Solution (Long Term)	
2465	There is a risk to patient safety caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	In interim work has commenced to move to centralised email boxes by SST for clinical issues. Communication to highlight all urgent request should not use email as means of communication, clarified with key areas eg. SACT, Med sec roles and responsibilities and to not send emails 'just in case'.	Safety	05/11/2021	Velindre Cancer Centre	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	29/12/2023	09/10/2023	IB to undertake an audit into the use of email within the medical directorate across VCC. Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft IMTP 2046-27.	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Assurance Framework

DATE OF MEETING	16.1.2024

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

EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and this paper proposes Quality, Safety & Performance Committee endorse for Trust Board approval. To note, the Strategic Development Committee will also be asked to endorse the refreshed strategic risks in January Committee.

RECOMMENDATION / ACTIONS	The Committee is asked to **ENDORSE** the Trust Assurance Framework for Trust Board approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (risks 1-6)	13.11.2023
Quality, Safety and Performance Committee (risks 1-6)	16.11.2023
Trust Board (risks 1-6)	30.11.2023
Audit Committee (risks 1-6)	19.12.2023
Executive Management Board	2.1.2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

- Of the refreshed Trust Assurance Framework risks, risks one to six were included in the November cycle of governance for noting. It was to present the full set of eight to the Trust Board when completed in January 2024.

- In this November Quality, Safety and Performance Committee it was discussed and agreed that there needed to be alignment to the Integrated Medium Term Plan goals and then triangulation against the progress on these goals is an important element of first line of defence assurance.

- It is important to note that embedding of the Trust Assurance Framework, as a valuable management tool, through the Divisional leadership teams and senior management across the organisation remains a priority for the next phase of the Governance, Assurance & Risk development.

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	***Report for Noting***

APPENDICES

1	Summary of Strategic Risk Refresh outcomes
2	New Trust Assurance Framework

1. SITUATION

A review of the Trust Assurance Framework (TAF) and Strategic Risks have been undertaken, following collaboration with the divisional Senior Leadership/Management Teams, Committee members, Executives and Independent members.

The new Strategic Risks are included in this paper for information, following a review process through divisional Senior Leadership Teams, Executive Management Board and Committees.

The revised Trust Assurance Framework is appended.

2. BACKGROUND

The Trust Assurance Framework (TAF) was established in 2020, detailing ten strategic risks. A dashboard was developed to record the TAF and support ongoing management by Executive Leads.

The Trust Assurance Framework template was reviewed, updated and discussed with Independent Members who sit on the Audit Committee who reviewed the template. The template was endorsed by the Executive Management Board ahead of Audit Committee approval in April 2023.

The Strategic Risk Refresh started with divisional teams, Velindre Cancer Service (VCS) Senior Leadership Team, also attended by some Executive colleagues, and Welsh Blood Service (WBS) with a core group of attendees. These sessions were an opportunity to review the current risks, their appropriateness from a service perspective and to gather suggestions of key areas for inclusion in the refresh. Similar discussions took place in the Executive Management Board and Strategic Development Committee.

The National Risk Register was published in August 2023, a review of which was undertaken and key areas highlighted of relevance to Trust have been considered as part of the Strategic Risk Refresh.

As background, it is important to note that Audit Committee, Strategic Development Committee, Quality, Safety & Performance Committee and Trust Board have all expressed concern over recent months that during this review

period, a Trust Assurance Framework was not operational for six months. Overarching lessons learnt from this has been discussed in various Committees and Trust Board, and is broadly two-fold:

- The refresh of strategic risks will take place annually going forwards, in line with the Integrated Medium Term Plan review. The Trust Assurance Framework guidelines are being updated to reflect this.
- During all subsequent reviews, the existing risks will be reported on until the refresh has taken place.

3. ASSESSMENT

3.1 Following the Strategic Risk Refresh the outcome is included in Appendix 1.

The refreshed Strategic Risks have been populated on to the new Trust Assurance Framework Dashboard, which has previously been reviewed by this Committee and approved by the Audit Committee. The new template links with strategic frameworks, includes an area for reference to operational risk related to the strategic risk and have SMART action plans, alongside the core information around key controls, sources of assurance and gaps in controls.

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

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Populate refreshed TAF on Bower BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	March reporting cycle
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	Propose to close – Included in this paper
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of	Progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the	March reporting cycle

	first line of defence assurance.	Planning team to map and then populate with Executive leads at next review.	
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	March reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may including further Board development time etc.	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Committee are asked to:

- Consider and **ENDORSE** the Strategic Risk Refresh, as detailed in Appendix 1 of this report.
- **NOTE** the next steps, both in respect of governance and operationalisation, as detailed in section 3.2 of this report.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust

	business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

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

SECTION 1

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	
RISK LEADS	Cath O'Brien	Rachel Hennessey	Alan Prosser	RISK THEME	Service Capacity		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: RATING: PE

Overall Trend in Assurance: THIS WILL INCLUDE A

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function	Director WBS	X			E	System pressures can be flagged at an	PA	Performance Report to Senior	PA	Welsh Government Quality, Planning	PA
C3	Continuity of core service delivery functions supporting	Director WBS	X			E	Business Impact Assessments across	PA	Escalation through VUNHST	PA	Invoke UK Blood Services Memorandum	PA
C4	Delivery of business as usual core services and capacity to	Director WBS, VCS	X			E	Implementation group for programmes	PA	Highlight and performance	PA	QSP committee and Board and external	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety)	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, JPAC, SaBTO Regular liaison with Blood Policy and	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing		A1.1
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3184	There is a risk to VCC as a result of no Lead Digital Pharmacist in post resulting in multiple risks for VCC and the trust. These include for example lack of	20	Risk Increasing
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed	15	Stable/No Movement
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	IA	Jul-25	National oversight group is currently discussing with CAV in light of new supplier for All Wales LIMS soplution.	14.11.23	No current funding route idetified within LIMS and may be identified as a core recommendation	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise	Lee Wong	IA		Discussions ongoing about funding solutions	14.11.23		

A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	**PA**		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	14.11.23	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service on commencing role ?Dec 2023			

SECTION 1

RISK ID	02	**RISK TITLE**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and	**STRATEGIC GOAL**	2 - An internationally renowned provider of exceptional clinical services that always meet and	**RISK SCORE TREND**	
RISK LEADS	**Carl James**	**Jacinta Abraham**	**Nicola Williams**	**RISK THEME**	Partnership Alignment		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: **RATING** **PE**

Overall Trend in Assurance THIS WILL HAVE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		
1.3	Performance data and measures to clearly track progress				X	PE
2.1	Blood - core blood services commissioning arrangements			X		E
3.1	Local Partnership Forum		X	X		E
4.1	South Wales Collaborative Cancer Leadership Group system			X		PE
5.1	Partnership Board arrangements with partner Health Boards			X		E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Linked through performance framework	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Commissioning contracting reporting in	PA	Strategic Development	PA	Regulatory scope re MHRA tbc; clear	E
Feedback from LPF; proven to be effective	PA	Strategic Development	PA	Wales Audit Office	E
Agreed to model for next phase	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Agreed to model for each organisation	PA	Strategic Development	PA	Wales Audit Office/Welsh Government	E

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further	First line and second lines of defence assurance are in place to a certain extent	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James		Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce		Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)		tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by CEOs	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountabilioty arrangements will potentially identify how	Carl James		April/May 2024	Trust received request to feed into the review process	22-Dec-23	Unknonw at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James		tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023	22-Dec-23	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system	The level of assurance should increase

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE						
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	IA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	21/12/2023	Plan is moniitoted via Health and Engaged Steering group and plan in place until March 2024	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	PA	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA	Mar-24	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	PA	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Mar-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy	21/12/2023	Presenting update to EMB Shape on 18.12.2023	
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Feb-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly	21/12/2023	Appointed Nurse Retention Lead who is developing a plan which will be updated to EMB in February 2024.	
1.7	Review Exit Interview Process	Susan Thomas	IA	Feb-24	Task and Finish group to consider Exit interview process	21/12/2023	T and F group piloting improved processes to be finally implemented in Feb 2024.	

SECTION 1

RISK ID	04	**RISK TITLE**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**STRATEGIC GOAL**	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	Developed Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training steering group	IA	Trust Board reporting on strategy and controls via cycles of business	IA	To be completed as per compliance/ reg tracker updates	IA
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training steering group	PA	Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE	Healthy and Engaged Steering Group and Education and Training Steering Group	PA	Reported through EMB Shape to Strategic Development Committee	IA	Internal Audit Reports	IA
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Workling Group					
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings and Educationa and Training Steering Group		Supply and Shape paper to EMB then QSP		Internal Audit Reports	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed	
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		Mar-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message.	21/12/2023		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey will be distilled to further develop our work programme	21/12/2023		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		Feb-24	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive	21/12/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	21/12/2023	A programme of work is in train with three work streams, leads attached. The programme will provide an update in March 2024.	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E
C2	Active work ongoing to leverage existing and deliver on new	Chief Digital Officer		X		E
C3	Training & Education packages to develop internal	Chief Digital Officer	X			PE
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE
C5	Ring-fencing digital advancement in Trust budget –	Chief Digital Officer	X			E
C6	Specifically development of digital resources capacity and	Chief Digital Officer	X			PE
C7	Digital inclusiion in wider community	Chief Digital Officer	X			PE
C9	Prioritisation and change framework to manage service	Chief Digital Officer	X			PE
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE
C11	Trust digital Governance	Carl James		X		E
C12	Framework of lead and lag indicator reporting into Trust	Chief Digital Officer			X	PE
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		PE
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits	PA	EMB Shape	PA	SIRO Reports/ Strategic Development	PA
Trust Digital governance reporting	PA	EMB Shape	PA	SIRO Reports/ Strategic Development	PA
Staff feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development	PA
Patient and Donor feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
Review of proposals via EMB/Board	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development	IA
Review of proposals via EMB/Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development	PA
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	Not Assessed
Trust Digital governance reporting	PA	EMB Shape	IA	SIRO Reports/ Strategic Development	PA
Trust Digital governance reporting	PA	EMB Shape / EMB Run /	PA	SIRO Reports/ Strategic Development	PA
Trust Digital governance reporting	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/	PA
Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ Strategic Development	PA
Review via Divisional SMT / SLT/ Cyber	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development	PA
Digital Programme Board Digital Design Authority being established	≤	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Agreed Digital Inclusion plan - C4,C7	Assurance Arrangements for Digital Architecture will need to be established -	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation	15	Cyber Security Manager has been recruited and has started at the Trust - risk will be closed

SMART ACTION PLAN

Action Ref	Action Plan	Ownder	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Nov-22	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	Dec-23	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The	Dec-23	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as	Chief Digital Officer	IA	Feb-24	Non-Recurrent Revenue has been made availanble to support the	Dec-23	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer	IA	Mar-24	Head of Cyber Security has been appointed from Dec	Dec-23	Dedicated post now in place to lead on cyber - will still be a	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the	Chief Digital Officer	IA	Apr-24	Assistant Director of Data and Insight starts in post on 3rd Jan 24. Future	Dec-23	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital	Chief Digital Officer	IA	Apr-24	Will start with identification of standards for Digital Service (through new	Dec-23	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Aiudit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	6	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	6	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	6
C5	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	4		

C6	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self- assessment exercise. All actions complete /on track to complete by end of this financial year.	5			Audit Wales review of Quality Governance Arrangements	5
C7	Qulaity of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	Third line of defence in respect of C5 - Board Development Programme: No course of action is proposed.	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
C5	Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	6	Complete	Supported by the development priorities identified through an externally facilitated programme of Board development underway.			
	Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	6	Complete	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.			
	Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Dec-23	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work			
	Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	4	Mar-23	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.			
	Refresh of Trust Assurance Framework risks	Lauren Fear	3	Dec-23	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly			
	Revised reporting mechanism to be developed	Lauren Fear	3	Mar-23	Project TAF 3.0 withint he GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, led by Execs			
	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Mar-23	Work is ongoing mapping the Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board			

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS | **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO	As per TAF 01 C12									not assessed
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	not assessed
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NA
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	PE	Executive Management Board	PE	Quality, Safety and Perfromance Committee	?
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	PE	Executive Management Board	PE	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	not assessed
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	not assessed
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	PE	Executive Management Board	PE	Quality, Safety and Perfromance Committee	IA

C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	NE	VCS Quality & Safety Group / VCS SLT	NE	Integrated Quality & Saefty Group / Executive Management Board	NE	Quality, Safety and Perfromance Committee	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE		A1
Service level to Board intergrated dashboards		A2
Patient reported outcome measures across all SSTs, with service level to Board reporting		A3
Robust and consistent administrative processes for referrals and bookings		A4, A5, A6,A7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND

SECTION 5

SMART ACTION PLAN - DRAFT requires further development

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	08/01/2024		
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	08/01/2024		
A3	Intergrated Qaulity and Safety dashboards to be developed that align with PMF	Transofrmation, planning, performance and digital	2	CJ to confirm	Initial quality, safety and outcome metrics& implementation plan agreed	08/01/2024		
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implimneted)	Exec Medical Director / Exec Finance Director	2	MB/JA to confirm	Working Group established within VCS, Lead by the VBHC Team & external company PCS	08/01/2024		
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	RH to confirm		08/01/2024		
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS	1	RH to confirm		08/01/2024		
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	0	TBC	SACT telephone helpline improvement project underway (revised triage tool and escalation process implimented) External SACT treatment helpline peer review undertaken December 2023 - report expected January 2024	08/01/2024		
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce		TBC		08/01/2024		

A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	0	TBC	Data tool in development, system validation issues identified	08/01/2024								
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	TBC		08/01/2024								
A11	Fully roll out the Q-Pulse system across all services at VCS	Interim Director VCS	1	TBC	Project group being established, project leads identified	08/01/2024								
A12	Implementation of the patient engagement framework	Head of Comms / Interim Director VCS	2	TBC		08/01/2024								
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Director / Exec Director Nursing, AHP & HCS	2	TBC		08/01/2024								
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024.	08/01/2024								
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	TBC										

SECTION 1

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

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA

FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

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

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

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	**Second Line of Defence** functions that oversee or specialise in risk management	**Third Line of Defence** functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management	Quality & Safety	External Audit
Staff training and compliance with policy guidance	IT	Regulators & Commissioners
Teams take responsibility for their own risk identification and mitigation	Governance (corporate/Clinical)	Wales Audit Office reviews
		Stakeholder reviews
		Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures	*Board, Committee and Management Structures which receive evidence from*	*Recent internal audit reviews and levels of assurance*
Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting	*Compliance against Policies*	
Staff Training Programmes		

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

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

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

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

RISK MATRIX	LIKELIHOOD(*)				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

IMPACT MATRIX

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

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

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

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

SUMMARY STATEMENTS OF 7 LEVELS

RAG		

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

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	16th January 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 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 – 'buying' our workforce (2) ensure a work environment that supports staff's wellbeing - 'binding' our workforce (3) develop effective service and workforce plans to 'boost' our workforce. 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 interventions ongoing to manage

	vacancy gaps and support staff wellbeing. A summary of divisional operational service and workforce plans is provided to support workforce change to further mitigate workforce supply and shape issues.

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

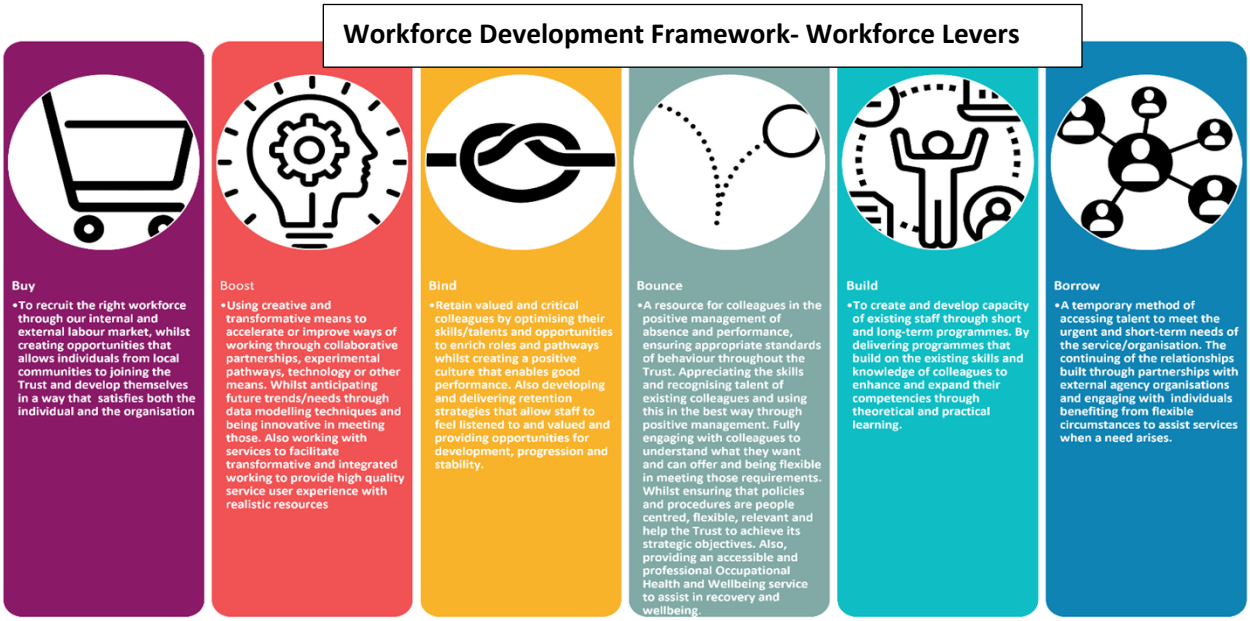
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date n/a**
Executive Management Board	2/1/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The paper was noted with some small recommendations for amendments to the text which have been made and a clarification of the number of vacancies. In addition a recommendation that analysis of vacancies by staff group be added.	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
	No Appendices

1. SITUATION/BACKGROUND

The key to ensuring a robust plan around workforce supply and shape is to strengthen our current workforce planning approach. A workforce development framework has been approved by the Trust to support this. The framework includes a series of workforce levers – (see figure 1) to ensure we plan, recruit, retain, skill and develop our workforce and manage the health and engagement of our staff effectively to ensure we are the employer of choice, meeting the commitments laid out in our people strategy.



(Figure 1)

This report concentrates on our key risks in delivering an effective workforce Supply and Shape, noting the actions, outputs and timelines for improvement to mitigate risk. A focus is provided on (**1) Recruitment and Retention (Buying/Building our workforce) (2) Service and workforce planning interventions to boost the workforce and (3) Keeping our valued staff and supporting wellbeing – binding our workforce**

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

Each risk is summarised below with supporting narrative on actions.

2.1 Buy/Build the Right Workforce – Recruitment and Retention

The number of vacancies for the Trust as of November 2023 is 98 (WTE). VCC (54WTE), WBS (30WTE), Corporate (7WTE), R&D (3WTE), TCS (2WTE) and HTW (2WTE). Vacancies over time can be seen in section 3 of the report,

An analysis of the vacancy hotspots, summary of challenges and current interventions to mitigate the risk is summarised in the table below.

Divisional Vacancy Hotspots (VCC)	Challenges	Interventions to mitigate risk
SACT Nursing	Fewer going through training Many leave to go to Band 6 roles in HBs High turnover	• Skill mix assessments and departmental re-design to ensure that registrants are doing what only registrants can do • increase HCSW and other non-registered workforce numbers where roles can best support the registrant workforce, aligned to the Nurse Delegation Framework • New and re-designed role such as the Assistant Practitioner • Targeted recruitment campaigns and rolling adverts • Flexible working opportunities • Implementation of the national Nursing Retention Plan • Participating in 23/24 student nurse streamlining • International recruitment – 13, commencing March 2024

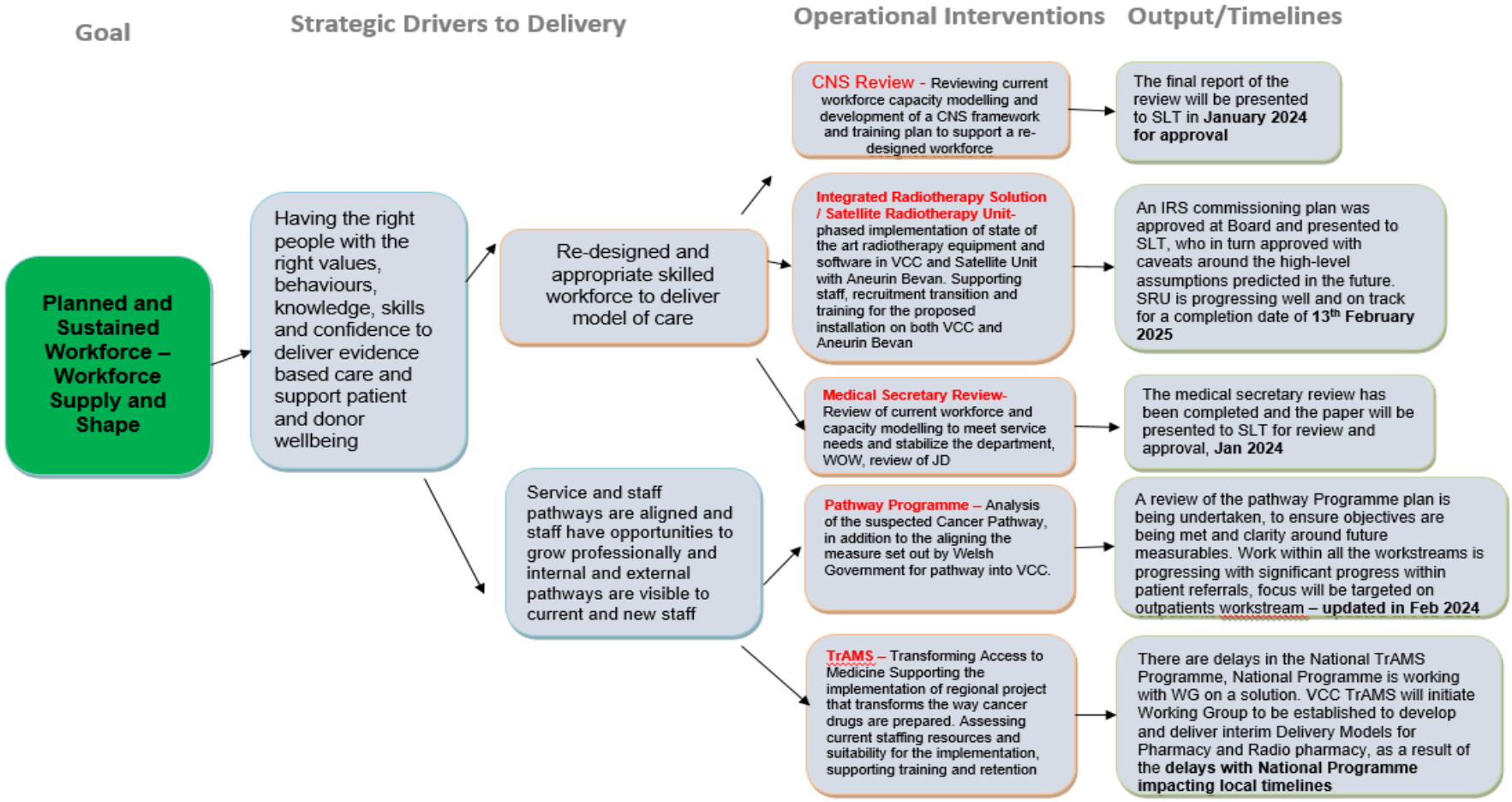
Radiotherapy Physics	UK shortage of registered Clinical Scientists Ageing workforce profile, many due to retire in the next few years	• Recruit permanently for nVCC and SRU, more attractive and can help with implementation on the projects prior to launch • Succession plan now in place to recruit earlier to ensure training can take place, apprenticeship scheme also being explored • Recruit for Clinical Scientists in Q4 23/24 – to attract those in last year of national scientists training scheme/course • Bandings lower in Velindre compare to other centres and HBs (WOD looking at job descriptions and Agenda for Change profiles to assess) • Use of agency staff • Skill mix being considered
Vacancy Hotspots - WBS	**Challenges**	**Interventions**
Nursing	Number of secondments – substantive appointments planned for 2024	• Workforce planning review • modernisation project • Changes to recruitment methods and induction methods • Exit interviews
Collection Teams	A great deal of work has been undertaken in this area – whilst recruitment and retention issues remain this is greatly improved	• Recruitment campaign • Workforce model changed

2.2 Boost the Workforce – Interventions to Deliver Services

A planned and sustained workforce is key to delivering services for our patients and donors. An overview of the operational and strategic interventions to boost the workforce in both divisions is highlighted below. The diagrams highlight the Programmes of work being taken forward in the Divisions to boost the 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.

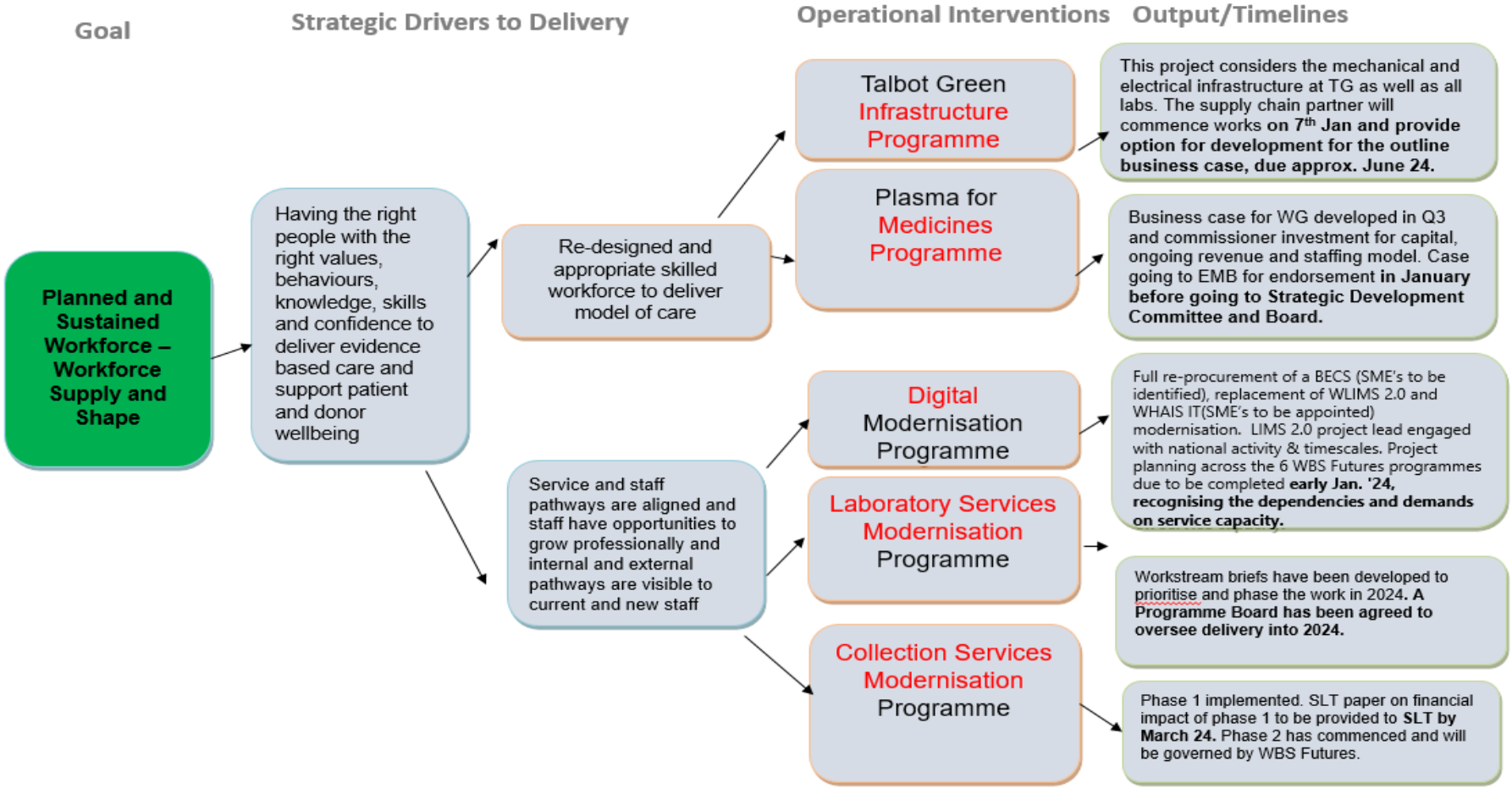
2.2.1 Velindre Cancer Service

Planned and Sustained Workforce – Overview of the Strategic and Operational Interventions to Boost the Workforce – **VCC** – November to March 2024



2.2.2 Welsh Blood Service

Planned and Sustained Workforce – Overview of the Strategic and Operational Interventions to Boost the Workforce – **WBS** – November to March 2024



2.3 Bind the Workforce – Keeping our Valued Staff and Supporting Wellbeing

A Healthy and Engaged workforce is key to blinding our workforce, ensuring we keep our valued staff. Trust risks (notably Risk 3001) describes work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction of people having excessive pressure or other types of demand placed on them. Due to the wide range of factors that cause stress, within work and outside of work, no single action will address the issue. Moreover, progress towards stress reduction will take time as new ways of working come into effect.

Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.

The Healthy and Engaged Steering group oversees the Trust Health and Wellbeing plan. Of specific note the following interventions are being taken forward to support a culture of wellbeing where staff are engaged:

2.3.1. A Psychologically Safe Place to work

The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.

2.3.2 Our Retention plan

Working closely with HEIW and the All Wales Nurse Retention Workstream the Trust has appointed a Retention lead to develop its Plan with specific priority being given to the Trust Nurse Retention Plan. A dedicated resource will assist in aligning the work already being undertaken and focus on priority areas for the Trust. Updates on the Retention Plan will be monitored via EMB Run.

2.3.3. Wellbeing

A raft of wellbeing interventions is in place within the Trust to support staff wellbeing. The Staff Psychologist works closely with the Workforce function to

review the effectiveness of interventions. The Health and Wellbeing Work plan is monitored via the Healthy and Engaged Steering group.

The narrative above highlights the overarching plans in place to mitigate the workforce risk.

3. **Quarterly update: The associated financial risk to Workforce Supply and Shape**

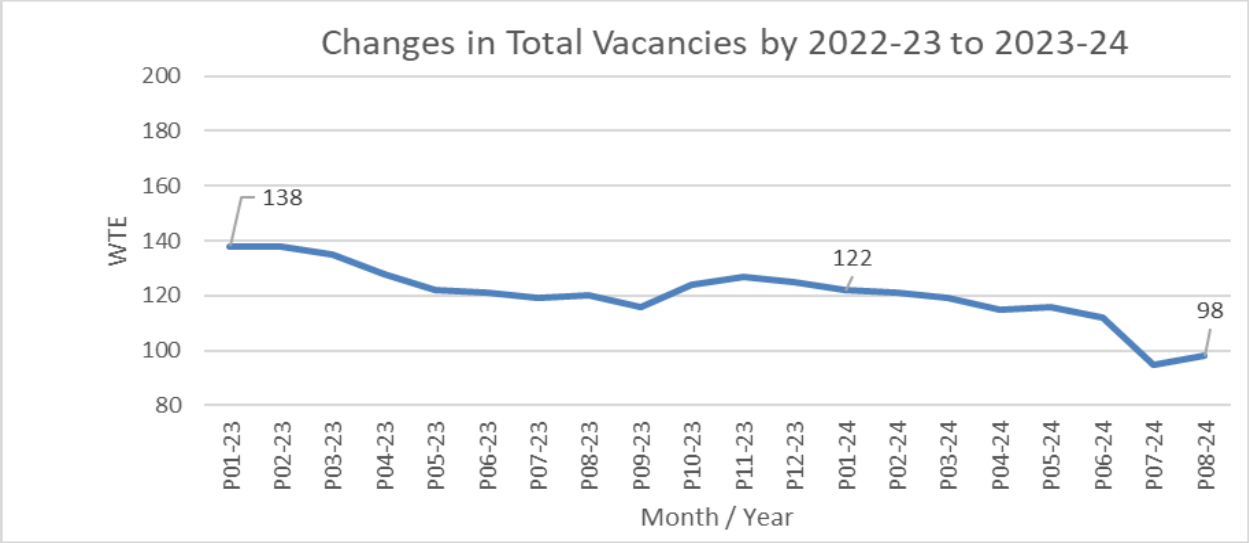
The financial risk associated with workforce supply and shape will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available. Funding is now linked to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

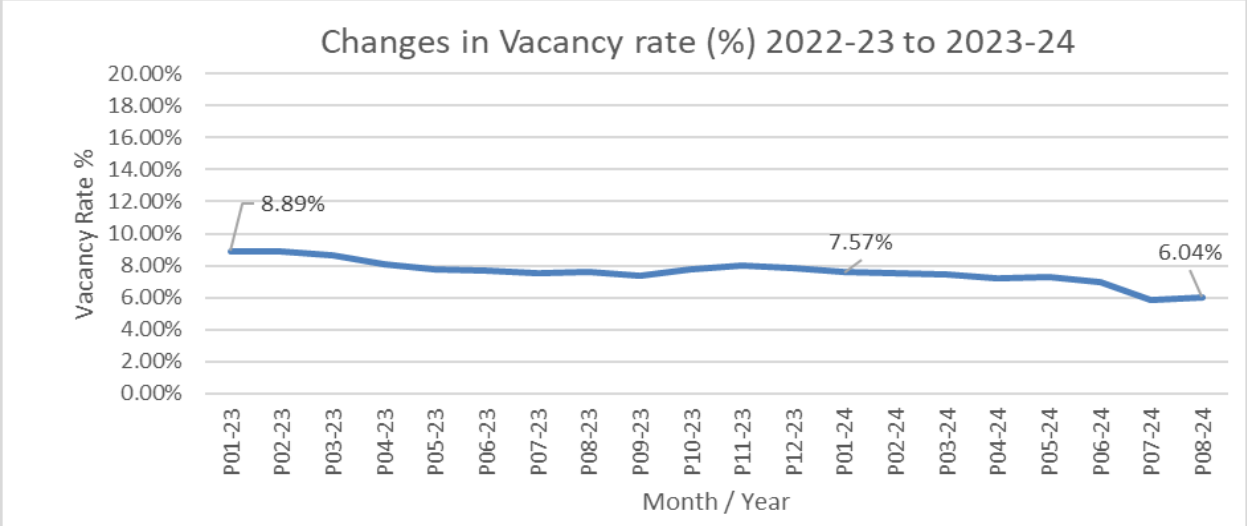
Pay Budget 2023/24

The full year pay budget as at end of November 2023 is £85.22m based on 1,622 WTE. The Trust has reported cumulative year to date spend of £57.049m on pay against a budget of £57.280.m resulting in an underspend of £0.231m as at November 2023. The pay costs include the costs of agency staff, on-call and overtime.

As at November 2023, the current staff in post is 1,524 WTE. The number of vacancies for the core Trust including HTW is 98 WTE, which represents a vacancy rate of 6.04%. 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 the Trust are reducing, however remains relatively high particularly in Nursing, as noted in the assessment above. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to November 2023:





The table below provides the total budgeted WTE agaisnt the actual WTE, and includes WTE Vacancy and Vacany rate as at Nov'23 split by staff category.

Staff Category	WTE Budget	WTE Actual	WTE Vacancy / Over Establishment	WTE Vacancy "+" / Over-establishment "-" Rate %
Add Prof Scientific and Technical	61.65	58.02	3.63	5.89%
Additional Clinical Services	249.23	227.19	22.04	8.84%
Administrative & Clerical	552.25	519.81	32.44	5.87%
Allied Health Professionals	149.59	154.82	(5.23)	(3.50)%
Estates and Ancillary	71.56	67.08	4.48	6.26%
Healthcare Scientists	182.02	172.81	9.21	5.06%
Medical & Dental	119.77	112.59	7.18	5.99%
Nursing & Midwifery Registered	232.09	207.85	24.24	10.44%
Students	4.04	4.04	0.00	0.00%
Total	**1,622.20**	**1,524.21**	**98.00**	**6.04%**

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 is that the contract performance income has recovered however the full year position is reliant on forecast activity levels from Commissioners for Velindre Cancer Services and will need to be closely monitored over the coming months. Work will therefore 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.

Pay Award

At this stage the Trust is expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m) and 5% (c£3.5m) consolidated pay award which was processed in July. The Trust has now received full funding for the one off recovery pay award which was paid in June

The 5% medical pay award back dated to April 23 was processed in October. The Trust is currently assuming that this will be fully funded by WG.

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	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population

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

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?	*This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Speaking Up Safely Framework – Implementation Update

DATE OF MEETING	16th January 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 OD and Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	As part of delivering a Healthy and Engaged Workforce the Trust is keen to deliver an effective culture around Speaking up Safely. Following a self-assessment against the WG Speaking up Safely Framework gaps in (1) Communication (2) process (3) governance around Speaking up Safely have been identified. An programme of work has been established to mitigate any risk of a psychologically unsafe environment where issues are not addressed and staff feel unsafe to raise issues.

RECOMMENDATION / ACTIONS	To ***Note*** the update on the Trust Action plan to promote a culture of Speaking Up Safely

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	4th December
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The paper was noted	

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

APPENDICES	
Appendix A	Speaking up Safely @ Velindre – Shaping our Work plan

1. SITUATION

NHS Wales's organisations have committed to developing healthy working relationships, an approach which aims to foster more compassionate, collective, healthier and fairer behaviours, workplaces and organisations. Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, donors the public and the NHS workforce, as well as helping to improve our population's experience of healthcare. It is essential to ensure that all individuals have a voice, are listened to, and receive a timely and appropriate response.

The Trust undertook a self-assessment mapping exercise against the Welsh Government (WG) Speaking up Safely framework. A Trust action plan was submitted to WG on the 31st October 2023. The paper summaries the work that has been taken forward to address the actions to date.

2. Background/ Matters for Consideration

Following the submission of the mapping exercise and action plan on the Speaking up Safely Framework to Welsh Government an initial meeting with corporate and divisional colleagues was called to shape our Speaking up Safely approach at Velindre. Discussions focused on what, who, how, when and where the work needs to progress. A summary of discussions are contained in Appendix A. A Task and Finish Steering Group to convene on the 30th November has now been established to deliver the objectives below:

- Baseline Organisational opinion regarding Speaking up Safely via pulse surveys and the Trust engagement exercise already ongoing
- Benchmark Employee Voice good practice across public sector organisations
- Agreed and communicate processes for Speaking up Safely including the implementation of WG toolkits
- Agreed training plan for managers
- Agreed communication plan and communication channels for Speaking up Safely
- Agreed governance processes for updates and escalation
- Agreed roles and responsibility including any additional resources required

A draft outline for the Independent Member and Chief Executive Champion roles has been drafted for consideration at the Steering group on the 30th November. All roles and responsibilities will be agreed at that meeting. The timing of paper submissions negates the ability to provide the committee with an update at the point of writing.

An engagement exercise with staff will be launched in January to co-incide with the Listening exercise already ongoing.

Alongside the engagement exercises with staff clarity around processes for speaking up safely will be communicated to staff.

3. Next Steps – Reporting to EMB

The Task and Finish Steering group will convene monthly and include a highlight report to EMB for consideration. The action plan, to be delivered by the Task and Finish Steering group, is to be delivered by March 2024.

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*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial resources are currently being assessed to support the implementation of the Speaking up Safely Framework and will be reported to EMB via the Steering Group
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 Framework being implemented has already been subject to an EQIA 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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Taf 04*
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	

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

Appendix A

Speaking up Safely @ Velindre – Shaping our Work Plan

Following the launch of the NHS Wales Speaking up Safely Framework an initial meeting with corporate and divisional colleagues was called to shape our Speaking up Safely approach at Velindre. Discussions focused on what, who, how, when and where the work needs to progress. A summary of discussions is below with proposed next steps noted.

What are we trying to achieve?	Ensuring a Psychologically Safe place to work in which we have a culture where staff can speak up safely, via clear communication and processes, without any fear of recriminations. Governance process are in place to escalate and report on issues.
Who need to be involved?	All staff – working in partnership Divisional teams and SLTs Clear leadership and priority from EMB and Trust Board with this work communicated
How – what actions do we need to take to achieve the plan?	Engage with staff: • Develop an engagement exercise – link to current work areas – current listening exercises, NHS Staff Survey promotion, Safe Care Collaborative work Ask staff how they feel currently? Do they feel they can speak up freely? If so, do they know how to do this? • Alongside engagement undertaken an exercise on Employee voice – best practice within the NHS and outside – can be undertaken. Requirements to benchmark across NHS Wales to learn lessons from other and avoid any duplication. • Utilising the WG Toolkit @ Velindre ensuring clarity of process and communicating the processes for Speaking up • Define roles and responsibilities in Speaking up Safely. Leadership roles must be evident – including IM lead and CE lead • Agree the governance mechanisms for communication, assurance and escalation in relation to speaking up safely • Agree success measures for speaking up safely

	• Agree a clear Communication plan – understand how we inform, involve and engage staff in Speaking up safely
When	Immediate action to communicate with staff the work ongoing. Agree a work plan to be completed by March 2024, including a collaborative leadership and governance approach.
Where	Relates to all staff across our whole org throughout Wales – our all Wales position needs to be considered in our communication plan

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

RECRUITMENT AND RETENTION AUDIT AND ACTION PLAN

DATE OF MEETING	16th January 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 Morley, Executive Director of Organisational Development and Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	Following an Internal Audit review of elements of Recruitment and Retention an opinion of Reasonable Assurance has been given. Four recommendations have been made across the objectives audited.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the audit and action plan in place

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date n/a**
Audit Committee	DEC 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
Appendix A	Internal Audit – Recruitment and Retention – Velindre University NHS Trust

1. SITUATION/BACKGROUND

The Internal Audit into Recruitment and Retention focussed on four objectives:

Objective 1: There is a Trust strategy that focuses on initiatives to attract and retain a skilled workforce across the organisation and is aligned to the Trust's aims and objectives

Objective 2: There is a recruitment and selection policy evident which details staff roles and responsibilities, and staff recruitment is carried out in accordance with the policy and framework

Objective 3: Effective initiatives are in place to recruit and retain staff, for example recruitment events, social media, engagement, succession planning and staff surveys

Objective 4: Adequate mechanisms exist to monitor staff recruitment and retention throughout the trust at a local and Board level

2. ASSESSMENT

The Audit issues assessments of Reasonable Assurance against all four objective areas and made four recommendations.

1. The Trust should look at ensuring the People Strategy: Being an employer of choice is communicated effectively throughout the organisation. (Low Priority)
2. The Trust should ensure the Recruitment and Selection Policy is approved and communicated throughout the Trust. (Medium Priority)
3. The Trust should implement performance measures to ensure regular monitoring of the current position and the impact of actions implemented. The information should be reported into appropriate committees. (Medium Priority)
4. The Trust should measure the effectiveness of its recruitment and retention initiatives. (Medium Priority)

3. SUMMARY OF MATTERS FOR CONSIDERATION

A Management Response has been accepted against each of the recommendations and actions are being monitored through the Audit Action Tacker.

The full audit report is attached as Appendix A.

4. IMPACT ASSESSMENT

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

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A 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 the audit response 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	

Recruitment and Retention
Final Internal Audit Report

December 2023

Velindre University NHS Trust

Contents

Review reference:	VT-2324-04
Report status:	Final
Fieldwork commencement:	19 September 2023
Fieldwork completion:	09 November 2023
Debrief meeting:	14 November 2023
Draft report issued:	17 November 2023
Management response received:	01 December 2023
Final report issued:	01 December 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Rhian Gard, Audit Manager
Executive sign-off:	Sarah Morley, Director of Workforce & OD
Distribution:	Susan Thomas, Deputy Director of Workforce & OD
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To review the effectiveness of the Trust's recruitment and retention activities. The review focussed on whether activities are enhancing recruitment and retention. We did not audit compliance with the Trust recruitment processes.

Overview

We identified many different initiatives being implemented across the Trust to assist with recruitment and retention, against a backdrop of considerable work pressures. Alongside this, the Workforce and Organisational Development Team is progressing the implementation of these initiatives.

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Workforce Strategy, 'People Strategy: Being an employer of choice' has been approved since May 2022, but has yet to be communicated across the Trust.
- The Recruitment and Selection Policy has not been approved. Therefore, there is a risk of recruitment practices not being adhered to.
- Whilst we found that monitoring and reporting is taking place, there is no specific reporting over the effectiveness of recruitment and retention initiatives. Furthermore, there is no review of the success or otherwise of the initiatives implemented.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

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	Trust workforce strategy	Reasonable
2	Staff recruitment	Reasonable
3	Recruitment and retention initiatives	Reasonable
4	Monitoring and reporting	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Trust workforce strategy	1	Operation	Low
2	Staff recruitment	2	Design	Medium
3	Monitoring and reporting	3,4	Design	Medium

1. Introduction

1.1 The demands upon the health services, increasingly complex service-user needs, and difficulties with recruitment and retention of staff (particularly nurses) have created significant challenges for Velindre University NHS Trust (the 'Trust') and other organisations in NHS Wales. The Trust is in the process of reviewing the supply and shape of its workforce to ensure it has the right people in the right place with the right skills, recognising the need to move away from traditional staffing models to deliver the changing service needs.

1.2 The Trust has approved a new workforce development framework (the 'framework'). Within the framework there are levers in place to ensure the Trust recruits, upskills and develops its workforce and manages the health, wellbeing and engagement of its staff. The aim is to ensure the Trust is an employer of choice, which in turn meets the commitments laid out in the Trust's People Strategy: Being an employer of choice. Work has been completed to ensure the framework is aligned to the All-Wales Workforce Planning Strategy, and training has been delivered to managers within the Trust to implement this approach.

1.3 The key risks considered in this review were:

- continued reduction in the Trust's workforce due to recruitment and retention issues not being monitored and / or corrective action being taken;
- insufficient staff within departments meaning that they are unable to consistently deliver the level of services required in a safe manner; and
- additional costs incurred by the Trust because of additional recruitment campaigns and agency costs.

2. Detailed Audit Findings

Objective 1: There is a Trust strategy that focuses on initiatives to attract and retain a skilled workforce across the organisation and is aligned to the Trust's aims and objectives

2.1 The 'People Strategy: Being an employer of choice' (the 'Strategy') was approved by the Trust's Board in May 2022. The focus of the Strategy is to ensure there is progress towards a planned and sustained workforce which are skilled and developed people who are engaged in the workplace.

2.2 The Strategy is one of a suite of enabling strategies underpinning the Trust Strategy: Destination 2033. The Strategy is aligned with the objectives and vision of the Trust and identifies the current and future workforce challenges. The main themes of the Strategy tie in with the Trust's strategic goals and values; to be accountable, to be bold, to be caring and to be dynamic.

2.3 We confirmed that the Strategy has not been communicated across the Trust and some staff are not aware of its existence. Furthermore, there is no stand-alone

implementation plan to support its deliverables, which makes it harder for the Trust to identify how successful they are in achieving them, regarding recruitment and retention. However, there is an Attraction, Recruitment and Retention (ARR) group whose role is to ensure processes for recruitment and retention are streamlined and there is appropriate engagement within these practices.

2.4 The ARR group has a project initiation document (PID) documenting its objectives, from reviewing these along with highlight reports we can see that many of the objectives have been achieved on time. However, objectives where there are external dependencies have experienced delays.

2.5 The ARR group does not maintain minutes, but a live document is in place, which is updated after meetings. Highlight reports are sent to the Executive Management Board (EMB), the last one which went to the EMB was during January 2023 and further updates are sent to the Quality, Safety and Performance (QSP) Committee. However, the ARR group has not met since December 2022, but a final evaluation report is scheduled to go to EMB in January 2024.

The above points are included within **matter arising one.**

Conclusion:

2.6 There is a Strategy in place which is one of a suite of enabling strategies underpinning the Trust's Corporate Strategy and has been approved since May 2022. However, the Strategy has not been communicated to staff. Although there is no stand-alone implementation plan in place to support its deliverables, the ARR group focuses on the implementation of some of those deliverables, but this has not met since December 2022. Therefore, we have provided **reasonable assurance** for this objective.

Objective 2: There is a recruitment and selection policy evident which details staff roles and responsibilities, and staff recruitment is carried out in accordance with the policy and framework

2.7 The Recruitment and Selection Policy (the 'Policy') was completed in January 2023 but has not yet been approved, because of this we did not undertake testing relating to the Policy content. The Policy was submitted to QSP in September 2023 for approval. We were informed that the Policy was not approved due to the lack of completion of an equality impact assessment. Consequently, the Policy will now be represented at the next available QSP Committee.

2.8 As part of the audit, we reviewed the Policy and found that it details important elements of recruitment, Welsh language, induction attendance and roles and responsibilities.

2.9 Over the last 18 months the Workforce Team has worked to implement the recruitment framework through: the Policy, a recruitment toolkit, an updated incremental policy and a new Disclosure Barring Service (DBS) procedure. However, we were informed that there is no specific work plan in place for recruitment because of the limited workforce resource available.

The above points are included within **matter arising two.**

Conclusion:

2.10 There is a Recruitment and Selection Policy, but it has not yet been approved and communicated across the organisation. The Policy is an important part of the recruitment framework so should be communicated as a matter of urgency. Therefore, we have provided **reasonable assurance** for this objective.

Objective 3: Effective initiatives are in place to recruit and retain staff, for example recruitment events, social media, engagement, succession planning and staff surveys

2.11 The Trust is involved with multiple recruitment and retention initiatives, with promotion of the Trust on the website. The Trust, alongside other NHS organisations, operates in a difficult environment when seeking to recruit and retain a skilled workforce.

2.12 There are a range of initiatives introduced to improve the overall position. For example, the revamp of the corporate induction to ensure it is more concise and engaging for new starters and to help embed them into the organisation. Furthermore, there is ongoing work regarding medical work experience, RCN nurse cadets, the armed forces covenant, and the NHS graduate scheme.

2.13 Likewise, we found numerous retention initiatives embedded to ensure staff feel valued and included.

2.14 Alongside this, a Health Education and Improvement Wales (HEIW) two-year funded role is set to be recruited and this will assist with retention in the Trust. Furthermore, exit interviews are being reviewed to ensure that they are completed and add value to the retention process. In addition, the Trust retains a clinical psychologist in post to help individuals and teams in the Trust with any issues they may have and need assistance with.

2.15 As part of the audit, we reviewed the initiatives embedded, but found that there is no ongoing monitoring over the success of these actions completed. Therefore, initiatives may or may not be effective in achieving their aims.

The above points are included within **matter arising three.**

Conclusion:

2.16 From reviewing the different initiatives for recruitment and retention it is clear to see the Trust understand the importance in ensuring they recruit and retain a skilled workforce. However, the initiatives are not currently being measured on their effectiveness. Therefore, the Trust should review on a regular basis to check what impact they are having and whether any additional work is required. Therefore, we have provided **reasonable assurance** for this objective.

Objective 4: Adequate mechanisms exist to monitor staff recruitment and retention throughout the trust at a local and Board level

2.17 There are forums within the Trust which discuss recruitment and retention. The ARR group, solely discusses the recruitment and retention process, but also

produces highlight reports for the EMB and updates are also provided to the QSP Committee, as their responsibility is to scrutinise workforce matters.

2.18 As part of the audit, we reviewed the ARR highlight reports and found the group has not met since December 2022 with the last highlight report going to EMB in January 2023. Within these reports we identified that many of the ARR group's objectives and deliverables have been completed, except where external factors are involved. An evaluation report is scheduled to go to the EMB in January 2024.

2.19 We reviewed 12 months of minutes from Strategic Board Committee (SDC), QSP Committee and Board and identified there are regular updates provided, but not on performance measures or indicators within the reporting process. Furthermore, we were not able to see any reporting or monitoring on measuring the effectiveness of the recruitment and retention initiatives. There are dashboards in place within the divisions and these are for management teams to review and put in place actions for the coming months concerning sickness, vacancy, PADR compliance and head count.

The above points are included within **matter arising three.**

Conclusion:

2.20 There is reporting and monitoring taking place, but these are mainly updates rather than performance information and measures. There does not appear to be regular monitoring or reporting of the effectiveness of recruitment and retention initiatives. Performance information should be reported to the relevant forums on a regular basis, to determine if recruitment and retention matters are improving or if further work is required. Therefore, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Trust Workforce Strategy (Operation)	**Impact**
The People Strategy: Being an Employer of Choice (the 'Strategy') was approved by the Board during May 2022. The Strategy is aligned with the corporate objectives of the Trust and is one of a suite of enabling strategies underpinning the Trust's Strategy 'Destination 2033'. The focus of the Strategy is to ensure progress is made for a sustained workforce with skilled and developed people who are engaged in the workplace. Within the document there are six main themes, including attracting and retaining the best talent. The Strategy does not include a stand-alone implementation plan (or equivalent) to support its deliverables, however there is an Attraction, Recruitment and Retention (ARR) Group (the 'Group') established. The role of the Group is to ensure processes for recruitment and retention are streamlined and there is appropriate engagement within these practices. Although the Strategy has been approved for over a year, it was hard to locate on the Trust's website and workforce staff also found it difficult to locate. The Strategy has not been communicated to staff throughout the Trust or made widely available, to assist in communicating the deliverables.	Potential risk of: • The Trust's Strategy has not been communicated resulting in staff not being fully aware of the Trust's deliverables and practices.

Recommendations		**Priority**
1.1	The Trust should look at ensuring the People Strategy: Being an employer of choice is communicated effectively throughout the organisation.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The People Strategy was formerly launched alongside the Trust strategy and other enabling strategies on the 10th November 2023. This was followed with Trust wide communications through the weeks following the launch. The strategy is now widely available and easy to locate on the Trust Intranet. The narrative and terminology within the People Strategy will be used in all staff engagement events and work programmes going forward. The Trust will have specific articles highlighting the People Strategy in January 2024 Trust and Divisional Newsletters.	31 January 2024	Deputy Director of WOD

Matter Arising 2: Staff Recruitment (Design)	**Impact**
The Trust has developed the People Strategy: Being an employer of choice, with a supporting framework in place. Within this framework there is a Recruitment and Selection Policy which was completed during January 2023. However, this policy has not yet been formally approved by the Quality Safety & Performance (QSP) Committee. It was scheduled to be approved at the September 2023 Committee, but this did not happen. It is understood there was confusion surrounding the EQIA assessment being completed. As it has not been formally approved it has not been communicated throughout the Trust. Upon reviewing the policy, we noted that the Policy uses interchangeable terminology between "policy" and "procedure" and some of the responsibilities for the applicant, recruiting manager and NHS Shared Services Partnership (NWSSP) are not clearly defined. There is no specific recruitment work plan in place, although there is a workforce alignment plan aligned with the Strategy Progress has been made with staff recruitment initiatives, in spite of the work pressures facing existing staff. Examples include: the introduction of a managers recruitment toolkit, Disclosure Barring Service (DBS) procedure and development of the incremental credit policy, and a governance process which links with successful recruitment.	Potential risk of: • Staff not aware of roles and responsibilities regarding recruitment. • The Policy has not been approved by the appropriate forum so not in accordance with the framework. • Without an approved policy in place there is a risk that the Trust will not be able to attract, recruit and develop qualified staff with the appropriate skills required.

Recommendations		**Priority**
2.1	The Trust should ensure the Recruitment and Selection Policy is approved and communicated throughout the Trust.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The Recruitment and Selection Policy has been endorsed by EMB and is on the agenda for January 2024 Quality, Safety and Performance Committee for endorsement before approval at Trust Board on 30th January 2024. The Policy will then be promoted and published on the Trust Intranet by the end of February 2024.	29th February 2024	Head of Workforce

Matter Arising 3: Monitoring and Reporting (Design)	**Impact**
There are different layers of reporting within the Trust including divisional, the Steering Group, committees, and Board level. We were able to see the flow of information regarding recruitment and retention within the divisions through dashboard reporting, the ARR Group through to the QSP Committee and then the Board. Updates are usually in the form of highlight reports and workforce updates. We reviewed highlight reports from the Attraction, Recruitment and Retention (ARR) group, but found that it last convened during December 2022 and last reported to the Executive Management Board (EMB) in January 2023. An evaluation report is scheduled to go to the EMB during January 2024. We confirmed that there is an overview of workforce issues at a Board and committee level, but there is an absence of monitoring / tracking of the success of recruitment and retention initiatives introduced. Furthermore, there is some information presented in the forums about vacancy rates decreasing, but there is no information regarding staff turnover or other related metrics.	Potential risk of: • Limiting reporting around performance of recruitment and retention actions runs the risk of progress not being fed to Board if required.

Recommendations		**Priority**
3.1a	The Trust should implement performance measures to ensure regular monitoring of the current position and the impact of actions implemented. The information should be reported into appropriate committees.	**Medium**
3.1b	The Trust should measure the effectiveness of its recruitment and retention initiatives.	

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Currently the Trust has in place Divisional dashboards to monitor recruitment and retention which are updated monthly. The Supply and Shape report that is reported to Quality Safety and Performance Committee via EMB quarterly will have a robust section on Attraction and Retention and monitor recruitment measures and hotspot areas from January 2024.	31st January 2024	Deputy Director of OD & Workforce

3.1b	The People Strategy Implementation Plan contains details of recruitment and retention activities. General reporting takes place on a monthly basis, however, the effectiveness of specific initiatives will be monitored throughout and reported on a quarterly basis through EMB onto Quality, Safety and Performance Committee. To allow sufficient time to embed current initiatives, reporting will commence in July 2024.	31st July 2024	Head of Workforce

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST NOVEMBER (M8)

DATE OF MEETING	16/01/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	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 October2023. 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, however an unlikely risk remains around securing funding for additional nVCC project management costs, with a request having now been submitted to the Minister by WG officials seeking funding approval. **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 Nov '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 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.

RECOMMENDATION / ACTIONS	**QSP** is asked to:

	NOTE 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 WG Capital funding being approved. **ENDORSE** 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.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	02/01/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

EMB endorsed for 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.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed. N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the **"How to Guide for Reporting to Trust Board and Committees"*** N/A

APPENDICES	
Appendix 1	Trust Finance Report - November 2023
Appendix 2	TCS Finance Report – November 2023

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of November 2023 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 £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.011	0.017	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	5.054	19.331	28.557
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	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 November'23 is an underspend of **£0.017m**, 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	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m 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	1.991	

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 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.

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 97.6% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently also achieving a target of 97.6% as at the end of October.

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 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.

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 which may arise over the remainder of the year, however, if this reserve and other reserves are not utilised the Trust may 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 have now either been managed or mitigated for 2023/24.

There are still several risks that may impact from 2024/25 with the material risks being SDEC Funding uncertainty, Whitchurch site security costs and operational cost pressures highlighted within the main finance report.

2.8 Capital

All Wales Programme

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) Projects the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG in September, with the caveat that the funding will be re-provided in future years.

Capital funding has not been allocated for the additional nVCC Project costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding, with the latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Additional costs of c0.750m are also now expected to be incurred on the nVCC advanced design works following the delay to the nVCC.

WG officials have informed the Trust that a request has been submitted to the minister seeking funding approval to cover these additional costs.

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 (for all capital programmes apart from the nVCC Project), 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 cash position has been further escalated recently as the Trust is yet to receive funding for the 2023-24 AfC or Medical pay awards which led to a net cash outflow directly in relation to the unfunded pay awards of c£13m as at the October pay 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: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply

	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.017m** for November'23 which is in line with the IMTP financial plan. The capital position is forecast overspend as the Trust is awaiting confirmation that additional nVCC Project costs

	and additional advanced design work costs will be funded by WG.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

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

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2023/24

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
16/02/2023

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.

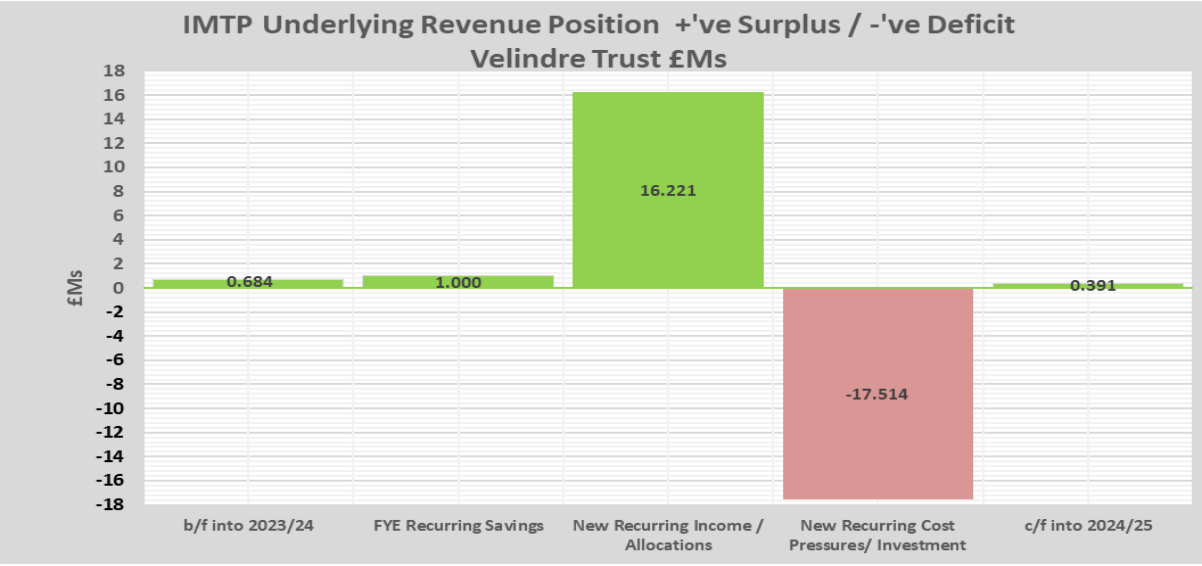
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- 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.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1.000	16.221	-17.514	0.391

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.011	0.017	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	5.054	19.331	28.557
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	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 **£0.011m** underspend on the in-month position for November in '23, which gives a year to date cumulative underspend of **£0.017m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of November 2023 is **£26.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to Novemberr'23 of £19.331m and is currently forecasting to remain within the CEL of £26.469m, however is reliant on the Trust receiving funding from WG to support the nVCC project costs and additional costs advanced design works following the delay of Financial close.

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 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
Cyber Security		0.051	0.051
Total All Wales Capital	**22.733**	**0.233**	**22.966**
Total CEL	**24.416**		**24.649**

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.

PSPP

During November '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.6%** as at the end of month 8, and a Trust position (including hosted) also of **97.6%** 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

Cumulative				Forecast		
£0.017m Underspent				**Breakeven**		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(129.557)	(131.308)	1.751	(198.253)	(200.006)	1.753
Pay	57.280	57.049	0.231	85.218	85.009	0.209
Non Pay	72.277	74.241	(1.964)	113.035	114.997	(1.962)
Total	**0.000**	**(0.017)**	**0.017**	**0.000**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of November 2023 is an underspend of **£0.017m** 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 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	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m 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	1.991	

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

It is 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. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position (Nov'23 M8) 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 November '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	-0.039	0.244	-14%
Swansea Bay (7A3)	0.294	-0.007	0.287	-2%
Cardiff & Vale (7A4)	15.036	1.485	16.522	10%
Cwm Taf Morgannwg (7A5)	13.221	1.146	14.367	9%
Aneurin Bevan (7A6)	17.344	1.442	18.786	8%
Powys (7A7)	0.758	0.179	0.938	24%
WHSSC	2.633	-0.314	2.319	-12%
Total	**49.569**	**3.893**	**53.463**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Radiotherapy	17.929	-0.162	17.766	-1%
Nuclear Medicine	0.923	-0.043	0.880	-5%
Radiology Imaging	2.840	0.540	3.381	19%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.155	2.749	6%
Delivery of Systemic Anti-Cancer Therapy	5.935	0.953	6.888	16%
Ambulatory Care Services	1.235	0.251	1.486	20%
Outpatient Services		2.241	11.470	24%
Inpatient Admitted Care	9.229	-0.041	8.843	0%
Total	**49.569**	**3.893**	**53.463**	**8%**

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date (£3.5m). However, there remains a small risk that planned growth for the remainder of the year may not transpire at the projected levels.

Pay Highlights / Key Issue

At this stage the Trust is 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). 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) and WBS (£0.450m) hold a vacancy factor target, which will need to be achieved during 2023-24 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.

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£0.700m. As noted above this potentially releases c£0.491m back into the system to support the NHS Wales Financial Pressures.

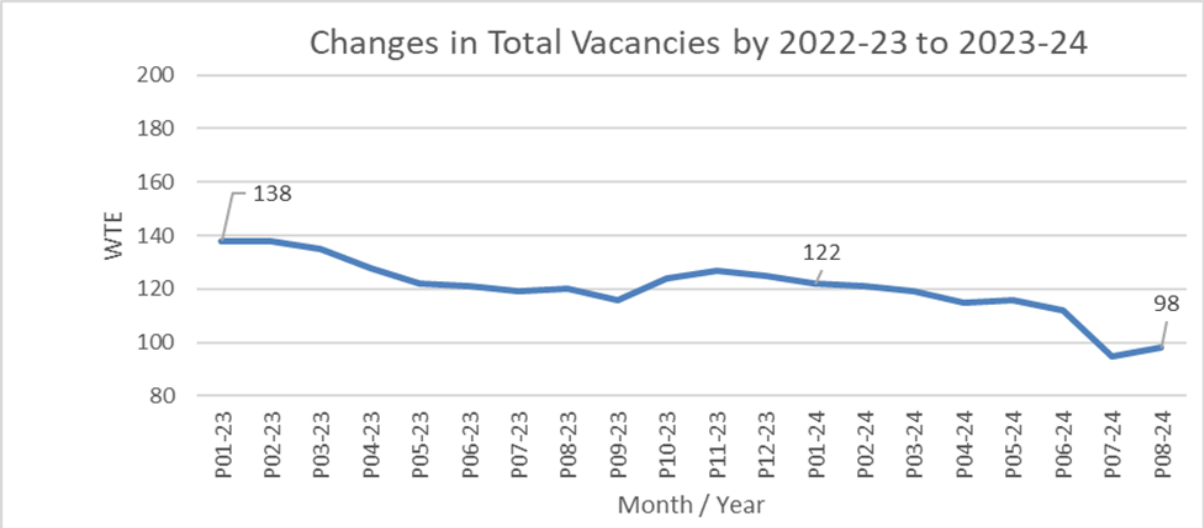
The Trust emergency reserve remains uncommitted at this stage and should it not be required may be released to support the overall NHS Wales Position. The budget for the reserves is held in month 12 and is released into the position to match agreed spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

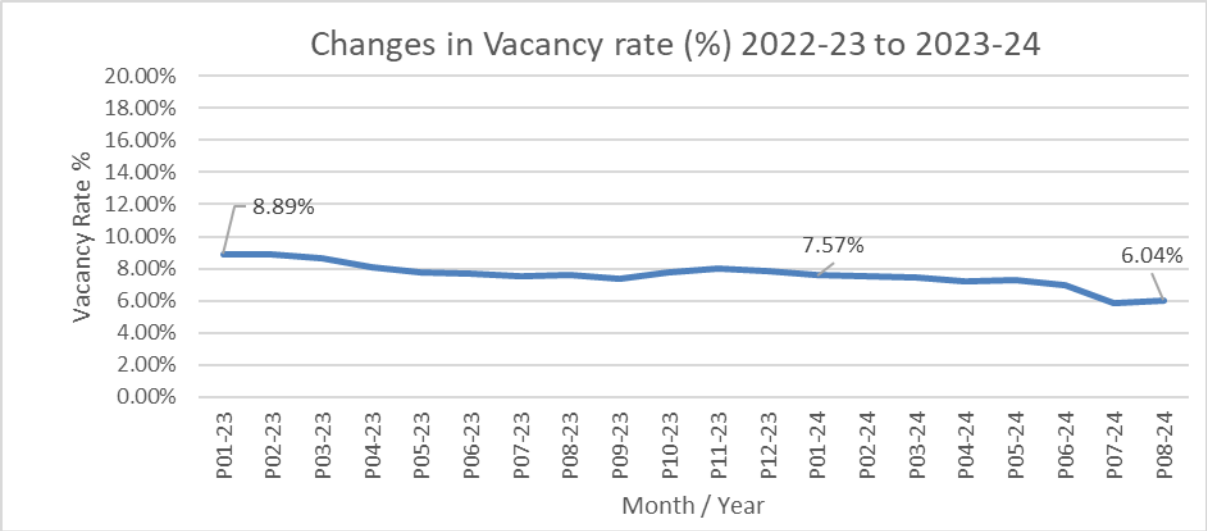
As of November 2023, the current staff in post is 1,524 WTE. The number of vacancies is 98 WTE, which represents a vacancy rate of 6.04% against the budget of 1622 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

Vacancies throughout the Trust is reducing, 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 exploring the international recuritment scheme. During October'23 VCS filled 10 vacancies across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy.

