Public Quality, Safety & Performance Committee

Thu 14 November 2024, 08:30 - 12:00

Hybrid meeting

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Agenda

1. PRESENTATION

1.1. Welsh Blood Service - Donor Story

To be led by Andrew Harris, Interim Head of Donor Engagement

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 meetings of the Public Quality, Safety & Performance Committee held on 12th September 2024

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

2.4.0 Draft minutes - Public Quality Safety and Performance Committee 12th September 2024 - VM.pdf (17 pages)

2.5. Minutes from the meetings of the Private Quality, Safety & Performance Committee held on 12th September 2024

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

2.5.0 Draft minutes - Private Quality Safety and Performance Committee 12th September 2024 - VM.pdf (3 pages)

2.6. Review of Action Log

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

2.6.0 PUBLIC QSP ACTION LOG - SEPTEMBER 2024.pdf (2 pages)

2.7. Matters Arising

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

2.7.1. SACT Gold Update

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Chair SACT Gold and Anne Carey, Interim Chief Operating Officer

2.7.1 GOLD SACT REPORT NOV 2024.pdf (9 pages)

2.7.2. Sickness Absence Data Analysis

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

2.7.2 Sickness Absence Data Analysis - QSP Nov 2024.pdf (14 pages)

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3. MAIN AGENDA

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

3.1. Finance Report for the Period Ended 30th September 2024

To be led by Matthew Bunce, Executive Director of Finance

3.1.0 Month 6 Finance Report Cover Paper - QSP 14.11.2024.pdf (11 pages)
3.1.0 Appendix 1 - M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPTEMBER 2024 - QSP 14.11.2024.pdf (30 pages)
3.1.0 Appendix 2 - TCS Programme Finance Paper (September 2024) - Main Report.pdf (15 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

- Workforce
- Finance

3.2.0 Supply and Shape Paper - QSP Nov 24.pdf (11 pages)

3.3. 2024-2025 Quarter 2 Trust Quality & Safety Report

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

3.3.0 Q2 QS report 2024-25 cover paper QSP.pdf (7 pages)
3.3.0 APPENDIX 1 - QUARTER 2 QS 2024-25.pdf (67 pages)
3.3.0 appendix 2 Q2 Inspection actions QSP.pdf (18 pages)
3.3.0 appendix 3 AMAT summary.pdf (3 pages)
3.3.0 APPENDIX 4 Patient and Donor Experience QSP (003).pdf (7 pages)

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

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

3.4.0 MASTER DOCUMENT - QSP CTTEE SEPT PMF - Final.pdf (101 pages)

3.5. Health & Safety Highlight Report

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

3.5.0 QSP Highlight Report (SAFETY) vFINAL.pdf (8 pages)

3.6. Building Backlog Maintenance - Velindre Cancer Centre

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

3.6.0 Building Backlog VCC Final Version -FINAL.pdf (17 pages)
3.6.0 Appendix 1 - Risk Implementation plan Estates Condition Works 2024-25.pdf (1 pages)

3.7. Trust Risk Register

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

- 3.7.0 QSP - NOVEMBER TRR - 2024 -V07.pdf (8 pages)
- 3.7.0 APPENDIX 1 - Trust Risk Register - QSP -V05.pdf (7 pages)

3.8. Trust Assurance Framework

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

- 3.8.0 TAF Cover Paper - QSP - 15.11.2024 - V04.pdf (12 pages)
- 3.8.0 TAF 01 - V73 TAF DASHBOARD (2).pdf (3 pages)
- 3.8.0 TAF 02 - V73 TAF DASHBOARD (2).pdf (2 pages)
- 3.8.0 TAF 03 - V73 TAF DASHBOARD (2).pdf (3 pages)
- 3.8.0 TAF 04 - V73 TAF DASHBOARD (2).pdf (3 pages)
- 3.8.0 TAF 05 - V73 TAF DASHBOARD (2).pdf (2 pages)
- 3.8.0 TAF 06 - V73 TAF DASHBOARD (2).pdf (8 pages)
- 3.8.0 TAF 07 - V73 TAF DASHBOARD (3).pdf (3 pages)
- 3.8.0 TAF 08 - V73 TAF DASHBOARD (2).pdf (3 pages)

BREAK - 10 minutes

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4. 2023-2024 ANNUAL REPORTS

4.1. FOR APPROVAL

4.1.1. Medical Devices Annual Report 2023-2024

To be led by Anne Carey, Interim Chief Operating Officer

- 4.1.1 FINAL-Nov2024---Medical Devices Report (003).pdf (6 pages)
- 4.1.1 Appendix 1 - Medical Devices - November 2024 - FINAL.pdf (6 pages)

4.2. ENDORSE FOR TRUST BOARD APPROVAL

Nil items

4.3. FOR NOTING

4.3.1. Annual Medical Education Governance Report

To be led by Louise Hanna, Associate Medical Director for Medical Education

- 4.3.1 Trust Medical Education Annual Report 2023-24 - QS&PC 14.11.24.pdf (19 pages)
- 4.3.1 Appendix 1 HEIW Faculty Team Appraisal 2024 – Full Report.pdf (5 pages)
- 4.3.1 Appendix 2 GMC National Training Survey Results 2024.pdf (21 pages)
- 4.3.1 Appendix 3 Annual Teaching Review (Undergraduate) Report 2024.pdf (26 pages)

4.3.2. Health Technology Wales Annual Report 2023-2024

[HTW representative will attend January Committee in the event of any queries raised]

- 4.3.2 HEALTH-TECHNOLOGY-WALES_ANNUAL-REPORT-2024_AW-1 (4).pdf (34 pages)

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5. NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

5.1. Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)

To be led by Gareth Tyrrell, Accountable Pharmacist, NWSSP

- 5.1.0 NWSSP PTS QSP Submission - November.pdf (6 pages)

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6. CONSENT ITEMS

6.1. FOR APPROVAL

6.1.1. Trust Policies for Approval

- Mobile Phone Policy (IG10)

  To be led by Carl Taylor, Chief Digital Officer

6.1.1 20240625 QSPC Cover Paper - Mobile Phone Policy.pdf (5 pages)
6.1.1a APPENDIX 1 - IG10 VUNHST Mobile Phone Policy_v2_NOV 2024.pdf (13 pages)
6.1.1b APPENDIX 2 - VUNHST Mobile Phone Policy - EQIA.pdf (10 pages)

6.2. CONSENT ITEMS FOR ENDORSEMENT

6.2.1. People and Organisational Development Policies and Processes

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

- Welsh Language Policy (WF16)
- Addendum to Managing Attendance At Work Policy (WF08)
- Flexible Pensions Policy (New)
- Respect and Resolution Policy (WF01)

6.2.1 People and OD Polices and Processes - QSP Nov 24.pdf (6 pages)
6.2.1(i) Welsh language Policy v.5.pdf (10 pages)
6.2.1(ii) Addendum to MAWW October 2024.pdf (1 pages)
6.2.1(iii) 2024_09_28 Flexible Pensions Policy Final Approved.pdf (29 pages)
6.2.1(iii). 2024_09_28 Flexible Pensions Policy Final Approved-en-cy-C.pdf (30 pages)
6.2.1(iv) 2024_07_09 Respect and Resolution at Work FINAL.pdf (9 pages)
6.2.1(iv). 2024_07_09 Respect and Resolution at Work FINAL-en-cy-C.pdf (9 pages)

6.3. CONSENT ITEMS FOR NOTING

6.3.1. Trust Integrated Medium Term Plan – Progress against Quarterly (Q2) Actions for 2024/2025

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

6.3.1 QSP CTTEE 14.11.24 IMTP 2024.25 Quarter 2 Update FINAL version Master - Final.pdf (92 pages)

6.3.2. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Reports - 23rd July 2024

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

6.3.2 QSP Highlight Report Public 23.07.2024 - NG.pdf (4 pages)

6.3.3. Research, Development & Innovation Sub Committee Highlight Report

To be led by Mick Button, Consultant Clinical Oncologist

6.3.3 RDI Highlight Report to QS&P 14.11.24.pdf (4 pages)

6.3.4. Research, Development & Innovation Annual Committee Report

To be led by Mick Button, Consultant Clinical Oncologist

6.3.4 RDI Annual Committee Report 2023-24 to QS&PC 14.11.24.pdf (15 pages)

6.3.5. Research, Development & Innovation Annual Effectiveness Report

To be led by Mick Button, Consultant Clinical Oncologist

6.3.5 RDI Annual Effectiveness Survey 2023-2024 to QS&PC 14.11.24.pdf (15 pages)

6.3.6. Estates Highlight Report

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

6.3.6 Report estates october Quarter 2 2024.docx QSP - FINAL 2.pdf (14 pages)

6.3.7. Fire Safety Highlight Report

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

6.3.7 QSP Highlight Report (FIRE SAFETY)_FINAL.pdf (9 pages)

6.3.8. Sustainability Update Report

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

6.3.8 QSP Cover Paper Sustainability Q2 Update 24.10.2024 v.final.pdf (13 pages)

6.3.9. Anti-Racist Wales Action Plan

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

6.3.9 QSP Anti-racist Action Plan Update 14.11.24.pdf (5 pages)
6.3.9 Appendix 1 -Anti racist Action Plan 22.10.24.pdf (9 pages)

6.3.10. NHS Staff Survey 2023 Action Plan

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

6.3.10 QSP NHS Staff Survey 2023 Actions 14.11..24.pdf (6 pages)
6.3.10 Appendix 1- NHS Staff Survey cross referenced actions 22.10.24.pdf (3 pages)

6.3.11. Implementation of Duty of Quality Update (NWSSP)

[NWSSP representative will attend January Committee in the event of any queries raised]

6.3.11 QSP Velindre Duty of quality update Nov 2024_.pdf (6 pages)

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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. November 2024 Analysis of Triangulated Meeting Themes

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

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

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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 16th January 2024 from 10:00-13:00.

11. CLOSE

WELSH BLOOD SERVICE – DONOR STORY

Please visit the link below to view the Welsh Blood Service Donor Story video prior to the Quality, Safety & Performance Committee meeting on 14th November:

https://www.youtube.com/watch?app=desktop&v=uK9PfM7NftM

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: Thursday 12th September 2024
Time: 10:00-13:30
Location: Hybrid meeting – Microsoft Teams/Velindre NHS Trust Headquarters
Chair: Mrs Vicky Morris, Independent Member

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

ADDITIONAL ATTENDEES		
Kay Wilson	Operational Senior Nurse, VCS	KW
Claire Budgen	Head of Organisational Development	CB
Amanda Jenkins	Head of Workforce	AJ
Oghogho Oyan	Workforce Development Manager [observing]	OO
Georgia Stephens	Head of Transplant Laboratory Services, WBS [observing]	GS
Vivienne Cooper	Head of VCS Nursing	VC
Emma Rees	Deputy Head of Internal Audit, NWSSP	ER
Katrina Febry	Audit Wales	KF

APOLOGIES		
Emma Stephens	Head of Corporate Governance	ES

		ACTION
1.0.0	**PRESENTATIONS**	
1.1.0	**Velindre Cancer Service - Patient Story** Led by Kay Wilson, Operational Senior Nurse, Velindre Cancer Services KW provided the Committee with a letter from the wife of a 46-year-old cancer patient who had suffered a rapid decline in his health during May of this year and sadly passed away in respite care three months later. The letter, written just prior to the patient's discharge from the Cancer Service, detailed the empathy, respect and exemplary care shown, not only to the patient in all aspects of his treatment, but also to his family and other visitors during his stay at the Cancer Centre. The Committee were advised of how this powerful letter had a significant impact on First Floor ward staff who very much valued the opportunity to reflect on such positive feedback. NW suggested that whilst there is inevitably a focus on patient care on the few occasions when things go wrong, sharing of and focus on the much positive feedback received from patients and their families is also extremely important. NG highlighted the intranet-based Wall of Thanks which allows for brief messages but acknowledged the opportunity to review the way in which this is co-ordinated to allow for longer, more detailed messages. NG to look further into this and to discuss with the Governance team as to how messages of thanks can be formally captured. SH queried how staff members who are not direct recipients of the compliments and positive feedback in which they are referenced, are made aware of these comments. NG advised that, although a more formal process is needed, VCS managers are regularly reviewing and commenting on the Wall of Thanks and passing feedback on during their team meetings. SH highlighted the discussions at this meeting as an example, that the Committee recognises the important role that all of the staff play in providing care.	**NG**
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** received from: Apologies were received as noted above.	
2.2.0	**In Attendance** Additional attendees were as noted above.	

2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no declarations of interest.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 9th July 2024** Led by Vicky Morris, Quality, Safety & Performance Committee Chair LLF advised that her attendance at the July Committee meetings was in the capacity of observer, however the minutes list LLF as an attendee. Pending the amendment noted above, the Committee **REVIEWED** and **APPROVED** the minutes from the 9th July 2024 Public Committee.	**LW**
2.5.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 11th July 2024** Led by Vicky Morris, Quality, Safety & Performance Committee Chair Pending the amendment noted at 2.4.0 above, the Committee **REVIEWED** and **APPROVED** the minutes from the 11th July 2024 Public Committee.	**LW**
2.6.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed and Committee members confirmed that they were assured that all actions identified as closed had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed. The remaining action log was reviewed, and the following agreed: ***Action 9.1.0 [13.07.23] - Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future annual reports*** - NG advised that although a template has been produced, the summer annual leave schedule has caused a delay in progress. A plan is in place which is anticipated to allow the closure of this action during the November cycle. ***Action 4.1.0 [09.05.24] - Establish whether any additional costs (e.g. double running) are covered by the overall risk and contingency funds*** - The Committee noted the update provided. LW to contact the action owner to obtain cost information in order to allow the closure of this action.	**LW**

2.7.0	**Matters Arising**	
2.7.1	**SACT Gold Paper** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Chair SACT Gold NW presented the SACT Gold report to the Committee and the following queries were raised: • Referencing the forecasted increase of regimens per week by September, LLF queried the degree of confidence around this forecast and whether this would be sufficient to manage the demand. AC advised that this data is currently being worked through, however the increase in capacity in Pharmacy has continued through August and into September to allow for the delivery of 614 regimens per week. In terms of demand, this is certainly sufficient to accommodate the new patients being referred, but there is some uncertainty in respect of the number of current patients who may go on to receive further cycles. Work is underway with the Data and Insight team to look at this in more detail. In addition, the pre-SACT assessment elements are under review, with the aim of flattening the demand across the week. • SH queried how the Service is engaging with patients to communicate the expectations in terms of their treatment targets. NW advised that communications have been a feature to be considered in every SACT Gold meeting and that working with clinical colleagues, the expectations are set with patients at the outset. For patients experiencing delays a prioritisation process is in place to ensure patients in the greatest need of treatment are prioritised. Members of the SACT team are contacting patients as much as possible and some general comms has also been released. The Committee **NOTED** the current position and ongoing recovery work.	
3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
3.1.0	Workforce Supply and Shape & Associated Finance Risks Led by: Sarah Morley, Executive Director of Workforce & Organisational Development, Amanda Jenkins, Head of Workforce and Matthew Bunce, Executive Director of Finance AJ gave a brief overview of the paper and highlighted the following: • Referencing the detail on nurse attraction and retention and the earlier discussions around pharmacy capacity issues, HJ	

	queried whether there is a unified strategy for retaining both nursing and other staff. AJ advised that as the nurse retention plan is part of the national workforce implementation plan agreed by Welsh Government there are some specific targets to be achieved around nurse retention. However, any learning acquired from this will be taken into consideration in order to form the development of a Trust-wide staff retention plan. With regards to the issues around specific areas, e.g. Pharmacy, SM advised that targeted work is underway to focus on areas of specific risk and difficult to fill posts are under review in order to redefine the roles and potentially increase the level of interest. • CJ emphasised the importance of adapting to modern job application methods in order to attract younger talent in a competitive market. • DM queried the expected position at year end with regards to agency spend, as this has previously been coming down year on year. MB acknowledged that although there will be spikes in some months as required to meet the needs of the service, overall the Trust is expected to meet its own reduced agency spend target. The applied assurance level rating of 4 was discussed and agreed by the Committee. The Committee **NOTED** the Workforce supply and shape updates and associated financial impacts as outlined within the contents of the report and **AGREED** the level of assurance rating of **4**.	
3.2.0	**Anti-Racist Wales Action Plan** Led by Sarah Morley, Executive Director of Workforce & Organisational Development and Claire Budgen, Head of Organisational Development CB presented the paper; the following was highlighted: • With regards to the Anti-Racist action plan 2022-2025, HJ noted that a number of actions hadn't been completed and the target date passed. Revised dates and details of the reasons for the delays, along with a series of in-year targets to be provided to the November Committee. • Referring to the current engagement with the Welsh Government lead for the Race Equality Standard (RES), SM reported that the overall summation of the Trust's performance through the RES was very positive.	

	• LLF highlighted the need for *unconscious bias* training for recruitment panel members, primarily at shortlisting and interview. CB agreed that, although an element is included in the current INSPIRE programme, it would be a valuable addition to actions taken in direct response to the RES. • With regards to the Trust's recent cohort of internationally recruited nurses, LLF queried how the learning derived from this workstream is being used to refine and inform future international recruitment projects. CB agreed that the recent recruitment exercise had provided a rich area of learning, that this had been documented and would feed next cycle of recruitment. NW added that significant learning had been derived regarding the culture of our organisation, as it had become apparent that the teams were not properly prepared for the arrival of the cohort of international nurses. • DM highlighted the omission of research in the Action Plan. CB and SM to discuss this further with DM outside of the meeting. • Whilst noting the focus on black, Asian and minority ethnic groups, SH queried the reporting of discrimination against other white ethnicities (eastern European, other UK nations, etc.). SM advised that although this specific data was not focused on separately it would be picked up via the wider staff experience data. SM also noted that the current practices around the focus on ethnicity will only benefit the broader protected characteristics. The Committee **NOTED** the update for onward submission to the Trust Board and **AGREED** the applied assurance level of **3**.	**CB** **CB/SM**
3.3.0	**NHS Staff Survey 2023** Led by Sarah Morley, Executive Director of Workforce & Organisational Development CB provided a comprehensive overview of the 2023 staff survey results, noting the Trust's high response rate in comparison to that of the NHS nationally. The following was discussed: • HJ highlighted the significant length of time taken for the results of the survey, which took place in the autumn of 2023, to be analysed/reported. SM advised that although it had not been possible to bring the results to this Committee sooner due to a variety of factors, work had commenced on disseminating and actioning the findings much earlier in the year and was discussed at the Executive Management Board in May.	

	• Referencing the action points in the paper, HJ noted that no target dates had been set and requested that all actions be presented to the Committee in the form of SMART actions to enable the Board to effectively monitor progress against them. CB advised that this format has been used for the actions to be progressed via the Health & Engaged Steering Group and would be circulated to members outside of the meeting. • Acknowledging that progress is underway in terms of the actions arising from the 2023 survey results, LLF queried how staff are receiving feedback with regards to the steps being taken in direct response to the survey, highlighting the importance of ensuring that staff are aware of the survey's impact and the changes that have been made, as this will likely encourage engagement with future surveys. SM advised that information regarding this will be included when seeking responses to this year's survey. • Referencing the survey responses under diversity and equality theme. SH expressed concern around the negative responses relating to staff who had reported experiencing discrimination. SH felt that this was an area that required strengthening in the action plan. CB advised that this matter is to receive a full focus discussion at a meeting due to take place next week. • HJ highlighted the reported increase in staff experiencing or witnessing bullying or harassment at work. SM advised that a deep dive into this matter is to be undertaken next week and details around the points raised will be included in the November agenda. The Committee **NOTED** the report for onward submission to Trust Board.	**CB** **SM**
3.4.0	**Trust Values and Behaviour Framework** Led by Sarah Morley, Executive Director of Workforce & Organisational Development The Committee considered the draft Behaviour Framework. LLF queried what the Board actions were in relation to the Framework. It was identified that further engagement, particularly at Board level was required to strengthen the Framework as a standalone document. Through discussion it was identified that the appropriate assurance rating was currently a level **2**, with a view to progressing to a level 3 with a robust action plan to underpin the work required. The Committee **NOTED** the report.	

3.5.0	**Compassionate Leadership Pledge 2024** Led by Sarah Morley, Executive Director of Workforce & Organisational Development SM gave a brief overview of the paper and advised that as it currently stands, it is likely that an agreement to sign the pledge would be achievable through this governance cycle. The Committee **ENDORSED** the Compassionate Leadership Pledge for onward submission to Trust Board.	
3.6.0	**People and OD Policies and Processes** Led by Sarah Morley, Executive Director of Workforce & Organisational Development Amanda Jenkins (AJ) joined the meeting *SH left the meeting* VM highlighted some issues with the report cover paper which still made reference to the Executive Management Board instead of the Quality, Safety and Performance Committee. AJ clarified that the cover paper was the correct version for consideration by the Committee.. VM emphasised that whilst the Executive Summary was helpful in summarising the relevant revisions, the policy cover sheets needed to be fully completed with the policy reference numbers, review dates, approval dates and version control prior to submission to the Committee for consideration. *SH returned to the meeting* LLF queried the threshold on policies being reviewed and brought back through the governance route. SM advised that in terms of the internal policies, the governance route is determined by the Policy on Policies. NG suggested that the thresholds for review within the Policy on Policies is reviewed and brought to the Committee for consideration. In terms of all-Wales policies, following an agreement at the Welsh Partnership Forum these will only be changed in the event of legislative changes or other need for amendment. The Committee **ENDORSED** the amendments/new polices for approval and **AGREED** to consider reviewed policy review thresholds.	**NG**

3.7.0	**Finance Report for the Period Ended 31st July 2024** Led by Matthew Bunce, Executive Director of Finance MB presented the month 4 Finance Report which outlined the financial position and performance for the period to the end of July 2024. It was highlighted that although the financial forecast is challenging the Trust is on track to deliver against its key financial targets and there is a high level of assurance in respect of this. SH advised the Committee on discussions held with MB and the Trust's Deputy Director of Finance during which the financial challenges arising from the funding negotiations with Commissioners in terms of the IMTP were thoroughly reviewed, and the challenges and forward plan were discussed. SH expressed having gained assurance that the issues were clearly understood and that appropriate action is being taken to manage them accordingly. The Committee **NOTED** the contents of the July 2024 financial report and in particular: • The year to date and forecast revenue out turn position and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with commissioners on the contract re-base agreement. • That the Trust is still waiting to secure Capital funding from WG in relation to the nVCC, Enabling Works and Whitchurch	
3.8.0	**2024-2025 Quarter 1 Trust Quality and Safety Report** Led by: Tina Jenkins, Head of Quality and Safety, Vivienne Cooper, Head of Nursing VCS and Peter Richardson, Deputy Director / Head of Quality and Safety WBS The Committee welcomed and commended the first combined Trust Quality and Safety report that brings together the work of the three Trust Quality Hubs: Trust wide, Welsh Blood Service and Velindre Cancer Services incorporating what would previously have been contained in 6 separate and lengthy reports. The Committee considered the report which provided concise data driven analysis of key outcomes, activity, learning and improvement during the quarter. VM raised concerns with regards to the need for support from the Business Intelligence Team to progress the Quality Dashboard and the further development of the Quality Metrics / Quality Outcome Framework. These ongoing delays are impacting on the 'Always on Reporting' as a legislative requirement of the Duty of Quality. LF	

	advised that the implementation plan agreed in December 2023 had been impacted by the resource needed for the SACT transformation work. However, the delivery plan for the next three months is expected to be received at the next Integrated Quality & Safety Group meeting. The Committee **NOTED** and commended the Velindre University NHS Trust Quarter 1 Quality & Safety Report.	
3.9.0	**Performance Management Framework (PMF) Report and Supporting Analysis** Led by: Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital, Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance The areas of discussion in respect of the July 2024 Performance Management Framework were as follows: • VM sought further assurance in respect of any harm that may have occurred to the 3% of patients that did not receive their scheduled radiotherapy within the required 28-day target deadline. RH advised that all patients had been clinically prioritised and reviewed and no harm had been identified. It was identified that information in respect of high level harm review outcomes should be included in future reports. • LLF sought further detail around the increase in long term staff sickness levels. SM gave a brief summary of the support that is provided to staff and advised that themes and outcomes associated with interventions are documented and monitored through the Healthy and Engaged Steering Group. • VM raised concern around the inability to deliver Manual Handling Training which is impacting on compliance and increasing staff and patient risk. LF advised that an agreement with Cardiff and Vale University Health Board to provide the necessary training had seen a limited uptake from Trust staff. The Committee were advised that to address this training will now be delivered on site. • AP advised that the Welsh Blood Service (WBS) are experiencing significant supply chain strains, not only within Wales but also on a national level due to seasonal factors. Several issues are impacting operations, including staff onboarding, training, recruitment, sickness absence, etc. While a relatively positive month was reported in July, August has presented substantial challenges for the service despite significant efforts to mitigate them. September appears to be following a similar pattern, although the team is working tirelessly to improve the situation. AP advised that these challenges are not unique to Wales but are being experienced	**RH**

	across all our operations in the UK. VM requested that the next report to the Committee includes details of timelines for the planned preventative maintenance at Velindre Cancer Centre. The Committee: • **NOTED** the July 2024 Performance Management work • **NOTED** the targeted work being undertake through business continuity arrangements in respect of the delivery of SACT.	**LF**
3.10.0	**Trust Risk Register** Led by Non Gwilym, Interim Director of Corporate Governance The Committee discussed in detail the Trust Risk Register covering the period up to the end of July 2024. The following points were noted: • Referencing risks 3337, 3338, 3230, 2465 and 3431, VM highlighted their connection to SACT Escalation. These risks require review to ensure alignment and to remove any duplication. • Referring specifically to risks 3338 & 3366 LLF noted the inherent risk scores were lower than the current risk rating. It was agreed that these risks would be reviewed prior to Trust Board. • With reference to risk 3247 and given the growing demand for cancer services over the coming years SH queried whether there had been a consideration to review the distribution of clinics across the working week. AC advised that the service is looking at how to remodel the pathway in line with identified benchmarked models. In addition, RH advised that following publication of the report, capital for two further consultation rooms had been secured and procurement engaged. The Committee: • **NOTED** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above • **NOTED** the on-going developments of the Trust's risk framework • **NOTED** the work underway to improve organisational management of risk reporting.	**NG/RH**
3.11.0	**Trust Assurance Framework** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Assurance Framework was discussed. The Committee noted that it had not been updated in full and were advised that enhanced governance mechanisms were required in respect of this and the newly appointed Risk and Assurance Manager will be prioritising this.	

	The Committee **NOTED** the current status and ongoing development of the Trust Assurance Framework	
3.12.0	**Policy Compliance Update** Led by Non Gwilym, Interim Director of Corporate Governance NG presented the policy compliance report the following was highlighted: • VM noted that the appendices provided were extremely helpful, however some of the forward plans are not as comprehensive as hoped. • With regards to the eight Workforce policies due for completion by September, VM queried whether these were on target. SM advised that due to a current resource issue in the team it was not possible to give absolute assurance at this stage, but that completion of these policies is a key area of focus. The Committee discussed and **AGREED** the assurance rating of **3**. The Committee: • **NOTED** the contents of the report and the progress that has been made in respect of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. • Received **ASSURANCE** that progress is being managed via the Executive Management Board.	
4.0.0	**2023-2024 ANNUAL REPORTS**	
4.1.0	**FOR APPROVAL**	
4.1.1	**Wellbeing of Future Generations Act (2015) Annual Report** Led by Phil Hodson, Deputy Director of Planning & Performance **Deferred from July** *PR left the meeting* **Paper withdrawn as matter has completed governance cycle via Strategic Development Committee and Trust Board.**	
4.1.2	**Digital Services Annual Report** Led by Carl Taylor, Chief Digital Officer *Deferred from July - quarterly update report received at July meeting* LF presented the annual report following a six-month update provided to the Committee in July.	

	NW requested that future reports outline how the clinical and scientific requirements / voices are featuring in the prioritisation of digital programmes. The Committee **APPROVED** the Digital Services Annual Report.	**CT**
4.2.0	**ENDORSE FOR TRUST BOARD APPROVAL**	
4.2.1	**Communications and Engagement Annual Report** Led by Non Gwilym, Interim Director of Corporate Governance *Deferred from July* NG presented the report, the layout of which was commended. The Committee **ENDORSED** the Communications and Engagement Annual Report in advance of the Trust Board's consideration for approval.	
4.2.2	**Medical Devices Annual Report** Led by Anne Carey, Interim Chief Operating Officer *Paper not received* The Committee were advised that quality assurance review had found that insufficient detail had been provided in some areas. More senior ownership has now been allocated and the report will be brought to the November Committee.	**AC**
4.3.0	**FOR NOTING**	
4.3.1	**Wales Infected Blood Support Scheme (WIBSS)** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital LF presented the report to the Committee and wished to formally thank the WIBSS team for their work and commitment, this was echoed by the Committee. The Committee **NOTED** the Annual Report.	
5.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
5.1.0	**FOR APPROVAL**	

5.1.1	**Trust Policies for Approval** • ***IPC03 - Model Policy Aseptic Non-Touch Technique (ANTT)*** It was noted that this Item was incorrectly placed on agenda - this policy is for endorsement The Committee: • **ENDORSED** the National Model Policy Aseptic Non-Touch Technique (ANTT) – IPC 03 for adoption across the Trust for onward approval. • **ENDORSED** the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December 2024 for the national policy review and consultation to be completed.	
	• **QS02 - Management of Safety Alerts and Important Notification Policy** The Committee **APPROVED** the revised Trust Management of Safety Alerts and Important Notification Policy.	
	• **PP02 - Security Policy** The Committee **APPROVED** the final version of the Security policy.	
5.1.2	**Committee Terms of Reference** Led by Non Gwilym, Interim Director of Corporate Governance *Item incorrectly placed on agenda - this item is for endorsement* The Committee **ENDORSED** the amendments to the Committee's Terms of Reference.	
5.2.0	**FOR ENDORSEMENT**	
5.2.1	**Annual and three-year Assurance Reports on Compliance with the Nurse Staffing Levels (Wales) Act 2016** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **ENDORSED** the 2023/2024 Nurse Staffing Levels Wales Annual Report, and the 2021/2024 Nurse Staffing Levels Wales 3-year report prior to submission for onward approval by the Trust Board, prior to submission to the Welsh Government.	

5.2.2	**Trust Policies for Endorsement** • WF01 - Respect and Resolution Policy (All Wales) Led by Amanda Jenkins, Head of Workforce **Paper not received**	
5.3.0	**FOR NOTING**	
5.3.1	**Integrated Medium Term Plan (IMTP) Quarterly (Q1) Progress Report** Led by Phil Hodson, Deputy Director of Planning & Performance The Committee **NOTED** the progress made in the delivery of the agreed IMTP (2024 – 2027) actions as at Quarter 1 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide services.	
5.3.2	**Professional Nursing Forum Update** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience The Committee: • **NOTED** the Quarter 1 2024/2025 Professional Nursing update • **NOTED** the Restorative Clinical Supervision and Preceptorship self-assessment and delivery plan.	
5.3.3	**NHS – Regulation 28 Annual Report** Led by Tina Jenkins, Head of Quality, Safety & Assurance The Committee **NOTED** the NHS Wales – Regulation 28 Annual Report and the work being undertaken to enhance the response, investigation and learning when things go wrong.	
5.3.4	**Workforce and Organisational Development Implementation Plans** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee **NOTED** the Workforce and Organisational Development Implementation Plans.	
5.3.5	**Value Based Healthcare Report** Led by Matthew Bunce, Executive Director of Finance The Committee **NOTED** the continued progress of the Value Based Healthcare Programme including:	

	• The imminent procurement and implementation of a digital Patient Reported Outcomes Measures (PROMS) solution following the successful Business Case • The launch of an NHS Wales Preoperative Anaemia Pathway • The approval of the Velindre Food Mission and input from stakeholders to create an action plan.	
5.3.6	**Trust Estates Assurance Group Highlight Report** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital *Paper pulled from consent to address the three matters for escalation* LF presented the report highlighting the matters for escalation and the action plans stated. The Committee were content with the update provided and look forward to receiving further updates in the November Committee. The Committee **NOTED** the assurance in respect of the ongoing delivery of the Estates Services work programme across Velindre University NHS Trust.	
5.3.7	**Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Reports 16th May 2024 and 20th June 2024** Led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub Committee The Committee **NOTED** the contents of the report and actions being taken.	
5.3.8	**15-Step Visits Update** Led by Non Gwilym, Interim Director of Corporate Governance The Committee **NOTED** the work being undertaken for the programme of 15 Step Visits planned or being scheduled for 2024/25.	
5.3.9	**Llais Cymru Report** NW highlighted the positive feedback in respect of the recent Llais Cymru visit to Velindre Cancer Centre, as detailed within the report. NW advised that all actions identified to take forward are underway and good progress is being made against the. The Committee **NOTED** the Llais Cymru Report.	
6.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks).	

8.1.0	**September 2024 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members The Committee discussed and identified the following triangulated meeting themes: • The ***workforce Supply impact on core service delivery*** – action agreed in respect of Trust recruitment promotional approach and support and the impact of staff sickness levels. • ***Organisational and workforce culture*** – action agreed of specific work to enhance organisational culture and the working experiences of our staff. This includes specific Board training on setting organisational culture. • ***Requirement to strengthen organisational governance and business intelligence*** to ensure that core requirements and delivery is robustly achieved. To include enhancing outcomes based reporting, ensuring all actions are SMART, and enhanced integrated risk management. • ***Quality and Safety Reporting:*** Presentation of the first fully integrated Trust Quality and Safety Report, focusing on positive outcomes and ongoing efforts to develop a quality dashboard for better data analysis and reporting. • ***Performance Management Framework (PMF) Development:*** Discussion on the development of the PMF, including the implementation of improvements and the focus on creating a single source of truth for data. • ***Cancer Service Capacity:*** Efforts to improve cancer service capacity, including the commissioning of new equipment and the exploration of new service models, in response to growing demand.	
7.0.0	**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	
8.0.0	**ANY OTHER BUSINESS**	
	Prior approval by the Chair required.	
9.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on **Thursday 14th November 2024 from 10:00-1300**	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Private Quality, Safety & Performance Committee
Velindre University NHS Trust

Date: Thursday 12th September 2024
Time: 13:15-13:45
Location: Hybrid meeting - Velindre NHS Trust Headquarters/Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member (VM)

ATTENDANCE		
Professor Donna Mead	Velindre University NHS Trust Chair	DM
Carl James	Interim Chief Executive Officer	CJ
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Alan Prosser	Director of Welsh Blood Service	AP
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Matthew Bunce	Executive Director of Finance	MB
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Sarah Morley	Executive Director of Organisational Development & Workforce	SM
Annie Evans	Deputy Director Nursing	AE
Tina Jenkins	Head of Quality, Safety & Assurance	TJ
Anne Carey	Interim Chief Operating Officer	AC
Non Gwilym	Interim Director of Corporate Governance	NG
Liane Webber	Business Support Officer (Secretariat)	LW

APOLOGIES		
Emma Stephens	Head of Corporate Governance	ES
Lindsay Foyster	Independent Member	LF
Jacinta Abraham	Executive Medical Director	JA
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH

		ACTION
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** Apologies were noted as above.	
1.2.0	**In Attendance** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no additional attendees to note.	

1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no declarations of interest.	
1.4.0	**Draft Minutes from the meeting of the Private Quality, Safety and Performance Committee held on 9th July 2024** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from 9th July Private Committee.	
1.5.0	**Review of Action Log** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The action log was reviewed, and Committee members confirmed that they were assured that all actions identified as closed had been fully instigated and could therefore be closed. There were no remaining open actions.	
1.6.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
1.6.1	**Sarcoma Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science *DM left the meeting* NW presented a paper detailing patient safety concerns that had been raised in respect of the Sarcoma Services by an employee and outlined service resilience issues. The paper details the actions that have been undertaken to enhance the service resilience and assure safety and the further proposed measures that include the commissioning of an external peer review. The Committee discussed the position and actions being taken to increase the resilience of the service and to have an external peer review. The Committee requested that the Sarcoma Risk Assessment is reviewed by the Division and to receive an update of progress at subsequent meetings. The Committee **NOTED** the current position and discussions that have taken place since the verbal overview provided on the 11th July 2024.	
2.0.0	**MAIN AGENDA**	
	There were no items for discussion.	

3.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
3.1.0	**FOR APPROVAL**	
3.1.1	**Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Reports 16th May 2024 and 20th June 2024** To be led by Stephen Harries, Independent Member and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the contents of the report and actions being taken.	
4.0.0	**ANALYSIS OF TODAY'S MEETING OUTPUTS**	
	Led by Vicky Morris, Quality, Safety and Performance Committee Chair Due to the small number of papers in the private Committee themes and triangulation was not possible.	
5.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	There were no items identified to alert/escalate to Trust Board.	
6.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
7.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on Thursday 14th November 2024 from 13:15-13:45.	
CLOSE		

MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)
13.07.2023			**JULY 2023 ANALYSIS OF TRIANGULATED MEETING THEMES**			
	9.1.0	**1**	Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future annual reports	~~Head of Corporate Governance~~ ~~Director of Corporate Governance & Chief of Staff~~ Interim Director of Corporate Governance	~~**31.03.202**~~ ~~**12.09.2024**~~ **20.1.25**	**Update 5.11.2024:** Template delivered by end of September. SOP for Annual Report being considered in time for 2024-25 reporting cycle, which will include training for relevant departments responsible for annual reports on agreed templates.
21.03.2024			**TRUST RISK REGISTER**			
	2.1.0	**2**	Executive Management Board, to look at how some of the risks could be combined and how the material total of the risk applies to the organisation and patients in terms of the root cause.	~~Director of Corporate Governance & Chief of Staff~~ Interim Director of Corporate Governance	~~**11.07.2024**~~ ~~**12.09.2024**~~ **14.11.2024**	**Update 5.11.24:** November risk report provides narrative to describe impact of thematically associated risks e.g. SACT and Medical Workforce.
09.05.2024			**TrAMs PROGRESS UPDATE**			
	4.1.0	**3**	Establish whether any additional costs (e.g. double running) are covered by the overall risk and contingency funds.	Accountable Pharmacist, NWSSP	**11.07.2024**	**Update 06.11.24:** Gareth Tyrrell to provide verbal update at November committee to enable the closure of this action
11.07.2024			**HEALTH & SAFETY ANNUAL REPORT**			
	3.1.6	**4**	Review reporting mechanism to ensure that any future improvement notices are brought through the Integrated Quality and Safety Group.	Interim Executive Director of Strategic Transformation, Planning & Digital	~~**12.09.2024**~~ **14.11.2024**	**Update 06.11.24:** Future Improvement Notices will be reported to the Integrated Quality and Safety Group from the November meeting onwards. In addition, the PMF will include on an on-going basis from next reporting cycle also.
11.07.2024			**BUSINESS CONTINUITY & EMERGENCY PLANNING ANNUAL REPORT**			
	5.3.1	**5**	Provide details of the rationale of actions by the Committee in respect of all Trust annual reports.	Interim Director of Corporate Governance	~~**12.09.2024**~~ **16.01.2025**	**Update 5.11.24:** Standard Operating Procedure to support future Annual Report process to be developed by January 2025.
12.09.2024			**VCS PATIENT STORY**			
	1.1.0	**6**	Review formal capture and sharing of messages of thanks	Interim Director of Corporate Governance	**14.11.2024**	**Update 5.11.24:** work being progressed by Head of Patient Engagement and linked to ongoing work being undertaken by Head of Quality, Safety and Assurance on Patient and Donor Experience (on agenda for November meeting).
12.09.2024			**ANTI-RACIST WALES ACTION PLAN**			
	3.2.0	**7**	Discuss with Trust Chair re the omission of research in the Action Plan	Executive Drector of Organisational Development & Workforce/Head of Organisational Development	**14.11.2024**	**Update 06.11.24:** This discussion will be scheduled for November.
	3.2.0	**8**	Ensure that learning derived from international recruitment workstrean is used to refine and inform future international recruitment projects.	Head of Organisational Development/Head of Workforce	**01.11.2024**	**Update 06.11.24:** Evaluation underway – will report to EMB and escalate as necessary
12.09.2024			**NHS WALES STAFF SURVEY RESULTS 2023**			
	3.3.0	**10**	SMART action plan with target dates to be circulated to the Committee	Head of Organisational Development	**14.11.2024**	**Update 06.11.24:** Included in Paper on agenda
	3.3.0	**11**	Results of deep dive in respect of bullying or harassment at work data to be reported to the Committee	Executive Drector of Organisational Development & Workforce	~~**14.11.2024**~~ **16.01.2025**	**Update 06.11.24:** Moved to January QSP
12.09.2024			**PEOPLE AND OD POLICIES AND PROCESSES**			
	3.6.0	**12**	Policy on Policies be brought to the Committee for review.	Interim Director of Corporate Governance	**01.03.2025**	**Update 24.10.24:** To be presented to at March governance cycle, culminating in QSP Committee and Trust Board.
12.09.2024			**PERFORMANCE MANAGEMENT FRAMEWORK**			
	3.9.0	**13**	nformation in respect of high level harm review outcomes to be included in future reports.	Interim Director, VCC	**14.11.2024**	**Update 06.11.24:** PMF to note that all patients that are identified as breeching treatment targets are reviewed. Where clinical harm is confirmed this will be identified, by clinical pathway and detailed as appropriate.

	3.9.0	**14**	Next report to the Committee to include details of timelines for the planned preventative maintenance at Velindre Cancer Centre.	Interim Executive Director of Strategic Transformation, Planning & Digital	**14.11.2024**	**Update 06.11.24:** Included in November agenda
12.09.2024			**TRUST RISK REGISTER**			
	3.10.0	**15**	Risks 3338 & 3366 - inherent risk scores and current risk rating to be reviewed	Interim Director of Corporate Governance/Interim Director, VCC	**17.09.2024**	**Update 4.11.24:** All scores have been reivewed, as per paper presented to QSP Committee.
12.09.2024			**DIGITAL SERVICES ANNUAL REPORT**			
	4.1.2	**16**	Future reports to outline how the clinical and scientific requirements/voices are featuring in the prioritisation of digital programmes	Chief Digital Officer	**16.01.2025**	
12.09.2024	**4.2.2**		**MEDICAL DEVICES ANNUAL REPORT**			
		17	Report to be brought to the November Committee.	Chief Operating Officer	**14.11.2024**	Included in November agenda

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Quality, Safety and Performance Committee

SACT GOLD REPORT

DATE OF MEETING	14th November 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	Tersa Humphreys, SACT Transformation Lead & Anne Carey, Interim Chief Operating Officer
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science & Anne Carey, Interim Chief Operating Officer
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science & Anne Carey, Interim Chief Operating Officer

EXECUTIVE SUMMARY	Business Continuity arrangements were commenced in relation to SACT Treatment delivery in February 2024. There is a SACT Transformation lead in post who is supporting enhanced monitoring and capacity and demand modelling as well as delivering the required delivery improvements and efficiencies. Since January 2024, performance against the 21-day non-emergency SACT treatment standard has been 64-91%. • June '24 – 88% • July '24 – 89% • August '24 – 87% However, the length of time that some patients are waiting to start their SACT treatment is 35 days. Bi-weekly SACT Gold meetings have continued, and the following outcomes / actions have taken

	place since the last report (September 2024): • No harm reported due to SACT treatment delays. • 55 additional treatment regimens introduced per week between April-September 2024. • 55 further regimens per week remains to be implemented as part of the SACT Treatment expansion plan. The focus of the programme of work has extended to include the front end of the SACT Pathway in line with service risks identified. A Business Case has been developed to support the required changes for Pre-SACT Assessment, which will be reviewed by VCC SLT, ahead of consideration by EMB on 11th November 2024.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to ***NOTE*** the current position and ongoing recovery work.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
SACT Gold Command	July-September 2024
Executive Management Board	11th November 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Matters discussed, oversight provided and decisions made on matters escalated.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Assurance rating increased from 2 to 3 as impact is starting to be seen by actions, longest numbers of days waiting for treatment is reduced, there is increased capacity, fewer concerns, and due to robust clinical review mechanisms no harm identified.	

1. BACKGROUND

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

Gold Command is chaired by the Executive Director of Nursing, AHP & Health Science with the Executive Medical Director as Vice Chair. At this time, the main capacity /

demand gap was identified as being the provision of the required treatments (pharmaceuticals).

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

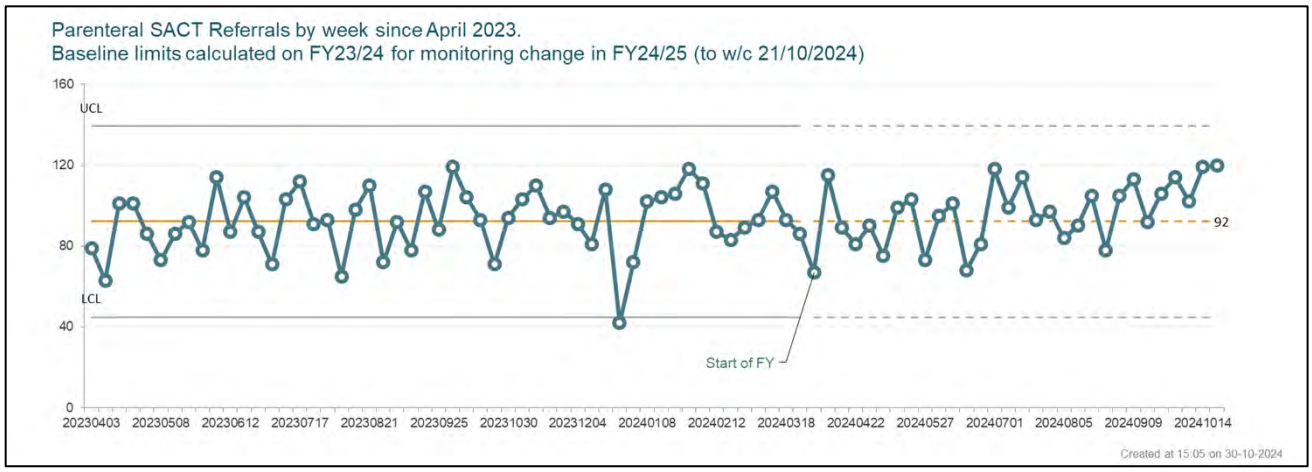
2. SACT PERFORMANCE

2.1 Emergency Performance

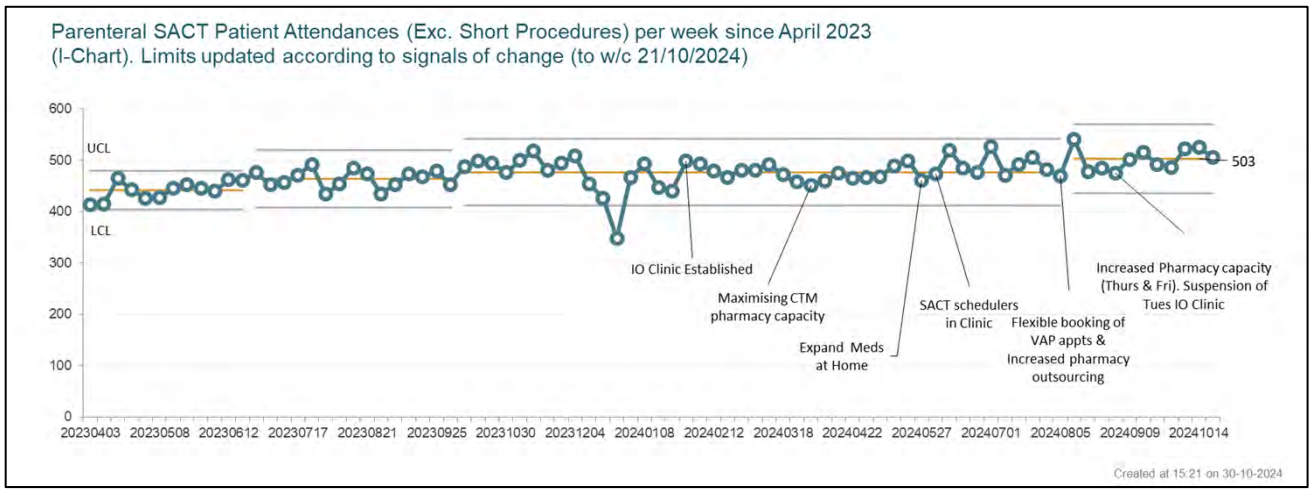
Emergency patients have all been prioritised and treated within the target of 5 days maintaining 100% performance over the last 12 months. This is not anticipated to change, as this activity will be prioritised.

2.2 Non-Emergency Performance

The graph below provides an overview of Parenteral SACT referrals for Cycle 1 treatment since April 2023 to 21st October 2024. Seven of the last eight weeks has shown higher level of referrals than the mean of 92.



Parenteral SACT attendances for the same period has demonstrated an increase since April 2023.



The table below provides an overview of the validated breach position in respect of non-emergency SACT against the 98% treatment standard.

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Non-Emergency referrals	358	434	386	280	443	457	356	361	445	341	395	413
Non-Emergency Compliance	90%	98%	85%	90%	64%	79%	91%	75%	76%	88%	89%	87%
Total number of non-emergency referrals treated within 21 days	323	424	329	251	283	362	323	271	338	341	352	358
Total Number of breaches	**35**	**10**	**57**	**29**	**160**	**95**	**33**	**90**	**107**	**41**	**43**	**55**

Longest Waits Non-Emergency

The length of time three patients waited to start non-emergency SACT treatment was in excess of 35 days.

	Jun-24		Jul-24		Aug-24	
Number of days waiting	Referrals	Percentage of referrals treated within time frame	Referrals	Percentage of referrals treated within time frame	Referrals	Percentage of referrals treated within time frame
0-7 days	131	37.50%	151	37.80%	167	39.80%
8-14 days	44	12.60%	74	18.50%	85	18.90%
15-21 days	133	38.10%	132	33.00%	113	25.10%
22 - 28 days	32	9.20%	39	9.80%	48	10.70%
29 - 35 days	9	2.60%	2	0.50%	6	1.30%
36 - 42 days			1	0.30%	1	0.20%
43-49 days			1	0.30%		
Total	349		400		420	

The September forecasted position is expected to be similar to June to August 2024 performance position, with a further improvement in performance of +6% expected for patients treated in October 2024.

2.3 Pre-SACT Assessment

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

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

A Business Case has been developed to support the required changes for Pre-SACT Assessment which will be consideration by the Executive Management Board on the 11th November 2024.

The Business Case provides solutions:

- for stabilising the current workforce gap in Pre-SACT Assessment capacity to meet current demand for Pre-SACT Assessment,
- focuses on increasing non-medical capacity solutions and,
- starts the process of moving from a medically delivered to a medically-led service model.

3. ENSURING PATIENT SAFETY

Consultant-led clinical prioritisation continues and to date no harm to any patients has been identified.

4. SACT DELIVERY IMPROVEMENTS

4.1 Overarching Improvement Plan

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

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

The plans to increase the Nurse and Pharmacy provision (expansion plans) are underway with posts being actively recruited into. Some challenges experienced with the recruitment of the Pharmacy Band 5 and Band 7 posts. Options being explored on how to mitigate this risk.

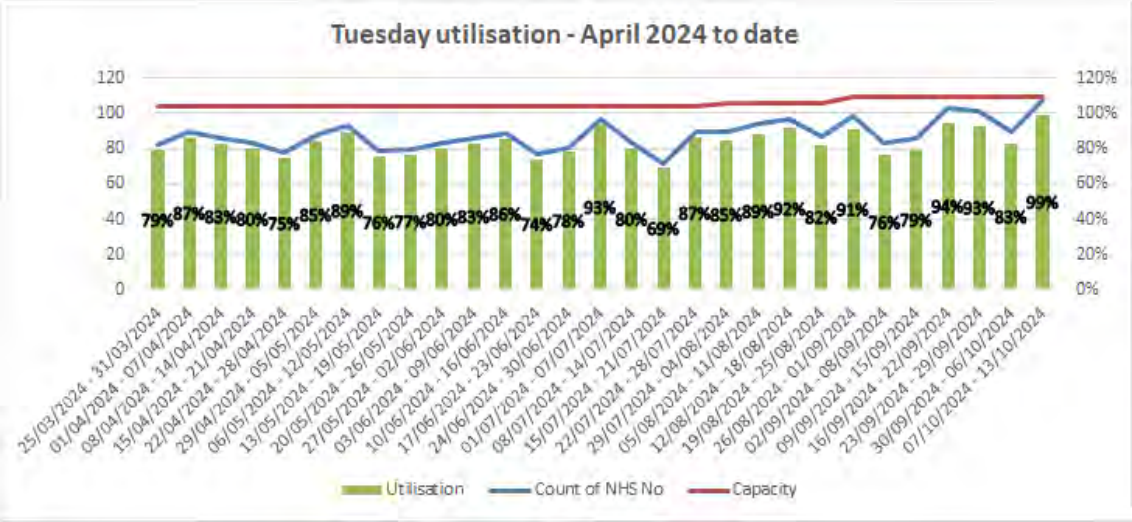
4.2 Capacity Increases

Since April 2024 the total number of regimens per week has increased by 55 (this excludes the utilisation benefits described below).:

- Mobile Unit – capacity increased from 24 in April 2024 to 48 by the end of August 2024. 4th Day of Mobile Unit introduced during September 2024 and IO Clinic in VCC stood down.
- VCC Pharmacy Capacity plan has increased from 515 in April 2024 to 525 in August 2024 and to 550 per week by 2nd September 2024.

In addition, there has been a focus on improving the utilisation of available SACT treatment capacity, with improvements delivered in:

- The utilisation of the Pharmacy capacity provided by Cwm Taf University Health Board in support of patient treatments delivered in Prince Charles Hospital increasing from an average of forty treatments per week in 2023/2024 to an average of forty-five treatments per week in 2024/2025 to date.
- Utilisation of treatment capacity on a Tuesday, which historically has been lower than other days of the week, has been significantly enhanced.



The final phase of the SACT treatment capacity increase is dependent on Nursing and Pharmacy recruitment and equates to a further 55 regimens per week. Start date for this next step up in capacity remains dependent on recruitment progress.

5. FUTURE FORECASTING

In line with the forecast of a more stable SACT Treatment performance position post September 2024 for the remainder of 2024/2025, the unvalidated performance for October 2024 is showing a 6% improvement compared to the performance between June 2024 to September 2024 position. Maintaining this level of performance improvement is based upon the forecast demand, which remains a risk given the current volatility.

The final phase of the SACT plan will release another 55 regimens per week but is dependent on recruitment, with Pharmacy recruitment proving especially challenging.

A Patient Tracking List is in development with Digital Insight team to develop a real time 'single source of truth' for each patient pathway, linking with the Health Boards to provide an understanding of the demand for individual components of the service

including oral and parental SACT, pharmacy, nursing and booking and to allow a higher degree of visibility on the number of patients waiting more than 21 days for treatment to be able to refine the improvement trajectory.

6. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☒ • 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. ☒	
s *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The provision of timely cancer treatment will impact on all aspects of Quality & Safety and the Trust's requirements to meet the Duty of Quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Provision of timely cancer treatment directly impacts on Trust's Healthier Wales responsibilities.

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There is a cost implication due to additional front-line capacity to deliver the required increase in SACT provision over and above IMTP provision. This is across the whole SACT delivery pathway which is being quantified in the related business cases.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for this type of report
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any group of people.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There is the potential for litigation due to the potential of harm which may be caused by delayed to SACT treatment beyond clinical optimal timescales.

7. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	There is a risk that patients are missed because of multiple lists being used to manage booking leading to clinical harm
WHAT IS THE CURRENT RISK SCORE	20
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	It is anticipated that the introduction of a Patient Tracking List as well as the actions set out in the SACT Improvement Plan, specifically the expansion of SACT treatment capacity will reduce the risk significantly
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Improvement and risk reduction should commence in September 2024, with further improvements in subsequent months. Initial target risk score is twelve.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Finance, availability of the required trained personnel across Clinical & the Data & Insight, teams.
WHAT IS THE RISK?	There is a risk of inability to meet demand for SACT service provision because of lack of

	pharmacy capacity leading to delay to patient treatment
All risks must be evidenced and consistent with those recorded in Datix.	

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Sickness Absence Data Analysis

DATE OF MEETING	14th November 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	Amanda Jenkins, Acting Assistant Director of Workforce
PRESENTED BY	Amanda Jenkins, Acting Assistant Director of Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	This paper provides a deep dive analysis into the Trust's sickness absence activity, providing assurance to QSP on the appropriate management of individual staff sickness aligned to the Managing Attendance at Work Policy and highlights some key actions for maintaining improvement towards the Velindre University NHS Trust agreed sickness absence target.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee are asked to **NOTE** the content of the paper and agree the assurance level and improvement actions.

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

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Cancer Centre Senior Leadership Team	23/10/2024
Welsh Blood Service Senior Leadership Team	23/10/2024
Executive Management Board	29/10/2024
Professional Nurse Forum	07/11/2024
Health and Safety Board	Out of meeting
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS VCC noted the content of the paper. People and OD have requested a dedicated agenda item at a future performance meeting to discuss key hotspot areas and operational action plan to address these. WBS noted the content of the paper. EMB have endorsed the paper for escalation to QSP and approved the assurance rating. PNF noted the content of the paper and discussed how they can support delivery of the action plan. H&S Board have noted the content of the paper and a discussion on supporting the action plan is scheduled for December 2024.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended There is evidence of delivery to improve specific performance concerns in the fact that since Feb 2023 there has been a gradual decline in sickness absence levels, however further actions have been identified and have not yet realised or achieved their desired outcomes.

1. Sickness Absence Deep Dive

Introduction

Velindre University NHS Trust recognises there will be occasions when employees will become sick during their working lives, and that each instance of sickness is treated in accordance with the individual's circumstance, in a fair and respectful way. The Trust however wants to work proactively with our people knowing that a good experience in the workplace is recognised to be positive on the wider health economy and outcomes.

The Trust has developed a number of proactive and integrated initiatives that underpin our strategic aim of having a healthy and engaged workforce to support the delivery of outstanding, quality, and safe services for patients and donors. As a Trust we value our staff and recognise they are core to the success of the organisation, something that underpins the Trust's People Strategy: Being an Employer of Choice, and within this strategy we have set our key objectives for well-being and engagement:

- Develop Health and Well-being Framework across the Trust setting out clear and measurable standards to help drive improvement
- Provide an Engagement Strategy to ensure staff are informed and involved, issues are raised and resolved, staff are rewarded and engagement can be measured
- Deliver equality, diversity and inclusion plans and a Welsh language plan which will promote a culture of true inclusivity, fairness, and equity across the workforce
- Ensure that our people are reflective of the Welsh population's diversity, Welsh language, and cultural identity

As well as committing holistically to supporting the health and wellbeing of our people in our strategic plans, the Trust aims to proactively manage absence and support staff should health issues arise though the NHS Wales Managing Attendance at Work Policy, which is monitored within the Trust's Performance Management Framework.

Policy and Performance Management of Sickness Absence

The principles and approach to management of sickness absence is detailed in the NHS Wales Managing Attendance at Work Policy which has the overarching objective to guide people and managers in supporting the health and well-being of employees in the workplace, during periods of sickness and upon their return to work.

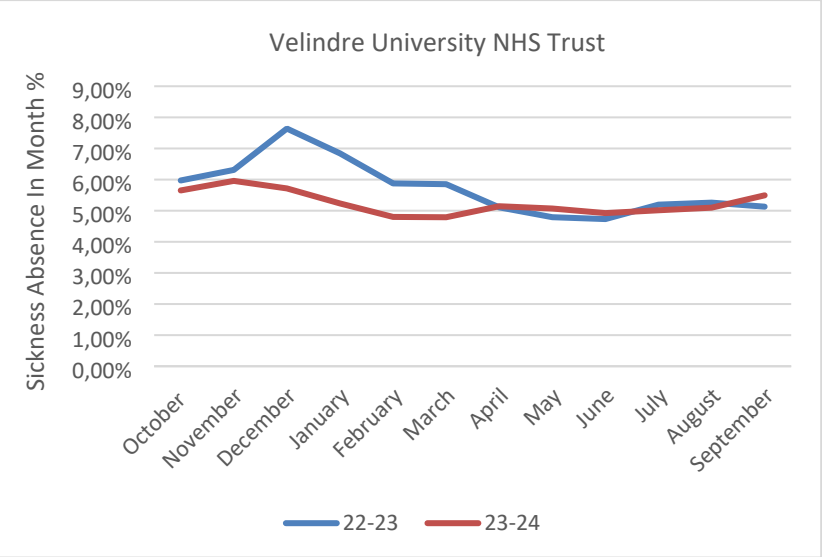
To monitor the effectiveness of managing sickness absence Welsh Government set a tier one target for each organisation in NHS Wales which is reported through various governance processes on a monthly basis. The current sickness absence target for the Trust is 3.54% however in August 2023 the Trust agreed an internal improvement target of 4.7% based on current labour market statistics and benchmarking of sickness absence levels across a number of health and social care organisations.

Sickness Absence Data

The following data has been pulled from the Electronic Staff Record and does not include any information related to organisations hosted by the Trust.

In Month Sickness Data

In recording in month absence data, we consider availability of working time within the given period and understand what % of this time is lost to sickness absence. This type of data is helpful for identifying operational pressures and supporting immediate interventions on a short-term basis. The following data represents the Trust in-month sickness absence for a two-year period to the end of September 2024.



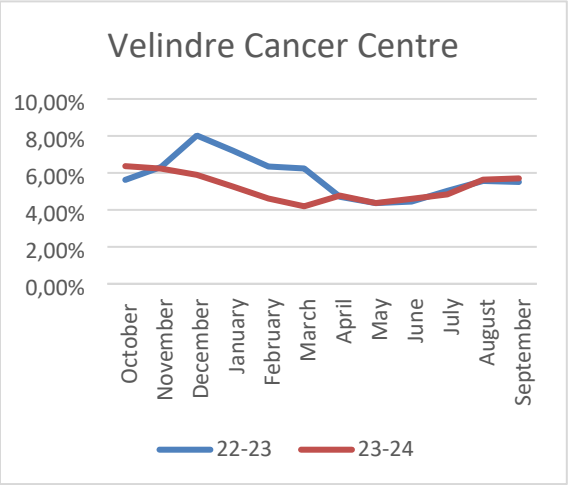
The overall Trust position of in month sickness absence demonstrated that there has been a spike in sickness absence during the winter months, specifically in the years 2022-2023, however this has changed in 2023-2024 year where the in-month absence percentage has remained relatively consistent between 5-6%.

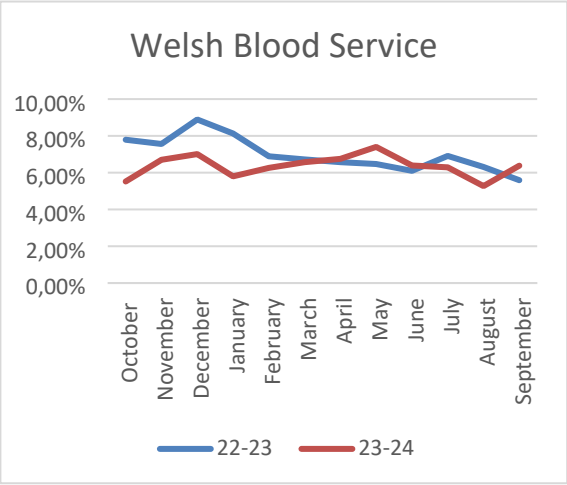
Targeted interventions to support during these pressured months have included:

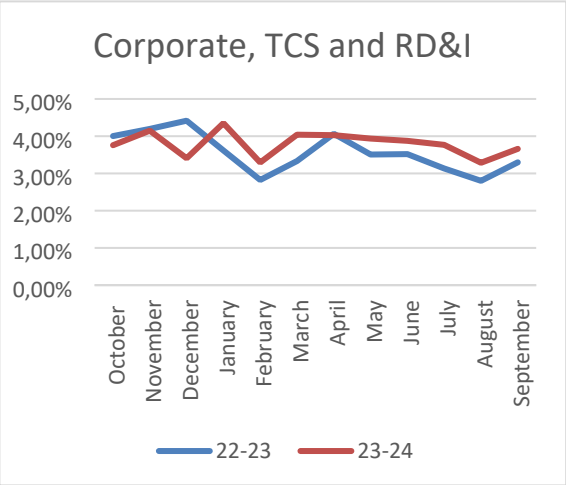
- Flu and winter respiratory vaccinations programmes
- Staying Well at Work initiatives – focused on diet and exercise
- Support from People and OD Team to proactively manage absence cases
- Stress management support and risk assessment

We will continue to monitor in month sickness absence rates to identify trends and possible interventions to improve absence.

The challenge with in month sickness absence reporting, as we can see in the divisional breackdowns, is that month on month there can be significant change in the data which does not demonstrate the more holistic upward or downward trend in sickness absence within the organisation.



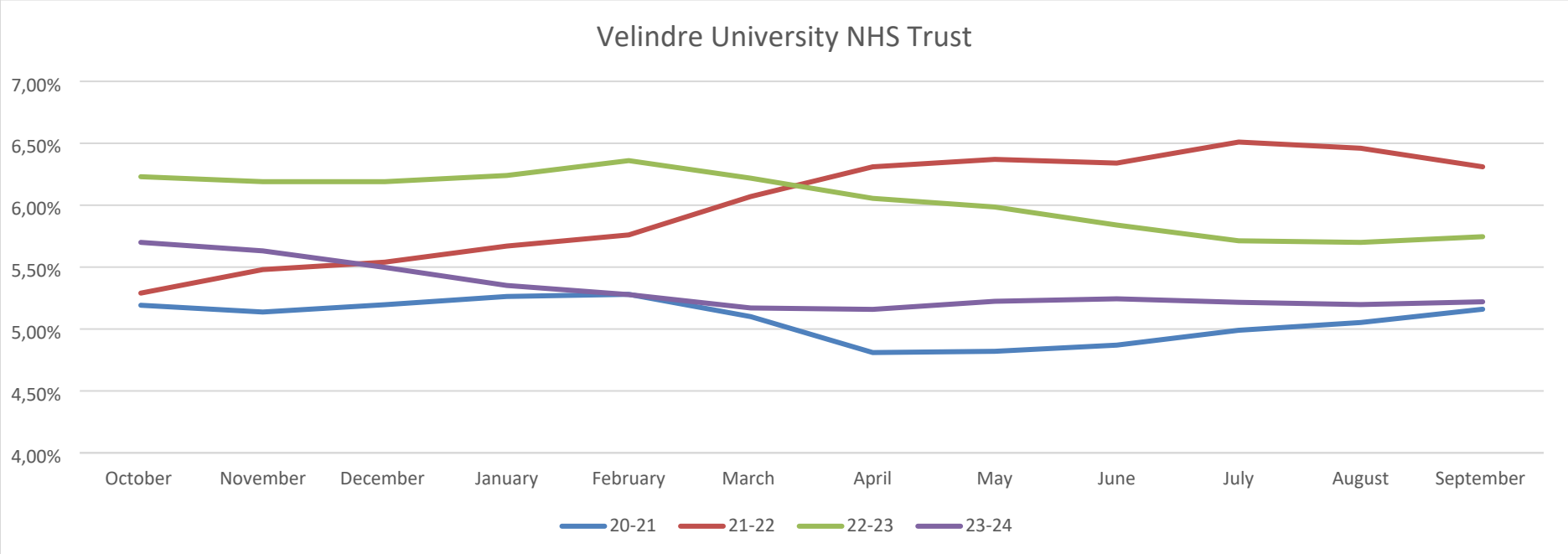




12-Month Rolling Sickness Data

To understand a more comprehensive and holistic picture of sickness absence, and more importantly to understand the general wellbeing of our workforce within the Trust we also measure sickness absence data over a 12-month rolling average. This helps us understand any long-term trends while not being impacted by seasonal fluctuations or specific spikes in the data. This way of reporting absence supports the Trust to make strategic decisions based on the overall increasing or declining position with sickness absence, and in understanding if interventions are supporting the longer-term wellbeing of our workforce. It is the 12-Month Rolling Sickness Data that all NHS organisations in Wales report to Welsh Government on a monthly basis.

The following data represents the Trust 12-month rolling sickness absence for a four-year period to the end of September 2024.



Considering our sickness absence in this way shows an interesting picture across the Trust. Historically prior to COIVD-19 there was a consistent rolling absence rate between 5-5.5% which significantly dipped in March 2020 and began to slowly rise until February 2023. Since February 2023 the Trust has seen an overall decline in sickness absence, returning back to the figures recorded pre-pandemic. The data since April 2024 (Quarter 1) to date suggests this picture of sickness absence is generally stabilising across the Trust between 5.1-5.2%.

Wellbeing Interventions and Support

The general decline of sickness absence since February 2024 can be attributed to a number of ongoing factors within the Trust, but specifically with the strategic focus and prioritisation on wellbeing interventions and support for staff. The following provides an overview of some of the strategic and operational initiatives to support wellbeing across the Trust.

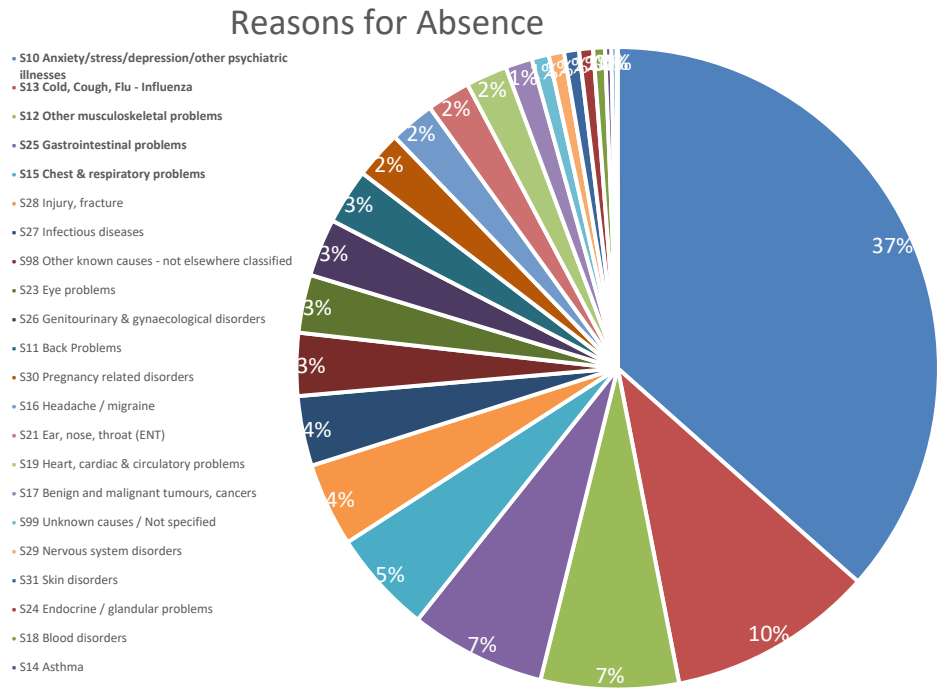
Trust Board Pledge to Compassionate Leadership	Senior Leadership Wellbeing Pledge	Development and approval of Trust Values and Behaviour Framework	Internal audits with completed recommendations
Speaking up Safely Framework Launched	Embedding Respect and Resolution Principles across the Trust	Programme of Reducing Avoidable Employee Harm actions undertaken	OD interventions in hotspot areas to support staff wellbeing
Recruitment of Wellbeing Coordinator	Recruitment of New Staff Psychologist	Move to a People and Relationship model of working within POD	Recruitment of new educator to support MAAW training
Monthly management reviews of sickness absences	Implementation of tailored adjustments to avoid future absence	Occupational Health advice and support	Phased returns and reasonable adjustments where needed
Developed comprehensive resource platform	Lunched Noddfa and WBS Wellbeing room as dedicates spaces	Financial Management drop-in sessions	Implemented Vivup – the new EAP for staff
Programme of ongoing support initiatives developed liked to five pillars of wellbeing	Safe conversations initiatives linked to underlying health conditions (i.e. Menopause Campaigns)	Operational workforce planning to identify capacity and workload issues	Developed Fundamental of Management Training

While there are still a number of actions to further improve the Trust's sickness absence position we can clearly demonstrate the effective influence these initiatives are having on supporting the overall health and wellbeing of people within the Trust.

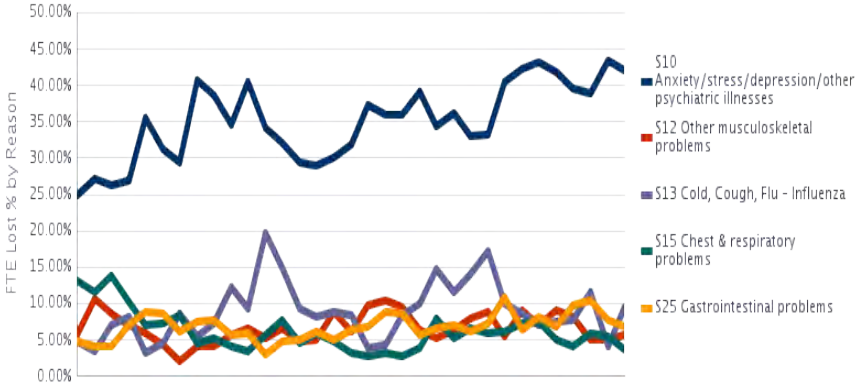
Detailed Analysis of Absence Data

When considering what further actions can be taken to support the overall improvement of sickness absence it is important for us to understand what the overall nature of the absence looks like across the Trust. Knowing reasons for absence, if specific groups are more impacted than others or if there is a correlation with long and short-term absence is important to developing targeted action plans and interventions.

The following data represents the breakdown of sickness absence information for the past two years up to the 30th September 2024.



The top 5 reasons for absence over the two-year period account of 66% of all sickness absence within the Trust. When we look at the FTE of working time over the past two years lost within these top reasons for absence we can clearly identify Anxiety/stress/depression/other psychiatric illnesses as a significant impactor on not only the absence data but the available time to work.



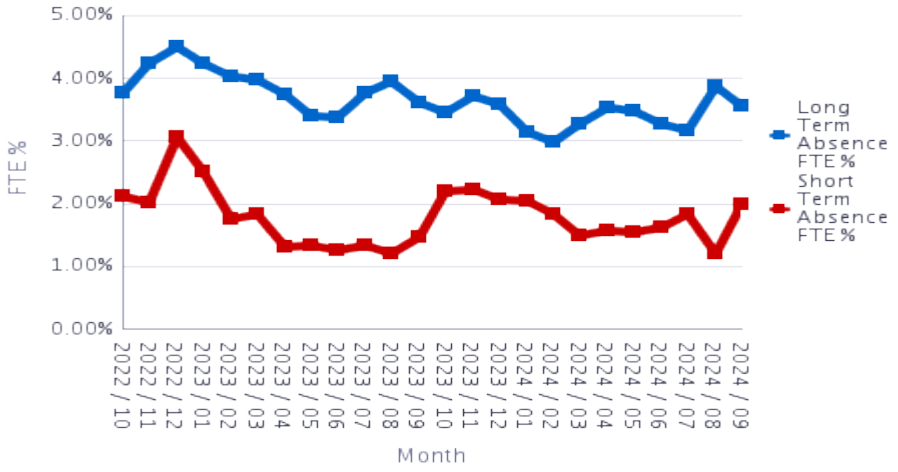
Mental health related absences continue to be the largest reason for sickness absence month on month. Between October 2022 and September 2023 there were 257 individually recoded instances of absence related to mental health with an estimated cost of £1,033,764.96. This grew by 4% in the year October 2023 to September 2024 with a total of 340 cases recorded and an additional cost of £203,000.00. The overall cost of mental health related illness alone in 2023 to 2024 is £1,236,625.00, whereas all other absences combined equate too £1,942,656.17.

Looking at reasons for sickness across age groups we are able to see when staff are more likely to experience one of the top five reasons for sickness absence. Interestingly most research will site an aging workforce for growing sickness absence. From this

data we are able to see those ages 46 to 60 are more likely to experience absence related to the top five reasons, with those age 26 to 40 having a high possibility of experiencing a mental health related absence.

Absence Reason	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Anxiety/stress/depression/other psychiatric illnesses	0.00%	29.00%	40.65%	41.67%	42.30%	38.93%	32.98%	35.78%	36.04%	30.95%	13.25%	12.00%
Other musculoskeletal problems	0.00%	3.24%	7.33%	1.59%	4.90%	3.17%	7.25%	11.67%	8.23%	11.76%	4.10%	0.00%
Cold, Cough, Flu - Influenza	57.26%	22.02%	14.02%	12.13%	12.38%	12.97%	6.25%	7.40%	7.50%	7.05%	8.08%	24.84%
Chest & respiratory problems	9.29%	2.05%	2.81%	2.00%	2.45%	2.49%	5.24%	4.47%	8.54%	16.46%	1.89%	4.25%
Gastrointestinal problems	4.69%	18.63%	9.85%	6.19%	8.55%	10.23%	5.80%	3.90%	4.58%	3.16%	2.35%	1.62%

As well as understanding the reasons for sickness is it important to breakdown the sickness data into long-term and short-term categories which are crucial for understanding the underlying causes of employee absences and addressing them effectively. Short-term absences often result from common illnesses or minor issues, while long-term absences may indicate more serious health conditions or personal challenges. Analysing both types separately helps organisations tailor their interventions, such as implementing return-to-work programs for long-term absences or improving workplace conditions to reduce short-term sick days. This distinction allows for targeted strategies to improve employee well-being and reduce overall absence rates.



We can see in the data a slow but overall decline in long-term sickness absence that can be attributed to the effective management of sickness cases including the many proactive measures in place to support the individuals return to the workplace, e.g. referring to Occupational Health, supporting

reasonable or tailored adjustments, offering redeployment options where appropriate, referring into internal wellbeing services and signposting staff to relevant external services.
Short-term sickness in general is relatively low (under 2%) across the Trust however in the last 12 months this has continued to steadily increase. There could be a number of reasons for this increase however the process is not currently monitored in regular meetings between the People and Relationship Team and managers, as is done with long-term sickness.

Action Plan
While overall there has been a significant focus on sickness absence and management of cases across the Trust there are some actions we can take to further support the workforce and focus on some of the highlighted areas from the data. The following action plan demonstrates some of the immediate actions we can put in place:

- Early management intervention (after 48 hours) for absences related to mental health reasons
- Communication and internal advertising of all health and wellbeing champions (i.e. Mental Health First Aiders, Menopause Buddies, etc.)
- Monitoring of short-term sickness absence in monthly Management meetings with People and Relationship Team and progression through Managing Attendance at Work Policy, if required
- Targeted Sickness Absence Audits to ensure compliance with Policy
- Monitoring of tailored adjustments within the workplace
- Monitoring of Flexible Working requests and outcomes
- Cross reference analysis with staff survey data, sickness absence data, recruitment, and retention data, to highlight specific challenging areas

Conclusions
In conclusion, the overall analysis of sickness absence data shows a positive trend, with a steady decline in the overall absence targets indicating that the Trust's efforts to support employee health and well-being are having a positive impact. However, despite this improvement, there remain specific areas of concern that require further attention. Mental health-related absences continue to be a significant challenge and more analysis is required to understand the reasons for mental health specifically in staff categories where there are higher absence reasons. Additionally, short-term absences are increasing contributing disproportionately to overall absence rates, highlighting the importance of monitoring and managing these cases as much as long-term cases. By focusing on these targeted issues over the coming 12 months the Trust can build on its progress and further improve.

2. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	01 - Demand and Capacity 03 - Workforce Planning 04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	In order to have a quality-led system, NHS Wales needs to ensure it has the right values underpinning it, with a just culture and compassionate leadership. The whole workforce needs to be engaged fully in the need to improve. Personal wellbeing is a fundamental requirement for this to take place. If members of staff are suffering from burnout or feeling disengaged from the organisation, service improvement will inevitably drop off, but if wellbeing is prioritised, patient care will be safer and of higher quality and continual service improvement will occur.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Improving the health and wellbeing of staff will not only support the organisation but the health economy outcomes within the regions that we serve. The future trends report demonstrates across Wales the number of adults being treated for mental health related conditions is also rising so supporting out staff in managing short-term and long-term conditions such as these in a proactive manner will help to support the wider health and wellbeing outcomes aligned to The Well-being of Future Generations Act, 2015
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:
	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream

	As outlined in the report, sickness absence has a significant cost not only to productivity in an organisation but also through the financial impact. Managing absence effectively and ensuring people are supported in a compassionate way will support the reduction in sickness absence and emphasis a more pro-active process for managing possible sickness within the workforce.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	EQIA has been completed nationally on the Managing Attendance at Work Policy accounting for any impact this may have on staff with protected characteristics. The actions and details of this report are undertaken in line with the principles and expectations of this NHS Wales Policy.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Ineffective management of sickness absence could lead to Employment claims for a number of reasons including but not exclusive too, discrimination, unfair dismissal or statutory breaches of employment rights.

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Risk 3001 - There is a risk to the health and wellbeing of the workforce in not appropriately managing sickness absence which in turn leads to a risk on capacity and resource to deliver safe and quality services. This risk is being managed through various operational and strategic risks within the Trust.
WHAT IS THE CURRENT RISK SCORE	TAF 01 – Risk Score 12 TAF 03 – Risk Score 12 TAF 04 – Risk Score 9

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The actions within this paper will support the further improvement of capacity by reducing sickness absence, and ensuring there are the right people with the right skills to undertake the work required. All of these things will in turn lend themselves to improving the overall organisational culture and engagement from staff who feel valued and motivated in their employment.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Ongoing through quarterly TAF reviews
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Effective engagement ad implementational from managers and leaders with agreed policies and principles around sickness absence and work life balance priorities.
All risks must be evidenced and consistent with those recorded in Datix	

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 30TH SEPTEMBER (M6)

DATE OF MEETING	14/11/2024

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	Steve Coliandris – Head of Financial Planning & Reporting
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 September 2024. The three main issues are highlighted below: 1. **Long Term Agreement (LTA) Financial values & Contract Rebase** <u>LTA Financial Values</u> All 2024-25 LTA financial values have been agreed, but the Trust is still awaiting return of LTA documents from three Health Boards.

The financial settlement resulted in a:

i. £318k reduction in recurrent NICE drug income (£145k Aneurin Bevan University Health Board (UHB), £115k Cwm Taf Morgannwg UHB & £58k reverting to old baseline) compared to plan.

ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services. The Trust is currently reviewing the Hywel Dda activity over the past 5 years and the elements of the LTA funding that are not activity related in order to argue a reduction in this income loss. This will need to be considered as part of the 2025-26 financial plan included with the IMTP.

LTA Contract Rebase

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

	2. Integrated Medium Term Plan (IMTP) – Financial Plan / Forecast • The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024. • Following agreement on the LTA the Trust financial plan was revised and the shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures thus ensuring that the Trust continues to have a balanced financial plan. • A new financial risk which has recently emerged whereby LTA income activity will not match the level of investment into services at VCS. As of August, there was an underachievement of c£0.700m against the target of £1.3m before 2024/25 which is the level of investment into VCS which is not yet reflected in the position. This is currently under urgent review within the Division to assess if the original forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being captured and costed correctly. **3. Key Financial targets / KPIs** • The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven. • The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSPP) target of paying 95% of non-NHS invoices within 30 days for 2024-25. • The Trust is expecting to achieve the Capital Expenditure Limit (CEL), however a risk remains as funding has not yet been secured from WG for several schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked **NOTE** the contents of the September 2024 financial report and in particular: • The year to date and forecast revenue out turn position and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with commissioners on the contract rebase agreement. • The latest position on the LTA Activity performance for 2024-25. • That the Trust is still waiting to secure Capital funding from WG in relation to the nVCC, Enabling Works and Whitchurch Hospital and land matters for 2024-25. • The Trust secured £0.220m from WG yearend slippage funds.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	29/10/2024
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE REPORT WAS RECEIVED AND NOTED AT EMB ON 29TH OCTOBER 2024.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	Trust Finance Report – September 2024
Appendix 2	TCS Finance Report – September 2024

1. SITUATION / BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of September 2024.

1.2 The financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.003	0.018	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.734	8.153	29.037
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.1%	97.1%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven however there are risks associated in achieving this.

The overall position against the profiled revenue budget to the end of September 24 is an underspend of **£0.018m** and a forecast outturn position of **Breakeven.**

There is a new financial risk which has recently emerged whereby LTA income activity will not match the level of investment into services at VCS. As of August, there was an underachievement of c£0.700m against the target which is not yet reflected in the position. This is currently under urgent review within the Division to assess if the original forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being costed and recorded correctly.

The Trust has received notification from WG on the pay award for 2024-25, however discussions are ongoing as to whether an incremental step will be included on the Band 8 and above pay levels. Finance colleagues are currently calculating the impact of the pay award which is expected to be paid in November. At this stage we would assume that it would be fully funded, albeit with some risk until WG confirm the funding allocation.

It is expected that cost pressures will be managed by budget holders in line with the Trust's budgetary control procedures to ensure the delegated expenditure control limits are not exceeded.

LTA Contract Position

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values in line with 30th June deadline which has led to a financial impact to the Trust for 2024-25 as follows:

- £318k Reduction in recurrent baseline uplift income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. Hywel Dda UHB has

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services. The Trust is currently reviewing the Hywel Dda activity over the past 5 years and the elements of the LTA funding that are not activity related in order to argue a reduction in this income loss. This will need to be considered as part of the 2025-26 financial plan included with the IMTP.

The shortfall in LTA inflationary uplift income has been recovered this financial year through a combination of increased savings target, pausing previously agreed investment decisions and mitigating cost pressures.

<u>LTA Contract Rebase</u>

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.

- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

The Trust is reporting a year end forecast revenue breakeven position; however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

2.3 Savings

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of Septmber'24 is an underachievement against plan of **£(0.074)m**, however at this stage is expected to deliver to target by the end of the Financial year.

2.4 PSPP Performance

During September'24 the Trust (core) achieved a compliance level of **98.1%** (August 96.6%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.1%** at the end of month 6, and a Trust position (including hosted) of **97.5%** compared to the target of 95%.

2.5 Covid Expenditure

The Trust is currently not expected to draw down any covid funding support during 2024-25.

2.6 Reserves

The financial strategy for 2024-25 has enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

2.7 Financial Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25. As of the end of September the majority have now either been reduced in risk or mitigated completely for 2024-25.

The reaming risk which have been flagged to WG and considered to be either high or medium risk is the potential that energy costs will exceed budget.

There are several opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the emergency reserve which would be used to support these risks should they crystallise. However, currently the non-recurrent reserve and emergency reserve are being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs subject to the Trust securing funding from WG.

2.8 Capital

All Wales Programme

Capital funding has not yet been allocated to several capital schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters requirement for 2024-25. WG are fully aware of the requirement with an expectation that a request will go imminently to the Minister to secure funding.

All other schemes without agreed funding are under discussion with WG colleagues with confidence at this stage that Capital funding will be provided to support the schemes.

Other Major Schemes in development that are detailed in the finance report will be considered during 2024-25 or beyond in conjunction with WG.

Discretionary Programme

The discretionary programme is currently fully allocated other than a contingency of £0.050m, however, WHAIS (£0.494m) and the WBS TGI OBC (£0.360m) are currently ringfenced from the discretionary fund with the expectation that if All Wales Capital funding can be secured, then £0.854m can be released back into the discretionary pot.

WG yearend Slippage

An e-mail was received from WG Capital colleagues on the 13th September asking the Trust to identify a prioritised list of backlog maintenance, infrastructure risks & equipment funding requests for consideration which need to be deliverable in-year. WG intention is to re-allocate the slippage on schemes already returned to the Welsh Government in early October (subject to Cabinet Secretary for Health and Social Care clearance) and for a further tranche should extra slippage / underspends be reported through the end of October 2024 exercise.

The Trust responded to this request on the 30th September with a prioritised list totalling c£1.300m which was submitted to and approved by EMB. WG informed the Trust on the 24.10.2024 that £0.220m has been awarded to support several schemes within the overall prioritisation list as detailed in the main report..

The schemes that were not approved will be considered for support should funding be provided from WG towards WHAIS and the WBS TGI OBC of £0.854m currently ringfenced against the discretionary programme or will need to be considered against the 2025/26 discretionary allocation.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

3. IMPACT ASSESSMENT

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*	08 - Trust Financial Investment Risk

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).
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

YES - Select Relevant Goals below

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐
- A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐
- 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. ☐

• Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.018m** underspend to September '24, whilst currently in line with the IMTP plan there are risks associated as outlined in the paper.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
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?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Trust Assurance Framework (TAF)
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	

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 SEPTEMBER 2024/25

EMB RUN
29/10/2024

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2024-25

2. Background / Context

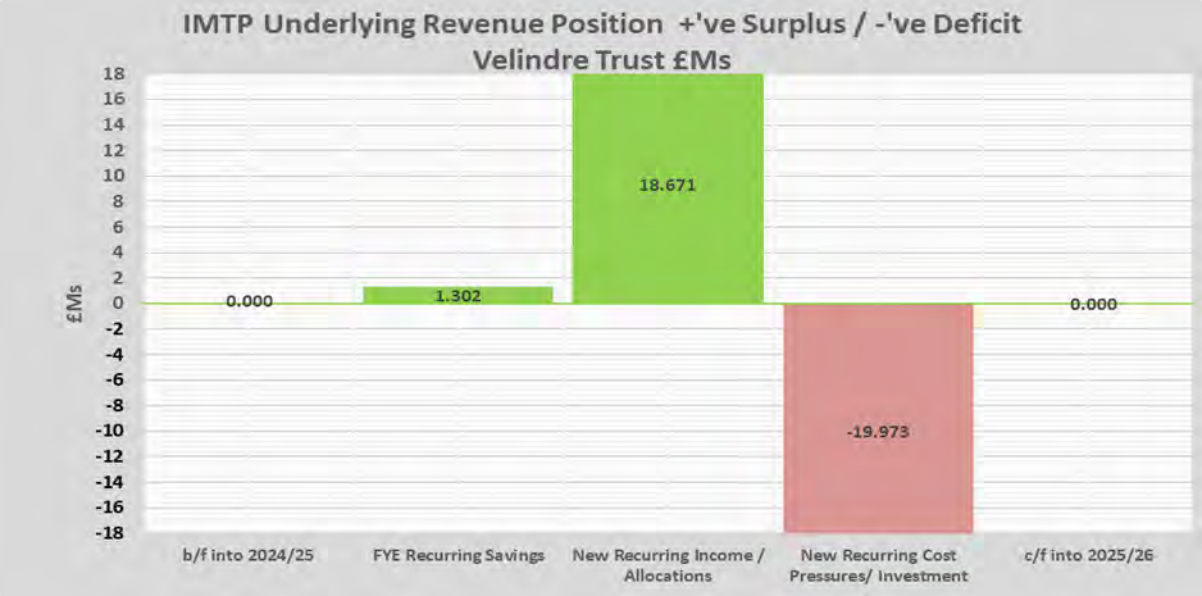
The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024.

- For 2024-25 the Plan included;
  - A balanced position brought forward from 2023-24,
  - FYE **of new cost pressures / Investment** of **-£19.973m,**
  - offset by **new recurring Income** of **£18.671m,**
  - and Recurring FYE **savings schemes** of **£1.302m,**
  - Allowing **a balanced position** to be carried into 2025-26.

- **A significant risk is currently associated with the income that the Trust is expected to receive from its commissioners in relation to the 3.67% discretionary uplift, which could impact on the plan and the ability to achieve a balanced financial position.**

- **To achieve a balanced financial position, the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2024/25	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.000	1.302	18.671	-19.973	0

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	0.003	0.018	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.734	8.153	29.037
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.1%	97.1%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.021)	(0.074)	0.000

Revenue

The core Trust has reported £0.003m underspend position for September 24, which give a cumulative year to date position of **£0.018m** underspent and an outturn forecast of **Breakeven.**

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of an increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures.

Capital

The approved Capital Expenditure Limit (CEL) as of September 2024 is **£19.600m**. This represents all Wales Capital funding of **£17.689m**, and Discretionary funding of **£1.911m.** The Trust reported

Capital spend to September'24 of £8.153m and is forecasting to remain within the CEL of £19.600m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.

The Trust's current CEL is broken down as follows:

	£m
Discretionary Capital	**1.911**
All Wales Capital:	
IRS	5.164
IRS RSC	11.265
Digital RISP	0.160
BECS	750
Backlog Maintenance	350
Total All Wales Capital	**17.689**
Total CEL	**19.600**

PSPP

During September'24 the Trust (core) achieved a compliance level of **98.1%** (August 96.6%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.1%** at the end of month 6, and a Trust position (including hosted) of **97.5%** compared to the target of 95%.

Efficiency / Savings

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875 was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of September'24 is an underachievement against plan of **£(0.074)m**, however at this stage is expected to deliver to target by the end of the financial year.

Revenue Position

Cumulative				Forecast		
£0.018m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(108.627)	(109.056)	0.430	(219.007)	(219.007)	0.000
Pay	45.497	45.303	0.194	89.735	89.735	0.000
Non Pay	63.130	63.735	(0.605)	129.272	129.272	0.000
Total	**(0.000)**	**(0.018)**	**0.018**	**(0.000)**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of September 2024 is an underspend of **£0.018m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast revenue breakeven position; however, this assumes that all planned additional income is received, the revised planned savings targets

are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

As per the IMTP Financial Plan the Trust brought a balanced position into 2024-25 and is expected to maintain this position over the course of the 3-year planning period.

To retain a balanced position, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge over the course of the period.

Income

The Trust continues to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

WBS overachievement on Plasma sales had been significantly impacted by supplier payment issues which has been referred to CCI debt management. However, Since the referral the Trust has negotiated a re-payment plan with the supplier Randox and the first instalment was received at the beginning of August with a repayment plan in place for the outstanding debt.

A new financial risk which has recently emerged whereby LTA income activity will not match the level of investment into services at VCS. As of August, there was an underachievement of c£0.700m against the target which is not yet reflected in the position. This is currently under urgent review within the Division to assess if the original forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being captured and costed correctly.

VCS Long Term Agreement (LTA) Contract Performance

The Trust has undertaken discussions with LHB Commissioners in accordance with a few important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.

- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. To manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

To avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement. The financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent baseline uplift income compared to plan.
- £483k Reduction in non-recurrent income compared to plan.

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services. The Trust is currently reviewing the Hywel Dda activity over the past 5 years and the elements of the LTA funding that are not activity related in order to argue a reduction in this income loss. This will need to be considered as part of the 2025-26 financial plan included with the IMTP.

LTA Contract Rebase

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

The Commissioner plan is set out below:

• Agree Proposed Baseline LTA for each HB & NHSWJCC	31/10/2024
• Agree Proposed Baseline NICE/HCD Expenditure for Each HB & NHSWJCC	
• Agree Resource Allocation Adjustment for notification to WG for Initial 2025/26 Allocation Letter.	30/11/2024
• Agree LTA Schedules for 2025/26 Velindre NHS Trust LTA	31/01/2025

Pay Highlights / Key Issues

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

The Trust has received notification from WG on the pay award for 2024-25, however discussions are ongoing as to whether an incremental step will be included on the Band 8 pay levels. Finance colleagues are currently calculating the impact of the pay award which is expected to be paid in November. At this stage we would assume that it would be fully funded, albeit with some risk until WG confirm the funding allocation.

Several 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. During August VCS were provided funding that was agreed as part of the IMTP to support several of the unfunded posts. The remaining unfunded posts are currently under review alongside the LTA activity to try and align the cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which will need to be achieved to balance the financial plan for 2024-25.

Non Pay Key Issues

Per the allocation letter the Trust has received £0.563m of recurrent funding from WG to support the increase in energy prices during 2024-25. The latest forecast schedule from NWSSP suggests that the full year energy costs will be c£1.745m, this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provided by WG) which is held by the Trust.

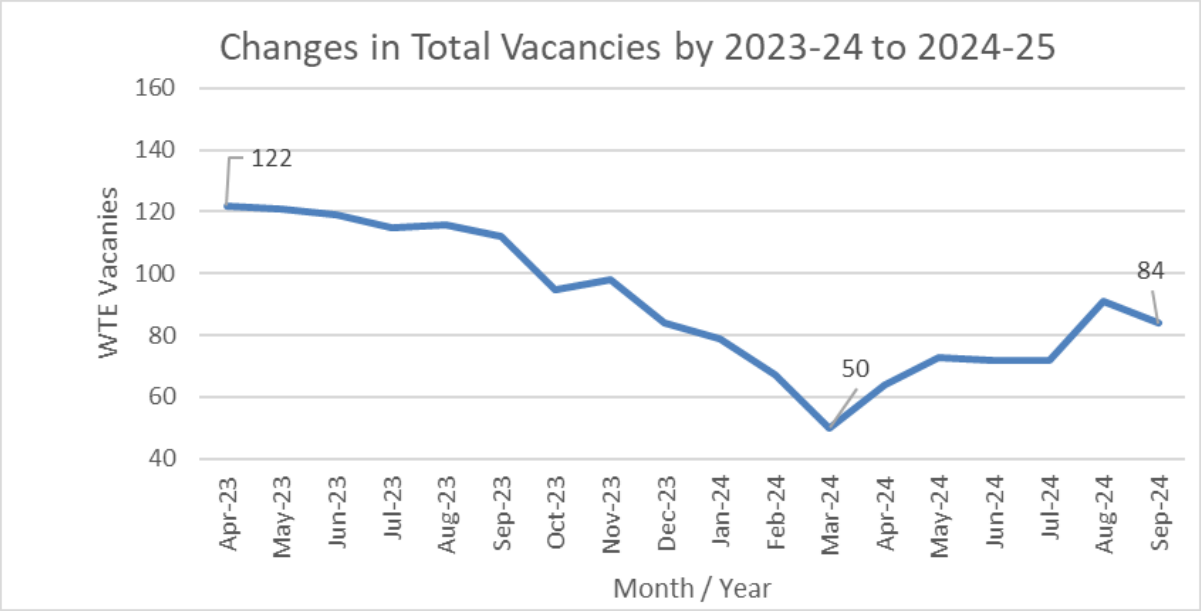
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust revised savings target for each division has been updated as VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

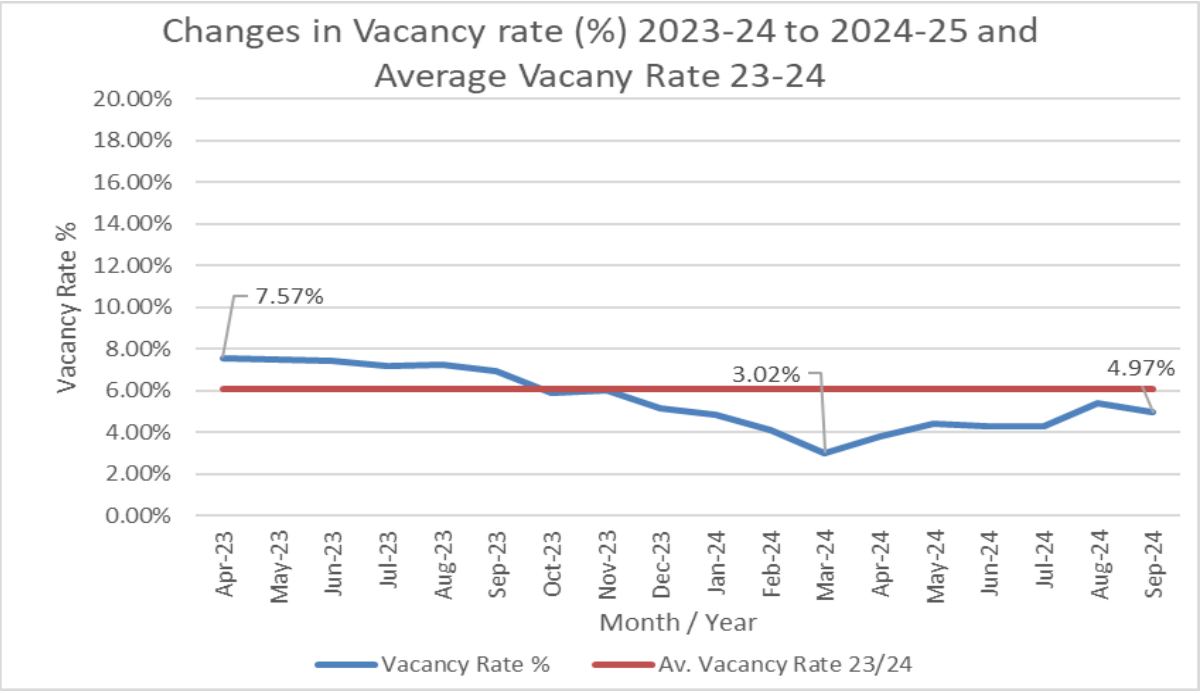
4.2 Pay Spend Trends (Run Rate)

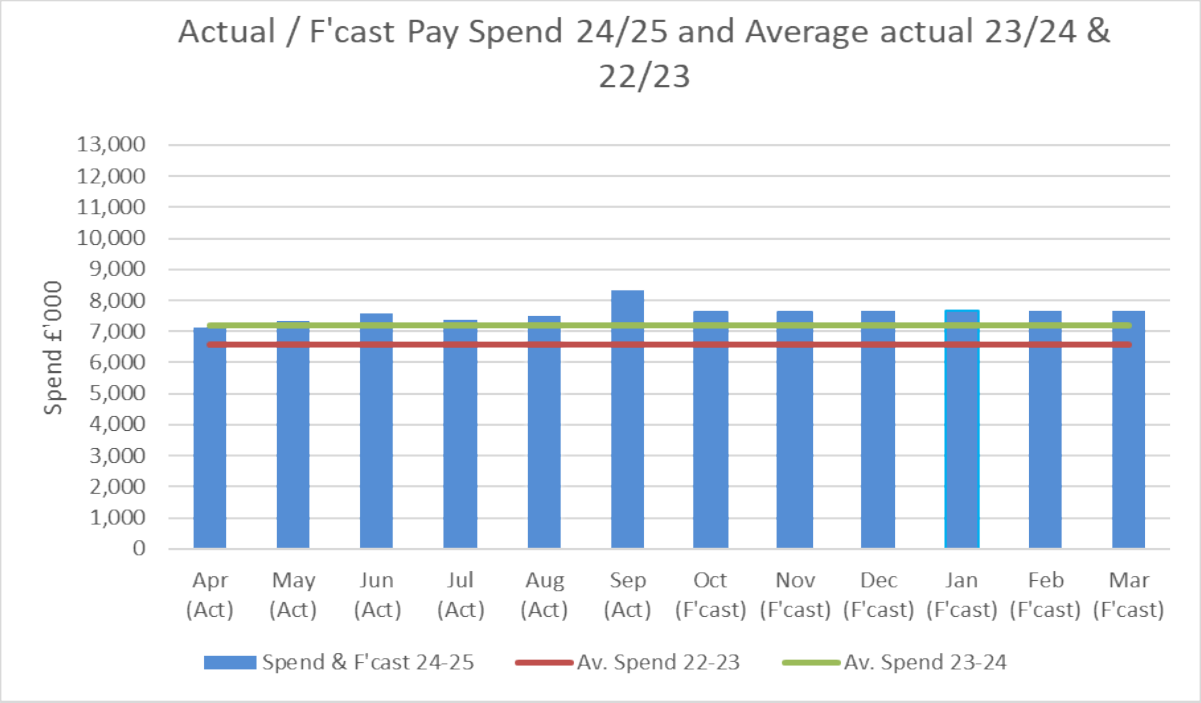
As of September 2024, the current staff in post is 1,614 WTE (August 1,608). The number of vacancies is 84 WTE, which represents a vacancy rate of 5% (5.4% August) against the budget of 1,698 WTE. The vacancy gap is largely being met using agency staff or overtime and is also supporting each of the division's vacancy factor savings target.

The level vacancies fell over the course of 2023-24 across several services areas, due to the recruitment of 17wte Nurses via the international recruitment scheme, which is demonstrated in the chart below and the historic trend line. As of September'24 vacancies have risen which is largely due to VCS receiving funding and setting budgets during the period for unfunded posts approved via the IMTP, and also for vacancies materialising from approved projects.



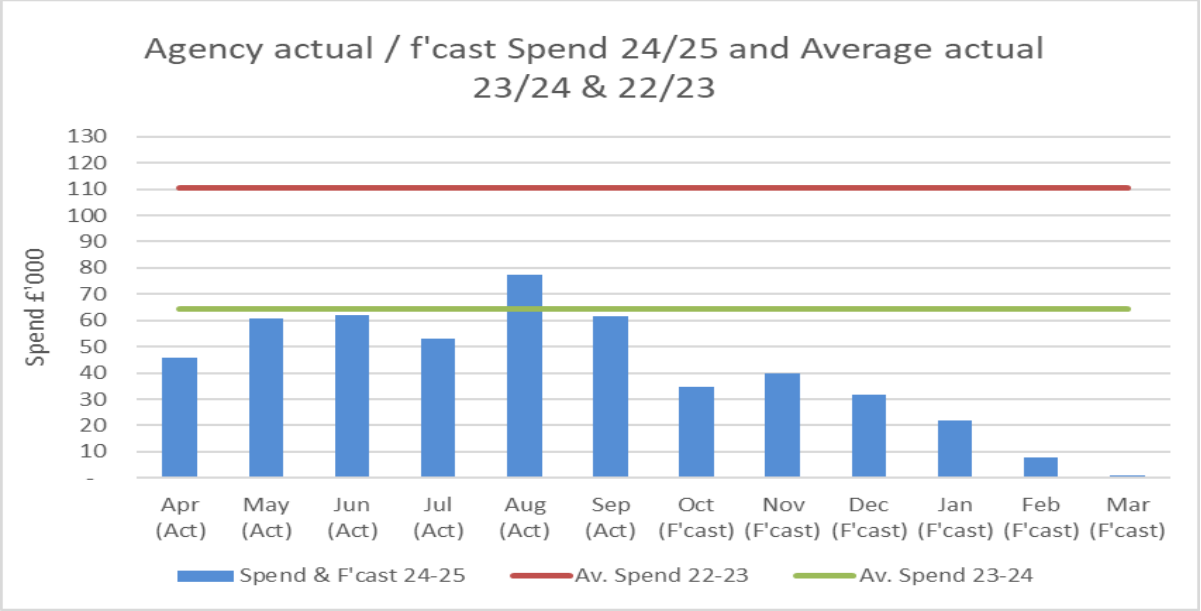
The total Trust vacancies as of September 2024 is 84wte (July 92wte), VCS (44wte), WBS (12wte), Corporate (12wte), R&D (15wte), TCS (0wte) and HTW (1wte).





The impact of the pay award for 2024-25 is currently being calculated by Divisions and therefore not currently reflected in the pay spend. The Trust is also awaiting on clarification from WG as to whether the incremental step will be included for the Band 8 and above pay levels.

The spend on agency for September'24 was **£0.061m** (August £0.077m) which gives a cumulative year to date position of **£0.361m** and a current forecast outturn spend of circa **£0.498m** (£0.775m 2023/24).



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

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that

some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

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

The use of agency within Medical has now ceased.

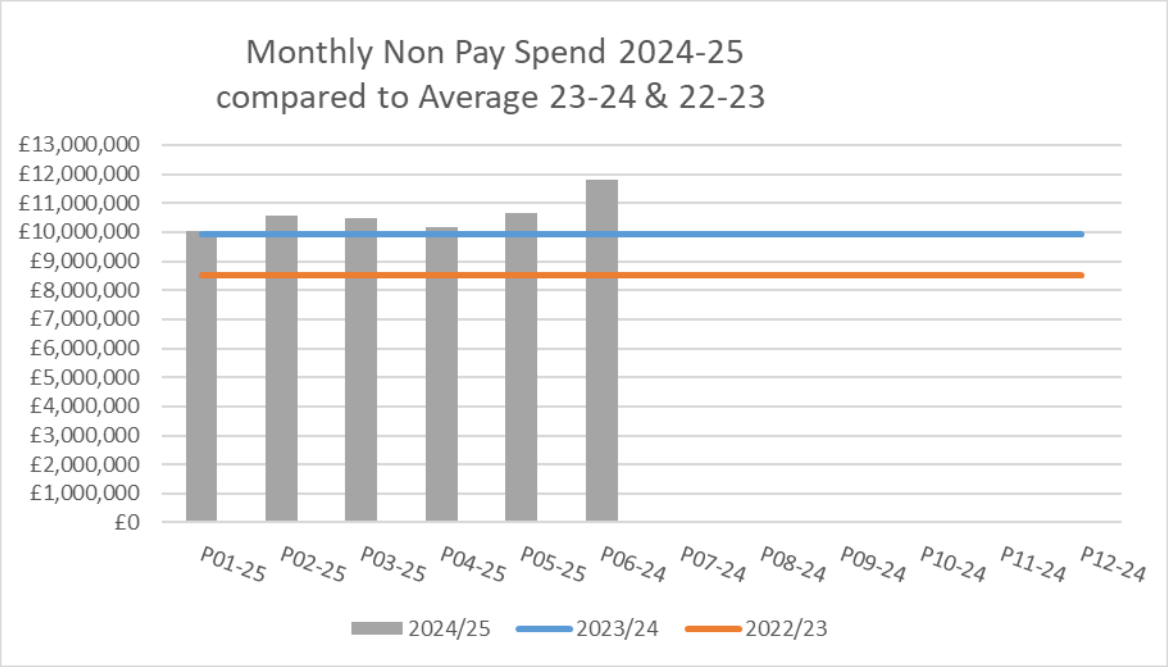
Where possible the Trust will aim to utilise bank staff to reduce reliance on agency and the premium costs associated.

4.3 Non Pay

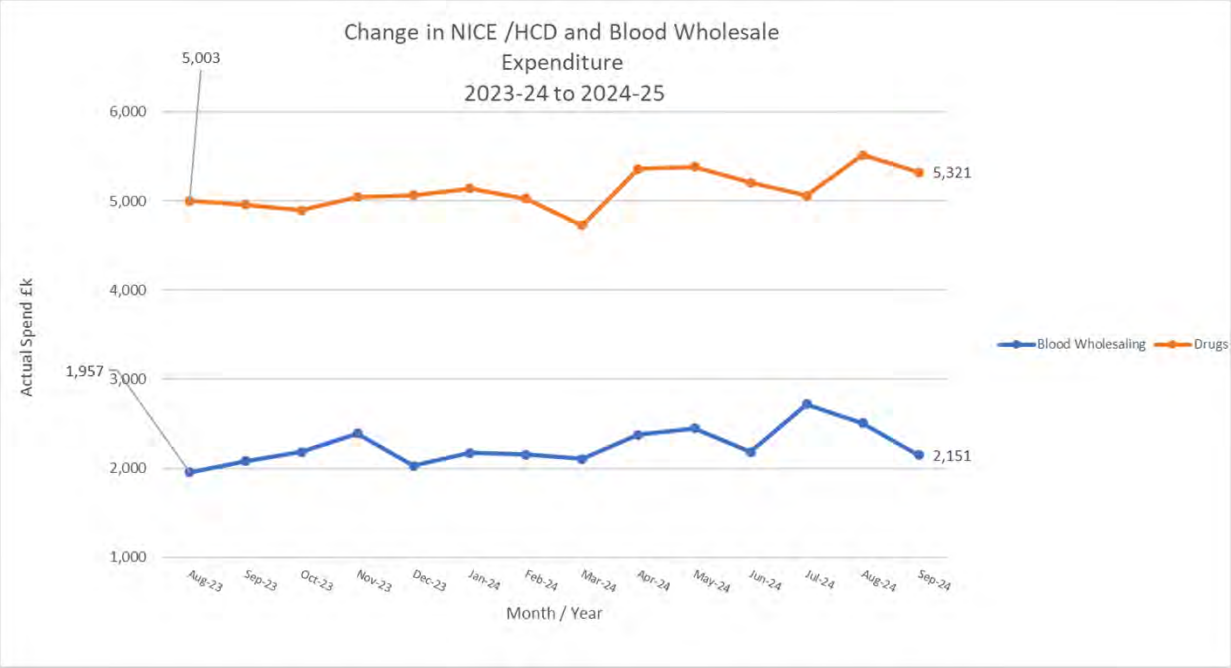
Average non-pay spend for 2023/24 was £9.8m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month.

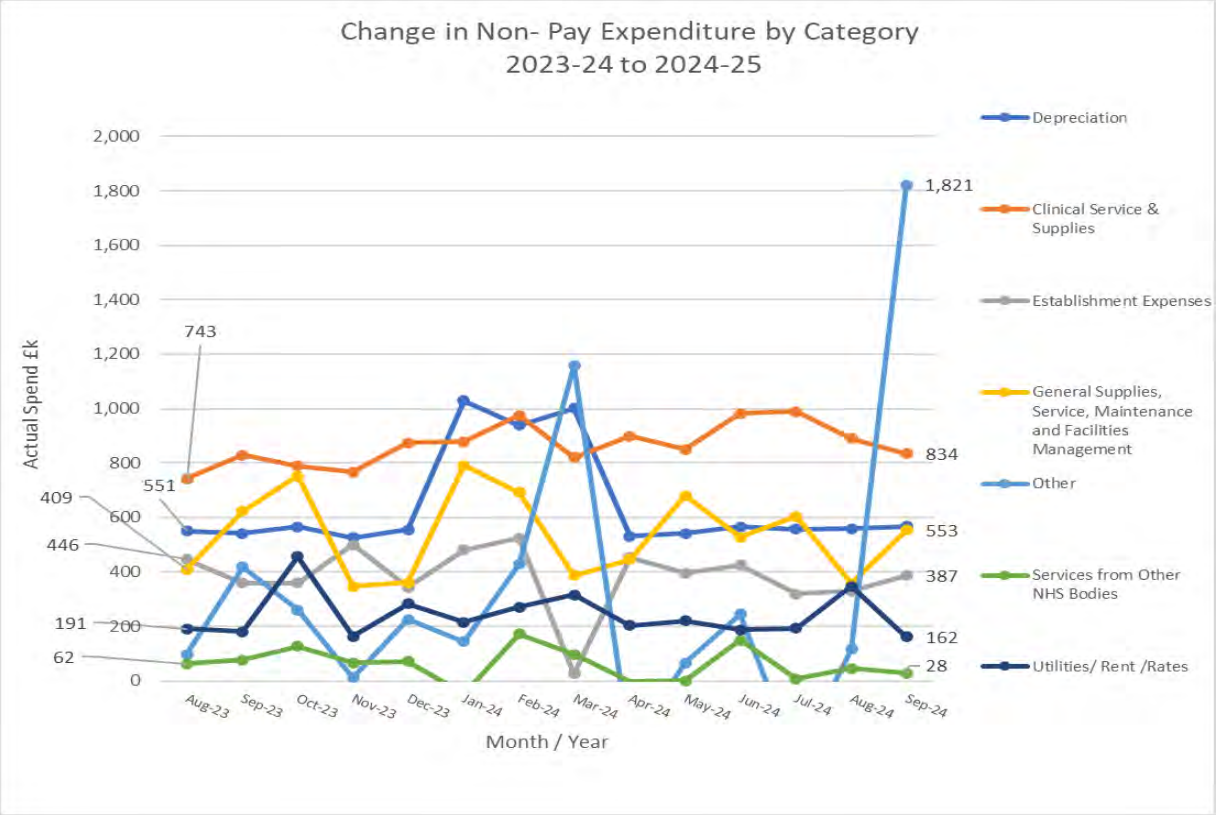
Non- Pay average so far for 2024/25 is currently £10.6m which is currently £0.9m higher than the average for last year. NICE and HCD drugs (£0.5m), blood wholesale costs (£0.4m) and Clinical Service & Supplies (£0.1m) have increased, whilst depreciation has currently reduced by £0.1m. All other costs have remined fairly static when you compare year on year average.

Lab consumables and blood collection costs (bags and Harnesses) have seen an increase in costs year on year in line with increased activity.



The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2023 to September 2024.





Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

*Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25. Spend in month 6 also relates to the provision for legal fees that was incorrectly accounted for as income at the end of 23-24.
*The graph excludes one off spends which incurred in period M12 23-24 which adversely affects the run rate such as the £7.35m AZ income received and transferred as expenditure to the Charity, along with the pass back contribution to WG which supported the overall NHS position.

4.4 Covid-19

The Trust is currently not expected to draw down any covid funding support during 2024-25. However, if at any point in the future the Trust is required to support the LHBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.876m was required to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

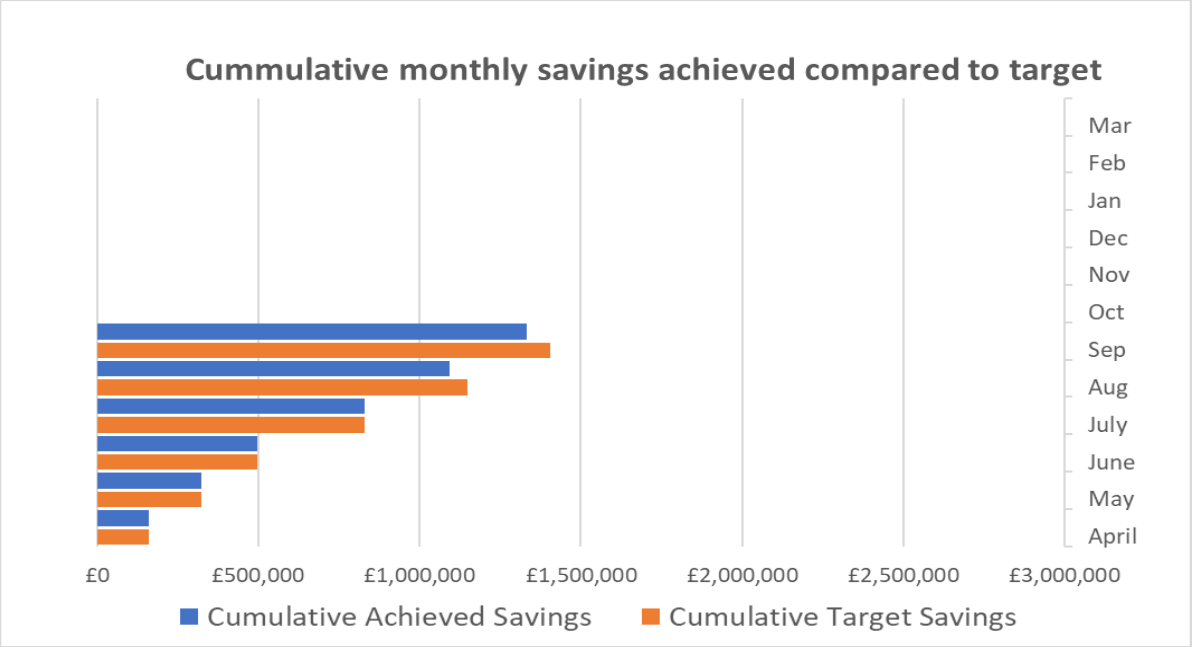
The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

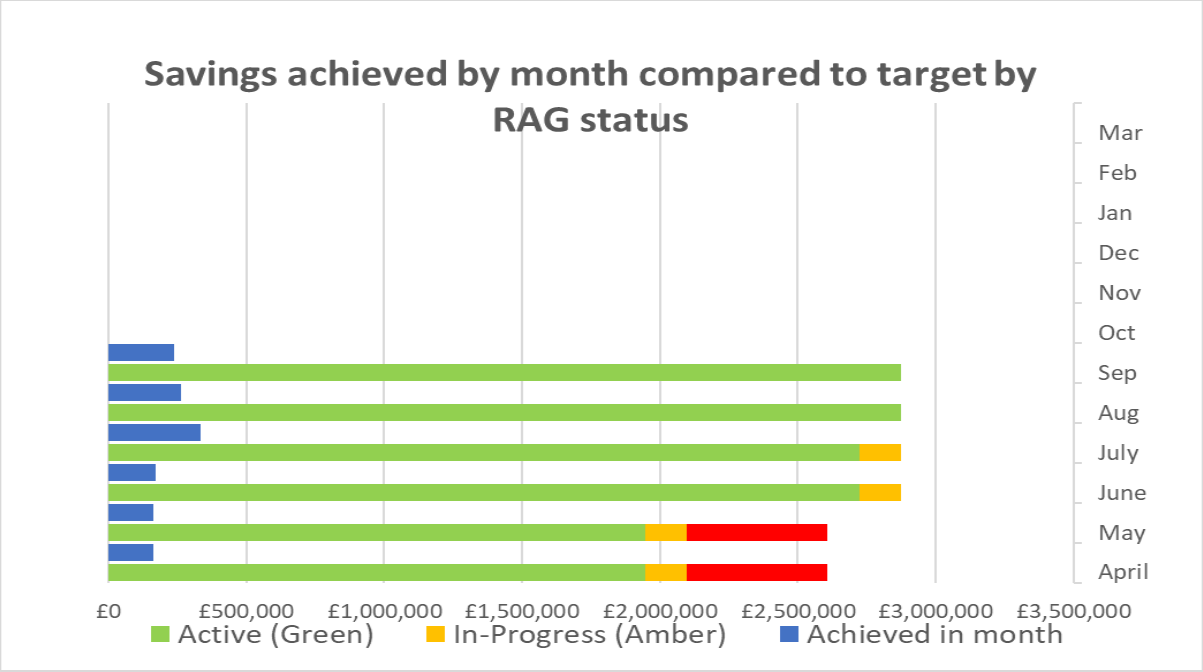
The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2025-26.

Performance

The overall Trust savings performance as of September'24 is a small underachievement against plan of **£(0.074)m**, however at this stage are expected to deliver to target by the end of the financial year. Whilst some savings schemes are overachieving against the target, there are some schemes within WBS and VCS such as the demand planning, procurement efficiencies and private patients which are underperforming against the original plan. The WBS Stock control has yet to realise any savings and will need to be monitored closely to ensure the target can be met during 2024-25.

It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the Savings target is met for 2024-25.