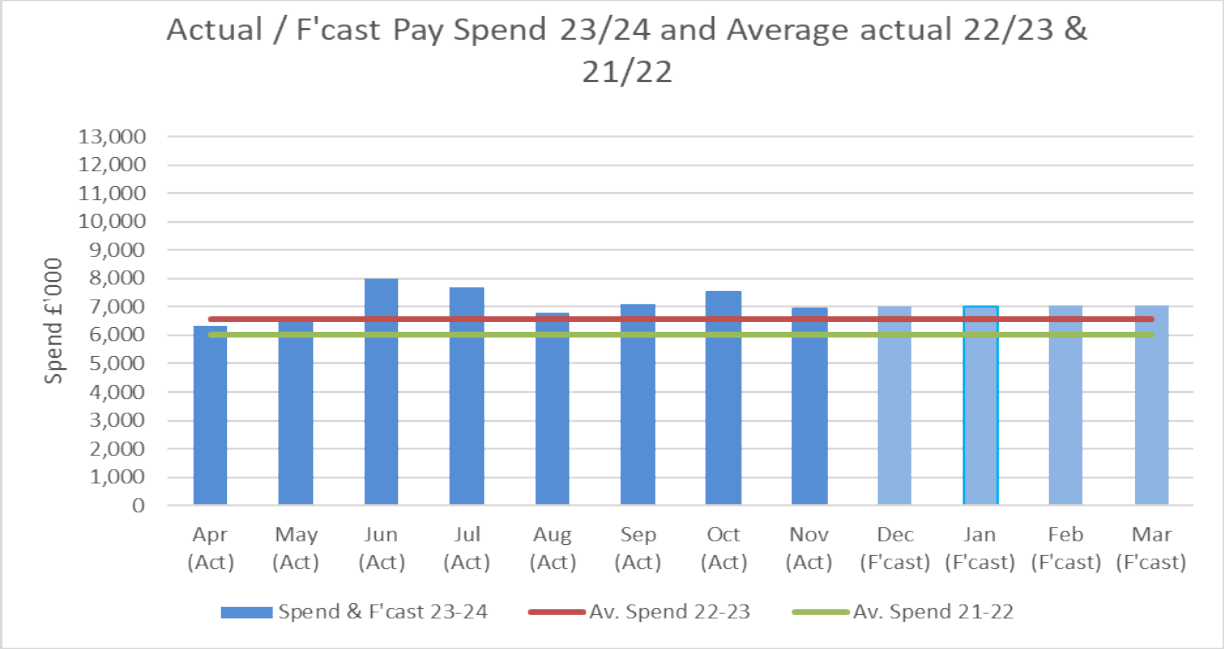
The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to November 2023:



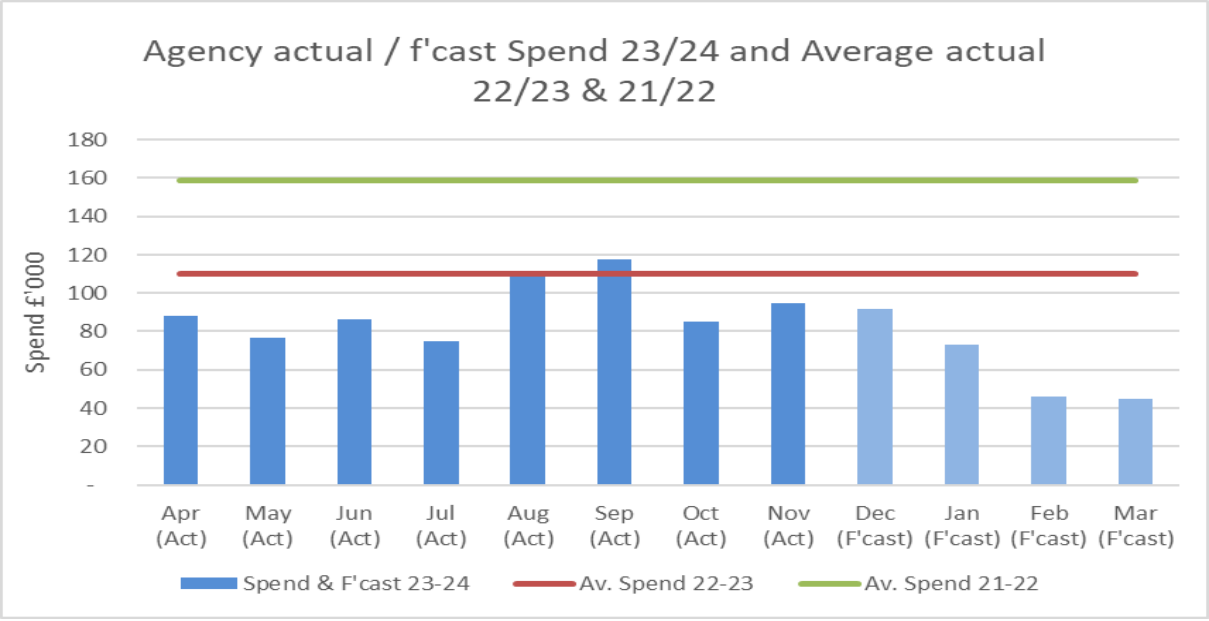
The total Trust vacancies as of November 2023 is 98wte (October 95wte), VCC (54wte), WBS (30wte), Corporate (7wte), R&D (3wte), TCS (2wte) and HTW (2wte).



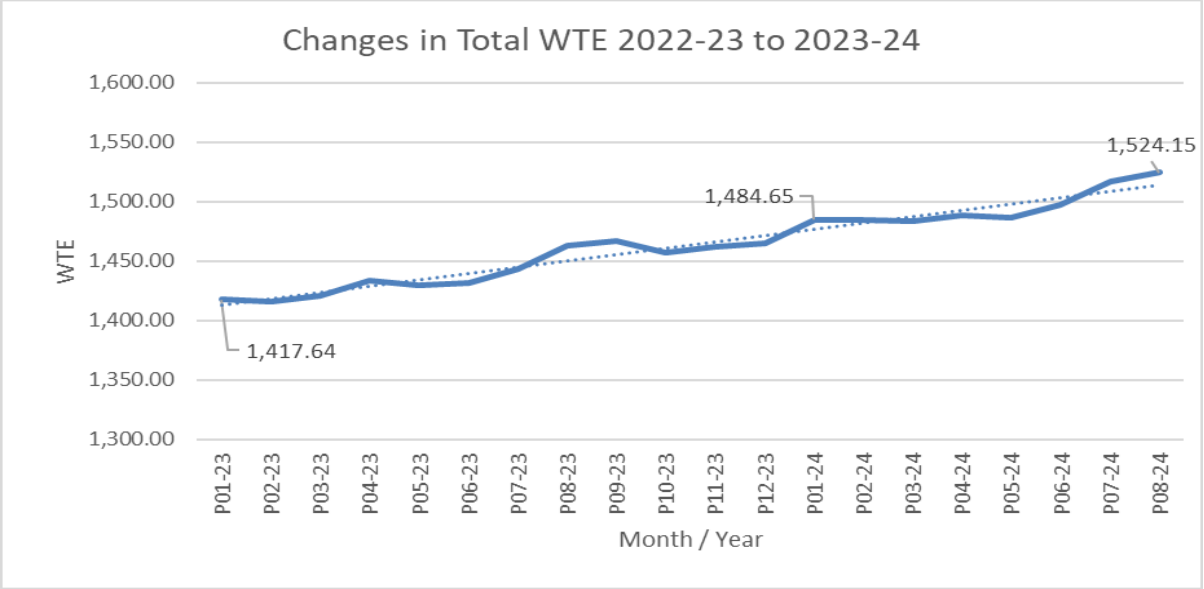
Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in 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.

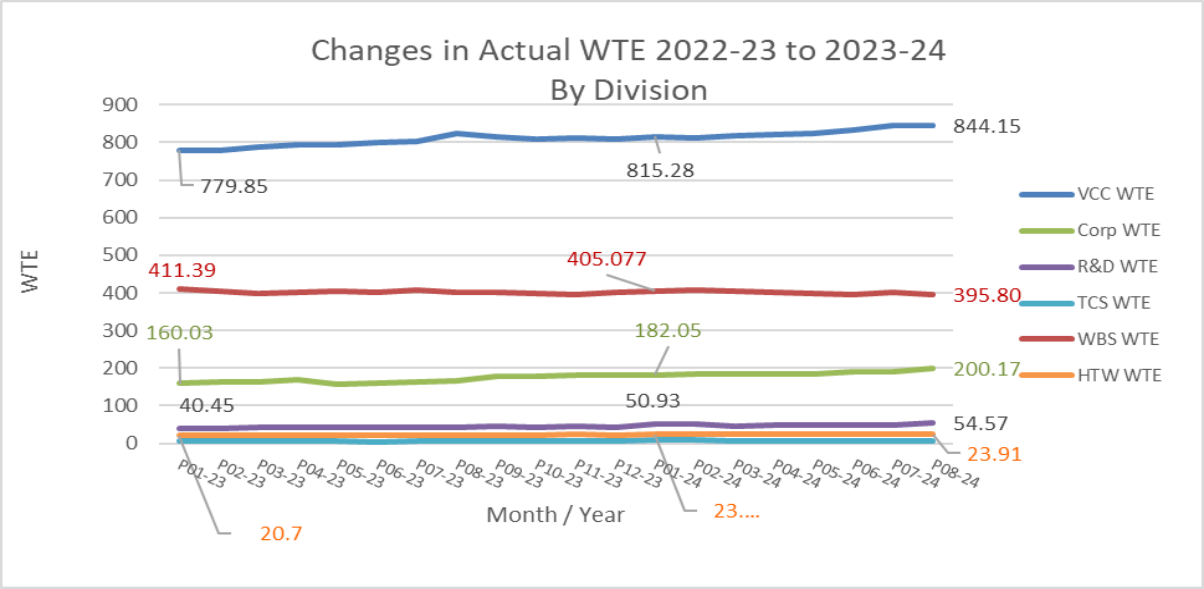


*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.



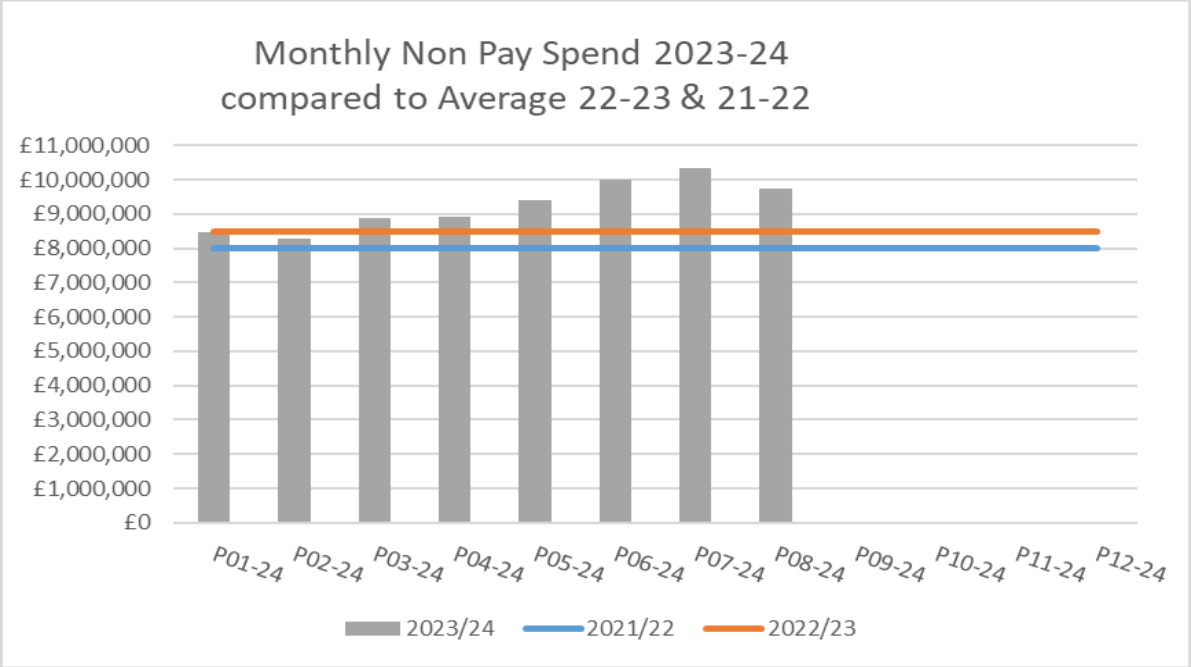
The spend on agency for Nov'23 was **£0.095m** (Oct £0.085m), which gives a cumulative year to date spend of £0.732m and a current forecast outturn spend of circa **£0.987m** (£1.323m 2022/23).





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 £9.2m per month which is a £0.7m increase from the previous whole year average. Largest movement is in drug spend which has increased by £4.2m ytd, or £0.7m 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 October 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.

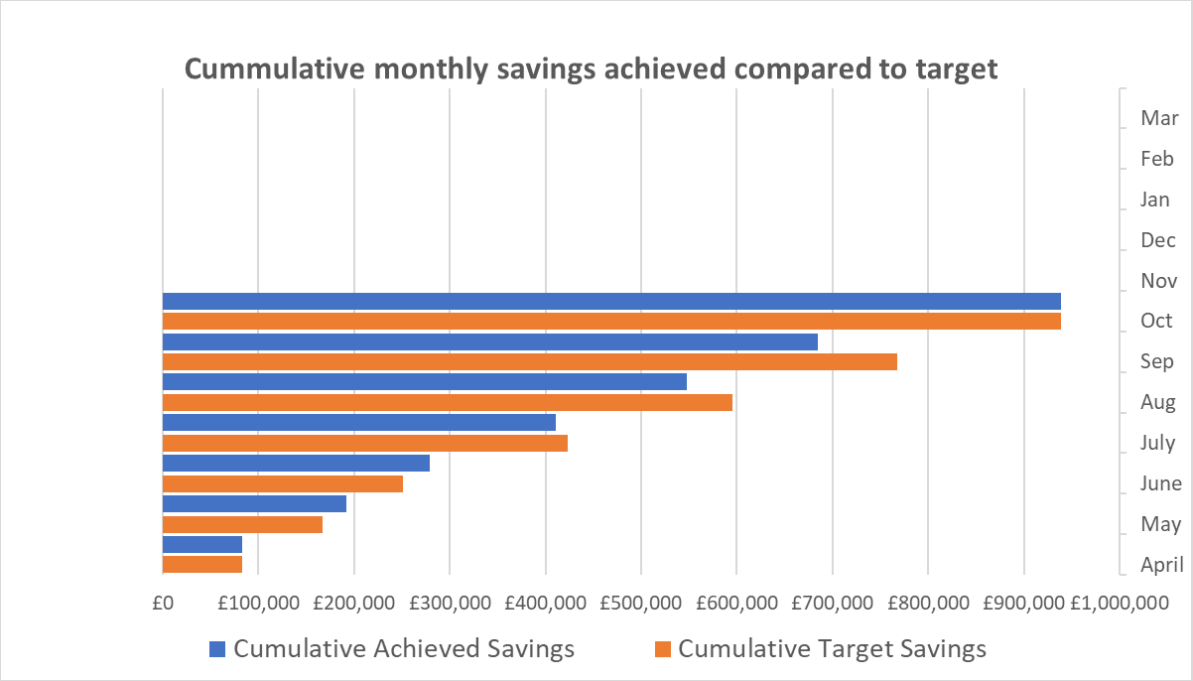
Service redesign and support service structures continue to be a key area for the Trust where it is focusing on to find efficiencies in the ways we are working, ensuring the appropriate staff are undertaking each activity. Whilst this remains a high priority the ability to enact change has been challenging 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 for 2023-24.

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**	**488**	**488**	**0**	**950**	**0**
			100%		**100%**	
WBS TOTAL SAVINGS	**700**	**364**	**364**	**0**	**700**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**150**	**88**	**88**	**0**	**150**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**939**	**939**	**0**	**1,800**	**0**
			100%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Establishment Control (N/R) (Corporate)	Green	75	44	44	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	44	0	(44)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	6	6	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	5	5	0	8	0
Establishment Control (R) (WBS)	Green	60	35	35	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	24	0	(24)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	15	0	(15)	25	0
Stock Management (NR) (WBS)	Green	125	73	125	52	125	0
Reduced Transport Maintenance (NR) (WBS)	Green	30	13	0	(13)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Green	137	61	23	(38)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	22	0	(22)	0	(50)
Establishment Control (NR) (VCS)	Green	175	78	78	0	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Green	150	67	67	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	73	73	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	29	29	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	44	0	(44)	0	(100)
Total Saving Schemes		**1,275**	633	484	(149)	970	(305)
Income Generation							
Bank Interest (R) (Corporate)	Green	75	44	44	0	75	0
Sale of Plasma (R) (WBS)	Green	150	88	88	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	117	117	0	200	0
Private Patient Income (R) (VCS)	Green	50	29	29	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	29	29	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	67	67	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	83	83	155	155
Total Income Generation		**525**	306	456	150	830	305
TRUST TOTAL SAVINGS		**1,800**	**939**	**940**	**0**	**1,800**	**0**
				100%		**100%**	



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 first 6 months of 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, if this reserve and other reserves are not utilised the Trust may 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 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

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.

VCS - SDEC Funding 2024/25 – *Risk 2024/25. £0.935m*

At time of submission of its Business Cases the Trust received assurance from WG Officers that the SDEC funding was recurrent in nature, however the Trust is yet to receive written confirmation to confirm the recurrent funding. Whilst the funding has been confirmed for the current financial year, if this is not secured recurrently it would impact the Trust's underlying position to be carried into 2024/25.

Opportunities

The majority of opportunities have now been accounted for into the overall financial position. The remaining opportunities which have been reported to WG which are in addition to those contributions that have been identified to support the delivery of a reduction in the NHS Wales deficit include:

VCS - Recovery and Planned Care Capacity- *Opportunity / Likelihood - Medium*

The current forecast activity and income to the end of the financial year would lead to £0.300m income opportunity. This income needs to be prioritised for investment against significant service capacity increases required and statutory / mandatory compliance cost pressures in the VCS. The ability to implement these investment priorities in 2023-24 may lead to further non-recurrent reserves being generated.

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 @ M8 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	8.690	0.000	2.206	10.896	0.000
nVCC - Project costs	0.000	2.308	0.000	(2.308)	3.141	(3.141)
nVCC - Advanced Works	3.882	3.171	0.000	0.711	4.631	(0.749)
nVCC - Whitchurch Hospital Site	0.000	0.018	0.000	0.000	0.018	(0.018)
Integrated Radiotherapy Solutions (IRS)	7.826	4.712	0.000	3.114	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Cyber Security	0.051	0.000	0.000	0.000	0.051	0.000
Total All Wales Capital Programme	22.966	18.899	0.000	4.034	26.874	(3.908)
Discretionary Capital	1.683	0.432	0.000	1.251	1.683	0.000
Total	24.649	19.331	0.000	5.285	28.557	(3.908)

The approved Capital Expenditure Limit (CEL) as at November 2023 is **£24.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.**

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

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG during this September, with the caveat that the funding will be re-provided in future years.

The discretionary allocation of £1.683m 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.

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 14th February 2024 for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received.

Performance to date

The actual expenditure to November 2023 on the All-Wales Capital Programme schemes was £18.899m, this is broken down between spend on the nVCC enabling works £8.690, nVCC Project Costs £2.308m, nVCC Advanced works £3.171m, nVCC Whitchurch Hospital Site £0.018m and IRS £4.712m.

Spend to date on Discretionary Capital is currently £0.432m.

Year-end Forecast Spend

Capital funding has not been allocated for the additional nVCC Project costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding, with the latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Additional costs of c0.750m are also now expected to be incurred on the nVCC advanced design works following the delay to the nVCC.

WG officials have informed the Trust that a request has been submitted to the minister seeking funding approval to cover these additional costs.

All other 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), 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 financial year cash flows for many of these schemes including the IRS and IRS Satellite projects require further re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will be revised due to the VCC project delays for inclusion in the final FBC. The Digital and Digital scanning infrastructure schemes are also being revised with expectation that costs will now land in future years. All schemes will be reviewed and updated as part of the IMTP process which is underway, and the first draft will be presented on the 16th January.

The schemes that were included within the IMTP for 2023-24 are provided below:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	10.896	0.000	1.547			12.443
Integrated Radiotherapy Solution (IRS)	10.326	14.697	6.150			31.173
IRS Satellite Centre	1.347	10.065				11.412
Digital Priority Fund - WHIAS Project	0.167					0.167
Total Approved Capital Schemes	**22.736**	**24.762**	**7.697**	**0.000**	**0.000**	**55.195**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital Scannining infrastructure	2.536	0.536				3.072
Total Unapproved Capital Schemes	**12.300**	**38.330**	**21.055**	**10.896**	**10.961**	**93.542**
Total All Wales Capital Plans	**35.036**	**63.092**	**28.752**	**10.896**	**10.961**	**148.737**

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.

	Opening Balance Beginning of Apr 23	Closing Balance End of Nov-23	Movement from 1st April Nov-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	170.418	181.802	11.384	181.802
Intangible assets	11.194	10.712	(0.482)	10.712
Trade and other receivables	1,107.047	1,111.837	4.790	1,111.837
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,288.659	1,304.351	15.692	1,304.351
Current Assets				
Inventories	34.070	30.950	(3.120)	30.950
Trade and other receivables	565.742	557.500	(8.242)	570.588
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	23.488	(7.648)	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.948	611.938	(19.010)	611.938
TOTAL ASSETS	1,919.607	1,916.289	(3.318)	1,916.289
Current Liabilities				
Trade and other payables	(226.254)	(218.423)	7.831	(218.423)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(431.449)	(38.924)	(431.449)
Current Liabilities sub total	(619.902)	(649.872)	(29.970)	(649.872)
NET ASSETS LESS CURRENT LIABILITIES	1,299.705	1,266.417	(33.288)	1,266.417
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	194.297	9.024	194.297
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	139.928	8.467	139.928
Retained earnings	19.104	19.536	0.432	19.536
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.273	194.297	9.024	194.297

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.

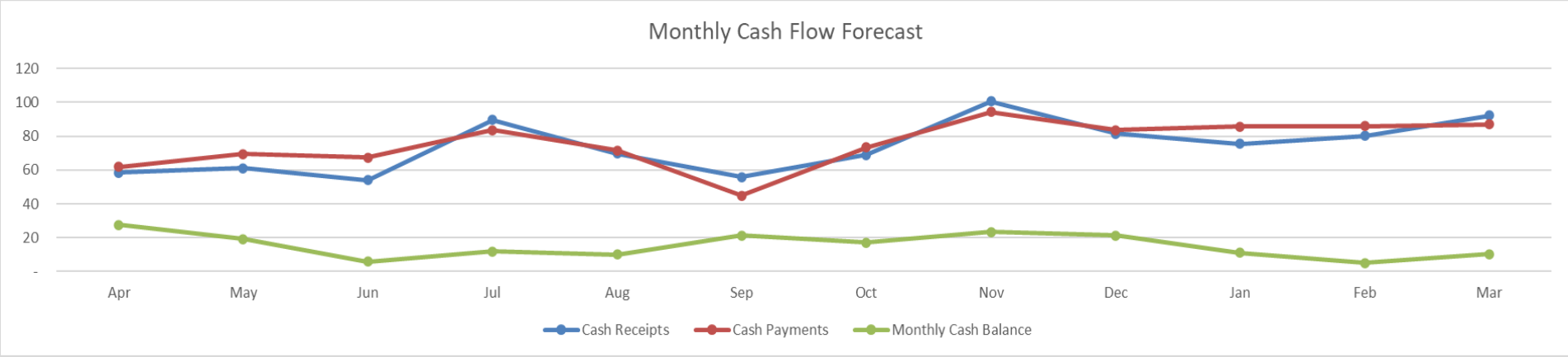
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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. The cash position has been further escalated recently as the Trust is yet to receive funding for the 2023-24 AfC or Medical pay awards which has left a net cash outflow directly in relation to the unfunded pay awards of c£13m.

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	45.997	45.302	46.530	47.662	522.297
2	WG Income	14.460	18.799	9.707	42.966	22.143	2.138	9.901	40.339	30.778	24.722	27.378	25.053	268.384
3	Short Term Loans													0.000
4	PDC							8.881					12.199	21.080
5	Interest Receivable	0.149	0.162	0.143	0.126	0.106	0.117	0.140	0.107	0.100	0.100	0.100	0.100	1.450
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	5.886	12.689	4.605	9.557	4.550	5.350	6.250	7.325	74.724
8	TOTAL RECEIPTS	**58.346**	**61.092**	**53.900**	**89.648**	**69.716**	**55.971**	**69.035**	**100.732**	**81.425**	**75.474**	**80.258**	**92.339**	**887.935**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	34.922	34.500	37.556	39.292	35.906	35.917	35.941	35.875	430.226
10	Non pay items	28.883	34.362	26.186	46.813	35.820	9.253	33.404	49.863	43.300	47.602	46.650	44.473	446.609
11	Short Term Loan Repayment											0.000		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	4.500	2.162	3.482	6.776	31.837
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.477**	**67.339**	**83.564**	**71.566**	**44.847**	**73.257**	**94.232**	**83.706**	**85.681**	**86.073**	**87.124**	**908.672**
17	Net cash inflow/outflow	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(4.222)	6.500	(2.281)	(10.207)	(5.816)	5.215	
18	Balance b/f	31.136	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	21.207	11.000	5.185	
19	Balance c/f	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	21.207	11.000	5.185	10.400	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(28,365)	(28,366)	0	(41,288)	(41,288)	(0)
RD&I	(399)	(397)	(1)	91	91	0
WBS	(14,726)	(14,725)	(0)	(21,666)	(21,666)	0
Sub-Total Divisions	**(43,490)**	**(43,488)**	**(1)**	**(62,862)**	**(62,862)**	**(0)**
Corporate Services Directorates	(8,895)	(8,897)	2	(13,188)	(13,188)	(0)
Delegated Budget Position	**(52,385)**	**(52,386)**	**1**	**(76,050)**	**(76,050)**	**(0)**
TCS	(501)	(484)	(17)	(744)	(744)	0
Health Technology Wales	(62)	(61)	0	(117)	(117)	0
Trust Income / Reserves	52,948	52,948	0	76,911	76,911	0
Trust Position	**(0)**	**17**	(17)	**(0)**	**(0)**	**(0)**

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**48.770**	**49.692**	**0.922**	**75.632**	**76.554**	**0.922**
Expenditure						
Staff	**33.361**	**33.470**	**(0.109)**	**49.589**	**49.698**	**(0.109)**
Non Staff	**43.775**	**44.588**	**(0.813)**	**67.331**	**68.144**	**(0.813)**
Sub Total	**77.136**	**78.057**	**(0.922)**	**116.920**	**117.842**	**(0.922)**
Total	**(28.365)**	**(28.366)**	0.000	**(41.288)**	**(41.288)**	**(0.000)**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of November 2023 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 8 represents a surplus of **£0.920m**. 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 small income overachievements in areas such as Catering and project income which are offset with non-pay costs.

VCS have reported a year to date overspend of **£(0.109)m** against staff. The division continues to have reasonably high levels of vacancies although reducing with VCS filing 10 vacancies in October across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy. Vacancies sickness, and maternity leave still remain relatively high across several services and particularly across 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 is being explored within Nursing to help fill current vacancies with posts expected to commence from December.

Non-Staff Expenditure at Month 8 was **£(0.813)m** overspent which is a result of the divisional management savings target, along with increased activity pressures which can be linked to contract performance and 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	**18.783**	**19.019**	**0.237**	**28.181**	**28.417**	**0.237**
Expenditure						
Staff	**12.307**	**12.271**	**0.036**	**18.442**	**18.407**	**0.036**
Non Staff	**21.201**	**21.473**	**(0.272)**	**31.404**	**31.676**	**(0.272)**
Sub Total	**33.508**	**33.745**	**(0.236)**	**49.846**	**50.083**	**(0.236)**
Total	**(14.726)**	**(14.725)**	0.000	**(21.666)**	**(21.665)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of November 2023 was **Breakeven** with an outturn forecast position of **Breakeven** currently expected.

Income overachievement of **£0.237m** to month 8. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities to support divisional investment. Temporary drop in plasma sales during November primarily due to staffing issues and temperature control of external freezer, issue has been reported and is being reviewed within the Service. 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 have previously run campaigns to try and grow the panel in sites such as schools and universities, however the year to date target is currently underachieving by c40%.

Staff reported a **£0.036m** underspend to November. 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 **£(0.272)m** to November. 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	**1.755**	**2.289**	**0.534**	**2.583**	**3.117**	**0.534**
Expenditure						
Staff	**8.195**	**7.907**	**0.288**	**12.206**	**11.918**	**0.288**
Non Staff	**2.456**	**3.279**	**(0.824)**	**3.566**	**4.388**	**(0.822)**
Sub Total	**10.651**	**11.186**	**(0.536)**	**15.772**	**16.305**	**(0.534)**
Total	**(8.895)**	**(8.897)**	(0.002)	**(13.188)**	**(13.188)**	**(0.000)**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of November 2023 was a small overspend 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 £0.288m as at month 8.

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	**1.661**	**1.723**	**0.063**	**3.330**	**3.392**	**0.062**
Expenditure						
Staff	**1.901**	**1.906**	**(0.006)**	**2.956**	**2.962**	**(0.006)**
Non Staff	**0.159**	**0.214**	**(0.055)**	**0.283**	**0.338**	**(0.055)**
Sub Total	**2.059**	**2.120**	**(0.061)**	**3.239**	**3.300**	**(0.061)**
Total	**(0.399)**	**(0.397)**	(0.001)	**0.091**	**0.092**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of November 2023 was **breakeven** with a current forecast outturn position of **breakeven**.

Trials Income fluctuations expected throughout the year.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	491	473	17	730	730	**0**
Non Staff	10	11	(0)	15	15	**0**
Sub Total	**501**	**484**	**17**	**744**	**744**	**0**
Total	**(501)**	**(484)**	**17**	**(744)**	**(744)**	**0**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of November 2023 is **£(0.017)m** overspent with a forecasted outturn position of **Breakeven.**

Interest received from the Escrow account is expected to be used to mitigate the current overspend which is reflected in the TCS report where the expenditure budgets have been inflated to match actual spend.

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	**1.050**	**1.047**	**(0.003)**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**1.026**	**1.022**	**0.004**	**1.545**	**1.545**	**0.000**
Non Staff	**0.086**	**0.086**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**1.112**	**1.108**	**0.004**	**1.794**	**1.794**	**0.000**
Total	**(0.062)**	**(0.061)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

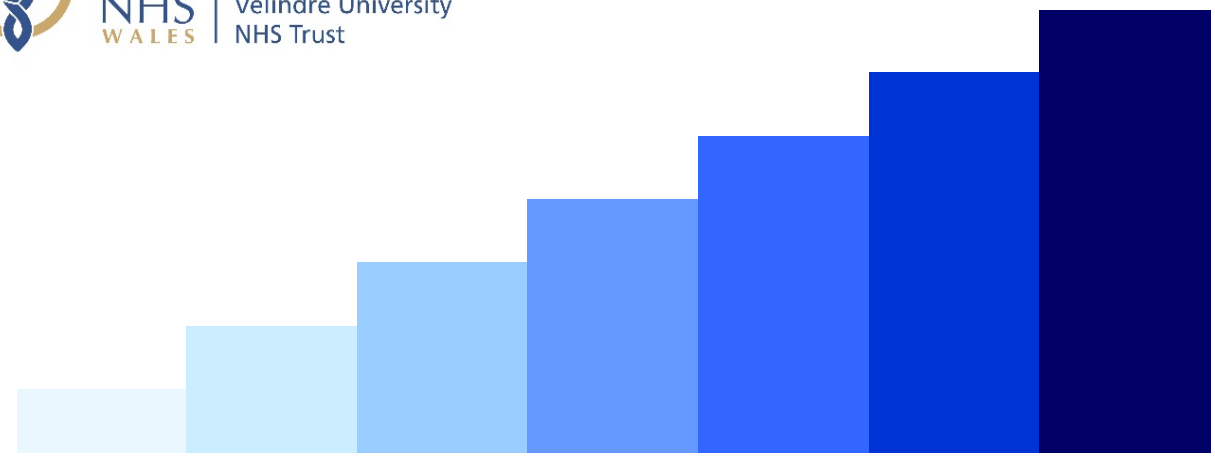
HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of November 2023 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW programme costs are funded directly by WG.

The pay award is to be funded via the Trust allocation for 2023/24 and going forward.

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



TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 30th November 2023

Presented to EMB Shape on
18th December 2023

Contents

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 30th September 2023 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 30th November 2023 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	£14.189m	£14.778m	£18.685m	-£3.907m
Revenue	£0.513m	£0.785m	£0.785m	£0
Total	**£14.702m**	**£15.564m**	**£19.470m**	**-£3.907m**

2.2 The overall forecast outturn for the Programme is an overspend of £3.907m for the financial year 2023-24 against a budget of £15.564m.

2.3 Capital funding has not been allocated for the FBC phase of the nVCC Project for this financial year. The funding request for c£2.800m made to WG will be increased to £3.140m.

2.4 Capital funding of £3.882m has been allocated to the nVCC Project by WG for advanced works for the FBC stage, confirmed in October 2023.

2.5 No revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year. These costs will be funded from the interest gained from the Escrow account for ASDA.

2.6 The current financial risks associated with TCS are:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

- The current risk to the nVCC Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

- There is a risk of a lack of funding for the Advanced Works Agreement element of the ADDA. This is being mitigated by A funding request is being submitted to WG, who have agreed to underwrite these costs.

- There is also the 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.

3. BACKGROUND

3.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

3.2 By 31st March 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2,293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018/19, increased to £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2023-24 is £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	-£0.230m	-£0.230m
nVCC Project	£0	£0
ADDA	£3.882m	£3.882m
Whitchurch Hospital Site	£0	£0
Total	**-£0.230m**	**-£0.230m**

Current Allocation (as at 30th November 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.667m	£10.667m
nVCC Project	£0	£0
ADDA	£3.882m	£3.882m
Whitchurch Hospital Site	£0	£0
Total	**£10.667m**	**£10.667m**

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 30th November 2023)

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 £0
- ADDA £3.882m
- Whitchurch Hospital Site £0

Total **£14.778m**

4.2 The capital position as at 30th November 2023 is outlined below, with a forecast overspend of £18.685.150m for 2023-24 against a budget of £14.778m. This is due to the lack of capital funding being allocated to the nVCC Project for this financial year.

Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£8.691m	£10.896m	£10.896m	£0.001m
nVCC Project	£2.309m	£0	£3.141m	-£3.141m
ADDA	£3.172m	£3.882m	£4.631m	-£0.749m
Whitchurch Hospital Site	£0.018m	£0	£0.018m	-£0.018m
Total	**£14.189m**	**£14.778m**	**£18.685m**	**-£3.907m**

4.3 A funding request has been made to WG for c£2.800m for the nVCC Project, which will be amended to reflect the increased overspend of £3.140m.

4.4 There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.300m. 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 30th November 2023 is outlined below, with a forecast break even position for the financial year for 2023-24 against a budget of £0.785m. This is due to the lack of funding for the nVCC revenue non-pay costs for this financial year.

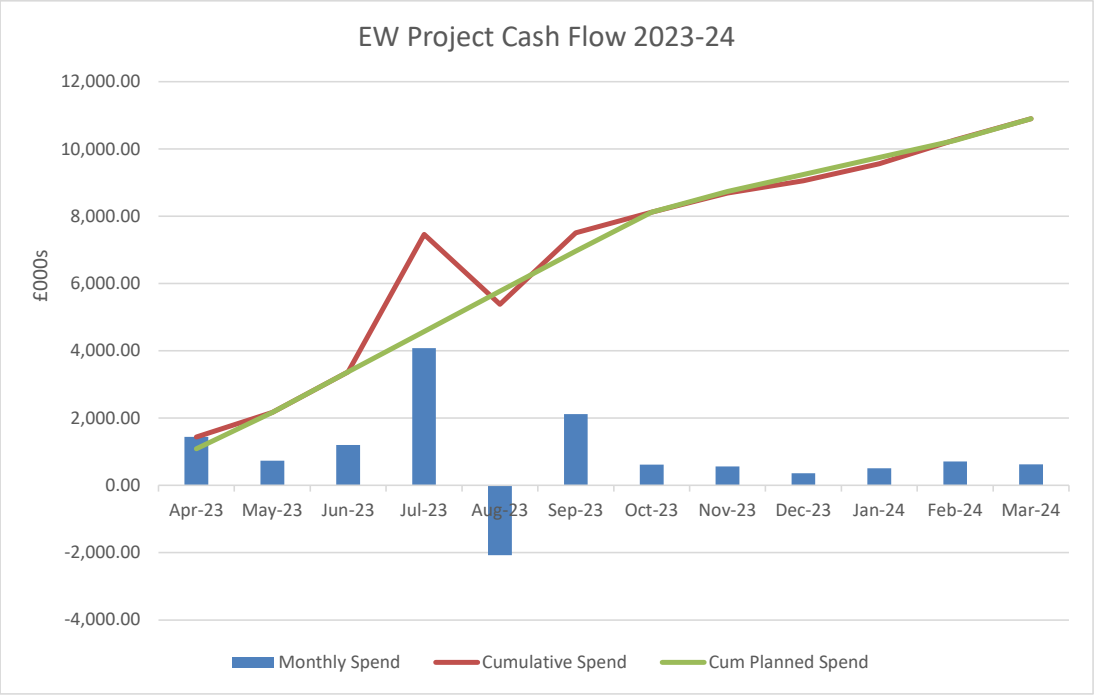
Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
PMO	£0.215m	£0.328m	£0.328m	£0
nVCC Project	£0.100m	£0.137m	£0.137m	£0
SDT Project	£0.198m	£0.320m	£0.320m	£0
Total	**£0.513m**	**£0.785m**	**£0.785m**	**£0**

5.3 Revenue funding of £0.041m will be provided to the nVCC Project for Project Delivery and Judicial Review costs.

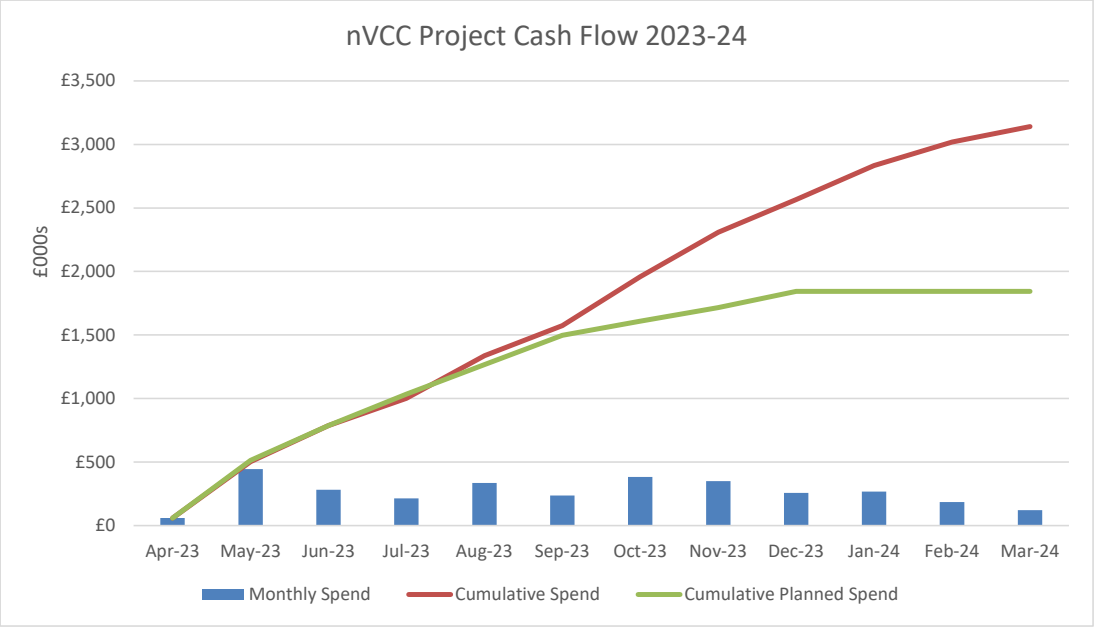
5.4 The 2022-23 one-off pay recovery payment was paid out in June 2023, with funding provided by WG in June 2023 via the Trust. Funding has also been provided by WG to cover the recurrent pay award for 2023-24 paid out in August 2023.

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.



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.



6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The current revenue funding for the PMO for 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 30th November 2023 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	£0.212m	£0.327m	£0.327m	£0
Non-Pay	£0.003m	£0.001m	£0.001m	£0
Total	**£0.215m**	**£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 30th November 2023 is shown below. The forecast position reflects an expected underspend of £0.001m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.213m	£0.230m	£0.297m	-£0.067m
Non-Pay	£8.478m	£10.667m	£10.599m	£0.068m
Total	**£8.691m**	**£10.896m**	**£10.896m**	**£0.001m**

7.8 There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.300m. 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 £0.250m inc VAT

Total **£2.300m inc VAT**

7.9 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2023-24

Description		Year to Date Budget Nov-23 £	Year to Date Spend Nov-23 £	Year to Date Variance Nov-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		171,227	212,987	-41,759	229,841	297,155	-67,314
Pay Capital Total		**171,227**	**212,987**	**-41,759**	**229,841**	**297,155**	**-67,314**
NON-PAY							
EF02	Utility Costs	2,134,351	1,491,385	642,967	2,873,927	2,491,385	382,542
EF03	Supply Chain Fees	233,333	306,688	-73,355	375,000	413,688	-38,688
EF04	Non Works Costs	208,337	83,100	125,236	312,505	173,000	139,505
EF05	ASDA Works	2,951,946	2,366,836	585,110	3,813,893	2,712,235	1,101,658
EF06	Walters D&B	3,033,982	4,229,954	-1,195,973	3,033,982	4,354,954	-1,320,973
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	0	0	0
EF08	Section 278	0	0	0	0	500,000	-500,000
EFQR	Quantified Risk	6,247	512	5,735	257,245	512	256,733
EFQS	QRA - SCP	0	0	0	0	0	0
EFRS	Enabling Works FBC Reserves	0	-549	549	0	-47,049	47,049
Enabling Works FBC Project Capital Total		**8,568,196**	**8,477,928**	**90,269**	**10,666,552**	**10,598,726**	**67,825**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**8,739,424**	**8,690,914**	**48,510**	**10,896,393**	**10,895,881**	**512**

7.10 There are currently two financial risks associated with the Enabling Works Project:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

New Velindre Cancer Centre Project

Capital

7.11 The nVCC Project has not been allocated capital funding for this financial year. A funding request has been made to WG for c£2.800m, which will be updated to £3.140m.

7.12 The capital financial position for the nVCC Project for 30th November 2023 is shown below, with a forecast overspend of £3.141m. This is due to the delay of the nVCC Financial Close into 2023-24 with no funding for the Project at this stage.

nVCC Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.761m	£0	£1.175m	-£1.175m
Non-Pay	£1.548m	£0	£1.966m	-£1.966m
Total	**£2.309m**	**£0**	**£3.141m**	**-£3.141m**

7.13 The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Year to Date Budget Nov-23 £	Year to Date Spend Nov-23 £	Year to Date Variance Nov-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC OBC	0	142,394	-142,394	0	215,952	-215,952
Project 2a - New Velindre Cancer Centre OBC	0	618,501	-618,501	0	959,028	-959,028
Pay Capital Total	**0**	**760,895**	**-760,895**	**0**	**1,174,980**	**-1,174,980**
NON-PAY						
nVCC OBC Project Delivery	**0**	**35,516**	**-35,516**	**0**	**63,000**	**-63,000**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	0	1,349,159	-1,349,159	0	1,727,159	-1,727,159
VC10 Legal Advice	0	9,398	-9,398	0	11,898	-11,898
VC11 S73 Planning	0	14,437	-14,437	0	14,437	-14,437
VC12 nVCC FBC	0	118,254	-118,254	0	118,254	-118,254
VCRS nVCC OBC Reserves	0	20,945	-20,945	0	30,945	-30,945
nVCC Project Capital Total	**0**	**1,512,193**	**-1,512,193**	**0**	**1,902,693**	**-1,902,693**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**2,308,604**	**-2,308,604**	**0**	**3,140,673**	**-3,140,673**

7.14 The current risk to the Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

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 superceded 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 30th November 2023 is shown below, reflecting a forecast break even position for the year against budget of £0.137m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.070m	£0.096m	£0.096m	£0
Project Delivery	£0.019m	£0.030m	£0.030m	£0
Judicial Review	£0.011m	£0.011m	£0.011m	£0
Total	**£0.100m**	**£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 capital financial position for this Project for 30th November 2023 is shown below, with a forecast spend of £4.631m against a current budget £3.882m for the year.

ADDA Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Non-Pay	£3.172m	£3.882m	£4.631m	-£0.749m
Total	**£3.172m**	**£3.882m**	**£4.631m**	**-£0.749m**

7.21 The spend relates to the following activities:

Advanced Design Development Agreement Capital Budget & Spend Summary 2023-24

Description	Year to Date Budget Nov-23 £	Year to Date Spend Nov-23 £	Year to Date Variance Nov-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year 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	2,422,896	2,422,896	1	3,881,995	3,881,994	1
AD02 Advanced Works Agreement	0	748,715	-748,715	0	748,715	-748,715
AD03 Advanced Works Deed of Variation	0	0	0	0	0	0
AD04 Advisory Services	0	0	0	0	0	0
ADRS ADDA Reserves	0	0	0	0	0	0
nVCC Project Capital Total	**2,422,896**	**3,171,611**	**-748,714**	**3,881,995**	**4,630,709**	**-748,714**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**2,422,896**	**3,171,611**	**-748,714**	**3,881,995**	**4,630,709**	**-748,714**

7.22 There is an increase of £0.750m in the forecast spend for the year due to the Advance Works Agreement. A funding request is being submitted to WG, who have agreed to underwrite these costs.

7.23 There is a risk of a lack of funding for these costs, which is being mitigated as noted above.

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 30th November 2023 is shown below, with a forecast overspend of £0.018m.

Whitchurch Hospital Site Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.018m	£0	£0.018m	-£0.018m
Total	**£0.018m**	**£0**	**£0.018m**	**-£0.018m**

Whitchurch Hospital Site Capital Budget & Spend Summary 2023-24

Description	Year to Date Budget Nov-23 £	Year to Date Spend Nov-23 £	Year to Date Variance Nov-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year 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	11,232	-11,232	0	11,232	-11,232
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**	**17,727**	**-17,727**	**0**	**17,727**	**-17,727**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**17,727**	**-17,727**	**0**	**17,727**	**-17,727**

7.26 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

7.27 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.

7.28 There is no capital funding requirement for the Project in 2023-24.

7.29 The SDT Project revenue position for 30th November 2023-24 is shown below, showing a forecast breakeven positon for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.190m	£0.306m	£0.306m	£0
Non-Pay	£0.008m	£0.013m	£0.013m	£0
Total	**£0.198m**	**£0.320m**	**£0.320m**	**£0**

7.30 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 TCS are outlined below:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

- The current risk to the nVCC Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

- There is a risk of a lack of funding for the AWA element of the ADDA. This is being mitigated by A funding request is being submitted to WG, who have agreed to underwrite these costs.

- There is also the 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.

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 October 2023

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date Budget Nov-23	Year to Date Spend Nov-23	Year to Date Variance Nov-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership nVCC OBC	0	142,394	-142,394	0	215,952	-215,952
Project 1b - Enabling Works FBC	171,227	212,987	-41,759	229,841	297,155	-67,314
Project 2a - New Velindre Cancer Centre OBC	0	618,501	-618,501	0	959,028	-959,028
Capital Pay Total	**171,227**	**973,882**	**-802,654**	**229,841**	**1,472,135**	**-1,242,294**
NON-PAY						
nVCC OBC Project Delivery	0	35,516	-35,516	0	63,000	-63,000
Project 1b - Enabling Works FBC	8,568,196	8,477,928	90,269	10,666,552	10,598,726	67,825
Project 2a - New Velindre Cancer Centre OBC	0	1,512,193	-1,512,193	0	1,902,693	-1,902,693
Project 2b - Advanced Design Development Agreement	2,422,896	3,171,611	-748,714	3,881,995	4,630,709	-748,714
Project 2c - Whitchurch Hospital Site	0	17,727	-17,727	0	17,727	-17,727
Capital Non-Pay Total	**10,991,093**	**13,214,974**	**-2,223,881**	**14,548,546**	**17,212,855**	**-2,664,309**
CAPITAL TOTAL	**11,162,320**	**14,188,856**	**-3,026,536**	**14,778,387**	**18,684,990**	**-3,906,603**

REVENUE	Year to Date Budget Nov-23	Year to Date Spend Nov-23	Year to Date Variance Nov-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
nVCC Pay Award	70,418	70,418	0	96,408	96,408	0
Programme Management Office	215,627	211,576	4,051	326,890	326,890	0
Project 6 - Service Change Team	204,752	190,389	14,363	306,290	306,290	0
Revenue Pay Total	**490,798**	**472,384**	**18,414**	**729,589**	**729,589**	**0**
NON-PAY						
nVCC OBC Project Delivery	2,394	18,933	-16,539	30,000	30,000	0
nVCC OBC Judicial Review	11,000	11,000	0	11,000	11,000	0
Programme Management Office	1,410	3,174	-1,764	1,410	1,410	0
Project 6 - Service Change Team	9,000	7,542	1,458	13,340	13,340	0
Revenue Non-Pay Total	**23,805**	**40,650**	**-16,845**	**55,750**	**55,750**	**0**
REVENUE TOTAL	**514,602**	**513,033**	**1,569**	**785,339**	**785,339**	**0**

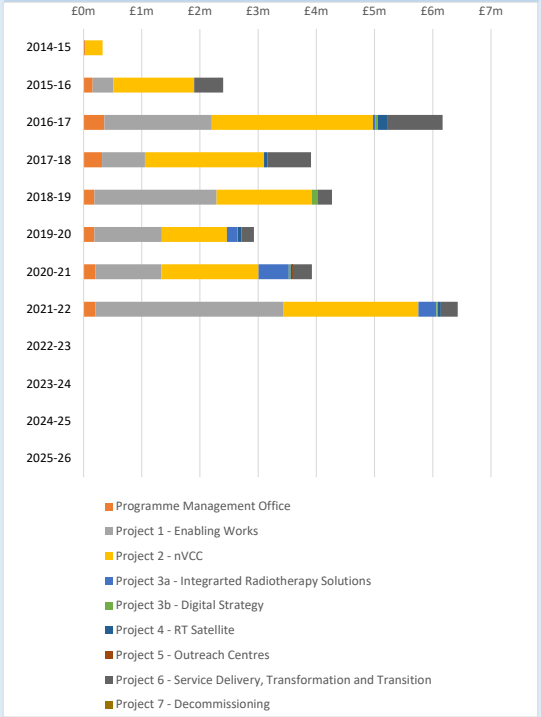
APPENDIX 2: TCS Programme Funding for 2022-23

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	**£0**	**£0.137m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Escrow Interest		£0.041m
Advanced Design Development Agreement	**£3.882m**	**£0**
2023-24 CEL from Welsh Government funding for ADDA approved October 2023	£3.882m	
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	**£14.778m**	**£0.785m**

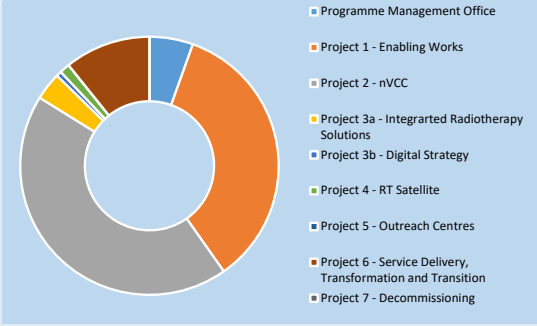
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

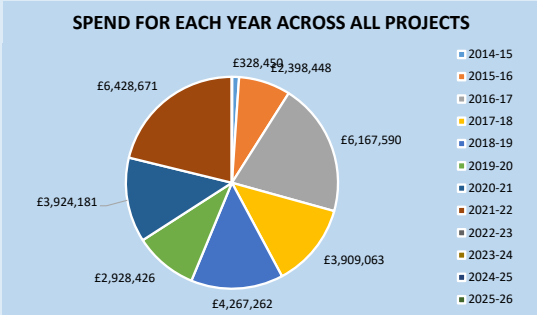
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS



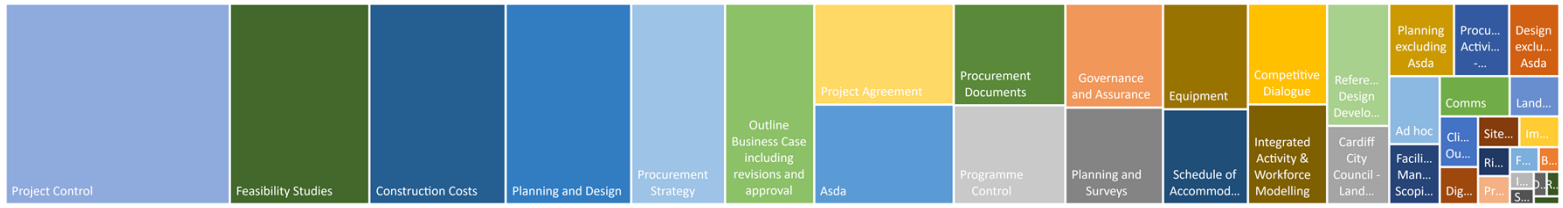
TOTAL SPEND BY PROJECT TO DATE — £30,352,092

Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - 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

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



QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	16/01/2024
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 Richardson, Head of Quality, Safety and Regulatory Compliance, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality, Safety and Regulatory Compliance
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between August 2023 and November 2023, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements. In light of a sustained red cell stock pressure during the period a summary of issues over the period supplemented by December activity and

	some forward planning within the service is included for discussion. The report also highlights key programmes taking place across the Division. The main report summarises: • Key performance outliers and associated actions to resolve. • Key quality and safety related indicators and remedial action identified. • Feedback from Donors and the responses to it. • Regulator and Audit Feedback, assurance and learning themes. • An outline of key service developments in WBS.

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

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Welsh Blood Service Senior Leadership Team	10/01/2024
Executive Management Board	02/01/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Senior Leadership Team at the Welsh Blood Service have considered the report and noted key issues.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating /*

	*Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the **"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	
1	**WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT August to November 2023**

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

1. SITUATION

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

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

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

2. BACKGROUND

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

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

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 Donors and the responses to it.
- Regulator and Audit Feedback, assurance and learning themes.
- An outline of key service developments in WBS.

3.1 Triangulated Analysis

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

- All clinical demand was met for red cells and platelets without requesting mutual aid. ***NB In December, mutual aid was requested due to sustained pressure an is highlighted in this report.***
- The service issued notice to hospitals of Blood Shortage Alerts 7 times during September, October and November, indicating the supply chain is under particular strain.
- Closure of quality incidents within the required 30 days has remained stable and consistently achieved between 96% and 98% for the whole reporting period.
- During the period seven Serious Adverse Events were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) via the SABRE portal. No incidents were reported to the Human Tissue Authority.
- 21 concerns were reported during the period, 20 of which were managed within timeline as early resolution as detailed in the report.
- Overall donor satisfaction improved slightly and continues to exceed target at 96.5% over the reporting period.

- The UK Health and Safety Executive team inspected the irradiation facilities at WBS in May 2023, findings from the inspection have all been addressed and confirmation of this has now been received from the inspectors.

3.2 Key Actions / Areas of focus during next period

Quality and safety and donor experience remains at the heart of our service during this period in all aspects of service delivery as well as the well-being of our staff. During the period December 2023 to March 2024 the following areas will continue to be a priority:

- Continue to monitor and grow blood stocks, whilst continuing to pursue prudent use across NHS Wales.
- Implement plans to increase both the number and diversity of bone marrow and blood donor volunteers.
- Identify a root cause and preventative action for the incidents relating to donor screening.

4. SUMMARY OF MATTERS FOR CONSIDERATION

5. IMPACT ASSESSMENT

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

RELATED STRATEGpIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* This report summarises the Welsh Blood Service performance across all six domains of quality and is divided into sections covering each domain.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why) *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* Paper is for noting and therefore out of scope of the legislation

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

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

6. RISKS

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

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

August to November 2023

INTRODUCTION

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

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

1. Safety

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

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

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

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

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

For the reporting period August to November 2023:

128 GMP incidents were reported via QPulse. These incidents were all closed, i.e. reviewed and Corrective/Preventative Actions (CAPA) assigned, within 30 days with one exception (34 days):

- "*INV-759 Group label had been attached to an unseparated red cell unit*" Remedial action had already been undertaken to rectify the problem, but it this instance the risk rating and remedial action was not formally recorded within Q Pulse in a timely manner. This has been rectified.

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

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

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

42 quality related incidents were reported in Datix Cymru, all were classified as low risk for actual harm with two events being classified as potentially high risk prior to investigation and which were reported to the Serious Adverse Blood Reactions and Events.

1.2 Areas of focus:

The WBS Senior Leadership Team are focussing on the number of incidents overdue for closure within Datix, as there was an upward trend from September and some reports had an

'opened' date two months after the event was first reported. Most of these events were Health and Safety related and assessed as low risk. Relevant managers were advised of those reports that required immediate review and closure (where possible). Following formal reporting of this concern to the WBS Integrated Quality and Safety Hub (IQSH) in November, a Task & Finish group will be set up in Q4 to uncover root cause and redesign the Datix review process so that reporting timelines can be met.

Three incidents reported via QPulse had a significant risk rating and were subject to a detailed root cause analysis investigation; two of these were externally reportable and included in the table under 1.4 below..

NV-800 *Hepatitis B core antibody positive result detected by reference centre following a look back at previous donations from this donor* (reported externally as SABRE 108, and recorded in Datix),

INV-808 *Supplementary donor eligibility questions not appearing beneath the correct primary question in the Donor Self-Assessment Questionnaire* (reported externally as SABRE 109, and recorded in Datix).

INV-897 *Apheresis donations placed directly on Roche testing system without pooling;* subsequent system 'shutdown' resulted in samples being rejected by the pooling machine and an unauthorised workaround was applied to recover the situation.

- Main categories of incidents reported via Q Pulse were Blood Pack Incidents (30%), Laboratory Errors (20%) and Equipment Problems (8%); another 8 events (6%) were categorised as 'incident'; 3 of these were related to equipment failure.

- The main locations reporting incidents continue to be Distribution (Hospital Services), Manufacturing Laboratory and the Stock Holding Unit (SHU), although it should be noted that some of the issues reported by Manufacturing have originated at donation clinics. These include a potential trend, which began to emerge through October and November, regarding the quality of Donation Identification number (DIN) labels:

    - A multi-disciplinary team has reviewed potential causes, no singular cause could be identified but Collections teams have reported difficulty removing the labels from the backing material, which causes the labels to tear.
    - DIN labels contain deliberate security cuts that are designed to tear if the label is tampered with and samples of batches of DIN labels are subject to rigorous Quality Assurance checks prior to issue for routine use.
    - The issues being reported by Collections teams have not been replicated on inspection of returned labels by the Quality Assurance department.

- Ongoing monitoring is in place and teams are required to report any issues immediately.

1.3 Regulatory Inspections

There have been no regulatory inspections within the reporting period. The action plan relating to the Health and Safety Executive inspection in May 2023 was closed out and confirmation received from the inspectors during September 2023.

1.4 Serious Incidents Reportable to Regulators

There were seven reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in this reporting period.

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

A summary of all 10 SABRE incidents reported in 2023, are included in the table below.

Incident Summary	SABRE reference	Frequency	Notes
Hardware Failure on bacterial monitoring system	105	1	Resulted in a recall of all platelets in stock across Wales. Faulty equipment has now been replaced
Platelets issued to hospital before product release process was completed	107	1	Arose from pressure by hospital to supply when stocks were very low. Review of release criteria showed that the product was suitable for release and safe for use with no risk to patients.
Incorrect donor screening assessment	106, 110, 111, 112, 113, 114	6	Reflects a national trend linked to the complexity of the donor screening process. Process review underway at WBS with learning being shared across the UK blood services. Longer term aim to

			simplify the screening criteria.
Positive test result following the introduction of mandatory screening for hepatitis b core antigen and re-testing of previous donations	108	1	Reference centre test results for this donor indicate a past and resolved hepatitis B infection. No risk to patients
Supplementary donor eligibility questions are displaying underneath the incorrect primary question on the donor Self-Assessment Health History (SAHH)	109	1	This is a known bug in the software but the risk of donor screening not being completed fully was not formally assessed when first identified. 100% reviews in place for all affected questionnaires pending deployment of a software fix

7 of the reported incidents are linked to either a software issue with the Donor Self-Assessment of Health Questionnaire or a wider issue with the complexity of the assessment of donor eligibility criteria which has been seen nationally. WBS is working with the other UK Blood Services to review and potentially simplify the donor eligibility assessment process, and in the meantime the Clinical Services team continue to review donor eligibility assessments each day.

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

2. Effectiveness

2.1 Blood Supply

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

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

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

All the above, have contributed to a significant loss of collection capacity during October and November. The pressure on stock has resulted in stock levels decreasing to below our optimum levels thus triggering blue alerts to all NHS Wales customer hospitals.

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

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

Date Alert Sent	Blood Group	Alert level	Date of Recovery	Duration of Days in Alert
20/09/2023	O D Negative	Blue	04/10/2023	14
30/10/2023	O D Negative	Blue	09/11/2023	10
30/10/2023	O D Positive	Blue	09/11/2023	10
20/11/2023	O D Negative	Blue	27/11/2023	7
20/11/2023	A D Negative	Blue	27/11/2023	7
04/12/2023	O D Negative	Blue	Currently in place (04/01/24)	
18/12/2023	O D Positive	Blue	Currently in place (04/01/24)	

In September, October and November the Blue alerts were lifted within one or two weeks. The alerts issued in December remain in place and will be reviewed on January 3rd 2024. The early lifting of the previous alerts may not have given the supply chain sufficient time to recover and hence may have led to the current prolonged alert.

2.1.4 Looking forward to the new year the following recovery plan is in place for January:

- 3 overtime clinics secured and further work continuing to secure more.
- requests made to WBS departments for release of seconded RNs to support on specific days when Collection RNs resources are insufficient.
- increased donor education to reduce deferrals.
- additional appointment slots included in grids to mitigate DNAs.
- refresher training for RNs outside of Collection Services to allow supporting activity.
- completion of initial training for existing cohort of trainee RN and CCAs.

Difficulties remain in the wide variations being seen in demand for blood components, and the impact of planned industrial action by junior doctors on demand for blood components which is proving difficult to assess. However, questions have been asked of NHS Wales Health Boards regarding usage plans and the service has been able to assess the impact of previous junior doctor strikes in England on the blood supply and is anticipating higher demand pre strike.

These mitigating actions are predicted to maintain existing stock levels in January if demand remains consistent against forecast. Further mitigation in underway for the medium term to support re-building stock levels. This includes:

Medium Term Recovery Plans

- continuation of additional planned clinics.
- new cohort of 11 staff starting training in January.
- recruitment to all vacancies.
- consideration of recalling Collection team staff on secondment.
- accelerate commencement of workforce review under WBS Futures programme.
- introduction of tours to improve north west Wales efficiency.
- introduction of West Nile Virus testing to reduce deferrals on clinic due to travel.

2.2 Bone Marrow / Stem Cell collections

Bone marrow and stem cell collection activity has increased over the reporting period with 24 collections being completed between August 2023 and November 2023. April and June were particularly encouraging with 6 collections in each month and 3 collections each for the other months. A review of the donor recruitment and retention strategy continues.

2.3 Audit Summary

There were 20 internal audits scheduled for completion between August and November; this includes Information Governance audits incorporated into the WBS internal audit schedule. These were undertaken by the Trust Head of Information Governance.

2 audits were conducted later than expected due to auditor/auditee availability (now complete) and 3 have been postponed. The risk from late completion has been assessed as low due to coverage within external and internal audits as standard. In the light of this observation, the WBS audit schedule will be reviewed for 2024/25 to identify and reduce overlapping audits and free up resource.

Where audit reports are still in progress all findings raised have been approved by auditees/HODs/Section Heads either during or following audit.

2.3.1 Corrective and Preventative Actions Summary:

- No critical findings raised.
- 5 major findings raised (in this period):

IA 47: Systemic breakdown in cleaning: benches, centrifuge and water baths
Raised against the UK National External Quality Assessment Scheme for Histocompatibility and Immunogenetics (UK NEQAS for H&I)
No evidence these tasks had been completed to schedule. Action now closed.

IA48: No Data Protection Impact Assessment (DPIA) has been undertaken for Social Media use, call recording or the WBS Daisy telephony system
Raised against the Donor Contact Centre under Information Governance Audit (ongoing).

IA49: **Housekeeping/systemic breakdown – several housekeeping issues identified, including small bag of food remnants found in a laboratory area**
Raised against the stock Holding Unit (SHU) (ongoing).

IA50: Reagent Management, validated stock has not been stored separately from non-validated stock
Raised against Stores (ongoing).

IA51: No Data Protection Impact Assessment for staff identification cards
Raised against Facilities (ongoing).

- Two actions are being carried forward from May:

IA40: Supplier Audit 22/01(S) NHSBT Colindale (Information Governance)

Raised against Automated Testing.
The WBS has not submitted a Data Protection Impact Assessment (DPIA), as mandated in Article 35 of UK GDPR, and Section 3.3 of the NHS Wales Records Management Code of Practice for Health and Social Care 2022.

IA41: Audit 22/37 Verto and Change Control
Raised against Quality Assurance Systems
Several closely associated issues with the Verto Change Management Process encapsulated within one major finding. One action remains ongoing (development of a revised quality checking process).

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

2.3.2 Audit Corrective/Preventative Action (CAPA) Trending:

- No significant trends were identified in this reporting period.
- CAPA findings from August to November 2023 remain consistent with the 2022/2023 categories.

3. Service-User Centred Feedback

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

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

Clinical Services

Responses	1 - The time taken to be contacted following the initial interaction was adequate	2 - The member of the Clinical Services support team introduced themselves in a warm and friendly manner	3 - The member of the Clinical Services support team made me feel at ease	4 - The member of the Clinical Services support team demonstrated knowledge and experience within their	5 - The member of the Clinical Services support team communicated effectively and used appropriate langu	6 - Appropriate and professional responses were given to the questions I raised	7 - I was actively listened to and was given the opportunity to ask questions	8 - Can we improve the service we provide? If yes please use the 'Other' box to tell us how	Overall
	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	
104	99	100	100	100	100	100	100	100	100
Overall	99	100	100	100	100	100	100	100	100
Benchmarks	95	95	95	95	95	95	95	95	

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

The aim of the Safe Care Collaborative project is to:

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

In November 2023, all adverse event information leaflets e.g. Bruising/Fainting were updated to include a QR code to the survey.

Donor Adverse Event Reporting (DAER)

Responses	1 - Based on your recent Complication/Adverse Reaction following blood donation, do you feel you receive	2 - Based on your recent Complication/Adverse Reaction, did you receive a full explanation and after car	3 - Did you understand the explanation and after care advice given? If no, please state why?	4 - Were you provided with an information leaflet(s) to support the advice given?	5 - Did you find the information leaflet useful? If no, please state why?	6 - Did you feel you were cared for with dignity? If no, please state why?	7 - Did you have the opportunity to ask questions?	8 - Were you given a contact telephone number to obtain further support and advice?	9 - Were you informed that you would receive a follow up call?	10 - Did you receive a follow up call as described?	11 - Based on your experience and care, would this put you off donating in the future? if yes, please sta	Overall
	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	
9	100	100	100	100	100	100	100	100	88	100	100	99
Overall	100	100	100	100	100	100	100	100	88	100	100	99
Benchmarks	95	95	95	95	95	95	95	95	95	95	95	

3.1.3 All donors are given the opportunity to feedback on their experience before leaving a donation session via a table-top electronic survey and or QR code. The overall satisfaction scores run at a consistent 98% well above the benchmark set at 95% as shown in the data attached below:

Collection Services

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?
98	100	100	100	100	100	100	100	100	100	99	99
98	100	100	100	100	100	100	100	100	100	99	99
95	95	95	95	95	95	95	95	95	95	95	95

Question 6: On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic today? (1 being completely dissatisfied and 5 being completely satisfied)

Available Answers	Responses	Score (%)
5- Completely Satisfied	3474	93.39%
4- Satisfied	200	5.38%
3- Neither Dissatisfied nor Satisfied	22	0.59%
2- Dissatisfied	8	0.22%
1- Completely Dissatisfied	16	0.43%
Total	**3720**	**100%**

3.2 Changes in response to Donor Feedback during the period of August – November 2023.

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

- Introduction of savoury snacks for donors to enjoy following their donation.
- Service Improvement Project (SIP) on-going to helps combat the issues raised around lack of suitable signage directing donors to a blood session venue once inside a building.
- Introduce a donor App as part of the WBS five-year strategy 2023-2028
- Welsh speaking staff have been provided with badges so donors can identify them.
- Floor-standing fans have been provided to all collection teams to help cool or warm a venue accordingly.
- Request for WBS to come to Blaenau Ffestiniog Rugby Club Ganolfan, or Ysgol y Moelwyn. A risk assessment was done on this venue and found it unsuitable for blood collection purposes, however another venue has been suitable assessed and the Planning department are hoping to book for February/March 2024.

3.3 Concerns

3.3.1 In the reporting period of August to November 2023, 29,441 donors were registered at donation session with 21 concerns being recorded, this constitutes 0.07%. 1 concern was managed as a formal relating to donor's donation experience. 20 Early resolution concerns were recorded in this period with one staff member being identified as needing further support from Clinical Lead Nurses.

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

During this reporting period two concern themes were noted, and measures have been put in place to alleviate the concerns as below: -

1. **A number of concerns received during this period related to staff communication skills:**
   Customer Care/Dealing with Difficult Conversation Training Sessions have been scheduled to take place for all Collection Team staff to commence in January 2024.

2. **Staff member identified as needing extra support from Clinical Lead Nurses:**
   The Education and Practice Development Manager and Clinical Lead RN's have been providing on-going support to this staff member to ensure confidence and competence is achieved.

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

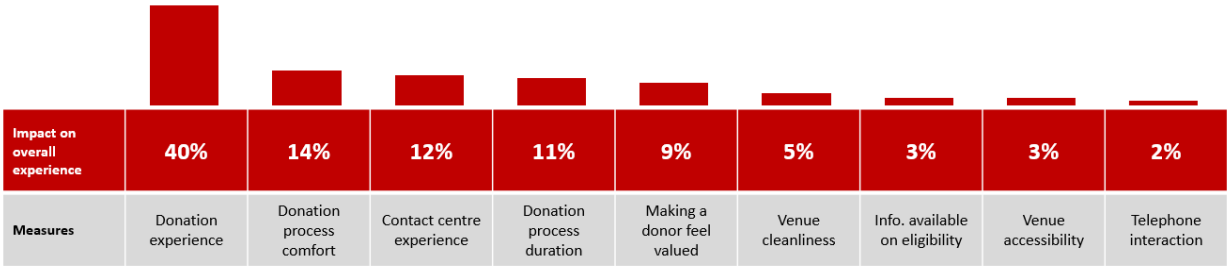
a. During the period August 2023 to November 2023, 4,444 responses were received (21.0% response rate)

b. Donor satisfaction for those who had successfully donated was 95.7%

c. In total 3,594 donors scored themselves as 'Totally Satisfied' and were invited to provide more details (81.6%).

d. Out of 4,444 responses, 93 donors (2.1% of responses) described themselves as 'Dissatisfied' or 'Totally Dissatisfied' and were invited to provide more details. The responses are analysed and followed up by the Collections Leadership team through their monthly operational service group.

e. WBS Business Intelligence team has calculated which survey metrics are statistically important to a positive donation experience. Of the questions asked, research found the measures and the degree of impact each measure has on overall satisfaction:
   I. 40% Donation experience
   II. 14% Donation process comfort
   III. 12% Contact centre experience
   IV. 11% Donation process duration
   V. 9% Making a donor feel valued
   VI. 5% Venue cleanliness
   VII. 3% Information available on eligibility
   VIII. 3% Venue accessibility
   IX. 2% Telephone interaction



Impact on overall experience	40%	14%	12%	11%	9%	5%	3%	3%	2%
Measures	Donation experience	Donation process comfort	Contact centre experience	Donation process duration	Making a donor feel valued	Venue cleanliness	Info. available on eligibility	Venue accessibility	Telephone interaction

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

4. Timeliness

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

Routine Antenatal testing turnaround performance consistently meets target, with 96% for the months of August to October and 92% in November.