Savings achieved by month compared to target by RAG status
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
£3,500,000
Active (Green)
In-Progress (Amber)
Achieved in month

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**939**	**389**	**382**	**(7)**	**939**	**0**
			98%		**100%**	
WBS TOTAL SAVINGS	**569**	**368**	**300**	**(67)**	**569**	**0**
			82%		**100%**	
CORPORATE TOTAL SAVINGS	**1,137**	**534**	**534**	**0**	**1,137**	**0**
			100%		**100%**	
RD&I TOTAL SAVINGS	230	**115**	**115**	**0**	**230**	**0**
					100%	
TRUST TOTAL SAVINGS	**2,875**	**1,405**	**1,331**	**(74)**	**2,875**	**0**
			95%		**100%**	

Scheme Type	Division	Recrrent / Non-Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services - Agency Reduction	VCS	NR	Green	50	25	50	25	50	0
Establishment Control	VCS	R & N/R	Green	234	107	115	8	234	0
Service Workforce Redesign	VCS	R & N/R	Red						
Procurement - Supply Chain	VCS	R	Green	50	17	17	0	50	0
Establishment Control	WBS	R	Green	54	50	67	17	54	0
Stock Control - Scan for Safety Enabled	WBS	NR	Green	150	75	0	(75)	150	0
WBS Demand Planning	WBS	R	Red						
WBS Demand Planning	WBS	NR	Green	75	50	25	(25)	75	0
WBS Productivity Efficiencies	WBS	NR	Red						
Procurement - Supply Chain	WBS	R	Green	50	17	2	(15)	50	0
Service Workforce Redesign	WBS	R	Red						
Departmental CIP	Corporate	R	Green	50	25	25	0	50	0
Establishment Control	Corporate	R & N/R	Green	75	38	38	0	75	0
R&D Establishment Control	RD&I	R & N/R	Green	80	40	40	0	80	0
New / Replacement Schemes					0		0	0	0
Productivity Efficiencies	VCS	R & NR	Green	35	12	12	0	35	0
SACT Provision	VCS	R	Green	150	60	60	0	150	0
Creditor Review	WBS	NR	Green	100	100	100	0	100	0
Budget Efficiences	WBS	NR	Green	40	13	27	14	40	0
Total Saving Schemes				**1,193**	628	576	(52)	1,193	0
Income Generation									
Private Patients - Recovery of Debt	VCS	NR	Green	150	75	48	(27)	150	0
Private Patients - Contract Renewal	VCS	R	Amber	150	50	38	(12)	150	0
Productivity Efficiencies	VCS	R	Red						
Sales of Plasma	WBS	R	Green	100	63	80	18	100	0
WBS Productivity Efficiencies	WBS	R	Red						
Bank Interest	Corporate	R & N/R	Green	662	331	331	0	662	0
R&D Commercial Income	RD&I	R	Green	150	75	75	0	150	0
New / Replacement Schemes					0		0	0	0
Private Patients	VCS	NR	Green	70	23	23	0	70	0
Maximising Income	VCS	R	Green	50	20	20	0	50	0
Bank Interest	Corporate	R	Green	350	140	140	0	350	0
Total Income Generation				**1,682**	777	755	(22)	1,682	0
TRUST TOTAL SAVINGS				**2,875**	**1,405**	**1,331**	**(74)**	**2,875**	**0**
						95%		**100%**	

5. Reserves

The financial strategy for 2024-25 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation, and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position undertaken in June £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

The non-recurrent reserve and emergency reserve are currently being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs until WG funding is secured.

6. End of Year Forecast / Risk & Opportunity Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are several financial risks that could impact on the successful delivery of a balanced position, although the majority have now either been reduced in risk or mitigated completely for 2024-25. The remaining key financial risks & opportunities which have been highlighted to Welsh Government are provided below.

Risks

Rise in Energy Prices above forecast MTP plans - *(£0.142m) Likelihood – High*

Latest forecast schedule from NWSSP suggests that the Trust energy costs for 2024-25 will be c£1.745m this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provide by WG) which is held by the Trust.

Management of Operational Cost Pressures - *(£0.250m) Likelihood - Low*

There are several cost pressures that are already within the service which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that these current pressures may be beyond divisional control which is being recognised within the table.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

Whitchurch Hospital Site Transfer – Financial Consequences – (Low)

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the cost implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. An updated briefing

paper was submitted to Matt Jenkins shared in WG on 3/9/24. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer is imminent and is expected to take place in the next couple of months once outstanding legal details are finalised. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the disposal or development of the residual Whitchurch estate. It is expected that the Trust will need to incur future capital cost to make good and dispose of the site.

The annual revenue costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT) p.a. and £0.767m (Inc VAT) p.a. The Trust doesn't have a formal funding letter yet, however the Deputy Chief Executive NHS Wales confirmed in a letter to VUNHST CEO and Cardiff and Vale LHB CEO on 26 March 2024 that the Health Strategy Board is aware of the on-going revenue costs that are linked to the site which will initially be covered by the Welsh Government but will be offset against any future disposal receipts for the site. The proposed funding model for this arrangement will need to be agreed between WG and VUNHST as the Trust will require revenue funding to cover the annual costs, whereas the proposed funding source is a future capital receipt on disposal. At the Trust CRM in May 2024, WG's Deputy Director for NHS Capital, Estates and Facilities confirmed the Trust should invoice the Capital Finance team for the revenue costs incurred so therefore the risk has been reduced to low.

The costs associated with the Whitchurch site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) & £0.360m (Inc VAT) with the latest estimate for the "Reduced Scope" option, which WG Officers asked the Trust to provide, to make the Whitchurch Hospital site safe being c£0.968m (Exc VAT) & £1.162m (Inc VAT) subject to negotiations with WG and Cardiff Council. It's important to note the briefing paper also includes the "Full Scope" option with a cost estimate of £2.610m (Inc VAT). There will also be upfront costs from the Trust advisors in relation to the disposal of the land which are estimated to be c£0.228m (Exc VAT) & £0.273m (Inc VAT) WG has requested the Trust submit a BJC to seek funding. To write the BJC the Trust needs to procure a Health Care planner and will require funding of c £0.072m (Inc VAT) prior to the BJC being submitted. This £0.072m is part of the total £0.273m advisor costs which will be incurred in 2024-25. The remaining costs which relate to the making the site safe, surveys, transactions and disposal costs will require agreed capital funding as part of the All Wales Capital Funding Programme during 2025/26.

Opportunities

Vacancy Turnover – (Low)

Further vacancy turnover savings above the vacancy factor held in divisions.

Emergency Reserve – (Medium)

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2024-25 then like in 2023-24 the Trust may be in a position later in the year to release this funding on a non-recurrent basis.

Reduction in Energy Prices – (Low)

At this stage the funding received to support the increase in energy prices is expected to be required by the Trust, however whilst unlikely given the latest forecast position from NWSSP if costs were to reduce then an opportunity may crystalise.

Savings Opportunities Pipeline

The Trust has identified some initial opportunities that could be explored but these require further development but are highlighted below:

Pre-Operative Anaemia Pathway Project (Health Board savings)

Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively and offered treatment with intravenous Iron as required prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.

Medicine Unit Supply

Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners

Workforce Re-design

Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.

Procurement

Procurement working with divisions on a regular basis to review non pay spend and ensure delivery of savings target and identify other cost improvement opportunities above the savings target.

7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL 2024/25 £m	YTD Spend £m	Budget Remaining @ M66 £m	F'cast Spend 2024/25 £m	Year End Variance 2024/25 £m
All Wales Capital Programme					
IRS - Integrated Radiotherapy Solution	5.164	2.324	2.840	5.164	0.000
IRS RSC - Radiotherapy Satellite Centre	11.265	1.227	10.038	11.265	0.000
nVCC Enabling Costs	0.000	2.688	(2.688)	3.810	(3.810)
nVCC Project Fees	0.000	1.146	(1.146)	4.530	(4.530)
nVCC Whitchurch Hospital Site	0.000	0.005	(0.005)	0.273	(0.273)
nVCC Governance Review	0.000	0.140	(0.140)	0.140	(0.140)
nVCC Governance Review Implementation (PW	0.000	0.000	0.000	0.320	(0.320)
WBS TGI	0.000	0.190	(0.190)	0.363	(0.363)
Digital - WHAIS	0.000	0.000	0.000	0.442	(0.442)
Digital - RISP	0.160	0.000	0.000	0.160	0.000
BECS	0.750	0.000	0.000	0.309	0.441
WBS Electrical Resilience - Backlog Maintenanc	0.350	0.019	0.000	0.350	0.000
WBS Liquid Nitrogen	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	17.689	7.739	8.709	27.126	(9.437)
Discretionary Capital	1.911	0.414	1.497	1.911	0.000
	19.600	8.153	10.206	29.037	(9.437)

The approved 2024-25 Capital Expenditure Limit (CEL) as of September 2024 was £19.600m. This includes All Wales Capital funding of £17.689m, and discretionary funding of £1.911m.

A total of £9.073m is now forecast to be required to support the nVCC enabling, project, Governance review costs and to make good the Whitchurch Site during 2024-25. WG are aware of the total requirement and are looking to put a request to the Minister imminently.

The Trust informed WG Capital colleagues at the CRM meeting on the 30th July that there will be an ask from the Trust to re-purpose funds from the IRS allocated budget to purchase 'Hypersight' which is an upgrade to imaging panels on the treatment machines (which was not available at the time of the Trust going out to tender) and will provide significantly improved quality of imaging. The service has drafted a paper which will be issued imminently to WG Capital colleagues and the Trust board seeking approval for the re-purpose of funds.

Discussions are ongoing with WG and DPIF colleagues around securing the funding requirement in relation to WHAIS and the costs associated with the WBS TGI OBC, with WG and DPIF having supported these projects up to this date.

The finance team continue to be in conversation with WG colleagues to ensure that the funding for all the above Capital Schemes form part of the CEL for 2024-25.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24.

The discretionary programme is currently fully allocated other than a contingency of £0.050m, however, WHAIS (£0.494m) and the WBS TGI OBC (£0.360m) are currently ringfenced from the discretionary fund with the expectation that if All Wales Capital funding can be secured, then £0.854m can be released back into the discretionary pot.

A review of the recent conditions survey of the VCC site is currently underway and will require funding support from the discretionary programme with a paper currently being developed which will be submitted to EMB. This is currently estimated to be c£0.160m which is required for repairs to the roof.

WG yearend Slippage

An e-mail was received from WG Capital colleagues on the 13th September asking the Trust to identify a prioritised list of backlog maintenance, infrastructure risks & equipment funding requests for consideration which need to be deliverable in-year. WG intention is to re-allocate the slippage on schemes already returned to the Welsh Government in early October (subject to Cabinet Secretary for Health and Social Care clearance) and for a further tranche should extra slippage / underspends be reported through the end of October 2024 exercise.

The Trust responded to this request on the 30th September with a prioritised list totalling c£1.300m which was submitted to and approved by EMB. WG informed the Trust on the 24.10.2024 that £0.220m has been awarded to support several schemes within the overall prioritisation list as listed below.

Capital Scheme	Capital Cost 2024/25 (£k)
Centrifuge	44
Centrifuge	44
WBS - Luminex Analyser (2)	58
Platelet Incubator - PC3200I	16
Platelet Incubator - PC3200I	16
PlateletTrac	20
Electronic Delivery Scanning System	12
UNOS Comparison Utility	10
Total	**220**

The schemes that were not approved will be considered for support should funding be provided from WG towards WHAIS and the WBS TGI OBC of £0.854m currently ringfenced against the discretionary programme or will need to be considered against the 2025/26 discretionary allocation.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

Performance to date

The actual expenditure to September 2024 on the All-Wales Capital Programme schemes was £7.739m, this is broken down between spend on the nVCC schemes of £3.979m, the IRS £2.324m, RSC £1.227m, WBS TGI £0.190m and WBS Electrical Resilience £0.019m.

The current spend on the Discretionary Capital programme as of August 2024-25 is £0.414m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position subject to the Trust securing funds for the nVCC and other projects on WG radar.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

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 position of schemes that was included in the IMTP for 2024-25 is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2024-25 £m	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works		1.547				1.547
Integrated Radiotherapy Solution (IRS)	5.164	2.040	15.800	0.839		23.843
Radiotherapy Satellite Unit	11.265					11.265
Total Approved Capital Schemes	**16.429**	**3.587**	**15.800**	**0.839**	**0.000**	**36.655**
All Wales Unapproved Schemes						
TCS nVCC	15.791	11.000	36.962	1.741		65.494
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.086	0.688	0.680	0.400		2.854
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	0.970	0.064	0.064	0.203		1.301
Talbot Green - Infrastructure	0.303	1.346	10.633	10.640	19.707	42.629
WBS Fleet Replacement		0.373	1.112	1.285		2.770
WBS Asset Replacement	0.100	0.494	0.121		1.560	2.275
First Floor Ward Ventilation	0.370					0.370
Condition Survey Recommendations	0.250	0.200	0.150			0.600
BECS Blood Mangagement System	0.100	0.200	0.200	1.000		1.500
Total Unapproved Capital Schemes	**23.184**	**14.457**	**50.522**	**15.269**	**21.267**	**124.699**
Total All Wales Capital Plans	**39.613**	**18.044**	**66.322**	**16.108**	**21.267**	**161.354**

8. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

	Opening Balance Beginning of Apr 24	Closing Balance End of Sep-24	Movement from 1st April Sep-24	Forecast Closing Balance End of Mar 25
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	226.135	229.839	3.704	235.839
Intangible assets	10.893	10.522	(0.371)	10.894
Trade and other receivables	1,316.876	1,317.012	0.136	1,317.012
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,553.904	1,557.373	3.469	1,563.745
Current Assets				
Inventories	31.227	30.547	(0.680)	30.547
Trade and other receivables	530.547	538.657	8.110	564.475
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	20.956	51.844	30.888	19.654
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	582.730	621.048	38.318	614.676
TOTAL ASSETS	2,136.634	2,178.421	41.787	2,178.421
Current Liabilities				
Trade and other payables	(229.886)	(271.269)	(41.383)	(271.269)
Borrowings	(1.020)	(1.067)	(0.047)	(1.067)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(338.517)	(588.723)	(250.206)	(588.723)
Current Liabilities sub total	(569.423)	(861.059)	(291.636)	(861.059)
NET ASSETS LESS CURRENT LIABILITIES	1,567.211	1,317.362	(249.849)	1,317.362
Non-Current Liabilities				
Trade and other payables	(3.330)	(3.330)	0.000	(3.330)
Borrowings	(31.785)	(33.186)	(1.401)	(33.186)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,320.849)	(1,069.027)	251.822	(1,069.027)
Non-Current Liabilities sub total	(1,355.964)	(1,105.543)	250.42	(1,105.543)
TOTAL ASSETS EMPLOYED	211.247	211.819	0.572	211.819
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	35.956	35.946	(0.010)	35.946
PDC	155.832	155.924	0.092	155.924
Retained earnings	19.459	19.949	0.490	19.949
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	211.247	211.819	0.572	211.819

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.

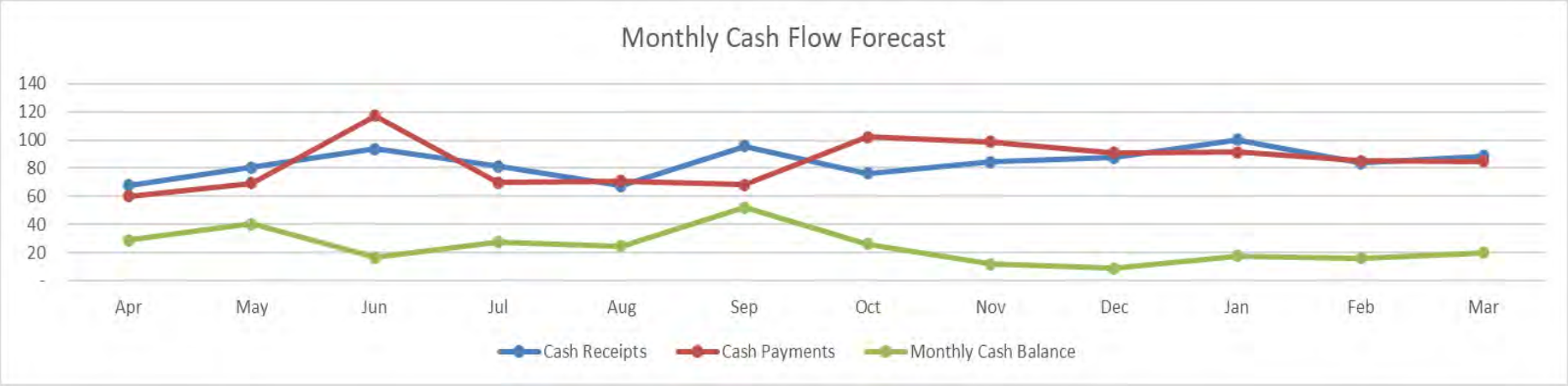
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however issued the additional stock and the £4.5m was repaid to WG during February '23.

The Junior Doctor pay award including the backdated pay is due to be processed in the September payroll which will be funded by WG via the HBs. The Trust has put measures in place to ensure that the Trust receives the funds in advance of the payment.

The A4C pay award is expected to be processed during November. Finance colleagues will engage with WG to ensure that the funds are received to support the payment.

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**	50.519	42.117	43.016	40.489	54.755	66.517	50.441	50.699	50.652	51.599	51.712	53.499	606.013
2	**WG Revenue Funding**	10.504	31.147	45.405	20.761	10.370	24.691	20.200	28.436	31.399	42.659	26.399	26.529	318.498
3	**Short Term Loans**													0.000
4	**PDC**							0.000					2.700	2.700
5	**Interest Receivable**	0.179	0.143	0.186	0.158	0.155	0.167	0.144	0.144	0.144	0.144	0.144	0.144	1.852
6	**Sale of Assets**													0.000
7	**Other**	6.657	7.151	4.914	19.701	2.092	4.223	5.600	4.923	5.450	5.800	5.450	5.625	77.587
8	**TOTAL RECEIPTS**	**67.860**	**80.558**	**93.521**	**81.109**	**67.372**	**95.598**	**76.385**	**84.201**	**87.644**	**100.201**	**83.704**	**88.496**	**1,006.650**
	PAYMENTS													
9	**Salaries and Wages**	25.845	35.256	35.185	35.848	37.838	48.036	59.319	55.691	41.466	41.485	41.488	41.326	498.784
10	**Non pay items**	31.288	30.780	81.237	33.050	32.438	19.146	42.041	35.313	46.537	47.912	41.432	39.084	480.257
11	**Short Term Loan Repayment**													0.000
12	**PDC Repayment**		0.000											0.000
14	**Capital Payment**	2.880	3.178	0.977	0.833	0.470	0.845	0.733	7.705	2.888	1.885	2.266	4.252	28.911
15	**Other items**													0.000
16	**TOTAL PAYMENTS**	**60.013**	**69.214**	**117.399**	**69.731**	**70.746**	**68.027**	**102.092**	**98.709**	**90.890**	**91.282**	**85.186**	**84.662**	**1,007.952**
17	**Net cash inflow/outflow**	7.846	11.344	(23.878)	11.378	(3.374)	27.571	(25.707)	(14.508)	(3.246)	8.919	(1.481)	3.834	
18	**Balance b/f**	20.956	28.802	40.146	16.268	27.646	24.272	51.844	26.137	11.629	8.382	17.302	15.820	
19	**Balance c/f**	28.802	40.146	16.268	27.646	24.272	51.844	26.137	11.629	8.382	17.302	15.820	19.654	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(22.741)	(22.741)	(0.000)	(45.322)	(45.322)	0.000
RD&I	0.163	0.146	(0.017)	0.394	0.394	0.000
WBS	(10.974)	(10.977)	(0.003)	(21.808)	(21.808)	0.000
Sub-Total Divisions	**(33.552)**	**(33.572)**	**(0.020)**	**(66.736)**	**(66.736)**	**0.000**
Corporate Services Directorates	(6.677)	(6.664)	0.013	(13.881)	(13.881)	0.000
Delegated Budget Position	**(40.229)**	**(40.236)**	**(0.006)**	**(80.617)**	**(80.617)**	**0.000**
TCS	(0.285)	(0.260)	0.025	(0.635)	(0.635)	0.000
Health Technology Wales	(0.046)	(0.046)	(0.000)	(0.092)	(0.092)	0.000
Trust Income / Reserves	40.560	40.560	0.000	81.290	81.290	0.000
Trust Position	0.000	0.018	0.018	(0.053)	(0.053)	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**42.232**	**42.678**	**0.446**	**83.839**	**83.839**	**0.000**
Expenditure						
Staff	26.773	26.782	(0.009)	52.378	52.378	0.000
Non Staff	38.200	38.637	(0.437)	76.782	76.782	0.000
Sub Total	**64.973**	**65.419**	**(0.446)**	**129.160**	**129.160**	**0.000**
Total	**(22.741)**	**(22.741)**	(0.000)	**(45.322)**	**(45.322)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of September 2024 was **breakeven**, and an expected outturn position expected at this stage of **breakeven**.

Income at Month 6 represents a surplus of **£0.446m**. A significant overachievement on private patient drug income and VAT Savings from delivering drug homecare, which is offsetting £0.400m of the ytd savings target. Other overachievements include catering income and an increase in the radiation protection SLA with C&V.

There is a risk that the LTA income activity does not match the level of investment into services. As of August, there was an underachievement of c£0.700m against the target which is not yet

reflected in the position. This is currently under urgent review within the Division to assess if the original forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being costed and recorded correctly.

VCS have reported a year to date overspend of **£(0.009)m** against staff. Snr Medical costs continue to be the largest pressure for VCS, however, have significantly reduced following funding being provided during August from the Trust Discretionary uplift in funding, agreed as a part the IMTP. Vacancies remain across several service areas in particular Radiation services and Pharmacy pending recruitment, which is supporting the current posts appointed at risk, and the divisional savings target and vacancy factor.

A review of the posts recruited in advance at risk is underway with a case being developed requesting Trust funding to support those relating to SACT.

Non-Staff Expenditure at Month 6 was **£(0.437)m** overspent which is largely due to an increase in facilities management expenses (mainly Postage), catch up of general drugs activity and cost increase expenditure and the divisional management savings target.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**17.218**	**17.215**	**(0.002)**	**31.536**	**31.536**	**0.000**
Expenditure						
Staff	8.968	9.100	(0.133)	17.543	17.543	0.000
Non Staff	19.224	19.092	0.132	35.801	35.801	0.000
Sub Total	**28.191**	**28.192**	**(0.001)**	**53.344**	**53.344**	**0.000**
Total	**(10.974)**	**(10.977)**	(0.003)	**(21.808)**	**(21.808)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of September 2024 was a small overspend of **£(0.003)m** with an outturn forecast position of **breakeven** currently expected.

A small income underachievement of **£(0.002)m** due to underperformance on bone marrow (currently achieving 50% of target year to date), partly offset by increased activity on plasma sales.

Whilst Plasma Sales activity has been increasing deliveries to Randox (main supplier) were suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year which has now been settled. The current year debt stands at £0.289m and a re-payment plan has been agreed, with three instalments expected to be paid over the final quarter of the calendar year. Due to the suspension of deliveries to Randox WBS are currently holding 18 pallets of plasma in storage and are currently looking for a new supplier to purchase the plasma, initial indications are that WBS will not be able to recover the full selling price which will impact on the Divisions income position.

There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, however, is starting to show signs of recovery with significantly more swab tests having taken place over the last couple of months. The payback from the additional swabs should start to be realised later in this financial year. WBS continue to run campaigns to try and grow the panel in locations such as schools and universities, and raise awareness through advertising on platforms such as social media.

Staff overspend of **£(0.133)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team are currently creating an unfunded post analysis to determine the in year and recurrent cost pressure taking into account any funding provided via the Trust IMTP.

Non-Staff reported an underspend of **£0.132m** as at month 6. There are overspends in areas such as room hire costs which are no longer funded by WHSSC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits and the Divisional non pay CIP. Expectation is that security at the site is currently committed until 31st August and is currently under review with a view to remove in the short term. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone Marrow which is a direct correlation with income under performance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**2.164**	**2.096**	**(0.068)**	**4.165**	**4.165**	**0.000**
Expenditure						
Staff	6.970	6.542	0.428	14.200	14.200	0.000
Non Staff	1.872	2.218	(0.346)	3.846	3.846	0.000
Sub Total	**8.842**	**8.760**	**0.082**	**18.047**	**18.047**	**0.000**
Total	**(6.677)**	**(6.664)**	0.013	**(13.881)**	**(13.881)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of September 2024 was an overspend of **£0.013m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

Staff expectation is that vacancies within the division, will help offset use of agency and the Head of Communications which has been temporarily appointed at risk and the divisional savings target.

A request is in the process of being submitted to EMB to support the Head of Communications post.

A non-pay overspend is again expected and largely relates to divisional CIP target and the increased running costs associated with the hospital estate. Funding was set aside as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2024-25 which was transacted during September.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**2.157**	**2.221**	**0.064**	**4.596**	**4.596**	**0.000**
Expenditure						
Staff	1.687	1.816	(0.128)	3.625	3.625	0.000
Non Staff	0.307	0.259	0.048	0.577	0.577	0.000
Sub Total	**1.995**	**2.075**	**(0.080)**	**4.202**	**4.202**	**0.000**
Total	**0.163**	**0.146**	(0.017)	**0.394**	**0.394**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of September 2024 was a small overspend of **(£0.013m)** with a current forecast outturn position of **breakeven**.

Pay overspend is a result of late charges from Cardiff University for staff relating to 2023-24 and cannot be recharged to the Charity in 2024-25.

Clinical Trials and Charitable funds income will fluctuate and is expected be drawn down in line with expenditure.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.028**	**0.028**	**0.000**	**0.028**	**0.028**	**0.000**
Expenditure						
Staff	0.292	0.271	0.021	0.621	0.621	0.000
Non Staff	0.021	0.018	0.003	0.042	0.042	0.000
Sub Total	**0.313**	**0.289**	**0.025**	**0.663**	**0.663**	**0.000**
Total	**(0.285)**	**(0.260)**	0.025	**(0.635)**	**(0.635)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of September 2024 is **a £0.025m** underspend with a forecasted outturn position of **Breakeven.**

Escrow bank interest is being brought into the position which is resulting in a year to date surplus position.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.825**	**0.816**	**0.009**	**1.649**	**1.649**	**0.000**
Expenditure						
Staff	0.807	0.793	0.014	1.614	1.614	0.000
Non Staff	0.063	0.068	(0.005)	0.127	0.127	0.000
Sub Total	**0.871**	**0.861**	**0.009**	**1.741**	**1.741**	**0.000**
Total	**(0.046)**	**(0.046)**	0.000	**(0.092)**	**(0.092)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of September 2024 was **breakeven,** with a forecasted outturn position which will be managed to a **breakeven** position.

HTW is funded directly via WG other than the pay award which is passed through the Trust commissioners in the same way as the core Trust.

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

TCS PROGRAMME FINANCE REPORT 2024-25

Period Ending 30th September 2024

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1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2024-25, outlining spend against budget as at 30th September 2024 and the current year-end forecast.

1.2 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the TCS Programme Delivery Board and Trust Board.

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2024-25 as at 30th September 2024 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Capital	£3.977m	£0	£7.956m	-£7.956m
Revenue	£0.289m	£0.666m	£0.666m	£0
Total	**£4.266m**	**£0.666m**	**£8.622m**	**-£7.956m**

2.2 The overall forecast outturn for the Programme is an overspend of £7.956m for the financial year 2024-25 against a budget of £0.666m.

2.3 No capital funding has been allocated yet for the projects for financial year, resulting in the aforementioned overspend. The nVCC FBC and EW FBC Addendum was submitted to WG on the 3rd September 2024 and funding should be released upon the approval of both FBCs.

2.4 The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the aforementioned funding request.

3. BACKGROUND

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

3.2 By 31st March 2024, the Welsh Government (WG) had provided a total of £63.295m funding (£60.246m capital, £3.049m revenue) to support the TCS Programme. In addition, the Trust had provided £0.264m from its discretionary capital allocation and £0.512m non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2024-25 is £0.663m revenue, with no capital funding allocated as yet. This is outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at 1st April 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Current Allocation (as at 30th September 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Sources of Revenue Funding

Initial Allocation (as at 1st April 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0	£0
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0**	**£0.638m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0	£0	£0	£0
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0	£0	£0	£0
Total	**£0**	**£0**	**£0.028m**	**£0.028m**

Current Allocation (as at 30th September 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0.028m**	**£0.666m**

4. CAPITAL POSITION

4.1 The current capital funding for 2024-25 is outlined below:

- Enabling Works Project £0m
- nVCC Project £0m
- Whitchurch Hospital Site £0m

Total £0m

4.2 The capital position as at 30th September 2024 is outlined below, with a forecast overspend of £7.956m for 2024-25. This is due to the lack of capital funding being allocated to the projects to date this financial year.

Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£2.688m	£0	£3.811m	-£3.811m
nVCC Project	£1.285m	£0	£3.871m	-£3.871m
Whitchurch Hospital Site	£0.004m	£0	£0.274m	-£0.274m
Total	**£3.977m**	**£0**	**£7.956m**	**-£7.956m**

4.3 A funding request for the nVCC Project has been submitted to WG for c£3.8m, and the EW Project funding request will be as part of the EW FBC Addendum.

5. REVENUE POSITION

5.1 The revenue funding for 2024-25 is outlined below:

- PMO £0.318m
- Enabling Works Project £0.028m
- nVCC Project £0m
- SDT Project £0.320m

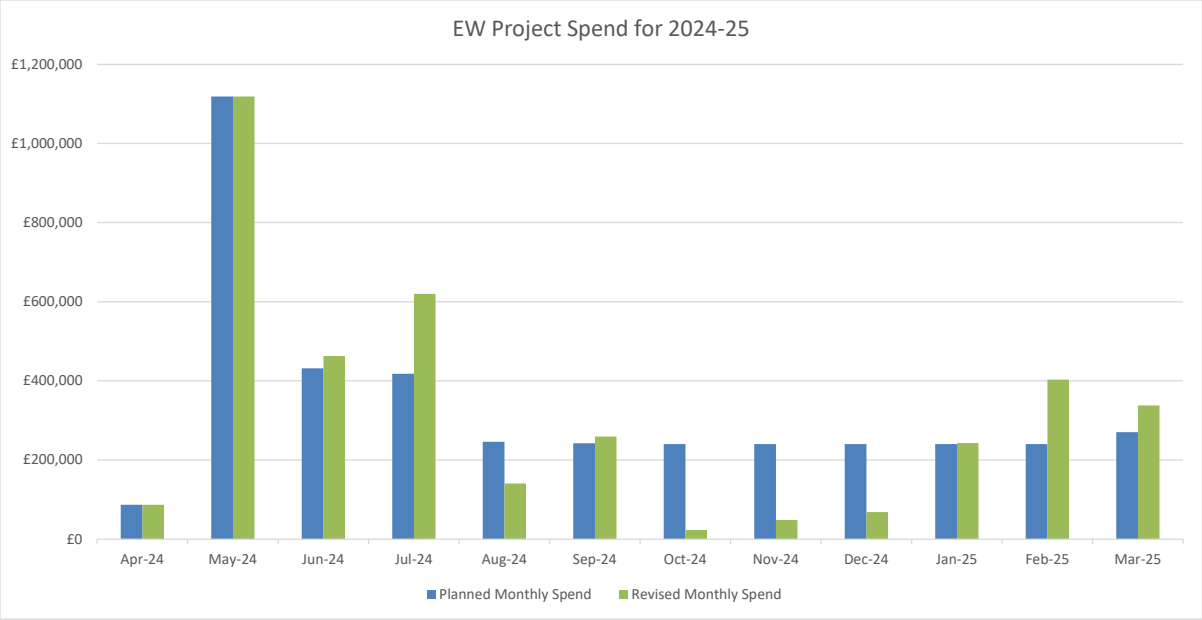
Total £0.666m

5.2 The revenue position as at 30th September 2024 is outlined below, with a forecast overall breakeven position for 2024-25 against a budget of £0.666m.

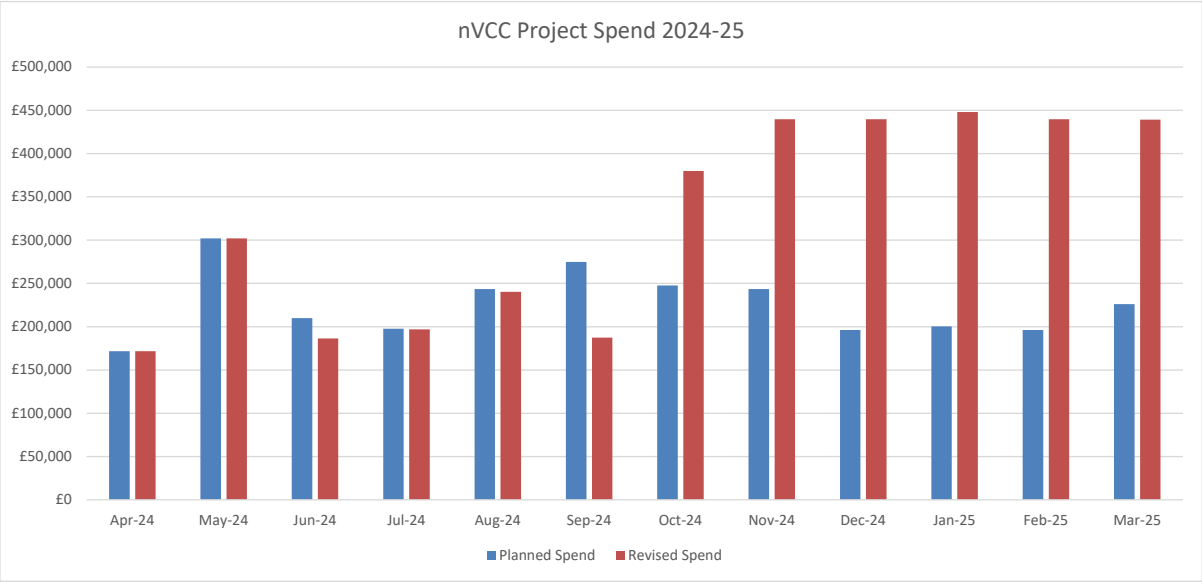
Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
PMO	£0.145m	£0.318m	£0.318m	£0
Enabling Works Project	£0	£0.028m	£0	£0.028m
nVCC Project	£0.015m	£0	£0.028m	-£0.028m
SDT Project	£0.129m	£0.320m	£0.320m	£0
Total	**£0.289m**	**£0.666m**	**£0.666m**	**£0**

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The actual capital spend to date is £2.688m, with a run rate to date in line than the planned spend.



6.2 The capital cash flow for the **nVCC Project** is outlined below. The actual capital spend to date is £1.285m, with a run rate to date similar to the planned spend.



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

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 The current revenue funding for the PMO for 2024-25 is £0.318m, with £0.240m of this provide from NHS Commissioners' funding and £0.078m from the Trust Reserves.

7.3 There is no capital funding requirement for the PMO in 2024-25.

7.4 The revenue position for the PMO as at 30th September 2024 is shown below, with a forecast breakeven position for the year against a budget of £0.318m.

PMO Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.142m	£0.317m	£0.313m	£0.003m
Non Pay	£0.003m	£0.002m	£0.005m	-£0.003m
Total	**£0.145m**	**£0.318m**	**£0.318m**	**£0**

7.5 There are currently no financial risks associated with the PMO for 2024-25.

Enabling Works Project

Capital

7.6 There is currently no capital funding for the Enabling Works Project for 2024-25.

7.7 The Project's financial position for 30th September 2024 is shown below. The forecast position reflects an expected overspend of £3.811m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.117m	£0	£0.238m	-£0.238m
Non Pay	£2.571m	£0	£3.573m	-£3.573m
Total	**£2.688m**	**£0**	**£3.811m**	**-£3.811m**

7.8 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2024-25

Description		Year to Date			Financial Year		
		Budget Sep-24 £	Spend Sep-24 £	Variance Sep-24 £	Annual Budget £	Annual Forecast £	Annual Variance £
PAY							
Project 1b - Enabling Works FBC		0	117,229	-117,229	0	237,597	-237,597
Pay Capital Total		**0**	**117,229**	**-117,229**	**0**	**237,597**	**-237,597**
NON-PAY							
EF02	Utility Costs	0	480,000	-480,000	0	502,000	-502,000
EF03	Supply Chain Fees	0	169,662	-169,662	0	187,662	-187,662
EF04	Non Works Costs	0	-5,386	5,386	0	34,614	-34,614
EF05	ASDA Works	0	1,456,219	-1,456,219	0	1,456,219	-1,456,219
EF06	Walters Design & Build	0	396,386	-396,386	0	396,386	-396,386
EF08	Section 278	0	22,000	-22,000	0	529,500	-529,500
EF09	Off Site Habitat	0	34,586	-34,586	0	309,586	-309,586
EF10	HV Intake Room	0	7,300	-7,300	0	337,300	-337,300
EFQR	Quantified Risk	0	0	0	0	0	0
EFQS	QRA - SCP	0	0	0	0	0	0
EFRS	Enabling Works FBC Reserves	0	9,921	-9,921	0	-180,079	180,079
Enabling Works FBC Project Capital Total		**0**	**2,570,689**	**-2,570,689**	**0**	**3,573,189**	**-3,573,189**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**0**	**2,687,918**	**-2,687,918**	**0**	**3,810,786**	**-3,810,786**

7.9 To date in this financial year, no capital funding has been provided by WG for the Enabling Works Project.

7.10 The EW FBC Addendum was submitted to WG on the 3rd September 2024 and funding should be released upon the approval of both FBCs. The additional funding request is c£7.8m, with funding of £3.8m required for 2024-.25. In addition, a QRA has been established of c£1.4m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.

Revenue

7.11 There is currently revenue funding of £0.028m for the Enabling Works nVCC Project for 2024-25. This is provided from the interest earned from the Enabling Works Escrow bank Account for the ASDA works.

7.12 The revenue financial position for the Enabling Works Project for 30th September 2024 is shown below, reflecting a current underspend of £0.028m for the year.

Enabling Works Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0	£0.028m	£0	£0.028m
Total	**£0**	**£0.028m**	**£0**	**£0.028m**

7.13 There is a risk of an underspend of £0.028m for the revenue element of the Enabling Works Project this financial year.

New Velindre Cancer Centre Project

Capital

7.14 There is currently no capital funding for the nVCC Project for 2024-25. A funding request has been submitted to WG for this financial year.

7.15 The Project's financial position for 30th September 2024 is shown below. The forecast position reflects an expected overspend of £3.871m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.681m	£0	£2.150m	-£2.150m
Non Pay	£0.604m	£0	£1.721m	-£1.721m
Total	**£1.285m**	**£0**	**£3.871m**	**-£3.871m**

7.16 The Project spend relates to the following activities:

nVCC FBC Project Capital Budget & Spend Summary 2024-25

Description	Year to Date Budget Sep-24 £	Year to Date Spend Sep-24 £	Year to Date Variance Sep-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	168,305	-168,305	0	416,128	-416,128
Project 2d - New Velindre Cancer Centre FBC	0	512,516	-512,516	0	1,733,782	-1,733,782
Pay Capital Total	**0**	**680,820**	**-680,820**	**0**	**2,149,910**	**-2,149,910**
NON-PAY						
nVCC Project Delivery	**0**	**15,635**	**-15,635**	**0**	**61,937**	**-61,937**
Work Packages						
VF01 RDD Process	0	196,820	-196,820	0	436,000	-436,000
VF02 Construction Phase	0	0	0	0	420,000	-420,000
VF03 Professional Advisors (Call-off Basis)	0	28,355	-28,355	0	110,355	-110,355
VF04 Reviews	0	224,687	-224,687	0	224,687	-224,687
VFRS nVCC FBC Reserves	0	138,337	-138,337	0	468,304	-468,304
nVCC Project Capital Total	**0**	**588,200**	**-588,200**	**0**	**1,659,347**	**-1,659,347**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**1,284,655**	**-1,284,655**	**0**	**3,871,193**	**-3,871,193**

7.17 The nVCC FBC was submitted to WG on the 3rd September 2024 and funding should be released upon the approval of both FBCs. The funding request is c£52.4m, with funding of £4.9m required for 2024-.25 but this includes IRS Project funding of £5.1m and Digital funding c£0.2m. In addition, a QRA has been established of c£17.3m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.

7.18 However, it should be noted that in the financial year 2023-24, the nVCC Project incurred additional costs of c£0.646m associated to achieving Financial Close. The additional costs relate to advisory support. These costs were funded by the EW Project, and it is imperative that this funding is re-provided for the EW Project in 2024-25. The funding has been confirmed with WG under separate cover.

Revenue

7.19 There is currently no revenue funding for the nVCC Project for 2024-25.

7.20 The revenue financial position for the nVCC Project for 30th September 2024 is shown below, reflecting a current overspend of £0.028m for the year.

nVCC Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.015m	£0	£0.028m	-£0.028m
Total	**£0.015m**	**£0**	**£0.028m**	**-£0.028m**

7.21 There is a risk of an overspend of £0.028m for the revenue element of the nVCC Project this financial year.

Whitchurch Hospital Site

7.22 There is currently no capital funding for the nVCC Project for 2024-25.

7.23 The Project's financial position for 30th September 2024 is shown below. This spend relates to legal fees associated with the Whitchurch Hospital Site. The forecast position reflects an expected overspend of £0.274m for this financial year.

Whitchurch Hospital Site Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.004m	£0	£0.274m	-£0.274m
Total	**£0.004m**	**£0**	**£0.274m**	**-£0.274m**

7.24 To date there is no funding provided by WG for the Whitchurch Hospital Site, however at present the risk to the Programme is low. The associated costs will be reimbursed by WG.

Service Delivery and Transformation Project

7.25 The revenue funding for the Project for 2024-25 is £0.180m from NHS Commissioners' funding and £0.140m from Trust reserves. The resulting budget is £0.320m for this financial year.

7.26 There is no capital funding requirement for the Project in 2024-25.

7.27 The SDT Project revenue position for 2024-25 is shown below, with a forecast breakeven position for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.129m	£0.306m	£0.306m	£0
Non-Pay	£0.000m	£0.014m	£0.014m	£0
Total	**£0.129m**	**£0.320m**	**£0.320m**	**£0**

7.28 There are currently no financial risks associated with the Project for 2024-25.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 The key financial risks to the TCS Programme at present are as follows:

- There is a lack of funding for the capital projects. A funding request for the nVCC Project has been submitted to WG for c£3.8m and the EW Project funding request will be as part of the EW FBC Addendum.

- There is no expenditure against the Enabling Work Project revenue budget, whilst there is revenue expenditure against the nVCC project with no corresponding budget.

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 2024. The report for 2024-25 is currently being developed and will be in line with the approved nVCC FBC.