4.2 Reference Serology Turn-around times

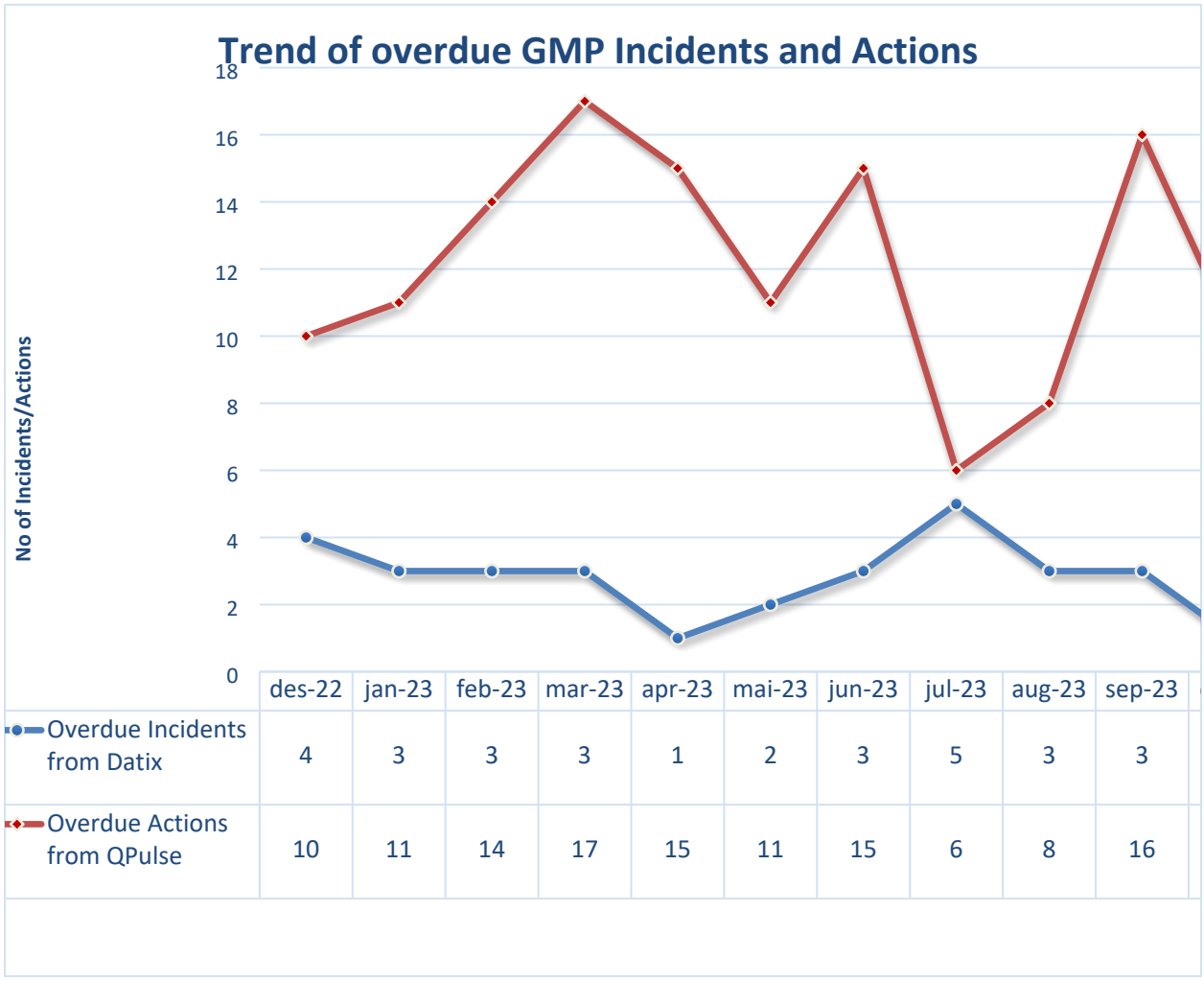
Reference Serology 'turnaround' performance showed 80% of results provided within 2 working days in August and 70% for the months of September to November.

Furthermore, 94% of all results were reported in 5 working days in August, 90% in September, 90% in October, 94% in November which is aligned with the agreed target with customer hospitals (90% within 5 working days).

Compatibility testing (approximately 40% of referrals) continues to meet clinical target and all time-critical tests are being completed on time whilst the volume of testing requests remains above previous years.

4.3 Overdue activity performance trends

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



	des-22	jan-23	feb-23	mar-23	apr-23	mai-23	jun-23	jul-23	aug-23	sep-23
Overdue Incidents from Datix	4	3	3	3	1	2	3	5	3	3
Overdue Actions from QPulse	10	11	14	17	15	11	15	6	8	16

There is a downward trend in Datix GMP incidents open more than 30 days, overall numbers remain low. Please note, this trend does not include non-GMP incidents.

The Quality Assurance (QA) team continue to work with operational teams to ensure that incidents are investigated and closed effectively, and in a timely manner, reasons for

delays are understood and any associated risks are recognised. Relevant managers have been advised of the requirement to review and close overdue reports, and to update the 'progress' field when reports remain open beyond the expected completion deadline.

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

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

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

There has been a recent decrease in the number of Datix reports open for more than 30 day; the majority of those which remain open after 30 days are still Health & Safety related events which can take some time to investigate fully.

4.4 Areas for focus:

There were a high number of overdue actions in August, and overall this measure remains high; it is noted that Laboratory Services own several overdue actions, these are being closely monitored by QA and the WBS lead for Transfusion Laboratories has been made aware of this concern. Additional staff have been allocated to this work in order deal with the backlog and prevent a recurrence.

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

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

5. Equity

The Welsh Blood Service strives to give everyone in Wales the opportunity to donate, this has traditionally been achieved through a peripatetic model of collection teams based in regional hubs and visiting community venues across Wales, supplemented by mobile collection vehicles where suitable premises are not available.

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

The Welsh Bone Marrow Donor Registry team have held productive meetings with several charities and partners to help in the overall recruitment of swab donors with particular emphasis on the recruitment of ethnic minority donors. These included Team Margot, African Caribbean Leukaemia Trust (ACLT), National Black, Asian, Minority Ethnic Transplantation Alliance (NBTA) and Race Against Blood Cancer.

6. Efficiency

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

Collection productivity has risen slightly from 1.12-1.18 over the period but continues to be below target. Contributory factors influencing the recent performance include:

- Reduced clinics duration due to short notice sickness absence.
- Reduction of clinic hours because of I.T and transport issues.
- Existing vacancies yet to be filled across Wales, which, along with 8 staff in training has impacted staffing capacity at larger sessions.
- Delivery of Statutory & Mandatory training across all donor teams.
- Lower donation capacity due to staff sickness in North Wales resulting in donation sessions staged with 2 donor chairs. Usually, these teams operate 4-6 donation chairs, depending on the venue size.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency fluctuated from 414 in August to 389 in November. This has been linked to the variation on blood collections especially during the winter months.

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses remained low and below tolerance and varied from 0.13% in August, 0.03% September, 0.02% in October and 0.08% in November.

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry remains extremely low and within target, 0% wastage reported for the last four months (August –November 2023).

6.5 Time Expired Platelets (Target 10% expired)

Platelet wastage performance has been significantly improved and sustained in 2023, specifically, further improvement observed from 12% in August to 10% in November. This improvement has been driven by recent changes to the production schedule for platelets and ongoing weekly reviews of demand trends. A formal platelet strategy project is now underway with workstreams looking at near to medium term forecasting, clinic planning and longer-term changes driven by clinical research.

Quality Safety and Performance Committee

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

Date of meeting	**16/01/24**
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, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager**
PRESENTED BY	**Cath O'Brien, Chief Operating Officer, 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	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD TO NOVEMBER 2023/24** **Overall Context** 1.1 This paper reports on the performance of our Trust for the month of November 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance. 1.2 The overview, in Section 2, draws attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas 1.3 The Performance Management Framework (PMF) Scorecards, in Section 3, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. 1.4 Each KPI is supported by data, in Appendices 1 to 3, that explain the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. 1.5 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings. 1.6 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services. **Key points to Highlight** 1.7 **Welsh Blood Service** • Clinical demand was met throughout November despite it being a challenging month. There was a significant reduction in collection capacity following clinic cancellations beyond the control of the service. January continues to look challenging for WBS, and a recovery plan is currently being implemented:

	1.8 Velindre Cancer Service • Radiotherapy performance remains consistent against RT treatment targets, despite challenges of fragility associated with aging equipment and recruitment challenges. There will continue to be improvements in the performance as we move through the IRS implementation. • SACT performance for non-emergency target has reduced as anticipated as a result of challenges with pharmacy capacity to support provision of chemotherapy treatment. The demand planning group within VCS is identifying opportunities to increase capacity across the service and concerted action is underway. • Work is in progress over the next few weeks looking at the demand forecast for SACT between now and year end, identifying the activity required to meet the demand and the capacity gap.

RECOMMENDATION / ACTIONS	**The Quality Safety and Performance Committee is asked to:** • **The QSP Committee is asked to NOTE 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.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**15 December 2023**
VCS SLT / Performance Review	**20 December 2023**
Executive Management Board – Run	**2 January 2024**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings and EMB and is presented to the QSP Committee for information and noting.**	

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

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

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts

2. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR NOVEMBER 2023

The following paragraphs provide an overview of our Trust-wide performance against key performance metrics through to the end of November 2023 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.1 Cancer Centre Services Overview

88% of patients referred for scheduled radiotherapy treatments began treatment within the 21-day target in November. This marks an improvement relative to performance in October (72% compliance). This is against the mandated target of 100% patients beginning treatment within 21 days. There is a stretch target of 80% within 14 days, which has not seen correlating improvement. Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment was 93%. 90% of patients requiring emergency radiotherapy treatment began treatment within the 2-day target and 86% within the 1-day stretch target. The sustained improvement in performance remains encouraging and can be attributed, in part, to detailed work to rationalise and shorten treatment pathways which has been undertaken throughout 2023 and targeted training delivered to clinical teams. Additionally, a new radiotherapy workflow system trialled in May 2023 has now been rolled out to all treatment sites. This new system has supported the delivery of marked efficiencies.

It should be noted that the number of patients referred for radiotherapy treatment and those actually beginning treatment in November were lower than anticipated based on historical patterns of demand. Relatively depressed demand for radiotherapy treatment has likely been a contributing factor in the improved performance reported since August 2023. Dialogue with health board operational teams has confirmed that the number of referrals for radiotherapy treatment during quarter 3 have been lower than anticipated. This pattern does not appear to have been replicated elsewhere in Wales, Other Welsh cancer centres have acknowledged receiving the normal, anticipated increase in demand following summer period. We are continuing to explore these trends with Health Boards.

SACT

Forecast demand modelling for SACT for the financial year 2023/24, anticipated a 8% growth in referrals based on outturn March 2023. The actual referral rate is currently showing approximately 6.8% above the forecast. During the month of November SACT performance for 5-day for the emergency time to treatment target was 100%. Delivery of 21day non-emergency SACT time to treatment target is a challenge for the service. The anticipated drop in performance for November has been realised with 85% (329) patients being treated within target date (target 98%). 57 non-emergency patients waited over 21 days. The majority of these patients (50 patients) were treated WITHIN 28 days, with 6 patients waiting more than 28 days, further 2 patients waiting more than 36 days. All patients within a trial were booked within Trial timeframes.

It is anticipated that there will be a further drop in performance against the non-emergency treatment target in December. At present the anticipated performance at the end of December is unknown. There is significant work taking place within the Division in order to develop a comprehensive plan to improve overall performance.

A working group has been established and a number of options identified to increase activity. The key barrier to implementation of these measures is availability of pharmacy provision to meet the increase in Chemotherapy treatment for the patients. An external audit has identified that in order to increase production within pharmacy, requires additional asceptic provision and supporting workforce. Capital funding was approved in December 2024, which will facilitate an expansion of asceptic dispensing capacity. Supporting reconfiguration of work plans will be completed by end March 2024 and the recruitment of staff to support professional and regulatory compliance is expected to be approved in January 2024. This will provide capacity initially but further work is also ongoing to plan for the interim period before the regional provision through TrAMS programme is delivered.

The longer term solution was previously identified as TrAMS, but due to the delay at a regional level, it is now a requirement of the Division to look at an alternative means of meeting the additional demand for pharmacy between now and the 'go live' date for TrAMS. The working group is also undertaking an extensive piece of forecast modelling to understand the demand on the service between now and year end (March 2024) and the activity required to meet the demand.

All services undertook extensive planning to prepare for the additional capacity challenges over the Christmas and New Year period and forward into January through any periods of Industrial Action.

2.2 Welsh Blood Service Overview

Clinical demand was met throughout November despite it being a challenging month. There was a significant reduction in collection capacity following clinic cancellations beyond the control of the service (4 donor sessions were cancelled/replaced at short notice due to leaks in Mobile Donation Clinics (MDC) where air vents were fitted for Infection Prevention Control (IPC) requirements & a further 3 donor sessions were reduced due to I.T. issues affecting on session connectivity). A total of 441 appointments were lost that could not be recovered during November. This resulted in 2 days where stock for blood groups O, A and B+ fell below 3 days.

To address this, a Blue Alert was issued 7th November for OD- and OD+ which ended on the 9th November 2023, and on the 20th November for OD- & AD- ending on the 27th November. This impacted blood stocks in December, which resulted in the requirement for mutual aid to cover the Christmas period.

January continues to look challenging for WBS, and the following recovery plan is currently being implemented:

- An additional 3 overtime clinics secured and further work continuing to secure more.
- Requests made to WBS departments for release of seconded RNs to support on specific days when Collection RNs resources are insufficient.
- Donor education plan to commence to reduce deferrals.
- Additional appointment slots made available to mitigate Did Not Attends (DNAs).
- Refresher training plan developed for Registered Nurses (RNs) outside of Collection Services to allow supporting activity.
- Completion of initial training for existing cohort of trainee RNs and Clinic Collection Assistants (CCAs).

These mitigating actions are predicted to maintain existing stock levels in January if demand remains consistent against forecast. Further mitigation in underway for the medium term to support re-building stock levels. This includes:

- Continuation of scheduling additional clinics.
- New cohort of 11 staff starting training in January.
- Recruitment to all vacancies.
- Consideration of recalling Collection team staff on secondment.
- Commencement of workforce review under WBS Futures.
- Introduction of tours to improve North West Wales efficiency.
- Introduction of West Nile Virus testing.

Quality incident investigations closed within 30 days remains well above target (90%) and increased to 97% in November. There were 4 reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in November. All relate to donor eligibility assessment of malaria risk, or supplementary questions appearing under the incorrect primary question. Root Cause Analysis investigations are in progress for all events. Findings will be presented to the Trust Integrated Quality & Safety Hub and Quality Safety & Performance Committee.

Donor satisfaction met target for November at 95%. 7,553 donors were registered at donation clinics 5 informal concerns raised (0.07% of all donors registered). All 5 informal concerns have been managed within the ‘Putting Things Right’ 2-day timescale. No formal concerns were raised in November.

Reference Serology performance remained slightly below target (80%) at 70% for November, however sustained improvement can be observed throughout 2023. Training and development of junior members of staff will be completed between December 2023 and April 2024 and performance levels are expected to improve during this period.

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

At 1.22 collection productivity performance just missed the target of 1.25 in November. Contributory factors influencing performance include operational issues beyond the control of the service that resulted in 5 donor sessions being either cancelled or delayed leading to a reduction in donation capacity. However, there has been an improving trend evidenced over the last 15 months and WBS are now approaching the productivity target of 1.25.

The number of stem cell collections just failed to meet the target (7) in November. The total cell provision for the service was 6 (3 collected and 3 imported for a Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). 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.

2.3 Workforce and Wellbeing

The ability of skilled people to provide the key services within the Trust remains one of the most significant risks for the Trust, alongside ensuring those we do employ are supported, valued and feel their wellbeing is central while in the workplace. The Trust's People Strategy ensures progress towards; a planned and sustained workforce with skilled and developed people who are healthy and engaged in the workplace. Alongside these work programmes there are key metrics the Trust analyses and evaluates to ensure the effective performance of the workforce.

Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.63% to November 2023 which is still above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. Trust wide PADRs this month remains at 72% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 86% and has been consecutively on target for the whole year to date. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

Additional Equity measures have been added at the Trust-wide level for Welsh Language declaration, Gender Pay Gap and Workforce Diversity.

2.4 Nursing and Quality

The Trust's Quality & Safety Framework continues to be developed by the Integrated Quality & Safety Governance Group at its monthly meetings. The Divisions are also developing a range of Service level Quality and Safety metrics to be included within the Performance Management Framework and these potential measures are given in Appendix 4

A new KPI measuring compliance against the World Health Organisation's 5 moments of hand hygiene best practice continues to meet target compliance of 100%.

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (94%) and 'Your Velindre experience?' (87%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% for November which continues to meet the target.

2.6 Digital Services

Performance largely stable.

Following a number of incidents in August and November 2023, the rolling 12-month position for the number of significant IT business has increased slightly to 12 in November 2023. However, service stability through most of 2023 should result in a significant improvement in performance from February 2024. Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites.

3 significant incidents occurred in November 2023 – these related to the expiration of digital certificates used to authenticate devices and users across a number of key IT systems – namely, Prometheus (Welsh Bone Marrow Donor Registry), ePROGESA (WBS Blood Collections) and the VCC Wi-Fi service. Root cause investigations for each incident have been completed and action plans agreed to mitigate the risk of re-occurrence. Two incidents related to certificates managed by DHCW – a digital certificate register is to be developed by Digital Services, to enable the team to proactively manage and, where required, renew certificates due to expire.

Resolution timescales for service requests and incidents remains between 80-85% for both measures, although there was a significant increase in performance (84%) in respect of the number of service requests resolved within the agreed timescale – a reflection of recent work to ensure the Digital Service Desk is fully staff and ongoing work to improve the efficiency of the service desk. However, both metrics measuring performance of the Digital Service Desk remain under the 85% performance – the aim is to achieve 85% performance by the end of the financial year. A new IT Service Management Tool is due to be deployed in Q4, which should significantly improve service desk efficiency, including the introduction of more automated call responses.

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 ben 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.

2.7 Estates Infrastructure and Sustainability

The period through to November has seen consolidation of levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment complete within the Estates Team. Two H&S posts are progressing through the recruitment process Head of H&S at interview and the H&S Technician being uploaded to Trac.

The Trust has appointed a bureau 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 month has seen similar issues and data will be uploaded once available.

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.

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.

2.8 Finance

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 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, however an unlikely risk remains around securing funding for additional nVCC project management costs, with a request having now been submitted to the Minister by WG officials seeking funding approval.

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 Nov '23 is that income will cover the cost of the additional capacity.

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 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.

3. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR NOVEMBER 2023

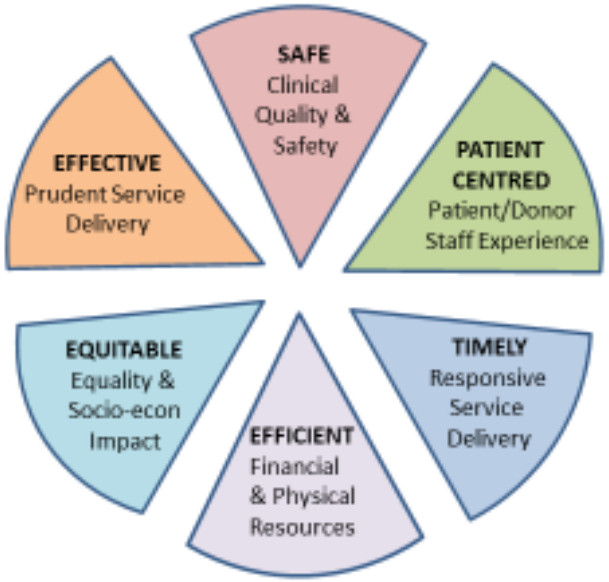
3.1 The following QSF Scorecard tables show the current performance of VCS and WBS Divisions and Trust-wide services against a range of National mandatory and local stretch targets, highlighting variances in performance. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching between the high-level positions to detailed analysis provided in Appendices 1 to 3, as below.

3.2 Navigating our PMF Performance Report

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.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

Quality Safety & Performance (QSP) Committee Scorecard as at November (Month 08) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 08 (November 2023)			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	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	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	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 Serious Untoward 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	4	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	11	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	102.7 C/m3 Sep	85.36 C/m3 Sep	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 08 (November 2023)			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%	107%	✓	🡹	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.00%	✓	🡺	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	115%	✓	🡻	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	10%	✓	🡹	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	6	✗	🡻	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.63%	✗	🡻	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%	✗	🡹🡻	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	94%	✓	🡺	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	95%	✓	🡹	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%	100%	✓	🡺	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	18% 88%	✗	🡻	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	13% 93%	✗	🡺	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	86% 90%	✗	🡻	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 08 (November 2023)			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%	83% 97%	✗	🡻	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	85%	✓	🡹🡻	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%	92%	✓	🡻	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	99%	✓	🡹	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.017m)	✓	➔	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£19.331m	£19.331m	✓	➔	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.535m	£0.732m	✗	🡻	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.106m	£1.106m	✓	➔	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	5.45%	✓	➔	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	4.90%	✓	➔	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	9.81%	✓	➔	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻

4. IMPACT ASSESSMENT

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

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

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

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

5. RISKS

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Return to Top

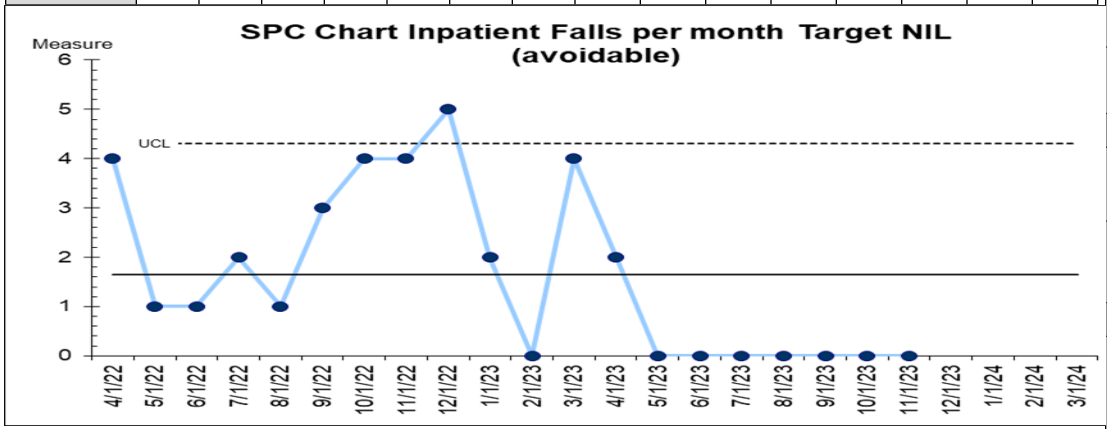
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul23	Aug 23	Sep 23	Oct 23	Nov 23
Actual Number	3	4	4	5	2	0	4	2	0	3	5	5	3	5	3
Avoidable Falls	1	2	2	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



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.

Performance

No avoidable falls in November 2023

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

-

KPI Indicator KPV.01

Return to Top

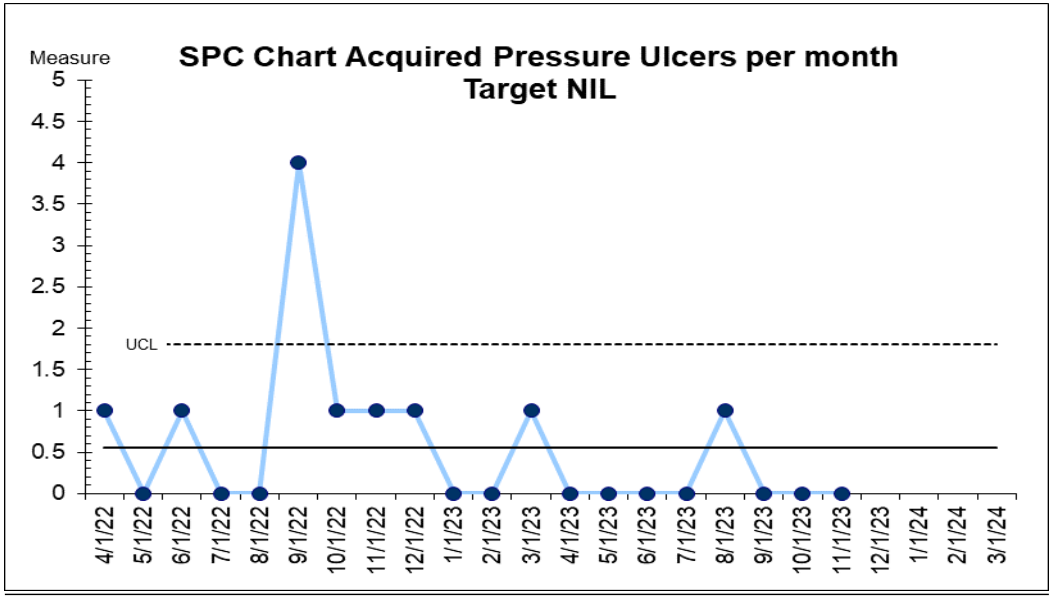
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	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
Actual Number	4	1	1	1	0	0	1	0	0	0	2	2	3	0	2
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

No avoidable pressure ulcers in November 2023

Service Improvement Actions – Immediate (0 to 3 months)

	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

KPI Indicator WOD.19

Return to Top

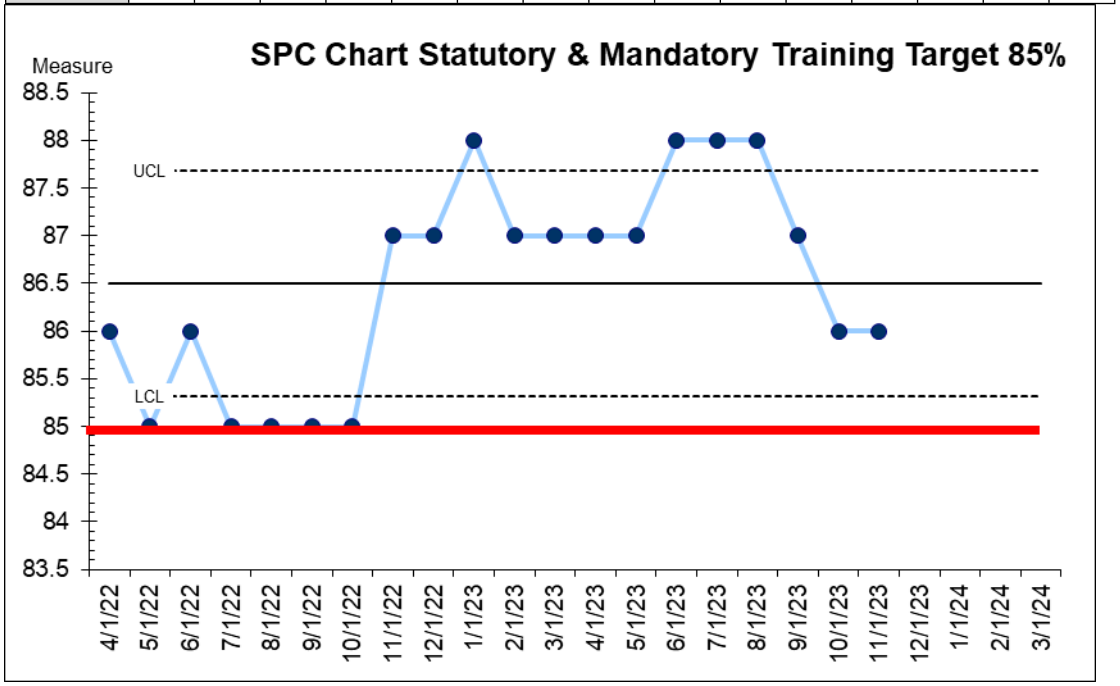
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	85	85	87	87	88	87	87	87	87	88	88	88	87	86	86
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Education and Development team will proactively work on the Stat. & Mand compliance framework in the All Wales network	**Monthly**	Head of OD 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.

KPI Indicator KPV.07

Return to Top

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

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

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

VCC	Sep 22	Oct 22	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
Hospital Acquired Thromboses	0	0	0	0	0	0	2	1	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

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

KPI Indicator KPV.04

Return to Top

Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period February 2022 to April 2023

VCC	Sep 22	Oct 22	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
C.diff	0	0	0	1	1	0	0	1	0	0	0	0	0	1	0
MRSA	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
MSSA	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	1	3	1	0	1	0	1	1	0	1	0	0
Klebsiella	0	0	0	0	1	0	0	1	1	0	1	1	0	0	0
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	0	0	0	1	4	1	0	3	1	1	3	1	1	1	0

Performance

Assessment of current performance, set out key points:

- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.08

Return to Top

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Sep 22	Oct 22	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
VCS Hand Hygiene										100 %	100 %	99%	99.6 %	100 %	99%
WBS Hand Hygiene										100 %	99.2 %	99%			
Trust Hand Hygiene										100 %	100 %	99%			
IPC Validation										100 %	100 %	100 %	99.4 %	100 %	96%
Target l00%	0	0	0	0	0	0	0	0	0	100 %	100 %	100 %	100 %	100 %	100 %

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

Plus Infection Prevention Control Team Validation Audits % compliance

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.60

Return to Top

Number of National VCS Serious Untoward Incidents(SUIs) recorded with Welsh Government in a calendar month

Target: NIL

SLT Lead:

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual															
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[SUI data to be input]

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

KPI Indicator KPI.30

Return to Top

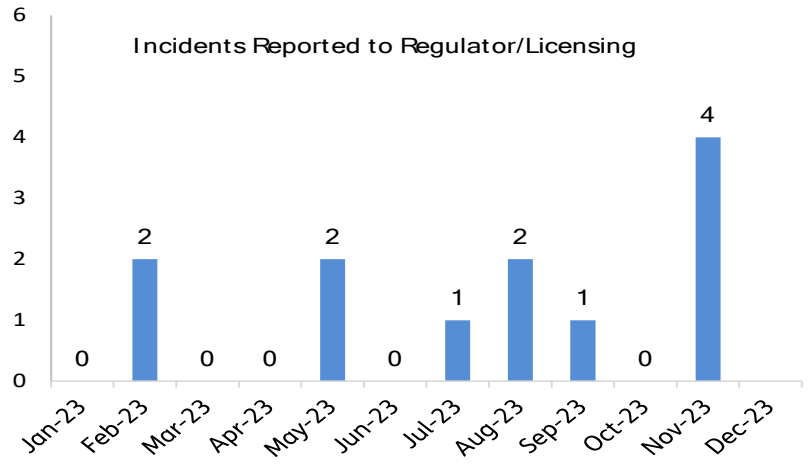
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual	0	0	0	2	0	2	0	0	2	0	1	2	1	0	4
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:
4 events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in November. All relate to donor eligibility assessment of malaria risk, or supplementary questions appearing under the incorrect primary question. Root Cause Analysis investigations are in progress for all events. Findings will be presented to the Trust Integrated Quality & Safety Hub and Quality Safety & Performance Committee.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:**
Daily 100% review of relevant donor screening questionnaires. A Task and finish group is being set up to fully review the screening process at WBS. The findings will also be fed back to the Standing Advisory Committee on the Care and Selection of Donors to inform a review of the national guidance on travel-related screening. 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	Peter Richardson **Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:** **Lead:**
Actions have been/will be introduced as outcome of root cause analysis of these incidents is known.	

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

KPI Indicator H&S.55

Return to Top

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

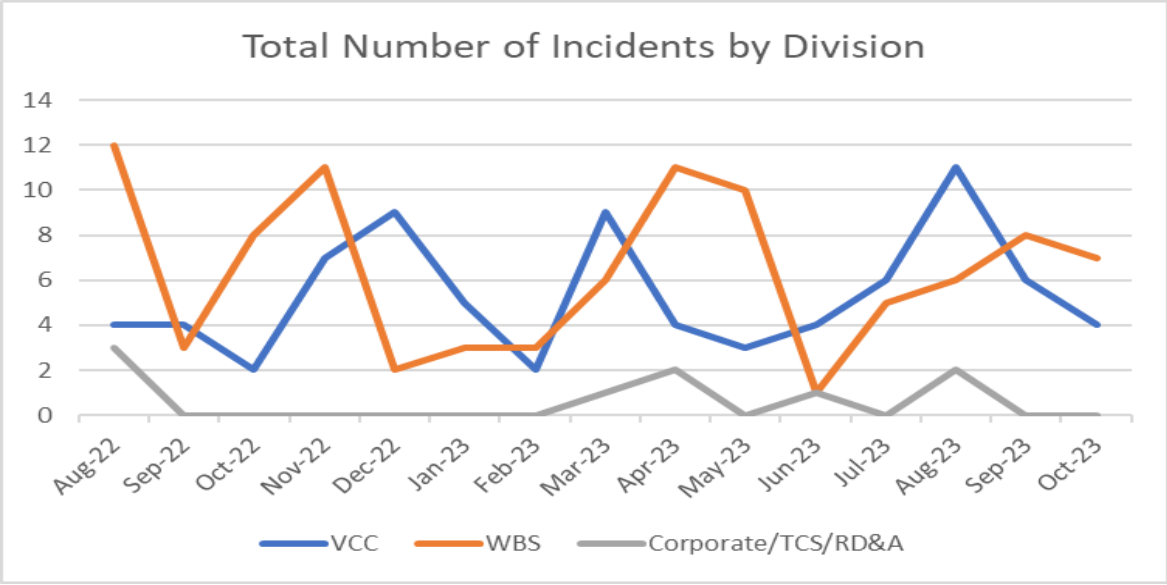
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Sep 22	Oct 22	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
VCC	4	2	7	9	5	2	9	4	3	4	6	9	6	4	7
WBS	3	8	11	2	3	3	6	2	10	1	9	6	8	7	4
Corporate	0	0	0	0	0	0	0	2	0	1	0	2	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incident investigation have been assigned and are currently ongoing	

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

KPI Indicator EST.06

Return to Top

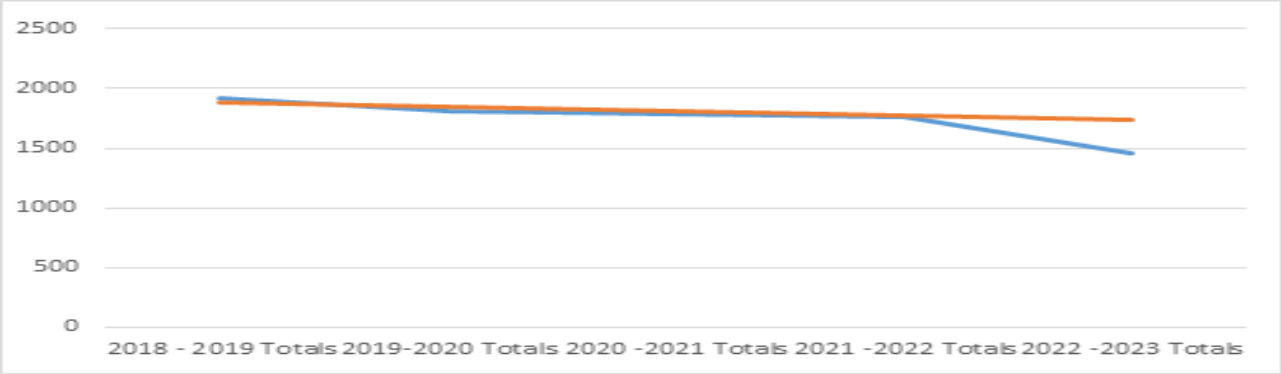
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual Number	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33	86.37	85.36		
Target (-3% from previous year emissions)	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858	95.86	102.66		



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

Performance

Assessment of current performance, set out key points:

- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- Issues have been raised during the transition form British Gas to EDF & Total Energies. Notably, meter reads. Therefore, these and consumption graphs for the previous 2 months may be subject to change.

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.

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

-

EFFECTIVENESS

KPI Indicator KPV.05

Return to Top

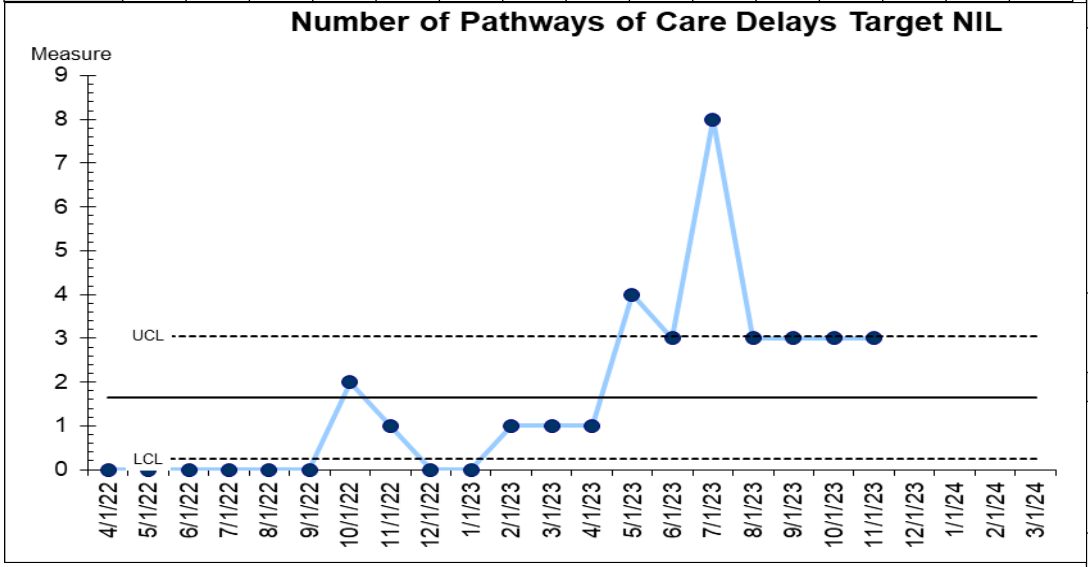
Number of Pathway of Care Delays

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	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
Actual DToCs Number	0	2	1	0	0	1	1	1	4	3	8	3	3	3	3
Days Delayed											32	19	43	73	
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

There was 1 Pathway of Care delay reported in November 2023

Patient 1: The patient had complex care needs and required support at home on discharge. A social work referral was submitted to support discharge planning. The total discharge delay was 25 days.

There were 2 Repatriation delays reported in November 2023

Patient 1: Awaiting repatriation to local hospital with a delay of 21 days.

Patient 1: Awaiting repatriation to local hospital with a delay of 4 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer. Pathways of Care NHS Executive team leads have visited VCC and provided additional training on the Six Goals of Emergency Care to further support and facilitate patient discharge.		**Matthew Walters Operational Senior Nurse** **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

KPI Indicator KPI.04

Return to Top

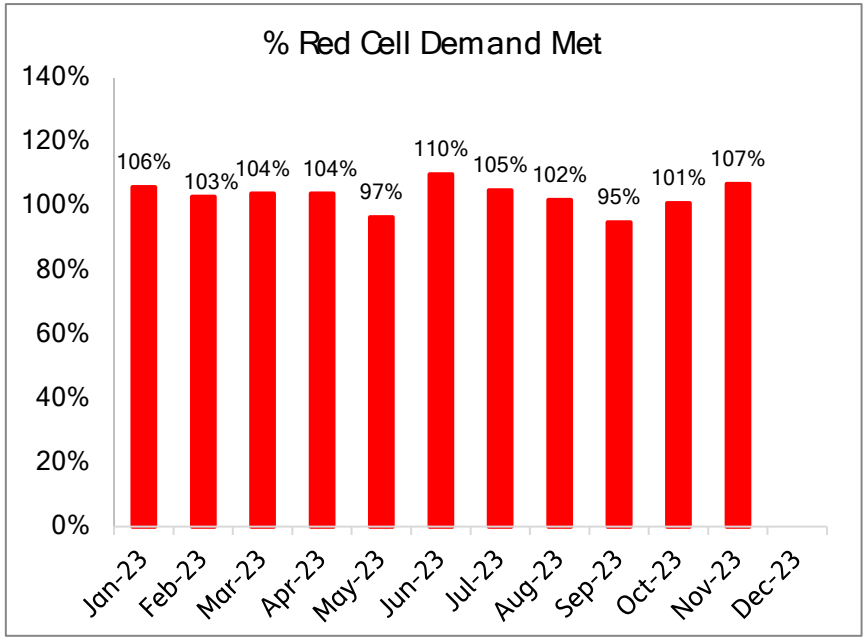
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	105	115	115	94	106	103	104	104	97	110	105	102	95	101	107
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.

The average weekly demand in November was slightly lower at 1374 compared to October at 1417 units per week.
There were 2 days in November where stock for blood groups O, A and B+ fell below 3 days. A Blue Alert was issued 7th November for OD- and OD+ which ended on the 9th November 2023, and on the 20th November for OD- & AD- ending on the 27th November.

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.

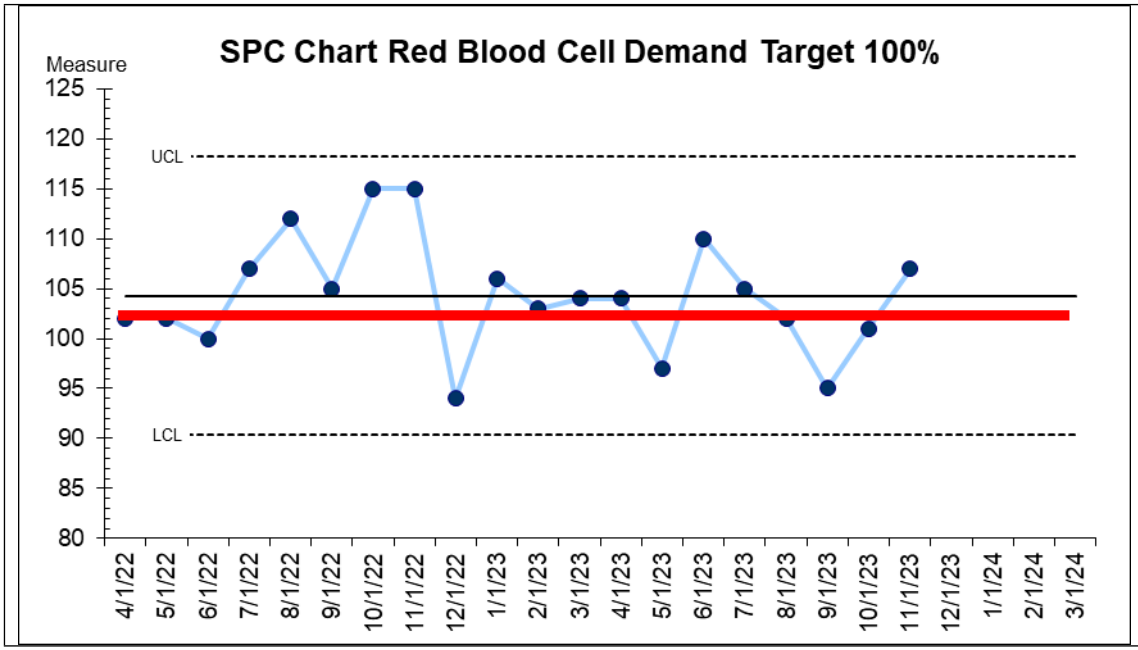
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
N/A	Business As Usual **Lead:** Jayne Davey / Georgia Stephens

Expected Performance gain – longer-term N/A

Risks to future performance

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



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. Performance has fluctuated in the previous three months, but has improved and exceeded target in November.

KPI Indicator KPI.26

Return to Top

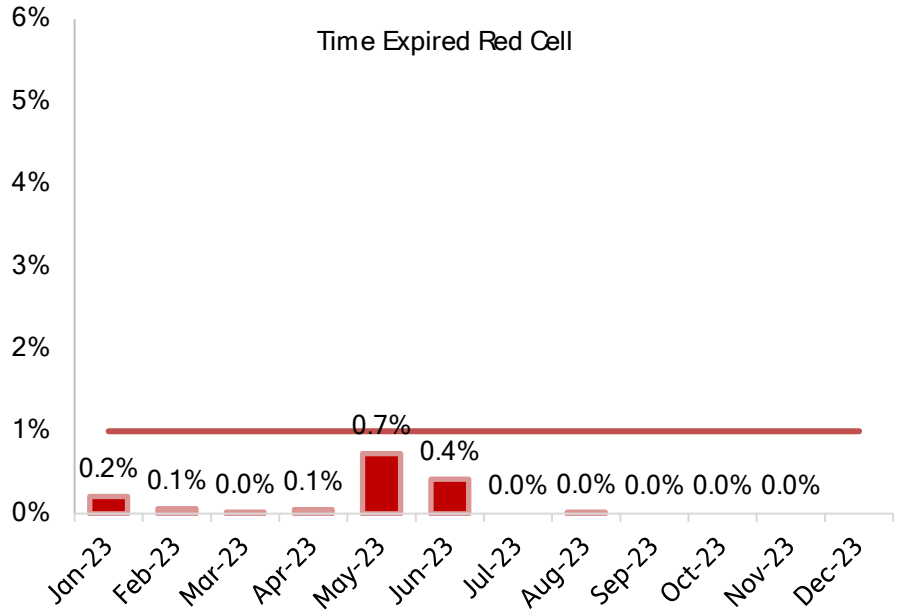
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	0.35	0.01	0.33	0.36	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0	0	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

Assessment of current performance, set out key points:
Performance of this metric has met target in November 2023, with no Red Cell wastage 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.	Daily (BAU)	Georgia Stephens

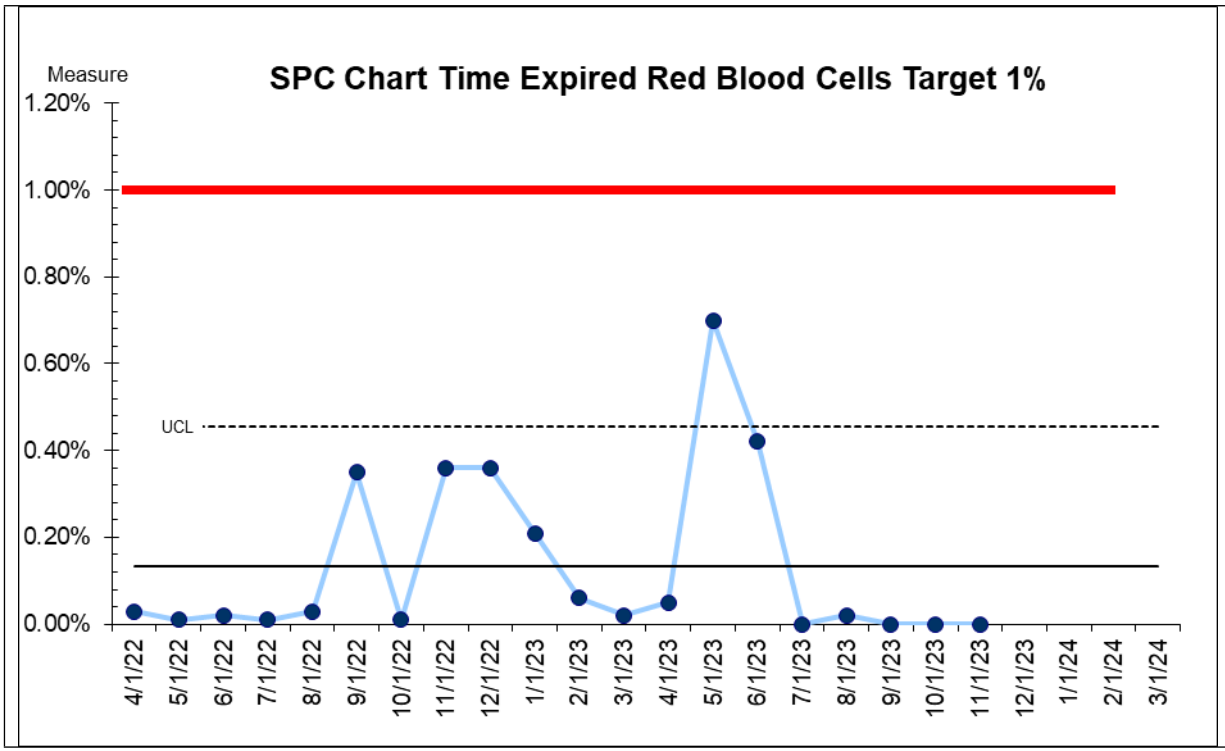
Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

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 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%

KPI Indicator KPI.05

Return to Top

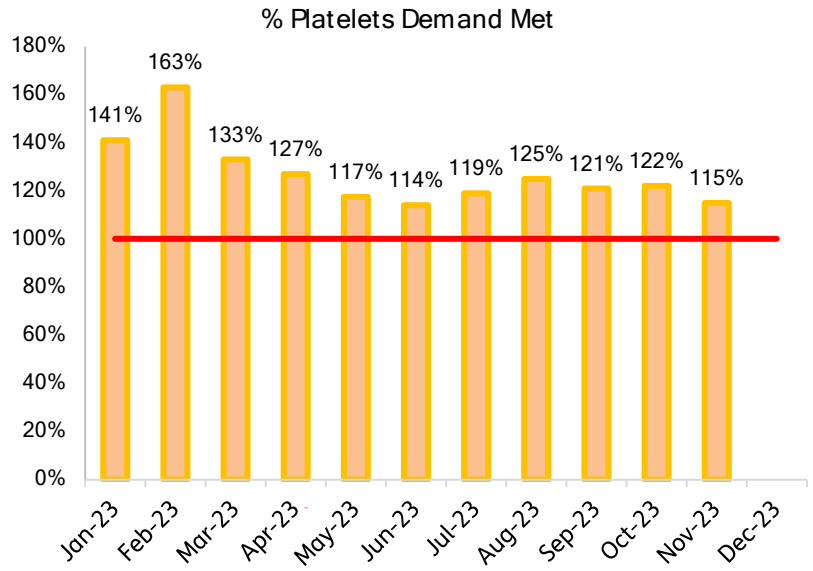
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	132	126	139	145	141	168	133	127	117	114	120	125	121	122	115
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



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

Performance

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

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

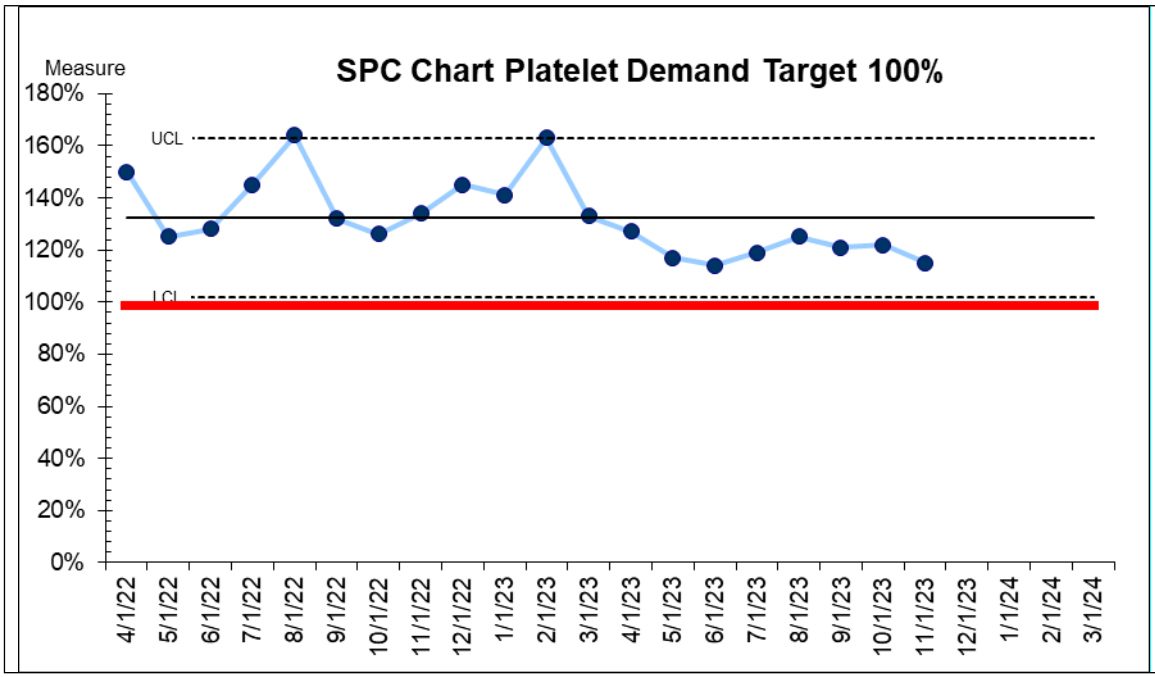
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under the Laboratory Modernisation work workstream for Platelet Strategy. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included. The workstream meetings have been initiated and the revised platelet strategy is expected to be completed by the end of March 2024.	**Timescale:** March 2024 **Lead:** Georgia Stephens

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

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



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 138% consistently exceeding the 100% target.

KPI Indicator KPI.25

Return to Top

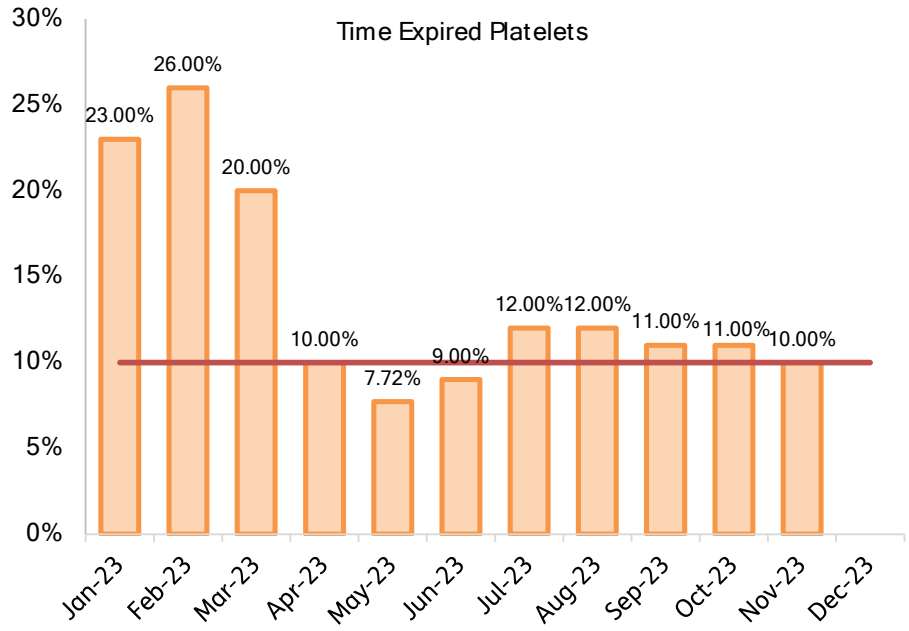
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	25	14	15	27	23	25	20	10	8	9	12	12	11	11	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before platelets are available for issue. This means in shortage

Performance

Assessment of current performance, set out key points:
At 10%, performance met target for November.

The significantly 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 focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under the Laboratory Modernisation work workstream for Platelet Strategy. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included. The workstream meetings have been initiated	Mar 2024 **Lead:** Jayne Davey/Georgia Stephens

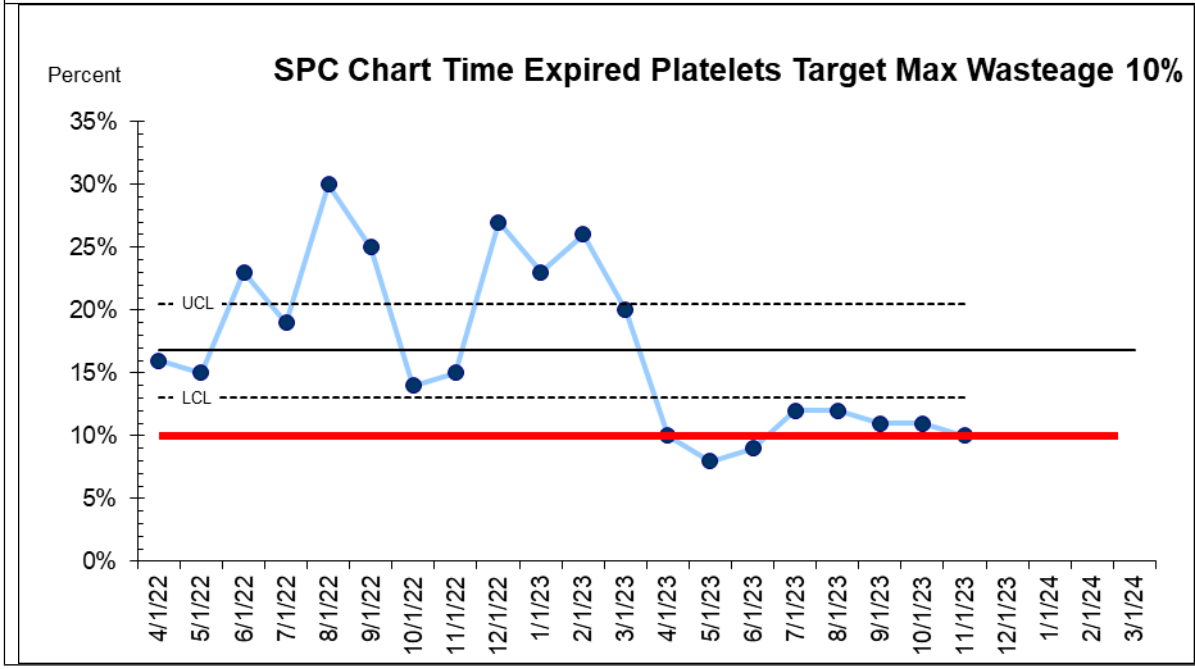
there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

and the revised platelet strategy is expected to be completed by the end of March 2024.

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 fluctuating special cause variation for this metric. Whilst the average performance of 18% remains above the maximum wastage limit of 10%, it is clear that there is a significantly improved performance, sustained since Apr. 2023.

KPI Indicator KPI.13

Return to Top

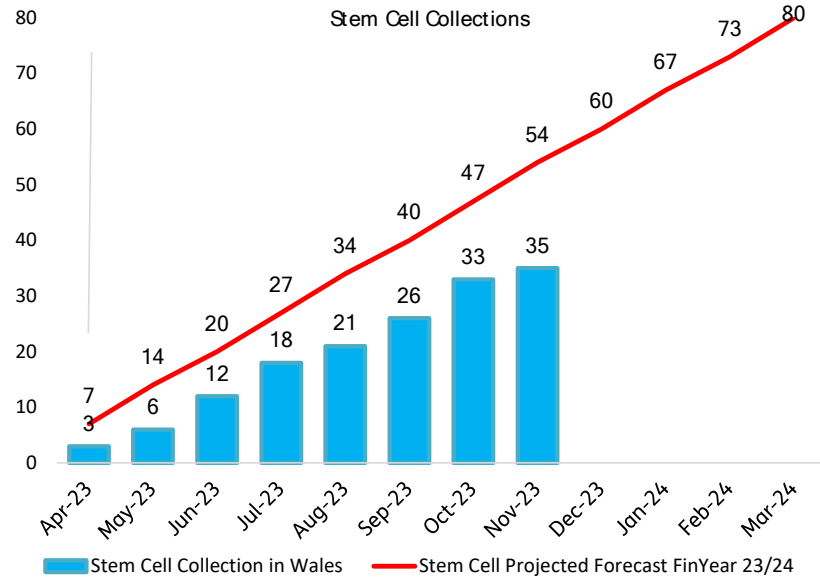
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Deborah Pritchard

Current Performance against Target or Standard

	Sep 21	Oct 22	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
Cumulative Actual	14	14	15	19	23	26	32	3	6	12	18	21	26	33	35
Cumulative Target p/a	42	49	56	63	70	77	84	7	14	21	28	35	42	49	56



Performance

At 6 total cell provision for the service just failed to meet the monthly target (7) in November. Provision was compiled of 2 Peripheral Blood Stem Cell, 1 Peripheral Blood Lymphocytes and 3 imports for a Welsh patient.

The Service continues to experience a cancellation rate of approx. 30%-40% 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 50-55 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.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
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	Q3 **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.

KPI Indicator WOD.37

Return to Top

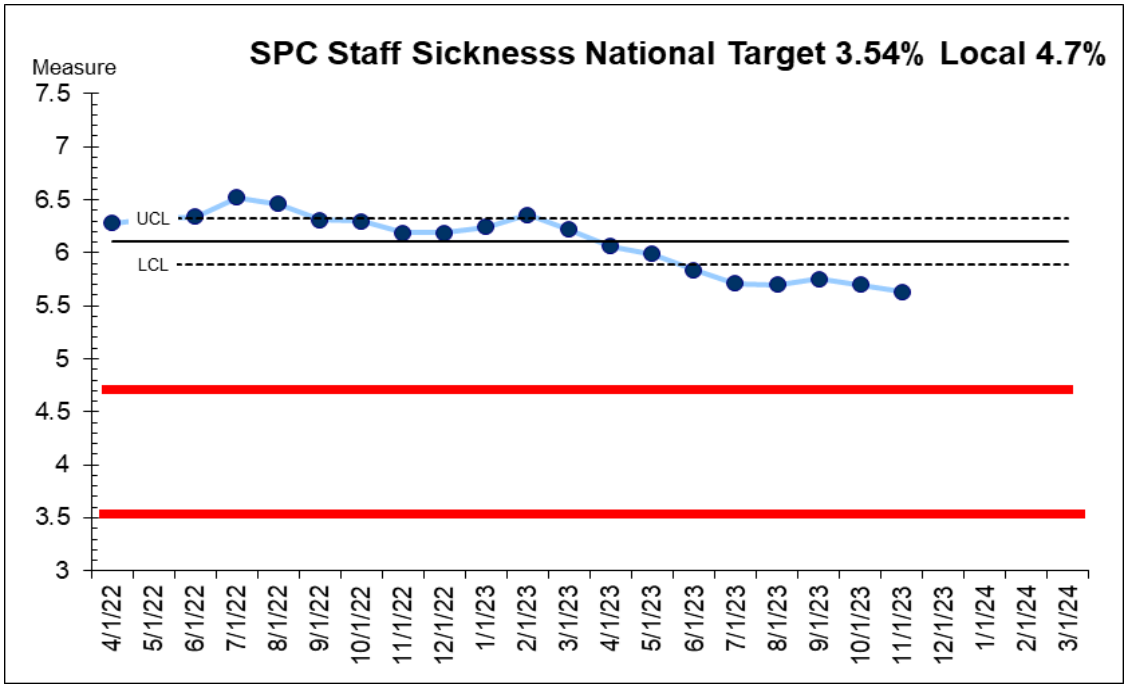
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	6.36	6.30	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
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



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

There is a slight decline in sickness following the winter months and as the People and Relationship Team continue to support managers in the application of the sickness policy. Corporate Services has significantly reduced their rolling 12 months from 5.37 to 2.85 in the year to date.

Short-term absence remains relatively low across the Trust.

Focused management on resolving long-term absence has seen in month figured reduce from 4.97% to 2.91% in the past 6 months. This continued reduction should see the overall rolling target reduce also.

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients (Closed)	01/09/2023 01/08/2023	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture	30/04/2024	Head of OD

	• Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board
	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		

KPI Indicator WOD.36

Return to Top

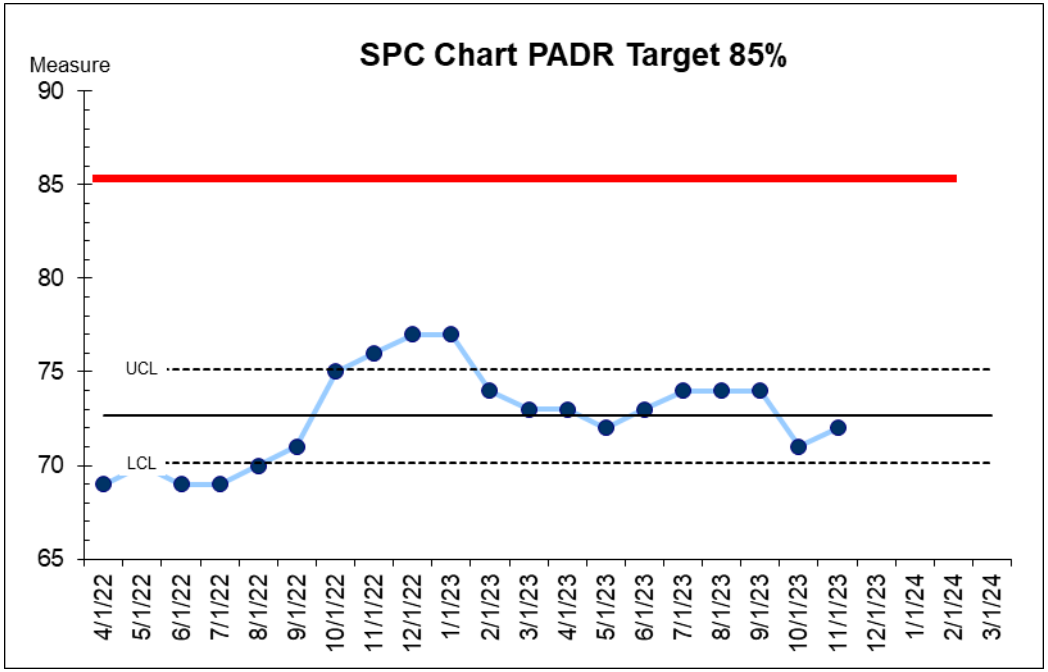
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	71	75	76	77	77	74	73	73	72	73	74	74	74	71	72
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	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.

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:
Support TCS with improvement plan	01/09/2023	Senior BP Head of Workforce
Continue to monitor for hotspot areas of concern and provide interventions for improvement.	01/09/2023	

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 Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Ongoing Monthly	Business Partners alongside SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance

- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

Return to Top

% of Patients that Rate Experience at Velindre at 9/10 or above

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	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
Would you recommend us? %	89	88	nda	nda	93	96	95	95	98	96	97	97	95	95	94
Your Velindre Experience? %			nda	nda	84	86	82	82	68	71	91	94	63	83	87
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:

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

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

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	33	86.84%
Good	2	5.26%
Neither good nor poor	0	0.00%
Poor	2	5.26%
Very poor	1	2.63%
Don't know	0	0.00%
Total	38	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	47	77.05%
9	6	9.84%
8	4	6.56%
7	1	1.64%
6	3	4.92%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0	0	0.00%
Total	61	100%

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

KPI Indicator KPI.09

Return to Top

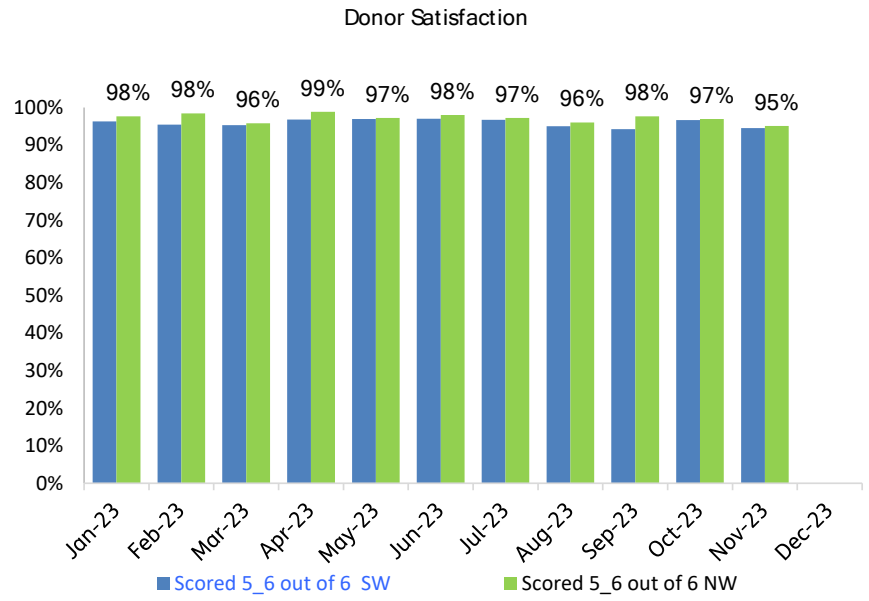
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	97	96	96	95	97	97	95	97	97	97	97	96	94.9	96.7	95.1
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95



Performance

Assessment of current performance, set out key points:
At 95.1%, donor satisfaction is above target for November. In total there were 1,193 respondents to the donor survey, 221 from North Wales (scoring satisfaction at 97.6%), and 961 from South or West Wales (scoring satisfaction at 94.5%).

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

N/A

KPI Indicator KPV.12

Return to Top

Number VCC formal complaints received under Putting Things Right within 30 days

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	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
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

Performance

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

KPI Indicator KPI.03

Return to Top

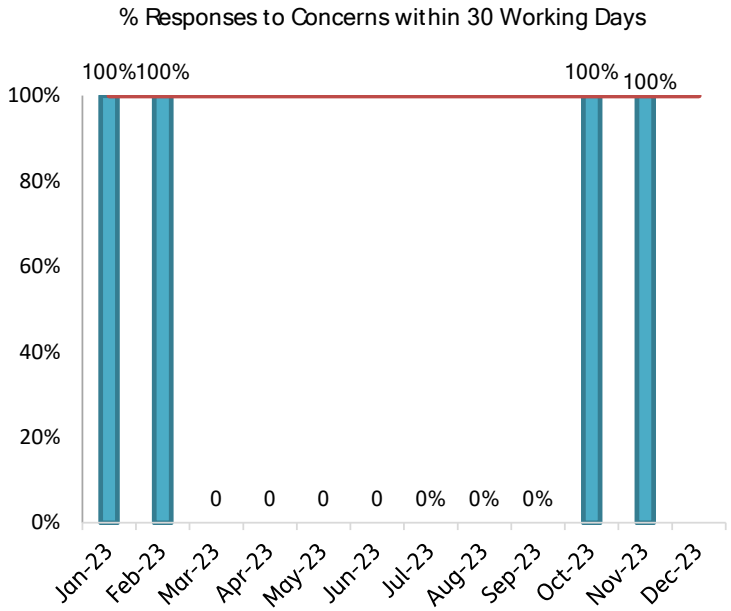
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Sep 22	Oct 22	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
Actual %	n/a	100	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



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

Performance

Assessment of current performance, set out key points:

Performance for November 2023 met target with the 1 formal concern received in October 2023 closed in November ahead of 30-day timeline.

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.

TIMELINESS

KPI Indicator KPV.14

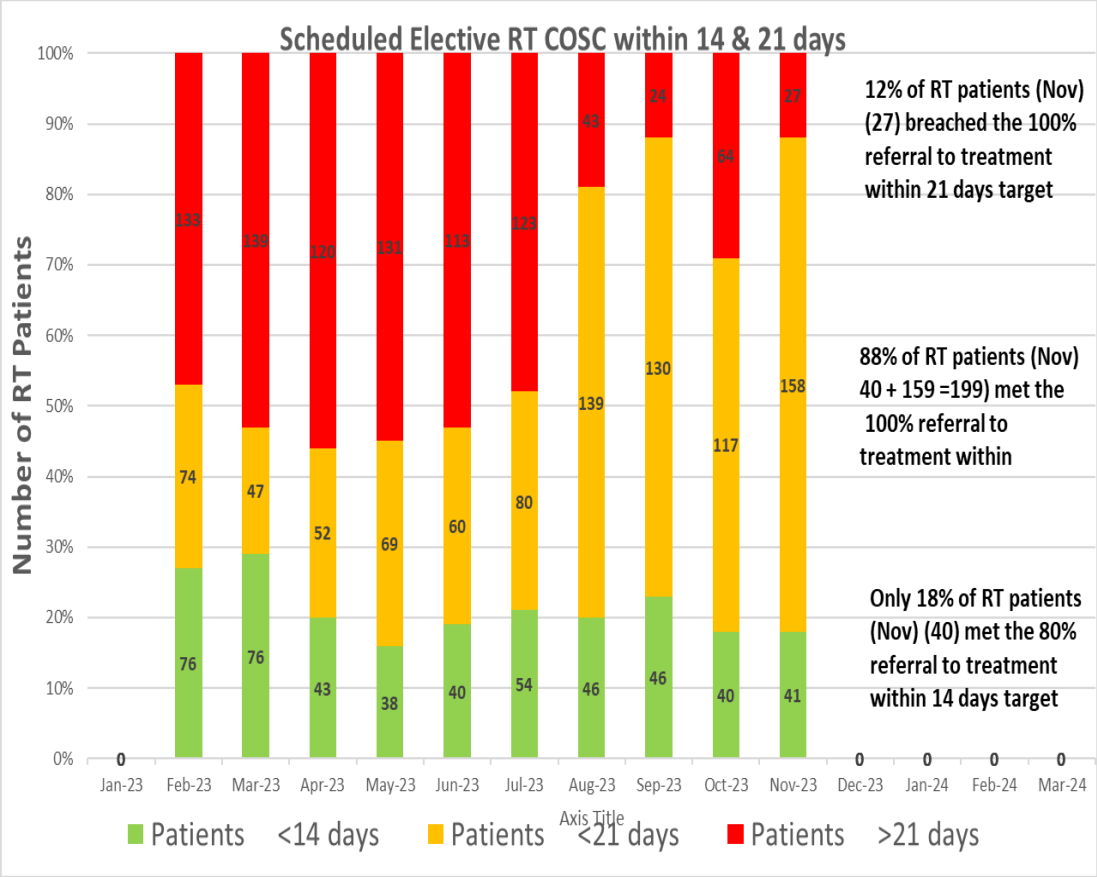
Return to Top

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



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	226	
treated within 14 days of referral (80% target)	40	18%
treated within 21 days of referral (100% target)	199	88%

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:	Lead:
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.	October 2023	Tom Rackley

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

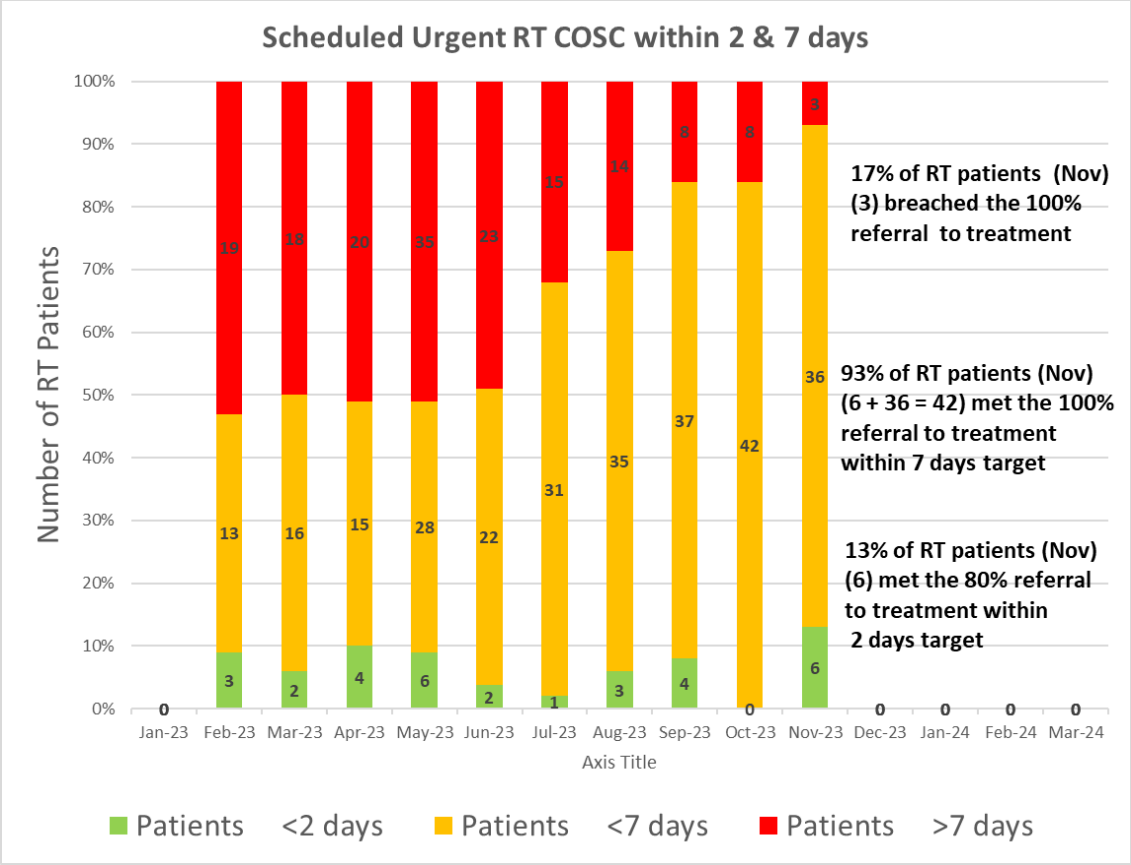
Linac replacement programme which has commenced

Sickness absence levels in radiotherapy workforce

KPI Indicator KPV.15

Return to Top

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**



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.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	45	
treated within 2 days of referral (80% target)	6	13%
treated within 7 days of referral (100% target)	42	93%

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	November 2023

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.16

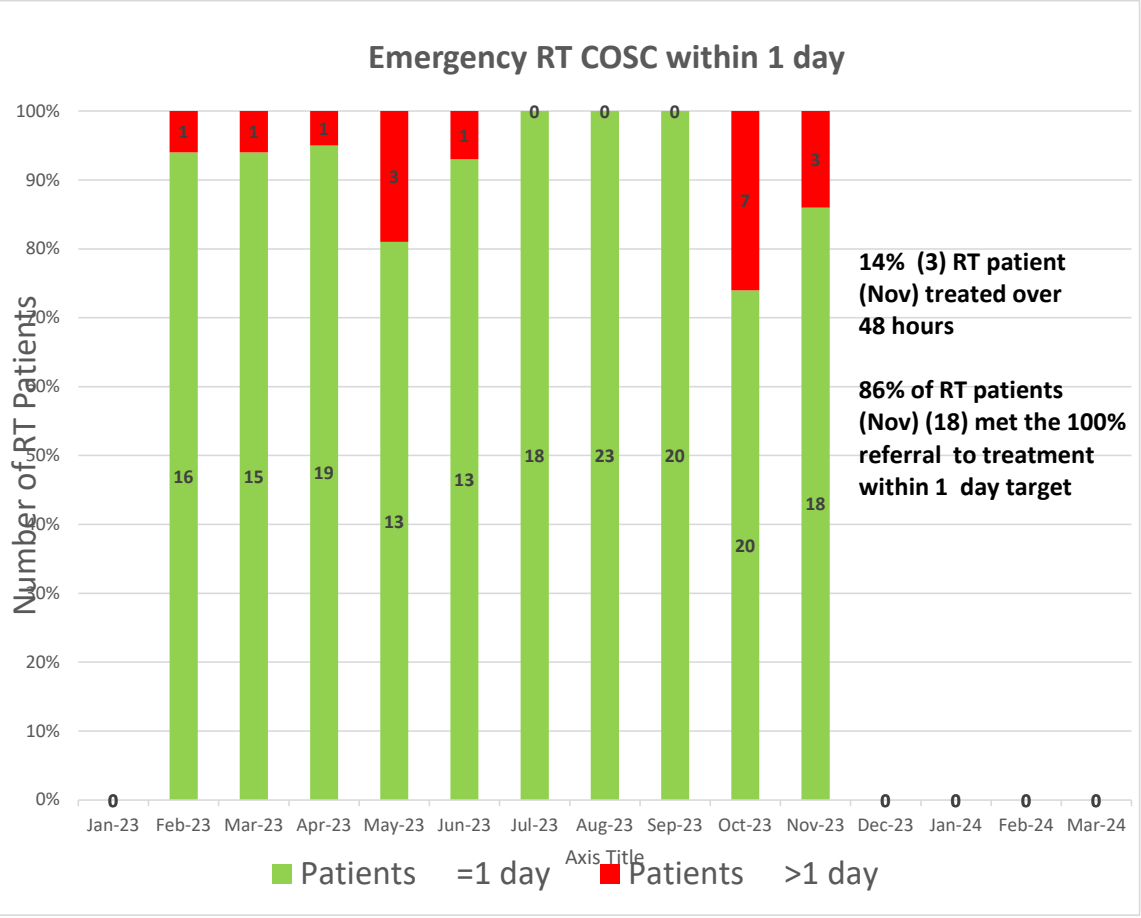
Return to Top

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



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Target Achieved

Number of referrals	21	
80% treated within 1 day of referral	18	86%
100% treated within 2 days of referral	19	90%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

Return to Top

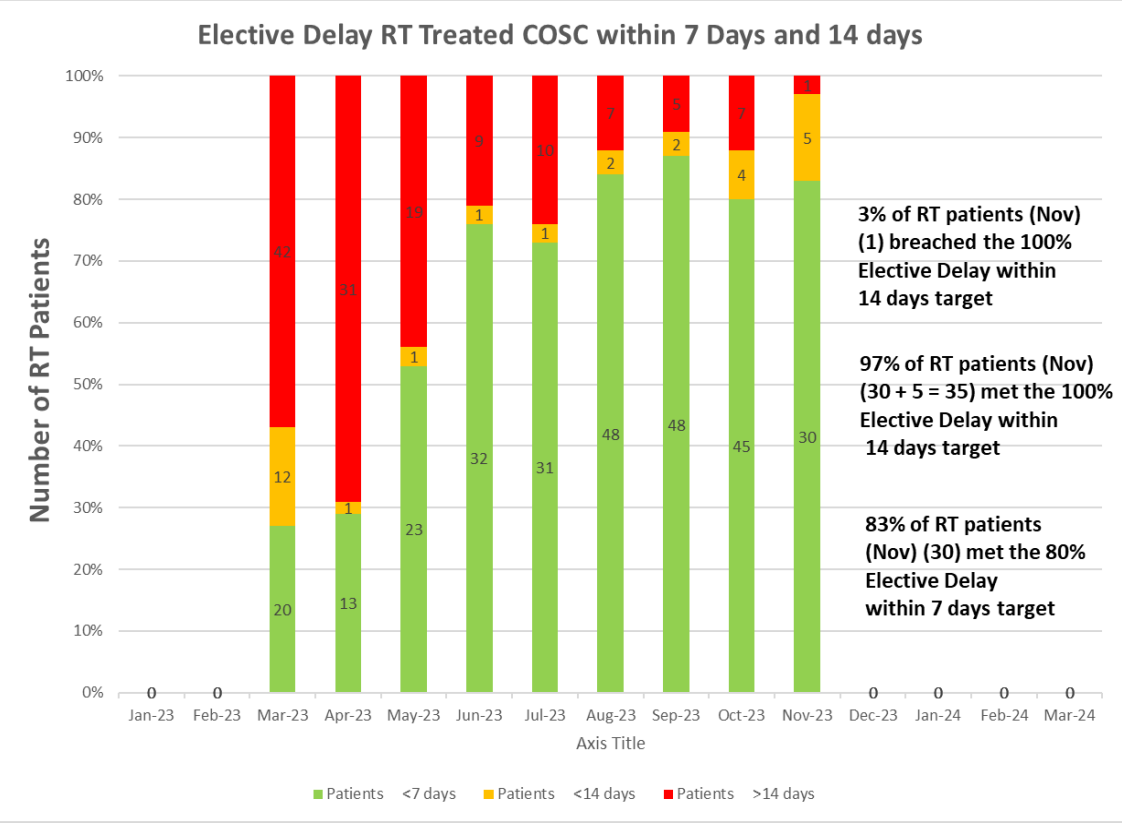
Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment



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	36	
treated within 7 days of referral (80% target)	30	83%
treated within 14 days of referral (100% target)	35	97%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.20

Return to Top

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	89	96	98	96	97	98	98	93	90	90	94	92	90	98	85
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days		14	6	12	9	9	8	26	40	40	25	32	35	10	57
Within 21 days		341	354	322	336	388	409	343	354	378	370	380	323	414	329

The number of patients scheduled to begin non-emergency SACT treatment in Oct 2023 was 424.

Parenteral Attendances (excludes patients on single agent oral SACT regimens)

	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	2,220	2,545	2,622	2,483	2,679	2,453	2824					

Performance

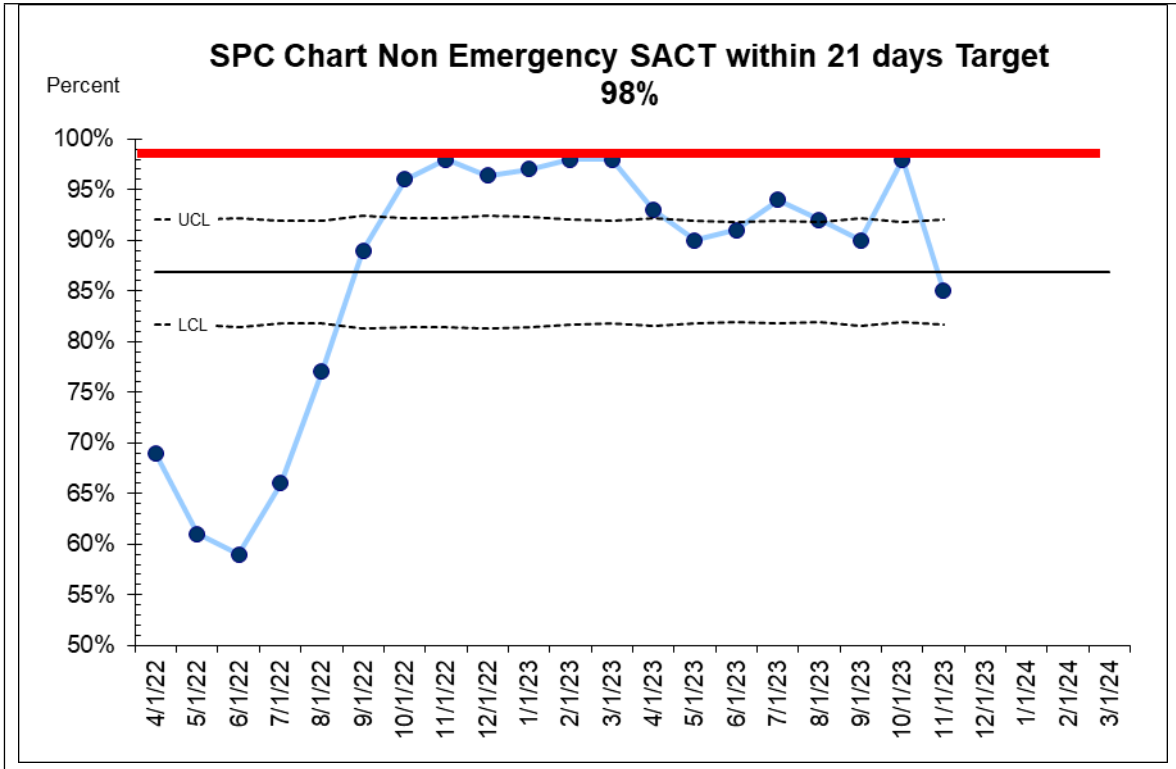
November 23 data and narrative:

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	50	5	1	1

All patients within a Trial are booked within Trial timeframes. Pharmacy capacity remains a challenge to delivering required activity levels.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead
Data model to be developed to understand demand and capacity required to meet demand	31/01/2024	WJ
Reconfiguration of accommodation to deliver increased asepctic capacity	31/01/2024	BT
following capital received December 2024	31/01/2024	BT
Recruitment of additional staff to support additional aseptic capacity	March 2024	VC
Appointment of SACT service Delivery manager		



SPC Chart Analysis

The SPC chart shows an improvement trend, followed by stable performance close to the 98% target.

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Review of SACT service delivery model		Planning
• Re-determine the impact of continued growth in demand across SACT teams	**01/04/24**	BW BT
• Nursing: international nurse recruitment and preceptorship recruitment	01/05/2024	RM Outreach board

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Pharmacy capacity
- Requirement for additional aseptic capacity to support preparation of additional chemo (including 'buy-in)
- Vacancies within SACT booking team
- Recent increase and complexity of in-patient SACT demand has impacted on pharmacy capacity to support day case workload

KPI Indicator KPV.21

Return to Top

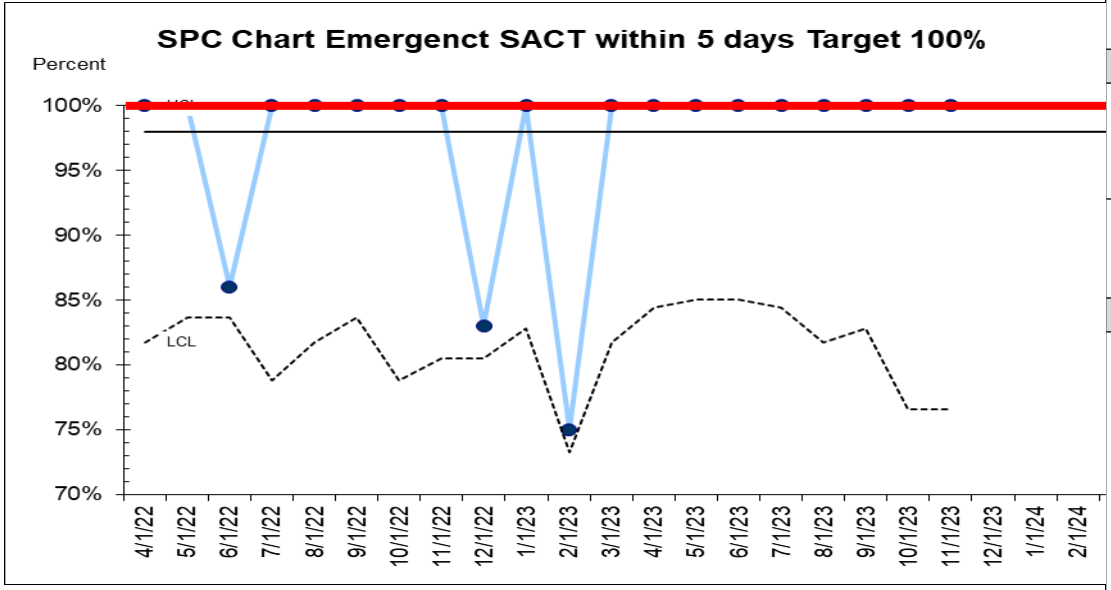
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Sep 22	Oct 22	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
Actual %	100	100	100	83	100	75	100	100	100	100	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	0	0	1	0	1	0	0	0	0	0	2	0	0	
Within 5 days	0	5	6	5	8	3		5	0	12	10	5	8	4	



SPC Chart Analysis

The SPC chart shows a fluctuating process starting to stabilize with average 97 % against the 100% target, however note small numbers involved.

Performance

Target achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

Return to Top

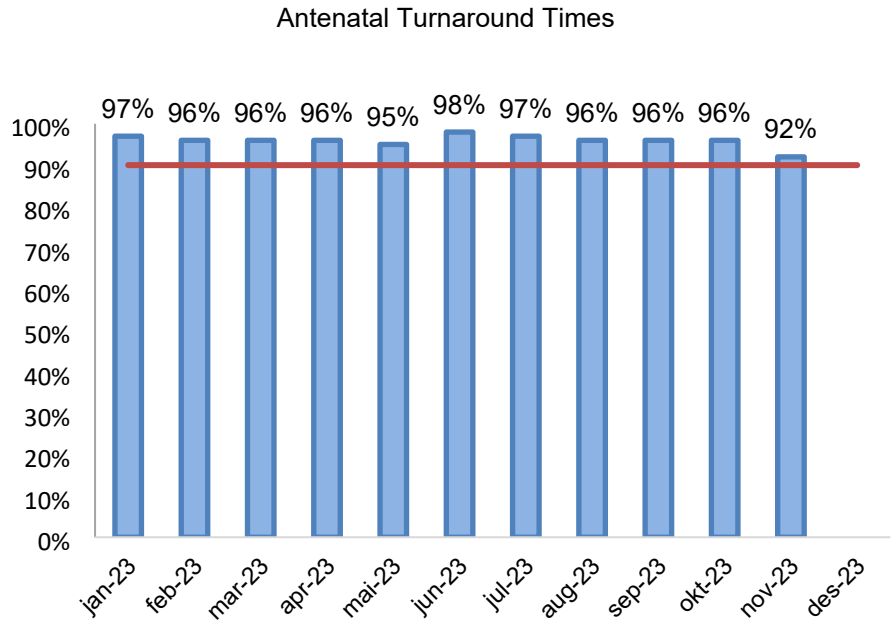
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Sep 22	Oct 22	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
Actual %	97	98	96	87	97	96	96	96	95	98	97	96	96	96	92
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 92% the turnaround time performance for routine Antenatal tests continued to exceed target in November 2023.

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.

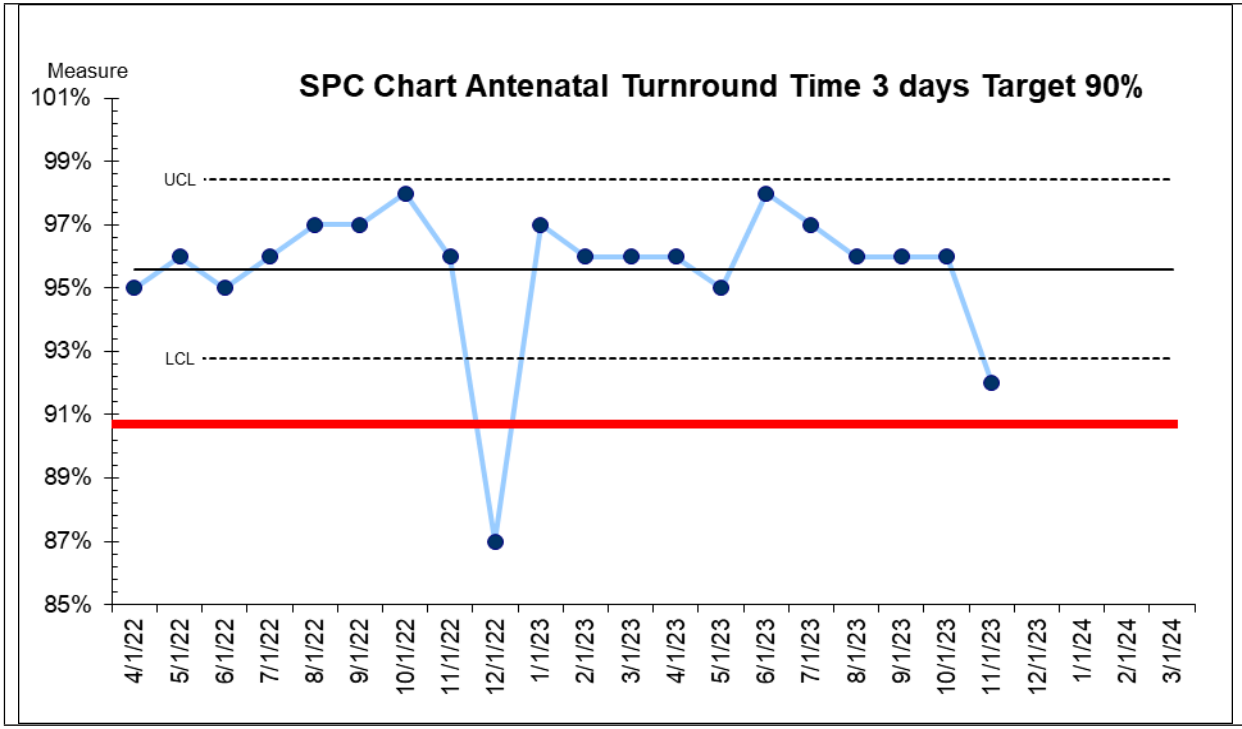
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance



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, with the average performance continues to exceed the 90% target.

KPI Indicator KPI.17

Return to Top

% 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

	Sep 22	Oct 22	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
Actual %	99	99	96	97	96	60	92	97	98	97	98	99	100	99	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	

Performance

There was excellent performance during Quarter 2 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 99% in October, performance averaged 99% for the quarter, meeting target and showing continuous performance improvement.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

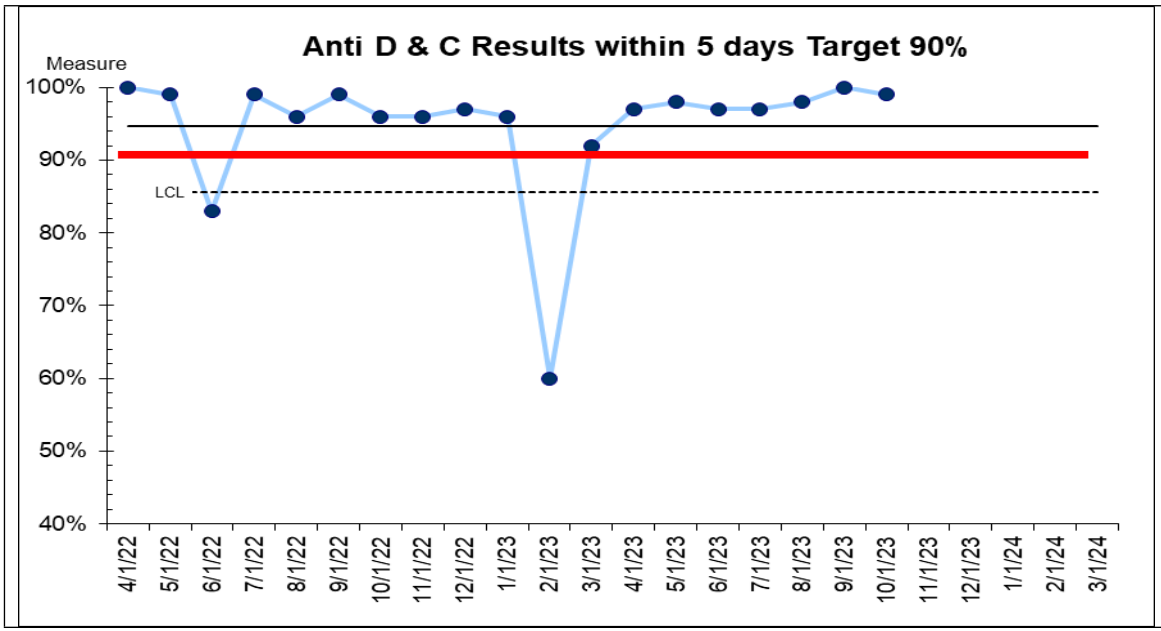
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



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. However, the average performance of 94% exceeds the 90% target overall.

EFFICIENT

KPI Indicator FIN.71

Return to Top

Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

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				
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at November 23

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(28,365)	(28,366)	0	(41,288)	(41,288)	(0)
RD&I	(399)	(397)	(1)	91	91	0
WBS	(14,726)	(14,725)	(0)	(21,666)	(21,666)	0
Sub-Total Divisions	**(43,490)**	**(43,488)**	**(1)**	**(62,862)**	**(62,862)**	**(0)**
Corporate Services Directorates	(8,895)	(8,897)	2	(13,188)	(13,188)	(0)
Delegated Budget Position	**(52,385)**	**(52,386)**	**1**	**(76,050)**	**(76,050)**	**(0)**
TCS	(501)	(484)	(17)	(744)	(744)	0
Health Technology Wales	(62)	(61)	0	(117)	(117)	0
Trust Income / Reserves	52,948	52,948	0	76,911	76,911	0
Trust Position	**(0)**	**17**	(17)	**(0)**	**(0)**	**(0)**

In response to the letter received from Judith Paget the Trust considered options at the extraordinary Board meeting on the 09th August and submitted the following financial improvement options to WG on the 11th August.

Performance

The overall position against the profiled revenue budget to the end of November 2023 is an underspend of £0.017m 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 all financial risks are mitigated during 2023-24.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organisations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions addressed through Divisional Action Plans		M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Further Non Delivery of recurrent savings plans

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	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m 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	**1.991**	

KPI Indicator FIN.73

Return to Top

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				
Target £24.416m CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m				

Capital Position as at November 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M8 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	8.690	0.000	2.206	10.896	0.000
nVCC - Project costs	0.000	2.308	0.000	(2.308)	3.141	(3.141)
nVCC - Advanced Works	3.882	3.171	0.000	0.711	4.631	(0.749)
nVCC - Whitchurch Hospital Site	0.000	0.018	0.000	0.000	0.018	(0.018)
Integrated Radiotherapy Solutions (IRS)	7.826	4.712	0.000	3.114	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Cyber Security	0.051	0.000	0.000	0.000	0.051	0.000
Total All Wales Capital Programme	22.966	18.899	0.000	4.034	26.874	(3.908)
Discretionary Capital	1.683	0.432	0.000	1.251	1.683	0.000
Total	24.649	19.331	0.000	5.285	28.557	(3.908)

The approved Capital Expenditure Limit (CEL) as at November 2023 is **£24.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.** During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

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 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.

NHS – All Wales Capital Prioritisation

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have now 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 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 14th February 2024 for ALL unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received.

Performance to date

The actual expenditure to November 2023 on the All-Wales Capital Programme schemes was £18.899m, this is broken down between spend on the nVCC enabling works £8.690, nVCC Project Costs £2.308m, nVCC Advanced works £3.171m, nVCC Whitchurch Hospital Site £0.018m and IRS £4.712m.

Spend to date on Discretionary Capital is currently £0.432m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding to support the Project with latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Furthermore, due to the delay additional costs are expected to be incurred on the nVCC advances design agreement which is highlighted within the table above.

Indication from WG colleagues is that funding will be provided to cover the additional costs. We understand that delay in approval of this funding is linked to the nVCC FBC approval and understanding the full cost requirement, which is anticipated to increase following the revised MIM Financial Close. The nVCC FBC is due to be submitted to WG in January '24.

All other 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), after this point the Trust is expected to internally manage any slippage pr overspends on the Capital programme.

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		
Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£4m for further advanced works and project costs.		

KPI Indicator FIN.72

Return to Top

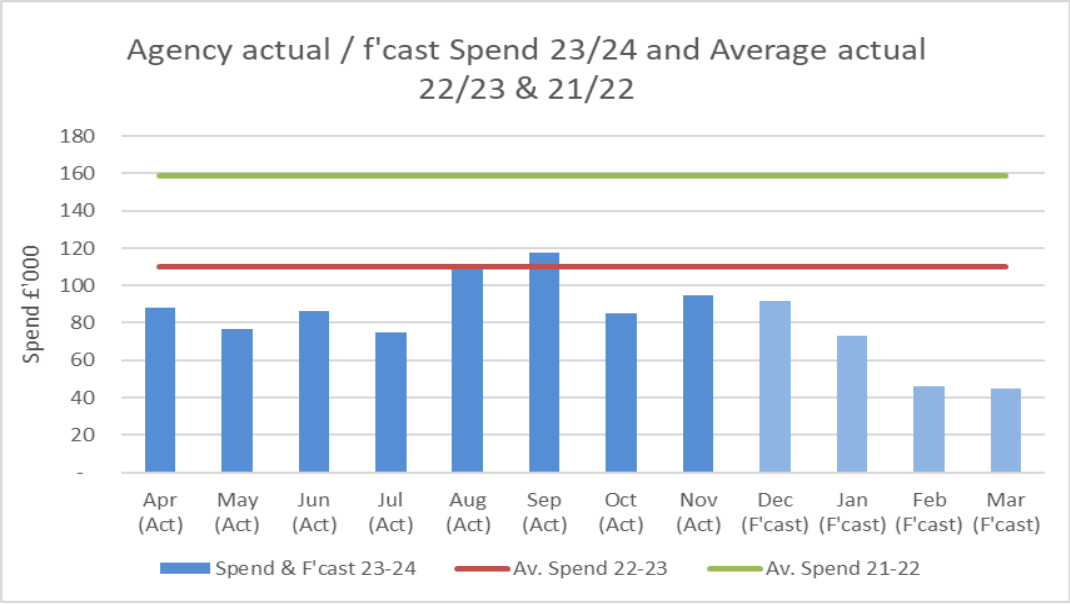
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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				
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for Nov'23 was **£0.095m,** which gives a cumulative year to date spend of £0.732m and a current forecast outturn spend of circa **£0.987m** (£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:
• Actions addressed via Divisional action plans		Matthew Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

Return to Top

Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

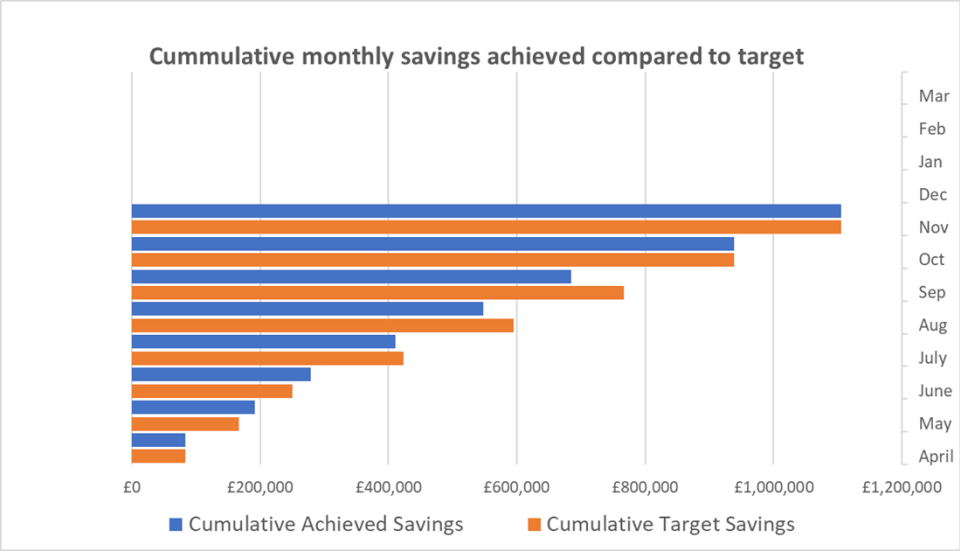
SLT Lead: Finance Director

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	0.169m				
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M



The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the £0.391m of underlying surplus which had been carried forward from 2022/23.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness
The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. 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.

KPI Indicator FIN.60

Return to Top

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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
Capital & Revenue Invoices	95	98	98	99	98	96	98	97	98				
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During November '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.6%** as at the end of month 8, and a Trust position (including hosted) also of **97.6%** 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

EQUITABLE

KPI Indicator WOD.81

Return to Top

% 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	Sep 22	Oct 22	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
Actual %	-	-	-	-	-	-	11.63	-	-	10.30	-	-	9.81	-	
Target %	-	-	-	-	-	-	0%	-	-	0%	-	-	0%	-	

Trust

Welsh Language (Listening/Speaking)

30th Sept 2023

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1042	1652	63.08%
1 - Entry/ Mynediad	235	1652	14.23%
2 - Foundation / Sylfaen	66	1652	4.00%
3 - Intermediate / Canolradd	40	1652	2.42%
4 - Higher / Uwch	46	1652	2.78%
5 - Proficiency / Hyfedredd	61	1652	3.69%
Not Stated	162	1652	9.81%
Grand Total	**1652**	**1652**	**100%**

Performance

Assessment of current performance, set out key points:

- Welsh Language declaration 'not stated' recorded quarterly
- Target agreed as 0% non-declaration

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator WOD.78

Return to Top

Mean Gender Pay Gap – Annual

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	-	-	-	-	-	-	13.45	-	-	-	-	-	-	-	
Target TBA%	-	-	-	-	-	-	TBA	-	-	-	-	-	-	-	

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%

Performance

Assessment of current performance, set out key points:

- Gender pay gap position recorded as at March 2023
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

Return to Top

Diversity of Workforce – % Black, Asian and Minority Ethnic people

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	-	-	-	-	-	-	5.18	-	-	4.56	-	-	5.45	-	
Target TBA%	-	-	-	-		-	TBA	-	-	TBA	-	-	TBA	-	

Trust

Ethnic Origin

30th Sept 2023

Ethnic Origin	Headcount	%	BAME %
Asian	51	3.09%	**5.45%**
Black	14	0.85%	
Chinese	10	0.61%	
Mixed	15	0.91%	
Not Stated or Unspecified	90	5.45%	
Other	8	0.48%	
White	1464	88.62%	
Grand Total	**1652**	**100%**	

Performance

Assessment of current performance, set out key points:

- Staff ethnic origin recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.80

Return to Top

Diversity of Workforce – % People with a Disability within workforce

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Sep 22	Oct 22	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
Actual %	-	-	-	-	-	-	4.63	-	-	4.9	-	-	4.9	-	
Target TBA%	-	-	-	-	-	-	TBA	-	-	TBA	-	-	TBA	-	

Trust

Disability

30th Sept 2023

Disability	Headcount	%
No	1354	81.96%
Not Declared	46	2.78%
Prefer Not To Answer	9	0.54%
Unspecified	162	9.81%
Yes	81	4.90%
Grand Total	**1652**	**100%**

Performance

Assessment of current performance, set out key points:

- Staff disability recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Integrated Quality and Safety Group Highlight Report

DATE OF MEETING	16th January 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	Chris Kelly, Deputy Head of Quality, Safety and Assurance
PRESENTED BY	Chris Kelly, Deputy Head of Quality, Safety and Assurance & Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists & Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	• ***Mortality Reviews*** **and 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy** - The Trust mortality review systems and processes are under review so that the Trust can provide as much assurance as possible in respect of mortality. This has included undertaking a gap analysis against: o The Medical Examiners Service All Wales Mortality Review Framework o National Chemotherapy Advisory Group Report, 'Ensuring Quality and Safety of Chemotherapy Services in England'

	○ The UK Department for Health report 'Improving Outcomes: A Strategy for Cancer' (2011), Velindre Cancer Service has provided assurance that all inpatient deaths are reviewed in line with national guidance. Remaining work is underway to ensure that all our mortality review processes are robust, follow national guidance and cover the required cancer specific Mortality Review requirements across all areas of the cancer service including 30-day SACT, 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy. • **Quality Framework Delivery Review -** A gap analysis was undertaken on the Trust Quality Framework **(Appendix 2)**. The group acknowledged the work that had progressed. However, some actions had been delayed, with a plan in place with amended timescales. • **VCS incident/concerns themes -** There has been a considerable increase in the concerns received relating to Velindre Cancer Service (6 a month early 2023, 20 during November 2023). A theme around communication and appointments continues with the number of incidents related to SACT booking increasing. An improvement plan has been requested to understand the complexity of the service issues for discussion at the January meeting. • **Quality & Safety Tracker** – Active work continues on the tracker. Full assurance can not yet be provided from the information contained within the tracker.

RECOMMENDATION / ACTIONS	To **NOTE** the discussions that took place during the meeting held on 19th of December 2023. **DISCUSS** the report in particular the issues highlighted above.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Integrated Quality and Safety Group Executive Management Board	19th December 2023 2nd January 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***Integrated Quality & Safety Group*** – agreed content of the report. ***Executive Management Board:*** Noted and discussed the report, agreed to maintain oversight of the mortality review work, approved the proposal to disband the current Datix Operational Group and develop a Datix User Group and requested to see the high-level improvement plan to address that, themes at the Cancer Service relating to patient level communications and administrative processes.	

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	AMaT Quality & Safety Tracker overdue actions March-September 2023 (excluding Brachytherapy)
Appendix 2	Quality Framework Review December 2023

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 on behalf of the Board 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 on 19th December 2023 were:

2.1 Mortality Reviews

A gap analysis was undertaken by VCS following the publication of the All-Wales Learning from Mortality Review Framework. This was discussed at the Group (report is available from Nicola Williams if required).

The group discussed the current VCS approach to both 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 Velindre University NHS Trust has a responsibility to undertake mortality reviews to ensure:

- A robust process is in place that covers every patient care pathway.
- There is a clear structure, governance process, and consistent approach for undertaking mortality reviews that aligns with the All-Wales approach.
- Mortality Reviews enable the identification of continuous learning and improvement opportunities.
- An integrated approach to the management of risk is incorporated within Mortality Reviews.

In addition to undertaking patient mortality reviews, the National Chemotherapy Advisory Group Report, 'Ensuring Quality and Safety of Chemotherapy Services in England' and The UK Department for Health report 'Improving Outcomes: A Strategy for Cancer' (2011) recommend that 30-day mortality as an indicator of avoidable harm from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy and that NHS organisations have effective reporting and review processes in place to capture:

- Patients who received intravenous, oral or subcutaneous chemotherapy, monoclonal antibodies, targeted therapies or immunotherapy who died within 30 days of receiving SACT.
- Patients who received emergency or urgent symptom control radiotherapy who died within 30 days of the first fraction of treatment.
- Patients who received scheduled or elective delay radiotherapy who died within 90 days of the first fraction of treatment.

The Cancer Service currently meets the Statutory requirement in line with the Medical Examiners Service and continues to develop this process for reviewing all inpatient deaths. Areas to further improve the learning feedback and regional communication have been identified. There is a need to work with the Wales Cancer Network to develop a local SOP for 30-day SACT and radiotherapy Mortality reporting to ensure a consistent approach both internally and across the region. Best practice would suggest that where 30-day mortality reviews need to be undertaken, these should involve (internal) peer review and a degree of independent scrutiny (outside of the relevant site-specific team). The Mortality team are currently working on a revised process and action plan to address these gaps. An updated report will be brought back to the Integrated Quality & Safety Group and the Quality, Safety & Performance Committee in March 2024.

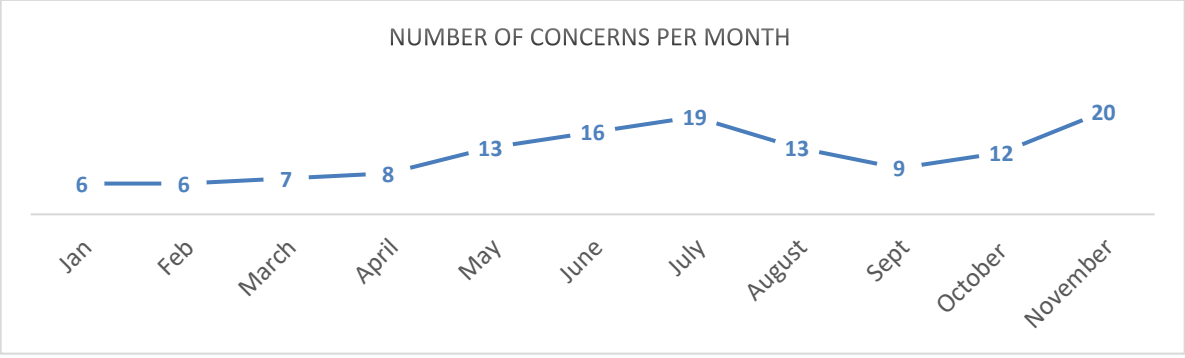
The Trust is also not able to review mortality data due to ongoing data validation issues that have been in place since implementation of WPAS. Several technical issues have been resolved. However, further technical issues have been identified. Urgent resolution is required with the support of the Business Intelligence team to understand the issues in the data validation process. Reviewing and understanding mortality data is an important aspect of patient safety.

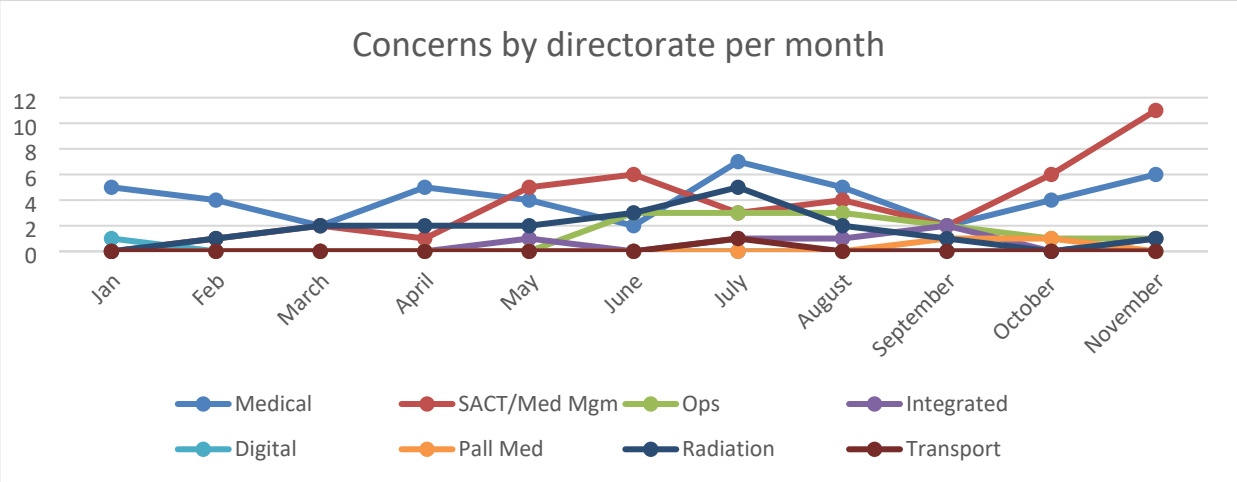
2.2 *Divisional and Departmental Quality and Safety Monthly Reports*

2.2.1 *Velindre Cancer Service:*

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

- ***Concerns and Incident Themes*:**
  There has been a considerable increase in the concerns received.





A theme around communication and appointments continues with the number of incidents related to SACT booking increasing. Patients continue to report difficulty contacting departments particularly medical secretaries (phones not being answered and voicemails are not returned).

Appointments – patients continue to report lack of communication around SACT and outpatient appointment date, location, and time changing without appropriate communication. Themes found within the medical concerns received related to communication within clinic, clinic organisation (over running, lost sample), and queries over clinical plan.

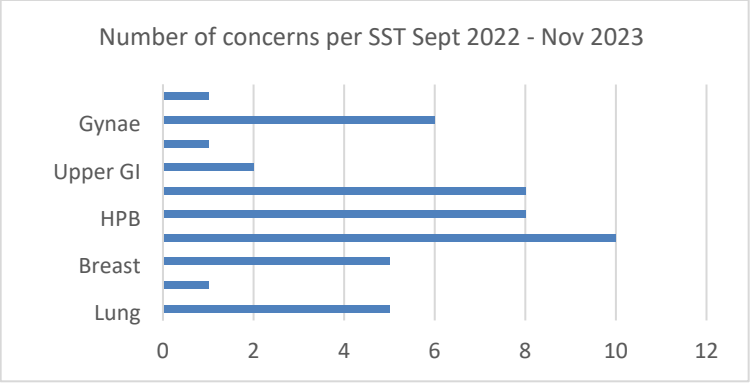
Further triangulated context was requested by the group to overlay activity, demand and vacancy data to identify any correlations. VCS provided assurance that improvements are underway to address all the themes. The Group requested that this is provided at the next meeting. The group discussed the current pressures within VCS and acknowledged that this is having an impact on patient experience.

To respond to these themes several interventions have been commenced at a Divisional level that include:

- Review of SACT appointment booking systems and processes
- Daily meetings are underway around the SACT booking process to address issues
- Work ongoing with Communications Team to help patients understand the booking process before they raise a concern.
- Establishment of a working group to address medical secretary communications.
- Telephony structure review.

There were 6 concerns related to consultants in November 2023. Data was also presented about the numbers of concerns per SST (see graph below). The group agreed that both require comparison against activity levels to provide further context

against themes identified. Further detailed analysis of these are being undertaken by the Cancer Service.



There has been a decrease in incidents open over 30 days, this is being monitored closely by the Senior Management Team.

2.2.2 Welsh Blood Service (WBS)

The WBS report covering November 2023 to was received. Work has been undertaken to reduce the number of incidents open over 30 days.

There were 4 externally reported events:

- SABRE 111: *"Malaria residency potentially not assessed correctly"*. No further action.
  MHRA Response - Event excluded from annual summary.
- SABRE 112: *"Donor previously accepted to donate, despite declaring taking medication that indicates the donor should have been deferred."* Actions implemented.
  MHRA Response - Event excluded from annual summary.
- SABRE 113: *"Incorrect Assessment of tetanus risk (linked to SABRE 109)"*. Still under investigation.
- SABRE 114: *"Donor travel risk not reviewed correctly (linked to SABRE 109)"*.
  Still under investigation.

Previously reported events, SABRE 109 and SABRE 110, have been closed by MHRA. Root cause analysis and actions have been accepted by the MHRA.

The themed analysis report following review of all Route Cause Analysis review of screening related incidents was circulated to members after the meeting. This will be discussed further at the next meeting.

Concerns remain at relatively low in numbers levels, there had been 5 early resolution concerns (relating to 0.07% of donors).

Audit

Two major findings raised in November:

- (IA50) Escalated issue regarding non-separation of validated and non-validated stocks of PBSS within Stores.
- (IA51) Information Governance audit identified that there is currently no Data Protection Impact Assessment (DPIA) in place for the staff card/ID supplier (Paxton).

In addition, the monthly QA Lab Cold Chain audit of the EMS identified two major findings:

- (IA52) Manufacturing Laboratory: core probe alarm; there is no recorded evidence that risk has been considered for the materials stored.
- (IA53) Manufacturing Laboratory - components stored outside of specification for 20 minutes. Close-out comment does not include a description of the materials that may have been impacted by this alarm.

The group requested further information in future reports that demonstrates learning has been taken from issues, and action taken to address them.

2.3 Quality and Safety Tracker

Following approval to use the AMaT system as the Trust Quality and Safety tracker to enhance assurance in respect of completion of agreed core quality and safety related improvements, significant work has been undertaken to transfer all open related improvement plans onto the AMaT system.

Action owners have been trained in how to use the system so that we can be assured that there is one live version service level to board. The group were advised that implementation is progressing well, with most actions now being correctly assigned and departmental lead training delivered. The area where further work was required, and a planned senior discussion was arranged was in respect of the brachytherapy improvement plan as this had not been updated on the tracker.

To complete roll out the system across the Trust and embed its utilisation in practice several further actions are required:

- Corporate Quality and Safety team to continue to work with Divisional leads to engage with the Brachytherapy Dept. to ensure an accurate, up to date picture of the current position re two Brachytherapy audits.

- Corporate Quality and Safety Team to provide numerous AMaT system workshops to train identified individuals and provision of AMaT academy training resources – planned for January 2024
- Development of a standardised approach to action allocation, management, and oversight to be developed by the corporate Quality and Safety team in partnership with relevant divisional leads. Discussions have been held with WBS leads, and awaiting a date to discuss with VCS leads. A Standard Operating Procedure has been developed in draft form and circulated for comments.

At time of report 18 inspections, 143 recommendations and 222 actions are contained upon the tracker. During November and December 2023, 15 actions were completed.

There has been an overall increase in the number of overdue actions during the reporting period, and an increase in the numbers of actions awaiting approval, and approved. One inspection has been completed – 'CHC visit to VCC Outpatients Department 8th February 2023'. The table below shows recommendations and actions by approval status, per inspection for January 2024.

Title	Date of Inspection	Recommendations	Actions total	In progress	Part. complete	Over due	Awaiting Approval	Complete
Brachytherapy Audit	02/02/23	46	46	0	0	45	0	1
Brachytherapy NRI steps 1-6	10/09/23	5	5	0	0	5	0	0
Fuller Action Plan following enquiry	01/03/23	18	18	0	0	1	17	0
HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	10/05/23	16	31	4	0	9	10	8
HIW Visit to VCC First Floor Ward 12th & 12th July 2022	12/07/22	1	1	0	0	1	0	0
Loss to follow up NRI steps 1-9	10/09/23	6	6	0	0	5	1	0
Management of unwell patient in radiotherapy	27/10/23	7	17	9	0	8	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	4	0	0	4	0	0
SACT NRI steps 1-7	11/09/23	7	7	1	0	4	1	1
SACT Treatment Helpline Incidents	01/01/23	1	28	0	1	3	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
VCC Q+S Unwell patients in review radiotherapy	18/10/23	3	8	4	0	3	0	1
VUNHST WRP Concerns Assessment Action Plan Oct 2023	31/10/23	11	23	4	0	4	12	3
WRP Concerns Assessment	17/03/23	1	1	0	0	0	0	1
WRP Validation	22/02/23	1	2	0	0	0	2	0
	Total	**143**	**222**	**25**	**1**	**99**	**70**	**27**

Support continues to be provided by Corporate Quality and Safety Team to assist divisions with regards to system implementation and development of a formal sign off process for actions, including a Standard Operating Procedure. It is anticipated that this will improve the accurate recording of action status on the tracker, by enabling Divisions to update accordingly.

Of the 99 overdue actions recorded on the tracker, 50 relate to Brachytherapy. These require updating in collaboration with the Brachytherapy Dept.

In relation to the additional actions that are overdue, the longest overdue is March 2023. The Brachytherapy overdue actions that were due for completion between March and September 2023 are provided in **Appendix 1**.These relate to:

- HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023 (1 action)
- HIW Visit to VCC First Floor Ward 12th & 12th July 2022 (1 action)
- Patient & Donor Experience (4 actions)
- SACT Treatment Helpline Incidents (1 action)

The Group welcomed the report and acknowledged the progression of the Quality and Safety Tracker. However, it was accepted that currently the system could not be utilised to provide assurance until all action plans are actively managed upon the AMAT system, and action dates are reviewed and assured as accurate.

In addition, reports have been received from Divisional leads who have identified some recommendations and actions contained within the system are not supported at a service level, despite their inclusion upon previous action plans. To resolve this issue, systems and processes need to be developed to ensure robust processes are in place to accept, review and approve actions, to achieve this the Corporate Quality and Safety Team will engage and work in partnership with Divisional and Departmental leads to develop and implment required processes.

The group discussed some of the issues that have been highlighted during the AMaT implementation phase are the approval and governance process regarding action plans. The Quality & Safety Team agreed to develop a Standard Operational Procedure to ensure that only action pans that have been through Divisional sign off will be included onto AMaT.

The extension of the AMaT contract beyond March 2023 has been agreed.

2.4 Safe Care Collaborative (SCC)

The Group received an overview of both the ongoing progress of the five Safe Care Collaborative projects, attendance on coaching calls, Improvement Coaching Information and outcomes of the Trust learning events held on 28th and 29th November

2023 'Maximising the Potential'. A Trust event held on the 28th November 2023 was an opportunity for project groups to demonstrate project approach, achievements, challenges and opportunities through presentation to Senior colleagues, whilst facilitating discussion about how project obstacles can be overcome. This session was attended by project teams, Executive leads and Improvement Cymru, with presentations being well received. Through these discussions several themes were identified:

- ***Communication issues internal and external***: the need to share the changes, aims and goals and their impact on the patients and services.
- ***The need for robust data collection and analysis*** to support service improvement and develop indicators of success.
- ***Further Quality and Safety culture development*** to support patient/ donor involvement and feedback, co-production, and psychological safety.
- ***Digital Systems and Support.*** Within several of the presentations further support with digital aspects of project delivery were identified e.g., enabling live Datix reporting within WBS, provision of a fit for purpose telephony system for the SACT treatment helpline, and enabling project teams to access relevant Business Intelligence Data.
- ***Workforce Resource*** to support and enable clinicians in delivery.

Following the presentations and discussions, colleagues in Improvement Cymru supported the development of a range of next step approaches for each project team through the utilisation of Ease / Benefit Matrix and Thematic Analysis. *Ease Benefit Matrix* is an improvement tool aimed at identifying and prioritising further improvement opportunities to support project delivery. The tool can be used to identify and approach project challenges and obstacles necessary to maximise project outcomes. The ease/benefit matrix are available from Nicola Williams if required.

2.5 Datix Operational Group.

The Datix Operational Group was originally established prior to the forming of the Integrated Quality and Safety Group, with the remit of providing oversight management of both the ongoing use of the Datix Cymru and Datix v14 systems, system upgrades, the supporting IT infrastructure and implementation of any new features/modules together with oversight of any risks and issues. As the Datix OFW systems are now fully integrated, and the IQSG has been established group members have identified the need to further review the Group and develop a Datix User Group and disband the Operational Group. Some elements of the Operational Group will be covered by the IQSG. The Terms of Reference for the User Group is under development and will be provided at the next IQSG meeting.

The Executive Management Board approved the proposal to disband the current Datix

Operational Group and develop a Datix User Group.

2.6 Quality & Safety Risk Report

This report was presented to provide the integrated quality and safety group with an overview of current quality and safety risks held within the corporate trust risk register. Two risks had been added, both scoring 9:

- **Datix 3281**- Quality and Safety Risk associated with the delay in development of digital Quality Metric reporting dashboard system.
- **Datix 3282**- Quality and Safety risk associated with the absence of required systems and processes to support the management and assurance of the quality and safety tracker which is impacting upon the ability to provide assurance.

Further consideration required of how Trust-wide Quality and Safety risks are reported into the meeting.

2.7 Quality Priorities

All Divisions discussed the quality priorities for 2024-25. The group acknowledged that further work was required and that agreed Divisional quality priorities to be presented at the January meeting.

2.8 Quality Framework Delivery Review

A gap analysis was undertaken on the Trust Quality Framework **(Appendix 2**). The group acknowledged the work that had progressed. However, some actions had been delayed, with a plan in place with amended timescales.

3 IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Provides Quality, Safety and Performance Committee details of discussions and decisions made at an integrated divisional level 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 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. There are risks associated with the current lack of assurance related to the quality and safety tracker.*
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	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Quality, Safety and Performance Committee

High level improvement Plan: Patient Administrative Processes

DATE OF MEETING	16th January 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rachel Hennessy, Interim Director
PRESENTED BY	Rachel Hennessy, interim Director
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	This briefing has been prepared to provide the Quality, Safety and Performance Committee with a summary of 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 Velindre Cancer Centre in the last 6 months. These were detailed in the Committee report provided in November 2023. A number of service improvement pieces of work aligned to the themes identified are already taking place. The Cancer Centre will continue to prioritise the improvement actions in respect of these incidents and concerns.
RECOMMENDATION / ACTIONS	To ***NOTE*** 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.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Cancer Service Senior Leadership Team	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Not Required incident overview report

APPENDICES	
Nil	

1. BACKGROUND

During the November 2023 Quality, Safety & Performance Committee a number of themes emerged from concerns, patient feedback and incidents (including Duty of Candour and Nationally Reportable Incidents) in relation to patient communication and administrative processes. These were:

- Patient referral processes
- SACT Booking
- General Booking Processes
- GP / patient letters post appointment.
- Response to patient telephone calls into Velindre Cancer Service

It was agreed that the high-level strategic improvement plan in respect of these matters would be provided to the Committee for assurance in January 2024.

2. High Level Improvement Plan

The improvement work in respect of these themes is being co-ordinated through the Cancer Service Improvement Office. Service Improvement Project Charters are being developed for each. .

The reporting structure is detailed below and regular highlight reports will be produced and reported:

The high-level plan is attached in ***Appendix 1***.

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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) Nil **Type of Funding:** **Revenue** Nil **Type of Change:** **Other (please explain)Other (please explain)** Please explain if 'other' source of funding selected: Not applicable.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Incident outcome report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text

3. 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.

Area	Outcome Measure	0-3 months	0- 6 months	6-12 moths
Telephone communications Objective To reduce the number of patient calls being directed to the incorrect department. Thus, ensuring a system is in place that supports patient communications.	• Reduction in the number of telephone communication reported incidents/queries per month. • An automated telephone system is in place to direct calls to the right dept. • Improved patient experience • Reduction in telephone messages left	Identify a process for data collection of calls and messages. Look to identify key themes regarding reason for contact, also time it takes to return a call. **Process Measures** • How many calls received by a secretary team per day. • How many messages left on an answer machine per day. • Time taken to return a call when a message has been left. • Reason for call **Balancing Measures** • How many calls are being received by other teams because they are unable to gain contact with original team requested. Link with the Quality and Safety team, gather data regarding number of incidents a month reported that link to telephone communications within the Cancer Centre. Identify common themes out of this information, e.g., department, reason for	Engage with the work being undertaken regarding the development of the new Telephone system - this will lead to a call system being in place for each department allowing patients to access the correct department via an automated system. Ensure opportunity for Welsh Language is considered Link with the Medical Records Manager regarding the management of appointment queries and which of the teams, Medical Secretaries or Medical Records should be responsible for these calls. Implementation of plan to address common themes	

		call and support the development of a plan to address this Link with the audit being undertaken regarding the use of answer machines with the Cancer Centre.		

Booking: Appointment Letters **Objective.** To reduce the number unnecessary appointment related correspondence between hospital and service users. Ensure appropriate correspondence between VUNHST and patients	• Reduction in multiple appt letters being sent to patients. • Patients having an increase in "live appt" i.e., booked on the day of attendance. • Reduction in postal costs. • Improve Patient experience. • Medical records staff have bespoke training and documentation to support WOW. • Digital method of communication in place to include appointment reminders	There has been an amendment letter in development with DHCW, which includes cancellation and re-booking information on the same letter. This is due to go into test environment in January 2024 for a period of 2 weeks, this will then be followed by a 2-week period to iron out any issues prior to it being deployed in the live environment in February 2024. **Process Measures.** • Number of letters sent per day. • Number of appointment amendments made. • Number of data quality issues. • Reason for data quality issues. • Number of patients able to book next appointment prior to leaving outpatients. **Balancing Measures.** • Increased waiting times on the day to process next clinic appointments prior to leaving the dept. • Increase in time spent prepping clinics and the OON's prior to clinic and the resource needed to do so.	Collaborative working between the Medical Records Manager and Digital Training and Apps Team to develop a bespoke training solution for Medical Secretary Staff. This would include; • Booking • Selection of the correct letter • Cancellations (choosing the correct option) – Batch printing. • Out coming – if to be seen in a different clinic Appointment of secretarial assistants to support release of secretaries to ensure clinic prep is completed Ensure appropriate information is completed by clinicians to enable medical records/reception to complete booking process in timely manner	Roll out of digital solutions to be in place to offer further support to management of booking for patients e.g. text message reminders

		Evaluation of the work undertaken in the Melanoma service regarding the preparation of the OON prior to clinic, whilst this has cut down the prep time for clinicians there needs to be evaluation to the benefit this has to the flow of clinic on the day. Considered whether this change enables service users to leave the outpatient setting with the details of their next appointment Review of quick reference guides and user guides to be undertaken.	Pilot Digital solutions to offer further support to management of booking for patients e.g. text message reminders	

Booking: Patient confusion regarding appointment type – Face to Face or Telephone **Objective;** To provide the correct appointment type to patients at time of booking. Ensure that patients do not attend VCC inappropriately due to inconsistency between appointment received by patient and type of appointment on system	• Reduction in the number of patient concerns/queries regarding appointment type. • Increase in the suitability of the appt for patients. • Reduction in unnecessary travel for patients	Review of clinic booking and amendment permissions Data collection regarding number of different appointment types per clinic code **Balancing Measures.** • Training needed to enable staff to use systems proficiently. • Space needed in outpatients to conduct face to face appointments. • Request for space to conduct virtual/telephone appointments. **Process Measures.** • Number of mixed clinics • Number of appointments (Face to Face, Virtual, Telephone) per week, per clinic code.	Explore the splitting of clinics within the same clinical session, having one clinic for face to face and one clinic for telephone/ virtual appointments - in consultation with Medical Records and Clinical colleagues. Identify opportunities for telephone/virtual consultations to be moved to VAP Identify opportunities for utilisation of CNS to support delivery of clinics improving flow. Staff training – ensuring the staff who are responsible for managing bookings are aware of the override option is used and correct letter is sent to patients regarding their appointment details Telephone hub in place in	Full review of complete of all SST clinics and revised clinic templates and delivery models in place where appropriate Funding agreed to support appointments to expand VAP

			Outpatient to facilitate change in clinic templates Pilot Digital solutions to offer further support to management of booking for patients e.g. text message reminders	

Referral process Objective To standardise the referral processes for all SST's	• Consistency of referral form • Use of electronic referral system • All new patients to be allocated a new patient appointment within 10 days of receipt of referral. • Baseline current measurements to prove improvements.	Identify all current routes of referral per consultant per SST. Aim to gain information needed for Breast SST and Colorectal SST and prepare for a pilot using the PDSA methodology for the interim solution. **Process Measures** • Number of referrals received via each current referral route. • Number of patients referred that are ready to be reviewed. • Number of referrals per consultant • Time spent processing new referrals. **Balancing Measures** Increase of time for referring LHB's to complete referral request	Gather key information needed in order to be ready to process a referral – per consultant/ per SST. Review New patient slot capacity and demand per SST. Establish a process that links to the longer term improvement of implementing Hospital to hospital. Assess and commence roll out across SSTs following implementation and review of interim solution in colorectal and Breast	DHCR to engage in electronic referral as part of phase2 linked to DHCR implementation Interim model fully rolled out across all SSTs.

Patient/GP letters: **Objective:** To ensure that correspondence post appointment is sent in a timely manner	• All clinical correspondence to be sent within 30 days of creation	Review of processes in place for clinical letters needing to be sent to patients Process measure: • No of letters in system needing to be authorized and sent • No. of letters where sending is delayed, by clinician Balancing measures • Increasing time for clinicians to complete approval process within WPAS	Understand processes currently in place and blockages in system Ensure process in place to monitor no. of letters in system waiting to be sent. Understand opportunities to utilise digital technology to support correspondence with patients	

Patient/GP letters: **Objective:** All hospital/GP correspondence to be sent to patients	• All clinical correspondence to be sent within 30 days of creation	Review of processes in place for clinical letters needing to be sent to patients Process measure: • Postage numbers and cost of letters to be sent • Increase in patient email and mobile phone number being captured on WPAS Balancing measures • Patient does not have access to email address • Patient not happy for correspondence via email or Text.	Understand current practice across SSTs Identify opportunities to pilot digital proposal within single SST Ensure processes in place to support capture of email address and mobile number and to allow information to be checked and updated at each point of contact with patients where appropriate	

Outpatient Clinic-Objective To be able to extract patient waiting time data from the data warehouse to gain an accurate reflection of outpatient waiting times.	• Waiting time per clinic is reduced. • The clinic times are consistent and appropriate.	Work with the BI team to extract patient waiting times from the data warehouse. Identify the number of appointments that are face to face or telephone/virtual. Review clinics start and finish time data. Outpatient dashboard to be developed and used to monitor demand and activity **Process Measures.** • Waiting time from time of arrival to time being called to the clinic room. • Waiting time per clinic code • Start time of clinic • End time of clinic • Clinic slot duration • Number of bookings • Number of clinics that have the required data recorded. **Balancing Measures.** • Clinic capacity • Number of times clinics finish late. Training needs to ensure staff are aware of the function to record information.	Review clinic booking rules. Review clinic templates	All SSTs clinic booking rules and templates reviewed and changes made to address needs of service

Outpatient Clinic: Phlebotomy Walk in's **Objective.** To reduce the number of patients attending Phlebotomy without a scheduled appointment time.	• Reduction in the number of patients classed as 'walk in' for the phlebotomy service. • Waiting times for Phlebotomy appts are reduced as numbers of walk in are reduced. • Better patient experience	Work with outpatient's manager to analyse the data captured looking for themes e.g., teams or departments regularly sending patients to phlebotomy without an appointment. OON's – identify reasons for variation in practice Share reminder regarding the process for requesting phlebotomy services. Identify change in practice/numbers from pre-covid activity and understand reason for this change **Balancing Measures.** • Increase in training requests for staff to be able to complete phlebotomy appt requests. **Process Measures.** • Number of phlebotomy 'Walk in' appointments per day. • Requesting department for the 'walk in' appointments. • Time it takes to facilitate the 'Walk in' appointments.	Work with the Outpatients manager to develop a SOP for unscheduled phlebotomy appointments. Discussions with commissioners/Health boards in relation to change in delivery model and implementation Determine Trust appetite for service to continue to be provided by VCS or return to pre-covid model of delivery (primary care)	Full develop case for agreed delivery model

		• Data quality issues in relation to phlebotomy. • Time spent in completing the admin process for 'Walk In' appts.		