9.3 The cumulative report shows a total spend for the TCS Programme of £68.635m (£63.443m Capital, £5.192m Revenue) to 31st March 2024. The total pay costs for this period were £15.239m.

9.4 The spend to 31st March 2024 for each Project within the Programme is summarised below.

Programme Management Office £2.187m
Project 1 Enabling Works £34.735m
Project 2a nVCC.....£26.221m
Project 2c Whitchurch Hospital Site £0.051m
Project 3a Integrated Radiotherapy Solution.....£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.393m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.798m
Project 7 Decommissioning £0m

9.5 The spend to 31st March 2024 for each financial year is summarised below.

2014-15 .....£0.328m
2015-16 .....£2.398m
2016-17 .....£6.168m
2017-18 .....£3.909m
2018-19 .....£4.267m
2019-20 .....£2.928m
2020-21 .....£3.924m
2021-22 .....£6.429m
2022-23 .....£17.365m
2023-24 .....£20.918m

9.6 The five deliverables with the highest spend during this period are:

Construction Costs £19.842m
ASDA Works.....£6.660m
Competitive Dialogue £6.196m
Advanced Design and Works £6.016m
Project Control.....£5.198m

APPENDIX 1: TCS Programme Budget and Spend as at 30th September 2024

TCS Programme Budget & Spend 2024-25

CAPITAL	Year to Date Budget Sep-24 £	Year to Date Spend Sep-24 £	Year to Date Variance Sep-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	168,305	-168,305	0	416,128	-416,128
Project 1b - Enabling Works FBC	0	117,229	-117,229	0	237,597	-237,597
Project 2d - New Velindre Cancer Centre FBC	0	512,516	-512,516	0	1,733,782	-1,733,782
Capital Pay Total	**0**	**798,049**	**-798,049**	**0**	**2,387,507**	**-2,387,507**
NON-PAY						
nVCC Project Delivery	0	15,634.69	-15,635	0	61,937	-61,937
Project 1b - Enabling Works FBC	0	2,570,689.17	-2,570,689	0	3,573,189	-3,573,189
Project 2c - Whitchurch Hospital Site	0	4,411.70	-4,412	0	273,912	-273,912
Project 2d - New Velindre Cancer Centre FBC	0	588,199.91	-588,200	0	1,659,347	-1,659,347
Capital Non-Pay Total	**0**	**3,178,935.47**	**-3,178,935**	**0**	**5,568,384**	**-5,568,384**
CAPITAL TOTAL	**0**	**3,976,985**	**-3,976,985**	**0**	**7,955,891**	**-7,955,891**

REVENUE	Year to Date Budget Sep-24 £	Year to Date Spend Sep-24 £	Year to Date Variance Sep-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Programme Management Office	146,378	142,060	4,318	316,500	313,417	3,083
Project 6 - Service Change Team	145,004	128,762	16,242	306,246	306,246	0
Revenue Pay Total	**291,382**	**270,822**	**20,560**	**622,746**	**619,664**	**3,083**
NON-PAY						
Enabling Works FBC	28,434	0	28,434	28,434	0	28,434
nVCC FBC	0	15,007	-15,007	0	28,434	-28,434
Programme Management Office	1,500	2,583	-1,083	1,500	4,583	-3,083
Project 6 - Service Change Team	6,064	259	5,805	13,754	13,754	0
Revenue Non-Pay Total	**35,998**	**17,848**	**18,150**	**43,687**	**46,770**	**-3,083**
REVENUE TOTAL	**327,380**	**288,670**	**38,709**	**666,434**	**666,434**	**0**

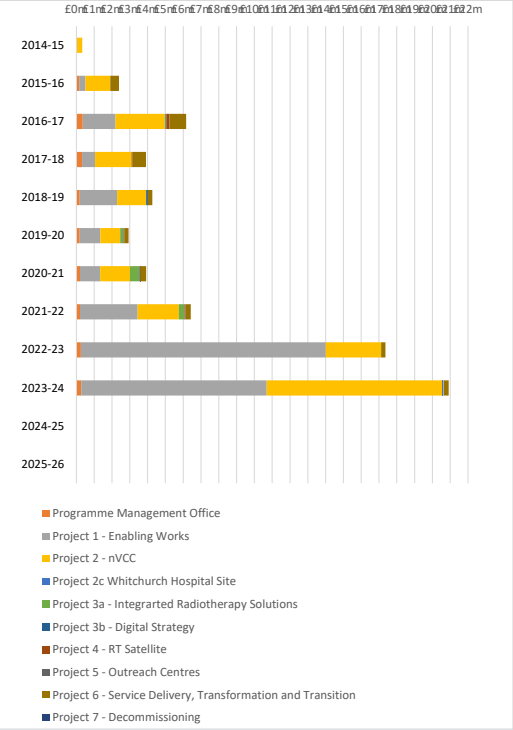
APPENDIX 2: TCS Programme Funding for 2024-25

Description	Date	Funding Type	
		Capital	Revenue
Programme Management Office		**£0**	**£0.318m**
Commissioner's Funding	01 April 2024	£0	£0.240m
Trust Revenue Funding	01 April 2024	£0	£0.078m
Enabling Works FBC		**£0**	**£0.028m**
WG Funding - tbc	-	£0	£0
Escrow Bank Account Interest	04 June 2024	£0	£0.028m
New Velindre Cancer Centre FBC		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Whitchurch Hospital Site		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Radiotherapy Satellite Centre	**-**	**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
SACT and Outreach		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Service Delivery, Transformation and Transition		**£0**	**£0.320m**
Commissioner's Funding	01 April 2024	£0	£0.180m
Trust Revenue Funding	01 April 2024	£0	£0.140m
VCC Decommissioning		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Total		**£0**	**£0.666m**

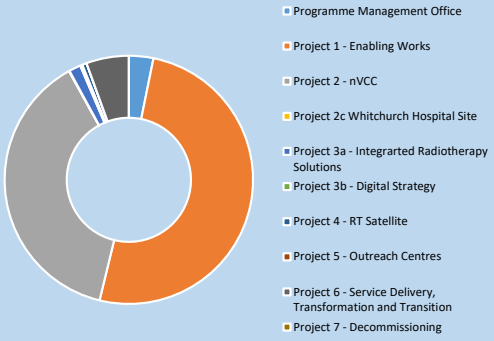
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2024

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2024

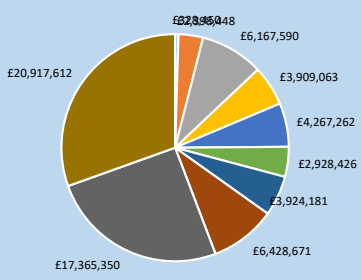
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS



TOTAL SPEND BY PROJECT TO DATE	£68,635,053
Programme Management Office	£2,186,915
Project 1 - Enabling Works	£34,734,803
Project 2 - nVCC	£26,220,533
Project 2c Whitchurch Hospital Site	£50,807
Project 3a - Integrarted Radiotherapy Solutions	£1,049,425
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£393,293
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,797,583
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£15,238,592
2	Walters	£14,593,900
3	Sacyr	£6,009,453
4	Asda	£5,856,199
5	Mott MacDonald	£5,840,369

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	14th November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Amanda Jenkins, Acting Assistant Director of Workforce Steven Coliandris, Head of Financial Planning & Reporting
PRESENTED BY	Amanda Jenkins, Acting Assistant Director of Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

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

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

RECOMMENDATION / ACTIONS	The Quality, Safety 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**
Velindre Cancer Centre Senior Leadership Team	23/10/2024
Welsh Blood Service Senior Leadership Team	23/10/2024
Executive Management Board	29/10/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS VCC Senior Leadership Team noted the content of the paper and asked for it to be recorded that agency spend within Radiation Services is specific to the IRS and nVCC programmes and is not part of routine service delivery. WBS Senior Leadership Team noted the content of the paper. Executive Management Board noted the content of the paper.	

7 LEVELS OF ASSURANCE	
4 – Increased extent of impact from actions	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Comprehensive actions have been identified and agreed upon to address specific performance concerns and recognise systematic reason for variation. There is evidence in the paper of these actions being delivered however there is no evidence currently of the achievement towards the desired outcomes.

APPENDICES	
	No Appendices

1. SITUATION/BACKGROUND

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

- Attraction and Retention
- Wellbeing and Equalities
- Education and Learning
- Workforce Supply and Shape
- Leadership and Succession

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

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Attraction and Retention

Attraction and Retention
Actions Delivered Qtr. 2 24/25
• Appointment of key leadership roles within the Trust. • Initial Velindre University NHS Trust Workforce Action Plan approved by EMB • Appointment of the Trust Attraction and Resourcing Lead to progress immediate objectives set out in the Velindre NHS Trust Workforce Action Plan • Options appraisal approved to undertake a Recruitment Campaign for Velindre University NHS Trust. • Implemented a People and OD Policy Review and Development Group • Engaged with NHS Wales Bank Incentivisation Project to assess national terms for Bank Staff in Wales • Began development of a Trust framework for managing industrial action locally. • Fully implemented the Trust Recruitment Policy with focus on workforce planning and establishment control • Development of a streamlined scrutiny process with POD and Finance approvals being made in Trac to reduce administrative burden on service leads. • Collaborative design of careers pages on social media and website with Communications Team • Self-assessment completed to become disability confident employer level 3

Actions Qt 3 24/25
• Undertake external assessment for disability confident employer level 3 • Evaluation of the International Nurse Recruitment Project and assess next steps for Trust Retention Plan. • Evaluation of targeted recruitment campaigns and improvement of key metrics • Finalise the Nurse Retention Plan with approval from Professional Nurse Forum. • Undertake lessons learn review of Nurse Retention Plan to build learning into Trust Retention Plan. • Scoping work on developing an internal Staff Bank to support replacement of agency resource. • Implement above inflation pay increase for all staff in the Trust, as agreed by Welsh Government for 24-25.
Issues/Mitigation
• Agency spend review ongoing – *more detail in section 3 – associated finance costs* • Labour market challenges – ongoing Trust activities to grow and develop our own workforce as well as a designed recruitment campaign to target roles
Levels of assurance
Level 5 – Evidence of delivery of majority of actions with no evidence of the achievement of desired outcomes.

2.2 Wellbeing and Equalities

Wellbeing and Equalities
Actions delivered Q2 2024-25
• NHS Staff Survey results 23-24 received and reported to Committees and Trust Board. • Engagement with HEIW on launching Staff Survey 2024-25 • Noddfa has been finished and launched as a dedicated wellbeing space for VCC. • Annual action plan to implement the Strategic Equality Plan developed and reported through Healthy and engaged steering group. • Launch NHS Wales Health and Wellbeing Framework nationally
Actions Q3 2024-25
• Trust analysis against the NHS Wales Health and Wellbeing Framework • Launch Staff Survey 2024-25 • Absence Deep Dive to be completed with action plan for improvements

• Bullying, Harassment and Discrimination Deep Dive to be completed with action plan for improvements
Issues/Mitigation
• Stress is biggest reason for sickness absence but further analysis required to understand this in detail. • Collaboration and engagement with service and workforce is key in addressing issues. People and OD workplan for 24-27 shared with EMB and Divisional Leads.
Levels of assurance
4 – Increased extent of impact from actions with evidence of several agreed actions being delivered.

2.3 Education and Learning

Education and Learning
Actions delivered Q2 2024-25
• New People Development Policy completed and approved. • New PADR Policy completed and approved. • Initial launch of Fundamentals of Management Training. • Began development of Trust Training Plan with service leads. • Completion of all recommendations from the Education Strategy Audit.
Actions Q3 2024-25
• Finalise the Trust's Training Plan • Fully embed Fundamentals of Management into the training plan for the Trust rolling
Issues/Mitigation
• The Education Strategy Audit has provided valuable feedback and has allowed the Trust to tighten its approach to planning and reviewing training and development. • Engagement and collaboration with the workforce is key to ensuring the actions are proactively taken forward. People and OD workplan for 24-27 shared with EMB and Divisional Leads.
Levels of assurance
4 – Increased extent of impact from actions with evidence of several agreed actions being delivered.

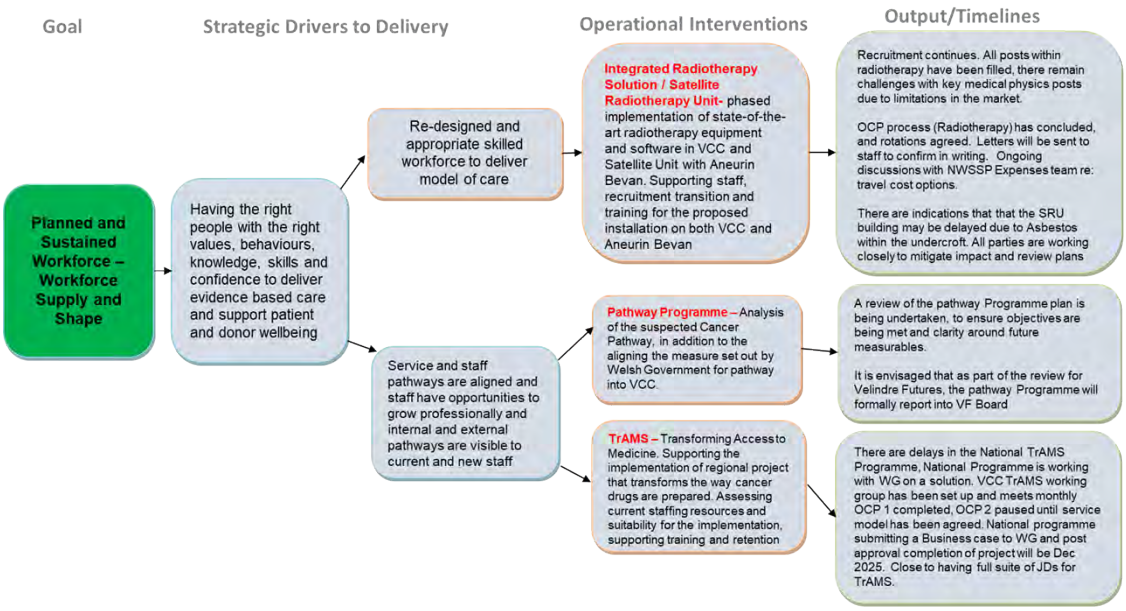
2.4 Leadership and Succession

Leadership and Succession
Actions delivered Q1 2023-24
• Approved Behaviour Framework and embed into People Processes. • New Values and Behaviour Framework launched.

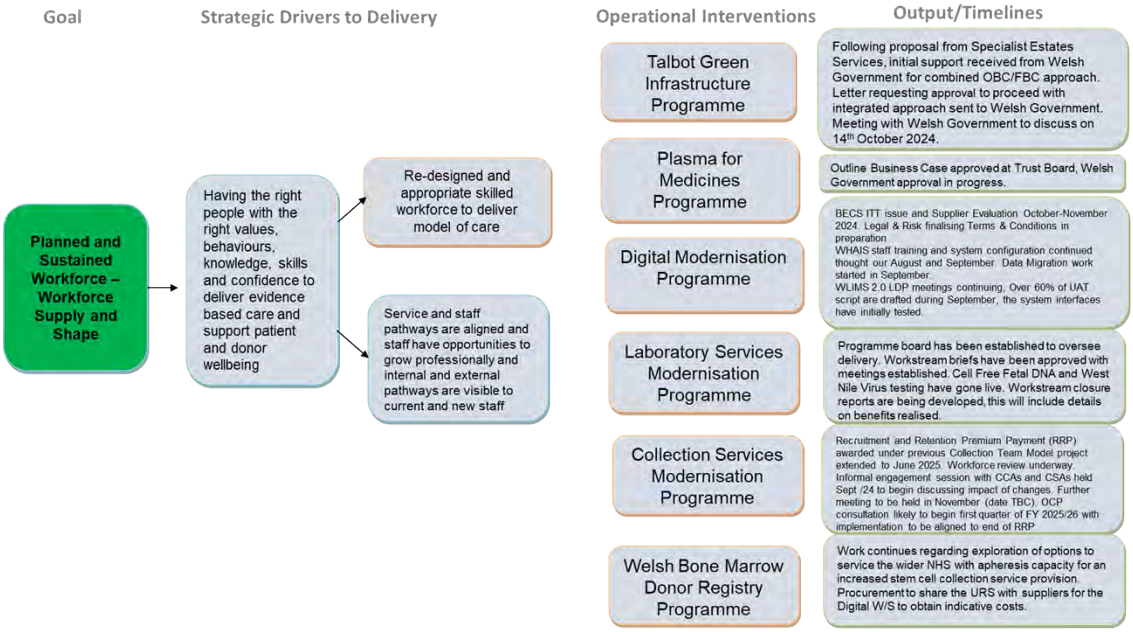
Actions Q2 2024-25
• Evaluation of Values and Behaviour Framework to begin • Staff engagement session on working with new Values and Behaviours • Development of a Culture and Inclusion Framework for reporting through committees and to Trust Board on a quarterly basis.
Issues/Mitigation
• The Values and Behaviour Framework represent aspects of the culture of the trust and it will take time for people to understand where they can develop their styles at work to better encapsulate Caring, Respectful and Accountable. • Key requirement for this to be led by Senior Leaders
Levels of assurance
4 – Increased extent of impact from actions with evidence of several agreed actions being delivered.

2.5 **Supply and Shape**

Supply and Shape
Actions Delivered Qtr. 4 23/24
• 3 Year implementation plan for the People Strategy shared with EMB and Divisional Leads. • Regular reporting and monitoring of work plans by Senior Leadership Teams, Executive Management Board and the Quality Safety and Performance Committee via monthly workforce dashboards and this paper quarterly respectively • Ongoing infrastructure of workforce planning training embedded via the Trust management and leadership Inspire Programme • Workforce planning and establishment control built into the Recruitment planning process through the new recruitment Policy.
• Divisional Updates
Velindre Cancer Centre



Welsh Blood Service



Issues/Mitigation

- Workforce plan across the Trust. Work underway to take this forward in Q2-Q4
- Engagement and collation with the service is key and is developing through the Business Partners
- Dependency on national initiatives impacting on deliverables
- Trust Workforce Action Plan agreed by EMB to deliver immediate (6 months) and imminent (12 months) actions

Levels of assurance
4 – Increased extent of impact from actions with evidence of several agreed actions being delivered.

3. The associated financial risk to Workforce Supply and Shape

The financial risk associated with workforce supply and shape will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available. Funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners. There is however a risk that activity income, specific to Velindre Cancer Center, does not match the level of investment into the services and a review with Finance and SLT is ongoing.

Pay Budget 2024/25

The full year pay budget as at end of September 2024 is £89.735m based on 1,706 WTE. The Trust has reported cumulative year to date spend on pay of £45.303m against a budget of £44.917m resulting in current overspend of £ (0.386) m. The pay costs include the costs of agency staff, on-call, and overtime.

Pay Award

The Trust has now received confirmation from WG via the pay matrix that the full 2023-24 consolidated pay award will be funded, however the Trust is still awaiting confirmation from WG on receiving funding to support the Junior Doctor pay award (£0.718m) which was agreed in 2024/25 and paid in September'24.

The Trust has received notification from WG on the pay award for 2024-25, with discussions ongoing as to whether an incremental step will be included on the AFC Band 8 and above pay levels. Finance colleagues are currently calculating the impact of the pay award which is expected to be paid in November. At this stage we would assume that it would be fully funded, albeit with some risk until WG confirm the funding allocation.

Agency

The spend on agency for September 2024 was £0.061m (August £0.077m) with a current forecast outturn spend of circa £0.498m (£0.775m 2023/24).

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

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with

expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing when compared to last year but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

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

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

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
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
	Permanent and some temporary staffing costs may not be fully covered by WG or Commissioner income. Ongoing premium cost of agency.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Individual elements of work described in this paper may be subject to EQIA.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*This is reflected in the Trust Assurance Framework Risk 03*

WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
2024-25 Quarter 2 Trust Quality & Safety Report	
DATE OF MEETING	14th November 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Trust-wide & Divisional Quality & Safety Teams
PRESENTED BY	Tina Jenkins, Head of Quality, Safety and Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

	This is the Trust's integrated quarter 2 Quality & Safety report covering the period 1st July 2024 to 30th September 2024, produced collaboratively by the three quality hubs: Trust wide; Welsh Blood Service; Velindre Cancer Service. Highlights for the period are: • High levels of patient and donor satisfaction: VCC 100%; WBS 99%. • Trust responded to 93.6% of Putting Things Right (formal) complaints within 30 working days (national target 75%). • There was an increase in the number of Duty of Candour incidents (assessed as having potentially caused moderate harm). Two related to clinical decision making, one related

	to a transcription error. Investigations are underway. • There have been no new referrals to the Public Service Ombudsman since October 2023, a positive indication of the Trust's handling of complaints.

RECOMMENDATION / ACTIONS	To ***DISCUSS*** the Velindre University NHS Trust Quarter 2 Quality & Safety Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group (IQ&SG)	21/10/2024
Executive Management Board	29/10/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Integrated Quality & Safety Group: The group all agreed that the new report format was much improved and supported divisional completion to amalgamate into a fully collaborative report. The group again discussed the dilemma regarding low reporting data e.g. Duty of Candour, National Reportable Incidents, and Safeguarding Reports to ensure information is not identifiable, recognising our Trust responsibilities around Duty of Quality reporting and transparency. Executive Management Board: Paper noted.	

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

APPENDICES	
Appendix 1	2024-2025 Quarter 2 Trust Quality & Safety Report
Appendix 2	Overdue regulatory tracker actions
Appendix 3	Summary regulatory tracker position
Appendix 4	Patient and Donor Experience Scoping

1. BACKGROUND

This is the second report within the new reporting arrangements that were agreed in February 2024 bringing six previous reports together as one. The report provides analysis of key outcomes, activity, learning and improvement during the quarter as well as contextualizing over time, will meet all legislative requirements i.e. Putting things Right Regulations and Quality & Engagement (Wales) Act 2020, Mortality, Duty of Candour & Duty of Quality and includes:

- VCC Divisional Report
- WBS Divisional Report
- Infection Prevention & Control
- Safeguarding and Vulnerable Groups
- Safety Alerts
- Datix standards
- Putting Things Right
- Claims, inquests, compliments
- Information Governance
- Health & Safety
- Quality outcome metric overview
- Mortality
- Regulatory compliance
- Assurance visits / inspections
- Learning from external reports.

2. ASSESSMENT

2.1 Quarter 2 Summary

The 2024-2025 Quarter 2 Trust Quality & Safety Report is attached. The report provides detail on the Trust's quality & safety activity between July and September 2024 and was co-produced by the three quality hubs.

The following are the report highlights:

- Welsh Blood Service have seen a trend in concerns related to appointments and communication – to address this they now communicating with donors when collection clinics are running late, to readjust appointments and reduce waiting times, as well as working to expand their range of venues.
- Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain high. Velindre Cancer Service's Friends and Family test score was 100%, while Welsh Blood Service donors returned a 99% overall experience satisfaction score.
- Compliance with Putting Things Right timescales for complaints responses is 93.6% (national target 75%).

- 3 incidents in Velindre Cancer Service triggered the Duty of Candour, having been assessed as having potentially caused moderate harm to a patient. Two related to clinical decision making, one related to a transcription error. Investigations are underway to identify learning and opportunities for improvement. No Duty of Candour triggers occurred in Welsh Blood Service.
- No incidents met the criteria for National Reportable incidents.
- The Trust continues to comply with legislative safeguarding responsibilities and reporting.
- Hospital Associated Infection rates have increased to 2 cases in Quarter 2, compared to 1 in Quarter 1. Learning from Root Cause Analysis concluded that communication between nursing and medical staff was disjointed and stool charts were not observed by medical staff.
- Infection Prevention & Control training compliance has reduced.
- One external review took place: Llais obtained feedback from people who have had recent contact with cancer services. Suggestions were made in regard to how Velindre Cancer Service communicates with patients, staff and other healthcare providers. The service has developed an improvement plan that will be kept on the Trust's Regulatory Quality and Safety Tracker. And monitored through the Integrated Quality & Safety Group.
- Further progress has been made to complete actions on the Regulatory Quality and Safety Tracker. The number of overdue actions has reduced from 25 at end quarter 1 to 18 at end quarter 2 **(details of overdue actions as at the end of quarter 2 is attached in *appendix 2***). A high-level regulatory tracker overview position (as of 06/11/2024) is attached in **appendix 3.** The full regulatory tracker that details all open actions is available for Committee members to view on the Trust Quality, Safety & Performance Committee Teams Chanel.

Moving forward to ensure that Quality, Safety & Performance Committee are provided full assurance on the Trust Regulatory Tracker a bi-monthly report will be prepared including spot check audits of closed improvement plans.

2.2 Quarter 2 Priority Delivery

All quarter 2 priorities identified in the quarter 1 report have all been delivered. These are:

- The quality hubs will undertake focused work using the Yorkshire Contributory Factors Framework (a tool that helps map the potential factors that led to a patient safety incident) to identify trend analysis learning from specific incident themes. (starting with a medication incident deep dive at VCC).
- To develop a patient and donor satisfaction survey to gather experience feedback following the concerns process.
- To develop a proportionate investigation template to improve consistency of investigations and put staff, patients' and donors' wellbeing and feedback at the centre of the process.

- To further develop collaborative working opportunities through the quality hubs to optimise quality and safety outcomes and support learning and continuous improvement.

2.3 Quarter 3 Priorities

The report identifies the following priority areas for quarter 3:

- Undertake focused work using the Yorkshire Contributory Factors (investigation tool) to identify trend analysis learning from specific incident themes.
- To explore further opportunities to gather patient and donor feedback to identify opportunities to improve our services.
- Following the Patient / Donor experience scoping exercise in quarter 2 **(detailed in appendix 4)** there is an opportunity to utilise the self-assessment within the People's Experience Framework to develop an improvement plan for our patient donor experience mechanisms across the Trust. The Trust requires a joined approach to gather and analyse patient/donor feedback to ensure that it can be utilised as an effective method of improving the quality of our services.

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 ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required Click or tap here to enter text. **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. • 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. • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being	☒ ☒ ☒ ☒ ☒ ☒ ☒

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are financial implications in regard to Claims and Redress, as outlined in the report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com*	Not required - please outline why this is not required Click or tap here to enter text.

/sites/VEL_Intranet/SitePages/E.aspx	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust has a requirement to comply with legislations and regulations. These include. Mental Capacity Act (2005) Social Service and Welling Wales Act (2014)Putting Things Right Regulations Health & Safety at Work Act (1974) General Data Protection Regulations (2016) There is evidence of compliance contained within the report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The theme of increasing concerns and incidents relating to administrative processes and the overuse of email for urgent clinical correspondence at Velindre Cancer Service which is resulting in a poor experience and harm to some patients. This risk has been identified previously and is documented upon the Divisional Risk Register.
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?	Yes - please detail below
	The Trust has developed improvement plans; however, this will require a change to systems, processes and ways of working that will require time to resolve.
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust Quality and Safety Report Quarter 2 2024-2025

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1 INTRODUCTION AND EXECUTIVE SUMMARY
2 QUALITY AND SAFETY INDICATORS OVERVIEW
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5 PATIENT AND DONOR EXPERIENCE
6 INCIDENTS
7 REDRESS
8 CLAIMS
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15 HEALTH AND SAFETY
16 REGULATORY QUALITY AND SAFETY TRACKER
17 ASSURANCE VISITS AND INSPECTIONS
18 QUALITY PRIORITIES 2024-25 UPDATE
19 LEARNING AND CULTURE
20 CONCLUSION
21 PRIORITIES FOR QUARTER 3

1. INTRODUCTION AND EXECUTIVE SUMMARY

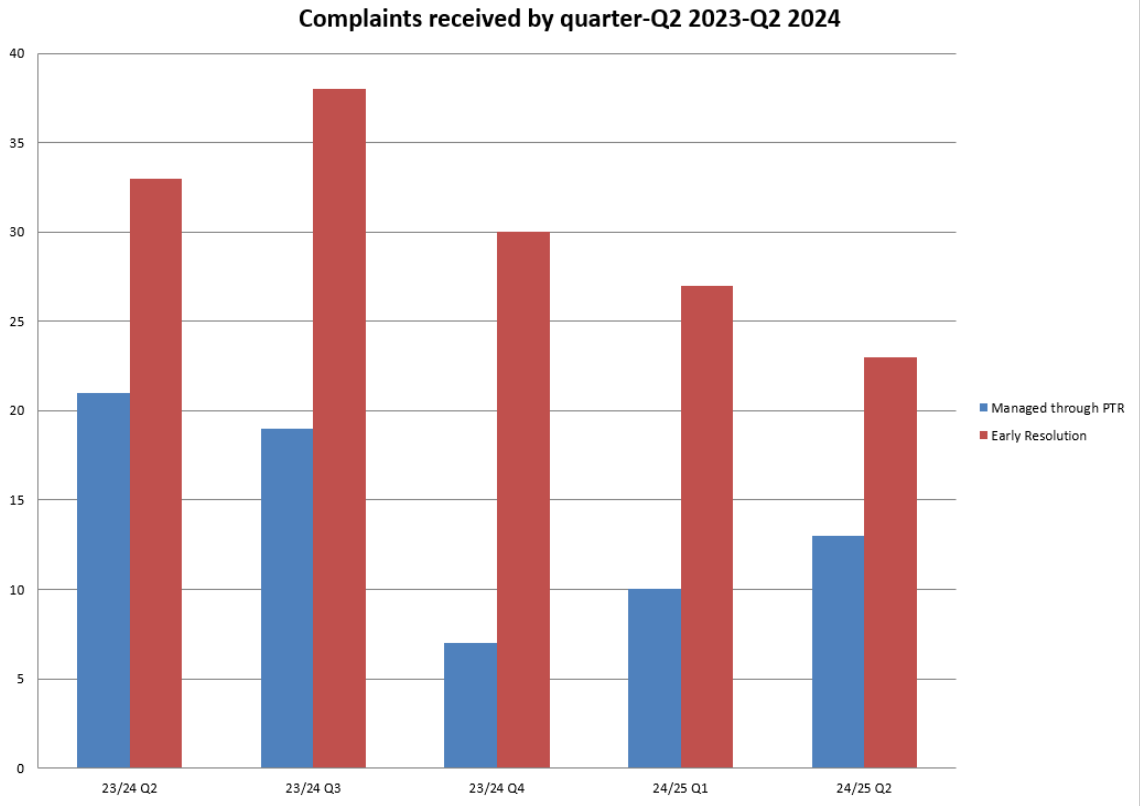
This is the Trust's second quarterly and fully integrated quality & safety report that has been co-produced by the Trusts three quality hubs. The report provides analysis of key outcomes, activity, learning and improvement during the quarter as well as contextualising over time so that we can meet the legislative requirements in line with the Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintain a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care.

2. QUALITY AND SAFETY INDICATORS OVERVIEW

	2023-24
13 Putting Things Right Formal Complaints	21
93.6% Putting Things Right Compliance	100%
23 Early Resolution Complaints	34
0 New Redress	1
2 New Inquests	4
0 Ombudsman cases	0
530 Incidents	595
3 Duty of Candour Incidents	2
0 Nationally Reportable Incidents	1
4 Safeguarding Duty to Report	4
99% Welsh Blood Service satisfaction	100%
100% Velindre Cancer Service satisfaction	92%
110 Incidents open over 30 days	Not captured

3. COMPLAINTS – TRUST OVERVIEW

Graph 1



As shown in **graph 1**, the Trust has seen an increase in complaints managed through Putting Things Right (formal) from the last quarter (although within normal variation). The number managed through Early Resolution has decreased, indicating that the Trust has been less successful at managing complaints in the early stages.

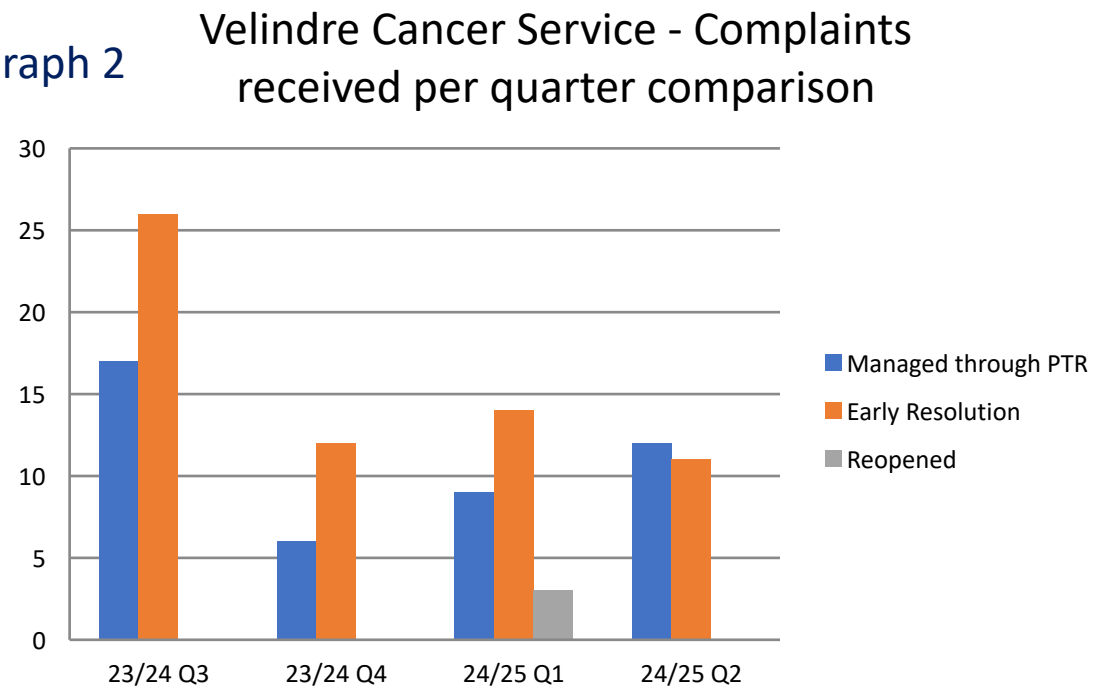
36 complaints were raised during quarter 2, which is a reduction in the number of complaints raised in previous quarters. All complaints were acknowledged within 5 working days. Once complaint was responded to 5 days outside the 30-day target. This was due to availability of clinicians to respond.

13 complaints were managed as Putting Things Right complaints.
23 complaints were managed as Early resolution complaints.

COMPLAINTS RESOLVED WITHIN 30 WORKING DAYS

3.1 COMPLAINTS – VELINDRE CANCER SERVICE

Graph 2



Total complaints raised
24

Number managed as Early Resolution
12

Number managed under Putting Things Right
12

As shown in **graph 2** there has been an overall reduction in the number of complaints received over the last year since the peak experienced in quarter 3 2023-2024.

24 complaints were received, amounting to 0.04% of patient attendances.

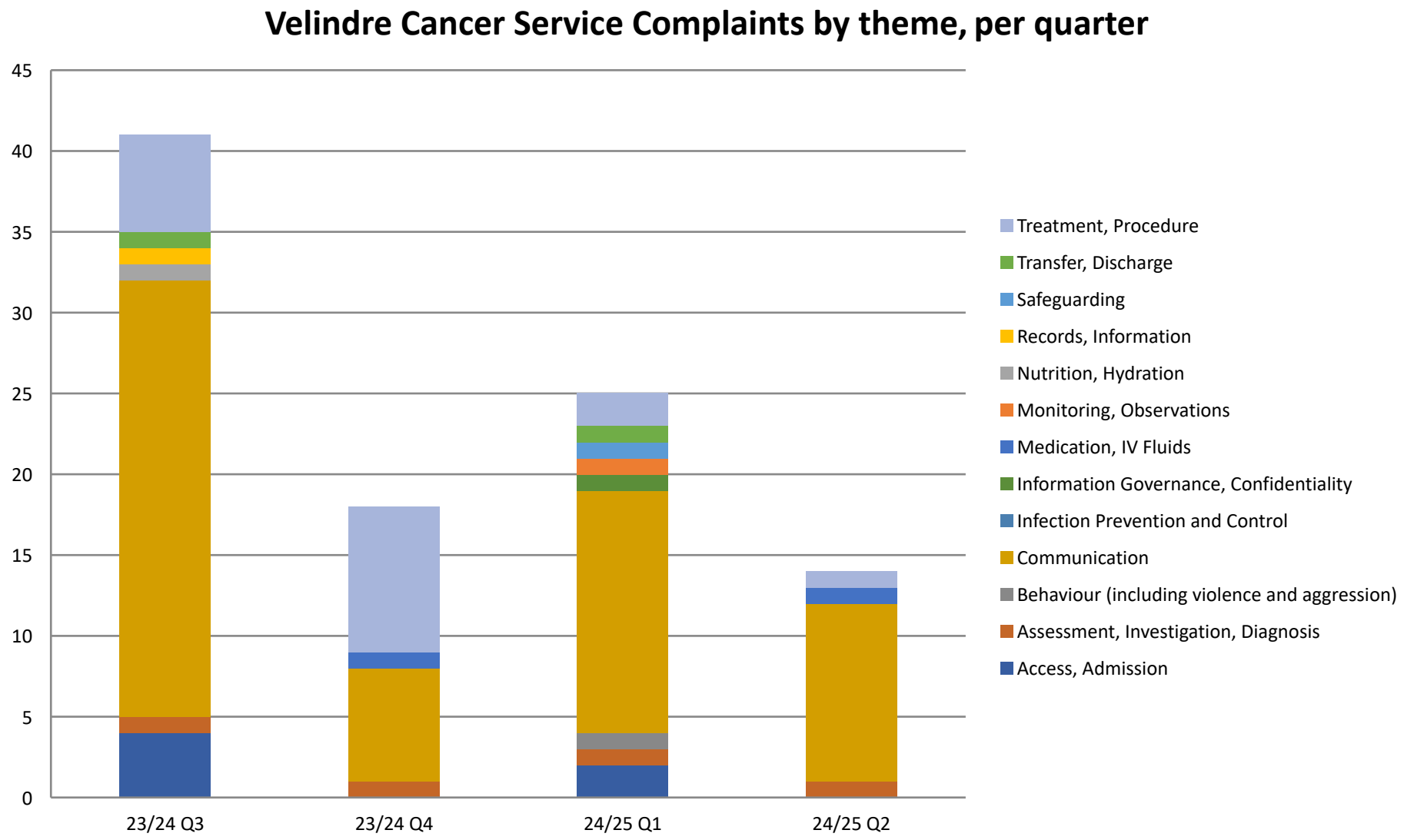
As shown in graph 2, there was a decrease in the number of **REOPENED** complaints in the Cancer Service with no concerns being reopened in quarter 2.

Graph 2 shows a reduction of early resolution concerns, in part due to reduction in concerns being received regarding SACT bookings.

There has been a slight increase in concerns being managed through PTR from previous quarter. No clinical harm identified in any concerns.

3.1 COMPLAINTS – VELINDRE CANCER SERVICE CONT.

Graph 3



3.1 COMPLAINTS – VELINDRE CANCER SERVICE CONT.

ANALYSIS

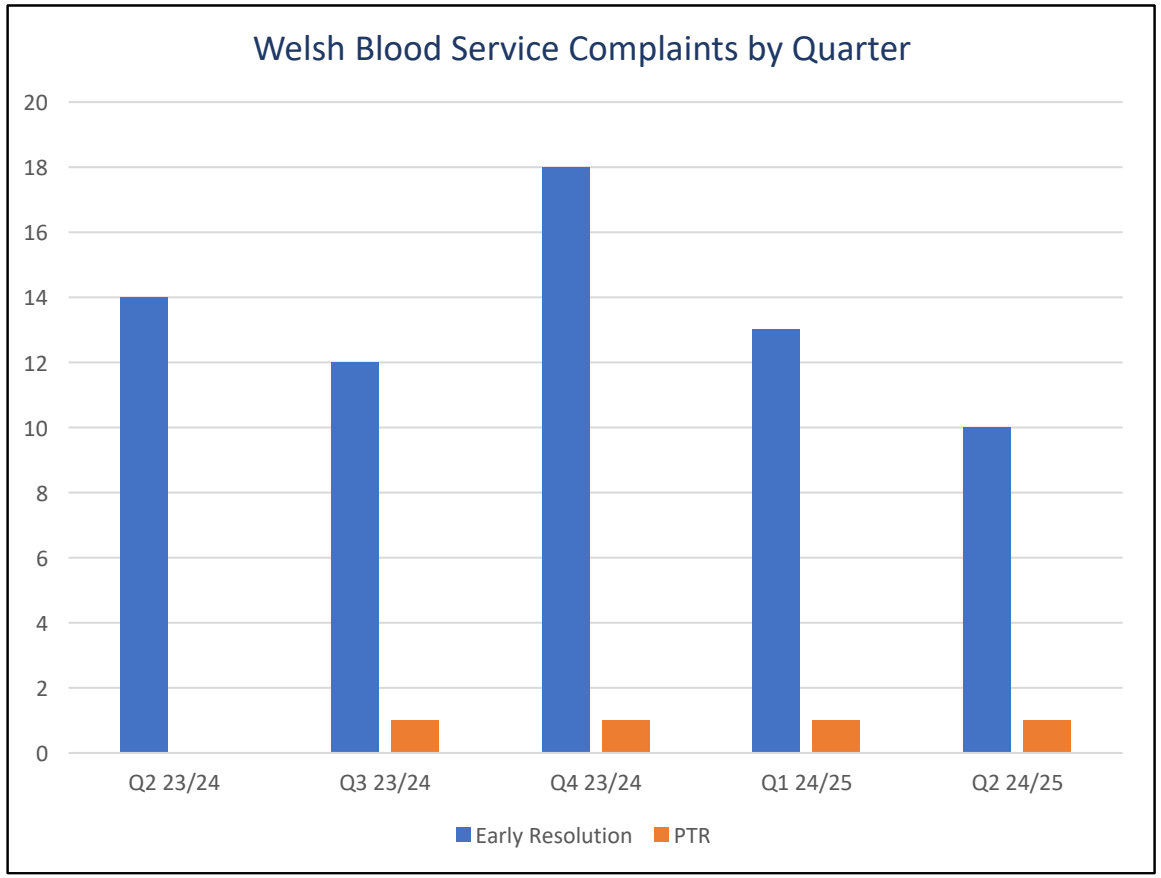
As shown in Graph 3, communication issues continue to be the main theme of the Cancer Centre complaints and there has been a decrease in concerns related to SACT bookings. SACT booking was previously one of the highest areas for early resolution concerns.
Concerns raised regarding information being given in consultations around treatment plans and prognosis is also identified as a communication theme, as well as patients concerned that they have not seen their named consultant since their first appointment. There are trends relating to individual clinicians. These have been discussed with the clinicians who are being supported by their manager. No clinical practice concerns identified.