Review and update of communication information on public facing internet pages **Objective** To reduce the amount of incorrect information on the Velindre Cancer Centre internet page.	• Intranet pages are easier to navigate. • Patients have access to information they require easily. • The contact numbers are consistent across all platforms, telephone, leaflets and intranet. • Reduction in the number of issues raised regarding contact information. • Improved patient experience	Ensure all contact numbers that are currently available on the VCC Internet page are correct and go through to a manned telephone. Work with Trust Communications team to identify what current development work they have planned in relation to the VCC internet site – opportunities to consolidate pages and therefore minimise pages not being updated **Process Measures.** Number of internet pages in need of review **Balancing Measures** • Time spent to review information. • Time spent to correct information. • Time needed to translate information into Welsh Language	Review quality of information available and identify person responsible to updates for each directorate.	Ongoing monitoring and updating of intranet

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
Trust Infection Prevention Management Group Highlight Report	
DATE OF MEETING	16th January 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	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The key highlights in the paper are: ***Healthcare Acquired Klebsiella bacteraemia*** – There were five cases reported during the first two quarters of 2023/24 (100% increase compared to the same period in 2022/2023). All cases have been genotyped differently to each other which supports the conclusion that there has been no transmission of infection. A route cause analysis investigation was undertaken for each which identified no practice issues. ***Laboratory Coats*** – Laboratory coats needing laundering at WBS Talbot Green was a feature in a previous 15-step visit. This was again identified in a recent Infection Prevention and Control (IPC) audit. Since the audit, Welsh Blood Service (WBS)

	has provided assurance that action has been taken to ensure this does not occur again in the future. A further assurance audit will be repeated. **Bare Below the Elbow** - There is a continued issue of non-compliance with adherence to the uniform policy, specifically Bare Below the Elbow, and occasionally unacceptable behavioural responses when staff are being challenged for being non-compliant with national standards. Divisions have been asked to discuss this with department managers so they can exercise their responsibilities to ensure all staff comply with uniform and dress code standards with particular focus on being bare below the elbows. **New Velindre Cancer Centre** - There remain unresolved design matters relation to IPC (detailed in main body of report).

RECOMMENDATION / ACTIONS	To **DISCUSS** 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. To **APPROVE** the revised Infection Prevention & Control Management group Terms of Reference.

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)	6th December 2023
Executive Management Board	2nd January 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • Agreed items for inclusion in the report agreed.	

• Executive Management Board - Agreed urgent robust communications in respect of bare below elbow unform standards and the role of managers in ensuring standards across areas of responsibility are adhered to.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
1.	Infection Prevention and Control Management Group – Terms of Reference and Operating Arrangements

1. SITUATION

The Trust Infection Prevention and Control Management Group (IPCMG) is chaired by the Executive Director Nursing, AHP & Healthcare Scientists and has a core membership of corporate and divisional managers / leads who are responsible for ensuring infection prevention and control / decontamination training requirements, standards, and practices within their divisions / services. Programmes for audit, training, surveillance, and policy provision are managed as key strategies for infection prevention and control. There is also an opportunity to share Good News Stories and share lessons.

2. BACKGROUND

The IPCMG meets quarterly. Divisional IPC meetings occur monthly and feed into this meeting, progress against the IPC standards is discussed, and priorities determined. Reporting to the Executive Management Board is a quarterly based on the content of the meeting held during the period.

3. ASSESSMENT

The following is a summary of the key outcomes from the IPCMG held on the 6th December 2023:

ALERT / ESCALATE	• ***Compliance with Uniform Standards –*** There is a continued issue of non-compliance with adherence to the uniform policy, specifically Bare Below the Elbow (BBE), and occasionally unacceptable behavioural responses when staff are being challenged for being non-compliant with standards. It is the responsibility of department managers to ensure all staff comply with uniform and dress code standards. The group agreed that there should be a zero-tolerance approach to non-compliance of uniform standards and noncompliance is in breach of policy and will be escalated. The revised national dress code has been delayed. However, the previous policy remains extant and the requirements for all staff in clinical areas and wearing uniform to be bare below the elbows is clear and managers are responsible for ensuring the dress code is followed. Noncompliance is in breach of Trust policy. Future communications with staff members involved also need to be more aware and ensure that as a Trust we maintain a professional image. • ***Laboratory Coats*** – Laboratory coats needing laundering at WBS Talbot Green was a feature in a previous 15-step challenge and again recently in an IPC audit. The guidance recommends laboratory coats be changed for a clean at least once per week or immediately if they become contaminated / solied. During the audit several laboratory coats were observed as visibly stained and soiled around the cuff/pocket areas. Since the audit, Welsh Blood Service (WBS) has assured that the issue has been rectified and that a Standard Operating Procedure is in draft. A repeat audit will be conducted.
ADVISE / ASSURE	• ***Klebsiella bacteraemia*** – There were five cases reported during the first two quarters of 2023/24, (a 100% increase compared to the same period in 2022/2023). This is also reflected in a 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 Cancer Service.

Learning identified from the lookback was to include Visual Infusion Phlebitis (VIP) scoring as part of the Root Cause Analysis investigation forms.

- ***Aseptic Unit, VCC Pharmacy* update** – following the incident of fungal environmental deviations in the aseptic unit at Velindre Cancer Centre Pharmacy department in July 2023 an update for assurance was submitted to the Group, which included confirmation that:
  - *Microbiological Reporting System (MRS) has been implemented to record, report and trend environmental deviations, which allow staff to have results early and act sooner if there is a change in the trend*
  - Pharmacy has begun to look at the implementation of ironised hydrogen peroxide (iHP) as a regular agent as part of the cleaning and decontamination schedule. The iHP is being validated in collaboration with NWSSP/IP5 and work is progressing to begin validation at Velindre Cancer Centre in January. A project team has been set up with staff from VCC and IP5 to manage the validation and possible implementation.
  - A new Standard Operating Procedure for supervisor roles and responsibilities has been drafted and is currently under review.

- ***IPCMG Terms of Reference*** - The group **ENDORSED** the Revised Terms of Reference (attached in Appendix 1). Executive Management Board subsequently **ENDORSED** the Terms of Reference and the Quality, safety & Performance Committee are asked to **APPROVE** them.

- ***IPC Policies*** -. The Group **ENDORSED** the following revised policies:
  - IPC 00 Infection Prevention and Control Framework – The Accountabilities and Responsibilities
  - IPC 11 Transport of Specimens Policy

  The Equality Impact and Quality Impact assessments were incomplete, these will be completed in early January and both policies will be submitted for endorsement at the next Executive Management Board meeting and onward approval at Quality, Safety & Performance Committee.

  All other IPC Policies are in date.

- ***Anti-microbial Stewardship*** – There was a drop in compliance with 2 of the 4 Start Smart Then Focus (SSTF) measures in October 2023. Additionally, there was no data collected in September 2023 – see Table 1 below. This period corresponds to when there was no antimicrobial pharmacist within VCC, however, this post has now been filled as of the start of November 2023. Going forward, it will be the responsibility of the

antimicrobial pharmacist to ensure that these measures are consistently collected on a monthly basis.

Table 1 - SSTF data from April 2023 onwards (audit target 100%).

SSTF audit compliance:	Target	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023
Documented indication for treatment	100%	100	80	100	100	91	No data	59
Compliant with guidelines / C&S or microbiology advice	100%	100	100	100	100	91	No data	68
Documented review / stop date	100%	100	100	100	100	91	No data	100
Documented senior review at 72hours (if applicable)	100%	100	100	100	100	60	No data	100
Number of prescriptions	≥10	10	10	11	9	11	No data	22

NOTE: the measures that relates to 'indication documented' can only be given a 'compliant status' if the indication is written on the medication chart (this is in line with the national protocol). For those months that do not have a 100% compliance percentage for 'indication documented', the indication for the antimicrobial has been documented in the patient medical notes, which is then used to assess whether the choice of agent is in accordance with guidelines / C+S or antimicrobial advise.

Significant action has been taken in relation to the areas of low compliance, the action plan is to feedback on these rates to the ward clinicians and to work with the ward clinical teams to try to identify barriers that prevent these measures from being completed when antimicrobial agents are prescribed. The outcome of this will be fed back at subsequent IPCMG meetings. The antimicrobial ward rounds are frequently cancelled and this will be discussed with Public Health Wales. Antimicrobial stewardship has been added back onto the Junior Doctors Induction Programme.

- ***Design Plans for the new Velindre Cancer Centre (nVCC)*** **–** Gail Lusardi Consultant nurse for Public Health Wales – Healthcare Associated Infection programme who is supporting the IPC element of the new Velindre Cancer Centre presented an update on IPC issues including cleaning issues, finishes, decontamination, PPE and key risks regarding water and ventilation. The main challenges and issues for resolution are:
    - Negative pressure isolation room agreement
    - Testing of surfaces – can the low emission finishes be cleaned and disinfected to NHS to standard with products in use, testing of product to be undertaken.
    - Confirmation of placement of clinical hand wash basin in two key areas so accessible to staff
    - Strategy for windows and patient privacy screens take to stage 4
    - Outlay of some key rooms yet to be done – autoclave room, inpatient decontamination room, two laundries
    - Waste chutes and sterile services disposal / Linen collection storage not yet confirmed
    - Theatre prep room door not yet on plan, humidity in here decontamination and autoclave

- Alcohol hand rub and mask placement plan
- Checking water source in changing rooms
- Ventilation and water plan, need an operational plan for natural ventilation risk
- Uncertainty over roof and playground

Further meetings have been planned to discuss the resolution of these matters.

- ***IPC Environmental Audits*** – During the reporting timeframe several areas have been audited across both divisions of the Trust:

Department	Overall Score
WBS Collection Team East B	100% for Hand Hygiene
WBS Apheresis	93%
WBS Laboratories	78%
WBS Trailer 1 & Support Vehicle	66%
LA 2	91%
LA 3	93%
LA 4	94%
Neville Hall Windsor Suite	94%
Rhosyn Day Unit	74%
First Floor Ward	89%
Outpatients	95%

Discussion took place in relation to the timescales when areas of low compliance were identified on an audit. It was identified that, any actions should be reported within 24 hours and the resolution identified within two weeks. The group acknowledged that areas are under pressure however, a resolution should be actioned as an urgent request given the IPC risks with low compliance.

Main areas of non-compliance are connected to flooring and paintwork which is part of the ongoing programme of work by estates. Other issues include dust visible on wheels, bases of equipment and damaged access panels near hand wash sinks. All audited departments are provided with an action plan and a two-week timescale for completion, the same is shared with operational services and estates teams. Any areas not achieving compliance are re-audited following this time. The Estates department has identified a contractor to commence work on the longstanding estates issues.

INFORM	• ***Window cleaning at VCC*** – A window cleaning company has been identified for the cancer centre and the Trust Water Safety Group is working with operational services and the contractor to progress to the procurement of services. • ***Decontamination*** - NWSSP Specialist Engineer highlighted that Welsh Heath Technical Memorandum 01/06 Part F Decontamination of Ultrasound Probes has been published. The group was provided with assurance that we are fully compliant as a Trust in respect of that. • ***VCC Clinical Area Flooring*** – There has been significant progress and improvements to the flooring in several departments and main thoroughfares in the cancer centre which has reduced the health and safely and infection prevention and control risk.

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 ☒

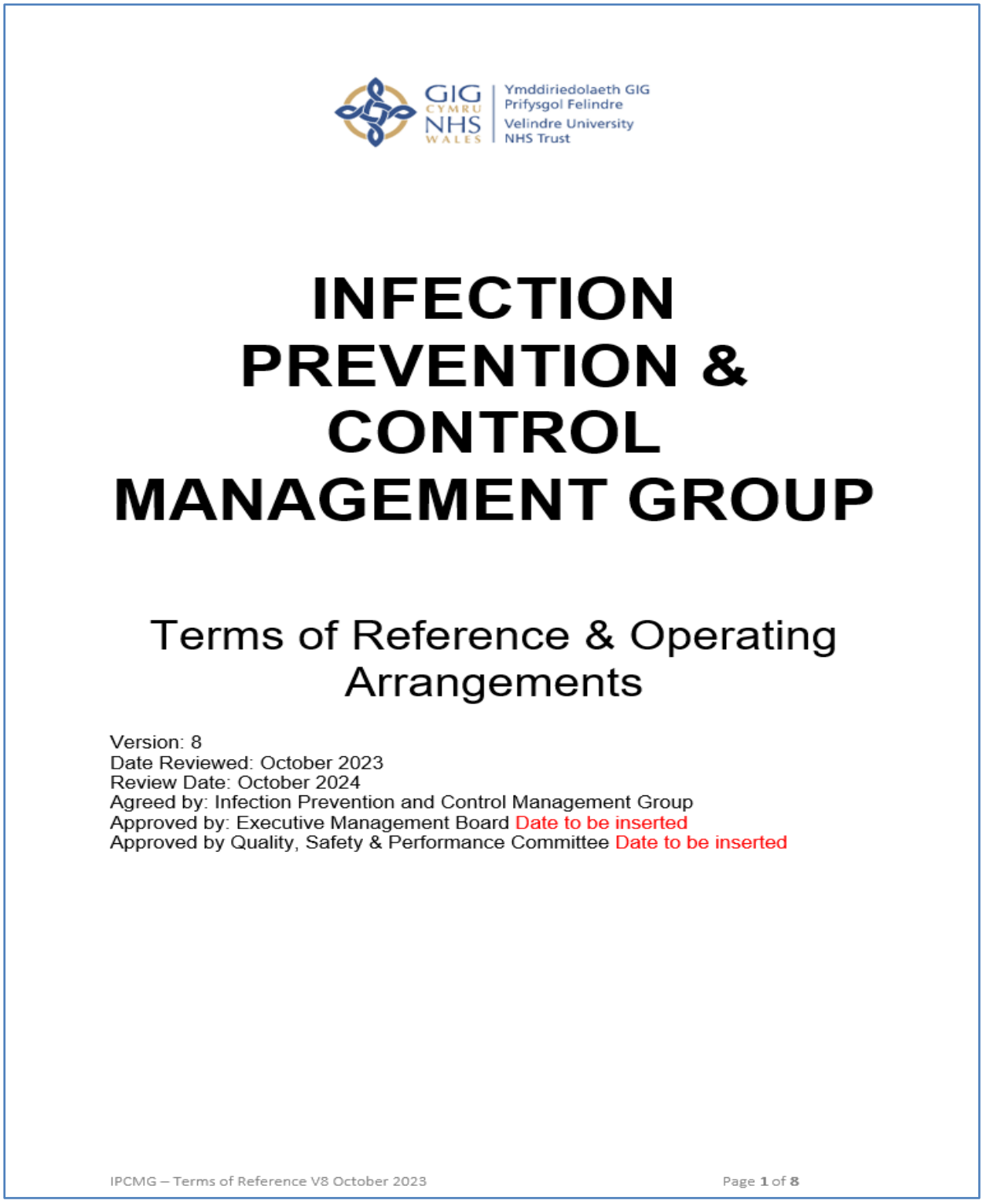
	Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). 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	Not required - please outline why this is not required

For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	*This is a highlight report following the Trust Infection Prevention and Control Management Group meeting.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Three risks identified during Infection Prevention and Control Management Group* *1. There is a risk to workforce/service delivery due to a measles outbreak in the Cardiff area (3275)* *2. There is a risk to workforce/service delivery due to low uptake of the seasonal flu vaccine (3274).* *3. There is a risk to patient and staff safety as a result of response to the management of High Consequence Infectious Diseases (HCID) (3276).*
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
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1:



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 Date to be inserted
Approved by Quality, Safety & Performance Committee Date to be inserted

IPCMG – Terms of Reference V8 October 2023 Page 1 of 8

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.

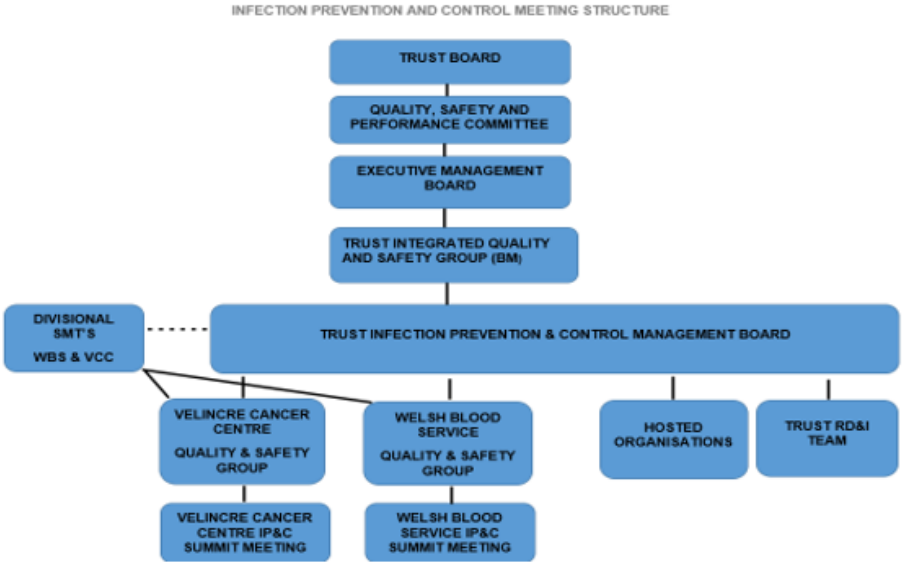
6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

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:



8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed in 12 months.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Nurse Staffing Levels (Wales) Act Update

DATE OF MEETING	16th January 2023
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	Rhian Wright – Nurse Staffing Programme Lead
PRESENTED BY	Anna Harries, Head of Nursing, Professional Standards & Digital
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	This 6-month report is to provide assurance to the Quality, Safety and Performance Committee in relation to how the Trust is meeting its responsibilities the Nurse Staffing Levels (Wales) Act. Key highlights are: • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • There have been occasions when the required roster on First Floor Ward (25b Ward) has not been met due to sickness absence and the need to provide cover in other areas where there are deficits such as SACT. Every effort has been made to fill any gaps in the roster utilising reasonable steps. The ward is rarely at full bed occupancy, therefore no impact on

	care delivery, however this has impacted on staff moral. • The nursing establishment on First Floor Ward is sufficiently funded and appropriate to provide the required roster identified through triangulated establishment reviews that include professional judgement. • There has been no change to the nurse staffing required establishment on First Floor in the last 12 months. • ***There has been no reported impact on patient care on First Floor Ward due to nurse staffing levels.*** • The establishment reviews conducted in October 2023 identified three 25A areas where it was deemed that the establishment was insufficient to provide sensitive care to patients. These were: SACT, Assessment Unit and Clinical Nurse Specialist Team. A request has been made for Velindre Cancer Service to include the required establishment in the IMTP.
RECOMMENDATION / ACTIONS	To **APPROVE** the paper and the 25A areas at Velindre Cancer Service that requires establishment enhancement.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	
Professional Nurse Forum	10.11.2023
Executive Management Board	04.12.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***ENDORCED***	

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

APPENDICES	
Appendix 1	Annual Presentation of Nurse Staffing Levels to the Board

1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Section 25A of the Act 'the overarching responsibility to have regard to providing sufficient nurses in all settings.'

Section 25B of the Act - requires organisations 'to calculate and take reasonable steps to maintain the nurse staffing level in all acute adult medical and surgical wards' and 'to inform patients of the nurse staffing level'.

Since the 1st of April 2021 the Executive Management Board/Trust Board agreed that the inpatient Ward at Velindre Cancer Service fell within the wider definition of a medical ward. The First Floor Ward is therefore subject to the full reporting requirements of the Act 2016. All remaining areas that deploy nurses across the Trust are subject to 25A.

Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

2. ASSESSMENT

2.1 Nurse Staffing Levels (Wales) Act 2016 Reporting

National reporting is yearly and 3 yearly, however an interim 6-month report is also required following acuity and establishment reviews. Mandatory reporting is required for first floor ward as a 25B ward with a summary of themes from non 25B areas. The Nurse Staffing Levels report using the required national template is attached in ***Appendix 1***. This report tells us that while the establishment for first floor is sufficient to provide sensitive care to patients, the level of support the ward is being required to provide to SACT services is a risk to this. The support to date has also not impacted on patient care as the numbers of occupied beds have been below capacity. There is no action to change establishment as deemed as sufficient.

2.2 National Acuity Review – First Floor only

Acuity data is entered daily as a standard, however in January and June each year this data is reported and presented through visualiser format. The June 2023 visualiser was fully populated, and through the discussion that took place at the establishment review, the recorded acuity level appeared accurate. Visualiser available via Nicola Williams if required. The acuity data reveals that patients are predominantly scoring a level 3 (complex care). Level 4 (urgent care) scores have significantly reduced which appears to be mainly attributable to the rollout of refresher training for staff on the Welsh Levels of Care Tool. Level 5 (on to one care) patients have also reduced from 6.5% to 0.5%.

2.3 Establishment Reviews

Following each acuity and nurse staffing audit the Executive Director of Nursing, AHP & Healthcare Science and the Divisional Head of Nursing undertake formal

establishment reviews across all patient / donor areas who deploy nurses across both divisions. The reviews for Spring and Autumn 2023 have both been completed. Each establishment review details:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Quality Indicators (25B ward)
- Service plans or Clinic Templates as applicable (not all areas)

In summary of the areas reviewed with nursing workforce, evident knowledge of areas data and information available. No incidents or complaints effecting care linked to staffing were reported. PADR compliance good and in some areas 100% with plans for those that are below. Training was good with reference to specific training focus and working at top of license. Discussions also held around consideration of Band 4 Practitioners based on NHS Wales agreed standards. It was, however, noted that staff moral has been impacted with the ongoing support ward staff are providing to maintain SACT services.

There were areas where the reviews identified that the establishments within Velindre Cancer Service were deemed not currently sufficient to provide sensitive care to patients/donors and urgent work was required to enhance/review establishments. These were:

- ***Clinical Nurse Specialist (CNS) Team*** – The triangulated establishment review identified that overall, the CNS Team is under established in line with what the team are required to deliver including ability to fulfil the key worker role. There is currently no headroom built into establishment resulting in considerable CNS service gaps when there is annual or unplanned leave. Nationally agreed nursing headroom level is 26.9% - covers annual leave, study leave, sick leave and other (maternity, compassionate etc). Although the recent CNS review has identified a number of efficiencies the workforce

is insufficient. After the headroom is factored into the establishment a further establishment review would be conducted.

- ***Assessment Unit*** - The triangulated establishment review identified that the afternoon staffing of the Unit did not meet the patient demand and that an additional Advanced Nurse Practitioner on the afternoon shift would be advantageous. The is also a requirement to add in headroom. There are efficiency opportunities through amalgamating responsibilities and coalescing services such as the Assessment unit, Ambulatory care, Immunotherapy services etc.

- ***Systemic Anti-cancer Therapy (SACT)*** - There was overall professional concern in relation to the SACT Nursing establishment. The establishment does not have the required support infrastructure to allow the registered nurse to do what only they can do. The support resources identified through the previous SACT workforce review have not all been enacted i.e. ensuring two band 3 healthcare support workers per unit per shift and unit reception cover. There are challenges with recruiting into vacancies, high levels of maternity leave and protracted timescales for new staff being signed off as competent to deliver all SACT as the trainers have been filling SACT delivery gaps. In addition, SACT trained nurses across the cancer centre are being moved regularly to provide SACT which is impacting on morale and staffing levels across the wider cancer service.

  Since the end of October 2023, the SACT trainers have been protected to prioritise SACT Competency sign off for those nurses who had not been signed off.

3.5 Implementation of SafeCare Module

The SafeCare module of RLDatix has assisted in facilitating automated Act reporting through Velindre University NHS Trust and to NHS Wales in line with National Nurse Staffing Act reporting requirements. Velindre University NHS Trust has completed its integration into a first floor and is now recording acuity and staffing levels data twice a day in line with the All-Wales Standards of Practice for SafeCare. This replaces use of Healthcare monitoring system and continue to allow organisations to report acuity in a similar way to the old system.

The implementation of SafeCare has provided a platform to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre, however, there is still work to be done in securing and developing an All-Wales data infrastructure to enable the smooth and efficient retrieval and reporting of meaningful visual data.

3. IMPACT ASSESSMENT

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

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required as report is for noting purposes.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*SACT Vacancy factor impacting on First Floor ward. Staff moral impacted but not patients as bed occupancy lower than capacity*
WHAT IS THE CURRENT RISK SCORE	9

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*Plans in place to reduce vacancy with international recruitment and student streamlining*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	March/April 2024 for recruitment (International and Students)
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Retention of staff is vital. *Attrition rates for international recruitment*
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1

Annual Presentation of Nurse Staffing Levels to the Board						
Health Board/Trust	Velindre University NHS Trust					
Date of annual presentation of Nurse Staffing Levels to Board	4th December 2023					
Period Covered	**01 October 2022 to 30 September 2023**					
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical inpatient wards** • **Paediatric inpatient wards**	Section 25B of the Nurse Staffing Levels (Wales) Act applies to one ward (First Floor) in Velindre Cancer Centre. There has been no primary change to the ward structure during the last year. Bed capacity has remained at full capacity of 32 beds during the last 12-month period. The bi-annual audit cycle took place as planned in both January and June 2023. The calculated Whole Time Equivalent (WTE) Registered Nurse for first floor is 29.69 (inclusive of the ward manager. Previously the ward co-ordinator was included in the figures hence the slight variation in the figures from October 22 and May 2023. WTE for Health Care Support Worker (HCSW) is 14.21, both figures are inclusive of the 26.9% headroom based on 32 bed occupancy.					
	Adult acute medical inpatient wards		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (October 2022)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	30.95	14.21	NA	NA	NA	NA
TE of required establishment funded (October 2022)	30.95	14.21				
Staffing requirements following Spring Cycle (May 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (May 2023)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	30.95	14.21	NA	NA	NA	NA
WTE of required establishment funded (May 2023)	30.95	14.21	NA	NA	NA	NA
Staffing requirements at end of reporting period (September 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	

Required establishment (WTE) calculated (September 2023)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	28.42	14.21	NA	NA	NA	NA
WTE of required establishment funded (September 2023)	28.42	14.21	NA	NA	NA	NA
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	1		NA		NA	
Required establishment (WTE) calculated and WTE of required establishment funded	Yes – fully funded					
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews have taken place bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Patient acuity is scored twice a day using the Welsh Levels of Care Toolkit. The ward manager and band 6 nurses measure patient acuity in a consistent manner using the Welsh Levels of Care lay descriptors and then clinical descriptors if required. The acuity data reveals that patients are predominantly scoring a level 3. Level 4 scores have significantly reduced from 46.7% to 19.2% which appears to be mainly attributable to the rollout of refresher training for staff on the Welsh Levels of Care Tool. Level 5 patients have also reduced from 6.5% to 0.5%.					

WLOC Level	2022-2023	Last 6 months	Trend
Level 5	6.5%	0.5%	↓
Level 4	46.7%	19.2	↓
Level 3	43.8%	57.1	↑
Level 2	3.1%	21.8	↑
Level 1	0.02%	1.5	↑

Level 5 **One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day

Level 4 **Urgent Care** - The patient is in a highly unstable, unpredictable condition either related to their primary problem or an exacerbation of other related factors.

Level 3 **Complex Care** - The patient may have a number of identified problems, some of which interact, making it difficult to predict the outcome of individual treatment

Level 2 **Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.

Level 1 **Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

There have been instances where the planned roster has not been met, however, professional judgement has been utilised and it was deemed safe due to the reduced number of beds, skill mix and patient acuity levels. Occasionally the planned roster has not been met due to staff sickness and unavailability of bank staff to fill the shift at short notice, all reasonable steps are considered to help deliver sensitive care on these occasions for instance, on rare occasions the ward manager has been required to work in the numbers due to sickness absence or increased acuity.

SafeCare has assisted in avoiding the over or under use of staff and helps in assuring that there is an appropriate and safe nursing skill mix. SafeCare has brought together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients at Velindre Cancer Centre. It aims help to ensure consistency in recording and reporting data across organisations and support the Once for Wales Approach, however, there are issues with data retrieval and reporting. SafeCare has enabled us to collate, review and report numerical data to demonstrate the extent to which the planned roster has been maintained but this is not a simple task and until a national approach for data retrieval is developed it remains an extremely labour-intensive task.

Finance and workforce implications

The establishment review identified that the first-floor ward establishment included the required 26.9% headroom to account for sickness, study leave and annual leave. It was deemed that the nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor.

There is a professional concern that staff from first floor are having to provide significant support for the SACT service. Having to release staff to cover SACT is impacting on the wards ability to provide effective care to patients and is also affecting staff morale.

	After undertaking a review of the current funded nursing establishment against the required establishment for First Floor ward, the directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to patients. First floor is carrying 6.58 registered nurse vacancies, however, there is a robust plan in place to recruit into these vacancies. Velindre University NHS Trust has joined student streamlining for the first time and is in the process of recruiting 6 newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. VCC have successfully recruited 15 registered nurses from Kerala, India, and are, for the first time employing new registrants through the student streamlining process.
Conclusion & Recommendations	
	Conclusion • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • First floor is open to full capacity of 32 beds, average bed numbers were 19 for the last three months. Five beds have been allocated to SACT. • There have been occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster utilising reasonable steps. • Currently there are 6.59 registered nurse vacancies on first floor which are due to be filled via student streamlining and international nurse recruitment. • The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor. • There has been no change in the nurse staffing establishment in the last 12 months. **Recommendations** • Continue plans with student streamlining and international recruitment to improve whole Trust vacancy figures. • Consideration of Band 4 Assistant practitioners to again improve vacancy and top of licence working. • Reduce impact of SACT services on the First floor Ward.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VUNHST MEDICAL DEVICES REPORT, JANUARY 2024

DATE OF MEETING	16/01/2024
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	Tim Register, Head of Engineering, Radiotherapy Physics, VCC Jignesh Raiyani, Medical Devices Officer, VCC Martin John, Regulatory Affairs Manager, WBS
PRESENTED BY	Peter Richardson, Head of Quality, Safety and Regulatory Compliance, WBS
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	This paper has been prepared to provide the Quality, Safety & Performance Committee with an update on medical devices and compliance with the medical devices regulations across operation Velindre University NHS Trust (VUNHST).
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **NOTE** the information in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Welsh Blood Service Senior Leadership Team	10/01/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Senior Leadership team at the Welsh Blood Service have considered the report and noted the overdue actions.	

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

APPENDICES	

ACRONYMS	
VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
C&V	Cardiff and Vale
POCT	Point of Care Testing
MDG	Medical Devices Group (VUNHST)
MHRA	Medicines and Healthcare Product Regulatory Agency
MDR	Medical Device Regulations

MDD	Medical Devices Directive
AIMDD	Active Implantable Medical Devices
IVDD	In Vitro Diagnostic Medical Devices
The Sharps Regulations	The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
SLA	Service Level Agreement
RFID	Radio-Frequency Identification
QA	Quality Assurance
CE	EU conformity mark
UKCA	UK conformity Assessment mark
FOI	Freedom of Information

1. SITUATION

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

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

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

2. SITUATION/BACKGROUND

'Medical device' means any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for a range of specific medical purposes including diagnosis, investigation or treatment. An 'accessory for a medical device' is also defined and accessories are regulated as if they are a medical device.

It is of note that 'software' can be a medical device if it is intended to have one of the specific medical purposes, therefore mobile apps and spreadsheets can be considered a medical device, as well as complex software such as treatment planning systems.

Medical Devices are regulated under The Medical Devices Regulations (MDR) 2002 (SI 2002 No 618, as amended) (UK MDR 2002. These regulations are intended to improve the safety and performance of medical devices and intends to provide a high level of protection for the health of patients and users of these medical devices are based on 3 EU directives.

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, known as 'The Sharps Regulations', build on existing health and safety law and provide specific detail on requirements that must be taken by healthcare employers and their contractors.

The Trust is either subjected to or can be inspected by regulatory authorities including Healthcare Inspectorate Wales (HIW), Medicines and Healthcare Product Regulatory Agency (MHRA), the Health and Safety Executive (HSE) and Wales Audit Office (WAO).

The VUNHST has responsibility for implementing the requirements of the regulations governing work involving MDR and The Sharps Regulations throughout all Services managed by the Trust. The Chief Operating Officer has been delegated responsibility at Trust Board level for the management of medical devices and equipment. Roles and responsibilities are defined in the Trust Medical Devices and Equipment Management Policy (QS24).

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Regulation changes

The EU introduced updated medical devices regulations in 2017, but the regulations did not come fully into force until 2021. The UK decision to leave the EU means that the latest EU regulations have not been enacted into UK law. The Medicines and Healthcare Products Regulatory Agency, recognising the need for updated legislation has recently consulted on the matter and updated regulations are expected to come in to force in July 2024.

It is expected that new, draft legislation (MDR), will be laid before the UK parliament in the near future and VUNHST must remain alert to the potential impacts of this. Whilst the legislation and advice from MHRA has yet to be published, it is anticipated that there will be a high level of alignment with existing (new) EU legislation, and this

may impact across the Trust, For VCC, in particular around inhouse manufacturing of medical devices and the development of software as a medical device and for WBS in the use of certain reagents and software.

Both WBS and VCC have undertaken a review of the potential impact if the UK adopted the same standard as EU regulations. This is still in draft, but areas of additional cost are being identified. For WBS in particular, the use of certain reagents will be impacted. This has been part of an ongoing discussion with WHSSC who have committed to funding these costs.

VUNHST is also actively engaged with Welsh Government through the Deputy Chief Medical Officer and the Chief Scientific Adviser, on the current state of preparation for the new UK MDR in every Trust and Health board within Wales.
The VUNHST preparedness is a standing item on the VUNHST Medical Devices Group and is also informed through active engagement with the Wales 'Medical Device Regulations Group' which provides an information sharing forum for NHS Wales in respect of current and future Medical Device Regulations as they apply to preparedness of NHS Health Boards and Trusts in response to those regulations and reports key items to the Welsh Scientific Advisory Committee (WSAC) and Welsh Therapies Advisory Committee (WTAC) on a quarterly basis.

The wider impact of these regulations are being assessed and incorporated into work plans and the procurement of new devices. The digital system impact is also being considered.

The VCC Radiotherapy Physics Engineering Section will continue to work to establish a QMS (ISO 13485) for in-house manufacturing of medical devices within Radiotherapy Physics.

The VUNHST Medical Device Group

The Trust has a Medical Devices Group (MDG), the purpose of which is to ensure that risks of all types associated with the lifecycle of medical devices (including acquisition, in-house manufacture or development, decontamination, use, maintenance and disposal) are controlled and minimised. It includes responsibility for formulating appropriate policies for the identification and management of any issues with medical devices in use or being maintained. This includes responding to any relevant MHRA or manufacturer alerts and keeping the Chief Operating Officer informed of specific issues that require their attention.

The group meets quarterly. It ensures that all MHRA and Manufacturer Medical Device Safety Alerts/Notices have been addressed. The group receives periodic reports from the Medical Gases Committee and Electrical Safety User Group for note of any medical device specific issues or actions to ensure areas of mutual interest are covered. Any urgent operational issues are dealt with in real time.

The governance route for assurance and escalation is via highlight reports to EMB and via discussions with the Chief Operating Officer. Currents issues are contained in a master actions log (e.g. Hoist management, Medical Devices Database) with target dates and progress information, these are discussed at each MDG meeting, the only current outstanding issue is with regard to the management of hoists within VCC, this has been resolved between VCC Estates and C&V's Manual Handling Advisor (H&S department), the task just requires signing off by the MDG (agreement by all parties) at the next meeting.

VCC update

There is a full cycle of maintenance for Medical Devices. Maintenance of the majority of VCC's portable powered medical equipment (including wall mounted oxygen flow meters and suction) are maintained by C&V Clinical engineering. The governance arrangement for the SLA with C&V Point of care testing services for POCT service is in place.

There are various maintenance and service contracts with manufacturers, suppliers or external service providers are in place to support and maintain various medical devices and equipment. We currently have more than 100 different types of devices which equates to in excess of 1200 individual portable medical devices within VCC (see Appendix A for details), of these, 672 devices are supported and maintained within an SLA with C&V, over 368 devices are maintained by VUNHST and 224 devices are maintained by manufacture or contractually with another 3rd party supplier. A rolling program of like for like device replacement has been instigated.

Various medical devices are used within the VCC and Outreach Clinics to support day to day activities. An inventory of equipment (medical devices) is available, however, to improve the management of this inventory, VCC has procured and populated a dedicated commercial software database, the work to complete and activate this database in awaiting final testing and is imminent. Once complete VCC will have an active comprehensive database for managing medical devices. An audit of current medical devices in use is now required and initial audit from one department has been

completed, however further auditing is to be carried out in conjunction with the nVCC project team, this information will feed into the nVCC equipment procurement project.

To comply with forthcoming new MDR, the VCC Radiotherapy Physics Engineering Section is working to establish a QMS (ISO 13485) for in-house manufacturing of medical devices within Radiotherapy Physics. The completion of the QMS is currently awaiting an update to the trust wide Q-Pulse (Ideagen) document control system. Please note that the development of the new QMS (ISO 13485) has been challenging due to the amount of documentation required, however this resource intensive task is on track for the anticipated MDR July 2024 implementation date. The implementation date for the MDR has now been revised to end of June 2025. MHRA have advised that the road map from UK government ministers will be out from early 2024, the regulations are due to be laid before parliament possibly before winter 2024 but this will depend upon national general election timing, however there will be a transition period before the regulation will be enforced, following their introduction in June 2025.

In the last six months, there have been 521 Medical Device Alerts, Medical Device Safety Bulletin, Field Change Order, and Field Safety Notices. Five of these were applicable to VCC and have all been actioned.

The equipment workstream of the nVCC project includes the procurement and commissioning of the medical devices for the new hospital. Work is underway to scope the detail of the work plan and the associated requirements for meeting the regulatory requirements. This will also be an opportunity to develop new approaches. The consensus of experts in this field recommends that the future direction of travel should be to procure and commission an asset tracking system for medical devices (e.g. RFID tracking), particularly for the new hospital. This will enable hospital wide visibility of all portable powered medical devices and can be useful when locating critical equipment. It will help to increase clinical and medical staff productivity by eliminating time spent searching for devices, hence providing prompt patient care. It will also help to maximise device utilisation. Overall, it will be an effective part of Medical Device management system.

We have received five FOIs (Freedom of Information) request in 2023. All have been delt with in the specified timeline.

The implementation of the IRS program is also part of the wider work plan.

WBS Update

In preparation for the new UK MDR the WBS conducted a series of classification meetings to identify in-house developed medical devices, medical device software and reagents that would be classified as medical devices under the new regulations, should those regulations align with the EU MDR/IVDR in terms of classification. From these meetings it was identified that several in-house developed software packages and some reagent kits would fall under the definitions of medical device software and in-vitro medical devices respectively.

Strategic decisions need to be made as to whether in-house development of software and reagent kits is to continue within the WBS or whether these are to be purchased from the marketplace. Should the new UK MDR Health Institution Exemption (HIE) align with the EU MDR HIE, there may be a very similar requirement around justification i.e., “the health institution justifies in its documentation that the target patient group's specific needs cannot be met, or cannot be met at the appropriate level of performance by an equivalent device available on the market” [Article 5.5(c) EU MDR]; cost is not considered a suitable justification. From the classification meetings it has been identified that it is unlikely that certain reagent kits can be purchased, and potentially the development of bespoke medical device software may need to continue.

The MHRA have advised that using a reagent concentration different to that intended and validated by the manufacturer would be regarded as “Off-label” use. If the IVD is used in any other way to that described in the manufacturer’s instructions, without the manufacturer’s approval, then liability will rest with the organisation and not the manufacturer.

As stated in the "Government response to consultation on the future regulation of medical devices in the United Kingdom 26 June 2022" it is expected that that health institutions will be required to meet many of regulatory requirements that apply to commercial manufacturers but will be exempted from

- UKCA marking,
- The requirement for Approved Bodies to be involved in the conformity assessment process.
- From having a certified QMS, though a QMS will still be required.

The WBS Quality Management System (QMS) is unique to the WBS and is based on the Council of Europe Good Practice Guidelines for Blood Establishments. If the

decision is made to continue with in-house developments, then the WBS plans to amend its QMS to meet the intent of the product realisation requirements of ISO 13485. This will ensure that an 'appropriate QMS' is in place.

The QMS amendment is expected to take the form a product development process (PDP) which will ensure good engineering practice is employed for any WBS in-house development of medical device software and/or reagent kits. The PDP will aim to ensure that any 'in house' manufacture or modified devices meet the relevant essential requirements of the UK medical devices regulations.

Implementation of a PDP that aligns with ISO 13485 product realisation aspects and the HIE requirements is expected to take 12 - 18 months to create and validate. To commence this development a change proposal will need to be submitted and a dedicated project team created.

Key Actions / Areas of focus during next period

- Ongoing development of the requirements for new regulatory changes (Medical Device Regulations)
- Planning and delivery of nVCC and IRS

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 ☒
	Compliance with the latest regulatory standards is a significant element of the overall system which assures the safety of patients.and donors
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Paper is for noting and therefore out of scope of the legislation
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Compliance with the Regulations may require investment however the potential financial impact has not been assessed at present. **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	No specific actions identified
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Potential failure to meet compliance with the Regulations once new UK legislation is introduced may have an impact.

5. RISKS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Management of Violence & Aggression Policy

DATE OF MEETING	16th January 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	Jason Hoskins, Assistant Director of Estates Ceri Pell, VCC Health & Safety Advisor
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	Staff and contractors are at risk of being exposed to violence or aggression by patients, doners, visitors or the public whilst carrying out their duties. The aim of the policy is to raise awareness that violence and aggression against NHS staff is unacceptable and will not be tolerated. It seeks to reduce and prevent incidents of violence and aggression towards NHS employees by supporting staff and managers to identify and deal with unacceptable behaviour.

	The templated letters in the appendices provides a consistent framework for managers outlining the sanctions available following investigation of reported incidents of violence and aggression. Training under the All Wales Passport can provide staff with the skills and confidence to minimise risk at the point of incident and reduce the severity of harm from physical incidents

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the policy revision.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Cynefin Group	26/09/2023
VCC Cynefin Group	26/09/2023
Senior Leadership Team Meeting	18/10/2023
Trust Health Safety & Fire Board Meeting	27/09/2023
Executive Management Board - RUN	04/12/2023
Summary and outcome of previous governance discussions No further amendments have been made following consultation of the policy document. Additional evidence has been included following consultation on the equality impact assessment.	

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

APPENDICES

1	Management of Violence & Aggression Policy
2	Equality Impact Assessment

1. SITUATION

The Trusts Management of Violence & Aggression Policy has undergone a review and consultation process in both VCC & WBS.
Minor amendments have been made to include updated legislation and letter templates to provide consistency when contacting patients and doners following investigations of reported incidents of violence and aggression.

2. BACKGROUND

The objectives of the policy are to: -

- Provide appropriate staff training as identified by risk assessment and training needs analysis in line with the V&A training scheme.
- Reduce the effects of violent incidents and the risk of intimidation by provision of managerial support and aftercare at the earliest opportunity.
- Reduce the severity of injuries from violent incidents, by building staff confidence in de-escalation skills and breakaway techniques gained at training.
- Identify staff/groups via risk assessment, who may be considered as higher risk and ensure adequate controls to minimise the risks arising from violent incidents.
- Establish sanction procedures for those who demonstrate violent behaviour towards staff and outline the circumstances where sanctions will be applied.

3. ASSESSMENT

The policy requires all employees are expected to:

- act in a responsible manner and treat others with dignity and respect whilst performing their duties.
- comply with policies and procedures developed to protect and control violence and aggression.
- report all violent or aggression incidents (verbal or physical) including any form of intimidation or harassment regardless of an injury.
- discuss any health and safety concerns with their manager.

Following a violent or aggressive incident the manger will:

- ensure that V&A incidents are reported in the incident reporting system Datix.
- discuss the incident with the staff member.
- where appropriate investigate the incident
- ensure the controls are adequate to manage the risk.
- provide a supporting role to encourage staff well being.
- refer staff to occupational health where required.
- advise on workplace options and counselling available.
- seek advice or guidance where necessary.
- identify and escalate any identified risks, in accordance with the Trust risk assessment policy.
- ensure that any outcome e.g. a change in process, further training required or a sanction against the perpetrator, will formally be fed back to the staff member concerned.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Velindre NHS Trust shall assess the risk of exposure to violence and aggression from patients, doners, visitors, or members of the public when staff are executing their duties.

This is a refresh of an existing Policy and amendments made have undergone a consultation programme within the Divisional H&S meetings and SLT. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and Fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT and V&A training programmes.

The policy protects the health of staff and patients by reducing the risk of exposure to V&A incidents and provide support mechanisms following reported incidents.

The Quality Safety and Performance Committee is requested to approve the policy revision and associated templated letters.

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). The policy provides a framework for reducing incidents of violence and aggression and supporting the wellbeing of staff, patients, doners and contractors.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: *https://www.gov.wales/socio-economic-duty-overview*	This policy applies to all staff, patients and donors equally regardless of the social economic status and has a positive impact on all groups in terms of keeping people safe and supporting recovery and positive wellbeing.

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:
	If more than one wellbeing goal applies please list below: This policy contributes to a healthier Wales by reducing the risk of V&A incidents in Healthcare and reducing the negative mental health impact and anxiety associated with violence at work.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. A positive impact has been identified.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999 Obligatory Response to Violence (NHS, Police & CPS) Assaults on Emergency Workers (Offences) Act 2018. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

6. RISKS

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

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Ref: QS15

MANAGEMENT OF VIOLENCE AND AGGRESSION POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. A positive impact has been identified.
Review Date:	16th January 2027
Version:	8.0

Item no	Contents	Page
1.	Policy Statement	3
2.	Scope of Policy	3
3.	Aims and Objectives	3
4.	Responsibilities	3
5.	Definitions	7
6.	Implementation/Policy Compliance	7
7.	Equality Impact Assessment Statement	10
8.	References	10
9.	Getting Help	11
10.	Related Policies	12
11.	Information, Instruction and Training	12
12.	Main Relevant Legislation	13

1. Policy Statement

Velindre University NHS Trust recognises its duty to provide a safe and secure environment of service users, staff and visitors. Violent or abusive behaviour will not be tolerated and appropriate action will be taken to protect staff, service users and visitors.

The Trust, whilst managing the risks from Violence and Aggression will work in partnership with the Welsh Government and will utilise guidance within the All Wales Violence and Aggression Training Passport and Information Scheme (V&A training scheme) to ensure adequate and effective training is provided to staff. The Trust is also supportive of the Obligatory Response to Violence published by the Welsh Government and the Crown Prosecution Service and supported by the All Wales Anti Violence Collaborative

Velindre Trust takes a zero tolerance approach to violent or aggressive behaviour, aiming to minimise the incidents of violence and aggression faced by staff and tackle these effectively where they do occur by utilising criminal, civil and internal managerial actions.

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations.

3. Aims and Objectives

The aim of the policy is to raise awareness that violence and aggression against NHS staff is unacceptable and will not be tolerated. It seeks to reduce and prevent incidents of violence and aggression towards NHS employees by supporting staff to identify and deal with unacceptable behaviour.

The objectives of the policy are to: -

- Provide appropriate staff training as identified by risk assessment and training needs analysis in line with the V&A training scheme.
- Reduce the effects of violent incidents and the risk of intimidation by provision of managerial support and aftercare at the earliest opportunity.
- Reduce the severity of injuries from violent incidents, by building staff confidence in de-escalation skills and breakaway techniques gained at training.
- Identify staff/groups via risk assessment, who may be considered as higher risk and ensure adequate controls to minimise the risks arising from violent incidents.
- Establish sanction procedures for those who demonstrate violent behaviour towards staff and outline the circumstances where sanctions will be applied.

4. Responsibilities

4.1 The Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety

- the Trust Board and Executive Management Board to be informed as required on violence and aggression issues that affect employees and/or the public
- the Trust's Management of Violence and Aggression Policy to be implemented
- supporting the training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy
- authorising the exclusion of service users or their relatives/carers or visitors, who represent an unacceptable risk of violence and aggression to staff and or other service users

4.2. Director of Strategic Transformation, Planning and Digital

The Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's Management of Violence and Aggression Policy is reviewed as and when appropriate
- regular updates on violence and aggression issues are reported to the Executive Management Board
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and health and safety risks arising from potential violence and aggression are minimised
- information regarding the management of violence and aggression is effectively communicated throughout the Trust
- The approach to the management of violence and aggression is both systematic and appropriate

4.3. Executive Director of Organisational Development and Workforce

The Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective mandatory and induction training programme that includes the management of violence and aggression, which is appropriately monitored and recorded.
- reports on work related illness or work related ill health are submitted to the Health Safety & Fire Trust Board Meeting. This should include information on work related stress and mental health wellbeing that may arise from an act of violence or aggression.
- arrangements are in place for health surveillance, support and counselling for employees.

4.4 Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where issues or concerns regarding the management of violence or aggression can be discussed.
- liaising with the Trust Capital Planning and Estates Department

- ensuring that local procedures for the management of violence and aggression are developed and implemented in line with the overarching trust policy.
- preparing and implementing the organisational structure and allocating responsibility for the management of violence and aggression within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility.
- ensuring that risk assessments for the management of violence and aggression have been implemented for all relevant activities within the service area.
- ensuring that employees have access to a level of training appropriate to their role.
- ensuring that they are familiar with and ensure that all employees under their control are aware of any emergency plans for the management of violence and aggression.
- ensuring that effective local arrangements are in place are proportionate to the risk within their service.

4.5. Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed local lead managers in developing and maintaining their safety management systems and training in the management of violence and aggression. Competent advice may be sourced both internally and externally, dependant on the nature of the topic.
- provide support to the Executive Director with delegated responsibility for risk and health and safety management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of policy,
- ensure that statistical information is available on health and safety performance throughout the Trust and interpret such information in order to evolve action plans to improve or maintain standards.
- investigate incidents and report to senior managers on findings and where necessary provide recommendations

4.6 Departmental Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any potential concerns arising from the management of violence and aggression on a day to day basis.
- ensure that a risk assessment is carried out, in line with current legislation and trust policy. The assessment should include sufficient information about the risks that are faced and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific training that may be required by departmental staff via the PaDR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance or support that may be required by staff following an incident and liaise with local Workforce personnel to ensure that an appropriate level of occupational health support is readily accessible to staff
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates Department

- ensure that individuals are aware of their responsibilities for the management of violence and aggression and have access to current information and risk assessments.
- develop and implement a local departmental procedure or safe system of work for the management of violence and aggression
- consult and involve staff and safety representatives with local management arrangements
- report **all** violent and aggression incidents.

Following a violent or aggressive incident the manger will:

- ensure that V&A incidents are reported in the incident reporting system Datix
- discuss the incident with the staff member
- where appropriate investigate the incident
- ensure the controls are adequate to manage the risk
- provide a supporting role to encourage staff well being
- refer staff to occupational health where required
- advise on workplace options and counselling available
- seek advice or guidance where necessary
- identify and escalate any identified risks, in accordance with the Trust risk assessment policy
- ensure that any outcome e.g. a change in process, further training required or a sanction against the perpetrator, will formally be fed back to the staff member concerned.

Services are strongly encouraged to ensure that their correspondence and information leaflets incorporate a statement to advise service users and their relatives of the appropriate standard of behaviour expected on Trust premises and towards Trust staff, noting that there will be consequences for non-compliance. Suggested wording for this statement is:

Velindre Trust aims to provide safe, high quality services to all service users. The Trust has a zero tolerance approach towards violence and aggression against our staff and on our premises and may utilise CCTV and/or audio recording devices whenever personal safety is threatened. Evidence obtained will be used to secure sanctions against perpetrators."

4.7 Employees

All employees are expected to:

- act in a responsible manner and treat others with dignity and respect whilst performing their duties
- comply with policies and procedures developed to protect and control violence and aggression
- report all violent or aggression incidents (verbal or physical) including any form of intimidation or harassment regardless of an injury
- discuss any health and safety concerns with their manager
- cooperate with their manager in relation to health and safety and risk assessment
- undertake the relevant level of Violence & Aggression training and maintain their competence
- consider the offer of support and advice or counselling when given.

4.8 Occupational Health Departments

The Trust has service levels agreements in place for the provision of Occupational Health which is covered by local procedures. Please seek advice from your Organisational Development and Workforce department, who will be able to direct you to the appropriate service provider. Where health issues have been identified, a self referral is available to the Employee Assistance Programme. The manager is also able to refer staff involved in an incident of violence and aggression to Occupational Health, however, this referral is not covered by the service level agreement and will incur an additional fee.

The role of the Occupational Health Department in the management of violence and aggression is to:

- provide expert advice on physical and psychological trauma
- undertake appropriate health evaluation
- provide a confidential counselling service that may be required following an incident of violence and aggression. (please note that a charge will be made for this service)

5. Definitions

The Health and Safety Executive define work related violence as:-

"Any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge to their safety, well-being or health. This can incorporate some behaviour identified in harassment and bullying, for example verbal violence".

6. Implementation/Policy Compliance

6.1 Incident Reporting

All violence and aggression incidents, including physical, verbal, harassment and abuse, must be reported through the Trust and Divisional Incident Reporting Procedures. Violent incidents where required should be appropriately investigated to identify the cause even where no injury occurs. Managers are responsible for ensuring any investigation outcome or further action required is added to the Datix incident system and any feedback to staff is formally noted on this record.

All Managers are required to assess whether staff involved in a violence and aggression incident require help and/or support, this could include:

- arranging cover for the staff member to seek medical advice
- providing assistance and support and appropriate debriefing
- where necessary staff should to be allowed to go home to recover
- arranging follow up support, occupational health or further training
- offering staff confidential advice from the employee assistance program (EAP).

It is recognised that staff have the choice as to whether debriefing or counselling is desired, it is not a mandatory requirement.

6.2 Risk Assessment

Managers are responsible for ensuring that risk assessments are completed for the staff within their control, including staff who are classed as public facing, lone workers and care or home visitors and also to ensure the risk assessment should identify the controls in place and any further actions required.

Individual risk assessments may be required for a small number of staff, (see appendix 3 All Wales V&A Training and Information Scheme Risk Assessment Form*).* It is not necessary to provide individual assessments for every staff member unless they have been identified as higher risk e.g. lone worker (including out of hours working and isolated working).

Consideration should be given to situations that may be identified both from local and national perspectives. These include service users and visitors who maybe under the influence of alcohol and/or drugs, confused, elderly, or suffering brain cancer/disease, suffering from a paranoid illness where their perception of reality is distorted and or unable to communicate or service users with a history of violent behaviour who are more likely to become violent again. However, it is essential to emphasise that reoccurrence of violence is not definite and may be preventable.

There are also some specific staff situations where the risk would appear to be higher, these include: Individuals or small numbers of staff alone on night duty, porters/security staff who assist others during violent incidents, dealing with relatives and carers who may be anxious or angry, areas with cash or drugs which could be deliberately broken into and or home visits

6.3 Lone worker assessment / domiciliary / home visits

The risk assessment needs to consider options to eliminate or control a hazard in order to decrease the degree of risk to as low as reasonably practicable. The assessment should consider the suitability of the member of staff to undertake Lone Worker duties – expert advice is available from Occupational Health.

Written procedures are also required to ensure that support systems are in place for lone working including home visits, out of hours working and working in isolated areas For further guidance on lone working please refer to the Lone Working Policy.

6.4 Personal Communication Devices

Due to the low severity of violence and aggression incidents, the Trust does not automatically provide staff with personal communication devices. If a need for staff to use such a device is identified via a risk assessment, local arrangements should be put in place to provide and monitor the use of such devices.

Personal communication devices could include telephones, mobile phones, radios, automatic warning devices and emergency alarms. It should be noted that personal communication devices alone will not prevent incidents from occurring. However, if used correctly and in conjunction with robust procedures, they will improve the protection of lone workers.

6.5 Sanctions available to the Trust

Managers may have an informal meeting with the perpetrator (service user) where a one off incident occurs and discuss requirements for an improvement in behaviour. However, if no improvement is noted a formal meeting may be held.

A warning letter may be issued to a perpetrator whose behaviour is violent or aggressive towards staff, where the unacceptable behaviour has been established and meets the advice given within the V&A Training Scheme. (See appendix 1 & 2 for example of the Patient Undertaking letters).

The removal of treatment/service is a significant action and must be approved by the Chief Executive prior to initiation. It will also ensure that those Trust services that may be affected are informed. This action will be undertaken within both the legal and control of data constraints.

Divisional procedures are in place for the removal of services for those service users who repeatedly refuse to co-operate with the required behaviour and/or present a serious threat. These procedures shall ensure that the service users and their GP are informed of the reason for and duration of such action.

Divisional sanctions may be developed, to ensure a consistent and common approach these will be discussed atHealth Safety & Fire Trust Meeting.

Information sharing protocols with the Police, GP's and Ambulance services have been established to ensure that communications and risks related to the violent service users are appropriately handled.

Patients without capacity

Where patients do not have capacity to understand the ramifications of their behaviour, punitive actions are inappropriate, and the emphasis must be placed upon risk control measures to ensure that care can be provided in as safe a manner as is reasonably practicable.
Patient Undertakings, exclusion and legal action are usually inappropriate in these cases, although prosecution to determine a finding of fact rather than to achieve a criminal sanction may be a consideration.

Patients with fluctuating capacity

Where patients have fluctuating mental capacity, their capacity at the time of the incident should inform the action taken. Where the patient does not have capacity at the time of the violent or aggressive incident, opportunities should be taken to discuss the behaviour in as part of the therapeutic engagement process at the point that the individual has capacity.

Implementing Remedies/Sanctions Against Visitors and Relatives

The majority of incidents involving visitors take the form of verbal abuse and/or threatening behaviour. Verbal abuse is a form of violence. All incidents must be reported to the line manager and an online incident report form must be completed. Harassment is a criminal offence and violent incidents should be reported to the police.

If a situation escalates and involves a vulnerable adult (patient or relative) then a vulnerable adult referral form should be completed.

The exclusion of a visitor does not prevent them from attending the Trust for their own treatment. Staff may wish to seek advice and support from the Health & Safety team when considering applying remedies and/or sanctions. Example of a visitor undertaking letter is listed in the appendices.

6.6 Security Guards

Security guards employed by the Trust should be trained to the appropriate level as indicated in the V&A training scheme. The degree of involvement expected from security guards in a V&A incident should be clearly identified within localised procedures / emergency plans and their job descriptions.

6.7 Case Manager

The Trust considers it is not appropriate at this time to employ a full time Case Manager, due to relatively size of the organisation. However, the Trusts Health and Safety Manager will act as the Case Manager. If an incident occurs that is of the severity that would require advice and support from a Case Manager, staff and/or Service leads should contact the Divisional Health and Safety Advisors in the first instance.

6.8 Contacting the Police

The Trust supports prosecution action against individuals acting in a violent or aggressive manner towards staff. However, the trust itself cannot initiate a prosecution, this needs to be done by the victim or a witness to the incident. If the victim wishes police action to be taken they, or local management on their behalf, should contact the police using either the 999 number in an emergency, or 101 where nonemergency crime or antisocial behaviour has been committed. Management/supervisory authorisation is absolutely not required before calling the police.

Staff should err on the side of caution and “if in doubt, call the police”

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. A positive impact on the safety and wellbeing of staff has been identified.

8. References

The Health and Safety Executive Guidance on Violence in Health and Social Care

All Wales NHS Violence and Aggression Training Passport and Information Scheme

Obligatory Responses to Violence in Healthcare.

9. Getting Help

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ
Health and Safety	**Trust Health & Safety Manager** Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522 **VCC Health & Safety Advisor** Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL Tel: 02920615888 **WBS Health & Safety Advisor** Welsh Blood Service Ely Valley Road Talbot Green Pontyclun CF72 9WB Tel: 1797 2356
Occupational Health	Cardiff and the Vale University LHB Heath Park Cardiff CF14 4XW E-mail: occupational.health@wales.nhs.uk Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above named local health board. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover pre-employment checks, formal health surveillance, health assessments in connection with fitness to work, identification of occupational hazards and risks, along with support and advice for staff.

Employee Assistance Programme (EAP)

The Trust's EAP provider is Workplace Options, who provide the Employee Assistance Program which has a wide range of health and wellbeing services including counselling available to staff. Information on services available:

- Free of charge
- Available 24 hours a day, every day of the year
- Confidential
- Independent from your employer
- Immediate access to impartial specialists
- Support on an unlimited number of issues
- Saves time and legwork
- Helps you plan ahead with practical matters
- Supports you during more difficult times

10. Related Policies

This policy should be read in conjunction with, or reference made to, the following trust documents: -

Health, Safety and Welfare Policy	QS18
Lone working policy	QS30
Incident Reporting and Investigation Policy	QS 01
Security Policy	PP 02
Risk Management Process	GC 04b

11. Information, Instruction and Training

The V&A Training Scheme was developed in conjunction with Welsh Assembly Government and many other interested parties.
Its aims are to:

- achieve consistency in violence and aggression risk assessment
- provide training methods that are standardised across Wales
- reduce training resources and duplication, where staff moved from one Trust to another.

Welsh Assembly Government mandated all NHS staff are required to undertake Module A. Staff requiring Module B and C training will be identified by the risk assessment and the training needs analysis.

Violence and aggression training will be available at a divisional level and attendance information will be held within the Electronic Staff Record (ESR) system. Training compliance is monitored on a quarterly basis at the Health Safety & Fire Trust Board Meeing.

Module A: Induction and Awareness (Induction or via E Learning)
Provides all staff with general awareness and highlights appropriate local policy and procedures in place. Also gives a clear definition of violence and aggression and raises the importance of managing and reporting violence and aggression incidents in the workplace.

Module B: Theory of Personal Safety and De-escalation
Provides selected front line staff identified via risk assessment /training needs analysis with a greater awareness of V&A issues and outlines the theory of personal safety and

de-escalation. Emphasis is placed upon the importance of de-escalation and the steps which can be taken to prevent incidents of violence and aggression occurring. This module is intended to develop the skills to recognise and de-escalate potential violent incidents and will include issues associated with customer care and diversity.

Module C: Breakaway and Escape Techniques
Provides selected front line staff identified via risk assessment /training needs analysis with practical skills to enable them to breakaway from a situation of violence and aggression. Emphasis will be placed upon the importance of communication skills and management of personal safety throughout all breakaway techniques.

Exemptions:
New staff to Velindre University NHS Trust will be required to attend the correct level of training as identified via Divisional risk assessment. Exemptions from training will only be accepted where the staff member provides the training department will evidence from their previous employer of training attended. Any refresher training will coincide with the original training date proven.

12. Main Relevant Legislation

The Health and Safety at Work etc. Act 1974
The Management of Health and Safety at Work Regulations 1999
Assaults on Emergency Workers (Offences) Act 2018

Appendix 1: **Velindre University NHS Trust**

Responsibilities and Rights – A Patient Undertaking

Patients Name:…….	
NHS number:…….	GP/Consultant:…….
Your Rights Velindre University NHS Trust and its employees owe to me, as a patient, a duty of care and aim to provide services to meet my needs for healthcare and treatment at all times. Velindre University NHS Trust and its employees aim to provide health services that are sympathetic and responsive to my individual needs within the resources, which the Trust has available. Velindre University NHS Trust and its employees want to deliver appropriate and effective health care and treatment to me. Velindre University NHS Trust expects all its employees to treat me with courtesy and respect. Velindre University NHS Trust will only restrict or withdraw my rights to care in exceptional circumstances when I have failed to comply with any of my responsibilities in a manner which is deemed unacceptable.	**Your Responsibility** I will not behave in a way, which can be considered to be violent or abusive. Violence includes any incident where any member of staff are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, wellbeing or health of any member of staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threat of injury, abuse of alcohol or drugs, destruction of Trust property as well as physical acts of violence. I will treat NHS staff, fellow patients carers and visitors politely with respect at all times. I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on any premises of the Trust. I accept and understand that Velindre University NHS Trust is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of staff has to jeopardise their safety in providing me with care.

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient, then this can result in the withdrawal of my rights as a patient and I can lose my right to receive care from Velindre University NHS Trust except for treatment in an emergency.

Signature of Patient: ……. Print Name:…….	Signature of Named Nurse/Core worker: …….. Print Name:……
Date:	Date
Witnessed by:……and Date……	

Patient letter 1 (Stage 2)

Insert patient name and address
Dear (insert patient name)
Re: Access to Velindre NHS Trust (insert name of service) Services

I write with reference to the alleged incident of violence and aggression on (insert date) at (insert site and location).
It is alleged that you (insert details of incident). An investigation has been undertaken as the Trust takes this issue very seriously and has a commitment and duty of care to ensure a safe and secure working environment for all members of staff.

I am taking this opportunity to express my concern at your behaviour towards staff involved; it is considered unacceptable and will not be tolerated by the Trust. As a result of the incident, I am writing you this letter. A meeting took place between (insert job titles of managers) on (insert date). We considered all of the evidence, which had been gathered from our investigation, including statements from staff and yourself. We also consulted relevant Trust policies and national guidance. After considering all of the above, we have come to the decision that although the Trust will continue to provide you with (insert service) Services at (insert site), your treatment will be subject to adherence to a Patient Undertaking agreement. A draft copy of the agreement is enclosed for your information.

A meeting has been arranged between yourself and (insert managers job title) on (insert date) at (insert location) in order to agree and sign the Patient Undertaking agreement. Failure to comply with conditions of the agreement, even if you refuse to sign it, is likely to lead to the Trust modifying services to you. Any future verbal or physical intimidation of staff is likely to lead to the Police being called and the Trust pursuing relevant legal sanctions.

In the meantime, to reduce the risk to our staff, I have put in place control measures (list control measures such as no home visits, visiting in pairs, no attendance at a base unless prior appointment arranged).

These control measures will be reviewed in (insert number) month's time. A copy of this letter will be kept on your patient record. Please note that if we consider you to be a risk to other healthcare professionals (such as your GP), we will inform them of the incident and the action we have taken.

Should you have any queries as to the contents of this letter, or arrangements for the meeting please do not hesitate to contact me.

Yours sincerely (Insert job title of Manager)

cc Insert details of patient/clients GP cc Prevention of Violence & Aggression Lead

Appendix 3 All Wales NHS Violence and Aggression - Risk Assessment Form

These risk assessments should be conducted in consultation with employees and reviewed at least annually or after a serious incident has occurred. If a major change is required as part of a review a new form must be completed.

Section A: Administration Details

Division ……..

Primary Location (e.g. VCC, WBS, etc.……

Exact Location, (e.g. Interview Room, Reception)……..

Name of Assessor:……..……..	Date of Review: …….
Designation:…….	Name/Designation of Assessor: …… …… ……
Date of Initial Assessment…….	Date of Review ……
	Name/Designation of Assessor …… ……

Section B: Task or Activity

Description of task or activity which could lead to a risk of violence and aggression.

Personnel involved (e.g. carer, nurse, security staff, contractor, off site worker, etc.

	Section C: Assessment of Risk h of the sections, tick the appropr		
1.a	**Is there any historical evidence of verbal or physical abuse to staff?**	Yes	No
	Verbal Abuse (with intent/directed at staff)		
	Verbal Abuse (abusive remarks not directed at staff)		
	Punch/strike/slap		
	Wounding		
	Kicking		
	Biting		
	Scratching		
	Grabbing by service user		
	Pushing or shoving		
	Hair Pulling		
	Stalking		
	Victimisation		
	Intimidation		
	Threat with / use of weapon (e.g. knives, needles, walking sticks etc.)		
	Harassment (racial, sexual, bullying)		
	Offensive Messages		
	Telephone abuse		
	Robbery		
	Other (Please specify)		
b	**Is it perceived that there could be a risk of any of the above** Please specify: If there is **no** perceived or known risk of verbal or physical aggression there is no need to continue with this assessment.		
2	**How often do violent incidents occur?**		
	Never		
	Every few months		
	Once a month		
	Several times a month		
	Once a week		
	Several times a week		
	Once a day		
	Several times a day		

3a	If hurt or wounded as a result of an attack, has it lead to:	Yes	No
	Bruising/swelling		
	Dislocation		
	Fracture		
	Cuts		
	Multiple injuries		
	Sprains		
	Stress		
	Other		
b	**Is it perceived that an incident could lead to any of the above**		
	Please Specify		
4	**Following attacks or incidents of abuse, has this led to time off work?**	**Yes**	**No**
	A few hours		
	Days		
	Weeks		
	Months		
5	**When are violent incidents more likely to occur (Please Tick)** 8am to 5pm 5pm to 12 midnight 12 midnight to 8am at any time **6. On what day of the week Mark days when incidents Are more likely to occur, If known 7 = most likely, 1 = least likely** Monday to Friday Saturday and or Sunday Any Day		
7	**Is the workplace overcrowded?** All the time		
	Never		
	During specific times Please specify		

8	Are the following adequate	Yes	No	N/A	Are the following readily available for service users?	Yes	No	N/A
	Lighting				Public telephones			
	Temperature				Toilet			
	Ventilation				Light refreshments			
	Décor /Colour schemes				Information service			
	Housekeeping				Up to date magazines			
	Seating for patients/visitors				Children's play area			
	Other Please Specify				Music			
					Tv/Videos			

9	Internal environmental issues	Yes	No	N/A
	Are there excessive noises which could cause distraction?			
	Are there isolated areas such as treatment rooms, offices, etc.?			
	Are the rooms laid out in such a way as to allow staff to exit in an emergency?			
	Could the aggressor be situated between the employee and the door?			
	Are there designated waiting areas?			
	Are these adequately supervised?			
	Are there corridors/areas where aggressors could hide/congregate?			
	Is there adequate signage displaying the Trust Zero tolerance stance?			
	Are staff protected by additional security measures where required e.g. screens, security locks, intercoms, Internal CCTV, panic alarms?			
	Is money/valuables kept in the work area?			

10	Are there potentially dangerous fixtures and fittings, e.g.	Yes	No	N/A	11	Is there room a room available to speak privately with:	Yes	No	N/A
	Ash Trays					Service users			
	Tables					Visitors			
	Waste bins					Other staff			
	Seats								
	Sharp corners								
	Surgical/medical equipment								
	Office equipment								
	Other Please specify								

12	External environmental issues	Yes	No	N/A
	Are there adequate parking spaces within suitable distance from work area?			
	Is there adequate lighting?			
	Is it distant from the work area?			
	Have routes to parking areas/external walkways been surveyed for safety?			
	Is there CCTV coverage of routes?			
	Are these cameras monitored?			
	Is there a security escort service to parking areas when walking on external routes?			

13	**Are there any times when tasks are undertaken alone?**		**Yes**	**No**
	If yes please specify			
	Are there any procedures in place to help ensure safety?			
	If yes please specify			
14	**Are there alarm systems in place by which you can summon help?**	**Yes**	**No**	**N/A**
	If yes please state type of system			
	Are alarms fitted in rooms used for interviewing potentially aggressive/violent individuals?			
	Are these alarms accessible to staff?			
	Are the alarms easy to activate			
	Are staff trained in its use?			
	Do others know how to respond if the alarm is raised?			
	Are there documented procedures in place for ensuring this?			
	Can the alarm be heard in all areas of the ward/department?			
15	**Have staff attended appropriate training in accordance with the All Wales Violence and Aggression Training Scheme and Trust Policy**		**Yes**	**No**
	Level of training required and number of staff identified in Training Needs Analysis as requiring each level of training:-			
	Module A - Induction and Awareness Raising			
	Module B – Theory of Personal Safety and De-escalation			
	Module C – Breakaway Techniques			
	Number of staff who have attended training:-		Numbers	
	Module A – Induction and Awareness Raising			
	Module B – Theory of Personal Safety and De-escalation			
	Module C – Breakaway Techniques			
	What procedures are in place to ensure that all staff (including medical staff) have information and access to violence and aggression training?			
16	**Is there a contingency plan if violence is threatened or breaks out toward:**		**Yes**	**No**
	Service users			
	Visitors			
	Staff			
	Please specify arrangements:			
	Are staffing levels adequate to ensure that contingency plans can be followed?			

17	Home / Community Visits	Yes	No	N/A
	Are home / community visits essential?			
	Is any information sought highlighting previous / known risks associated with the patient and / premises / or locality?			
	Where joint agency working takes place are there protocols for sharing information regarding known risks of violence and aggression?			
	Is joint agency visiting considered where appropriate?			
	Are individual risk assessments undertaken?			
	Is there a tracking system to ensure safety prior to, during and at the end of a visit (e.g. buddy systems, lone working procedures)?			
	Are mobile phones provided together with training in their use?			
	Are personal safety alarms provided and information given in their use?			

18	Policy / Procedure	Yes	No
	Is the Trust policy easily accessible to all staff?		
	Is there a Trust Information Leaflet available to all staff?		
	Do you have departmental policies / procedures?		

Section D: Current Risk Control Measures (see Section C)

Control Measures Currently in Use:

Section E: Initial Risk Rating Figure

Initial Risk Rating Figure

(to calculate see Risk Matrix):

Probable Likelihood Rating ☐ x Potential Severity Rating ☐ =

sk Rating Score ☐

Section F: Additional Risk Control Measures Required

ol measures to be recorded within this box. The request for these
prioritised risk a risk priority along with other risks within the location and will for
register.

No.	Risk Reduction Measures / Further Action

If the above control measures are implemented, calculate the **New** Risk Rating Figure:

Probable Likelihood Rating ☐ x Potential Severity Rating ☐ = **Risk Rating Score** ☐

Section G: Action Plan Agreed with Manager

…… ……

Managers Signature

No	Action Plan	Responsible Person	Projected Completion Date	Date Completed / Signature

Once the above action plan has been implemented, calculate the **Final / Residual** Risk Rating Figure:

Probable Likelihood Rating ☐ X Potential Severity Rating ☐ = **Risk Rating Score** ☐

Additional Comments

Appendix 4 – Unacceptable Standards of Behaviour

The following are examples of behaviours that are not acceptable on NHS premises, or locations where patients receive treatment:

- Excessive noise e.g. loud or intrusive conversation, shouting or uncontrollable misbehaviour
- Threatening or abusive language involving excessive swearing or offensive remarks
- Derogatory racial or sexual remarks
- Wilful damage to Trust property
- Malicious allegations relating to members of staff, other patients or visitors (N.B. any allegations made by children against staff must be reported to a Named Professional for investigation)
- Offensive and derogatory comments relating to members of staff, other patients or visitors
- Language that belittles a person's abilities
- Inappropriate behaviour as a result of alcohol or misuse of drugs
- Threats or threatening behaviour
- Violence, perceived acts of violence or threats of violence
- Unreasonable behaviour and non-cooperation such as repeated disregard for hospital visiting rules
- Bullying, victimisation or intimidation
- Stalking
- Spitting
- Any explicit or implicit challenge to the safety, well being or health of any member of staff or patient
- Theft
- Drug dealing
- Persistent smoking in inappropriate areas within the Trust (n.b., all Trust premises and property are smoke free.

It is important to remember that such behaviour can either be in person, by telephone, letter or email or any other form of communication such as graffiti on NHS property for example.

Appendix 5

VISITOR UNDERTAKING (Stage 1)

Your Responsibilities

I will not behave in any way which can be considered to be violent or abusive.

Violence includes any incident where any members of staff are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, well-being or health of any member of staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of hospital property as well as physical acts of violence.

I will treat NHS staff, fellow patients, carers and visitors politely and with respect at all times.

I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on any premises of Velindre Trust.

I accept and understand that the Trust is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of staff has to jeopardise their safety in providing me with information and my relative/friend with care.

I confirm that I understand that if my behaviour is unacceptable and I do not comply with my responsibilities this can result in the withdrawal of my rights as a visitor as outlined in the Trust's Policy for Management of Violence and Aggression Policy.

Signature of Visitor:	Signature of Velindre Representative:
Print name:	Print name:
Date:	Date:
Witnessed by:	Date:
Print name:	

Appendix 6

Visitor Undertaking Letter 1 (Stage 2)

Visitor's name……
Visitor's address ……..
……
……
Date:

Dear ……..

This is to formally confirm that due to your unacceptable behaviour on…… at……
You are now subject to the conditions outlined in Velindre Trusts Visitors Undertaking in order to protect the patient, other vulnerable adults and staff.

The procedure for using a Visitors Undertaking has been applied to you and enclosed is a copy of the Trust's Policy for Handling Violence and Aggression.

Should you, on any occasion in the future, fail to comply with the expected standards of behaviour explained to you by …….. and outlined in the Visitors Undertaking, you will become subject to the next stage of the Procedure which may involve your immediate exclusion from the Trust premises by our security staff/Police. Such an exclusion from Trust premises would mean that you could only attend the Trust premises accompanied by Security or the Police.

Yours sincerely

Senior Manager

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Safe Use of Display Screen Equipment (DSE) Policy

DATE OF MEETING	16th January 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	Jason Hoskins, Assistant Director of Estates Matthew Bellamy, WBS Health, Safety and Environmental Compliance Manager
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 outlines the requirements of VUNHST to ensure safe use of DSE within the organisation by staff that are identified as DSE users. The policy includes assessment and guidance for the staff members that may undertake hybrid or agile working to ensure that they are operating DSE and workstations safely in that setting. The Trust has a legal obligation to comply with The Health and Safety (Display Screen Equipment) Regulations and as part of this undertake a suitable and sufficient assessment of the risks to relevant staff

	of DSE use. The regulations require control measures to be put In place to manage eliminate of manage the risks in order to avoid work related upper limb disorders (WURLSD) and other Musculoskeletal injuries that may result from incorrect set up of workstation and use of DSE.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the policy revision.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Cynefin Group	04/04/2023
VCC Cynefin Group	21/03/2023
Senior Leadership Team Meeting	13/12/2023
Trust Health Safety & Fire Board Meeting	24/04/2023
Trust Hybrid working Board	26/04/2023
Hybrid Working – People T&F Group	26/04/2023
Hybrid working – Infrastructure T&F Group	26/04/2023
Summary and outcome of previous governance discussions No further amendments have been made following consultation of the policy document. Additional evidence has been included following consultation on the equality impact assessment.	

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

APPENDICES	
1	Safe Use of DSE Policy

2	Equality Impact Assessment

1. SITUATION

1.1 The Trust Display Screen Equipment Policy required review to ensure that it is in line with the Trust Hybrid Working principles and the reviewed Flexible Working Policy.

1.2 The Trust Display Screen Equipment Policy required review to ensure that it is in line with the Trust Hybrid Working principles and the reviewed Flexible Working Policy.

1.3 The Trusts Safe Use of DSE Policy has undergone a review and consultation process in both VCC & WBS.

2. BACKGROUND

The objectives of the policy are to: -

- Identify VUNHST staff that are DSE users.
- Provide guidance on how to assess their DSE and workstation to identify hazards and risks.
- Provide guidance on how to set up their workstation / DSE to minimise the risks.
- Ensure the safe use of DSE and workstations.
- Ultimately reduce the risks of Work-Related Upper limb disorders (WURLDS) and Musculoskeletal disorders (MSDs) amongst DSE users.
- Identify higher risks DSE users and ensure that mitigating measures are put in place to eliminate or reduce the risks.
- Implement within the division

3. ASSESSMENT

3.1 The policy requires:

- a DSE assessment is carried out on DSE Users workstations both in the office environment and when staff are working in a hybrid manner.
- risks from DSE workstations are eliminated or reduced.

- eye tests, paid for by the employer, are available if a DSE worker requests one.
- the employer will pay a specified amount for the provision of DSE specific glasses where the provisions of the Regulations apply
- DSE specific information and training is provided for DSE users.
- Additional information has been included about safe use of DSE during hybrid working.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The policy ensures that the risks of DSE use by those staff that are identified as DSE users who use a display screen for more than 2 hours per day, identify the hazards and risks associated with this. This includes those staff that are hybrid working helping to assess the home working environment.

A DSE assessment template is included along with guidance for staff around DSE use and workstation set up.

This is a refresh of an existing Policy and amendments made have undergone a consultation programme within the Divisional H&S meetings and SLT. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and Fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT and V&A training programmes.

The policy protects the health of staff identified as a DSE user and will ultimately reduce the risk of injury from DSE use.

The Executive Management Board is requested to endorse the policy revision and associated templated letters for approval at the Quality & Safety Performance Committee

5. IMPACT ASSESSMENT

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

If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The 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 policy provides a framework for reducing incidents of WRULDS and RSI, Musculoskeletal injuries, exacerbating existing conditions that DSE users may have and supporting the wellbeing of staff.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: *https://www.gov.wales/socio-economic-duty-overview*	This policy applies to all staff identified as DSE users regardless of the social economic status and has a positive impact on all groups in terms of keeping people safe and supporting recovery and positive wellbeing.

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 policy also covers hybrid working which reduces travel environmental impacts and therefore reducing carbon emissions contributing to a Sustainable organisation.
	If more than one wellbeing goal applies please list below: This policy contributes to a healthier Wales by reducing the risk of chronic injuries such as WURLDS, MSDs aches pains etc. that may result from unsafe DSE use.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Legal requirement to fund eye tests and funds towards glasses if needed as a result of DSE use **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. The majority of protected characteristic areas will have no impact. A positive impact has been identified for some of the protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999 The Health and Safety (Display Screen Equipment) Regulations Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

6. RISKS

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

Ref: QS26

POLICY FOR DISPLAY SCREEN EQUIPMENT

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital (Health and Safety)
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	16/05/2023
Date of Equality Impact Assessment:	27/04/2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	May 2025
Version:	7.0

Contents **Page**

1. Policy Statement

Velindre University NHS Trust (VUNHST) and its hosted organisations are committed to minimising the health and safety risks to staff who use display screen equipment and to complying with the legal obligations placed on it by The Health and Safety at Work etc. Act 1974 and the Display Screen Equipment (DSE) Regulations 2002

2. Scope of Policy

This policy applies to all employees of the Trust and Hosted Organisations, who use DSE for a continuous period of an hour or more (DSE users) whilst on Trust business. It also applies to workstations provided for use on Trust premises by persons who are not employees, i.e. service users, visitors, volunteers or staff of external bodies located on Trust premises.

Note – This policy refers to **hybrid working**, which is also called **agile working** in the hosted organisations.

3. Aims and Objectives

Aim

This Policy aims to manage so far as reasonably practicable the health and safety risk to staff from using display screen equipment both on VUNHST or hosted organisation premises and if undertaking hybrid working.

Objectives

This policy describes the ways in which VUNHST will comply with the requirements of the Health & Safety (Display Screen Equipment) Regulations 1992. It also outlines the way that the Trust complies with the Health and Safety Executive (HSE) guidance on hybrid working.

The Regulations require: -

- a DSE assessment is carried out on DSE Users workstations both in the office environment and when staff are working in a hybrid manner.
- risks from DSE workstations are eliminated or reduced.
- eye tests, paid for by the employer, are available if a DSE worker requests one.
- the employer will pay a specified amount for the provision of DSE specific glasses where the provisions of the Regulations apply (see section 6.5)
- DSE specific information and training is provided for DSE users.

4. Responsibilities

4.1 **The Chief Executive** has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety
- the Trust Board and Executive Management Board to be informed as required on health and safety matters affecting employees, patients, donors or others.
- the Trust's policy on the Safe Use of Display Screen Equipment to be implemented
- training and development of staff
- ensuring there are sufficient resources to implement this policy

4.2 **The Executive Director of Strategic Transformation, Planning and Digital** has delegated responsibility at Trust Board level for managing health and safety and is responsible for making sure that systems are in place to ensure:

- this policy is reviewed when appropriate.
- regular updates on issues raised are reported to the Executive Management Board.
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and risks arising from the use of display screen equipment are minimised.
- information and guidance regarding the safe use of display screen equipment is communicated throughout the Trust.
- training needs for the use of display screen equipment are identified and compliance with training is monitored and reported.

4.3 **The Executive Director of Organisational Development and Workforce** is responsible for ensuring that:

- there is effective induction training that includes safe use of display screen equipment advice and training, which is appropriately monitored and recorded.
- arrangements are in place to support and provide adjustments for employees with musculoskeletal injuries or other health issues that may arise from or be aggravated by the use of display screen equipment.

4.4 **Divisional Directors / Directors of Hosted Organisation**s are responsible for ensuring arrangements are in place for:

- the development and implementation of local procedures and organisational arrangements for the safe use of DSE in line with the Trust policy.

- processes are in place to ensure DSE assessments to be carried out for workplace and hybrid working
- staff receive DSE information and training.
- appropriate DSE equipment is made available to staff in the office and when hybrid working.
- suitably trained DSE Assessors are available to provide advice on DSE assessments and to refer to health and safety teams or Occupational Health where the issues are beyond their capacity.
- Processes are in place to ensure employees complete a homeworking assessment

4.5 **Assistant Director of Estates, Environment and Capital Development** has overall responsibility for the management of the working environment including lighting, temperature and ventilation in the buildings owned by the Trust.

4.6 **Departmental Managers** have responsibility for ensuring that there are arrangements in their department to:

- identify DSE users.
- ensure DSE users access DSE training and information including information on use of DSE during hybrid working and how to set up a work station at home.
- ensure DSE users complete a DSE assessment in accordance with the arrangements in their division or hosted organisation, including assessments for hybrid working.
- review DSE assessments and ensure that any issues identified are addressed and where necessary escalated to DSE assessors, health and safety advisors or Occupational Health.
- refer people to Occupational Health or expert ergonomic advice for health issues which may be related to or made worse by DSE work, for example musculoskeletal pain or other sensation or numbness in hands, arms shoulders, back or neck or DSE related eye problems, headaches or stress (not an exhaustive list). All referrals to Occupational Health must be accompanied where possible by an up-to-date display screen equipment risk assessment
- ensure that workers who working in a remote manner have been provided with suitable equipment (monitors, laptops, keyboard, mice etc.), requests for additional equipment should be considered on a case by case basis and where appropriate further support and guidance should be sought from DSE assessors, health and safety teams, Occupational Health, Digital, and/or Workforce as required.
- scrutinise and authorise payment for display screen related eye tests and glasses for use with DSE work (see section 6.5)
- ensure that any DSE Equipment, workstations, chairs provided in their areas of responsibility in the office meet the requirements of the DSE Regulations.
- enable work to be organised so that employees are able to take regular breaks and/or changes of activity.

- ensure that Trust, divisional or hosted organisations arrangements for checking equipment are implemented.
- Ensure that hybrid workers complete a home working risk assessment.

4.7 **DSE equipment 'users'** must

- complete the display screen equipment training in the format required by their division (on-line ESR) or by their hosted organisation.
- If they undertake hybrid working, familiarise themselves with the Trust, divisional and hosted organisation information and guidance on hybrid working and setting up a workstation at home.
- complete a DSE assessment for the work station they use in the office and (where applicable) for any workstation they use at home.
- escalate any issues identified by display screen assessment to their manager and where appropriate cooperate with any assessment carried out by a display screen assessor.
- inform their manager of any health issues potentially caused or made worse by DSE work including musculoskeletal pain, eye strain, headaches (not an exhaustive list), including issues that may be related to DSE use as part of hybrid working.
- ensure that any work station they use for home working is safe and without risks to health, set up in accordance with their DSE training and does not constitute a risk to other persons in their home environment.
- adjust any workstation they use whilst agile working/hot desking in accordance with their display screen equipment training.
- review their display screen equipment risk assessment if there is a significant change in working practice or their work station at the office or at home, the environment, the use of different equipment or software or a change in a health condition.
- Cooperate with Trust, divisional or hosted services arrangements for checking equipment.
- Complete a home working risk assessment if they work in a hybrid manner.

4.8 **Health and Safety Teams** - The Trust, divisional and hosted organisation Health and Safety Managers/Advisors will ensure that:

- training and information is available for display screen equipment users
- advice is available with regard to display screen equipment risk assessments
- systems are in place to monitor compliance with this policy as part of the health and safety audit process.

4.9 **Occupational Health** is provided via a service level agreement and includes the provision of advice on DSE related health issues. The service is also able to offer advice on the design and suitability of DSE Workstations through the Occupational Health Physiotherapy service.

All referrals to Occupational Health must be accompanied where possible by an up-to-date display screen equipment risk assessment.

4.10 **Digital Services**

Digital Services will coordinate the procurement of relevant equipment and software, as determined by departmental / line managers or based on the recommendations from formal DSE and/or Occupational Health assessments.

5. Definitions

- **Display Screen Equipment** are devices or equipment that have an alphanumeric or graphic display screen and includes display screens, laptops, tablets, touch screens and other similar devices

- **Display Screen Users** are workers who regularly use DSE as a significant part of their normal work (daily, for continuous periods of an hour or more) and include users of Portable Laptops/Notebooks.

- **Hybrid working, Remote working, Agile working** are terms used where time is split between a central workplace (VUNHST or Hosted Organisation premises) and other locations including working at home.

- **Agile** working applies where staff do not necessary have an allocated desk but may work at 'hot desks' at VUNHST or Hosted Organisation or other NHS premises.

6. Implementation/Policy Compliance

6.1 DSE Workstation Assessments

Workers who use DSE continuously for an hour or more a day must complete a DSE assessment for both office and home working where applicable.

Where DSE related risks are identified, steps must be taken to reduce them as soon as reasonably practicable. Users can make straightforward adjustments to workstations themselves following instruction, training and guidance. Managers must review DSE Assessments and request additional advice and guidance from trained DSE assessors, health and safety teams and/or Occupational Health as appropriate where unresolved issues are identified.

Where DSE assessments of home workstations identify issues, which may require additional equipment, managers should consider these matters on a case-by-case

basis and obtain further advice from DSE assessors, health and safety teams, Occupational Health, Digital, and/or Workforce as required.

Where workers work at multiple workstations (hot desking) they should use the information, training and guidance they have received to adjust each workstation to meet their needs and to reduce the risk from DSE work.

DSE assessments should be completed when a new workstation is set up, when a new user starts work, when a change is made to an existing workstation or when a user experiences pain or discomfort or other possibly DSE related health effects.

6.2 Appointment of Display Screen Equipment Assessors

DSE assessors will be trained and appointed to support the display screen risk assessment processes, and to provide advice and guidance on workstation set up, provision of equipment and working practices. DSE assessors will signpost to additional support such as health and safety teams, Occupational Health, Workforce and Digital as appropriate.

6.3 Work Routines

DSE users should organise their work to take regular breaks whether working in the office or at home. Regular breaks, which may involve a change of activity and an opportunity to move around and/or change position. Breaks support musculoskeletal health, allow a break from looking at the screen and support mental wellbeing avoiding extended periods of concentration without respite.

Generally speaking staff should take short regular breaks (e.g. at least five minutes in every hour) away from the workstation.

6.4 Training and Information

Employees will be provided with training, information and guidance about the use of DSE.

6.5 Eye and Eyesight Tests

Eye tests will be provided for DSE users, if requested, in line with the requirements of the Display Screen Regulations.

The Trust will pay up to £50 for glasses if the test shows an employee needs special glasses specifically for DSE work. The Trust will not reimburse the cost of glasses

where an ordinary prescription is suitable for DSE work. The requirement for a DSE specific prescription must be confirmed in writing by the Optician.

The DSE user must take the Display Screen User Eyesight Request Form authorised by their Line Manager prior to the visit, with them to the appointment for the Optician to complete. The frequency of repeat testing will be at the clinical judgement of the Optician.

Claims for reimbursement must be submitted via the e-expenses portal on the Display Screen User Eyesight Request Form together with relevant receipts.

7. Hybrid Working

Guidance on hybrid working can be found in the Trust Hybrid Working Toolkit and in guidance provided by divisions and hosted organisations.

Hybrid working is where an employee splits their time between, the workplace and working remotely either at home or another workplace location. Hybrid working can be undertaken in non-traditional environments through remote and virtual work, hot desking at alternate bases.

Wherever an employee is working , they should use the information provided to them in their DSE training and information to adjust their workstation to avoid discomfort.

When working from home as part of Hybrid working arrangements agreed with they manager, they should make every effort to set up the work space as close to the office provision as possible, remembering posture and the positioning of equipment e.g. laptop, keyboard and mouse, monitor.

Staff are required to complete a display screen assessment for their work station at home as well as for their workstation on VUNHST or hosted organisation premises.

Staff must also complete the Home working risk assessment and ensure that their working area is safe and without risk to health. Further guidance is available in the Hybrid Working toolkit and in guidance provided by the trust, divisions and hosted organisations.

Staff will be provided with training and guidance on basic electrical safety. They must regularly inspect all DSE related equipment provided to them by the Trust or hosted organisation. If it is visibly damaged or shows signs of being defective, they must not use it and must report the issue to their manager and/or Digital Services as appropriate for remedial action to be taken.

8. Reasonable Adjustments

DSE assessments completed in the office or hybrid working may identify requirements for reasonable adjustments for persons with a disability as defined under the Equality Act 2010. Each person must be considered on a case-by-case basis. Managers must seek further advice from health and safety teams, Occupational Health and/or Workforce and Organisational Development as appropriate to ensure the requirements of the Equalities Act 2010 are adhered to.

9. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

10. References

Working Safely with Display Screen Equipment – HSE website
Velindre University NHS Trust Hybrid Working Toolkit.

11. Getting Help

Please approach the Trust, divisional or hosted organisation's health and safety team for additional guidance or advice.

11. Related Policies

Reference should also be made to the following Trust Policies:

- Health, Safety and Welfare policy PP10
- Workplace Equipment Policy PP17
- Home Working Policy WF45
- Supporting Staff with Specific Needs – disability Guidance
- Hybrid Working Tool Kit .

13. Related documents and forms

- DSE Assessment and Guidance Form
- Home working assessment
- Home working DSE Assessment and Guidance
- DSE Guidance available on Trust, Divisional and Hosted Organisations' SharePoint pages.
- DSE Training available on ESR
- Annual DSE equipment questionnaire (Trust and divisions only)

14. Monitoring Arrangements

Completion of the display screen equipment e-learning on ESR will be monitored by divisional and Trust quarterly health and safety meetings.

Compliance with this policy will also be monitored as part of the HSG 65 Health and Safety audit process.

13. Main Relevant Legislation

This policy supports the legal duties placed on the organisation by the following: -

- Health and Safety at Work etc. Act 1974
- Health and Safety (Display Screen Equipment 1992
- Provision and Use of Work Equipment Regulations 1998
- Workplace (Health, safety and Welfare) Regulations 1992
- The Electricity at Work Regulations 1989

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Safer Manual Handling Policy

DATE OF MEETING	16th January 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	Jason Hoskins, Assistant Director of Estates Ceri Pell, VCC Health & Safety Advisor
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 outlines the requirements for safer manual handling within the organisation, in accordance with current legislation and the current All Wales NHS Manual Handling Passport Scheme. The Trust has a legal obligation under the Manual Handling Operations Regulations 1992 to make a suitable and sufficient assessment of the risk to employees from the manual handling of loads.

	The Regulations set out a hierarchy of measures that should be followed to reduce the risks from manual handling which are: - • to avoid manual handling operations so far as is reasonably practicable, • to assess the risk in any manual handling operations that cannot be avoided and • to reduce the risk of injury so far as reasonably practicable

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the policy revision.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Cynefin Group	26/09/2023
VCC Cynefin Group	26/09/2023
Senior Leadership Team Meeting	18/10/2023
Trust Health Safety & Fire Board Meeting	27/09/2023
Executive Management Board - RUN	04/12/2023
Summary and outcome of previous governance discussions No further amendments have been made following consultation of the policy document. Additional evidence has been included following consultation on the equality impact assessment.	

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

APPENDICES

1	Safer Manual Handling Policy
2	Equality Impact Assessment

1. SITUATION

The Trusts Safer Manual Handling Policy has undergone a review and consultation process in both VCC & WBS.

Minor amendments have been made to include updated links to relevant legislation, staff changes, and internal policies, procedures and pathways developed by the Integrated Care Team.

2. BACKGROUND

The aim of this policy is to minimise the risk of Musculo-skeletal injuries by maintaining a structured method of training and risk assessment, to reduce the need to undertake manual handling activities so far as is reasonably practicable.

To achieve this, it is necessary to ensure that adequate arrangements are in place to ensure the effective management of manual handling operations.

The Trust will ensure, so far as is reasonably practicable, an ergonomic approach to the provision of work equipment. Where identified by the risk assessment process and employees will be provided with the appropriate level of training.

The Trust is committed to complying with the standards set by the current All Wales NHS Manual Handling Passport Scheme.

3. ASSESSMENT

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any potential concerns arising from manual handling on a day-to-day basis.
- ensure that a risk assessment is carried out, in line with current legislation and trust policy.

- Identify any specific training that may be required.
- identify any health surveillance or support that may be required by staff that have an existing Musculo-skeletal injury / related illness, in order to maintain their safety whilst in work.
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates Department
- ensure that individuals are aware of their responsibilities for safer manual handling and have access to current information and risk assessments.
- consult and involve staff and safety representatives with local management arrangements.
- report all manual handling incidents.
- develop and implement a local departmental procedure or safe system of work for safer manual handling which will include.

  - ensuring that any manual handling equipment and manual handling operations under their management (whether owned, leased or contracted) satisfies the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) e.g.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Velindre NHS Trust shall assess the risk of exposure to staff and patients whilst performing manual handling techniques as part of their duties.

This is a refresh of an existing Policy and amendments made have undergone a consultation programme within the Divisional H&S meetings and SLT. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and Fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT and Manual Handling training programmes.

The policy protects the health of staff and patients by reducing the risk of exposure to incidents and muscular skeletal injuries associated with the moving and handling of patients and inanimate objects.

The Quality Safety and Performance Committee is requested to approve the policy revision and associated templated letters.

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).

	The policy provides a framework for reducing incidents and injuries associated with the manual handling of patients and inanimate objects and supporting the physical and mental wellbeing of staff following an incident.
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 in terms of keeping people safe and supporting recovery and positive wellbeing.

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:
	If more than one wellbeing goal applies please list below: This policy contributes to a healthier Wales by reducing the risk of Manual Handling incidents in Healthcare and reducing the negative mental health impact and anxiety associated with muscular skeletal injuries at work.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. No negative impacts has been identified.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999 Manual Handling Operations Regulations 1992 Provision and Use of Work Equipment Regulations 1998 Lifting Operations & Lifting Equipment Regulations 1998 Workplace (Health, Safety & Welfare) Regulations 1992 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 All Wales Manual Handling Passport and Information Scheme

6. RISKS

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

Ref: QS14

SAFER MANUAL HANDLING POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	16th January 2027
Version:	8.0

1. Policy Statement

Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, staff and visitors, whilst fulfilling its statutory obligations within the law.

The Trust has a legal obligation under the Manual Handling Operations Regulations 1992 to make a suitable and sufficient assessment of the risk to employees from the manual handling of loads.

The Regulations set out a hierarchy of measures that should be followed to reduce the risks from manual handling which are: -

- to avoid manual handling operations so far as is reasonably practicable,
- to assess the risk in any manual handling operations that cannot be avoided and
- to reduce the risk of injury so far as reasonably practicable

This policy outlines the requirements for safer manual handling within the organisation, in accordance with current legislation and the current All Wales NHS Manual Handling Passport Scheme.

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations, that are required to undertake any form of manual handling during the course of their duties.

3. Aims and Objectives

The aim of this policy is to minimise the risk of musculo-skeletal injuries as a result of manual handling by maintaining a structured method of training and risk assessment, to reduce the need to undertake manual handling activities so far as is reasonably practicable.

To achieve this, it is necessary to ensure that adequate arrangements are in place to ensure the effective management of manual handling operations.

The Trust will ensure, so far as is reasonably practicable, an ergonomic approach to the provision of work equipment. Where identified by the risk assessment process, employees will be provided with the appropriate level of training.

The Trust is committed to complying with the standards set by the current All Wales NHS Manual Handling Passport Scheme.

4. Responsibilities

4.1 The Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety

the Trust Board and Executive Management Board to be informed as required on manual handling issues that affect employees and/or the service users
- the Trust's Safer manual Handling Policy to be implemented
- supporting the training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy

4.2 Director of Strategic Transformation, Planning and Digital

The Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's Safer Manual Handling Policy is reviewed as and when appropriate
- regular updates on manual issues are reported to the Executive Management Board
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and health and safety risks arising from manual handling activities are minimised
- information regarding safer manual handling is effectively communicated throughout the Trust
- The approach to safer manual handling is both systematic and appropriate

In addition to the delegated responsibilities for managing Health and Safety, the Director of Strategic Transformation, Planning and Digital should ensure that: -

- risks to the health and safety of employees and others from manual handling operations affected by constraints of workplace environments, in property owned or leased by the Trust, are eliminated and / or reduced where possible
- risks to the health and safety of employees and others from manual handling operations affected by constraints of workplace environments, in new build and / or refurbished property owned by the Trust are eliminated / reduced by ensuring that suitable and sufficient space for manual handling operations and equipment is incorporated at the design stage of any new build or refurbishment to Trust property
- manual handling equipment provided as part of a new build or refurbishment scheme is suitable for the work environment and for employees that use the equipment. Work equipment should not pose a risk to the health and wellbeing of employees so far as is reasonably practicable.

4.3 Executive Director of Organisational Development and Workforce

The Director of Organisational Development and Workforce is responsible for ensuring that:

- there is an effective mandatory and induction training programme that includes manual handling advice and training, which is appropriately monitored and recorded
- arrangements are in place for health surveillance, support and counselling for employees with musculo-skeletal injuries.

4.5 Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for: establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where issues or concerns regarding manual handling can be discussed.

- liaising with the Trust Capital Planning and Estates Department
- ensuring that local procedures for the safer manual handling are developed and implemented in line with the overarching trust policy
- preparing and implementing the organisational structure and allocating responsibility for manual handling within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility
- identifying all manual handling risks associated with work and ensuring that associated risk assessments for manual handling activities have been implemented within the service area
- ensuring that employees have access to a level of training appropriate to their role
- any manual handling equipment and manual handling operations to satisfy the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)
- any manual handling equipment to satisfy the requirements of the Provision and Use of Work Equipment Regulations

4.6 Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to: -

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed local lead managers in developing and maintaining their safety management systems and training for manual handling . Competent advice may be sourced both internally and externally, dependant on the nature of the topic.
- provide support to the Executive Director with delegated responsibility for risk and health and safety management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of policy,
- ensure that statistical information is available on health and safety performance throughout the Trust and interpret such information in order to evolve action plans to improve or maintain standards
- investigate incidents and report to senior managers on findings and where necessary provide recommendations

4.7 Departmental Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any potential concerns arising from manual handling on a day to day basis.
- ensure that a risk assessment is carried out, in line with current legislation and trust policy. The assessment should include sufficient information about the risks that are faced and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific training that may be required by departmental staff via the PaDR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance or support that may be required by staff following an incident and liaise with local Workforce personnel to ensure that an appropriate level of occupational health support is readily accessible to staff

- identify any health surveillance or support that may be required by staff that have an existing musculo-skeletal injury / related illness, in order to maintain their safety whilst in work
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates Department
- ensure that individuals are aware of their responsibilities for safer manual handling and have access to current information and risk assessments.
- consult and involve staff and safety representatives with local management arrangements and report all manual handling incidents.
- develop and implement a local departmental procedure or safe system of work for safer manual handling which will include

  - ensuring that any manual handling equipment and manual handling operations under their management (whether owned, leased or contracted) satisfies the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) e.g.

    - all equipment used for lifting is fit for purpose, appropriate for the task, suitably marked and subject to statutory periodic 'thorough examination'. Records must be kept of all thorough examinations and any defects found must be reported to both the person responsible for the equipment and the relevant enforcing authority.

  - ensuring that any manual handling equipment under their management (whether owned, leased or contracted) satisfies the requirements of the Provision and Use of Work Equipment Regulations e.g.

    - the equipment is constructed or adapted to be suitable for the purpose it is used or provided for
    - take account of the working conditions and health and safety risks in the workplace when selecting work equipment
    - work equipment is only used for suitable purposes
    - work equipment is maintained in an efficient state, in efficient working order and in good repair
    - where equipment has a maintenance log, keep this up to date
    - where the safety of work equipment depends on the manner of installation, it must be inspected after installation and before being put into use
    - where equipment is exposed to deteriorating conditions liable to result in dangerous situations, it must be inspected to ensure faults are detected in good time so the risk to health and safety is managed
    - ensure that all people using, supervising or managing the use of work equipment are provided with adequate, clear health and safety information. This will include, where necessary, written instructions on its use and suitable equipment markings and warnings
    - ensure that all people who use, supervise or manage the use of work equipment have received adequate training, which should include the correct use of the equipment, the risks that may arise from its use and the precautions to take
    - that work equipment is provided with appropriately identified controls for starting, stopping and controlling it, and that these control systems are safe
    - where appropriate, provide suitable means of isolating work equipment from all power sources (including electricity)

Following a manual handling incident the manger will:

- ensure that the incident is reported in a timely manner into the Datix Risk Management system
- discuss the incident with the staff member
- where appropriate investigate the incident
- ensure the controls are adequate to manage the risk
- provide a supporting role to encourage staff well being
- refer staff to occupational health where required
- seek advice or guidance where necessary
- identify and escalate any identified risks, in accordance with the Trust risk assessment policy
- ensure that any outcome e.g. a change in process, further training required, will formally be fed back to the staff member concerned.

4.8 Employees

All employees are expected to:

- act in a responsible manner and treat others with dignity and respect whilst performing their manual handling duties
- comply with policies and procedures developed to protect their health and safety
- report all manual handling incidents and near misses
- discuss any health and safety concerns with their manager that may affect their ability to undertake manual handling duties
- cooperate with their manager in relation to health and safety and risk assessment
- undertake the relevant level of manual handling training

4.9 Occupational Health Departments

The Trust has service levels agreements in place for the provision of Occupational Health which is covered by local procedures. Please seek advice from your Organisational Development and Workforce department, who will be able to direct you to the appropriate service provider. The manager is able to refer staff involved in a manual handling incident where health issues have been identified and a self-referral is available to members of staff that have existing musculo-skeletal injuries that affect their ability to undertake their manual handling duties. For those with access to the Cardiff and Vale University Health Board Occupational Health Service, there is a self-referral pathway for OH physiotherapy.

5. Definitions

Terminology used throughout this policy is defined below:-

- ***Manual Handling Operation*** - Any transporting or supporting of a load, including the lifting, putting down, pushing, pulling, carrying or moving by hand or bodily force.

- ***Minimal Handling*** - The process by which risks associated with a manual handling operation are reduced as far as is reasonably practicable.

- ***Load*** - a moveable object, including any person or animal

- ***Hazard*** - something with the potential to cause harm.

- ***Risk Assessment*** – The calculation of the likely outcome of the hazards posed by a manual handling operation should they come to fruition weighed against the control measures in place.

- ***The Ergonomic Approach***- the matching of the demands of work with the worker's capabilities and limitations.

- ***Emergency Situation*** - An unforeseeable situation in which an individual must be moved to safety immediately and there is no time to get equipment or plan the move in detail. Risks may have to be taken. It should be appreciated that these situations will be extremely rare.

6. Implementation / Policy Compliance

To ensure the effective implementation of this Policy the following local arrangements must be put into place: -

- ***Manual Handling Trainers*** – An adequate number of trainers will be identified (either internally or externally) to ensure that all members of staff who perform manual handling tasks receive appropriate training. Each trainer will be expected to have the level of training and skills to perform their roles in accordance with the All Wales Manual Handling Training Passport and Information Scheme.

- ***Employees*** – the training needs of each employee will be assessed in accordance with the requirements of the Core Skills Training Framework and the All Wales NHS Manual Handling Passport Scheme.

- ***Agency/Temporary Staff*** – All agency/temporary staff must have received adequate training prior to commencing any duties within the Trust. This instruction must provide them with the basic skills that they will need to fulfil their placement safely.

- ***Students/Trainees*** – All students/trainees must have been provided with adequate instruction by their training provider prior to commencing a placement with the organisation. This instruction must provide them with the basic skills that they will need to fulfil their placement safely.

- ***Volunteers -*** All volunteers should also receive adequate training to enable them to undertake any duties within the Trust.

- ***Uniforms / Clothing*** - The Trust will ensure that uniforms and personal protective equipment provided are compatible with the handling tasks to be undertaken.

  Staff that do not wear a uniform must ensure that clothing they wear at work is compatible with the handling tasks they undertake at work. They should ensure that the fit of their uniform/clothing allows them to move freely and adopt positions required for any manual handling task.

Footwear worn by staff that perform a considerable amount of manual handling tasks, or where tasks that are performed require it, should have an enclosed heel and toe, which will help to provide a stable base for the handler.

Where personal protective equipment is required in order to undertake manual handling duties safely, this will be provided by the Trust, without charge.

- ***Provision of Equipment*** - Appropriate handling equipment should be provided where a risk has been identified. The following should be taken into consideration: -

  - An inventory of handling equipment used within an area should be held locally
  - All equipment must be suitable and fit for the purpose for which it has been provided and a suitable quantity supplied.
  - Any equipment that is/or thought to be faulty must be taken out of use and repaired or a replacement provided.
  - All employees should receive suitable and sufficient instruction and training on all aspects of specific manual handling equipment before use.
  - Local arrangements should outline the role of the manual handling trainer and the role of infection control in the procedure for the purchase of equipment
  - Local arrangements should outline the requirement for maintenance of equipment and inspection in accordance with LOLER 1998.

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. References

Health and Safety Executive (HSE) Manual Handling At Work
Health and Safety Executive – MusculoSkeletal Disorders (MSDs)
Health and Safety Executive – Thorough examinations and inspections of lifting equipment
All Wales NHS Manual Handling Passport Scheme

9. Getting Help

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ
Health and Safety	**Trust Health & Safety Manager** Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522 **VCC Health & Safety Advisor** Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL Tel: 02920615888 **WBS Health & Safety Advisor** Welsh Blood Service Ely Valley Road Talbot Green Pontyclun CF72 9WB Tel: 1797 2356
Occupational Health	Cardiff and the Vale University LHB Heath Park Cardiff CF14 4XW E-mail: occupational.health@wales.nhs.uk Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above named local health board. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover pre-employment checks, formal health surveillance, health assessments in connection with fitness to work, identification of occupational hazards and risks, along with support and advice for staff.

10. Related Policies

Reference should also be made to the following Trust Policies:

- Bedrails Procedure
- Falls Pathway
- VCC Falls Policy
- Enhanced Supervision Policy
- Health, Safety and Welfare policy QS18
- Workplace Equipment Policy QS36
- Medical Devices and Equipment Management Policy QS 24
- Decontamination Policy IPC 04

11. Information, Instruction and Training

Currently, there are 3 main levels of training within the Core Skills Training Framework: -

- Level 1a Theory of Inanimate Load Handling, which covers Module A of the All Wales Manual Handling Training Passport and Information Scheme
- Level 1b The practical implementation of Inanimate Load Handling, which covers Module B of the All Wales Manual Handling Training Passport and Information Scheme.
- Level 2 (Client Handling) includes Modules A,B, C plus any other relevant module of the All Wales Manual Handling Training Passport and Information Scheme

It will be for each departmental manager to determine which level of training is required by undertaking a Training Needs Analysis (TNA) for all staff. Where level 2 training contains elements of tasks that are not undertaken, e.g. hoisting, this element of the training will not be required. This should be documented on the appropriate Training Record.

Frequency of training and / or refresher training should be based on competency and should be undertaken as required by the Core Skills Training Framework.

Initial training should take place upon employment with the organisation unless the employee can demonstrate existing compliance by the submission of a current Passport form from their previous NHS employer.

No manual handling operations should be undertaken until training has been completed in accordance with the required TNA.

12. Main Relevant Legislation

This policy supports the legal duties placed on the organisation by the following: -

• Health & Safety at Work etc. Act 1974
• Management of Health & Safety at Work Regulations 1999
• Manual Handling Operations Regulations 1992
• Provision and Use of Work Equipment Regulations 1998
• Lifting Operations & Lifting Equipment Regulations 1998
• Workplace (Health, Safety & Welfare) Regulations 1992
• Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2013

Appendix 1 - Link to the All-Wales NHS Manual Handling Passport Scheme - Standards

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Control of Substances Hazardous to Health (COSHH) Policy

DATE OF MEETING	16th January 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	Jason Hoskins, Assistant Director of Estates Matthew Bellamy, WBS Health, Safety and Environmental Compliance Manager
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 COSHH Policy outlines how the VUNHST will ensure that chemicals stored and handled in a safe manner and exposure to hazardous substances is managed during activities across the divisions. The policy sets out how the Trust meets the requirements of the Control of Substances Hazardous to Health Regulations to allow the safe storage, handling and use of chemicals. The policy outlines the requirements to complete a suitable and sufficient COSHH risk assessment for all hazardous chemicals and substances used and ensure that the relevant

	controls are put in place following the hierarchy of elimination, substitution, isolation or engineering controls, administrative controls and PPE.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the policy revision.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Cynefin Group	26/09/2023
VCC Cynefin Group	26/09/2023
Senior Leadership Team Meeting	13/12/2023
Trust Health Safety & Fire Board Meeting	27/09/2023

Summary and outcome of previous governance discussions

No further amendments have been made following consultation of the policy document. Additional evidence has been included following consultation on the equality impact assessment.

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

APPENDICES	
1	**Control of Substances Hazardous to Health (COSHH) Policy**
2	Equality Impact Assessment

1. SITUATION

1.1 The Trust COSHH Policy required review to ensure that it is in line with legislation. The review and consultation process in both VCC & WBS.

2. BACKGROUND

The objectives of the policy are to: -

- To ensure that chemicals and substances are stored and handled safely within the divisions of VUNHST.
- Provide detail on how the COSHH assessments are undertaken, recorded and reviewed to identify hazards and risks associated with the use of hazardous substances.
- Provide information to employees on the risks and the precautionary measures for each substance.
- Provide detail of the training and support that is available to employees that use the particular hazardous substances and around the completion of COSHH assessments.
- Ultimately help to eliminate or where this is not possible reduce the risks of exposure to the hazards associated with the use of hazardous substances.
- Look at substituting more harmful with less harmful materials.
- Identify higher risks hazardous substance users and ensure that controls measures are put in place to eliminate or reduce the risks.
- Implement within the division.

3. ASSESSMENT

3.1 The policy requires:

- A COSHH assessment is carried out for each hazardous substance that may be used by employees within VUNHST.
- The risks from the use of these materials are eliminated or reduced by implementing control measures set out in Material Safety Data sheets and the COSHH assessment.
- Departmental COSHH champions identified to coordinate the COSHH assessments on Sypol COSHH Management System

- COSHH specific information and training is provided for substance users.
- Ensures that the relevant information is available to those involved in the storage and handling of hazardous materials.
- Ensures that contractors have COSHH assessments in place for the materials that they use or may be exposed to.
- Costs associated with the purchase of licenses for the Sypol COSHH management system. Sypol completes and stores the COSHH assessments and prompts review.

4. SUMMARY OF MATTERS FOR CONSIDERATION

This is a refresh of an existing Policy and amendments made have undergone a consultation programme within the Divisional H&S meetings and SLT. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and Fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT and V&A training programmes.

The policy protects the health of staff that use hazardous chemicals within VUNHST and will ultimately reduce the risk of injury.

The Executive Management Board is requested to endorse the policy revision and associated templated letters for approval at the Quality & Safety Performance Committee

5. IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ The 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 policy provides a framework for reducing risks of staff that are using hazardous chemicals during their day to day work ensuring that information is available on the hazards and the controls and precautions for safe use of materials supporting the wellbeing of staff.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required This policy applies to all staff identified as involved in the storage and handling of potentially hazardous substances regardless of the social economic status and has a positive impact on all groups in terms of keeping people safe and supporting recovery and positive wellbeing.

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:
	If more than one wellbeing goal applies please list below: This policy contributes to a healthier Wales by reducing the risks associated with the use of chemicals that may be hazardous. Ensures that
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Legal requirement to fund eye tests and funds towards glasses if needed as a result of DSE use **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. The majority of protected characteristic

	areas will have no impact. A positive impact has been identified for some of the protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999 The Control of Substances Hazardous to Health Regulations Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

6. RISKS

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

Ref: QS33

POLICY FOR THE CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

Executive Sponsor & Function	Director of Strategic Transformation, Planning, and Digital Health and Safety Function
Document Author:	Trust Health and Safety Manager
Approved by:	Quality and Safety Committee
Approval Date:	September 2023
Date of Equality Impact Assessment:	May 2018
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	September 2026
Version:	5.0

Contents **Page**

2. Policy Statement

Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, staff and visitors, whilst fulfilling its statutory obligations within the law.

This policy outlines the requirements for the management and control of substances that are hazardous to health (CoSHH) within the organisation, in accordance with current legislation. It includes the use of and the storage and transportation of any substance that is hazardous to health.

3. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations. It applies to all areas where hazardous substances are used, stored or generated.

Failure to follow guidance in this policy will increase the risk of hazardous substance related injuries / illness to the user, other staff, patients, donors and visitors.

4. Aims and Objectives

Velindre University NHS Trust intends, so far as is reasonably practicable, to protect its employees and those affected by its undertaking from the harmful effects of substances that may be used in fulfilling its business.

5. Responsibilities

5.1. Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- ensuring that there is an Executive Director appointed as a lead for health and safety
- ensuring that the Trust Board and Executive Management Board is informed as required on health and safety matters affecting employees and/or the public
- ensuring that the Trust's CoSHH policy is implemented
- supporting training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy

5.2. Director of Strategic Transformation, Planning and Digital

The Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's CoSHH policy is reviewed as and when appropriate
- regular updates on health and safety issues are reported to the Executive Management Board

In addition to the delegated responsibilities for managing Health and Safety, the Director of Strategic Transformation, Planning and Digital should ensure that:

- there are appropriate arrangements in place to respond to major incidents and emergencies which could expose people to substances hazardous to health.
- risks to the health and safety of employees and others from workplace environments, in new build and / or refurbished property owned by the Trust are eliminated / reduced by ensuring that precautions for the control of substances hazardous to health are incorporated at the design stage of any new build or refurbishment to Trust property
- work equipment provided as part of a new build or refurbishment scheme is suitable for the work environment and for employees that use the equipment. Work equipment (including the relevant level of personal protective equipment), should not expose employees to any hazardous substance so far as is reasonably practicable.

5.3. Executive Director of Organisational Development and Workforce

The Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective training programme that includes specific CoSHH training where required, which is appropriately monitored and recorded
- reports on work related illness or work related ill health that is attributable to substances hazardous to health, are submitted to the trust Estates Assurance Meeting.
- pre-employment screening is carried out and provide advice to managers on any pre-existing conditions identified as part of that process
- arrangements are in place for health surveillance of in-service employees and others, such as work experience and students, where there is a specific requirement under CoSHH regulation.

5.4. Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to: -

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed health and safety lead managers in developing and maintaining their CoSHH safety management systems and training. Competent advice may be sourced both internally and externally, dependant on the nature of the topic.

- provide support to the Executive Director with delegated responsibility for CoSHH management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of, and monitoring compliance with, the CoSHH policy.
- ensure that information is available throughout the Trust on the management of CoSHH in order to evolve action plans to improve or maintain standards
- provide support to investigate incidents and report to senior managers on
- findings and, where necessary, provide recommendations

5.5. Health and Safety Manager and Divisional H&S Advisors/Leads

The Health and Safety Manager with the support of Divisional H&S leads is responsible for providing advice and guidance to managers on the effective implementation of this policy and safe working methods.

5.6. Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where CoSHH issues or concerns can be discussed.
- liaising with the Trust Capital Planning and Estates department.
- ensuring that local CoSHH procedures are developed and implemented in line with the overarching trust policy
- preparing and implementing the organisational structure and allocating responsibility for CoSHH management within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility
- ensuring that CoSHH risk assessments have been implemented for all relevant activities within the service area
- ensuring that employees are trained to use, handle and store safely and correctly, any substances used in work activities
- ensuring that they are familiar with and ensure that all employees under their control are aware of:
- any contingency plan involving spillage
- the safe disposal of unwanted substances
- first aid arrangements appropriate to the substances used

5.7. Department Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any substances hazardous to health that are in use within their department and ensure that the appropriate paperwork is accessible to staff e.g.
- safety data sheets etc.

- ensure that a CoSHH hazard and risk assessment is carried out, in line with current legislation and trust policy. The assessment should detail all exposure scenarios and include all activities to ensure that staff have access to sufficient information about the risks they face and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific CoSHH training that may be required by departmental staff via the PaDR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance that may be required for staff and liaise with local Workforce personnel to ensure that an appropriate level of occupational health surveillance is readily accessible to staff, e.g. skin checks, lung function tests etc.
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates department
- ensure that individuals are aware of their responsibilities for CoSHH management and have access to current / up to date safety data sheets and risk assessments.
- develop and implement a local departmental CoSHH procedure or safe system of work
- consult and involve staff and safety representatives with local CoSHH management
- ensure that all hazardous substances are used, stored and handled in the prescribed manner

5.8. CoSHH department Leads

Department Managers will designate a member of staff within the department that will have the responsibility to manage the CoSHH arrangements for that particular Department. They will be trained on the use of Sypol the current CoSHH management system. This will ensure that effective CoSHH management system is maintained within the departments that are using the hazardous substances. Divisions may rely on divisional safety leads to provide them with advice and guidance appropriate to their service needs.

CoSHH compliance within the department will be monitored by the divisional H&S Managers and will act as the main contact between the division Health & Safety Groups and the Trust Health Safety and Fire Board in order that effective communication is created and maintained.

5.9. Safety Representatives

Employees who have been formally appointed by their professional organisation or Staff Side organisation, to act as a health and safety representative for their members are entitled to make representation to their managers on general matters affecting the health safety and welfare at work of any employee and investigate potential CoSHH related hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace

5.10. Individual Employees

All employees have a statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.

- all employees are required to co- operate with their Manager/Supervisor to enable the Trust to meet its own legal duties under CoSHH regulation
- all employees are expected, in the course of their employment, to report to their Manager/Supervisor any hazardous situations or defective equipment that could result in exposure to a hazardous substance and to report incidents in line with local reporting procedures
- to follow the guidance contained in CoSHH risk assessments and to follow the risk reduction control measures recommended, e.g. using/wearing safety equipment / devices provided to them
- where appropriate, to attend occupational health medical examinations at the appointed time and give information about their health that may be reasonably required.

5.11. Committees and Management Groups

The following committees / groups will provide advice to the appropriate Executive Director in order to ensure that accountability is being discharged properly and to ensure that the aims and objectives of the Trust are being achieved. Committees include:

- Trust Estates Assurance Meeting
- Trust Infection Prevention and Control Management Group
- Trust Medical Devices and Equipment Management Group and / or relevant sub group
- Trust Water Safety Group
- Trust Research, Development and Innovation Operational Management Group

6. Definitions

6.1. Hazardous substances include:

○ Substances used directly in work activities (e.g. cleaning agents) ○ Substances generated during work activities (e.g. fumes from welding) ○ Biological agents such as bacteria and other micro-organisms.

Under CoSHH Regulations, there are a range of substances regarded as hazardous to health which include: -

- Substances or mixtures classified as dangerous by law (listed in table 3.2 of part 3, Annex VI of (CLP Regulations). These can be identified by their warning label which will have one or more of the following hazard symbols and the supplier must provide a safety data sheet for them: -

 Explosive (Symbol: exploding bomb)	 Hazardous to the environment (Symbol: Dead tree and fish)	 Corrosive (Symbol: Corrosion)
 Flammable (Symbol: flame)	 Health hazard/Hazardous to the ozone layer (Symbol: Exclamation mark)	 Gas under pressure (Symbol: Gas cylinder)
 Oxidising (Symbol: flame over circle)	 Serious health hazard (Symbol: health hazard)	 Acute toxicity (Symbol: Skull and crossbones)

- Substances with workplace exposure limits are listed in the HSE publication EH40
- Biological agents (bacteria and other micro-organisms), if they are directly connected with the work e.g. exposure to bacteria from an air conditioning system that is not properly maintained).
- Any kind of dust if its average concentration in the air exceeds the levels specified in the CoSHH regulations.
- Any other substance which creates a risk to health, but which for technical reasons, are covered by different legislation including asphyxiates, pesticides, medicines, cosmetics or substances produced in chemical processes.

Substances that are hazardous to health, can take many forms and include liquids, fumes, dusts, vapours, mists, nanotechnology, gases (and asphyxiating gases) and biological agents (germs) that cause diseases such as leptospirosis or legionnaires disease and germs used in laboratories

If the packaging has any of the hazard symbols then it is classed as a hazardous substance.

CoSHH does not apply to: -

- Asbestos, Lead or Radioactive Substances, which have their own legislation
- Biological Agents not directly related to the work environment (e.g. flu)
- Substances which are hazardous only because they are radioactive, at high pressure, at extreme temperature or have explosive or flammable properties (other regulations apply to these risks)

7. Implementation/Policy Compliance

In order to comply with the CoSHH Regulations, the following action must be taken locally to prevent or reduce workers exposure to hazardous substances: -

• Identify what substances are present, or in use, that would be classed as hazardous to health and find out what the health hazards are;

Consider the following:

- What do you do that involves hazardous substances?
- Can you avoid using a hazardous substance or use a safer process – preventing exposure, e.g. using water-based rather than solvent-based products, applying by brush rather than spraying?
- Can you substitute it for something safer – e.g. swap an irritant cleaning product for something milder, or using a vacuum cleaner rather than a brush?
- Can you use a safer form, e.g. can you use a solid rather than liquid to avoid splashes or a waxy solid instead of a dry powder to avoid dust?

• decide how to prevent harm to health by undertaking a CoSHH risk assessment;

If you can't prevent exposure, you need to control it adequately by applying the HSE's principles of good control practice.

Minimise emission, release and spread
Consider routes of exposure
Choose control measures proportionate to the risk
Choose effective control options
Personal protective equipment – the final control option
Review the effectiveness of controls
Provide information and training
New measures, new risks

The above principles are all equally important in achieving adequate control. Also, the Principles are not listed in rank order: The first principle is not more important than the last principle, although there is a logical progression in how they are presented and should be considered.

7.1. Risk Assessment

The COSHH Regulations require an assessment of risk to be undertaken for tasks involving the use of hazardous substances (see section 5 for definition of a hazardous substance).
When undertaking the assessment, consideration should be given to the following:

- The hazardous properties of the substance
- Information on health effects provided by the supplier
- The level, type and duration of exposure
- The circumstances of the work, including the quantity used
- The potential routes of exposure, e.g. inhalation, ingestion, injection and absorption
- Activities such as maintenance where there is the potential for a high level of exposure
- Any relevant workplace exposure limit or similar occupational exposure limit
- The effect of preventive and control measures which have been or will be taken
- The results of relevant health surveillance
- The results of monitoring of exposure
- The risk presented by exposure to a combination of substances
- Any additional information needed in order to complete the risk assessment.

The Health and Safety Executive (HSE), in collaboration with the Trades Union Congress (TUC) and the Confederation of British Industry (CBI), have developed a *COSHH Essentials* website and where there is no local access to COSHH risk assessments, this website can be referenced. *COSHH essentials* is a generic risk assessment scheme for a wide range of hazardous substances covered by CHIP and COSHH. It leads users to appropriate control advice for a range of common tasks.
COSHH essentials can be used as a basis for the recording of the risk assessment. Whilst *COSHH essentials* has been designed to ensure that a precautionary approach is taken towards control it is a generic guide and cannot guarantee that in all circumstances it will lead to full compliance with the Regulations assessment control requirements.

7.2. Information, instruction and training

Following the completion of a COSHH risk assessment the need for information, instruction and training must be considered and appropriate arrangements made by the manager. These might range from a simple instruction to regular formal sessions. Wherever employees are exposed to hazardous substances they must receive information, instruction and, where appropriate, training in the following:

- The risks to health created by their exposure
- The precautions that should be taken
- Control measures, their purpose and how to use them

- How to use personal protective equipment and clothing provided ● Results of any exposure monitoring and health surveillance.

7.3. Health surveillance

In certain circumstances it will be necessary to undertake health surveillance for employees. Health surveillance is a systematic process which is required when:

a) there is an identifiable disease or adverse health effect associated with the work,
b) there is a reasonable possibility that the effect may occur under the conditions of the work (e.g. if control is dependent on Personal Protective Equipment) and
c) there is a valid means for detecting the effect before it becomes permanent.

The objective of health surveillance is to:

- Protect the health of individual employees by detecting as early as possible adverse changes which may be caused by exposure to hazardous substances
- Help evaluate the measure(s) taken to control exposure
- Collect, keep up to date, and use data and information for determining and evaluating hazards to health.

Health surveillance will be undertaken via the Occupational Health Service, under local arrangements, as required.

7.4. Emergency Arrangements

Where the risks of a substance escaping are high, or the substance is especially hazardous, the local manager will ensure that emergency arrangements are in place as part of the risk assessment process. Guidance can be found on the supplier's Safety Data Sheet.

7.5. Personal Protective Equipment

Where the risk assessment has concluded that it is necessary to use personal protective equipment (PPE), this shall comply with the provisions of the Personal Protective Equipment Regulations 2002.

The main requirement of the Regulations is that PPE is to be supplied and used at work wherever there are risks to health and safety that cannot be adequately controlled in other ways.

The Regulations also require that PPE

- is properly assessed before use to ensure it is suitable;
- is maintained and stored properly;
- is provided with instructions on how to use it safely; and ● is used correctly by employees.

PPE, including protective clothing, must be

- properly stored in a well-defined place;
- checked at suitable intervals; and
- when discovered to be defective, repaired or replaced before further use.
- personal protective equipment which may be contaminated by a substance hazardous to health must be removed on leaving the working area and kept apart from uncontaminated clothing and equipment. This equipment must be subsequently decontaminated and cleaned or, if necessary, destroyed.

7.6. Engineering controls

All control measures in use should be visually checked, where possible, at appropriate intervals and without undue risk to maintenance staff. In the case of local exhaust ventilation (LEV) and work enclosures, such checks should be carried out at least once a week.

Procedures for servicing equipment should specify:

(a) which engineering control measures need servicing;
(b) the work to be carried out on each of them;
(c) when the work should be done;
(d) who is to do the work and who is responsible for it; and (e) how to put right any defects found.

In most circumstances control measures will include defined working procedures. These should be observed regularly to check that they are still being followed. They should also be reviewed periodically to confirm that they are still appropriate and workable and to see whether they can be improved.

Local exhaust ventilation plant (e.g. fume cupboards) must be inspected at least once every 14 months. Where respiratory protective equipment (RPE) (other than disposable RPE) is provided, thorough examination and, where appropriate, testing of that equipment must be carried out at suitable intervals. Records of examinations and tests carried out, and of any repairs carried out as a result of those examinations and tests, must be kept for at least 5 years.

7.7. Exposure monitoring

Where the COSHH assessment shows it is necessary, valid and suitable occupational hygiene techniques should be used to estimate the amount of employees' exposure to substances hazardous to health. For airborne contaminants, this measurement will normally involve collecting a sample of air from the employee's breathing zone using personal sampling equipment. It may also, where appropriate, involve sampling the air at the workplace periodically or continuously, using static sampling equipment.

Where air sampling techniques alone may not give a reliable indication of exposure, e.g. where there is skin absorption, ingestion or where RPE is being used to adequately control exposure, biological monitoring is often a useful complementary technique to air monitoring.

7.8. Monitoring and auditing

As part of the Health and Safety Audit process, evidence will be required to demonstrate that assessment of the use of Hazardous substances has looked at: -

- Investigation into whether there is a less hazardous alternative for the particular hazardous substances in current use.
- Any concerns in relation to occupational exposure to hazardous substances
- Confirmation that risk assessments have been either completed or reviewed and that all staff have been made aware of any associated risks through Sypol.
- The availability of current Safety Data Sheets for all hazardous substances in use within their remit.
- Confirmation that engineering controls such as LEV are inspected and maintained to schedule and that records are kept for the required 5 years
- The above information will be provided via Sypol.

7.9. General Housekeeping

It is vitally important that all chemicals that are used, handled and stored, are kept within their original packaging as far as reasonably practicable. This will ensure that the necessary information / hazardous nature of the chemical is available and visible to all. If the safety data sheet requires a specific method of storage e.g. locked cabinet, then this should be available prior to the procurement of the hazardous substance. Suitable spill kits should be readily available for use, along with PPE required to control or clear a spillage, as required by the safety data sheet. Decontamination procedures should be utilised as appropriate and appropriate measures in place to dispose of any spillage.

7.10. Procurement

Procurement have a role to play in ensuring that any potentially hazardous materials that they may procure or assist with procuring are as safe as possible for use.

This involves ensuring that Safety Data sheets can be obtained form the supplier and that the least harmful alternative is available / considered.

They would need to be aware of legislation such as REACH that may apply to certain chemicals and pass this information on to the end user.

Where necessary Procurement would need to pass on information that they are sent from the supplier, relating to he hazards of he chemical, to the end user.

8. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

9. References

- The Health and Safety Executive provides access to a wide variety of guidance and information via its website
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Approved code of practice and guidance
- Working with substances hazardous to health - What you need to know about COSHH
- HSE COSHH Essentials Website
- Personal Protective Equipment relevant to CoSHH Regulations
- EH40/2005 Workplace Exposure Limits: Containing the list of workplace exposure limits for use with the Control of Substances Hazardous to Health Regulations 2002 (as amended)
- The European Regulation (EC) No 1272/2008 on classification, labelling and packaging of substances and mixtures

10. Getting Help

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined overleaf:-

Assistant Director of Estates, Environment and Capital Development	Mr Jason Hoskins Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ E-mail: Jason.Hoskins@wales.nhs.uk
Health and Safety	Ceri Pell VCC Health & Safety Advisor Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL United Kingdom E-mail: ceri.pell@wales.nhs.uk Matthew Bellamy WBS Health Safety & Environmental Compliance Manager Welsh Blood Service

Talbot Green
Pontyclun CF72 9WB
United Kingdom
E-mail: matthew.bellamy@wales.nhs.uk

Fire (precautions and training) Robin Weaver
Velindre University NHS Trust
Headquarters
2 Charnwood Court
Heol Billingsley, Parc Nantgarw
Cardiff CF5 7QZ

E-mail: Robin.Weaver@wales.nhs.uk

Infection Prevention and Control Hayley Jeffries
Senior Infection Control Nurse
Velindre Cancer Centre
Whitchurch
Cardiff CF14 2TL
Tel: WHTN 01875 6129
E-mail: Hayley.Jeffreys@wales.nhs.uk

Occupational Health Cardiff and the Vale University LHB
Heath Park
Cardiff CF14 4XW
Tel: 02920743264
E-mail: occupational.health@wales.nhs.uk

Occupational Health provision has been established via formal service level agreements with the above named local health boards. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover formal health surveillance and health assessments in connection with identification of occupational hazards and risks, along with support and advice for staff.

11. Related Policies

There are numerous policies which should be considered alongside this policy. They are available via the trust's intranet page.

12. Information, Instruction and Training

See sections 4.7, 4.8, 6 & 6.2.

13. Main Relevant Legislation

- The Health and Safety at Work etc., Act 1974
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Supported by the control of substances hazardous to health (L5) sixth Edition, published 2013, Approved Code of Practice and Guidance
- See also section 8 – “References”

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Policy for Management of Latex and Latex Allergy

DATE OF MEETING	16th January 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	Jason Hoskins, Assistant Director of Estates Matthew Bellamy, WBS Health, Safety and Environmental Compliance Manager
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 following policy sets out how exposure of VUNHST staff to latex is managed and that those that are allergic to latex are protected. The policy sets out a latex free approach to items such as PPE that may come into contact with the skin. The trust has a legal obligation to comply with the COSHH regulations under which Latex is classed as a potentially hazardous substance.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the policy revision.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Cynefin Group	26/09/2023
VCC Cynefin Group	26/09/2023
Senior Leadership Team Meeting	13/12/2023
Trust Health Safety & Fire Board Meeting	27/09/2023
Summary and outcome of previous governance discussions No further amendments have been made following consultation of the policy document. Additional evidence has been included following consultation on the equality impact assessment.	

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

APPENDICES	
1	**Policy for Management of Latex and Latex Allergy**
2	Equality Impact Assessment

1. SITUATION

1.1 The Trust Policy for Management of Latex and Latex Allergy required review to ensure that it is in line with legislation and the current practice with in the VUNHST.

2. BACKGROUND

The objectives of the policy are to: -

- To ensure that any employees that may have an allergy to latex are identified and protected.
- That Items containing latex are not purchased and a Latex Free policy is maintained by Procurement services.
- Provide guidance to employees on the hazards and risks.
- Ultimately reduce the risks of latex exposure to those that may have an allergic reaction.
- Identify higher risk groups that may have latex allergy
- Ensure that mitigating measures are put in place to eliminate or reduce the risks.
- Implement within the division

3. ASSESSMENT

3.1 The policy requires:

- Education in the recognition and management of reactions to latex
- Employees who may have latex allergy to highlight to their manager DSE.
- Link in with Occupational Health if required
- Procurement to monitor items that may contain latex and adopt a latex free policy.
- Purchase from an all Wales health supply contract

4. SUMMARY OF MATTERS FOR CONSIDERATION

The policy ensures that the risks of Latex use by those staff that are identified as vulnerable to allergic reaction are identified and managed.

Guidance to be made available to staff on the risks and the requirements through the policy.

This is a refresh of an existing Policy and amendments made have undergone a consultation programme within the Divisional H&S meetings and SLT. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and Fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT and V&A training programmes.

The policy protects the health of staff identified as at risk from exposure to Latex and will ultimately reduce the risk of exposure and a reaction as a result.

The Executive Management Board is requested to endorse the policy revision and associated templated letters for approval at the Quality & Safety Performance Committee

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ The 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 policy provides a framework for reducing incidents of WRULDS and RSI, Musculoskeletal injuries, exacerbating existing conditions that DSE users may have and supporting the wellbeing of staff.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required This policy applies to all staff identified as DSE users regardless of the social economic status and has a positive impact on all groups in terms of keeping people safe and supporting recovery and positive wellbeing.

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:
	If more than one wellbeing goal applies please list below: This policy contributes to a healthier Wales by reducing the risks from exposure to Latex
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. The majority of protected characteristic areas will have no impact. A positive impact has been identified for some of the protected characteristics.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 The Management of Health and Safety Regulations 1999 The Control of substances Hazardous to Health Regulations Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

6. RISKS

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

Ref: QS09

POLICY FOR THE MANAGEMENT OF LATEX AND LATEX ALLERGY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital Health and Safety
Document Author:	Trust Health and Safety Manager
Approved by:	Quality and Safety Committee
Approval Date:	September 2023
Date of Equality Impact Assessment:	23 May 2018
Equality Impact Assessment Outcome:	This policy has been screened for to equality. No potential negative impact has relevance been identified.
Review Date:	Sept 2026
Version:	7.0

Contents **Page**

1. Policy Statement

The Health and Safety Executive (HSE) advise that Natural rubber latex (NRL) proteins have the potential to cause asthma and urticaria. More serious allergic reactions, such as anaphylaxis, are also possible. NRL proteins are substances hazardous to health under COSHH (Control of Substances Hazardous to Health Regulations).

Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, donors, staff and visitors, whilst fulfilling its statutory obligations within the law.

This policy outlines the requirements for the management of Latex and Latex Allergy, within the organisation, in accordance with current legislation and should be read in conjunction with the Trust Policy QS33 Policy for the Control of Substances Hazardous to Health (CoSHH)

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations. It applies to all areas where products containing NRL are used or stored.

Failure to follow guidance in this policy will increase the risk of NRL related allergies to the user, other staff, patients and visitors.

3. Aims and Objectives

Velindre University NHS Trust intends, so far as is reasonably practicable, to protect its employees and those affected by its undertaking from the harmful effects of NRL that may be used in fulfilling its business. Every effort has been undertaken to ensure that all gloves used and purchased by the organisation are now latex free. However there may be other products in use that may contain NRL. It is also recognised the NRL may be in products within other NHS organisations or in the community, where staff undertake their duties.

The policy includes sections relating to the management of staff or service users with known or suspected latex allergy and for the management of those considered to be at increased risk.