LEARNING AND IMPROVEMENTS IDENTIFIED FROM VELINDRE CANCER SERVICE COMPLAINTS

- Safeguarding has been identified as a theme in a small number of Velindre Cancer Centre concerns and incidents. Closer working and earlier referral/discussion with Trust safeguarding has been actioned leading to strengthened collaborative working.
- Further work is needed to gain a standard practice for sending clinic letters to patients across all site specific Teams.
- Theme identified around patients' expectation of seeing consultant each time in clinic. Improved communication to be shared with patients around the role of the multi-disciplinary team especially in outpatient clinics – working with patient engagement team and communications team to utilise the screens and include information about MDT in patients first clinic letters.
- Work to support individual clinicians following theme identified from concerns around communication

3.2 COMPLAINTS – WELSH BLOOD SERVICE

Graph 4



ANALYSIS

As shown in **graph 4** there has been a decrease in Welsh Blood Service complaints. All were managed in line with Putting Things Right timescales and no complaints were reopened.

0.05% of donors made a complaint about their experience.

The main themes and opportunities for improvement related to **attitude, behaviour** and **communication** mainly within donor collection teams.

These concerns continue to be spread across a variety of teams and locations, with no specific trend was identified.

3.2 COMPLAINTS – WELSH BLOOD SERVICE CONT.

LEARNING AND OUTCOMES

Further learning and improvement areas following concerns have led to:

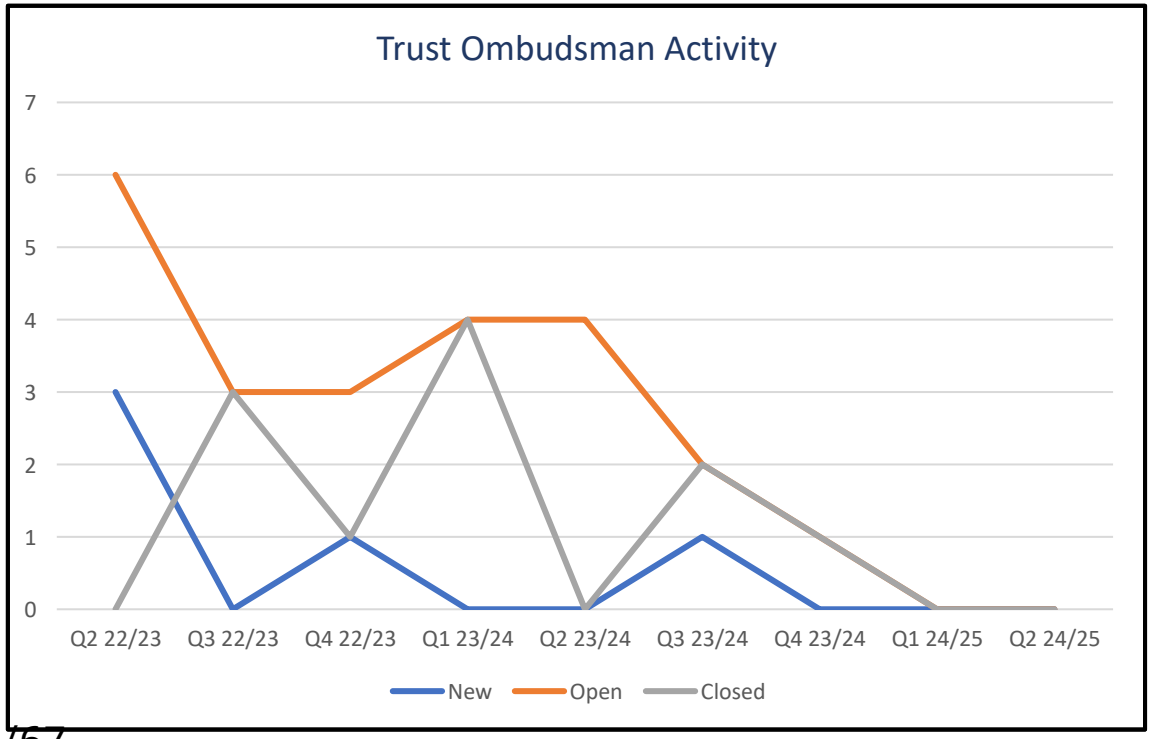
- Operational Managers ensuring that when circumstances occur where the start of a donation session is delayed, donors booked later in the day are, where possible, contacted to move appointments to reduce donor inconvenience.
- Operational Managers reminding staff of the importance of:
  - being mindful that donors can potentially be in earshot of their personal conversations whilst on session and that conversations need to remain professional
  - being open and honest with effective communication with our donors at the time that errors occur.
- Collections Team continuing to work in collaboration with Planning to look at alternative venues across the Service, particularly in North Wales.

4. PUBLIC SERVICES OMBUDSMAN

Ombwdsmon
Ombudsman
Cymru · Wales

The Public Services Ombudsman Wales investigates complaints about unfair treatments by Welsh Public Service and works to improve standards. The Ombudsman can consider complaints made to her within one year of the matters complained about or within one year of when you became aware. All Trust complaints letters and correspondence informs the public of how to contact the Ombudsman if they are unhappy with our complaints handling.

Graph 4



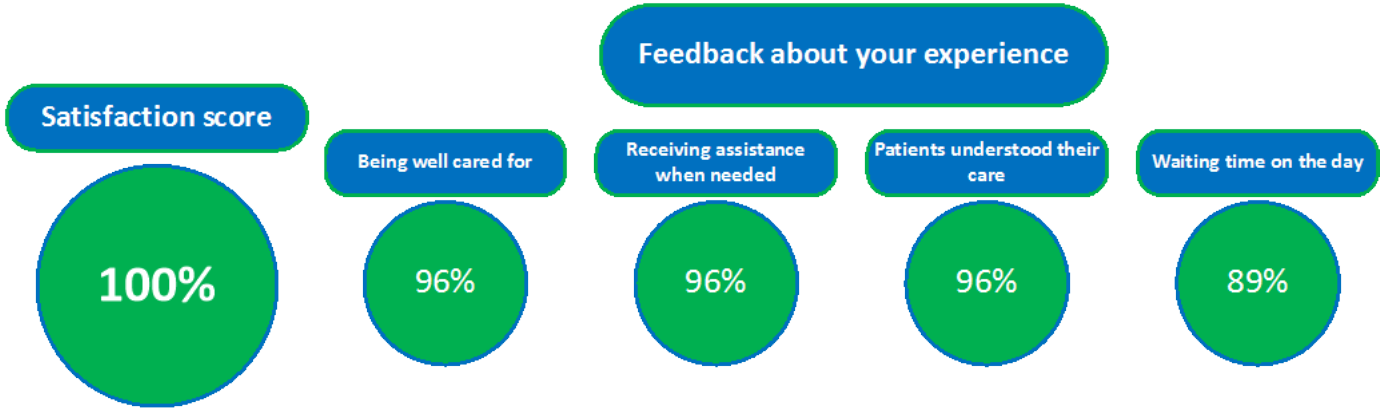
ANALYSIS

As shown in graph 4, the Trust continues to see no complaints referred to the Public Services Ombudsman. There are currently no cases open to the Ombudsman. This could be seen as a positive quality indicator of the Trust's handling of concerns process.

5.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE

Two national surveys are used, the longer "Your Velindre Experience", and the shorter "VCC Friends and Family'' (would you recommend this area to your friends and family). The findings from both surveys are included in the satisfaction scores below. 494 patients (0.8% of patient attendances) provided feedback (a decrease from previous quarter (523) but an increase from Q2 2023 (332)). 209 patients completed "Your Velindre Experience" survey and 285 patients completed VCC Friends and Family" survey.

Work is being undertaken across VCC to increase the numbers of patients we get feedback from. This has included reviewing management responsibilities and work with the volunteers who have started within the cancer centre to help supporting this.



ANALYSIS AND LEARNING

100% of patient stated they overall were satisfied with their care. However, 4% of respondents did not feel they well cared for, received assistance when needed, or understood their care. 11% of patients felt they waited longer than they expected on the day.

In addition, the heat map on graph 6 indicates provided less positive feedback related to waiting times on the day in outpatients. CIVICA has been reconfigured to be able to break feedback down to individual site teams which will facilitate more detailed analysis and targeted improvement work and allow teams to track their patients experience throughout the service.

Outpatient improvement work taken to improve in recent months include: a review of the structure of clinics and the workplans of clinical teams, an information board to display waiting times to keep patients informed, and reallocating office space into clinic rooms.

Medicine has received negative scoring but this relates to feedback from only 3 patients. 1 responded "always" and 2 responded "sometimes" to questions regarding the Welsh language, and receiving assistance when required.

5.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

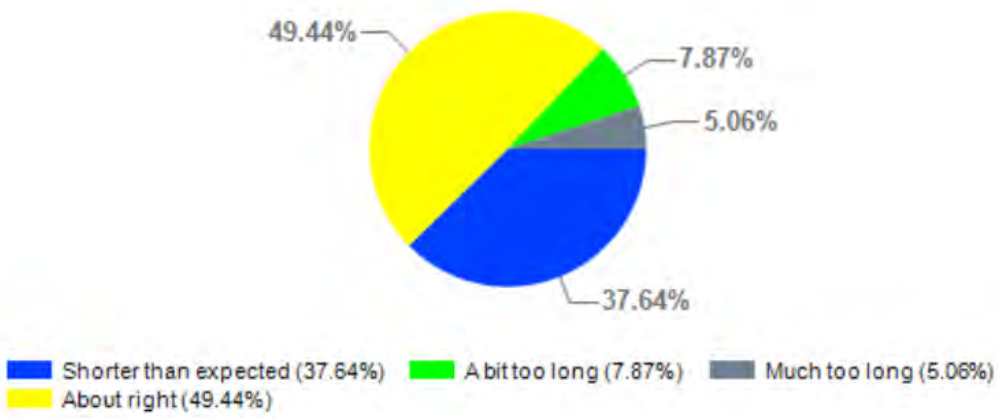
Graph 5

Question 5: During your most recent visit to Velindre Cancer Centre, how did you find the waiting time?

Create new action

Available Answers	Responses	Score (%)
Shorter than expected	67	37.64%
About right	88	49.44%
A bit too long	14	7.87%
Much too long	9	5.06%
Total	**178**	**100%**

Score: 89%

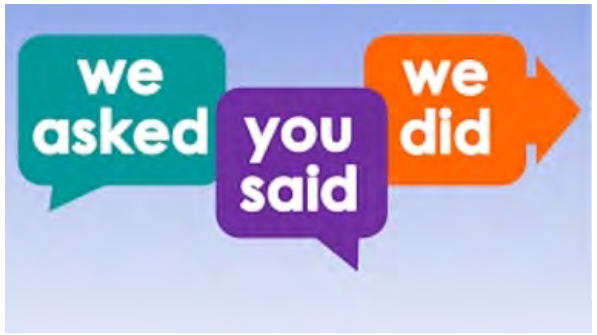


5.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

Graph 6

Directorate	Responses	1 - Overall, how was your experience of our service?	3 - Did you feel that you were listened to?	4 - Were you able to speak Welsh to staff if you needed to?	5 - How did you find the waiting time in your recent visit?	6 - Did you feel well cared for?	7 - If you asked for assistance did you get it when you needed it?	8 - Did you feel you understood what was happening in your care?	9 - Were things explained to you in a way that you could understand?
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience
Integrated care	93	100	99	93	91	99	98	99	100
Medicine	3	-	100	78	100	100	63	100	100
Operational Services and Delivery	195	99	91	94	78	87	90	88	93
Pharmacy	5	100	-	-	-	-	-	-	-
Radiation services	101	100	100	90	100	100	100	100	98
SACT	67	100	95	85	85	94	100	88	94
	Overall	**100**	**97**	**92**	**89**	**96**	**96**	**96**	**97**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**

5.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.



You Said	We Did
It would be nice to be able to buy snacks while waiting for Clinic.	New coffee shop has now opened
Recognised I was unwell without me saying- escalated for increased care.	Staff are trained to observe all patients and escalate if they have any concerns.
More transparency as regards appointment purpose and duration.	Due to the nature of the AU, length of stay cannot always be predicted, however we will try our best to communicate openly and update you.
Things could be have been put in place quicker, i.e. mental health.	Whilst referrals to other services can take some time, we will endeavour to sign post to other resources in the meantime, e.g. VCC Mindfulness app.
Hight time to wait for patient education	Phone line now available.
Requested the option of vegan food.	We linked with the cafeteria to make this possible.
Magazines or newspapers in the waiting room.	Infection control looking into the risks of spread.
Concern raised regarding lack of signage where work is being undertaken by estates team	Raised with estates and health and safety to ensure appropriate signage is in place.
Time on waiting times electronic board is incorrect.	Raised with IT support to resolve.

Wall of Thanks

"Just to say a very big thank you to everyone at Velindre for helping me through my course of radiotherapy with your wonderful welcome, your dedication, your smiles and good humour throughout my 30 visits. I wish everyone of you all the very best."

"Thank you all so much for the friendly, caring service you have given me during my radiotherapy. It is very much appreciated and has made my cancer journey so much easier."

"No words can summon up how wonderful this hospital is and all those who work there. I will always be grateful for what you have done for me and keep continuing to do. Thank you for everything, Velindre."

"A massive thanks to all who have been involved with my treatment but a special thanks to those on the help line. They have been so supportive and caring and the aftercare has been amazing! Thank you!"

"Velindre is the cleanest hospital I have ever been to. You all do an amazing job. Thank you."

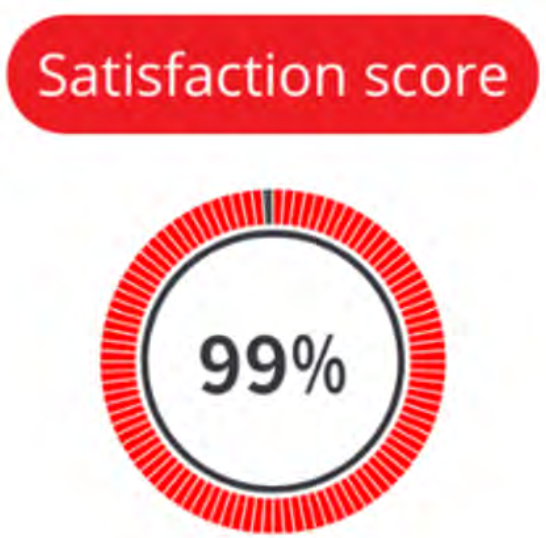
"Thank you all so very much. You have provided excellent daily care to me. You are all heroes to me, you are all so friendly and happy and that means so much when going through cancer treatment. You have made my journey a pleasure everyday. Keep up the great work, you are an exceptional team."

5.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE

2684 donors provided feedback

The Welsh Blood Service values all patient and donor feedback received and assists in understanding both successes and further opportunities to improve, to both effectively capture and trend our donor experience, and share feedback with our donors, their families and staff across the service in line with the requirements of the Duty of Quality (2023).

2,684 donors (12%) provided feedback this quarter - a very slight decrease on Quarter 1, 2706 (12%). Welsh Blood Service and the Collections teams strive to reinforce to staff how valuable collecting donor feedback is to inform service improvements and donor satisfaction.



5.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE

1% of the donors who provided feedback through CIVICA indicated that they were dissatisfied with their experience:

WBS continue to receive feedback related to dietary requirements, specifically vegan snack options. A Service Improvement Project was initiated, and posters were laminated and issued to each team to help address some negative responses.
Operational Managers are reminding staff that they must order enough regular supplies of alternative snack options. This was also identified in Q1 as a concern for a small number of donors despite efforts to improve.

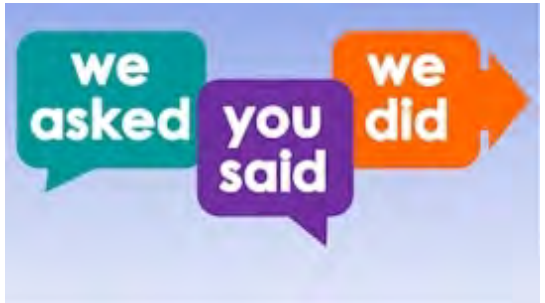
The planning department are continuing to review new/alternative suitable venues for the purpose of blood collection paying particular attention to the North Wales area and are in the process of looking to re-instate venues in Machynlleth & Aberdyfi.

5.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.

Graph 7

Location	Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Based on today's visit did you find staff helpful & knowledgeable?	4 - Based on today's visit did you find staff professional, compassionate & caring?	5 - Based on today's visit do you feel you were treated with dignity & respect?	6 - Based on today's visit were you provided with enough information about the donation process?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Based on today's visit did you find a good standard of hygiene & cleanliness?
		Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team	Compliments and Concerns. West Team
Bangor Team	285	98	100	100	100	100	100	100	100
Donation Clinic (TG)	21	100	100	100	100	100	100	100	100
East A	323	97	100	100	100	99	100	100	99
East B	380	98	100	100	100	100	100	99	100
East C	390	99	100	100	100	99	100	100	100
West Team	798	99	100	100	100	100	100	100	100
Wrexham Team	487	99	100	100	100	100	100	100	100
	Overall	**99**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	Benchmarks	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**

5.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.



You Said	We Did
Donor unhappy to be deferred following Clinical Assessment, felt staff wanted to go home rather than let him donate	Reminded by Manager the importance of effective communication
Donor unhappy to not be seen earlier than his appointment time	Consideration of flexible options.
Donor unhappy to be turned away from donating 1 day earlier following a medical procedure, also unhappy with website & 60 second donation video (found it patronising)	Donor booked appointment online-assuming his dates were accurate to donate. Comm's Manager & Clinical Services Support RN explained acceptance criteria and window period for possible transfusion related infections. Website checked information regarding issues raised was available, team will continue with on-going regular review of website. Explanation regarding 60 second video to accommodate a diverse population.

5.2 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.

Welsh Blood Service Wall of Thanks

East B – Nothing about today's visit can be changed or improved. All staff are lovely and can answer any questions. Great experience

Bangor – Popeth yn grêt. Diolch o galon am gymaint o staff yn siarad Cymraeg x

East A – Not given blood for some time. Very impressed with the setup, professionalism from all staff from start to finish… even had mini cheddars! Thanks so much and see you next time

Apheresis – As always, the staff are professional and friendly so there is nothing more they could have done.

East C – The overall experience was excellent, and the staff are always friendly and professional

West – Couldn't possibly improve! Great staff looked after me as always. Even took the time to fuss over me as it was my 75th donation. Made a special day very enjoyable. Thanks all.

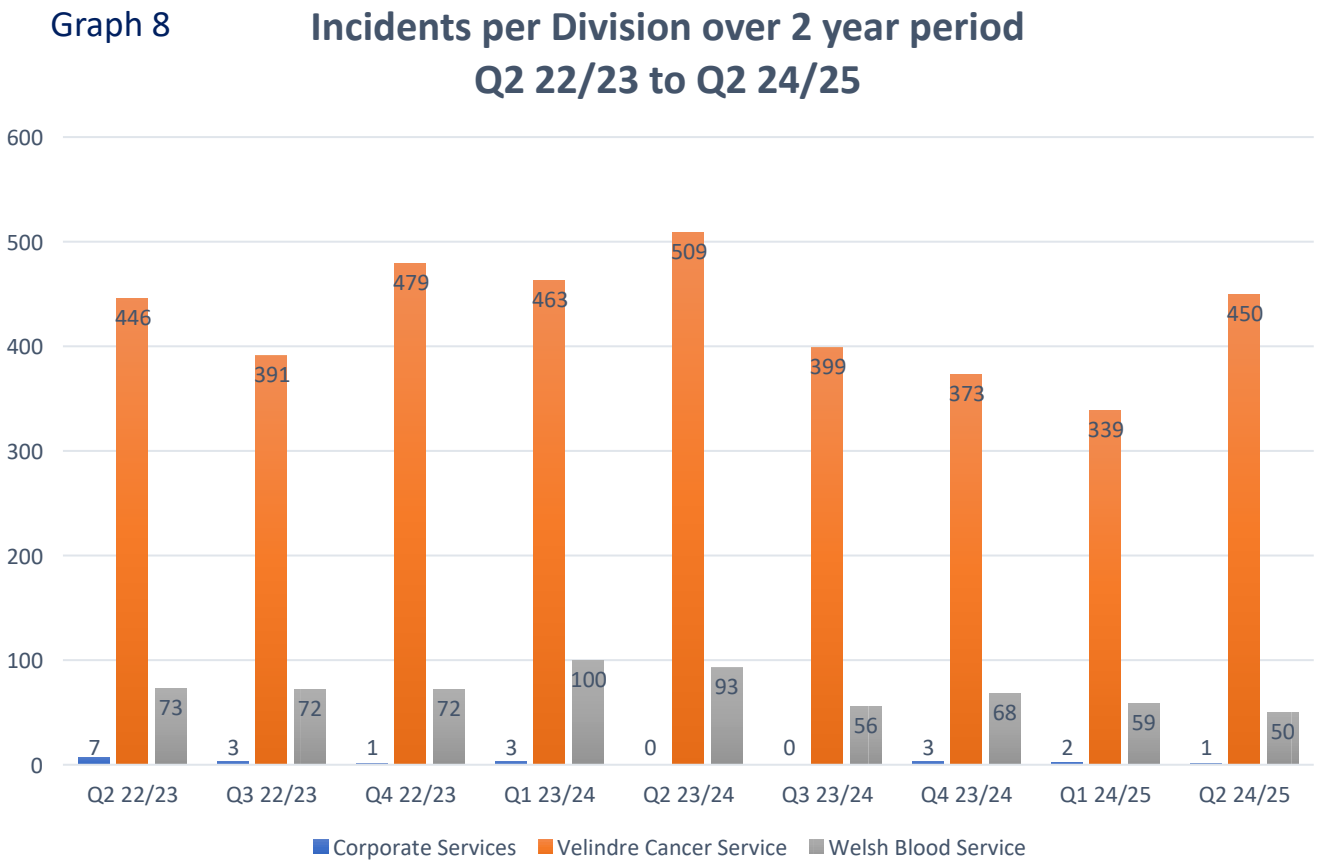
Wrexham -Thank you very much for keeping me up-to-date all the way through 😁 You've been a life-saver in making the whole process stress-free knowing it's running smoothly in the background

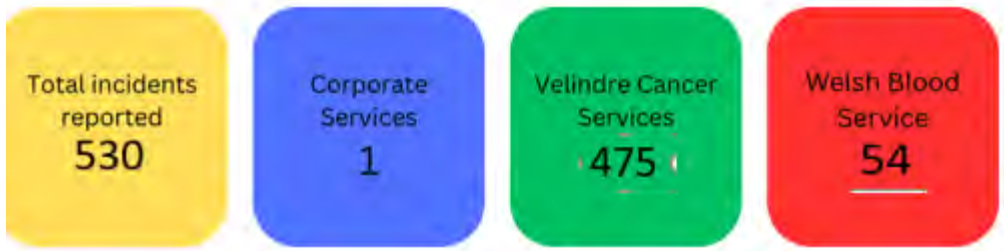
6. INCIDENTS – TRUST-WIDE OVERVIEW

Patient and donor safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients/donor's receiving healthcare. Incidents are all reported incidents being reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

Quarter 2 Trust Incident Summary

Graph 8

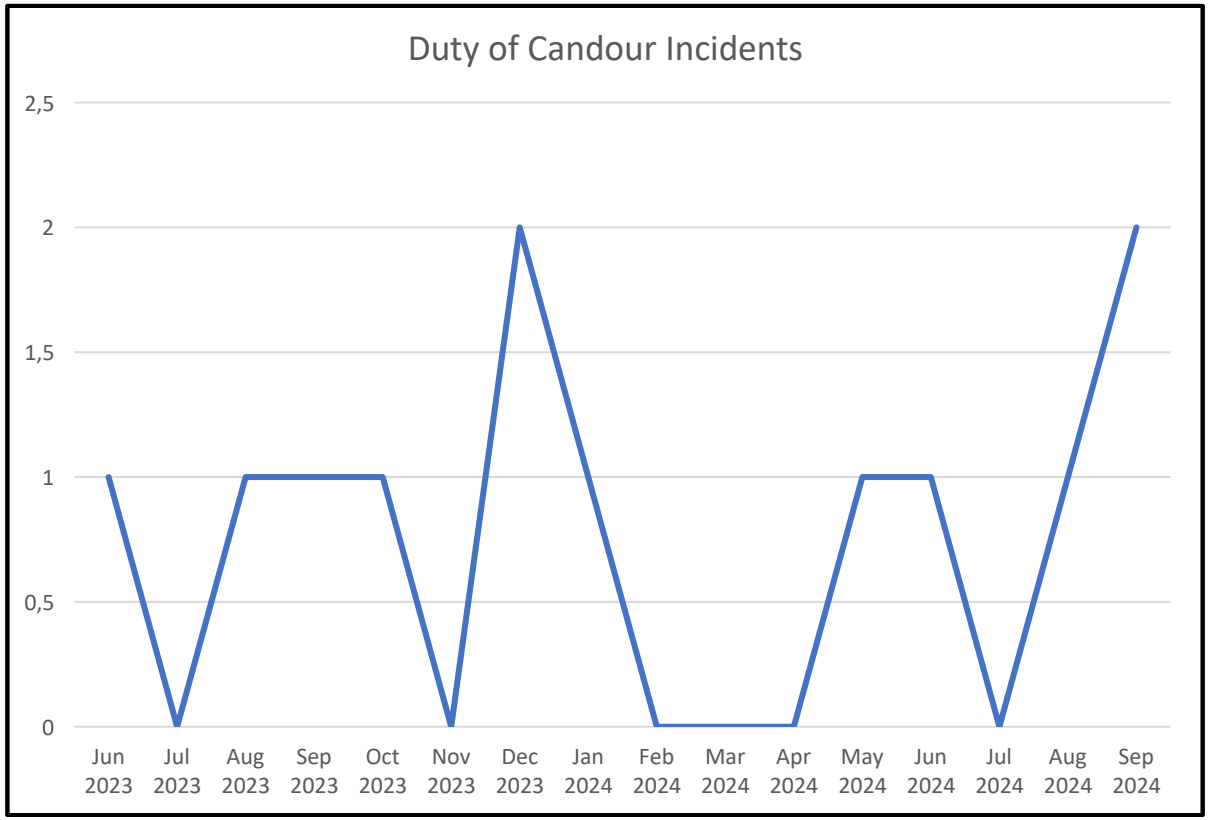




Analysis of incidents is provided per Division in later slides.

6.1 INCIDENTS – DUTY OF CANDOUR

Graph 9



ANALYSIS

As shown in **graph 9** there has been an increase in the number of incidents triggering the Duty of Candour (moderate harm or above), although within 'normal variation'. Two related to clinical decision making, one related to a transcription error.

An incident theme was identified around the management of patient symptoms when they are unwell at home following contact with the SACT Treatment Helpline. One such incident resulted in the tiggering of the Duty of Candour. More detail is provided in section 6.4. A full investigation is being undertaken.

Moderate Harm:
A service user experiences a moderate increase in treatment and significant but not permanent harm, and the care provided by the NHS did or may have contributed.

LEARNING AND OUTCOMES

Immediate make it safe actions:

- Provision of staff support.
- A speedy cascade sent to all staff with information about the management of SACT patients with a temperature of 37.5C or above, and reminding them to follow the UKONS triage tool
- Staff have been encouraged to escalate any clinical concerns to a senior colleague

Velindre University NHS Trust

The ethical duty of openness applies to all incidents, and any failure in care that has occurred whilst being treated through the healthcare that we provide.

The Duty of Candour applies to incidents whereby moderate harm, significant harm, prolonged psychological harm or death has occurred.

Teams across the Trust have engaged in using a matter of judgment that needs to be exercised on a case-by-case basis to determine whether an incident has met the Duty of Candour criteria.

*Our clinical colleagues and support teams have enabled The Trust, **MAKE IT SAFE** reviews, to effectively identify improvements by raising incidents that may not appear to be significant incidents at the outset, however, look very different once more information comes to light.*

A **speedy cascade** is one mechanism used to **share key learning** and messages identified through **patient safety incidents and follows rapid action implementation** after an incident has occurred.

On completion of the full investigation process, a **Learning from Review** event is held, and **feedback is provided to all those involved**, plus the wider teams, to share the **investigation outcome and learning.**

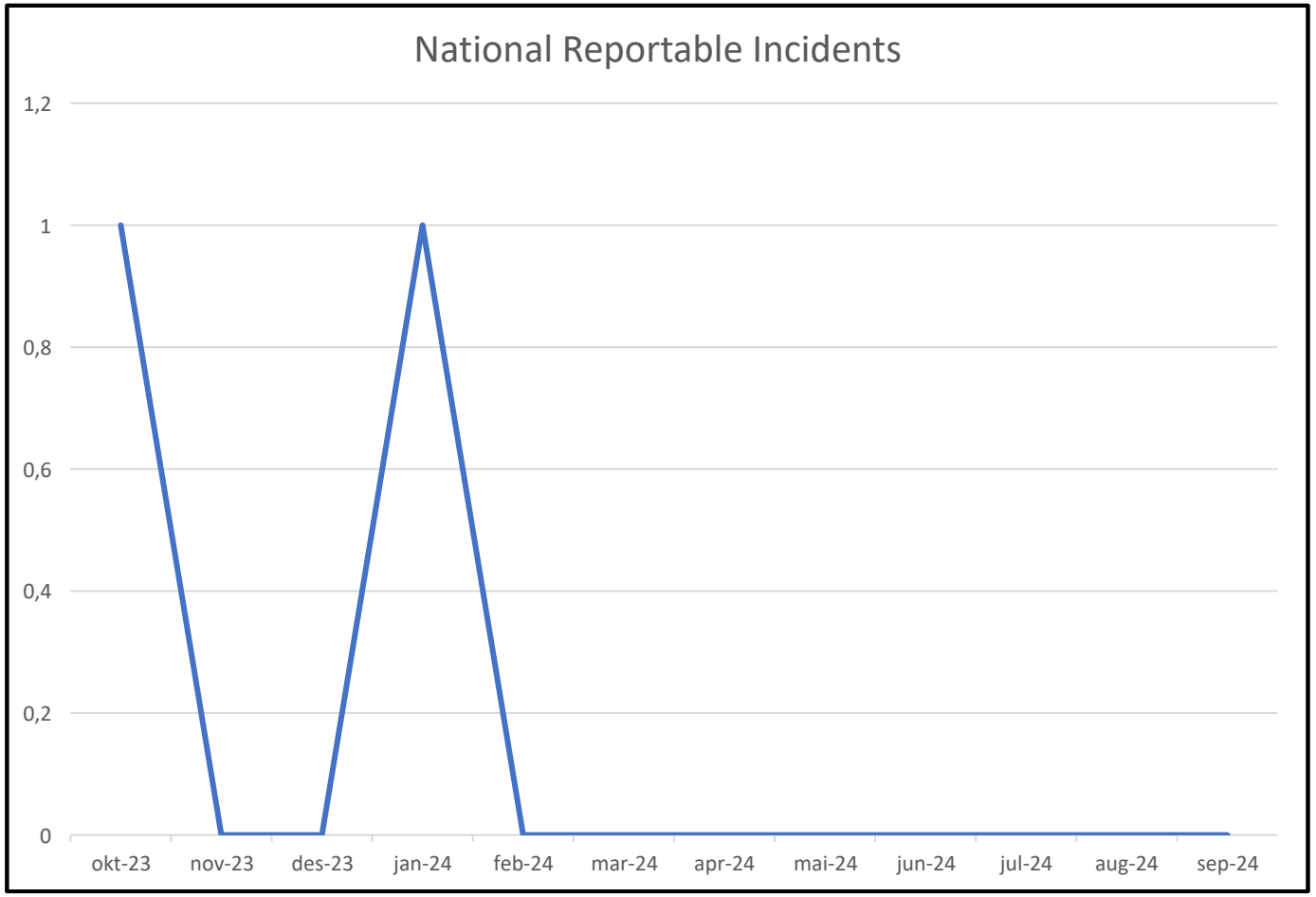
5
MAKE IT SAFE MEETINGS

1
LEARNING FROM REVIEW EVENTS

3
SPEEDY CASCADES

6.2 NATIONAL REPORTABLE INCIDENTS (NRI)

Graph 10



ANALYSIS

Any patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare, is nationally reportable.

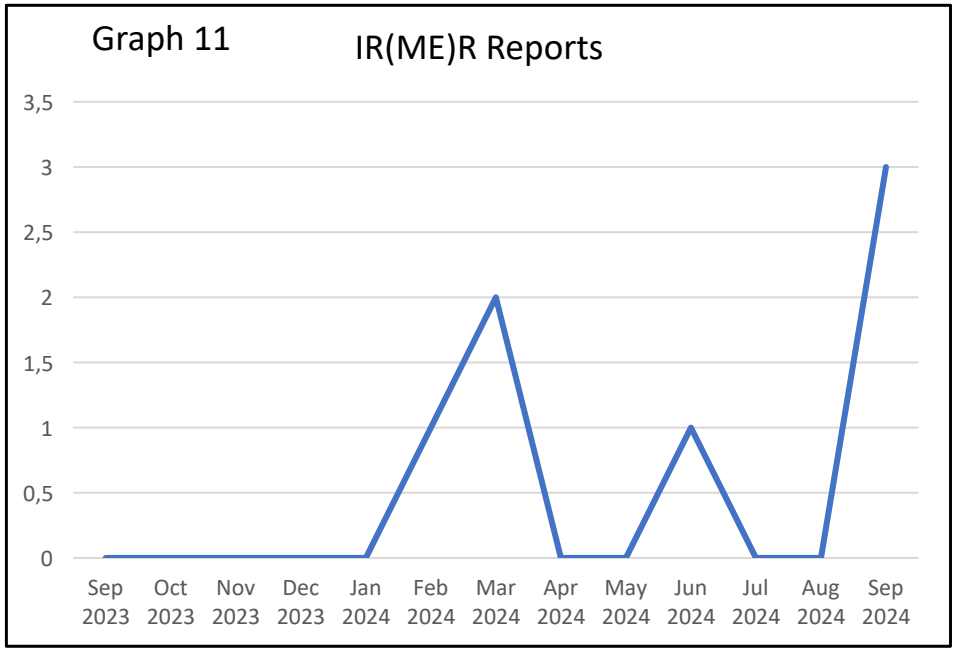
Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

Death:
A service user dies and the NHS care did or may have contributed to the death.

ASSURANCE

As shown in graph 10 there have been no reportable incidents since January 2024.

6.3 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS (IR(ME)R) REPORTABLE INCIDENTS



There were 4, Level 1 Radiation Incidents (RT) reported to HIW during Q2, all during September.

- 1 from Radiotherapy (Incorrect Imaging Preset)
- 3 from Radiotherapy Physics (XVI CBCT failure) as a result in a change in Significant Accidental and Unintended Exposure (SAUE) Guidance.

As shown in **Graph 11** – 4 ionising radiation (medical exposure) regulations IR(ME)R incidents were reported to Health Inspectorate Wales (HIW) during quarter 2.

These incidents relate to patient over-exposure to radiation because of unnecessary scanning.

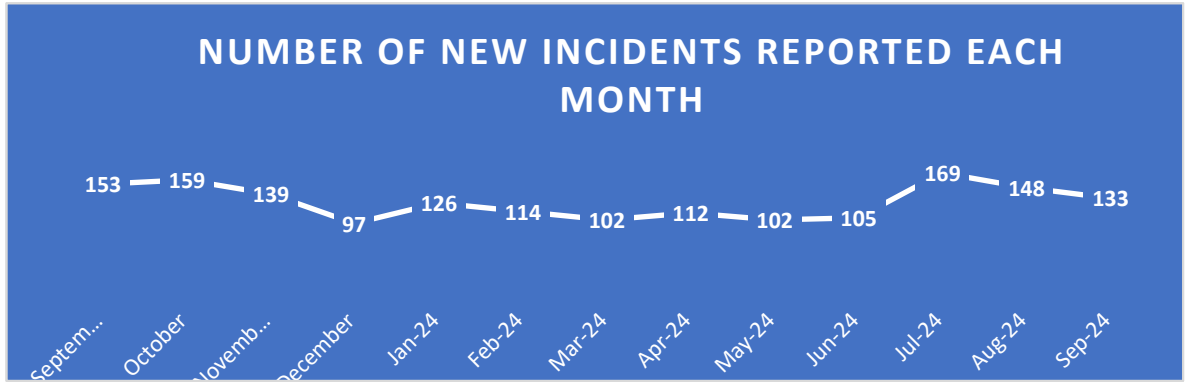
A recent change in Significant Accidental and Unintended Exposure (SAUE) guidance is likely to increase the number of radiation incidents reportable to HIW.

These incidents were previously reported under version 2 of SAUE guidance, were removed from version 3 and have been reintroduced in version 4.

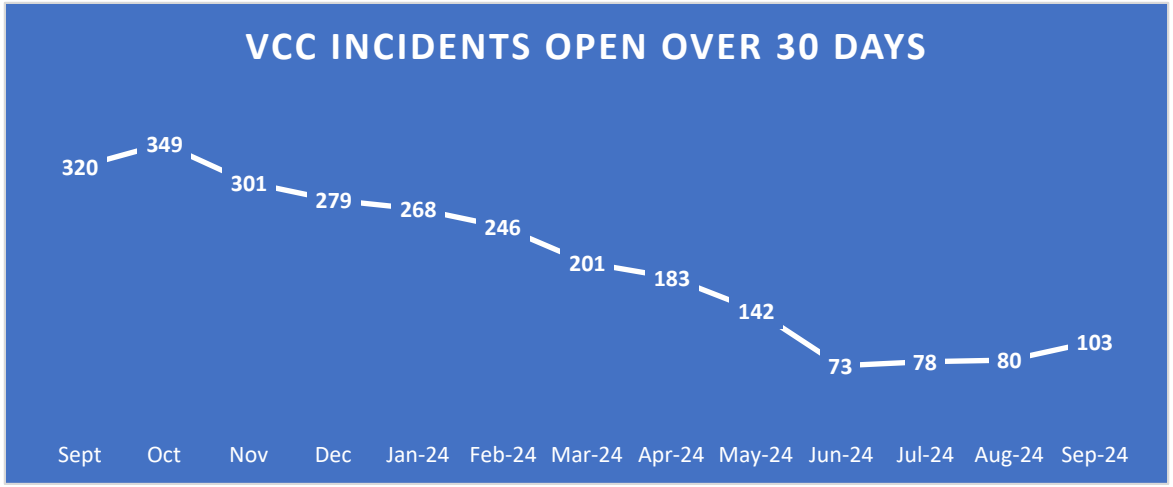
The 3 from RT Physics have long standing mitigations and have been discussed in depth with the IR(ME)R expert from UK Health Security Agency (UKHSA). These are included as a result of the recent change in guidance.

6.4 VELINDRE CANCER SERVICE – INCIDENTS

Graph 12



Graph 13



ANALYSIS

Graph 12: 475 incidents were opened. This is an increase from Q1 (319) but within 'normal variation'. Analysis of the incidents reported do not identify a theme or any increase in incidents that have resulted in patient harm.