4. Responsibilities

4.1 Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- ensuring that there is an Executive Director appointed as a lead for health and safety
- ensuring that the Trust Board and Executive Management Board is informed as required on health and safety matters affecting employees and/or the public
- ensuring that the Trust's policy on the Management of Latex and Latex Allergy is implemented
- supporting training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy

4.2 Director of Strategic Transformation, Planning and Digital

The Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's policy on the management of Latex and Latex Allergy is reviewed as and when appropriate
- regular updates on health and safety issues are reported to the Executive Management Board

4.3 Executive Director of Organisational Development and Workforce

The Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective training programme that includes specific CoSHH training where required, which is appropriately monitored and recorded
- reports on work related illness or work related ill health that is attributable to substances hazardous to health, are submitted to the Trust Estates Assurance Meeting.
- pre-employment screening is carried out and provide advice to managers on any pre-existing conditions / allergies identified as part of that process
- arrangements are in place for health surveillance of in-service employees and others, such as work experience and students, where there is a specific requirement under CoSHH regulation.

4.4 Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to: -

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed health and safety lead managers in developing and maintaining their CoSHH safety management systems and training. Competent advice may be sourced both internally and externally, for expert advice on NRL allergy.

- provide support to the Executive Director with delegated responsibility for CoSHH management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of, and monitoring compliance with, the policy on the management of Latex and Latex Allergy.
- ensure that information is available throughout the Trust on the management of Latex and Latex Allergy in order to evolve action plans to improve or maintain standards
- provide support to investigate incidents and report to senior managers on findings and, where necessary, provide recommendations

4.5 Health and Safety Manager and Divisional H&S Advisors/Leads

The Health and Safety Manager with the support of Divisional H&S leads is responsible for providing advice and guidance to managers on the effective implementation of this policy and safe working methods.

4.6 Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where NRL information or concerns can be discussed.
- liaising with the Trust Capital Planning and Estates Department
- ensuring that local CoSHH procedures are developed, which include reference to NRL, and implemented in line with the overarching trust policy
- ensuring that NRL health assessments have been implemented for all relevant staff and service users where required

4.7 Department Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- ensure that general NRL risk assessment is undertaken with regard to work and clinical activities within their areas of responsibility. Specific individual risk assessments will be required where service users or staff are identified as allergic to NRL.
- identify and implement any action/control required following the NRL risk assessment, (further advice may be sought from Occupational Health).
- ensure that staff are given the necessary information, instruction and training to enable them to manage NRL allergy and comply with this policy, including the need for reporting:
- report NRL allergic reactions suffered by patients via the critical incident reporting mechanism.
- report symptoms suggestive of NRL allergy in staff to the Occupational Health Department.

4.8 CoSHH Departmental Leads

Department Managers will designate a member of staff within the department that will have the responsibility to manage the CoSHH arrangements for that particular Department They will be trained to use Cypol our CoSHH Management system. This will ensure that effective CoSHH management system is maintained within the departments that are using the hazardous substances. Divisions may rely on divisional safety leads to provide them with advice and guidance appropriate to their service needs.

CoSHH compliance within the department will be monitored by the divisional H&S Managers and will act as the main contact between the division Health & Safety Groups and the Trust Health Safety and Fire Board in order that effective communication is created and maintained.

CoSHH leads should ensure that CoSHH assessments consider NRL and be able to provide managers and staff with safety data sheets for products containing NRL.

4.9 Individual Employees

All employees have a statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.

Having been provided with information, instruction and training, staff will comply with this policy and follow safe systems of work for their area(s) of work and responsibility.

4.10 Committees and Management Groups

The following committees / groups will provide advice to the appropriate Executive Director in order to ensure that accountability is being discharged properly and to ensure that the aims and objectives of the Trust are being achieved. Committees include but are not limited to:

- Trust Health Safety and Fire Board

5. Definitions

The Health and Safety Executive (HSE) advises that Natural rubber latex (NRL) is a milky fluid obtained from the Hevea brasiliensis tree, which is widely grown in South East Asia, and other countries. NRL is an integral part of thousands of everyday consumer and healthcare items.

As with many other natural products, natural rubber latex contains proteins to which some individuals may develop an allergy.

NRL is not only contained within single-use disposable gloves, but can also be found in a number of medical products, such as catheters, elasticised bandages, wound

dressings etc. It is also in the packaging for a number of medical products. While these may pose a low risk of sensitisation, they can pose a significant risk (eg anaphylactic shock) to sensitised individuals, either patients or healthcare workers.

The majority of healthcare products containing NRL are 'medical devices' as defined by the Medical Devices Regulations 1999. Therefore, their manufacture and provision are regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA).

6. Implementation/Policy Compliance

6.1 Responsibilities to Employees

Existing staff need to be aware of the following: -

6.1.1 Diagnosis

Employees who think they may have latex allergy can self-refer to the Occupational Health Department, but ideally they should go through their managers who can arrange a quick referral through the Organisational Development and Workforce department and also arrange for the appropriate actions to be taken. The Department of Occupational Health will be able to undertake all necessary measures to diagnose Type 1 latex allergy. Appropriate advice is available on any work related medical conditions.

6.1.2 Management

Advice regarding latex avoidance will be given. The Department of Occupational Health will review latex allergic employees after avoidance advice has been given to ensure symptom control. If necessary the Trust will support the employee by redeployment and retraining in the case of allergic reactions unresponsive to avoidance precautions. In some cases ill-health retirement may be appropriate where the aforementioned options fail or are not possible.

New employees must complete a Pre-employment health pre-placement questionnaire. The questionnaire asks about known allergies it includes questions regarding possible latex allergies. These staff will usually include all those working in clinical areas or in contact with service users in the community.

If latex allergy is identified and confirmed in a prospective employee the Occupational Health department will advise management and the employee of any adjustments needed to the working practices or workplace to accommodate the employee. The Trust will consider any reasonable adjustments necessary to comply with this advice. The Department of Occupational Health will review latex allergic employees after avoidance advice has been given to ensure symptom control.

6.2 Responsibilities to Service Users

6.2.1 Screening for Risk of Allergy

Careful history taking from patients, should identify the high risk groups. These include:

- atopic allergic disease / known allergies, including but not limited to eczema, hay fever and asthma
- patients with spina bifida,
- health care workers,
- Service users with a history of multiple surgical procedures.

Specific questioning will be included in the routine nursing procedures for units where the possibility exists for mucosal exposure to latex (for example, patient undergoing selectron treatment). Service users will be questioned regarding a history of immediate reaction to skin rubber contact such as:

- following dental surgery,
- blowing up rubber balloons,
- wearing of rubber gloves,
- any history of immediate allergic reaction to fruit, especially banana and kiwi fruit. The issue of latex sensitivity will be raised at relevant departmental meetings on a regular basis to ensure that all new staff are made aware of this problem.

6.2.2 Diagnosis

Service users giving a history of atopy (A hereditary disorder marked by the tendency to develop immediate allergic reactions to substances such as pollen, food, dander, and insect venoms and manifested by hay fever, asthma, or similar allergic conditions. Also called *atopic allergy*) and of adverse reaction to fruit, or those giving a history of immediate adverse reaction to rubber contact should have their surgery deferred if possible. An IgE RAST test to latex protein should be carried out and a referral made to the dermatology department for further diagnosis and investigation.

6.2.3 Latex avoidance

For service users who are confirmed as having latex protein sensitivity, or in those in whom it is suspected from the history but emergency treatment is unavoidable, appropriate alternative equipment packs will be made available. The risk of adverse reaction during clinical examinations including manual pelvic examinations will be brought to the attention of appropriate staff.

6.2.4 Anaphylaxis

Education in the recognition and management of anaphylactic reactions must be facilitated by each division. Each division must have an Anaphylaxis policy/SOP, if possible backed up by posters in the appropriate areas.

6.2.5 Management of non-life threatening reactions

A service user suffering from milder reactions which do not compromise the airway or lead to cardiovascular collapse should be managed with intravenous antihistamine followed by oral antihistamine therapy. Referral to the dermatology department may be considered appropriate if the cause of reaction is unclear. A service user suffering from milder reactions away from a hospital environment should be transferred to an appropriate place of treatment.

6.3 Responsibilities of the Procurement Department

It will be the responsibility of the procurement department to monitor all products which have the potential to contain NRL by liaising with manufacturers and advise management of their findings and to provide advice on the availability of alternative products.

6.3.1 Use of low protein devices

Sensitisation can be prevented by the use of devices low in protein. Currently, the accepted method for assaying protein in latex devices is the Modified Lowry assay.

The Surgical Materials Testing Laboratory carries out testing of medical devices for the All Wales Contracts. Part of this work includes assaying protein levels in medical devices. Reports are available from SMTL on request and on their Internet site which documents protein levels in various medical devices, including gloves and urinary catheters.

Devices used especially gloves must be those on the All Wales Welsh Health Supplies contract.

6.3.2 Use of non-latex devices

The use of non-latex devices is recommended in situations where staff or patients have a known latex allergy, and contact with the device is unavoidable. All divisions must identify where latex free devices are available and identify a person who will be responsible for maintaining this equipment.

6.4 Responsibilities of the Occupational Health Service

Where covered by an appropriate Service Level Agreement (SLA), Occupational Health Departments, have a responsibility to: -

- Ensure staff (or prospective staff) with NRL allergy and their managers, are advised of any necessary adjustments or restrictions to their work activities, using an evidence and risk assessment based approach
- Provide guidance to staff and managers on suitable and safe working environments for NRL sensitised employees.
- Facilitate investigation of staff suspected of having NRL allergy.

- Provide statistical and other relevant information concerning NRL allergy in staff to the Trust Estates Assurance Meeting, whilst maintaining individual confidentiality.

6.5 Housekeeping

Good housekeeping practices should be followed to remove latex-containing dust from the workplace. Areas potentially contaminated with powder from latex devices should be identified for frequent cleaning. Ventilation filters and vacuum bags should be changed frequently in these identified areas

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. References

- The Health and Safety Executive provides access to a wide variety of guidance and information via its website
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Approved code of practice and guidance
- Working with substances hazardous to health - What you need to know about COSHH
- HSE COSHH Essentials Website
- Personal Protective Equipment relevant to CoSHH Regulations Latex allergies in health and social care

9. Getting Help

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Jason Hoskins Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ E-mail: JasonHoskins@wales.nhs.uk
Health and Safety	Ceri Pell VCC Health & Safety Advisor Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL United Kingdom E-mail: ceri.pell@wales.nhs.uk Matthew Bellamy WBS Health Safety & Environmental Compliance Manager Welsh Blood Service Talbot Green Pontyclun CF72 9WB United Kingdom E-mail: matthew.bellamy@wales.nhs.uk

Occupational Health	Cardiff and the Vale University LHB Heath Park Cardiff CF14 4XW E-mail: occupational.health@wales.nhs.uk Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above named local health boards. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover formal health surveillance and health assessments in connection with identification of occupational hazards and risks, along with support and advice for staff.

10. Related Policies

This policy should be read in conjunction with, or reference made to, the following trust documents: -

Health, Safety and Welfare Policy	QS18
Control of Substances Hazardous to Health (COSHH)	QS33
Incident Reporting and Investigation Policy	QS 01
Medical Devices Equipment Policy Final	QS 24

11. Main Relevant Legislation

- The Health and Safety at Work etc., Act 1974
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Supported by the control of substances hazardous to health (L5) sixth Edition, published 2013, Approved Code of Practice and Guidance

Appendix 1 Health and Safety Executive – About Latex Allergies

What is Natural Rubber Latex?

Natural rubber latex (NRL) is a milky fluid obtained from the Hevea brasiliensis tree, which is widely grown in South East Asia, and other countries. NRL is an integral part of thousands of everyday consumer and healthcare items.

As with many other natural products, natural rubber latex contains proteins to which some individuals may develop an allergy.

What is the cause of Natural Rubber Latex Allergy?

The introduction of Universal Precautions in the late 1980s mandated that healthcare workers protect themselves against the risk of cross-infection from blood-borne pathogens such as HIV and Hepatitis B. This demand led to an unprecedented demand for NRL gloves, which was met by changes in some manufacturers' practice (i.e. high protein [allergen] examination gloves coming onto the market place) and is believed to be the primary cause of the increased number of healthcare workers with NRL allergy. At the same time there has been an unrelated and dramatic rise in incidence of atopic allergic disease in the past 30 years, which is also thought to be a major factor.

Who is most at risk?

- Healthcare workers (some studies have reported that up to 17% are at risk of reactions to NRL)
- Individuals undergoing multiple surgical procedures (some studies have reported that up to 65% of Spina Bifida children are sensitised to NRL)
- Individuals with a history of certain food allergies, such as banana, avocado, kiwi and chestnut
- Individuals with atopic allergic disease (estimated at some 30 - 40% of the UK population)
- Individuals exposed to NRL on a regular basis e.g. workers in the car mechanics, catering and electronics trades

Around 1-6 % of the general population is thought to be potentially sensitised to NRL although not all sensitised individuals develop symptoms.

Are all latex allergies the same?

There are two Types of allergy related to natural rubber latex, one caused by the natural proteins, the other by chemicals that are used to convert the NRL to a usable item. They are respectively called Type I and Type IV allergy.

Some people may experience an irritant reaction when using products made from natural rubber latex, which is known as irritant contact dermatitis. This is not, however, a true allergy.

Type IV allergy

Some people react to the chemicals used in the manufacturing process, mostly accelerators. The chemicals most likely to cause a reaction are thiurams, dithiocarbamates and mercaptobenzothiazoles (MBT). This is a delayed hypersensitivity reaction which occurs 6 - 48 hours post-exposure.

Symptoms of Type IV allergy

- Red itchy scaly rash, often localised to the area of use, i.e. wrists and forearms with glove use, but which may spread to other areas

Management of Type IV allergy

Occupational Health or medical advice should be sought and avoidance of the specific chemicals in future use.

Type 1 allergy

- Type I natural rubber latex allergy is an immediate allergic reaction to NRL proteins and is potentially life threatening.
- Deaths have occasionally been reported due to latex allergy.

Symptoms of Type I allergy

- Urticaria (hives) and hay fever Type symptoms, asthma.
- Though rare, more severe symptoms such as anaphylaxis (a condition where there is a severe drop in blood pressure leading to possible loss of consciousness or severe breathing difficulty)

Months or even years of exposure without symptoms may precede onset of clinical symptoms of Type 1 NRL allergy. In many cases symptoms become progressively more severe on repeated exposure to NRL allergens, so it is important for sensitised individuals to avoid further contact with NRL proteins.

NRL allergens attach to cornstarch used in powdered gloves. This powder acts as a vehicle making the NRL proteins airborne when these gloves are used, enabling the allergens to be inhaled. This means that NRL allergic individuals may experience symptoms of an allergic reaction, by being in a room where powdered NRL gloves are used even though they are not in contact with these gloves directly.

Management of Type 1 allergy

Avoidance of the allergen is the best treatment option. There is no cure for NRL allergy but medications are available to treat symptoms of NRL allergy once it develops.

Natural rubber is found in many thousands of consumer and medical products. There are two Types of natural rubber products. Dipped or stretchy NRL products (e.g. gloves, balloons, condoms, rubber bands) are a more frequent cause of allergic reactions to latex proteins than dry rubber products (e.g. tyres, tubing). Reactions to dry rubber products are less common and only experienced by severely sensitised individuals.

How are allergies diagnosed?

There is currently no completely reliable investigation for Type 1 NRL allergy, and diagnostic practice varies across the country. In general, the diagnosis is made on the basis of clinical history plus either positive allergen-specific IgE blood test or skin prick / glove challenge test. Type IV allergy is diagnosed by standard patch testing.

Use of Medical equipment.

Many items contain NRL but are often not usually labelled to warn of NRL content. Because a much more serious reaction may occur when these items contact internal body surfaces, e.g. mucosal, parenteral and serosal contact, it is very important for sensitised patients to inform healthcare providers of their allergy so that only NRL-free medical equipment is used.

How can sensitised individuals avoid NRL?

- Avoid contact with NRL gloves or products where possible
- Inform employers and healthcare providers of NRL allergy
- Avoid areas where inhalation of powder from NRL gloves worn by others or from balloon displays may occur
- Recommend use of Medic-Alert bracelet, stating natural rubber latex allergy

How is NRL used?

Gloves are the single most widely used device containing natural rubber latex. The Health and Safety Executive has stated that, "Single use disposable natural rubber latex gloves may be used where a risk assessment has identified them as necessary. When they are used they must be low-protein and powder-free".

In many situations a risk-assessment will suggest that in the presence of a risk of bloodborne pathogen transmission, for example surgery and body fluid contact, NRL is the safest choice of material provided the worker and patient are not sensitised to this. If a person is sensitised to NRL proteins, NRL-free gloves and equipment must be used.

Not all NRL-free gloves afford the same protection against blood-borne pathogens so care must be taken in the choice of substitutes. Some gloves may only be suitable for nonclinical tasks as they may not afford the same level of protection against transmission of blood-borne pathogens. If there is doubt suppliers can be asked to provide test data proving the glove's suitability.

NRL gloves are also often used in catering, domestic services, motor industry, hairdressing and other professions and trades where, if there is no contact with blood or body fluids, they should be substituted by an alternative non-latex product.

Why use NRL?

NRL is a widely-used and cost-effective material, which for the majority of the population is not a clinical risk. The importance of risk-assessment is to make an informed decision as to whether an alternative is effective for the task.
NRL has many benefits which are yet to be equalled where there is a requirement for specific tactility and dexterity qualities, for example in surgical practice. Where it is used, the gloves must be low protein (<50mcg/g) and powder free.

Products containing NRL

There are many medical and consumer products that contain natural rubber latex. Healthcare providers must ensure that latex-free medical supplies are available for use on or by sensitised individuals. Here are some examples of products that may contain natural rubber latex:

Medical Equipment

Examination and Surgical gloves	Dental dams
Oral and Nasal airways	Wound drains
Endotracheal tubes	Anaesthesia masks
Intravenous tubing	Blood pressure cuffs
Surgical masks	Syringes
Rubber aprons	Stethoscopes
Catheters	Tourniquets
Injection ports	Electrode pads
Bungs and needle sheaths on medicines	
Consumer items	
Erasers	Rubber bands
Balloons	Condoms
Contraceptive Cap	Hot water bottles*
Baby teats	Swimming cap and goggles
Stress balls	Carpets
Washing-up gloves	Tyres *
Adhesives	Shoe soles*
Underwear elastic	Calculator/remote control buttons
Sports equipment (e.g. hand grips and gym mats)	* dry rubber

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

People Policies

DATE OF MEETING	16th January 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?	Choose an item
PREPARED BY	AMANDA JENKINS, HEAD OF WROKFORCE
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This paper sets out the key updates and changes to a number of Workforce and OD polices within the Trust.
RECOMMENDATION / ACTIONS	QSP are asked to endorse the amended and new policies and processes for Board approval

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (Run)	30/10/2023
Local Partnership Forum	07/12/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
Executive Management Team endorsed the Policies for Board approval. Local Partnership Forum endorsed the Policies for Board approval

APPENDICES	
Ap. 1	All Wales NHS Dress Code
Ap. 2	Annual Leave Policy (Agenda for Change)
Ap. 3	Redundancy and Security of Employment Policy
Ap. 4	Recruitment and Selection Policy

1. SITUATION

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

2. SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that LPF are endorse for Board approval, as required:

All Wales NHS Dress Policy

- Amendments to the principles set out in the Policy, specifically in relation expectations of all NHS Staff and those working in a clinical environment

Annual Leave Policy (Agenda for Change)

- Policy revised in partnership with TU colleagues and consulted with both divisions
- Policy sets out terms and conditions and expectation of staff who are employed under the agenda for change terms and conditions
- Aligned to updates in relevant polices, i.e. MAWW, Special Leave etc.

Redundancy and Security of Employment Policy

- Policy revised in partnership with TU colleagues and consulted with both divisions
- Legislative updates made
- Aligned to relevant polices, i.e. OCP and Redeployment Procedure

Recruitment and Selection Policy

- New Policy developed by the Attraction, Recruitment and Section Task and Finish Group

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 04 – Organisational Culture Having appropriate people related polices ensure staff know the expectations upon them to deliver the role they are employed to undertake.
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 ☒
	When staff have clear guidance and expectations set through relevant policies and procedures there is improved impact on the work undertaken.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Ensuring the trust has adequate polices and procedures that are full assessed against the impact on equality and socio-economic duty ensure that there are no adverse impacts on people who may be at a disadvantage. There are no identified impactors in any of the polices or procedures outlined in the paper.

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
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Having a set of standards and principles that all staff work towards, that have been full assessed for their socio-economic impact and equality impact ensures people are clear on the expectations set for them by the Trust. This will provide a healthier workplace where people feel they have physical and mental well-being in the workplace.
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
	All polices new and revised have undergone a detailed EQIA utilising the Trust's toolkit. In relation to the annual leave policy amendments have been made regarding part-time staff returning from maternity leave and the potential of discrimination. The policy has been amended following this review to state that staff should work in partnership with managers on returning form maternity leave to take their annual leave.

	All other policy or procedure no issues identified.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having relevant policies and procedures could lead to employment law challenges because people won't know the expectations upon them from the Trust.

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

www.cymru.gov.uk

All Wales NHS Dress Code
Free to Lead, *Free* to Care

GIG CYMRU NHS WALES

Her Iechyd Cymru Health Challenge Wales

Introduction

The All Wales Dress Code was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The public expect all healthcare workers to project a professional image. Though not all staff may be required to wear a uniform, the requirement to present a smart, professional image applies to everyone.

Securing the confidence of the public is paramount in delivering exemplary health care services. Evidence has shown that the public is concerned about a number of issues relating to the wearing of NHS uniforms and the comportment of NHS staff.

The evidence base for the All Wales Dress Code was developed by the Department of Health in England. *"Uniforms and Workwear: an evidence- based document on the wearing and laundering of uniforms"* was originally published in 2007 and updated in 2010. It is available at **http://www.dh.gov.uk/publications**.

The wearing of an NHS uniform and/or workplace clothing must address key Health and Safety recommendations:

- Adhere to infection prevention and control protocols especially in relation to hand washing techniques
- the identification a corporate image for the individual
- provide a professional image to promote public confidence
- provide the wearer with mobility and comfort
- be resilient to withstand rigorous laundering
- take into account staff safety in relation to situations involving violence and aggression

The dress code specifies the principles that all NHS staff must adhere to and highlights specific expectations for all staff directly involved in the delivery of clinical services. The dress code applies equally across clinical and non-clinical staff working within NHS Wales.

Principles and expectations

PRINCIPLE 1

All staff will be expected to dress in smart (that is, neat and tidy) clean attire in their workplace.

Expectation:

All staff

- Staff must adhere to the NHS Wales Dress Code principles on the wearing and laundering of uniforms/work attire
- Staff must wear their uniforms/work clothes in a manner that will inspire public confidence
- The special needs of pregnant staff must be assessed and advice obtained from their occupational health departments
- The special needs of disabled staff must be assessed and advice obtained from their occupational health departments

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Staff working in the clinical environment

- Clean uniform/work attire must be worn for each shift/work day
- Clinical staff must have access to a change of uniform should their uniform be contaminated during their shift/work day
- Where staff launder their own uniforms, written instructions must be adhered to which reflect current best practice guidelines (Appendix 2)
- Staff should use additional protective clothing when anticipating contact with blood and/or bodily fluids in line with their local infection prevention and control policies

PRINCIPLE 2

All staff will present a professional image in the workplace.

Expectation:

Staff working in the clinical environment

- Staff will wear their hair neatly; medium length/long hair must be tied up off the shoulder and secured
- Staff must not wear jewellery except for plain wedding ring/kara/ear studs
- No wrist watches are to be worn under any circumstances in the clinical environment
- Staff with pierced ears may wear one set of stud earrings only
- Staff with new piercings (where the piercing cannot be removed for a specific time period) must cover them with a 'Blue' plaster
- Staff with established body piercings, other than earrings, (one set of studs) should cover them when in the workplace
- Staff with beards must keep the beard neatly trimmed
- Staff must not wear false nails and/or nail varnish
- Staff must keep their finger nails clean and short
- Staff must wear footwear that complies with the relevant health and safety requirements, for example, soft soled for reduced noise, low heeled for manual handling and ease of movement, and closed toes for protection

PRINCIPLE 3

Staff should not socialise outside the workplace or undertake social activities while wearing an identifiable NHS uniform.

Expectation:

Staff working in the clinical environment

- Where changing facilities are available, staff must change out of their uniform at the end of a shift before leaving their place of work
- Where changing facilities are **NOT** available staff should ensure their uniform is covered up before leaving their place of work
- Staff must not wear their uniforms in public places, for example, shops (if staff need to enter public places in the course of their duties they must make every effort to cover their uniforms)
- Staff who are permitted to wear a uniform to and from work, or work in the community setting, must cover their uniform when travelling

PRINCIPLE 4

All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.

Expectation:

Staff working in the clinical environment

- Staff will comply with the above in order to ensure that correct hand hygiene can be performed before contact with patients

PRINCIPLE 5

All staff must wear clear identification at all times.

Expectation:

All staff

- Staff must wear identification (for example, a security coded name badge) that includes their title, name and profession at all times , in line with their local policies, for example, a Lone Worker Policy
- Staff identification must be clearly visible

PRINCIPLE 6

Staff who wear their own clothing for work should not wear any clothing that is likely to cause a safety hazard.

Expectation:

All staff

- Staff should not wear any loose clothing that may compromise their health and safety in the work place
- Footwear should be comfortable and practical for the role undertaken

Implementation and monitoring

The All Wales NHS Dress Code will replace any local policy in order to ensure equity and parity across all healthcare organisations. Compliance will be monitored through local agreement at a local level.

In line with the Welsh Assembly Government Inclusive Policy Guidelines this document will be reviewed in December 2012.

References

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Department of Health (2006) Safety First: a report for patients and healthcare managers DoH: London

Health and Safety Commission (2000) Securing Health Together HSE: London

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HMSO (1999) Management of Health and Safety at Work Regulations
HMSO: London

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HMSO: London

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HMSO: London

HMSO (2006) Health Act 2006 Code of Practice HMSO: London

Jacob, G (2007) Uniforms and Workwear. An evidence base for developing local policy Department of Health, London

NHS Borders (2004) Dress Code/Uniforms Policy

Royal College of Nursing (2009) Guidance on uniforms and work wear

Royal College of Nursing (2005) Wipe It Out. RCN Campaign on MRSA. Guidance on uniforms and clothing worn in the delivery of patient care Royal College of Nursing: London

Appendix 1

Supporting information

Good Practice	Rationale	Supporting Information and /or additional comments
Wear short sleeves or roll the sleeves to elbow length before carrying out clinical procedures	Cuffs become heavily contaminated and are more likely to come into contact with patients They may act as a vehicle for transmitting infection Long sleeves or cuffs prevent effective hand washing and compromise patient safety	Some staff working in an outdoor environment, for example, ambulance personnel, paramedics and others delivering emergency care, may be exempt from this requirement
Dress in a manner which is likely to inspire public confidence	People may use general appearance as a proxy measure of competence and professional practice	
Clinical staff who do not wear a uniform should not wear any loose clothing such as unsecured ties, draped scarves, headdress or similar items	This type of clothing may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	This type of clothing could have staff safety implications. A risk assessment should be carried out.
Where changing facilities **are provided** clinical staff who wear a uniform must change out of their uniform before leaving the workplace Staff who are permitted to wear a clinical uniform to and from work should have it covered up when travelling	There is no current evidence of an infection risk caused by travelling in uniform, but patient confidence in the health and social care staff may be undermined Staff may be vunerable to attack if seen off site in uniform	This does not apply to staff who are permitted to travel during the course of their duties, for example, community staff

Good Practice	Rationale	Supporting Information and /or additional comments
Staff should not go shopping, socialising or undertake similar activities in public when in uniform	There is no current evidence of an infection risk from travelling or shopping in uniform, but patient confidence in health and social care staff may be undermined	There is a public perception (as evidenced by the media) that associates staff wearing uniforms with the spread of infection
Wear clear identifiers; uniform and/or, name or identity badge	Patients wish to know who is caring for them. Name badges and uniforms help them to do this	Identification is important to promote patient and client safety
Staff must change as soon as is practical if uniform or clothes become visibly soiled or contaminated with blood or body fluids	Visible soiling or contamination might be an infection risk, and is also likely to affect patient confidence	Organisations must ensure that there is a local arrangement for this
All staff should secure long hair	Patients generally prefer to be treated by staff with tidy hair and a neat appearance. Long or unsecured hair may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	Long hair should be tied back and off the collar
Staff must be issued with a sufficient number of uniforms to allow them to wear a clean uniform each shift Written instructions must be provided to staff who launder their own uniforms; the guidance must reflect current best practice guidelines	A clean uniform should be worn for each shift A sufficient supply of uniforms for the recommended laundry practice should be provided	Providing staff with clear instructions on the cleaning of uniforms means that uniforms will be processed in line with the current recommendations (Appendix 2) Staff who have too few uniforms may be tempted to reduce the frequency of laundering

Good Practice	Rationale	Supporting Information and /or additional comments
Wrist or hand jewellery must not be worn in the clinical environment	Wrist watches must be removed before performing any clinical procedure and to promote good hand hygiene Hand/wrist jewellery can harbour microorganisms and can reduce compliance with hand hygiene	Centres for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/ SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16)
Clinical staff should keep finger nails short and clean Clinical staff must not wear false nails or nail varnish	Long and/or dirty nails can present a poor appearance and long nails are harder to keep clean. Long and/or dirty nails may be a vehicle for transmitting infection	Centres for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/ SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16)
Footwear worn in the clinical areas should be suitable for purpose and comply with the relevant health and safety requirements	Closed toe shoes offer protection against spills. Soft soles reduce noise, low heeled to comply with manual handling policies	

October 2010

Appendix 2

Guidance for healthcare staff laundering uniforms/workwear in the home

For staff working in some clinical environments a laundry service is provided by the employing organisation. With the introduction of a national NHS uniform and the instigation of on-site changing facilities for all healthcare staff, the next logical progression will be the reintroduction of laundry services to negate the need for staff to leave the premises with used or contaminated clothing.

Until such services have been reinstated and where currently the employer does not provide such a service it is sensible to issue staff with guidance on how best to launder their uniforms at home.

Such guidance should include:

- Where on-site changing facilities already exist and once they have been made available, staff should remove their uniform on site.
- For transportation, uniforms should be placed in a clear plastic bag or a water soluble bag suitable for use in domestic washing machines*.
- Uniforms should be washed at the hottest temperature suitable for the fabric. A wash for 10 minutes at 60°C should remove most micro-organisms**.
- Ensure that the machine is not overloaded to allow for optimum wash efficiency and dilution factor.
- Staff should wash their hands after loading the machine.
- Use of a biological washing agent is preferable.
- Tumble dry on the hottest temperature as recommended by the manufacturer or air dry thoroughly before ironing on the hottest setting as advised by the manufacturer.

* *Plastic bags with a water soluble tie and seam, suitable for use in domestic washing machines, clearly labelled for staff use with instructions printed on them, are now available through a Welsh Health Supplies contract. Ideally these should be available for the transportation of all uniforms but as a minimum should be considered for use where uniforms are visibly soiled or during an outbreak of disease. The use of such a bag would negate the need for staff to handle the uniform in the home. The whole bag can be placed safely into the machine. On no account should the soluble bags used by hospital laundries be issued to staff even during an outbreak. They are not suitable for use within a domestic machine where the dilution and temperatures reached are not of the magnitude that can be achieved in a commercial setting.*

** *Employing organisations should take into account the manufacturer's washing instructions during the procurement process for uniforms purchased outside of the national contract.*

Ref: WF35

Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change Terms and Conditions)

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
Document Author:	Senior People & OD Business Partner
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	September 2023
Equality Impact Assessment Outcome:	No identified impact
Review Date:	Three years from date of approval
Version:	

Table of Contents

1. Policy Statement

Annual leave is an important wellbeing entitlement, which is encouraged to be taken by all employees to assist them to achieve a healthy balance between their work and home life. The Trust recognises that the effective management of annual leave by individual employees and line managers is essential to the health, safety and well-being of our employees and the ability of the Trust to continue to deliver high quality services which meet the requirement of its service users.

There is a requirement to provide a statutory minimum amount of annual leave each year. However, NHS employers want to reward and retain high quality, hardworking staff and therefore offer an enhanced annual leave entitlement. Whilst it is important to book annual leave at regular intervals for adequate rest breaks, it is also recognised that annual leave requests may be declined due to operational requirements and in exceptional situations, an employee may be asked not to take previously agreed annual leave or previously agreed annual leave may need to be cancelled, if not doing so would cause a detriment to the operation of the service. In these cases, managers will be mindful of providing as much notice as possible and will seek to be as flexible as possible with the employee.

2. Scope

This document provides a consistent, fair and equitable approach to the management of annual leave and bank holiday entitlements for agenda for change staff groups employed within Velindre NHS Trust.

It does not vary any contractual terms which apply but provides clarity and consistency in the way these are applied within Velindre University NHS Trust.

3. Aims and Objectives

The aim of this document is to provide guidance on how to manage annual leave and bank holiday entitlements, including when transferring or leaving the organisation, and the provisions relating to the carrying over of annual leave due to absence from work.

4. Responsibilities

4.1. Individual Employee Responsibilities

Employees are responsible for:

- Ensuring that their annual leave is planned and taken, where possible, at regular intervals throughout the leave year, subject to approval and the needs of the service.

- Ensuring that where staff work shifts, weekends and bank holidays, they request their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on particular shifts. If this occurs

managers will speak to staff to discuss reasons and agree an outcome that takes account of business and personal needs.

- Requesting leave via ESR providing a minimum of 72 hours' notice, prior to taking such approved leave. In exceptional circumstances shorter notice periods may be approved by departmental managers. Ensuring that, in exceptional circumstances, where the provision of notice has not been possible, ESR should be completed (and authorised by management) within 72 hours of the employee's return to work.

- Ensuring that the Bank Holiday process below is followed.

  Bank Holidays **<u>are included</u>** in all employee's annual leave entitlement balances. Therefore, any bank holidays not worked (that fall on an employee's normal working day) needs to be booked off as leave on ESR in the same way as annual leave.

  If an employee is not scheduled to work on any of the bank holidays, the relevant number of days (up to the maximum for that year* days (pro-rata part time staff) needs to be booked at the start of the annual leave year. Staff should book these days on ESR at the commencement of the new annual leave year (or when they commence in post), but in any event no later than the actual bank holiday date(s).

  If an employee is scheduled to work, or as part of their shift pattern may be required to work on a bank holiday, they are not required to this day / these days off on ESR at the start of the annual leave year. Where an employee is required to work or be on-call on a bank holiday they are entitled to take the equivalent of their bank holiday day off, at another time. By not booking their Bank Holiday entitlement off on ESR in advance this ensures that the corresponding number of hours are still available within the employee's annual leave allowance to be taken at another time.

  Employees should note that the Trust regularly undertakes audits to ensure ESR is up to date and to provide assurance that leave is being accurately recorded. Should an employee not book their bank holiday leave and this results in them overtaking their annual leave entitlement, the monetary value of these days will be claimed back as an overpayment of salary, via payroll, in accordance with the Trust's Recovery of Overpayments Policy. It is an employee's responsibility to maintain accurate records and their manager is accountable for ensuring this compliance. If an audit shows that records are repeatedly not up to date, both the employee and their line manager may be asked to explain the reason. If this is identified as a conduct concern the matter may need to be dealt with under the Trust's Disciplinary Policy.

N.B **The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly*. * Noting that where the annual leave year runs from 1st April to 31st March, the Easter bank holiday dates may fall in the same annual leave year, resulting in one year having more bank holidays than the annual statutory days and the next one having fewer.

4.2. Managers Responsibilities

Managers are responsible for:

- Working with their employees to ensure that they appropriately manage their annual leave throughout the leave year and ensuring that they apportion their leave so they can have regular rest breaks across the year.

- Calculating the annual leave entitlement for those staff employed on part-time contracts, who have not completed a full 'ESR' month who are, reaching 5 or 10 years' service during the annual leave year; who have requested to change their contracted hours during the annual leave year. In these circumstances the manager is responsible for checking the accuracy of the leave calculation on ESR and recalculating where necessary. (ESR will calculate annual leave entitlement automatically for staff where applicable and managers can use the annual leave calculators on the intranet for this purpose).

- Checking that where a bank holiday(s) fall on an employee's normal working day and they are not required to work it, that the leave has been requested and approved. Should an employee not book a bank holiday(s), the manager will bring this matter to their attention immediately and request that they submit retrospective and if appropriate prospective bank holiday leave requests. Where this becomes a regular pattern and a cause for concern, the manager should seek advice from the People and OD Department.

- Approving annual leave requests in a timely manner when an employee submits it through ESR. Until leave is approved on ESR it will not be deducted from the employee's annual and bank holiday leave total, resulting in an inaccurate entitlement.

- Ensuring that employees take the minimum statutory leave per year, in accordance with the Working Time Regulations (advice on this can be sought from People and OD).

- Encouraging staff to use their full contractual entitlement to support and promote their health and wellbeing.

- Ensuring service delivery is maintained by arranging appropriate cover for staff on annual leave. This may mean that managers have to decline annual leave requests where it would have an extreme negative impact on the service, or not agreeing to colleagues in the same team, taking their leave at the same time.

- Ensuring that where staff work shifts, weekends and bank holidays, they take their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on weekend shifts and discussing the reasons with staff where there are any business concerns or wellbeing concerns around how leave is being taken.

5. Booking Leave and Compliance

5.1 Annual Leave Year

Agenda for Change Staff

The annual leave year will run from 1st April to 31st March for all staff groups covered by Agenda for Change NHS Terms and Conditions of Service.

5.2 Annual Leave Entitlements

Part-time employees will be entitled to a pro-rata share of the whole-time equivalent annual leave and bank holiday entitlement (as defined in ***Appendix 1 and 2)***
All employees are required to book and take their annual leave in hours. Their leave application will be based on the actual hours due to be worked on the day in line with normal working patterns.

Please Note: *The calculation of annual leave entitlements in hours contained in Appendix 1 have been rounded up or down to the nearest 0.5 decimal point (i.e. the nearest ½ hour). Velindre NHS Trust* may use of their discretion to round to the nearest ¼ hour.

5.3 Bank Holiday

The NHS terms and conditions of service allows for 8 bank holiday days per year*: Good Friday, Easter Monday, May Day, Spring Bank Holiday, August Bank Holiday, Christmas Day, Boxing Day and New Year's Day.

To ensure consistency and equal allocation of bank holidays for all employees the Trust also converts this element of leave into hours **which are** then added to an employee's overall annual leave entitlement. *This will result in a deduction of hours, equivalent to those that would have been worked, from the employee's aggregated entitlement on each bank holiday that falls on a scheduled working day, on which they are not required to work.*

*Staff who are not rostered to work on a bank holiday but agree to do so on a voluntary basis, will be entitled to paid overtime. They are **not** however, entitled to an additional day off in lieu, as this day is already added into their annual leave / bank holiday entitlement and can therefore be taken off on an alternative date.*

N.B **The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly*

5.4 Calculation of Annual Leave

- Annual Leave entitlements are set out in Appendix 1
  An annual Leave calculator is available on the People and OD pages of the Trust intranet, under the policies and procedures section". Search for the

Annual Leave and Bank Holiday Policy and Procedure. The annual leave calculator is an accompanying document.

5.5 Entitlement on Joining the Trust

Annual leave and bank holiday entitlement in the first year will be pro-rata, based on the number of complete days worked after the date of joining and before the end of the annual leave year (rounded up or down to the nearest *½ hour)*.

For Example*:*
Mr. Jones joins the Trust on 12th September and works 32 hours per week.

Annual Leave

(Full annual entitlement ÷ days per year) x No of calendar days remaining in the leave year
(173hrs ÷ 365 days) x 201 days = 95.25 hours (*Rounded to **95 hours**).*

Bank Holidays

(Pro rata bank holiday entitlement in hours ÷ 8) x No of bank holidays remaining in the leave year in days.

(51 ÷ 8) x 3 = 19.12 (Rounded to **19 hours** bank holiday leave).

Total entitlement for that year: = 95 +19 *= 114 hours.*

In some annual leave years, there may be 9 bank holidays, if Easter is early and falls in March. In this situation the formula should be (51÷ 9) x 4 = 22.66 (Rounded to **23 hours** bank holiday leave).

5.6 Booking Annual Leave and Bank Holiday Leave

Staff should book annual leave or bank holiday leave, according to the number of hours they would have been due to work during the shift or working day on which they wish to take leave.

For example:

Part-time employee works 22 hours;
Monday and Tuesday's – 7.5 hour days;
Wednesday and Thursday's 3.5 hour days.

For recording purposes for a day's leave on ESR, the employee would book either 7.5 or 3.5 hours depending on the working day the annual leave falls.

5.7 Entitlement on Termination from the Trust

Employees who leave the Trust will be entitled to the pro-rata of their annual leave and bank holiday entitlement for each completed day worked in the current leave year (round up to the nearest ***½ hour***).

For Example
Mr. Jones works 22.5 hours per week and leaves the Trust on 27th July. .
Annual Leave
(Yearly entitlement ÷ days per year) x No of days worked up until & including termination date (121.5 hrs ÷ 365 days) x 118 days = 39.27 hrs (*Rounded to **39.5 hours** annual leave).*

Bank Holidays
(Pro rata bank holiday entitlement ÷ number of bank holidays in the year) x No of days worked in the leave year.

(4 ÷ 8) x 36 = **18 hours** bank holiday leave).

Total entitlement for the year: = 39.5 + 18 *= 57.5 hours.*

***Please note** - Managers need to remember to deduct any annual leave and bank holidays already taken to calculate if there is any outstanding leave accrual due to be paid upon leaving.*

5.8 Transferring to another post within the same Trust (Velindre)

Both positive and negative annual leave balances will be carried with the individual when they transfer to another post within the Trust.

5.9 Outstanding Leave on Termination from the Trust

The manager will work with the employee to ensure that all outstanding annual leave is taken before their termination date, where possible.

Where service provisions, long term sickness or maternity/adoption leave prevent the employee taking their leave, the Trust will make a payment to the employee for outstanding leave due. Advice from the People and OD Department needs to be sought in all cases of this nature.

5.10 Carry Over of Annual Leave

5.10.1 Normal circumstances

Employees are responsible for managing their annual leave throughout the leave year, ensuring that they take regular annual leave for rest breaks across the whole year.

NHS Terms and Conditions of Service Annex 0, confirms existing arrangements (Section 1) which state that where employees are prevented from taking their

full allowance, they shall be allowed to carry forward annual leave into the next holiday year.

Subject to the exigencies of the service up to a maximum of 5 days can be carried forward on application and approval by the line manager to be taken in the following leave year. Any one-off exceptions to this, will be agreed by the Executive Management Team and communicated as appropriate.

5.10.2. Long Term Sickness Absence

Where staff return from long term sickness absence, they should be expected to take any outstanding leave within the current leave year. This should be managed carefully, taking account of the needs of the service and the practicalities of the employee being able to use up all of their entitlement in that leave year.

Employees on long term sick leave will be given the opportunity to take annual leave during their sick leave period. Please refer to Trust Managing Attendance at Work Policy.

Where the employee has not taken their annual leave entitlement during the period of sickness absence, and the sickness absence spans two or more leave years, they will accrue annual leave for the period of their sick leave and can be asked to take all of their accrued, but untaken annual leave, by the end of the leave year in which they return.

The leave entitlement for the previous year/years will be the ***statutory*** element of their leave not their full contractual annual leave and bank holidays.

Where an employee returns to work in a new leave year, after a period of long term sickness absence, they are entitled to carry over the statutory element of their leave, in line with (Working Time Regulations. - refer to the Trust Managing Attendance at Work Policy, Section 8.4). Managers need to remember to deduct any annual leave and/or bank holidays that they took before or during their period of sickness absence.

Any annual leave accrued, at the time of the return to work, may also be taken to extend an agreed phased return to work i.e. in exceptional circumstances whereby a phased return to work is extended beyond the maximum 4 weeks period (in line with the Trust Managing Attendance at Work Policy).

5.11 Sickness Occurring during Annual Leave

When an employee falls sick during annual leave they will be required to report that episode of sickness in line with normal notification procedures and produce a fit note covering the period from the first day of sickness (in line with Section 7 of the Trust Managing Attendance at Work Policy).

In order to allow annual leave to be reinstated a medical fit note needs to be received within 3 working days of the beginning of the illness (unless abroad). In such cases

the employee will be deemed to have been on sickness absence rather than annual leave from the date of the certificate.

Only in exceptional cases will a foreign medical certificate of more than one month be accepted for payment purposes. A United Kingdom fit note should be obtained on return to the country.

5.12 Maternity/ Adoption and Parental Leave

5.12.1. Annual Leave

Annual leave will continue to accrue during all forms of paid and unpaid parental leave, as set out in the NHS Terms and Conditions of Service. Managers are encouraged to discuss with employees prior to their leave and reach agreement where possible when they will take said leave. Employees are encouraged to take any outstanding annual leave due to them before the commencement of Occupational Maternity Leave / adoption or parental leave, or towards the end of the leave period, if the leave period falls within the current annual leave year and there is sufficient time to take this leave. It should be noted that the provisions relating to the carry forward of annual leave will apply equally to staff on all forms of parental leave.

Employees returning to work on reduced hours need are encouraged to take any accrued annual leave either prior to the commencement of all forms of parental leave or prior to their return.

Employees not intending to return to work following all forms of parental leave should take any outstanding annual leave prior to commencement of that leave. The date of termination of service will then be calculated as the last working day plus any outstanding annual leave days, plus the full parental leave period.

As statutory paternity leave is shorter in length, the above provisions do not apply, apart from leave continuing to accrue during periods of paternity leave.

5.12.2. Accrual of Bank Holidays

In accordance with the Maternity and Parental Leave Regulations 2008, employees are entitled to accrue bank holidays (pro rata) that fall during their parental leave. Please refer to the Maternity, Adoption, Paternity and Parental Leave Policy for further information.

5.13 Annual Leave Entitlement on Changing Contracted Hours

Where employees change their contracted hours / sessions, this will result in a re-calculation of their annual leave entitlement based on completed days on the new and the old contracted hours /sessions to give the full year entitlement. Depending on the change, the annual leave entitlement may go up or go down. *For staff on ESR the system will calculate this automatically, managers should however check the accuracy of this calculation (please refer to section 4.2).*

If a reduction in contracted hours /sessions results in leave being overtaken, upon agreement with the individual, this will either be deducted from the following years annual leave entitlement, or a financial deduction made from their salary.

5.14 Annual Leave Entitlement for Term-time Working

An employee who wishes to work term time will have their annual leave and bank holiday entitlement annualised, and the entitlement *included* in their salary payments, over the period of the year.

Please liaise with the Trust's Payroll Department, should you wish to see your calculations.

5.15 Annual Leave Entitlement for Annualised Hours Working

The calculation of annual leave for employees who work annualised hours is as follows:

Total hours worked in the year = 850.
Annual weekly average = 850 ÷ 52.143 = 16½ hours (to the nearest ½ hour).

Refer to **Appendix 1** for appropriate entitlements.

e.g. 89 hours annual leave, 26½ hours bank holiday leave.

Total entitlement = **115½ hours.**

*** Employees may opt to reduce their annualised hours by deducting their annual leave entitlement. Any subsequent time off with then be unpaid and agreed by the manager.*

5.16 Annual Leave accrual for regular overtime

The Trust's position on this is to pay as overtime rather than given as annual leave.

6. Bank Holidays Falling on Saturday or Sunday

When any of the Christmas /New Year bank holidays falls on a Saturday or Sunday arrangements will be made to ensure that the right of staff to receive three public holidays are preserved. The Trust will communicate this, as relevant, on the years that it applies.

7. Sickness Occurring during a Bank Holiday

Employees **will not** be entitled to an additional day if they fall sick or are already away from work sick on a bank holiday. Please refer to the Managing Attendance at Work Policy for further information Statutory Entitlements during long term sickness absence.

8. Annual Leave When Under Suspension

Please refer to the Trust's Disciplinary Policy and Procedure Section 10.7.

9. Purchase of Annual Leave

The Trust operates an Annual Leave Purchase Scheme, which provides staff with the opportunity to apply to purchase additional annual leave, with the associated cost being deducted from their salary on a monthly basis, if approved. The purchase of additional annual leave is subject to certain conditions and is at the line manager's discretion. Please refer to the Trust's Purchase of Annual Leave Scheme Procedure.

10. Equality Impact Assessment Statement

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

The Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this document and the way it operates. The EQIA has been undertaken to identify and address any possible or actual negative impact that this document may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, gender, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

11. Getting Help

Further information and support is available from your divisional People and OD Department.

NWSSP staff should refer any queries to nwssp.hrcontactpoint@wales.nhs.uk.

12. Related Policies

Recovery of Overpayments Policy;
Purchase of Annual Leave Scheme;
Managing Attendance at Work Policy;
Maternity, Adoption, Paternity and Parental Leave Policy;
NHS Terms and Conditions Handbook;
Special Leave Policy

Appendix 1 – Annual Leave Entitlement – Agenda For Change (A4C) Staff

In accordance with Section 12 of the NHS Terms and Conditions of Service annual leave entitlement, all previous NHS service, whether continuous or not, will be aggregated. The Trust will verify as much previous NHS service as possible e.g. contacting the previous employer using an Inter Authority Transfer (IAT).

In circumstances where it is not possible for the Trust to confirm all of the employees previous NHS service (i.e. previous NHS employer no longer exists) the employee will be required to provide evidence to confirm these periods of employment e.g. contract of employment, offer letter, payslips etc.

Employees are entitled to receive extra annual leave at defined intervals, as shown in the table below.

Annual Leave entitlement increased by 1 day per annum following Pay Circular AFC, M&D & ESP (W) 01/2021 issued in December 2021

Table 1:- ANNUAL LEAVE ENTITLEMENT (COMPLETE YEAR) FOR A4C STAFF EXCLUSIVE OF BANK HOLIDAYS

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Formula: Weekly contracted hours ÷ 5 x No. of annual leave days' entitlement based on 28 days, 30 and 34 days

WEEKLY BASIC CONTRACTED HOURS	ON APPOINTMENT	AFTER 5 YEARS' SERVICE	AFTER 10 YEARS SERVICE
	28-DAYS	30-DAYS	34- DAYS
HOURS EQUIVALENT:			
37.5	210	225	255
37.0	207.25	222	251.75
36.5	204.5	219	248.25
36.0	201.75	216	245
35.5	199	213	241.5
35.0	196	210	238
34.5	193.25	207	234.75
34.0	190.5	204	231.25
33.5	187.75	201	228
33.0	185	198	224.5
32.5	182	195	221
32.0	179.25	192	217.75
31.5	176.5	189	214.25
31.0	173.75	186	211
30.5	171	183	207.5
30.0	168	180	204
29.5	165.25	177	200.75
29.0	162.5	174	197.25
28.5	159.75	171	194
28.0	157	168	190.5
27.5	154	165	187
27.0	151.25	162	183.75

26.5	148.5	159	180.25
26.0	145.75	156	177
25.5	143	153	173.5
25.0	140	150	170
24.5	137.25	147	166.75
24.0	134.5	144	163.25
23.5	131.75	141	160
23.0	129	138	156.5
22.5	126	135	153
22.0	123.25	132	149.75
21.5	120.5	129	146.25
21.0	117.75	126	143
20.5	115	123	139.5
20.0	112	120	136
19.5	109.25	117	132.75
19.0	106.5	114	129.25
18.5	103.75	111	126
18.0	101	108	122.5
17.5	98	105	119
17.0	95.25	102	115.75
16.5	92.5	99	112.25
16.0	89.75	96	109
15.5	87	93	105.5
15.0	84	90	102
14.5	81.25	87	98.75
14.0	78.5	84	95.25
13.5	75.75	81	92
13.0	73	78	88.5
12.5	70	75	85
12.0	67.25	72	81.75
11.5	64.5	69	78.25
11.0	61.75	66	75
10.5	59	63	71.5
10.0	56	60	68
9.5	53.25	57	64.75
9.0	50.5	54	61.25
8.5	47.75	51	58
8.0	45	48	54.5
7.5	42	45	51
7.0	39.25	42	47.75
6.5	33.75	39	44.25
6.0	33.75	36	41
5.5	31	33	37.5
5.0	28	30	34
4.5	25.25	27	30.75
4.0	22.5	24	27.25
3.5	19.75	21	24
3.0	17	18	20.5
2.5	14	15	17

2.0	11.25	12	13.75
1.5	8.5	9	10.75
1.0	5.75	6	7
0.5	3	3	3.5

Appendix 2 – Calculation of Bank Holiday Entitlement

CALCULATION OF BANK HOLIDAY ENTITLEMENT (COMPLETED YEAR)

Formula: Weekly Contracted Hours ÷ 5 x No. of Bank Holiday Days Entitlement

WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR	WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR
	(8 BANK HOLIDAYS)		(8 BANK HOLIDAYS)
37.5	60.0	**20.0**	32.0
37.0	59.0	**19.5**	31.0
36.5	58.5	**19.0**	30.5
36.0	57.5	**18.5**	29.5
35.5	57.0	**18.0**	29.0
35.0	56.0	**17.5**	28.0
34.5	55.0	**17.0**	27.0
34.0	54.5	**16.5**	26.5
33.5	53.5	**16.0**	25.5
33.0	53.0	**15.5**	25.0
32.5	52.0	**15.0**	24.0
32.0	51.0	**14.5**	23.0
31.5	50.5	**14.0**	22.5
31.0	49.5	**13.5**	21.5
30.5	49.0	**13.0**	21.0
30.0	48.0	**12.5**	20.0
29.5	47.0	**12.0**	19.0
29.0	46.5	**11.5**	18.5
28.5	45.5	**11.0**	17.5
28.0	45.0	**10.5**	17.0
27.5	44.0	**10.0**	16.0
27.0	43.0	**9.5**	15.0
26.5	42.5	**9.0**	14.5
26.0	41.5	**8.5**	13.5
25.5	41.0	**8.0**	13.0
25.0	40.0	**7.5**	12.0
24.5	39.0	**7.0**	11.0
24.0	38.5	**6.5**	10.5
23.5	37.5	**6.0**	9.5
23.0	37.0	**5.5**	9.0
22.5	36.0	**5.0**	8.0
22.0	35.0	**4.5**	7.0
21.5	34.5	**4.0**	6.5
21.0	33.5	**3.5**	5.5
20.5	33.0	**3.0**	5.0
		2.5	4.0
		2.0	3.0
		1.5	2.5
		1.0	1.5
		0.5	1.0

Ref: WF53

Redundancy and Security of Employment Policy

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
Document Author:	Senior People & OD Business Partner
Approved by:	Trust Board
Approval Date:	
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Equality Impact Assessment Outcome:	No identified impact
Review Date:	Three years from date of approval
Version:	

Contents

1 Policy Statement

Velindre University NHS Trust will take all reasonable steps to provide a stable work environment and to prevent all avoidable compulsory redundancies. It is the aim of this policy to ensure that the Trust retains the valuable knowledge, skills and experience of its workforce, by utilising a number of strategies, to assist employees at risk of redundancy to find suitable alternative employment.

At times of organisational change, it is particularly important to ensure that the Trust supports, guides, trains and develops its workforce, to minimise the risk of redundancy.

The policy should be read in conjunction with the relevant NHS Wales Organisational Change Policy (OCP). This policy will be applied to all proposed redundancy situations.

2 Scope of Policy

This policy will apply to all employees of Velindre University NHS Trust who are employed on a substantive or a fixed term contract (which is being terminated by reason of redundancy) where, at the proposed date of dismissal, they have accrued two years continuous service with the Trust / hosted organisation or another NHS employer.

3 Policy Principles

Subject to the procedures and processes outlined in this policy, when a potential redundancy situation arises the Trust will:

a) use early retirement and / or the Trust's Voluntary Early Release Scheme (VERS) where circumstances and / or resources allow.

b) after consultation identify, where possible, suitable alternative employment in the Trust for employees who have been identified as being at risk of redundancy.

c) liaise with local NHS employers, to establish whether they can assist with offering suitable alternative employment to those employees identified at risk of redundancy via the OCP or another process.

d) support employees who wish to retrain and are qualified to undergo training for posts in other disciplines / areas, where this option is reasonable and affordable.

e) take all steps to ensure that it can demonstrate that it has acted reasonably and fairly in respect of the reason for dismissal and the dismissal process.

4 Policy Legislation

For the purposes of this policy, the term "at risk" will apply to any employee or staff group who as a result of any of the reasons detailed below, face the possibility of being made redundant.

The Employment Rights Act 1996, Section 139(1) states that redundancy arises when an employee is dismissed in the following circumstances:

(i) Where the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed, or has ceased, or intends to cease to carry on that business in the place where the employee was so employed; or

(ii) The fact that the requirements of that business for employees to carry out work of a particular kind or for employees to carry out work of a particular kind in the place where they were so employed, have ceased or diminished or are expected to cease or diminish.

The Trust will comply with the legislative requirements relating to individual and collective redundancy consultations. In particular, where the Trust is proposing to dismiss 20 or more employees, over a period of 90 days or less, it will consult with the appropriate trade union representatives. The Trust will also consult with each employee "at risk" of redundancy, on an individual basis.

All employees will have the right to representation by a trade union representative or accompanied by a Velindre University NHS Trust workplace colleague, at a redundancy consultation meeting.

5 Policy Operation

The policy shall operate in the following cases: -

1. Where the Trust Board has agreed, following discussions with the appropriate Divisional Director or hosted organisation director, that a department / ward, in their division / hosted organisation shall close (either temporarily or permanently), whether or not the services are to be transferred or are expected to do so.

2. Where it has been identified that a post or posts which is required to enable the Trust / hosted organisation to carry out work of a particular kind has ceased or diminished (or is expected to cease or diminish), including where this is necessitated by cost reduction.

3. Where it has been identified that a post or posts which is required to enable the Trust / hosted organisation to carry out work of a particular kind in the place where the posts are based has ceased or diminished (or is expected to cease or diminish), including where this is necessitated by cost reduction.

It should be noted that the above list is not exhaustive and could cover a range of service and organisational change situations.

6 The Policy Aims and Objectives

The main aim of the policy is to provide clear advice, support and guidance to managers and affected employees regarding their role(s) and responsibilities, in respect of a redundancy process. Both the manager and the affected employees, in consultation with the relevant trade

union representatives, will seek to explore all reasonable and practical measures, which could avoid the need for a compulsory redundancy situation.

The Trust will aim to prevent or reduce the need for compulsory redundancies, where appropriate, by taking advantage of other potential alternatives. Depending on the circumstances, these may include: -

(i) consider the withdrawal or elimination of overtime where management considers this to be practicable and it will not negatively impact on service delivery.

(i) Place restrictions on the filling of any Trust vacancies, which may provide "suitable alternative employment" for those employees identified as being 'at risk' of redundancy.

(ii) consider the use of short-term temporary staff in any period of organisational change, where it is necessary to appoint into vacant posts, to maintain service requirements, until the programme of change has been completed.

(iii) maintain a Trust Redeployment Register which will contain details of all employees at risk of redundancy. All vacant posts will be made available to suitable employees on the Trust Redeployment Register, in the first instance. Suitability will be assessed with reference to the information contained in the employee's CV and Collection of Information Document (*the Collection of Information Document is available from the People Team/Intranet).*

(iv) implement the NHS Wales OCP Appendix 5 Redeployment Policy. This policy will only apply where an OCP process results in a redundancy situation.

(v) implement the Velindre University NHS Trust Redeployment Procedure). This procedure will apply to any redeployment situations which fall outside the remit of an OCP process.

(vi) consider re-training of employees where this option is reasonable and affordable.

(vii) ensure that wherever possible or affordable, the reductions in employee numbers are achieved through a process of natural wastage, voluntary early release or by means of voluntary early retirement. It should be noted there is a lead time of approximately five months between the granting of early retirement and the payment of pension benefits.

(viii) consider proposals from employees who are prepared to reduce their hours voluntarily or request a flexible working arrangement etc.

(ix) liaise with local NHS organisations to identify potential suitable advertised posts. It should be noted that NHS organisations only have a responsibility to co-operate in respect of those staff seeking redeployment as the result of an OCP process.

(x) redeployment of the employee to a vacant post at a lower salary band / grade (this will not be more than one band lower than the employee's substantive band / grade). This option will only be considered by the Trust where an employee has been identified as being at risk of redundancy due to an OCP process. Protection

of earnings in such circumstances will be in accordance with Section 10 of the NHS Wales OCP. The employee will have a responsibility to actively seeking and applying for further suitable alternative posts, commensurate with the level of their pay protected band/ grade, as and when they arise within the Trust and local NHS organisations.

7 Roles and Responsibilities

7.1 Line Managers

Line managers have a duty to familiarise themselves with the policy and associated processes and to treat all employees fairly and equitably. Managers are responsible for identifying situations where redundancy may be a potential outcome of the process and to consider and lead on a fair redundancy process.

The line manager will be required to make the People Department aware of the details of any employee who has been identified as being potentially at risk of redundancy, to ensure that they and the affected employee receive timely and appropriate advice and support, throughout the process.

The following checklist should be used by the manager to confirm the support facilities which may be available and offered to affected employees during this process:

- Access to career advice.
- Access to advice on CV writing, statements of suitability, application forms, preparing for an interview and interview skills etc.
- Assistance to prepare CVs and submit personal details to be included on the Trust's Redeployment Register
- Assistance with access to job websites such as NHS Jobs, the Job Centre, recruitment agencies etc.
- Provided with information on how to access reasonable and affordable retraining opportunities, further education establishments etc.
- Access to suitable Trust and hosted organisation employees to act as mentors, provide advice and guidance as appropriate to the employee's needs.
- Signposting to independent financial and pension advice in the event of redundancy or early retirement situation; or
- Access to the Employee Assistance Programme, Occupational Health Services etc.

The above list is not exhaustive, it is intended to be general guidance on areas of possible advice and support.

7.2 Employees

Where it has been confirmed that an employee is at risk of redundancy, they will be designated by the Trust as a redeployment candidate.

Redeployment candidates may also request that their details be notified to other NHS Wales organisations for consideration of vacancies. It should be noted that these organisations have no obligation to co-operate with the redeployment process, unless the redeployment is related to an OCP case (covered under the separate OCP policy).

Where an employee is interested in a post advertised in another NHS organisation, the People Redeployment Case Manager will ensure that their details (as contained in the Information Collection Form) are forwarded to the Workforce Department of the NHS organisation, for consideration during the shortlisting process.

It will be the responsibility of the employee identified as at risk of redundancy to:

- maintain regular contact with their Redeployment Case Manager, including notifying them of any extended periods of absence, such as sick leave, annual leave, maternity leave etc., to ensure that information about appropriate vacancies is made available to them during the redeployment period.

- complete and sign the Information Collection Form (Appendix 1 of the Redeployment Procedure), within 7 days of receipt, providing all relevant information / documentation in relation to contact details, employment record, qualifications, experience and role / job preferences.

- complete and sign the Redeployment Scheme Employee Agreement Form (Appendix 2), within 7 days of receipt, to comply with the terms of the redeployment scheme and work proactively with the Trust to secure alternative employment, within the prescribed notice period timescales.

- access and review NHS jobs and other relevant internet job search sites, recruitment media etc. on a daily basis, to assist in the identification of potentially suitable internal and external NHS / public sector vacancies.

- consider and pursue all reasonable suitable alternative employment opportunities within the Trust / NHS Wales etc. as appropriate.

- comply with the relevant process for applying for / considering vacant posts for which they are potentially suitable (with reference to their knowledge, skills, qualifications and experience).

- bring to the attention of their Redeployment Case Manager any vacancies which they are interested in, and their Redeployment Case Manager may not be sighted on, to enable such opportunities to be explored via this process, if appropriate.

- contact the Redeployment Case Manager, should they require any additional information regarding vacant posts, to assist them to make an informed decision regarding the suitability of the vacancy.

- complete the relevant process for applying for / considering all identified suitable alternative posts and attend all associated arranged meetings, assessments, interviews etc.

- approach their manager to request reasonable time off work to attend meetings etc. in relation to their redeployment.

- co-operate fully when considering and being considered for suitable alternative posts. Whilst reasonable attempts will be made to accommodate employee's preferences, they should not unreasonably refuse to accept an offer of suitable alternative employment. Should an employee unreasonably refuse a post that has been assessed by the Trust as being one which could provide suitable alternative employment, the matter will be investigated. Should this process determine that the employee has unreasonably refused to participate in the relevant process / accept an offer of suitable alternative employment, it may result in the employee losing their entitlement to a contractual redundancy payment, upon termination of their employment.

- meet with a People and Relationship Manager should their Redeployment Case Manager believe that they have unreasonably refused an offer of suitable alternative employment.

All redeployment candidates will be entitled to be accompanied by a trade union representative or a work colleague, if they so wish during any redeployment related meetings. The employee's trade union representative or workplace colleague will not be permitted to attend any suitability assessment meetings / discussions or interviews.

7.3 People and Relationship Advisor / Manager

The Trust will nominate a People and Relationship Advisor/ Manager, to support employees at risk of redundancy. The People and Relationship Advisor/ Manager will act as the "Redeployment Case Manager" for all such redundancy cases.

It will be the role of the nominated Redeployment Case Manager to:

- work proactively with employees at risk of redundancy, to assist them to secure where possible, suitable alternative employment.

- ensure the identified employee's information is recorded on the Trust's Redeployment Register, to facilitate the appropriate management of their case.

- ensure the details / information contained within the Trust's Redeployment Register are maintained and kept up to date.

- review all vacancies that are submitted via the Trust's / hosted organisation's Scrutiny Process, to establish whether any of these posts could offer potential suitable alternative employment opportunity, to any employees on the Trust's Redeployment Register.

- as necessary, assist staff at risk of redundancy to access NHS jobs and any other

online recruitment sites, recruitment media etc. and to download / access vacancy information, if applicable.

- ensure that all appropriate, suitable vacancies and the associated recruitment documentation is made available to employees at risk of redundancy.

- discuss appropriate vacancies with employees on the redeployment register to assist them to assess and make an informed decision regarding their suitability of vacant posts, with particular reference to the person specification, job description and any other available vacancy related information.

- ensure that employees designated at risk of redundancy who meet the essential person specification criteria for the post are offered the opportunity to discuss the job with the appointing manager. This process will assist the manager to assess the employee's potential suitability for the post.

- liaise with the relevant People Manager, should a manager fail to agree to make an offer when an employee clearly meets the essential person specification criteria for the post. The People and Relationship Manager will ensure the matter is investigated and resolved appropriately and in a timely manner.

- liaise with the relevant People Manager, to determine the legal and contractual consequences, should an employee on the redeployment register decline to apply for a potential suitable alternative employment post, which has been brought to their attention or accept the offer of such a post.

- ensure employees designated as being at risk of redundancy have access to Employee Assistance Programme (EAP) support services, careers advice services etc., communicating the availability of such services as appropriate; and

- manage the workforce transactional processes associated with the redeployment or redundancy of an employee e.g. preparing reports for the Remuneration Committee etc.

7.4 Trade Union / Professional Organisation Representative

At the request of the employee identified as at risk of redundancy the trades union / professional organisation representative is responsible for:

- Supporting the employee and attending meetings with them in relation to their redundancy / redeployment. This **will not** include attendance at any formal meetings with a manager to discuss the suitability of a specific post or recruitment interviews.

- Working with the People Department to address any concerns the employee may have regarding the Trust's adherence to the provisions of this policy and associated terms and conditions of employment. Seeking to resolve any issues of concern, informally where possible.

8 Consultation and Selection for Redundancy Procedures

8.1 Ad Hoc / Individual Redundancy Consultation (Non OCP Related) (Less than 20 Employees)

In the event of the manager having to make an employee with two or more years continuous NHS service redundant, not as a result of an OCP process e.g., at the end of a fixed term contract, they are required to follow the three-step dismissal procedure, as set out below.

8.1.1 Three Step Dismissal Procedure

1. Provide the employee with a **written invitation to attend a dismissal meeting,** to set out the arrangements and reason for ending the contract of employment.

2. **Meet with the employee** to confirm the reason for the dismissal and to provide them with contractual notice.

   If the employee has 2 or more year's continuous NHS service, they may be entitled to a contractual redundancy payment. In these circumstances the employee must be advised of the redeployment process and the need to create a formal record using a 'Collection of Information Document" (*available from the People Team/Intranet*) to record their relevant personal details, circumstances, preferences, knowledge, skills, qualifications and experience. This information will be utilised to populate the employee's Trust Redeployment Record and assist with the search for suitable alternative employment to try to avoid a redundancy situation.

   Following the meeting we will provide the employee with **written confirmation** of the consultation meeting discussions. This letter must outline the reason for their dismissal and confirm the notice period and contract end date. If the employee is entitled to a contractual redundancy payment, this information along with the redeployment process information must also be outlined in the letter.

3. Provide the employee with a **right to appeal**. This must be clearly set out in the written confirmation of the consultation meeting discussions letter.

Where a fixed term post becomes redundant and the employee has less than 2 years continuous NHS Service, while they will not be entitled to a redundancy payment, the manager will still be required to follow the three-step procedure.

Approval must be obtained from the Trust Remuneration Committee for all redundancy payments and therefore, a paper with full details of the situation and costs should be submitted in advance. The paper should be written by the Manager, with input from the People and OD Team. A template can be obtained from the People and OD Team.

8.2 Ad Hoc / Individual Redundancy Consultation (OCP Related) (Less than 20 Employees)

In the event of the manager having to make an employee redundant as a result of an OCP process, they are required to adhere to the Organisational Change Policy requirements relating to at risk employees, set out below, prior to and in addition to the *three-step dismissal procedure* (*See 8.1.1 above*).

1. Identify the employee(s) who are at risk of redundancy. The timing of this decision should be discussed and agreed with the local trade union representative(s).
2. Issue the employee with an OCP 'at risk' of redundancy letter.
3. If suitable alternative employment cannot be secured within the new structure the manager must instigate the *three-step dismissal procedure.*

The Trust will work in effective partnership with trade union representatives on all potential OCP redundancy situations to effectively manage and where possible minimise, the potential workforce implications.

8.3 Collective Redundancy Consultation (20 or More Employees)

Where it is anticipated that a significant number of compulsory redundancies may be required as a result of organisational change etc., the relevant Divisional / hosted organisation's Director will inform the Executive Management Board (EMB). There is no requirement to notify the Executive Management Board of ad hoc redundancies which arise outside of an OCP process. Such ad hoc cases will however (as noted above) be notified to the Trust's Remuneration Committee, by the People and OD Department.

In respect of potential collective redundancies (20 or more employees) which arise because of an OCP or any other process, the Trust will follow and adhere to the consultation principles outline in Section 5 and Appendix 2 of the OCP.

In respect of collective redundancies, the consultation should begin in good time and must, in any, event adhere to the following requirements:

20 – 99 employees are to be made redundant over a 90-day period; consultation must begin at least 30 days before the first dismissal takes effect.

100 plus employees are to be made redundant over a 90-day period; consultation must begin at least 45 days before the first dismissal takes effect.

NHS Wales and the Trades Unions recognise that should the Trust propose the need to dismiss 20 or more employees as redundant (within the meaning of the definition within the Trade Union and Labour Relations (Consolidation) Act 1992 (TULRCA)) at one establishment within 90 days or less, then the statutory consultation framework under Section188 TULRCA will be engaged.

During any collective redundancy consultation process the Trust will inform the relevant trade union representatives of the reason for the proposed redundancies and the number of employees affected. During the consultation process the following areas will be covered:

(i) A commitment to keep local trade union representatives informed as fully as possible about workforce requirements and the proposed redundancy situation.

(ii) Information on alternative proposals which may be considered to avoid or reduce the number of redundancies.

(iii) Possible steps to take in order to mitigate or reduce the consequences of the redundancies.

(v) Disclosure of information relating to:

(a) the reason for the proposal(s).
(b) the number and description of the employees affected by the proposals.
(c) the proposed redundancy selection criteria and seek to agree this in partnership.
(d) the dismissal process and the period over which the dismissals will take effect.
(e) the method of calculating (contractual or statutory) the amount of redundancy payment to made to the affected employees.
(f) arrangements for time off for employees to seek alternative employment opportunities or retraining opportunities; and
(g) arrangements for the additional assistance which will be provided to staff as outlined in Section 7.

The information set out in ***point (v)*** above will be provided in writing to each trade union representative during the meeting or as soon as practicable after the meeting.

Should the collective consultation process confirm that 20 or more employees will be made redundant, the next stage of the consultation process will commence. The manager, along with a People and Relationship Advisor / manager, will arrange one to one meetings with the affected employees and outline the selection for redundancy process.

During this meeting the manager and the People and Relationship Advisor / manager will provide appropriate support and advice to the affected employee. They will also create a formal record to record their relevant personal details, circumstances, preferences, knowledge, skills, qualifications and experience on an 'Collection of Information Document" (*available from the People Team/Intranet*). This information will be utilised to populate the employee's Trust Redeployment Record and assist with the search for suitable alternative employment.

Following this meeting, or where it is proposed that less than 20 employees will need to be made redundant, the process will revert back to the three-step dismissal procedure (See Section 8.2 above).

9 Suitable Alternative Employment

All eligible employees will be supported where possible to secure a suitable alternative employment post, with similar pay and conditions of service to avoid a redundancy situation. An offer of suitable alternative employment may be made without the employee participating in an interview / selection process, if the job is deemed to be same or very similar to the employee's existing job.

If there is only one suitable 'at risk' employee identified for a redeployment post, the Trust may offer it to that employee without any formal suitability assessment process.

An employee who is offered a new job to avoid compulsory redundancy will be provided with a copy of the job description and person specification, detailing the post and the requirements to perform effectively in the role. Where any of the terms and conditions attached to the post

differ from the employee's current post, these will be set out separately, in writing as will any protection arrangements which may apply.

There will be no limit on the number of posts which the Trust or the employee may identify as offering potential "suitable alternative employment". The limiting factor will be the number of vacant and fully funded posts available during the redeployment period.

The refusal to accept or apply for suitable alternative employment posts will affect an employee's eligibility to receive a contractual redundancy payment, as set out in Section 16.17 of the NHS Terms and Conditions of Service Handbook.

Any employee who unreasonably refuses an offer of suitable alternative employment will lose their entitlement to a contractual redundancy payment. In relation to redeployment into a suitable alternative employment post, the following criteria will be considered, as will the reasonableness of the employee's refusal of the post, if applicable:

(i) Nature of the job, including job content (including similarity to existing role)

(ii) Status of the role

(iii) Salary

(iv) Hours of Work

(v) Workplace (Base, including potential travel distance / time / modes of transport etc.)

(vi) Work environment

(vii) Job / career prospects

(ii) Qualifications, knowledge and skills required for the role

(iii) Personal and/or domestic circumstances. In relation to personal circumstances employees will be expected to show some flexibility by adapting their domestic arrangements where possible*

*Account must be taken of the requirement to make reasonable adjustments for staff covered by the Equality Act 2010.

Any offer of employment, which is considered to be suitable by the Trust must be made in writing, providing sufficient details of the post and allowing reasonable time for the employee to consider it, prior to expiry of the notice period. The offered post should be available no later than four weeks, from the date the existing contract is due to end by reason of redundancy. The offer should, where appropriate, indicate any terms and conditions which differ between the existing and the new job. Where this procedure is followed and the employee fails to respond to any such offer, the employee shall be deemed to have refused the offer of suitable alternative employment.

The acceptance of a post which is considered suitable, may be subject to a four-week trial period. Trial period arrangements, including the mechanisms for assessment and review are set out in section 8 of the Velindre University NHS Trust Redeployment Procedure and Section 6.6 of the NHS Wales OCP Redeployment Policy.

In exceptional circumstances, the trial period can be extended for a maximum of 4 weeks by mutual agreement. This should be on the basis that further assessment of progress needs to take place, based on the assessment process, established, and agreed prior to the commencement of the trial period.

If the Trust and the employee agrees that an offered post does not provide suitable alternative employment, on or before the completion of a four-week trial period, a contractual redundancy payment may be payable, if suitable employment cannot be found before the end of the notice period.

If it is established by the Trust that an employee has unreasonably terminated their employment on or before the completion of an agreed trial period, they will not be entitled to a contractual redundancy payment.

10 Selection for Redundancy

The Trust will make appropriate arrangements to ensure that all employees affected by change and at risk of redundancy, including those on any form of authorised absence, which may include maternity leave, parental leave, carers leave, term-time working, long term sick leave or secondment, are considered at each stage of the process and are not disadvantaged in any way.

The organisational change process will, were applicable, identify the relevant group of employees from which redundancies may be necessary. This is known as the potential 'pool for selection'. The timing of when employees will be declared at risk of redundancy will be agreed in partnership with the trade unions, during any period of organisational change.

The pool for selection process will not apply to one off redundancy situations e.g. an employee's fixed term contract expires without renewal or a single employee (in a single, unique post) is determined to be at risk of redundancy as the result of an OCP process.

A redundancy selection process will comply with the following broad OCP principles:

- All employees affected by the proposed changes will be treated on the basis of equality.
- All employees at risk of redundancy will be supported, where possible, to secure a post with similar pay and conditions of service (suitable alternative employment).
- All employees will be treated fairly and with dignity and respect: Principles of equality will apply, and the processes will be transparent.
- Where there are fewer posts than employees, the selection for redundancy decisions will be based on the outcome of the prior consideration or restricted competition selection process. This process will fully consider the merits and the suitability of each of the eligible employee, identified as being at risk, based on a selection process which will thoroughly assess their knowledge, skills, experience etc.,
- The minimum required for a prior consideration or restricted competition selection process will be a formal selection interview.

10.1 The Selection Criteria

The Trust must use an objective redundancy selection criteria and process which is non-discriminatory and is applied in a fair and consistent manner to all affected employees, when there are more employees than posts. The following selection criteria will be applied in a redundancy situation (involving more than one employee) in accordance with the NHS Wales Organisational Change, Appointment and Selection Process.

(i) The qualifications which are essential for the post.
(ii) The knowledge and skills which are essential for the post.
(iii) Experience which is relevant to the post and the needs of the business.
(iv) Suitability for trial period / re-training to meet the criteria; and
(v) The need for reasonable adjustments to be made to the post in accordance with the Equality Act (2010).

Every employee involved in the process will be entitled to receive feedback on their performance during the selection process, from a nominated member of the interview selection panel.

11 Notification of Redundancy

Once employees selected for redundancy have been identified, they will be invited to discuss the matter at a formal meeting. During this meeting, they will be served in accordance with their contractual notice period. Following this meeting they will receive writing confirmation of their redundancy dismissal and right of appeal. In the absence of any agreement with the Trust, the employee will be obliged to serve their notice period. This process will be managed in accordance with the three-step dismissal procedure (noted in section 8.1.1).

All employees who are served with redundancy notice will be given reasonable time off work with pay to seek alternative employment. Employees will normally be allowed to leave before the expiry of the period of notice, if they have been offered other employment to begin prior to their termination date. In such cases it is important that the manager and the employee discusses this with the People Department, to ensure that the appropriate paperwork is completed in advance.

12 Notice Periods

Contractual notice should be served on any employee selected for redundancy unless their statutory notice period is greater.

In exceptional circumstances the Trust may, with the agreement of local Trade Union representatives offer an extended notice period, to maximise the possibility of redeployment opportunities arising.

Subject to mutual agreement an employee may leave before the expiry of notice and not lose their entitlement to their redundancy payment if the employee, obtains suitable employment outside the Trust / and wishes to take up the post before the end of the notice period. In such cases the new termination date will become the revised date of redundancy for the purpose of calculating the redundancy pay and;

In the event that an employee' engages in conduct resulting in a fair reason for dismissal during the notice period, they will lose their entitlement to a redundancy payment.

In respect of the notice, the Trust reserves the right to make a payment in lieu of notice and a contractual redundancy payment in full and final settlement (subject to statutory regulation in force from time to time) of the redundancy dismissal case.

13 Redundancy Pay

Contractual redundancy pay will be payable to employees dismissed by reason of redundancy who, at the date of termination of their contract, have at least 104 weeks of continuous full time or part time service with the Trust or another NHS employer. For the definition of continuous service, reckonable service, a month's pay and calculation of a redundancy payment please refer to section 16 of the NHS Terms and Conditions of Service Handbook.

There are also arrangements for early retirement on grounds of redundancy and in the interest of the service. Details of these arrangements can be found under Section 16.12 of the NHS Terms and Conditions of Service Handbook. To be eligible for this element of the scheme employees must have at least two years of continuous full-time or part-time service and two years qualifying membership of the NHS Pension Scheme.

14 Appeal Procedure

Employees have the right of appeal against a redundancy dismissal decision. Appeals should be made in writing to the Executive Director of OD and Workforce within 14 calendar days of receipt of written notification of the dismissal decision.

The appeal hearing should take place within 28 calendar days of the notification of the appeal being received. In some circumstances, it may be necessary to extend this deadline, but every effort will be made to hear the appeal promptly.

The dismissal appeal hearing will be undertaken in accordance with the provisions set out in the Dismissal Appeal Hearing Procedure (***Appendix 1***).

15 Equality Statement

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

The Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups where

appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

In the application of this policy all employees will be treated with dignity and respect, taking into account equality legislation.

The Trust is required to monitor the implications of this policy and to ensure that it assesses the impact of any proposed redundancies across the 'protected characteristics' and in respect of individual's human rights.

16 Getting Help

Employees at risk of redundancy have access to various support options. These can be accessed via the People and OD Department:

(i) assistance in accessing vacancies as appropriate.
(ii) support to prepare a CV, write an application form, update their interview skills etc.
(i) assistance in accessing vacancies as appropriate.
(ii) use of Trust facilities and assistance in applying for suitable alternative posts.
(iii) reasonable paid time off to attend interviews.
(iv) Access to training / re-training opportunities where these are reasonable and affordable.
(v) Signposting to financial and pension advice.
(vi) Access to Employee Assistance Programme, Occupational Health advice and support etc.

17 Related Policies and procedures

- All Wales Organisational Change Policy
- All Wales Organisational Change Redeployment Policy – Appendix 5
- Redeployment Procedure
- Retirement Policy
- All Wales Disciplinary Policy
- All Wales Respect and Resolution Policy

Appendix 1

VELINDRE UNIVERSITY NHS TRUST

DISMISSAL APPEAL PROCESS

1. The individual to whom an appeal is made, must be specified within the letter informing the employee of the manager's decision to dismiss the contract i.e., Executive Director of OD and Workforce.

2. An employee who wishes to appeal against a dismissal must lodge their appeal within 14 calendar days of receiving written notification of original dismissal decision.

3. The employee's written request to lodge an appeal must clearly set out the reason for and the grounds on which the appeal is based.

4. An "appeals officer" will be appointed by the Executive Director of OD and Workforce. In dismissal appeal cases the appeals officer will be a senior manager nominated by the Executive Director of OD & Workforce, in line with the Trust's scheme of delegated authority.

5. The appeals officer nominated to hear an appeal must not have been involved in the process at any earlier point.

6. The appeal will be heard within 28 calendar days of the notification of the appeal being received. In some circumstances, it may be necessary to extend this deadline, but every effort will be made to hear the appeal promptly.

7. At least 14 calendar days before the appeal hearing the employee should submit, to the nominated appeals officer, any additional information / documentary evidence in support of their appeal.

8. The "manager" who made the original dismissal decision is required to provide a written Statement of Case, justifying the action taken at the dismissal meeting. This documentation must be exchanged with the employee and the appeals officer at least 10 days before the appeal hearing date. The Statement of Case may contain supporting documents and relevant policies etc.

9. The manager may be accompanied by a People and Relationship Advisor/People colleague, who supported the dismissal meeting process.

10. Another member of the People Team will be in attendance throughout the appeal hearing, to provide professional advice and to support the appeals officer and the employee. It is their role to ensure that all aspects of the appeal are fully explored. The appeals officer must ensure that they have access to appropriate professional, specialist, or technical advice, where necessary.

11. The purpose of the appeal hearing is to establish if the decision made by the manager was reasonable and fair in the circumstances.

12. The appeal hearing must restrict itself to looking at the grounds of appeal made by the employee and ensuring that these grounds are adequately examined, to reach a proper judgement on whether the appeal should be upheld or not. In most circumstances, the appeal hearing will not be a re-examination of all the evidence.

13. The appeal hearing will consider specifically whether the action decided upon by the manager was fair and reasonable at the time that the action was taken. The appeal hearing may also consider whether the procedure was applied correctly, when deciding on the action taken to dismiss.

14. The appeal will take account of any substantial new information cited in the grounds for appeal or presented during the appeal hearing process.

15. The decision(s) reached by the appeals officer is considered final. No further appeal mechanism will operate within Velindre University NHS Trust.

Conduct/Order of the Appeal Hearing

1. The Appeal Officer will act as chair of the appeal hearing and will introduce those present.

2. The manager (who made the dismissal decision or the previous course of action), the People and Relationship Advisor (who supported the dismissal meeting), the employee and his/her representative will remain present throughout the proceedings until the appeals officer adjourns, to deliberate in private.

3. The employee and his/her representative shall confirm the reason for and the grounds of their appeal and provide information supporting their case.

4. The appeals officer and their People support will have the opportunity to ask questions of the employee.

5. The manager and the People and Relationship Advisor will have the opportunity to ask questions of the employee.

6. The manager will present the justification for the decision that they took to dismiss the employee.

7. The employee or their representative will have the opportunity to ask questions of the manager and the People and Relationship Advisor.

8. The appeals officer and their People support will have the opportunity to ask questions of the manager.

9. The employee or their representative will have the opportunity to sum up their case. New information must not be introduced at this stage.

10. The manager will have the opportunity to sum up. New information must not be introduced at this stage.

11. The appeals officer may, at their discretion, adjourn the appeal hearing in order that further information may be sought and reviewed.

12. The appeals officer shall deliberate in private with their People support (to provide professional advice and support) only, recalling both parties to clarify points of uncertainty on evidence already given. If a recall is necessary, all parties shall return to the hearing.

13. When a decision is reached by the appeals officer, they should inform the employee and manager (who made the decision on the previous course of action) of the outcome immediately or within 7 calendar days. In either case, the decision will be notified in full, to all parties in writing, within 7 calendar days of the appeal hearing date.

14. The decision of the appeals officer is final and there is no further internal right of appeal.

Ref: TBC NEW POLICY

RECRUITMENT AND SELECTION POLICY
AGENDA FOR CHANGE

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
Document Author:	Head of Workforce
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	December 2023
Equality Impact Assessment Outcome:	No identified impact
Review Date:	Three years from date of approval
Version:	

1. Policy Statement

To ensure the Velindre University NHS Trust (the Trust) delivers its strategic aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that the recruitment and selection of our people is conducted in a systematic, comprehensive and fair manner, promoting equality of opportunity at all time, eliminating discrimination and promoting good relations between all.

The Trust recognises our employees are fundamental to the success of the organisation and we are committed to attracting, appointing and retaining qualified, motivated people with the right skills and experience to ensure the delivery of a quality service for patient and donors.

In order to achieve this we will:

- Provide a well-defined Policy and supporting Procedures for managers to work within and ensure they are clear about the principles underlying the recruitment and selection processes
- Promote the values of the Trust and ensure that this is reflected in the selection of candidates
- Work at all times within current employment legislation and best practice guidelines to ensure a fair and equitable recruitment process
- Provide a workforce planning structure to ensure recruiting managers are fully considering the needs of the service before advertising
- Ensure that every post has a written job description and person specification that has been appropriately evaluated in line with Agenda for Change Handbook
- Employ staff on permanent contracts of employment as the norm, with fixed term contracts only used where necessary and appropriate. *NB: Any employee engaged on a fixed term contract will be entitled to terms and conditions of employment that are no less favorable on a pro-rata basis than the terms and conditions of a comparable permanent employee, unless there is an objective reason for offering different terms.*

2. Introduction and Aim

This policy aims to provide the framework for managers to recruit talented and motivated staff to deliver for our patients and donors within a positive legal and regulatory framework.

By following this Policy, appointing managers can be assured that they are operating within the confines of current employment legislation, and they are able to avoid discrimination and recruit safely without putting the Trust, our staff or patients and donors at risk.

3. Objectives

The objectives of this policy are to:

- Ensure that appointing managers and applicants are clear about their role and the role of other stakeholders in the recruitment and selection process
- Ensure that appointing managers and applicants are clear about the principles underlying the recruitment and selection processes
- Support managers in appointing the best candidate for each position
- Ensure that all necessary steps are taken before a new member of staff starts with the Trust
- Promote the Trust's vision and values ensuring that these are embedded into the recruitment and selection process and wider organisational culture

4. Scope

This procedure applies to all managers and staff who are involved in the recruitment and selection of staff employed under Agenda for Change Terms and Conditions and any other employees except for those appointed onto Medical and Dental Terms and Conditions.

For information on the appointment of employees under the Medical and Dental Terms and Conditions of Service please contact the People and OD team.

5. Responsibilities

Applicants are responsible for:

- Submitting an accurate, honest and complete application
- Rising requests for reasonable adjustment during the assessment process
- Notifying the appointing manager if they are unable to attend an assessment
- Providing the appropriate documentation to enable pre-employment checks to be undertaken

Mangers must:

- Effectively workforce plan their services ensuring vacancies are designed to meet the Trust's goals and objectives
- Detail the skills and requirements for the role in line with the Job Evaluation Procedure and DBS Procedure.
- Ensure that they follow this Policy and adhere to the recruitment and selection principles set out in the relevant documents
- Act in a way that ensures the Trust's recruitment, selection and appointment of staff is undertaken in a fair, anti-discriminatory and safe manner, and that the Trust's vision and values are considered as an integral part of the recruitment process
- Understand their role as recruiting manager and the role played by People and OD and Employment Services Team (NWSSP) and ensure that those elements of the process that they are responsible for are completed thoroughly and in a timely way
- Seek advice from the Workforce and OD function before making an offer of employment if they are unsure about the appointment or starting salary

The People and OD team is required to:

- Ensure individuals involved in the recruitment process are appropriately trained to undertake their roles
- Provide advice on legislation and the principles that govern the recruitment and selection process
- Provide advice on starting salaries and authorise any applications under the Incremental Credit Procedure.
- Ensure that managers have adequate information, guidance and support to fulfil their role in the recruitment and selection of staff
- Offer support and guidance to managers to help them meet the Disability Confident requirements
- Maintain close links with NWSSP to ensure compliance, quality and efficiency in all aspects of the recruitment and selection process

NHS Wales Shared Services Partnership provides recruitment services for all non-medical and dental appointments in NHS Wales. The Employment Services team is responsible for advertising and on-boarding into vacant posts in a professional, timely manner and ensuring that all the required pre-employment checks take place.

6. Values Based Recruitment

Values Based Recruitment is an approach to help attract and select employees whose personal values and behaviours align with those of the Trust. It is about enhancing existing processes to ensure that we recruit the right workforce not only with the right skills and in the right numbers, but with the right values to support effective team working and excellent patient and donor care.

Values Based Recruitment can be delivered in a number of ways, for example through pre-screening assessments, values based interviewing techniques or assessment centre approaches. It can sit within a competency based interview through asking questions that address matters such as ethical questions, interpersonal relationships or decision making.

6. The Recruitment and Selection Process

6.1 Before deciding to advertise a post, managers should be certain that a real vacancy exists and be clear about the requirements of the job. Like for like replacements should not be taken for granted. Consideration should be given to whether or not there is scope for modernisation before replacing posts – when determining this managers may want to undertake a workforce planning exercise with support from the People and OD team. If there is a fundamental change to the post or this is a new post, the vacancy will need Scrutiny approval.

6.2 Each job should have a written job description and person specification that has been evaluated in line with the Agenda for Change Job Evaluation Procedure. These should be reviewed every time a vacancy occurs to ensure that they remain relevant and flexible, including making reasonable adjustments should people with disabilities apply. Changes to the job description or personal specification will need to be

reviewed by the People and OD team to ensure there is no impact to the pay band of the post.

6.3 Managers need to consider the role requirements to undergo criminal records checks through the Disclosure and Barring Service (DBS CHECK) to ensure the safety or our patients and donors. The requirement and level of checks needs to be clearly articulated on the Job Description. The DBS Procedure provides detailed information on assessing the role requirements for a DBS check.

6.3 When the appointing manager is satisfied that the vacancy details and job description are correct they should submit this for approval via Trac to the Head of Service, Finance Business Partner and People and OD team. NWSSP will then publish the vacancy to advert.

6.4 On occasion where a vacancy is a short-term secondment (no longer than 12 months) or a Temporary Movement to a higher band in line with Agenda for Change terms and conditions managers may be able to advertise through and expression of interest. All expressions of interest must be approved Scrutiny.

6.5 Applicants must provide detailed information regarding their full employment history to date in all cases.

6.6 All applicants will be shortlisted for interview on the basis of the information they provide on their application form. It is the responsibility of the appointing manager to oversee the shortlisting process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is best practice for more than one person to shortlist candidates. Candidates who do not meet all of the essential criteria should not be shortlisted. In order to ensure a fair and transparent process, reasons for the selection or rejection of all candidates must be recorded on Trac.

6.7 The Trust is committed to improving the diversity of our people and to being a fully inclusive employer. Research has shown that diverse teams make better decisions and are more productive. This means we actively look to recruit from underrepresented groups, provide a fully inclusive and accessible recruitment process, offer an interview to disabled people who meet the minimum criteria for the job, and are flexible when assessing people's skills so applicants have the best opportunity to demonstrate that they can do the job. We also proactively offer and make reasonable adjustments as required.

6.8 All applicants must have a formal interview before an appointment can be made. This is essential as it provides an opportunity to discuss the candidate's application and employment history fully, and explore any areas of doubt or concern prior to an appointment being made. It is the responsibility of the appointing manager to oversee the interview process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is expected that more than one person will interview candidates, and where possible, best practice would be for of an interview panel representing various gender and ethnicities undertake the interview process.

Discriminatory questions must be avoided (see Managers Guide to Conducting an Interview). To avoid discrimination during an interview, managers should bear in mind the following guidelines:

- Candidates should not be asked about their marital status, family commitments and/or domestic arrangements, nor should they be asked about any actual or potential pregnancy/maternity leave
- Ensure that questions focus on the applicant's ability to perform the role, not on potential difficulties he or she might have on account of an actual or potential disability
- Frame questions in a positive way so as to avoid the risk of the applicant believing you are looking for or anticipating problems
- Remember that there is no duty on applicants to voluntarily disclose a disability to a prospective employer and that it is unlawful to ask about an applicant's health (including any disability) before offering him or her a job.
- Don't place too much importance on length of experience as this will place younger applicants at a disadvantage. Instead, concentrate on the interviewee's type and breadth of experience, and their skills, competencies and talents.

6.9 Pre-employment checks seek to verify that an individual meets the preconditions of the role they are applying for. All offers of employment are therefore conditional and subject to the following pre-employment checks (as applicable to the post):

- Right to work checks (It is a criminal offence to appoint a candidate without the appropriate right to work in the UK)
- Identity checks
- Professional registration and/or qualification checks
- Employment history and references checks
- Work health assessments
- Discourse and Barring Checks

These checks are carried out by NWSSP Recruitment Services on behalf of the Trust more information can be found on the Trust's Attraction, Recruitment and Retention intranet page.

7. Recruitment and the Welsh Language

The Trust is committed to providing quality care for patients and donors through the medium of Welsh and Welsh language skills must be actively considered as part of the workforce planning and role design process.

Welsh language skills are needed to ensure patients and donors have access to services in their preferred language. Welsh language provision has been identified as a clinical need as well as a communication need as it enables a deeper understanding of patient outcomes and donor care.

To support these outcomes recruitment mangers are required to complete the following process:

- Complete the Welsh Language Assessment providing evidence of the language skills required for the specific post
- Ensure that the post has Welsh language support from the wider team should Welsh language skills not be needed for the specific role
- State the level of Welsh language skills required clearly
- State whether the post is Welsh language 'Desirable' or 'Essential'
- Ensure the Job description and advert are translated by sending it to Velindretranslations@wales.nhs.uk
- Send the completed language assessment form to the Trust Welsh language Manager

8. Making a Salary Offer

Velindre NHS Trust fully supports the principle of fair pay and want our people to be paid fairly and consistently for the work undertaken. The Agenda for Change NHS Terms and Conditions of Service Handbook (The Handbook), Section 12.2 gives the Trust discretion to take into account any period or periods of employment outside of the NHS judged to be relevant to NHS employment.

The appointing manager should not make a salary offer above the minimum of the pay band however managers can make an applicant aware of Incremental Credit Procedure and application process where reckonable service or equivalent relevant experience may apply.

9. Induction

It is vital for line managers to prepare for how a person is welcomed into their role and the Trust. Failure to do this can create a poor impression and undo much of the work which attracted the candidate to the job. As soon as the successful applicant accepts the job offer, managers should start to organise a carefully planned programme to settle them into the role, team and organisation, so they become effective as soon as possible, and want to stay.

In addition, the People and OD team delivers provides a Corporate Induction which is suitable for all new staff and which must be completed within eight weeks of starting employment. Line Managers must ensure that new starters are given time to undertake this programme.

10. Right to Recruitment Information

A candidate, both successful and unsuccessful, is entitled to make a request for their recruitment information, including shortlisting and interview criteria and scores or observations made on the candidate. It is therefore important that the process is accurately documented and the information is retained by the recruiting manager in the most secure and safe manner. The information should be destroyed after six months, unless there is a legal obligation on the Trust to retain this for longer (i.e. the recruitment process is subject to an employment tribunal claim against the organisation).

11. Audit and Monitoring

The Workforce and OD Department will monitor the application of this policy and documentation will be audited on a regular basis. All confidential records will be stored in line with the General Data Protection Regulations.

Anonymised data may be analysed to identify trends in recruitment relating to protected characteristics under the Equalities Act 2010 or other Trust initiatives. These findings may be used to inform future plans and activities for the Trust.

12. Review

The Workforce and OD Department will review the operation of the policy as necessary and at least every 3 years.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	16/01/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director
REPORT PURPOSE	FOR NOTING

ACRONYMS	
CRUK	Cardiff Research UK
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 07/12/2023. 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	**RADIOTHERAPY TRIALS SOLUTION GROUP** Dr Paul Shaw, Consultant Clinical Oncologist and Lead for Early Phase Drug Radiotherapy gave an update on the Radiotherapy Trials Solutions Group. The group have met on a number of occasions, working to identify and implement mitigation strategies to improve the radiotherapy service's capacity with regards to research studies and the wider service is progressing well. **ACTIVITY DATA BENCHMARKING WITH OTHER UK CANCER CENTRES** The Research Service's Senior Nursing Team provided an update of the activities and information from the benchmarking visits undertaken in 2023, visiting the Beatson, Institute for Cancer Research in Glasgow, the Christie Cancer Treatment Centre in Manchester and the Queen Elizabeth Hospital in Birmingham. The Research Service's Senior Nursing Team are also linking with Cancer Research UK (CRUK), who are currently developing a Research Nurse Competency framework, which will be considered for adaptation and adoption into the Research Service once published.
ASSURE	**TRUST RESEARCH, DEVELOPMENT AND INNOVATION SUB=COMMITTEE RISK REGISTER EXTRACT** No open risks recorded on Datix for escalation to December's 2023 Committee Meeting, in-line with the Trust Board risk appetite. Following a discussion, a summary of the risk profile for RD&I for assurance purposes will be presented at the next Committee Meeting for items below the threshold for escalated reporting. **TRUST RESEARCH, DEVELOPMENT AND INNOVATION INTEGRATED PERFORMANCE REPORT FOR QUARTER 2, 2023/24** The report provided an update on activities of the Trust's Research, Development and Innovation service during Quarter 2, Financial Year 2023/24. The newly revised report provided an update of activities against the Trust's Research, Development, and Innovation service's strategic priorities 1-4.
INFORM	**PRESENTATION** The RDI Sub-Committee received a presentation by Helen Roberston, Trust RDI Communications and Engagement Officer whose remit is to drive and co-ordinate RDI communications and engagement with patients, public, staff and other external partners and stakeholders about RDI matters (Welsh Blood Service (WBS) and Velindre Cancer Service (VCS). All RDI communications are aligned with the Trust's strategies and RDI strategies. Helen supports teams across the organisation to plan and produce high quality communication and engagement initiatives with content that is in-line with strategic objectives, tailored to specific audiences. The presentation was well received by the RDI Sub-Committee who conveyed their sincere thanks to Helen for the update.

EXECUTIVE SUMMARY HIGHLIGHTS

The Committee received the Executive Summary Briefing which reported high-level activities relating to Research, Development and Innovation during Quarter 2, Financial Year 2023/24 along with noteworthy items from the RDI environment since the last meeting of the Sub-Committee. Key highlights included :

- **Welsh Government / Health and Care Research Wales Annual Review meeting with Velindre University NHS Trust**

Velindre University NHS Trust's (VUNHST) Annual Review Meeting with Welsh Government (WG) and Health and Care Research Wales (HCRW) took place on 5th December 2023. The Trust was assessed against the ten pillars of the NHS Framework for Research and Development – Research matters: What excellence looks like in NHS Wales introduced in July 2023. This was the first year that the Trust had been assessed in this way. Prior to the meeting, the Trust completed a self-assessment against the NHS Framework for Research and Development, this was returned to Welsh Government in September 2023. Overall, the meeting was positive and the outcomes of the Annual Review Meeting once received from Health and Care Research Wales will be reported through the RDI Governance structures of the Trust.

- **Velindre Healthcare Cancer Research Fellowship Scheme**

In September 2023, a second call for applications to the Velindre Healthcare Cancer Research Fellowship took place and three staff members were successful in their applications for a Velindre "Introduction to Research" award:

- **Deborah Lewis,** Clinical Trials Research Nurse, will study post treatment trial emotional support needs.
- **Barbara Wilson,** SACT Team Lead, will compare different approaches for the training and education of nurses for safe SACT delivery.
- **Francis Brown,** SACT Clinical Education, will investigate the potential for education to improve the team management of acute adverse reactions to chemotherapy agents administered at the Velindre Cancer Centre.

The next call for applications will be January 2024 and will offer an opportunity for staff members to conduct research relevant to their clinical practice, two days per week over a two-year period.

- **US Food & Drug Administration approves Capivasertib with Fulvestrant for breast cancer**

On 16th November 2023, the US Food & Drug Administration approved Capivasertib with Fulvestrant for adult patients with the most common type of advanced breast cancer. The decision means people with oestrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER-2) negative breast cancer, with specific genetic alterations (PIK3CA, AKT1 or PTEN gene mutations), that has progressed after standard treatments, will be able to access the new drug in the USA.

The approval for Capivasertib has been granted based on study data generated from the international Phase III CAPItello-291 trial, that was hosted by the Trust and the Phase II FAKTION trial, sponsored by the Trust. Both trials showed significant improvements in the time it took for cancer progression in patients. Communications received by Prof Rob Jones, Associate Medical Director for RDI from Prof Paul Workman, Professor of Pharmacology and Therapeutics at The Institute of Cancer

	Research expressed thanks to the Trust for their involvement in this huge achievement. • **Velindre University NHS Trust – Medical Engagement Meeting** The Trust held a Medical Engagement Event on 8th November 2023, inviting attendees to discuss "Leadership, Research and Clinical & Scientific Strategy: How do we prepare for the next 5-years at VUNHST?" With introductions and opening remarks from Dr Jacinta Abraham, Executive Medical Director and Board Lead for RDI, and Prof Donna Mead OBE, Trust Chair, the event included updates and discussions on the following topics: • Medical Leadership: How do we prepare for the next 5-years? • Reflections from previous events: What's most important for you? • Research: What can we look forward to in the next 5-years? • Shaping our 5-year Clinical & Scientific Strategy. Sir Frank Atherton, Chief Medical Officer for Wales and Dr Paul Evans, Medical Director of the Faculty of Medical Leadership and Management shared their experiences and views as part of the Medical Leadership debate. This was followed by sessions on Reflections led by Dr Mick Button, Research led by Professors Rob Jones and Mererid Evans and Clinical & Scientific Strategy led by Joanna Doyle. With closing remarks from the Trust's Chief Executive Officer, Steve Ham the event produced valuable and interesting debate and discussion having been well attended by medical staff and RD&I staff. • **MediWales Innovation Awards 2023 – BedRace®.** An educational board game that encourages staff to discuss and explore palliative and end of life care, was nominated for an award at the MediWales Innovation Awards 2023. • **The impact of European Blood Alliance Funding** The Component, Development & Research Laboratory was successful in obtaining funding from the European Blood Alliance to investigate a new method to manufacture platelet concentrates for transfusion. The European Blood Alliance is an organisation that aims to be a voice for non-profit blood establishments across Europe. Collaborating with the European Blood Alliance enables our researchers to exchange knowledge from centres Europe-wide to improve the availability, quality, and safety of blood products. The Welsh Blood Service is eager to continue making a meaningful difference in the world of transfusion medicine and look forward to sharing the results of this exciting development. **WELSH BLOOD SERVICE RESEARCH, DEVELOPMENT & INNOVATION STRATEGY PROJECT UPDATE** Updating progress on the WBS RDI Strategy, committee members were asked for assistance in seeking their opinions and input into an open survey for external stakeholders for the RDI Strategy for WBS. The Committee agreed to partake in the survey and a link to the survey was to follow.

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 07/12/2023.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

2023/2024 Quarter 2 (1st July 2023 to 30th September 2023) and Quarter 3 (1st October 2023 to 30th November 2023)

QUARTERLY INFORMATION GOVERNANCE ASSURANCE REPORT

DATE OF MEETING	16/01/2024
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	Ian Bevan, Head of Information Governance Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide **ASSURANCE** about the way VUNHST manages its information in respect of patients, donors, service users and staff, highlighting compliance with Information Governance (IG) legislation and standards, actions to improve management of IG risks and reporting IG incidents and actions from lessons learned. The report highlights 3 of the 8 IG domains for reporting within the period, so over 12 month period all 8 domains are reported on to EMB and subsequently the Committee.

	The three domains and relevant highlights within them for this report are:
	
	(1) Data Protection
	
	• Data Protection Impact Assessments (DPIA) and their role in managing risk.
	  ○ Reviews of existing systems and projects to identify historical DPIA gaps. Where gaps are identified rectification work is underway led by service areas and supported by IG
	
	• Information Asset Registers (IAR) and their impact on assurance
	  ○ Head of IG (HoIG) has developed an Information Asset Owner (IAO) training package to support IAO's in implementing and managing their IAR's. Training and implementation activity for VCS and Corporate prioritised for Quarter 2023/24.
	  ○ IG audits focussing on the analysis and update of Information Assets, Registers and their Owners.
	
	• All-Wales IG policies review, update and amalgamation
	  ○ The 4 All-Wales IG policies have passed their planned review dates. The HoIG is leading on the All-Wales activity (supported by DHCW) to consolidate the 4 policies in to 1 overall IG Policy.
	
	(2) Patient Records
	
	• IG working with VCS Medical Records team providing advice and guidance to support the implementation of the Action Plan following the Subject Access Request (SAR) review.
	
	(3) Cyber Security (secure access)
	
	• Risk analysis against organisational policies and physical and technical measures in place to mitigate risks.

	• Assessment of the risks and potential impacts of four Cyber Incidents were considered in accordance with the Trust's Cyber Resilience and Response Plan Assessment of IG risks and development & monitoring of associated action plans to mitigate / remove risks is delivered through completion of IG reviews and DPIA's. Incidents that have taken place within the reporting period, their analysis and resultant actions which may include increased training provision are reported upon.

RECOMMENDATION / ACTIONS	The Committee are asked to note the contents of the report for **ASSURANCE**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	02/01/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

EMB **ENDORSED** the Information Governance quarterly report for 2023/2024 Quarter 2 (1st July 2023 to 30th September 2023) and Quarter 3 (1st October 2023 to 30th November 2023) for **ASSURANCE**. The report is available on request.

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

APPENDICES	
N/A	

Acronyms

Acronym	Full Title	Acronym	Full Title
DHCW	Digital Health and Care Wales	DPIA	Data Protection Impact Assessment
DPO	Data Protection Officer	EIR	Environmental Information Regulations
EBA	European Blood Alliance	FOIA	Freedom of Information Act 2000
GDPR	General Data Protection Regulations	HOIG	Head of Information Governance
HRM	Health Records Manager	ICO	Information Commissioners Office
IG	Information Governance	IGMAG	Information Governance Management Advisory Group
IM	Independent Member	M&S	Mandatory and Statutory
MVCC	Mount Vernon Cancer Centre	NIIAS	National Integrated Internal Audit System
NWSSP	NHS Wales Shared Services Partnership	RTTQA	Radiotherapy Trials Quality Assurance
SACT	Systemic Anti-Cancer Therapy	SAR	Subject Access Request
SIRO	Senior Information Risk Owner	VCC	Velindre Cancer Centre
VCC QSMG	VCC Quality and Safety Management Group	VCS	Velindre Cancer Services
VUNHST	Velindre University NHS Trust	WBS	Welsh Blood Service

1. SITUATION

The purpose of this report is to provide **ASSURANCE** about the way VUNHST manages its information in respect of patients, donors, service users and staff, highlighting compliance with IG legislation and standards, actions to improve management of IG risks and reporting IG incidents and actions from lessons learned.

The report outlines key **ASSURANCE** activities, (1) Data Protection, (2) Patient Records (3) Cyber Security (Secure Access). The report also includes data security incidents & investigations for the reporting periods of 1st July 2023 to 30th September 2023 and 1st October 2023 to 30th November 2023.

The Committee is asked to **NOTE** the report for **ASSURANCE**.

2. BACKGROUND

All NHS Bodies in Wales must ensure that they have in place organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the DPA (2018) GDPR, FOIA (2000) and EIR (2004).

VUNHST is committed to ensuring the provision of an effective IG Assurance Framework. This ensures that the Trust meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

3. ASSESSMENT OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the Quarter 2 for the period of 1st July 2023 to 30th September 2023 and the first two months of Quarter 3, 1st October to 30th November 2023.

- The three IG Assurance Framework areas being focused on are:

  (1) Data Protection

  (2) Patient Records

  (3) Cyber Security (Secure Access)

Work in these areas will lead to improvements in IG systems & processes.

(1) Data Protection

During the reporting period the activities undertaken to mitigate the risk to the rights and freedoms of data subjects being breached were:

Continued support to service areas in the completion of DPIA's which contributes positively to risk mitigation.

Continuing to conduct IG reviews across WBS focussing on the analysis and update of Information Assets, Registers and their Owners. In addition the reviews are identifying existing systems and projects to identify historical DPIA gaps. Where gaps are identified rectification work is underway led by service areas and supported by IG.

Information Asset Registers (IAR) are a key IG control mechanism, their importance was articulated in the February 2023 IG Audit Report. The Head of IG has developed an Information Asset Owner (IAO) training package to support IAO's in implementing and managing their IAR's. Training and implementation activity within VCS and Corporate is prioritised for Quarter 4 2023/24.

Currently all four All-Wales IG policies are out of date. The Head of IG is leading on the All-Wales activity (supported by DHCW) to consolidate the 4 policies in to 1 overall IG Policy. Timelines are for the Policy to be approved by Trust's and Health Boards via their individual governance processes to begin by 31st January 2024.

IG supported Corporate Governance by providing operational delivery of the Freedom of Information Act function between 16th December 2022 and 30th October 2023.

(2) Patient Records

The Trust must manage patient records in line with applicable legislation, codes of practice and statutory guidance.

The main activity during the period is the continuing need for IG to work with VCS Medical Records team providing advice and guidance to support the implementation of the Action Plan following the Subject Access Request (SAR) review undertaken in June 2023.

(3) Cyber Security (Secure Access)

The Trust has in place processes that enable it to meet it obligation to protect data by means of appropriate "technical and organisational measures", known as the security principle and is contained in both the Caldicott and Data Protection principles.

To ensure that appropriate technical and organisational measures are in place, the Trust conducts risk analysis against organisational policies and physical and technical measures in place to mitigate risk. E.g. service delivery risk balanced against potential cyber risk, which resulted in an SBAR paper that was presented to EMB via the project implementation board on 18th September 2023 in which there was a specific consideration of project and cyber risk due to the nature of the incident.

The EMB endorsed IG quarterly report contains detailed information in relation to four individual Cyber incidents where the potential risks and impacts were considered in accordance with the Trust's Cyber Resilience and Response Plan. A copy of the report is available upon request.

SAR'S, DPIAs, contract register and associated Data Processing/Sharing Agreements (included from previous reporting period to provide assurance) Data security incidents & investigations.

Data Protection SARs for clinical information and requests from third parties

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
2	27	16	59.26%
3	29*	10	34.48%

* 16 of this figure received in November 2023, or which 5 completed, of remaining 11, initial work completed, SOP followed and not expected to breach. Reported to IQSG in December 23 that updated stats will be provided in January 2024.

Data Protection SARs for non-clinical information

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
2	1	1	100%
3	0	0	100%

Data Protection SARs for non-clinical information – NWSSP

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
2	0	0	N/A
3	1	1	100%

Data Protection Impact Assessments

Trust DPIA Register 2023

The Register records the amount of DPIA's that have been completed or are in process between 1st January 2023 to 30th November 2023.

Division	On register	Completed	Not Started	Ongoing	Paused	Cancelled	Total
Corporate	11	2	4	3	0	2	11
VCC	31	10	8	7	1	5	31
WBS	23	7	1	14	0	1	23
TCS	0	0	0	0	0	0	0
HTW	1	1	0	0	0	0	1
Total	**66**	**20**	**13**	**24**	**1**	**8**	**66**

- 4 Trust DPIA's have been completed during Quarter 1 and July 2023/24.
- 7 Trust DPIA's have been completed during Quarters 2 and 3 (October/November) 2023/24

All DPIA's are led by Service areas supported by IG. Progress is achieved using a workshop approach providing advice, guidance and support as necessary. Further DPIA support activity took place in December 2023 and will be reported upon in the next quarterly report.

Completed NWSSP Data Protection Impact Assessments (DPIAs) and Legitimate Interest Assessments (LIA)

Type of Assessment	Quarter 2	Quarter 3 (October/November 2023)
Legitimate Interest Assessment	1	2
Data Protection Impact Assessment	7	3

NWSSP Overview

There are DPIA's which are not recorded, this is because they remain a work in progress with the project owners. There are others from 2023/24 that are also classed as work in progress as projects and their procurement/implementation process are ongoing with expected changes.

Data security incidents & investigations

There has been one incident of note during the reporting period. The incident related to the loss of Medical Records within the postal system, which were subject to a SAR made on 5th June 2023. Further details relating to the incident are contained within the EMB endorsed IG quarterly report which is available on request.

Incidents & Investigations for the period 1st July to 30th Sep (Quarter 2)

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	14	0	14	1	13	1	14	11	3	14
TCS	1	0	1	0	1	0	1	0	1	1
WBS	3	0	3	0	3	0	3	0	3	3
Total Trust	**19**	**0**	**19**	**1**	**18**	**1**	**19**	**12**	**7**	**19**

Incidents & Investigations for the period 1st Oct 2023 to 30th Nov 2023 (Quarter 3)

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	2	0	2	0	2	0	2	2	0	2
TCS	0	0	0	0	0	0	0	0	0	0
Information Technology	1	0	1	0	1	0	1	1	0	1
WBS	1	0	1	0	1	0	1	1	0	1
Total Trust	**5**	**0**	**5**	**0**	**5**	**0**	**5**	**5**	**0**	**5**

The top three themes of incidents have changed since the last report due to the increased incidence of Cyber-attacks. In respect of non-cyber related incidents they continue to be confidentiality breaches whereby;

- Patient records/information sent to wrong recipient (misdirection).
- Staff records/information sent to wrong recipient.
- Staff records/information inappropriately accessed.

It remains the case that most incidents could be avoided with improved IG awareness, education & training of staff as human error remains the common factor.

100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff.

Quarterly IG assurance meetings / updates between Stephen Harries (IM champion for IG), Matthew Bunce (SIRO), Head of IG/DPO and Chief Digital Officer take place to enable more detailed discussion and scrutiny of IG issues providing additional assurance to the committee.

Meetings between the Caldicott Guardians and SIRO are planned for each quarter from Apr ’24 which focus on patient and donor IG issues and risks and controls, systems and processes to mitigate.

Actions:

- IG induction sessions recommenced on 14th November 2023. One session per Trust site per month. Aim: to mitigate IG risk at the start of employment.
- Individual(s) who have caused incidents are required to re-take ESR IG awareness training as well as team specific training, these have continued during Quarters 2 and 3 2023/24. Current Trust compliance at the time of writing is 85.26% against a target of 85%.
- Enhanced IG training delivered by HoIG to teams and/or individuals using a risk-based assessment i.e., no. of incidents from each team balanced against impact.
- If an incident is assessed as potentially having a serious impact on the patient/donor or the family of a patient/donor a Root Cause Analysis investigation is undertaken in addition to the investigation template within DATIX.
- IG support to emerging incidents continues if that support is required.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☐

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

	Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Up to 4% of annual turnover of £17.5m whichever is the highest **Type of Change** **Other (please explain)** A financial penalty would be set by the ICO which would require significant Trust Board involvement
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Compliance with legislation is a mandatory obligation. Equality Impact assessments are undertaken at the time of royal assent for applicable legislation.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	An incident remains which does have significant legal implications for Trust, this case is ongoing and well documented
	1. *Legal costs for the Trust* 2. *Other non-legal costs for the Trust, which could result in;* *Possible non-recovery of costs from the other party*

5. RISKS

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	16th January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 23rd November 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	There were no items to advise the Quality, Safety & Performance Committee.
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	**TCS Programme Finance Report** The year-to-date spend for the TCS Programme is £11.576m Capital and £0.460m Revenue, with a forecast expenditure for the current financial year of £17.928m Capital and £0.785m Revenue against budgets of £14.778m and £0.744m respectively. It was confirmed the funding for the Full Business Case phase of the nVCC Project for £3.140m has been set aside by Welsh Government. The funding letter will be received soon. It is hoped the finance report for the December TCS Programme Scrutiny Sub-Committee will show a break even position because the funding has been received. The following additional Capital Projects commenced in October 2023: • Advanced Design Development Agreement – Capital funding of £3.882m approved in October 2023 • Whitchurch Hospital Site – Capital funding to be secured from Welsh Government as part of the Enabling Works Full Business Case addendum The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 31st October 2023. **Programme Director's Report** The TCS Programme Director and TCS Associate Director of Programmes reviewed TCS Programme's current performance for the reporting period 5th October – 9th November 2023 and concluded an **Amber status**.

	There is currently 10-12week delay on the original programme because of the ground issues experienced with the Satellite Radiotherapy Unit. The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Directors Report.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	16th January 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 26th October 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	**TCS Programme Finance Report** The TCS Programme Finance Report was delivered to the TCS Programme Scrutiny Sub-Committee. The purpose of the report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2023-2024, outlining spend to date against budget as at Month 06 and the current full year forecast. The overall forecast for the Programme is an overspend of £2.894m for the financial year 2023-2024 against a budget of £11.641m. Capital funding has not been allocated for the Outline Business Case phase of the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.800m has been made to Welsh Government. MB provided assurance to the TCS Programme Scrutiny Sub-Committee that he is confident that capital funding will be returned from Welsh Government. SA highlighted to the committee from a public perspective, the current financial situation being faced by the NHS is significant. It was queried based on the current situation, will the project slow down as a result of the current financial position the NHS Wales is in? It was explained that the majority of the investment Welsh Government are making is capital. The new Velindre Cancer Centre costs have been reflected in the Welsh Government capital plans. MB does not envisage issues in terms of Welsh Government capital funding for this project at this point in time. The TCS Programme Scrutiny Sub-Committee **noted** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 30th September 2023. **Programme Director's Report** The Programme Directors Report was delivered to the TCS Programme Scrutiny Sub-Committee. The reporting period for the Programme Director's Report covers from 7th September – 6th October 2023. If the mitigating actions do not deliver a positive outcome in this timeframe, it is possible that the Delivery Confidence Assessment (DCA) rating would change to Amber/Red in the next reporting period. A number of issues required to achieve financial close. These include: • Technical/Design matters • Commercial construct agreed with WG/Acorn • Agreement of governance timetable with Welsh Government • Confirmation of Gateway Review dates

- Completion of the FBC
- Clearance of site

- **Project 3a Integrated Radiotherapy Solution (IRS) and Project 4: Radiotherapy Satellite Centre:**

The Neville Hall Project is approximately 10 weeks behind schedule, it is hoped to claw back some time. RAAC has been identified within the Neville Hall Estate.

A more detailed update will be provided on Radiotherapy during the November TCS Programme Scrutiny Sub-Committee.

- **Project 5 Outreach:**

It has been identified that there is a requirement for 32.5 SACT Chairs by 2025 / 2026. This is calculated by identifying what the overall system requirement would be for the number of SACT chairs across the region to meet that level of expected demand.

The clinical operational model has identified ideally 10% of services will be delivered at home, 45% delivered within Outreach and 45% delivered within the new Velindre Cancer Centre which equals the total capacity of chairs.

Assurance was provided to the TCS Programme Scrutiny Sub-Committee that SACT and Outreach Services are running from Neville Hall Hospital. During COVID the SACT Services were not operating from Neville Hall but these services are since operating again.

The TCS Programme Scrutiny Sub-Committee **noted** the Programme Directors Report.

Tranche Report

The Tranche Report was delivered to the TCS Programme Scrutiny Sub-Committee.

As SHam couldn't attend the October TCS Programme Scrutiny Sub-Committee, the meeting Chair indicated that he and the Members would prefer that the Chief Executive Officer be present when discussing the Tranche Report in detail. Therefore only an initial view on the paper was sought in this meeting

It was decided following the initial conversation a refreshed version of the Tranche Report will be brought back to the November Committee subject to the Independent Members comments and feedback which will be emailed across to CJ.

	The initial comments have been received and Tranche Report was **noted**.
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	**Communications & Engagement** The Communication and Engagement paper was presented to the TCS Programme Scrutiny Sub-Committee. The report details the work to promote the nVCC project, detail the communications issued and highlight the engagement activities carried out recently. It was brought to the Committees attention within paragraph 1.3 correspondence, the key figures within the Communication paper states there are 27 correspondences received and 8 have been responded to. NG assured the TCS Programme Scrutiny Sub-Committee there is no delay in responding to the correspondence. Sometimes due to the nature of the correspondence there is a need to collate the information prior to responding which is why they are held up. The TCS Programme Scrutiny Sub-Committee **noted** the communication and engagement paper. **Nuffield Update** The Nuffield paper outlines the collective assessment of where we are against the Nuffield Trust recommendations. The following key points were highlighted to the TCS Programme Scrutiny Sub-Committee: - The agreed regional approval process for this collective report is via the Collaborative Cancer Leadership Group (CCLG). However, it has been agreed by the SE Wales Chief Executives to place the CCLG into the South East Wales Programme Portfolio programme from August 2023 to support its ongoing progress. As such, the report was received at the Portfolio Delivery Board on 5th October. - A single regional Cancer Programme Board will be established to reinvigorate the strategic system leadership that the CCLG first created. It will be chaired by the Chief Executive of Aneurin Bevan University Health Board and have a dedicated clinical lead, programme manager and supporting administration. - It is envisaged that a Cancer Programme will be developed through the same process adopted by the other regional programmes. This is likely to include a series of collaborative regional workshops to design, develop, articulate and prioritise the future cancer programme to anticipated to commence late 2023. Progress against the Nuffield

	recommendations will also inform these discussions and programme design. The TCS Programme Scrutiny Sub-Committee **noted** the collective South East Wales progress update against the Nuffield Trust recommendations.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NOVEMBER 2023 COMMITTEE EFFECTIVENESS: REFLECTIVE EVALUATION FEEDBACK REPORT

DATE OF MEETING	16th January 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	Liane Webber, Business Support Officer
PRESENTED BY	Liane Webber, Business Support Officer
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

EXECUTIVE SUMMARY	The key points of this report are as follows: • 35% response rate (8 out of 23) • Emerging themes: - Having sufficient time to review papers. - There was open and productive debate. - Cross-cutting themes could be identified. - Further work required in relation to writing for assurance.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to: • **DISCUSS** and **REVIEW** the November 2023 feedback evaluation. • **DISCUSS** the **35%** (8 out of 23) response rate and agree to prioritise evaluation completion moving forward. • **AGREE** the proposed next steps.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**
APPENDICES	
Appendix 1	November 2023 Committee Effectiveness: Reflective Evaluation Feedback Report

1. SITUATION

The Quality, Safety & Performance Committee Annual Effectiveness Survey provides a tool for the Committee to assess its effectiveness against more than just the basic requirements: it provides the opportunity for the Committee to check and assess its effectiveness and operations to give the Board greater confidence and assurance on how it can best meet the requirements of its role.

2. BACKGROUND

After each meeting the Committee issues a **Reflective Evaluation Feedback Survey** comprising of 6 focused questions, directly to all attendees. It has been agreed that the feedback results would be formally reported at each subsequent meeting with any highlights of good practice and proposed changes as a result of the feedback received.

Following previous concerns around the confidentiality of responses to the Quality, Safety & Performance Committee Effectiveness Survey, previously circulated and submitted by email, the use of the CIVICA system to conduct the survey commenced.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 November 2023 Reflective Evaluation Feedback - Methodology

The November 2023 survey consisted of 6 carefully selected and focused questions agreed with the Chair and Executive Lead of the Quality, Safety & Performance Committee. The questions were designed and selected to gain valuable feedback and harness the opinion of all attendees who were present at the meeting**,** to ascertain their views with respect to the Committee effectiveness. To ensure confidentiality no personal data was collected in the completion of the survey questionnaire; hence, all responses are anonymised.

3.2 Findings

23 people were asked to complete the survey and 8 responses were received, giving an overall response rate of 35%. The full survey results are attached in *Appendix 1.*

A review of the results has identified a minor issue with the survey template. As responders are currently able to proceed without selecting a yes/no/partial response the results appear inaccurate where no response has been given. This issue will be rectified prior to circulation of the survey following the January Committee.

Overall the findings identified that further work is required in relation to writing for assurance and the size and level of detail in papers.

3.3 Proposed Next Steps

Committee members and attendees are asked to prioritise completion of the post meeting effectiveness questionnaire / reflective feedback so that the true effectiveness of each meeting can be ascertained.

Corporate Governance team to conduct further work with Trust officers in relation to writing concise and relevant papers and writing for assurance.

Further work to be undertaken to further refine the CIVICA survey template to ensure the accurate collection of data.

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 effectiveness of the Committee is a critical element of the Trusts ability to effectively execute its Quality & Safety responsibilities.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This report provides feedback about the last Quality, Safety & Performance Committee as a process and method of continuous improvement.
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 the feedback received in relation to the last Quality, Safety & Performance Committee 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

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 8

Survey: Committee Effectiveness Survey

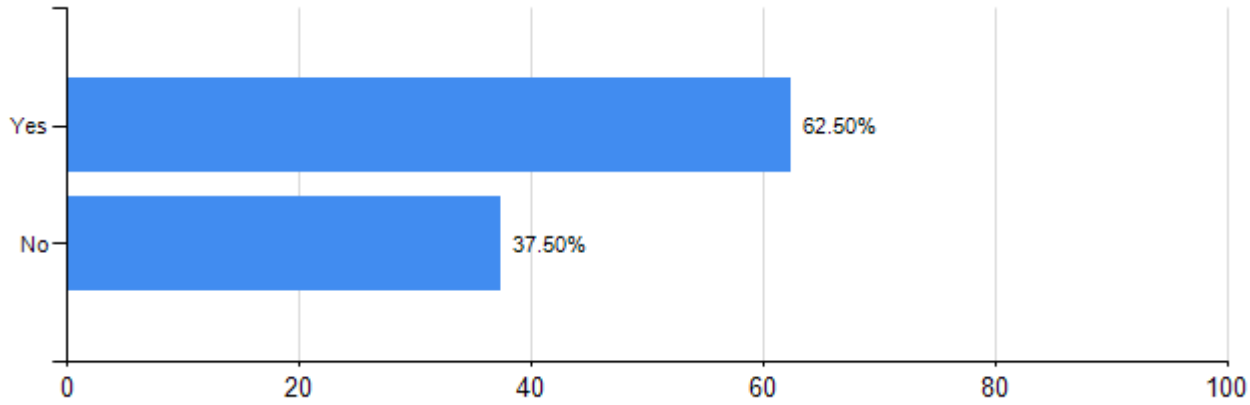
Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Results from: All Tiers

Question 1: Was sufficient time allocated to enable focused discussion for the items of business received at the Committee?

Create new action

Available Answers	Responses	Score (%)
Yes	5	62.50%
No	3	37.50%
Total	**8**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 8

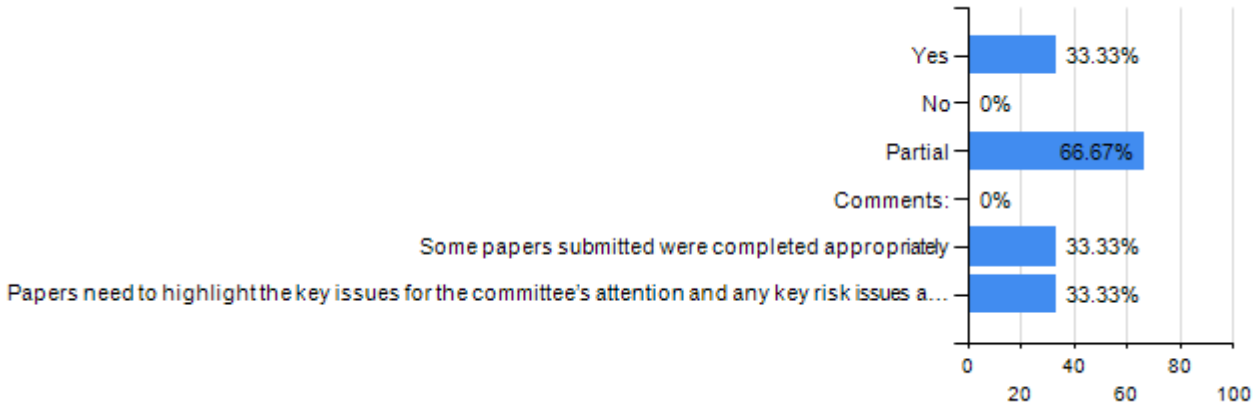
Survey: Committee Effectiveness Survey

Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Question 2: Were papers concise and relevant, containing the appropriate level of detail?(if no/partial, please provide further details)

Create new action

Available Answers	Responses	Score (%)
Yes	1	33.33%
No	0	0.00%
Partial	2	66.67%
Papers need to highlight the key issues for the committee's attention and any key risk issues arising from the paper	1	33.33%
Some papers submitted were completed appropriately	1	33.33%
Comments:	0	0.00%
Total	**3**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 8

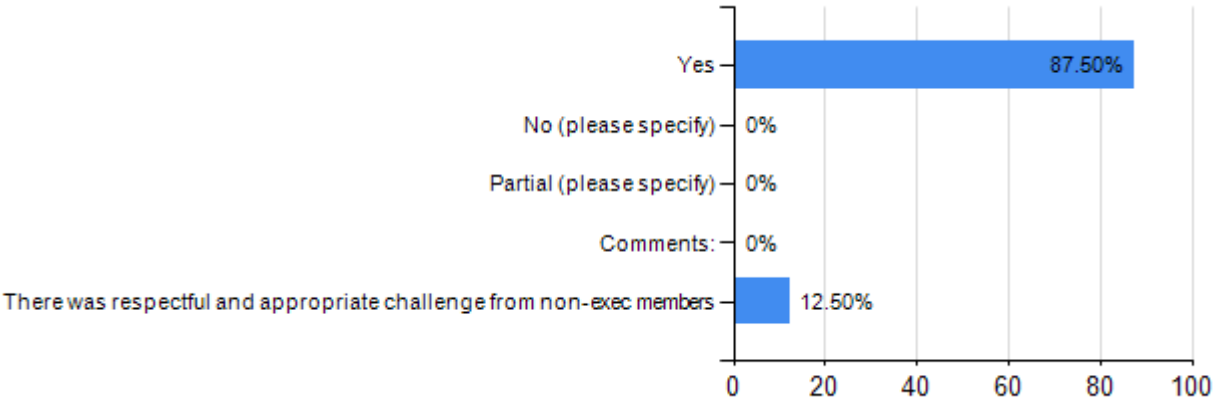
Survey: Committee Effectiveness Survey

Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Question 3: Was open and productive debate achieved within a supportive environment?(if no/partial, please provide further details)

Create new action

Available Answers	Responses	Score (%)
Yes	7	87.50%
No (please specify)	0	0.00%
Partial (please specify)	0	0.00%
There was respectful and appropriate challenge from non-exec members	1	12.50%
Comments:	0	0.00%
Total	**8**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 8

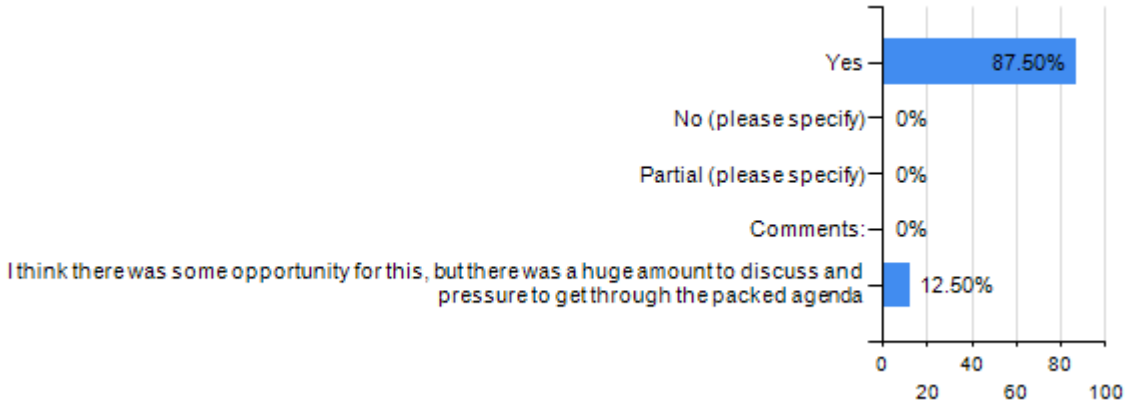
Survey: Committee Effectiveness Survey

Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Question 4: Was it possible to identify cross-cutting themes to support effective triangulation?(if no/partial, please provide further details)

Create new action

Available Answers	Responses	Score (%)
Yes	7	87.50%
No (please specify)	0	0.00%
Partial (please specify)	0	0.00%
I think there was some opportunity for this, but there was a huge amount to discuss and pressure to get through the packed agenda	1	12.50%
Comments:	0	0.00%
Total	**8**	**100%**



Survey Summary Report

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Total Respondents: 8

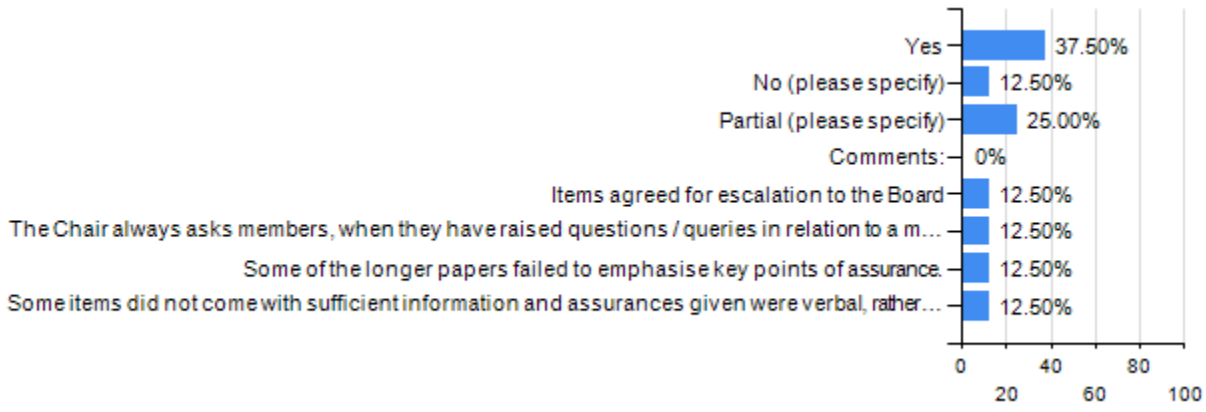
Survey: Committee Effectiveness Survey

Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Question 5: Was sufficient assurance provided to Committee members in relation to each item of business received?(if no/partial, please provide further details)

Create new action

Available Answers	Responses	Score (%)
Yes	3	37.50%
No (please specify)	1	12.50%
Partial (please specify)	2	25.00%
Some items did not come with sufficient information and assurances given were verbal, rather than supported by any evidence	1	12.50%
Some of the longer papers failed to emphasise key points of assurance.	1	12.50%
The Chair always asks members, when they have raised questions / queries in relation to a matter, whether they have received sufficient assurance following responses from Officers. Where sufficient assurance not received further info is requested from Officers. All papers need key issues, risks and actions highlighted which would provide greater assurance. Detail in the papers gives this usually	1	12.50%
Items agreed for escalation to the Board	1	12.50%
Comments:	0	0.00%
Total	**8**	**100%**



Survey Summary Report

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Total Respondents: 8

Survey: Committee Effectiveness Survey

Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

Question 6: Given the size and complexity of the agenda, how do you feel this could be managed differently?

Create new action

The Consent Agenda could be taken as one item unless someone wants to pull out a specific item. Asking the lead for each item on consent if they want to say something invites additional discussion when none is needed.	739e597e / 2023-11	Create new action
It is difficult, because there is a lot to get through, lots going on, and assurance needs to be provided. I think there are a few options: - A longer meeting could be scheduled, with a more substantial break - Reduced frequency of meetings - although this sounds as though the agenda would just get longer, many items would be the same and there would be more to update on - revise the whole cycle of business to provide greater efficiency - prioritise what needs to come to QSP	2f1f4cf6 / 2023-11	Create new action
Concise identification of risks and top 3 messages in exec summary. When discussing papers important to keep discussions strategic, assurance in nature and relevant Action Log to be fully updated by responsible officers in advance of paper publication to prevent unnecessary time being spent going through the agenda. Timescales of actions to be agreed within 5 days of meeting being held and action log published within 7 days	d0bbaa0f / 2023-11	Create new action
The chair requested all presenters to assume that all papers had been read in advance, and to limit their comments to two or three key points. Where presenters followed this the meeting flowed well, but many papers were too long and too detailed making such a summary difficult to deliver. Reducing the size of papers, and structuring the template to emphasise a small number of key points for assurance would help. There is a lack of clarity amongst presenters on what 'assurance' looks like.	43b4b293 / 2023-11	Create new action
Where there are particularly complex issues or risks arrange separate one-off meetings to discuss the detail in the papers to provide members with greater assurance, although this may be difficult in terms of additional time and governance process being clearly	fa814469 / 2023-11	Create new action

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Start Date: 2023-11-16 00:00:00 **End Date:** 2024-01-09 23:59:59

evidenced. Ensuring that each paper does highlight in Exec Summary the key issues, risk and actions that members need to be sighted on.		
A formal review of QSP and its wider remit needs review	2bea192c / 2023-11	Create new action
We did focus for too long on items trying to get into some operational detail eg Outpatient waits. It would be better to acknowledge/agree what more is needed and have the discussion with evidence available rather than make assumptions.	b86ff2f2 / 2023-12	Create new action
A very full agenda with only one break in the meeting. Whilst participants prefer shorter meetings, it was difficult to concentrate so personally would benefit to 5 min breaks to get up walk around. I thought the meeting was chaired very well.	4aac61e4 / 2023-12	Create new action

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Service Group	Corporate,Other,Velindre Cancer Centre,WBS
Directorate	Clinical Services,Collection Services,Education,Facilities,Information Governance,Integrated care,Medicine,Nursing,Operational Services,Operational Services and Delivery,Other,Palliative Medicine,Radiation services,Research, Development & Innovation ,SACT/Medicines Management,Service evaluation,Transforming Cancer Services,WBMDR
Service	Bone Marrow / Stem Cells,Cancer of unknown primary,Catering services,Clinical,Clinical Psychology,Clinical Trials ,Communications & Engagement,Donor Engagement,Education,General,Information Governance,Medicine,Nuclear Medicine,Nursing,Operational Services,Operations,Other,Outpatients,Palliative care,Pharmacy,Planning / Logistics,Plasma,Platelets,Professional Standards,Radiology,Radiotherapy,Radiotherapy/Brachytherapy,SACT,Safeguarding,Therapies,Training,Welfare rights,Whole Blood
Location	All Filters Selected

Survey	Committee Effectiveness Survey
Question	All Questions Selected
Response	All Responses Selected
Category	Standard

Start Date	2023-11-16 00:00:00
End Date	2024-01-09 23:59:59