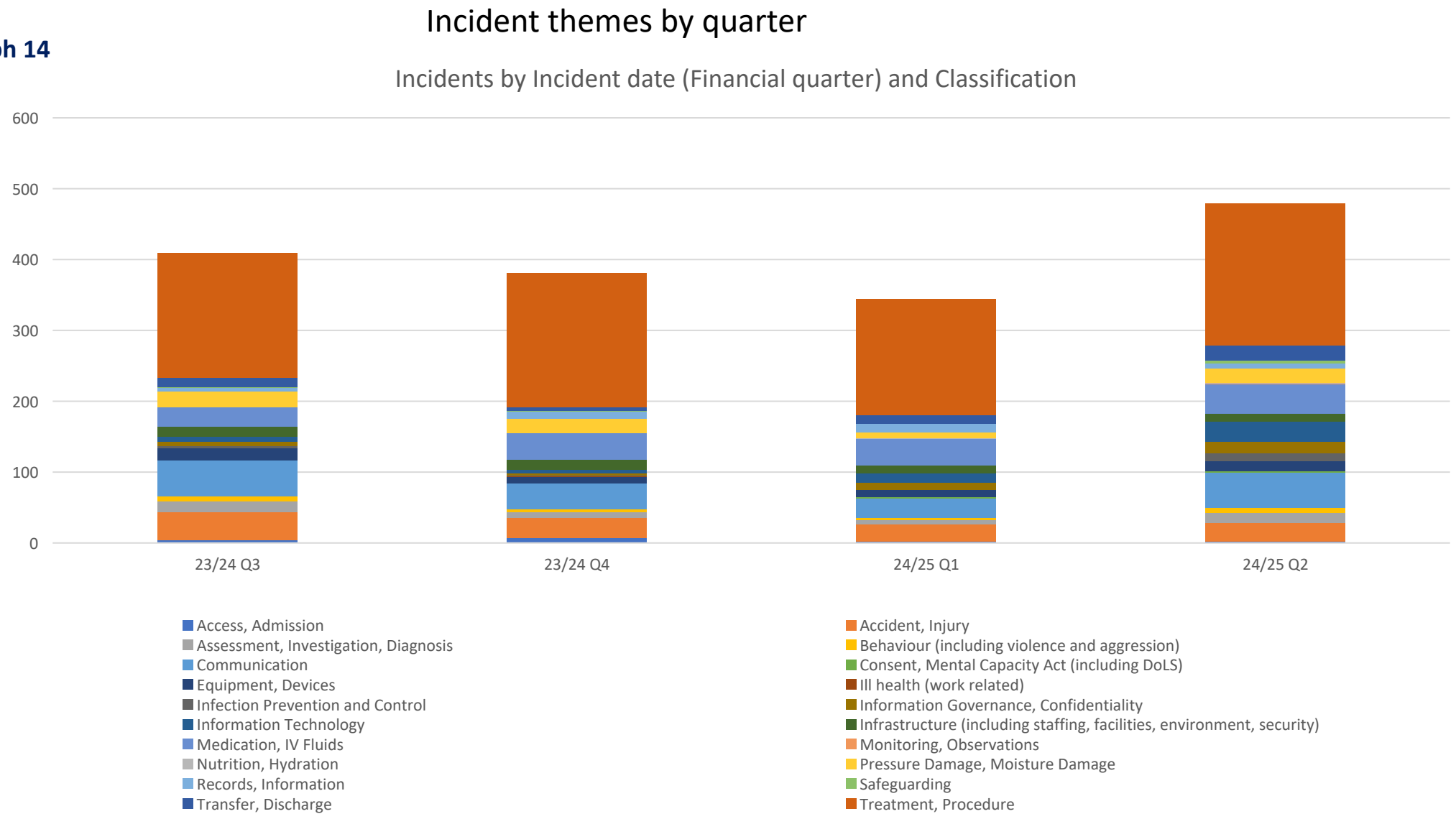
169 of the "Treatment" incidents sit within radiation services.

Graph 13: there has been a significant improvement in the number of incidents open over 30 days however the figures are increasing. The increase is seen in the areas with the highest clinical pressures. Within SACT, some staff changes have been undertaken which will see resources available to prioritise Datix incident management to ensure timely review and closure of incidents.

The increase in incidents open over 30 days is also compounded by a national issue within OFW Datix resulting in 69 previously closed incidents have been reopened by OFW Datix. The Quality and Safety team are working with the departments to manage these.

6.4 VELINDRE CANCER SERVICE – INCIDENTS

Graph 14



LEARNING AND OUTCOMES

3 incidents reported during the quarter are being managed in line with Duty of Candour regulations as they have potentially caused moderate harm to the patients involved. No incidents have been identified as causing severe harm.

A theme was identified around the telephone helpline management of patient symptoms when they are unwell (with a high temperature). Management of specific symptoms have been clarified and processes updated and shared with the treatment helpline staff. A speedy cascade has been shared with all VCC staff. Referral routes into Health Boards SDEC (Same Day Emergency Care) has been strengthened resulting in patients not always needing to self-present in the Emergency Department.

Learning and improvement has been made in relation to transcribing information and the importance of documenting patient information directly on to their electronic casefile (Welsh Clinical Portal). Learning has been shared via speedy cascade to all clinical staff regarding updating a patient's weight when prescribing chemotherapy.

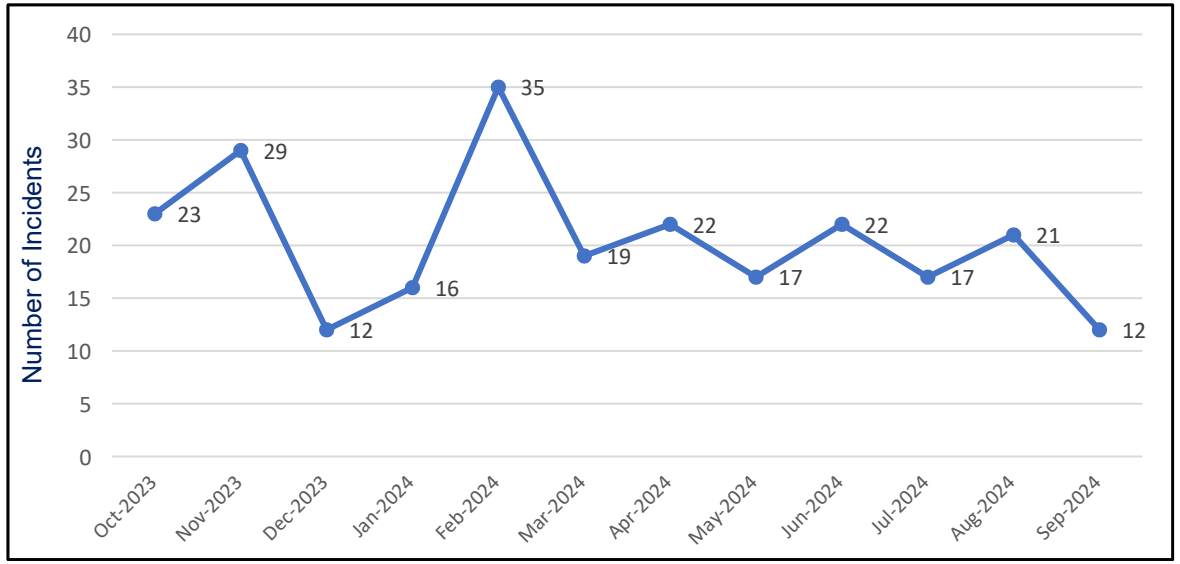
OTHER LEARNING IDENTIFIED THROUGH INCIDENTS

- Theme continues within incidents around the use of emails, particularly high-volume email traffic, and use of emails for clinical communication. An email working group has been established and met within the quarter to identify solutions and improved ways of working.
- There is a “Speedy Cascade” page on the Trust Intranet meaning vital patient safety learning is shared with all staff within the Trust and remains visible for ongoing reference and learning.
- It has been identified that there are a number of letters awaiting approval over 30 days. Improvement plan related to this issue has been reviewed and updated. The risk related to the issue has been reopened. It is a monthly KPI being monitored through SLT. Training and communication shared with all relevant staff.

6.5 WELSH BLOOD SERVICE – INCIDENTS

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

Graph 15 New incidents reported each month



Graph 16 Trend of overdue incidents and actions

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Overdue Incidents from Datix	1	0	8	0	1	6	6	2	2	3	2	7
Overdue Actions from QPulse	10	11	6	17	50	25	9	17	8	7	14	5

ANALYSIS

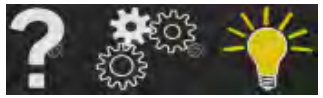
Graph 15: incident reporting via Datix remains consistent, except for September where there were fewer than average reports submitted. Presently this is not cause for concern but will be monitored.

There were only 7 incidents open in Datix beyond 30 days at the end of quarter two.

Overdue activity performance trends

The number of incidents exceeding the target date for closure (30 days) remains low, with the number of overdue actions increasing slightly during August, potentially due to summer holidays, although this number fluctuates month on month.

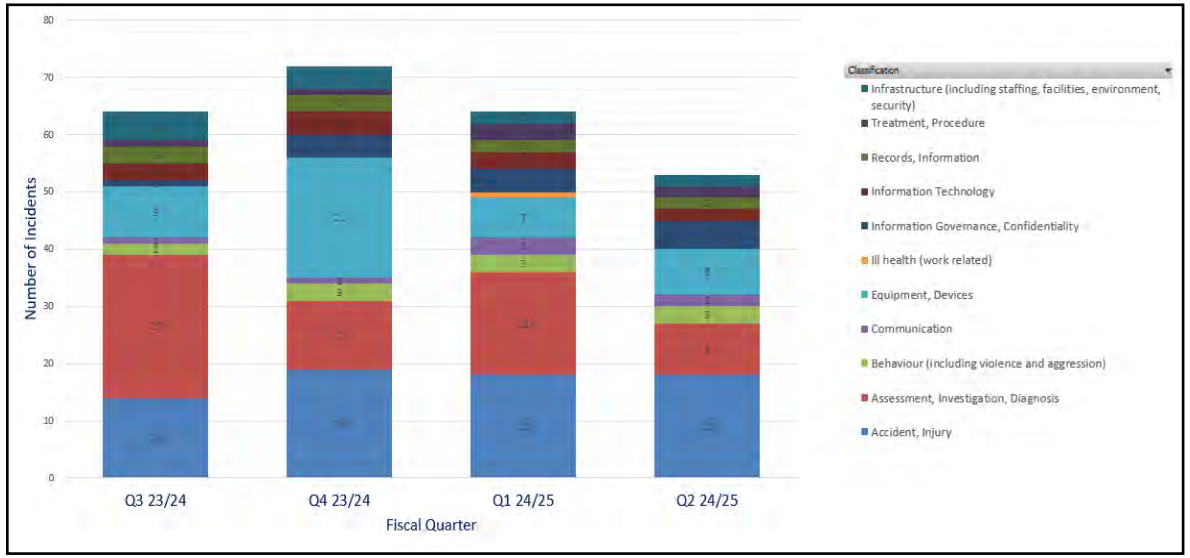
Quality Assurance Triage continue to engage with incident managers and investigators and information is shared with departmental managers and SLT, to help drive improvement in timely management of reports.



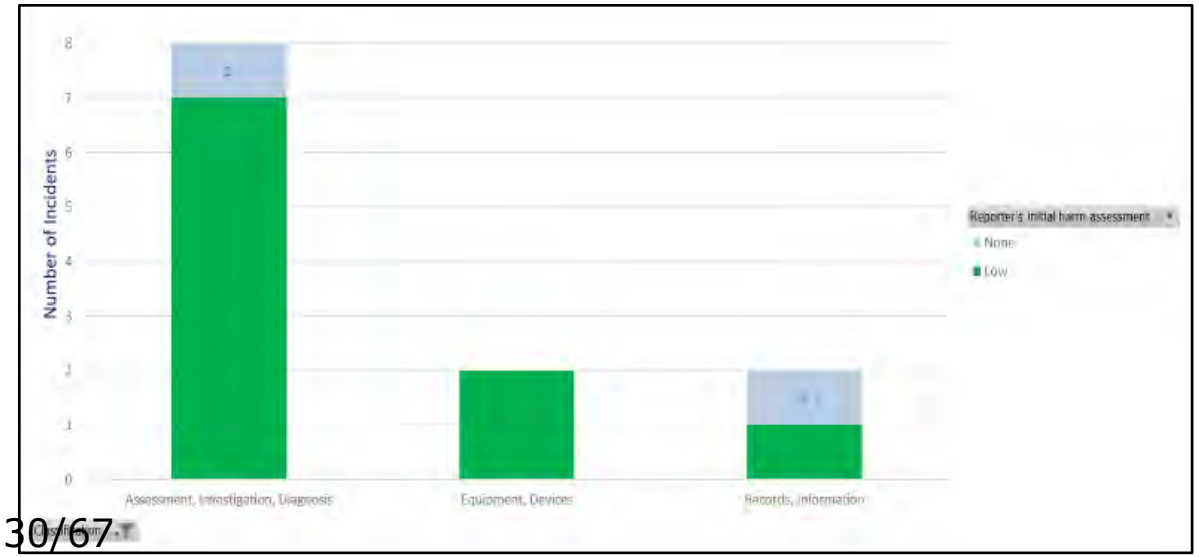
LEARNING AND OUTCOMES

A Task & Finish group has explored the cause of delays within the incident management process. This group identified a lack of clarity for users about ownership of the different incident management stages.
Two workshops are due to be delivered in November, to aid staff members' understanding of process of reviewing and moving reports through each stage and ensuring correct ownership of the stages.

Graph 19 WBS Incidents by theme – Quarterly comparison



Graph 20 Datix GMP Incidents reported July to September 2024



ANALYSIS

Graph 19: the most frequently reported themes in quarter 2 are:

- Accidental injury (18)
- Assessment investigation diagnosis (9)
- Equipment and devices (9)

LEARNING AND OUTCOMES

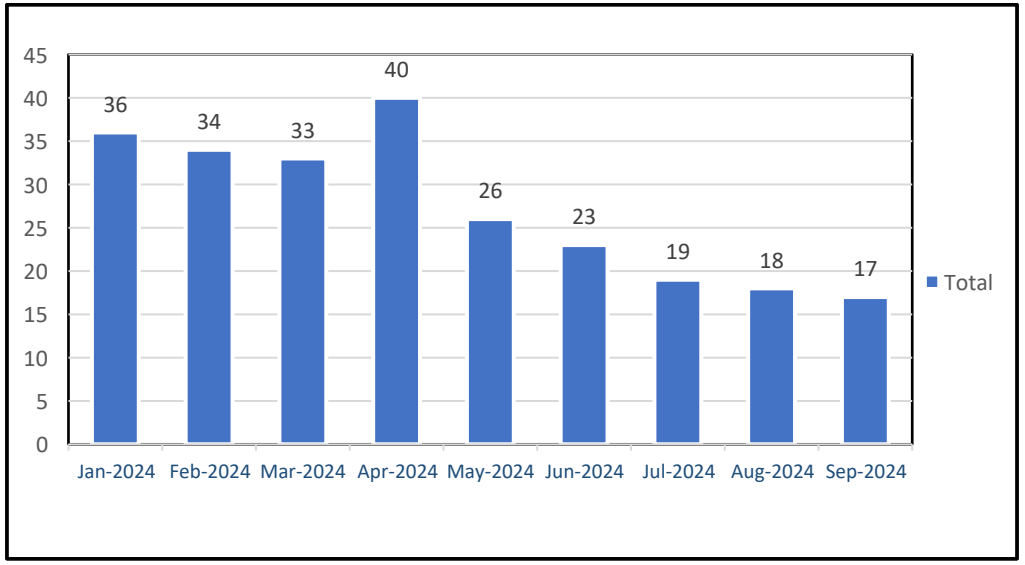
Graph 20: twelve incidents relating to quality and safety of blood components were reported.

All were ‘low’ or ‘no harm’ events which have been investigated, with no significant trends or learning identified.

More information on accidental injury reports can be found in the Health and Safety section of the report.

Good Manufacturing Practice (GMP) Incidents, i.e. those 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, 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.

Graph 21 - GMP Incidents reported via Q Pulse 2024



ANALYSIS

Graph 21: 54 Good Manufacturing Practice incidents were reported via Qpulse, compared to 84 in Quarter 1. The steady decline in reports since May reflects the decision by Welsh Blood Service Integrated Quality & Safety Hub to report events such as 'clip errors' only when there is an identified trend with an individual. The process for managing such events is proceduralised and therefore no process deviation has occurred. Where deviation from process does occur, this is reported as an individual event.

One event, involving a repeat result discrepancy for Foetal D Rh screening, was given a 'significant' risk rating. A full root cause analysis is being undertaken.

LEARNING AND OUTCOMES

The outcome and learning arising from the Root Cause Analysis investigation will be reported to the WBS Integrated Quality & Safety meeting.

ANALYSIS

There were **2 events** reported externally. Both incidents were investigated by multi-disciplinary teams involving subject matter experts and members of the Clinical and/or 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.

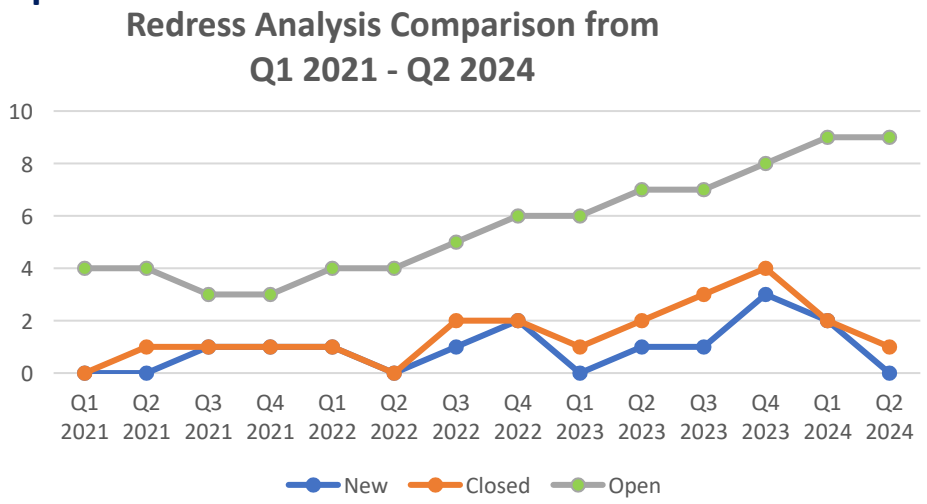
- 1 event was reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in this reporting period. This related to a donor selection error
- 1 event report to the Human Tissues Authority. This related to the incorrect reporting of a stem cell harvest yield as less than 90% of the requested dose.

Both investigation reports are awaiting formal reviewed and closure by the relevant regulator.

No theme or trend identified. Both incidents involve human error. Early learning shared some human factors findings and communicated with relevant teams.

7. REDRESS

Graph 22



LEARNING AND OUTCOMES

Whilst Redress cases are often seen as a negative, they nonetheless, offer the Trust an opportunity to improve its services with the aim of preventing future harm and loss. When harm is identified, the Trust addresses the learning by submitting a Learning from Events Report to the WRP. This incorporates the evidence of the learning undertaken. Without the WRP's approval, the Trust is unable to seek reimbursement and cannot recoup any monies paid out in settlement of a case. prevent missed follow ups and monitoring of patients:

-Strengthening the induction process for clinicians
-Introducing SpR and junior doctor handbooks
-Implementing a SHO practical guide
-Implementing the VCC Discharge Policy
-Implementing the patient discharge checklists

ACTIVITY

- **No Redress cases were opened**
- **5 cases remain under investigation**
- **1 submission of Learning from Events Report (LfER) and reimbursement sought from Welsh Risk Pool (WRP). The approval is awaited.**
- **2 cases presented at PTR Panel have not established a qualifying liability**
- **1 case closed following rejection of financial compensation.**

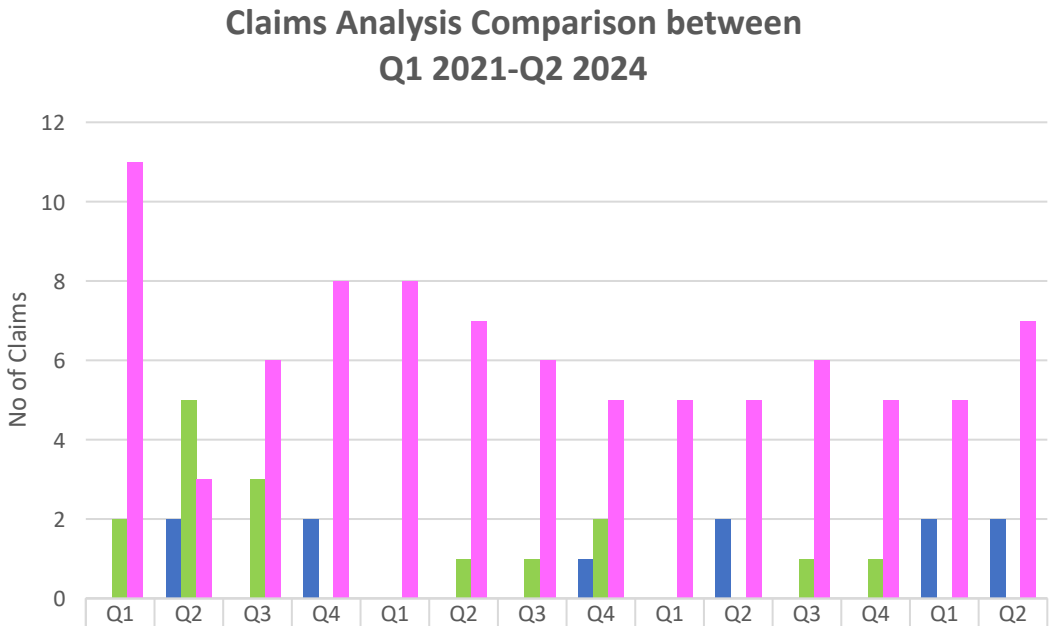
8. CLAIMS

Graph 23 provides an illustration of the claims activity in comparison to previous quarterly reporting, beginning with a data comparison of closed, new and open cases from Q1 2021/22 up until Q2 2024/25.

During Q2 no new claims were received and no claims were closed. The claims portfolio for the reporting period continues to remain relatively stable.

- **Financial Liability:** The Trust's estimated financial liability for claims at the end of the quarter was £2,514,576.23.
- In the event the Trust were to settle its current caseload, the Trust's liability has risen to £204,244.00.

Graph 23



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024
New	0	2	0	2	0	0	0	1	0	2	0	0	2	2
Closed	2	5	3	0	0	1	1	2	0	0	1	1	0	0
Open	11	3	6	8	8	7	6	5	5	5	6	5	5	7

8. CLAIMS CONT.

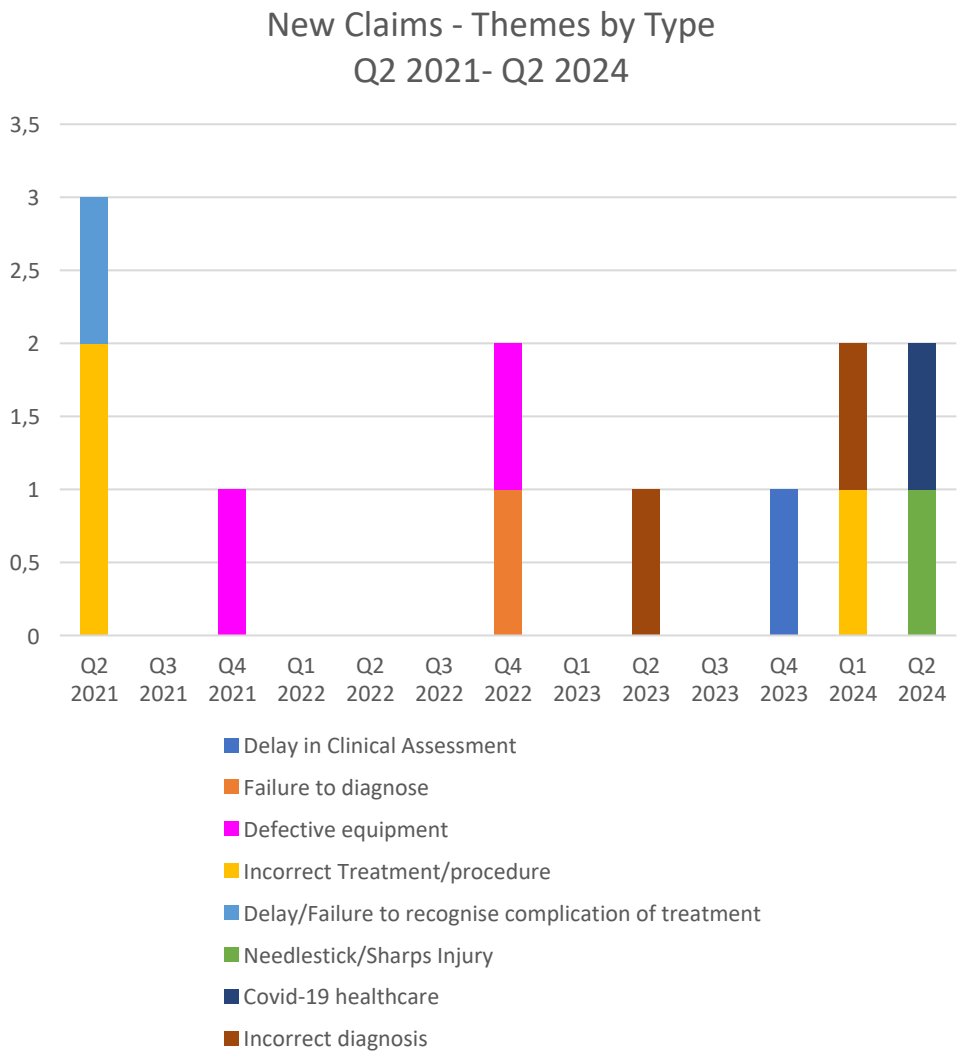
Themes and Trends

Graph 24 demonstrates the comparison of clinical negligence claims and personal injury claims against the Trust from Quarter 2 2021/22 up until Quarter 2 2024/2025.

The clinical negligence themes vary, as indicated in the chart opposite, however, the highest theme relate to allegations of incorrect treatment/procedure, followed by incorrect diagnosis. Delay in clinical assessment and failure to diagnose are the third highest themes identified from the data analysis.

A new theme of personal injury claims was seen during the quarter. These relate to defective equipment, sharps injury and healthcare acquired virus.

Graph 24

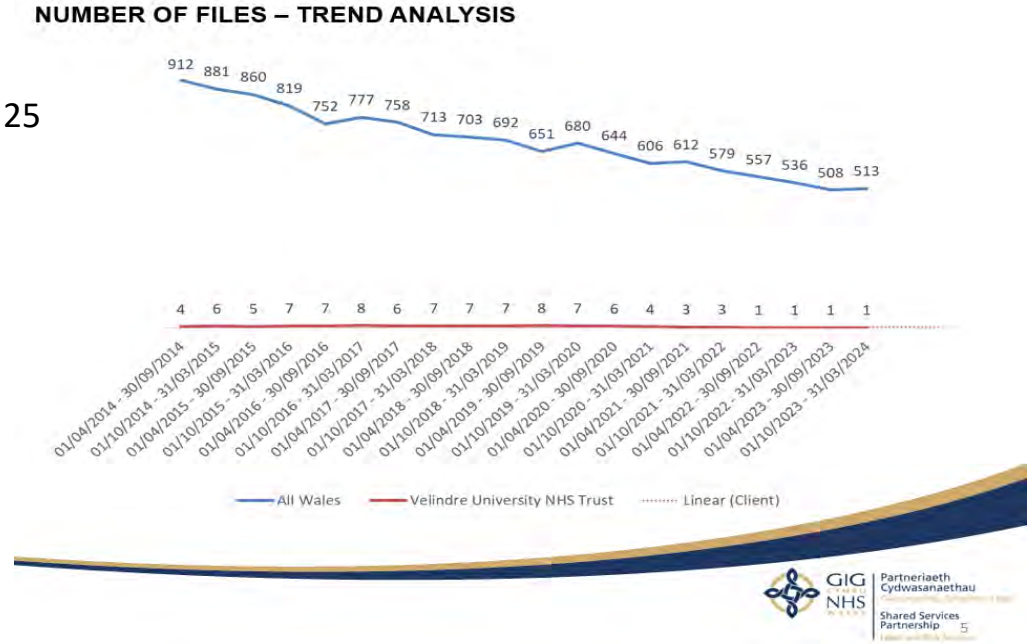


8. CLAIMS CONT.

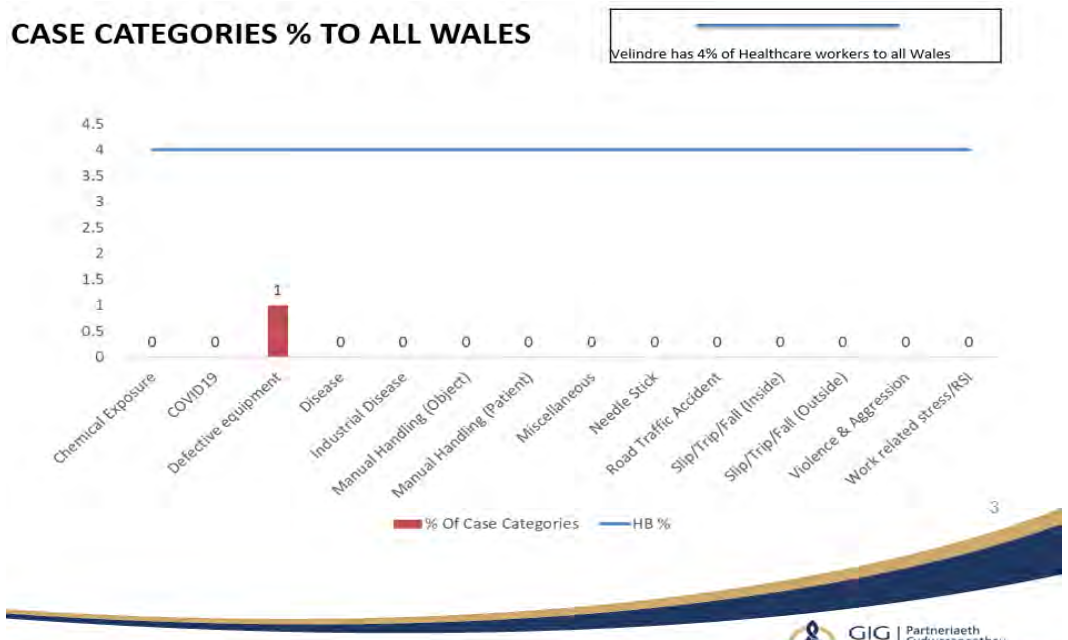
NWSSP L&R Personal Injury (PI) Claims Review

In comparison to other NHS Welsh Health Boards/Trusts, Personal Injury claims brought against the Trust continue to remain relatively small. During Q2, NWSSP Legal and Risk Services published their PI file review for the period October 2023 – March 2024. The data analysis in the graphs opposite and below, demonstrate an overall saving of **£3,021,214.12.** This is a testament to the collaborative working of NHS claims teams across Wales to robustly defend claims, where possible, with the aim of reducing costs and minimising damages.

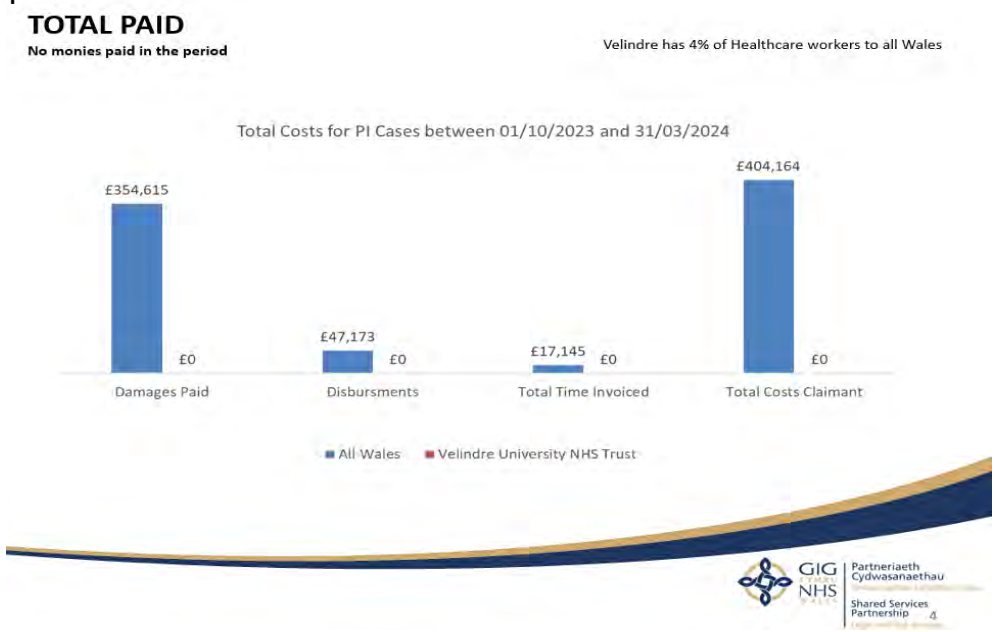
Graph 25



Graph 26

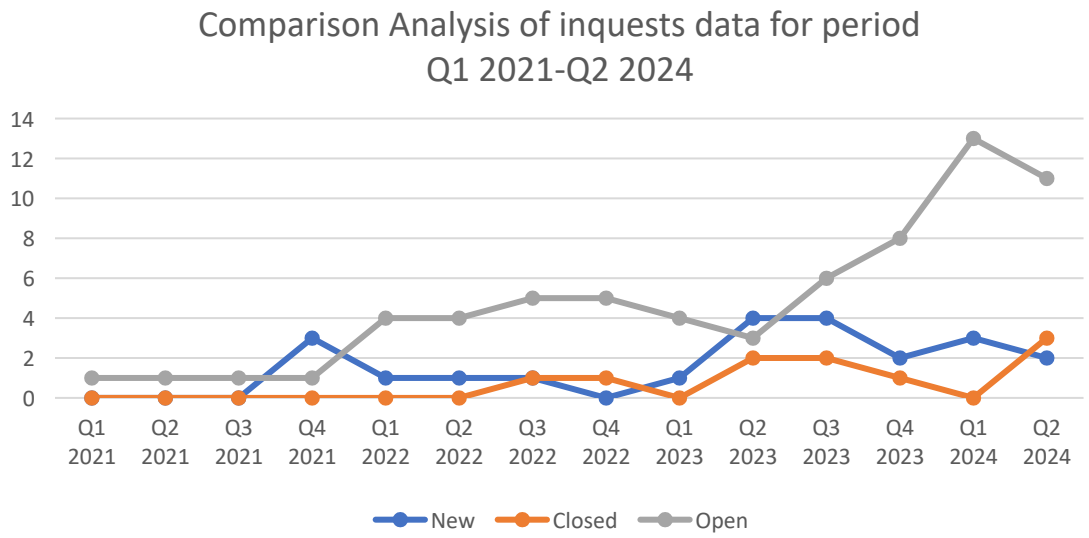


Graph 27



9. INQUESTS

Graph 28



During Quarter 2:-

- **2 new inquests were open**
- **11 inquests remain ongoing with 2 inquests listed for hearing (November 2024 & March 2025).**
- **3 inquests were closed during the quarter.**

**Please note that the graph above, no longer includes Marie Curie Hospice inquests. Trust personnel provide statements for the Coroner in such inquests.*

A Coroner will hold an inquest if the cause of death is unknown, unnatural or violent, or if a person dies whilst in Police custody.

ANALYSIS

Graph 28: Inquests have continued to see a steady rise, however, there are no trends or themes that indicate that the Trust is at risk.

The Trust Quality and Safety Team continues to work with divisions to ensure that learning is addressed to mitigate against the risk of a Regulation 28 Future Deaths Report and that the Coroner's timelines for disclosure of information and requests for Witness Statements are met.

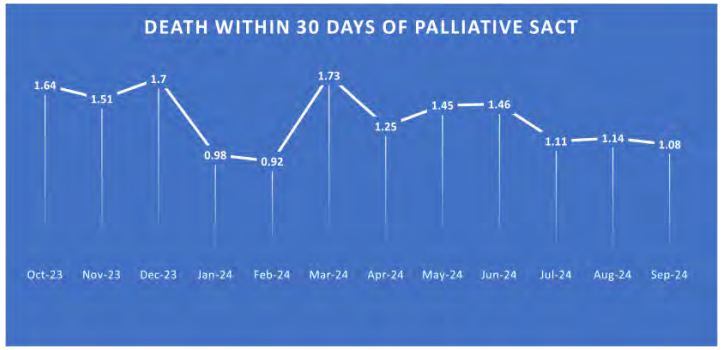
10. MORTALITY

Death within 30 days of Curative SACT
Graph 29 below demonstrates the percentage deaths following 30 days of curative SACT.

Graph 29

Death within 30 days of Palliative SACT
Graph 30 below demonstrates the percentage deaths following 30 days of palliative SACT.

Graph 30



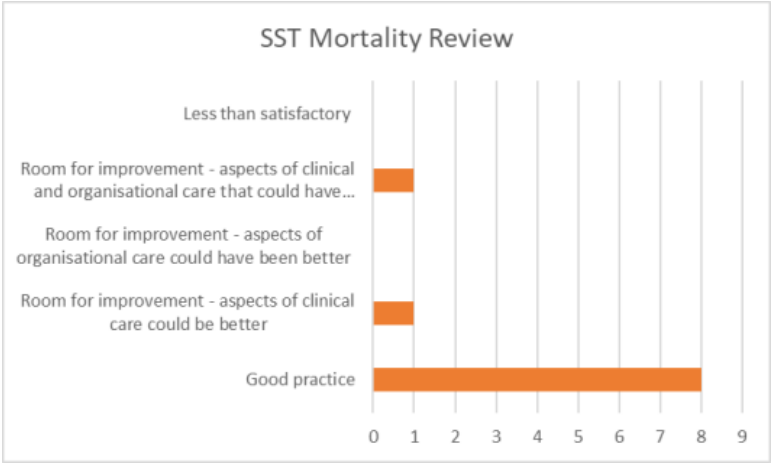
ANALYSIS

Systemic Anti Cancer Treatment (SACT) mortality data continues to be captured and reported monthly. There is no benchmark available for curative and palliative SACT, however an overall death within days of SACT mortality rate of 2% has been widely adopted following National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report in 2008. Velindre Cancer Centre SACT 30 days mortality figures remain below this.

Site Specific Tumour (SST) mortality reviews to review all patients who die within 30 days of SACT and 30 days of palliative radiotherapy and 90 days of radical radiotherapy have been established in nearly all SST's with one meeting being held in Q2.

There remains data validity issues with radiotherapy data resulting in radiotherapy mortality data not being yet reported. The data an insight team are working on resolving the issues with the hope of reporting radiotherapy mortality data in Q3. Death within 30 and 90 days of radiotherapy continues to be captured and reviewed by the mortality team and the SSTs.

LEARNING AND IMPROVEMENT



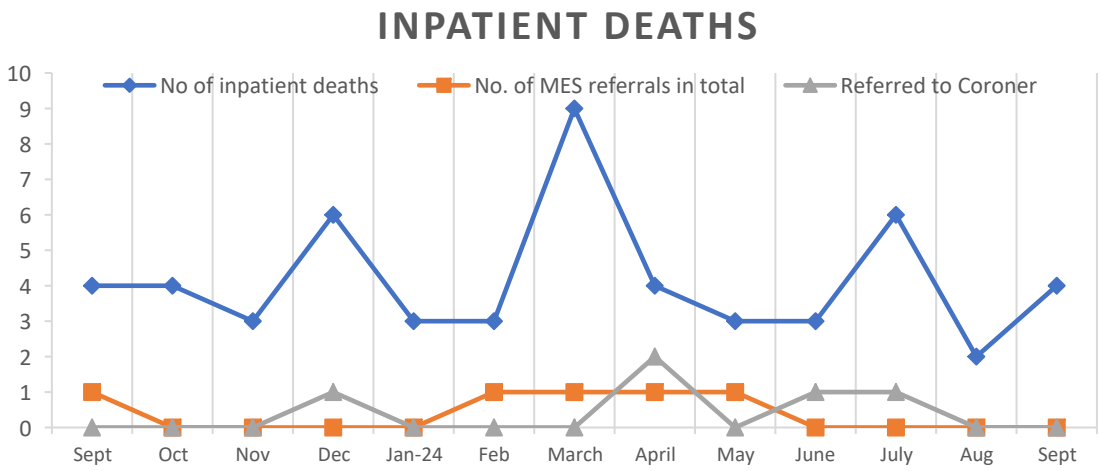
- Management of raised blood glucose on treatment helpline and education and guidelines updated for treatment helpline staff
- Importance of reviewing recent patient electronic case notes when attending for day treatment and escalating raised NEWS - highlighted the need for an Advanced Clinical Practitioner in outreach.

10. MORTALITY CONT.

ANALYSIS

The Cancer Centre is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCC and feeding back findings and identifying learning.
The Medical Examiner Service and Reforms to Death Certification came in to play on 9th September 2024. VCC are fully compliant and provided information and education to medical staff in preparation for the reforms. There have been no concerns or incidents raised. One case was referred to coroner due to potential delay in diagnosis of cancer.
During the quarter no clinical concerns were identified from MES or VCC Inpatient Mortality Reviews. No themes or trends were identified.

Graph 31



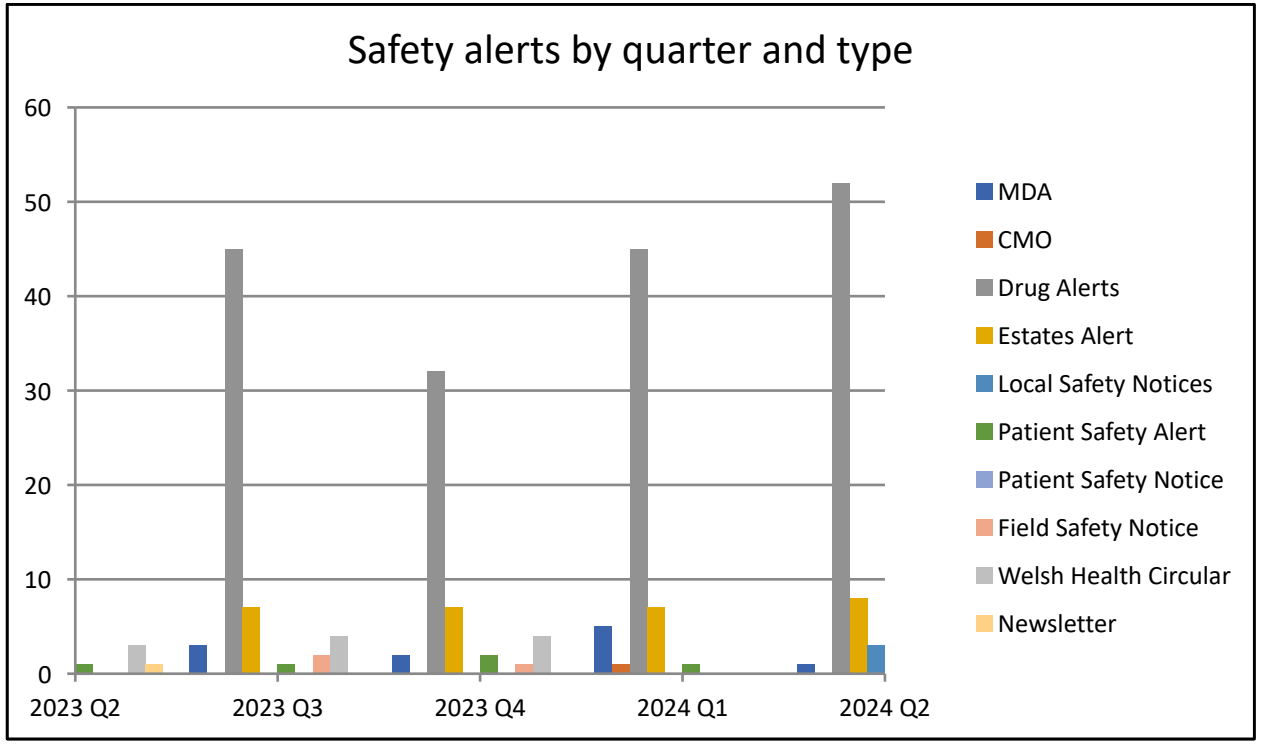
LEARNING AND IMPROVEMENT

Although no clinical concerns were identified from the medical examiner service, an opportunity for learning was identified form the inpatient mortality review meeting that resulted in:

- Identified need for stoma care education and knowledge within the cancer centre. ANP with extensive surgical experience and Tissue Viability Nurse to develop training session for nursing and palliative care staff.

11. SAFETY ALERTS

Graph 32



ANALYSIS

69 Safety alerts were received.

Overall, the number of safety alerts received over the year has steadily risen.

THEMES AND OUTCOMES

As shown in **Graph 32** - Drug and estates related safety alerts continue to be the highest number of alerts received every quarter.

2 Safety Alerts remain open for VCC, with action underway. These relate to shortages of Calcium Folinate 10mg in 1ml solution injectable vials and the Calde 1 Mpox virus. No issues to escalate.

POSITIVE ASSURANCE

Each of the alerts received have been emailed to, and reviewed by, subject matter leads who are responsible for reviewing the alert and providing confirmation back to Corporate Services as to whether the alert is applicable to the Trust.

Welsh Health Circular

Received
28th August 2024

Actions commenced
29th August 2024

Deadline for Compliance
30th September 2024

Oxygen Cylinders – Regulation 28 Report and Patient Safety Notice (PSN) 042 reminder

Letter from Sue Tranka
DOUBLE CLICK ON IMAGE TO VIEW…

A Regulation 28 'Prevention of future deaths' coroner's report has been received following the death of a patient in Welsh NHS after the incorrect use of Oxygen CD cylinders - manufactured by BOC. A Patient Safety Notice (PSN)041 was issued in 2018 which related to the operation of Oxygen CD cylinders, manufactured by BOC. Given the number of incidents that are still happening, the recommendations in PSN041 do not appear to have been fully implemented or addressed.

All NHS Wales organisations need to consider the lessons to be learnt from this Regulation 28 report, and the actions in (PSN)041 contained within the link below:
https://du.nhs.wales/files/notices/psn041-flow-failure-from-oxygen-cylinders-pdf/

Actions completed:

1. To identify if oxygen cylinders are used in your organisation, even if only in emergencies.
2. To bring this notice to the attention of all those with a leadership role in ensuring clinical staff understand how to operate oxygen cylinders safely.
3. To consider if immediate local action is needed and ensure that an action plan is underway to reduce the risk of incorrect use of oxygen cylinders.
4. To communicate the key messages in this notice and your local action plan to all relevant staff.

12. INFORMATION GOVERNANCE

Introduction - Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links data quality management, records management, information management, information sharing, information security (including ICT security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability, security and confidentiality and the collection, storage and dissemination of information.

Incidents and Investigations Total number of incidents for the quarter **plus** a 2-year run graph displaying the themes and trends.

Reported to the ICO – it is a legal requirement to report certain types of incident to the ICO (where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals). RCA will also be conducted as a matter of course.

Root Cause Analysis – where the cause of the incident is not immediately clear, the Head of IG to conduct a more in-depth investigation.

Subject Access Requests – the legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.

Data Protection Impact Assessments/Data Processing Agreements – it is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement.

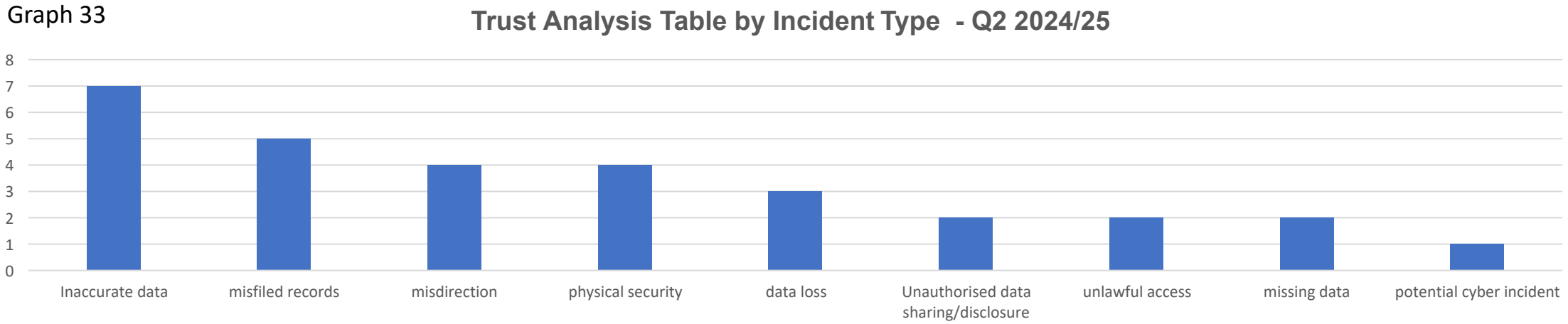
Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation			
					Low Risk / No Harm	Root Cause Analysis	Total	DATIX Open	DATIX Closed	Total	IG Complete
Corporate Services	1	0	1	0	1	0	1	1	0	1	1
Velindre Cancer Services	23	0	23	0	23	0	23	14	9	23	22
Information Technology	0	0	0	0	0	0	0	0	0	0	0
WBS	6	0	6	0	6	0	6	1	5	6	6
TCS	0	0	0	0	0	0	0	0	0	0	0
Total Trust	30	0	30	0	30	0	30	16	14	30	29

12. INFORMATION GOVERNANCE CONT.

Analysis Table for Trust Incidents – 1st July 2024 – 30th September 2024

Reason	Number of incidents	VCC	WBS	CORP	Open	Closed	IG Complete	RCA required	Reported to ICO
Misdirection	4	3	1	0	2	2	4	0	0
Unauthorised Data Sharing/Disclosure	2	1	1	0	0	2	2	0	0
Inaccurate Data	7	6	0	1	5	2	7	0	0
Unlawful access	2	2	0	0	2	0	2	0	0
Misfiled Records	5	5	0	0	5	0	5	0	0
Potential Cyber Incident	1	1	0	0	0	1	1	0	0
Physical Security	4	3	1	0	1	3	4	0	0
Data Loss	3	2	1	0	1	2	2	0	0
Missing data	2	0	2	0	0	2	2	0	0
Total Trust	30	23	6	1	16	14	29	0	0

Graph 33



12. INFORMATION GOVERNANCE CONT.

NWSSP Incidents – Q2 2024/25 – 1st July to 30th September 2024

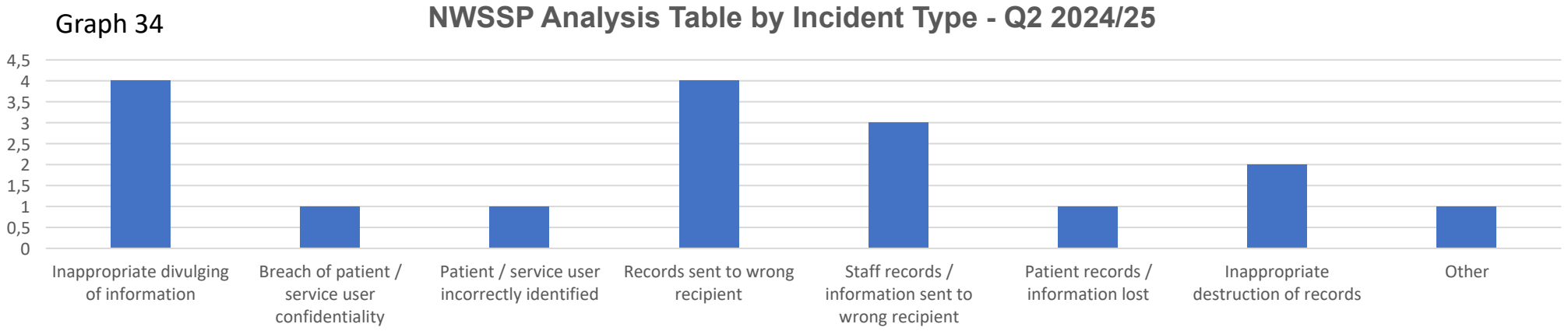
Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation			
NWSSP					Low Risk / No Harm	Root Cause Analysis	Total	DATIX Open	DATIX Closed	Total	IG Complete
Employment	4	0	4	0	4	0	4	0	4	4	4
Medical Examiner	4	0	4	0	4	0	4	0	4	4	4
Primary Care	8	0	8	0	8	0	8	0	8	8	8
Health Courier	1	0	1	0	1	0	1	0	1	1	1
Total	17	0	17	0	17	0	17	0	17	17	17

Analysis Table for NWSSP Incidents – Q2 2024/25 – 1st July to 30th September 2024

Reason	Number of incidents	Open	Closed	IG Complete	RCA required	Reported to ICO
Inappropriate divulging of information	4	0	4	4	0	0
Breach of patient / service user confidentiality	1	0	1	1	0	0
Patient / service user incorrectly identified	1	0	1	1	0	0
Records sent to wrong recipient	4	0	4	4	0	0
Staff records / information sent to wrong recipient	3	0	3	3	0	0
Patient records / information lost	1	0	1	1	0	0
Inappropriate destruction of records	2	0	2	2	0	0
Other	1	0	1	1	0	0
Total	17	0	17	17	0	0

12. INFORMATION GOVERNANCE CONT.

Graph 34



VCC (Medical Records) Subject Access Requests – 1st July 2024 – 30th September 2024

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
July	16	2	12	2	16	75%
August	27	3	24	0	27	100%
September	15	7(2*)	6	0	13	*expected to be high percentage

*2 paused due to awaiting further documentation/information, New member of Staff in place from 5/8/24, result is significant improvement.

Corporate (Non-Medical Records) Subject Access Requests – 1st July 2024 – 30th September 2024

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
July	3	3	100%
August	1	1	100%
September	0	0	100%

WBS (Donor Records) Subject Access Requests – 1st July 2024 – 30th September 2024

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
July	14	14	100%
August	11	11	100%
September	6	6	100%

12. INFORMATION GOVERNANCE CONT.

NWSSP Subject Access Requests – Q2 2024/25 – 1st July to 30th September 2024

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
July	0	n/a	n/a	n/a	0	n/a
August	0	n/a	n/a	n/a	0	n/a
September	0	n/a	n/.a	n/a	0	n/a

2024/25 Trust DPIA Activity

Quarter	DPIA'S Commenced	VCC	WBS	Corporate	TCS	Completed in Quarter (for entire financial year including DPIA commenced in previous quarters)	Ongoing	Not commenced	Paused
Q4 2023/24	15	9	1	5	0	3			
Q1 2024/25	13	5	5	3	0	2			
Q2 2024/25	19	12	2	4	1	12			
Total	47	26	8	12	1	17	27	2	1

NWSSP DPIA Activity 1st July to 30th September 2024

Quarter	DPIA'S Commenced	Complete	Ongoing	Not commenced
Q2 2024/25	3	1	2	0

2024/25 All-Wales DPIA Activity

Quarter	DPIA'S Commenced	VCC	WBS	Corporate	Complete	Ongoing
Q1 2024/25	6	3	0	3	0	6
Q2 2024/25	2	0	0	2	1	1
Total	8	3	0	5	1	7

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

2024/25 Trust Data Processing Agreement Activity

Quarter	DPA'S Commenced	VCC	WBS	Corporate	Complete	Ongoing
Q1 2024/25	5	4	0	1	1	4
Q2 2024/25	8	4	1	3	2	6
Total	13	8	1	4	3	10

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

Training Statistics by Division for the Trust – 1st July 2024 – 30th September 2024

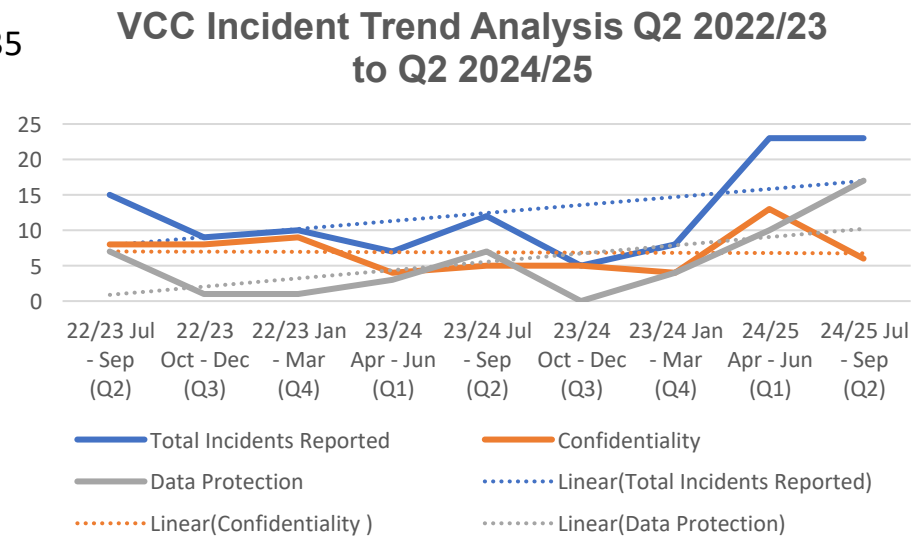
% Compliance Standards	% attainment
Minimum Standard	75%
Target Standard	85%

Division	% attainment		
	July	August	September
TCS	85.00	85.71	85.71
RD&I	88.33	91.53	90.16
WBS	92.64	90.28	86.48
VCC	78.44	77.64	77.52
Corporate	84.78	85.65	87.34
Trust Overall	83.52	82.63	81.70

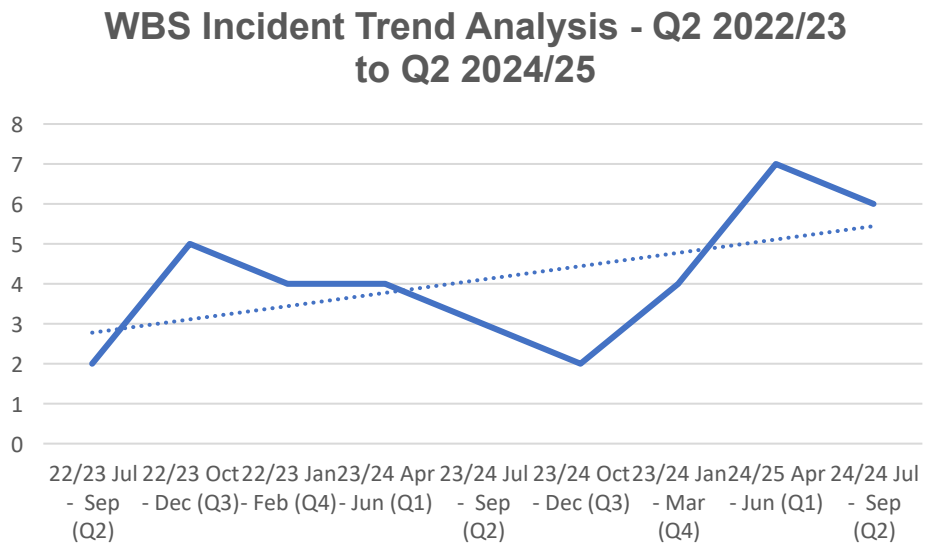
Division	% attainment		
	July	August	September
NWSSP	88.20%	89.90%	89.37%

2-year Trend Analysis and Monthly ESR Compliance

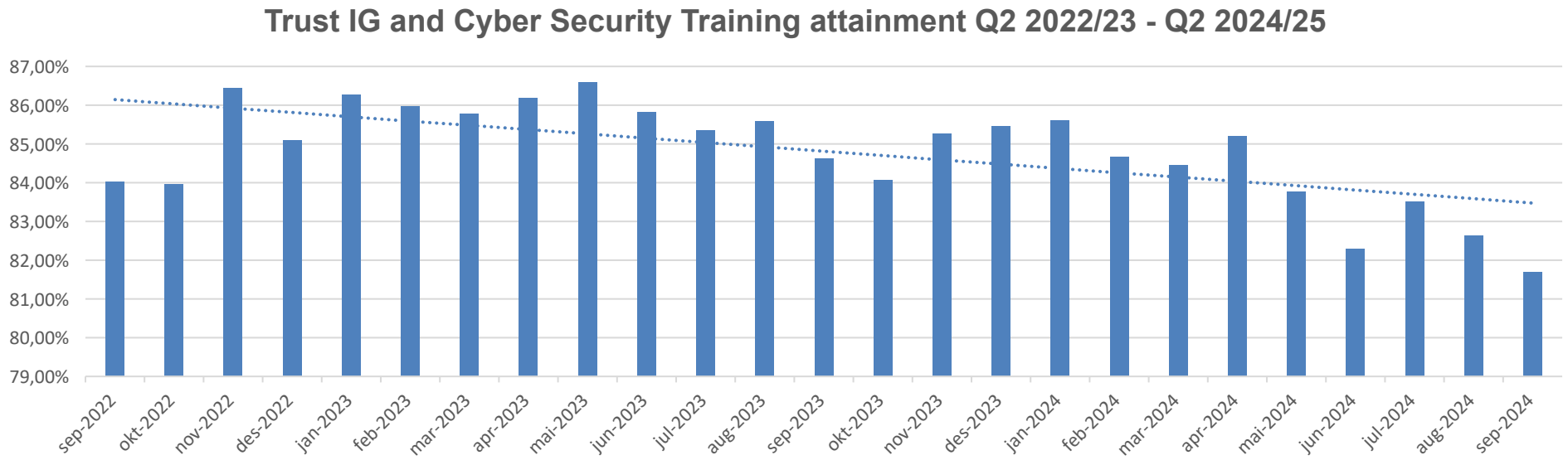
Graph 35



Graph 36

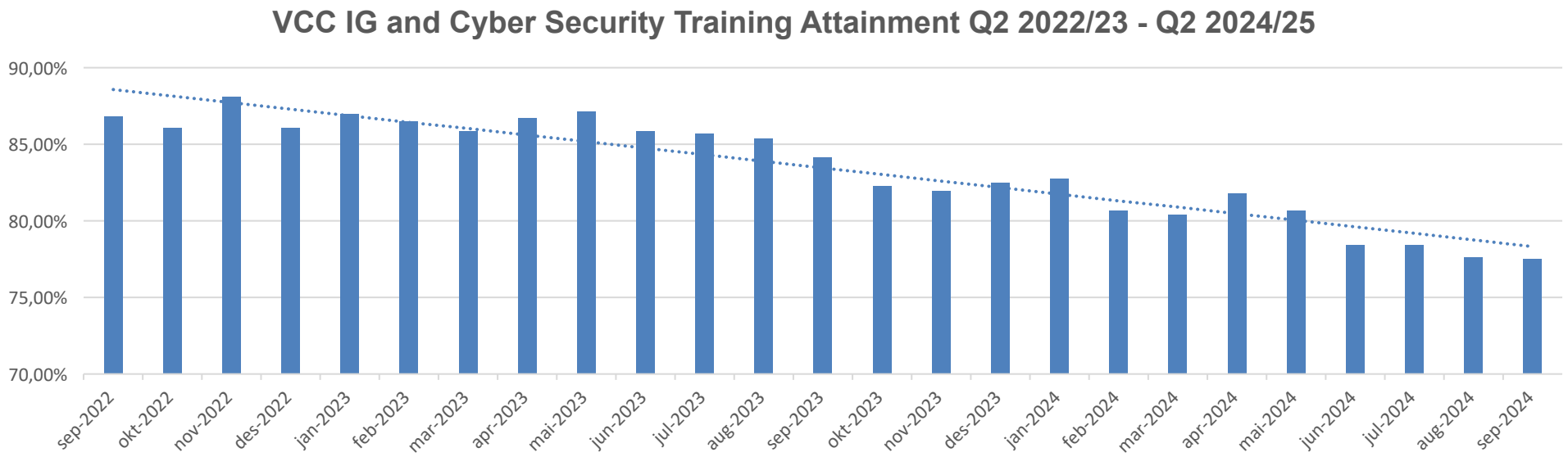


Graph 37

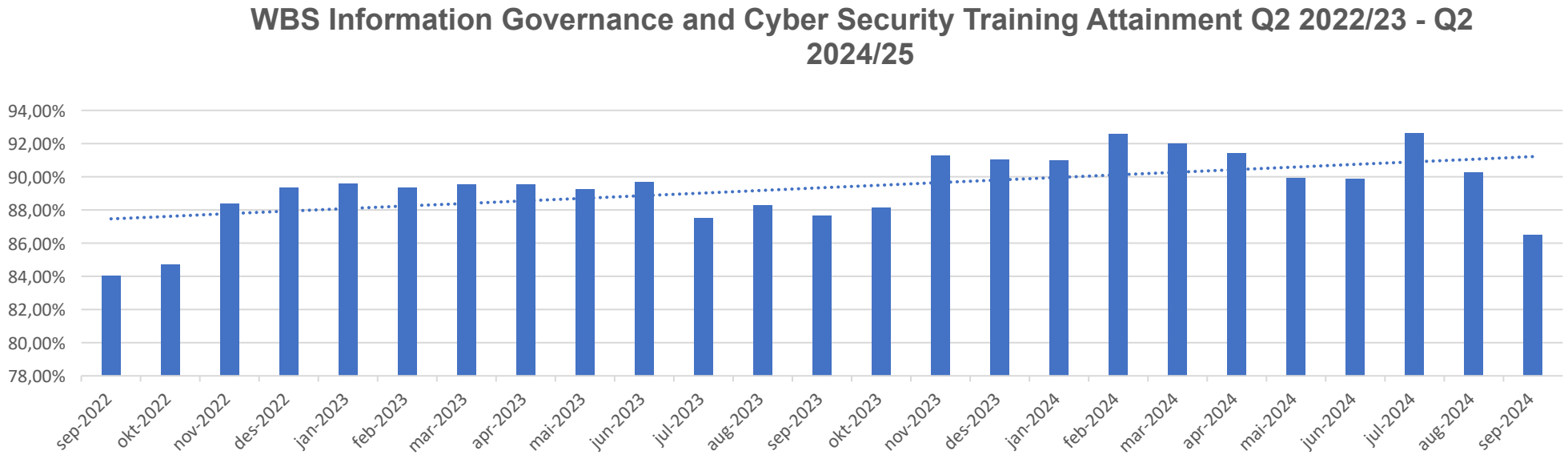


12. INFORMATION GOVERNANCE CONT.

Graph 38

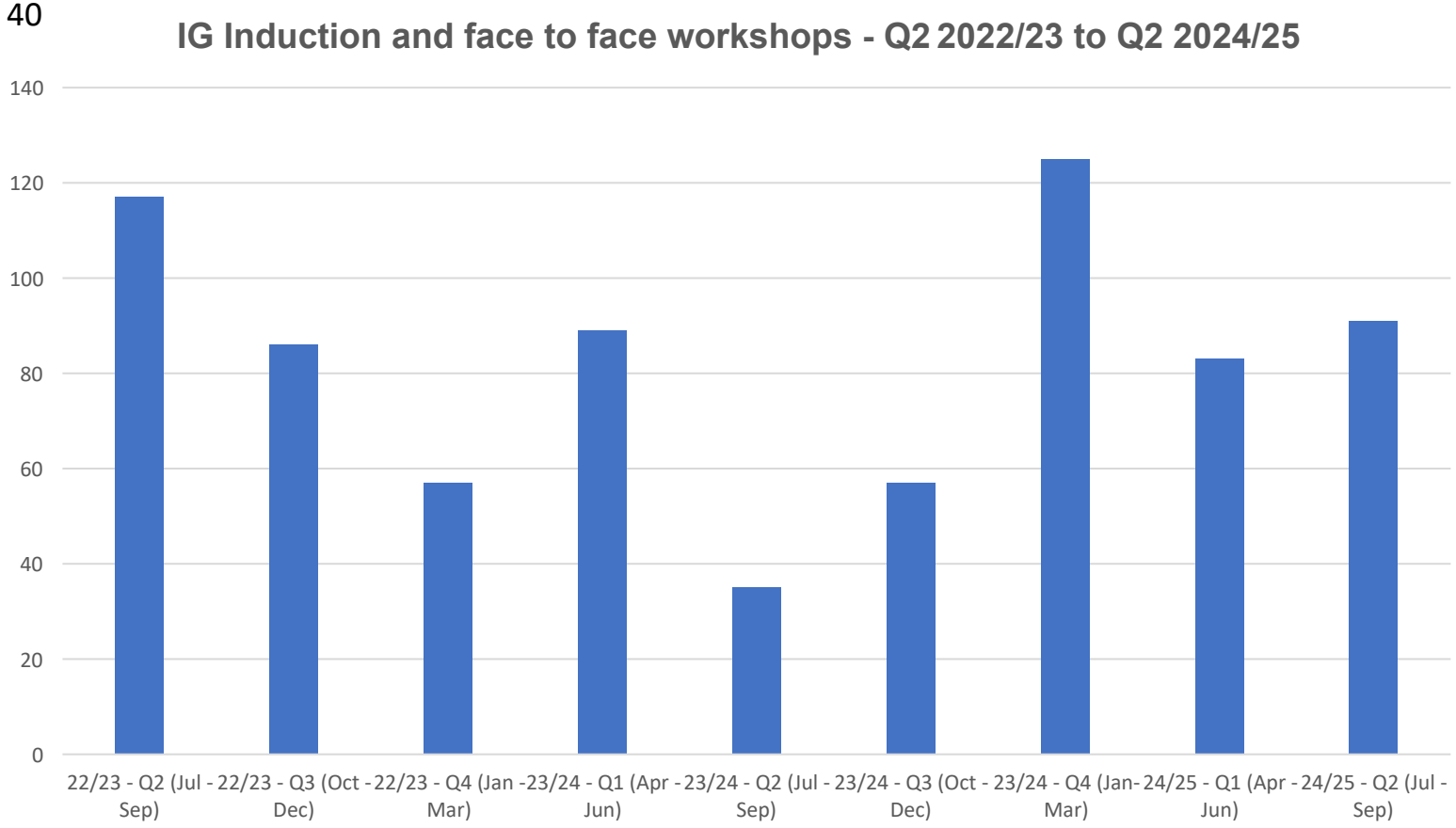


Graph 39



12. INFORMATION GOVERNANCE CONT.

Graph 40



12. INFORMATION GOVERNANCE CONT.

Assurance and Analysis

Positive assurance

1. **Training:**
   a. **Training** continues to be delivered via inductions and specific workshops and will continue to be for Q3 2024/25.
   b. **IG Training compliance** on 30th September 2024 for the Trust is 81.70% (minimum standard is 75%) and 89.37% for NWSSP.
2. **Email** - 5 golden rules and Etiquette published in Sep 24, SOP and Under Guide subject to further finalisation work - use of email by clinicians' post comments in IQSG in Sep 24.
3. **SAR compliance** - increased significantly to 100% in August 2024 for VCC.

Risks to compliance with Legislation, Policies, Procedures and Standards and mitigation activity

1. Compliance Risk – Risk of non-compliance with minimum M&S standards for IG and Cyber Security training in VCC, 78-77% for Q2 despite training offer.
2. TAF Risk – DPO reviewed TAF 05, will further with CDO in Oct 24, recommend focus is on test of Cyber Resilience Plan as soon as possible.
3. LPCH Risk – This risk is well known and subject to GOLD meetings in the Trust, no longer IG but contractual. Advice sought from L&R and shared with Procurement.
4. Overall IG Risk – Cyber risk is the overriding risk in line with the current threat environment.
5. Training Risk Mitigation – The provision of workshops and sessions throughout the Trust in Q2 whilst offered have not seen a huge take up (see IG Induction/Workshop diagram), Director VCC has supported approach with personal email to SLT in September 2024.

Analysis, themes and learning

1. Incidents –overriding theme in Q2 is inaccurate data, followed by misfiled records and misdirection. All of which are avoidable.
2. ICO Reported incidents – No reported incidents in Q2
3. Training - VCC Training compliance (77%) requires time investment in VCC in Q3 to reverse the trend.
4. VCC SAR Compliance – VCC Med Records have reversed the low compliance and are now at 100% for August and on track for the same result in September 2024, all reports will be in arrears due to timings.
5. DPIA – Remains the main methodology to assess compliance with data protection by design and default and address risk and information rights.
6. Triangulation – Training compliance correlates with incidents. Point 1&3 above demonstrates increased training and awareness can reduce incidents.

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

13. INFECTION PREVENTION AND CONTROL

	C *difficle*	MRSA	MSSA	E *coli*	P *aeruginosa*	Klebsiella *sp.*
2023 - 24	3	0	0	0	1	1
Q1 2024 -25	0	0	0	0	0	1
Q2 2024 - 25	1	0	0	1	0	0

Healthcare Associated Infections – There were two confirmed Velindre acquired infections.

Identified Learning : Communication between nursing and medical staff was disjointed and stool charts were not observed by medical staff.
Antimicrobial policy was not completed resulting in the patient receiving an extended course of antimicrobial therapy.

Flu plan – There is a comprehensive flu plan in place for the staff influenza vaccine campaign 2024/25. The current uptake for the Trust is 38%. COVID-19 Booster vaccines are available for frontline staff and links on how staff can access have been shared Trustwide.

Antimicrobial Stewardship report – there has been significant compliance with World Health Organisation antibiotic categories and the Start Smart and Focus measures. A new risk associated with long-term use of quinolones was discussed, with plans to introduce a prescribing checklist and patient counselling list to mitigate potential side effects. This work is being presented at the Medicines Management Committee before the change in process is ratified.

WORK UNDERWAY

Innovation and Sustainability – The IPC team are working with the sustainability lead to discuss how to safely introduce the RCN 'gloves' off campaign in practice. Further sustainability projects have been identified to influence how we procure and recycle in VUNHST.

The IPC team is creating an escape room across both divisions of the Trust as part of International Infection Control Week in October, to increase awareness of IPC practices. This interactive approach to education immerses staff in scenarios where they must identify and mitigate potential infection risks and by solving puzzles and overcoming challenges the aim is that participants will better retain information through experiential learning.

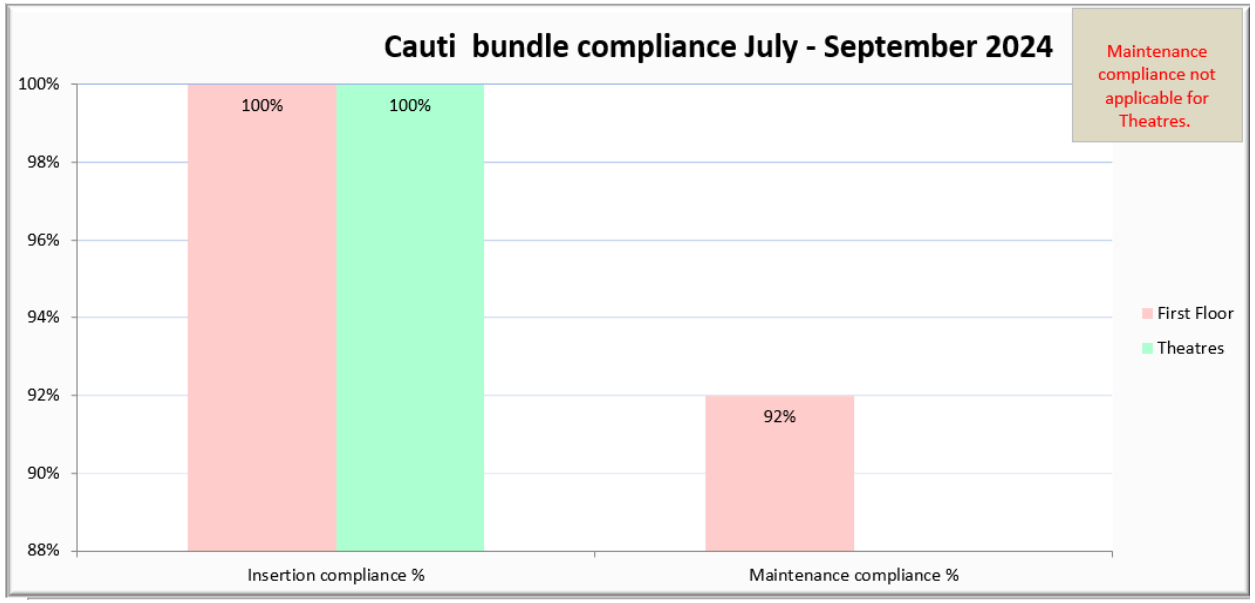
Mpox – the Trust IPC team have been part of a national project to produce action cards for the management of Mpox patients. Four Nation guidance has now been released and will be disseminated. The current guidance from PHW is to wear Enhanced PPE for Aerasol Generating Procedures. FFP3 training continues.

Compliance to CAUTI Urinary Catheter Bundles

The urinary catheter bundles compliance was monitored in First Floor Inpatient ward and Theatre department, only one insertion bundle was missing during the reporting period monitored in First Floor ward.

There have been no infections related to urinary catheters in July to September 2024.

Graph 41



Compliance with screening for Carbapenemase Producing Organisms

With emerging MDRO's (multi drug resistant organisms) and numbers increasing across Wales, in line with the national policy, we need to undertake routine CPO screening on all admitted patients within a specific time frame.

Reporting of compliance commenced in April 2023 and has remained difficult to embed. The IPCT have worked closely with the ward manager and key staff within the team to emphasise the importance of this swab.

The IPCT has benchmarked screening against other cancer centers outside of Wales and other cancer centers are screening for CPO without issue.

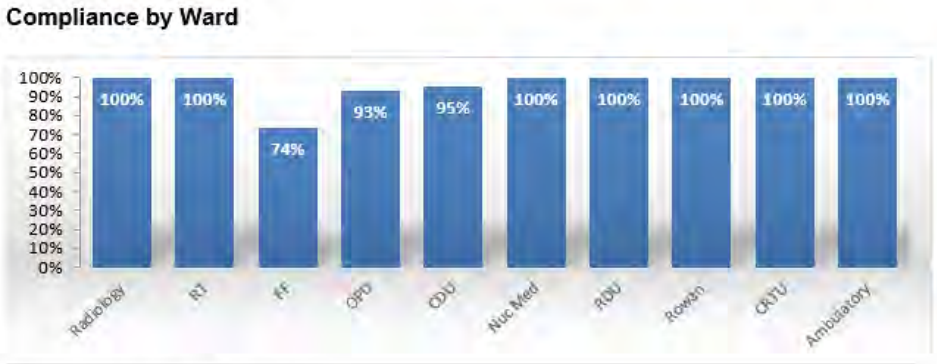
Graph 42

Hand Hygiene compliance

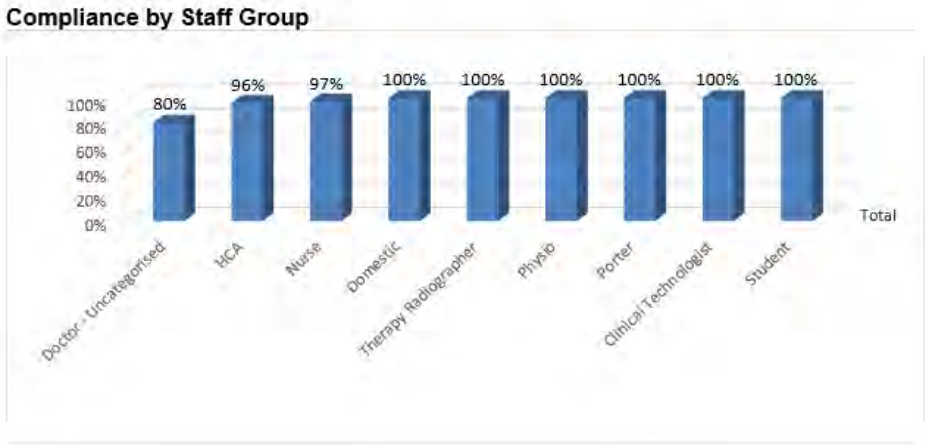
Hand Hygiene audits continue to be undertaken across the Trust.
The IPC Team continue to undertake spot checks to validate Hand Hygiene practice.

Overall compliance – 97%

Graph 43



Graph 44



13. INFECTION PREVENTION AND CONTROL CONT.

Infection Prevention & Control (IPC) Training: Across both divisions of the Trust, there has been reduced compliance with IPC training. The IPC team support workers are supporting departments with the practical training and assessments, however divisions have been tasked with increasing their compliance with IPC level 1 and 2 e-learning by August 2024. Trust wide risk assessment to be completed and item added to Trust risk register.

LEARNING AND OUTCOMES

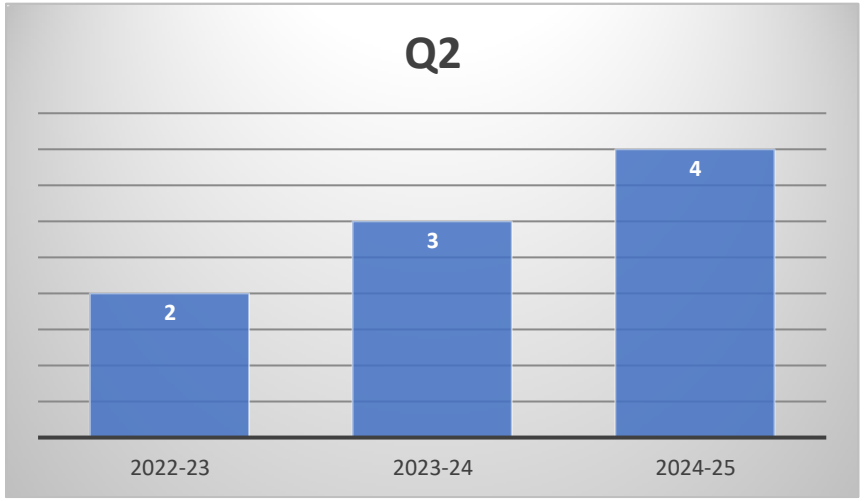
High-Level Decontamination of Ultrasound Probes – There is a discrepancy between the pre-clean wipes recommended by the manufacturer of the Trophon decontamination machine and the manufacturer of the ultrasound probe. Urgent work is underway with manufacturer and this has been added to the risk register.

Healthcare Associated Infections – In previous months there has been a delay in completing the RCA form following a healthcare-associated bacteraemia (bloodstream infection) and Clostridioidies *difficile* cases. Discussions highlighted the need for more efficient medical engagement and processes improvement was stressed to ensure timely investigations and learning. Actions plan agreed to address the RCA delays, including the appointment of additional consultants to support the process and the incorporation of RCA discussions into weekly multi-disciplinary team rounds and Acute Oncology Service morning meetings to maintain visibility and drive completion.

Carbapenemase Producing Organism (CPO) screening – Screening for these organisms is part of the admission screen of inpatients to the ward in the cancer centre and compliance has remained low since its introduction in April 2023. Training has been provided and IPC staff is available daily to provide education and support. The department has been tasked with improving the and qualifying the risk on non-compliance and risk will be added to the Trust risk register.

14. SAFEGUARDING AND VULNERABLE GROUPS

Graph 45



ANALYSIS

4 Duty to Reports were raised. This is an increase in safeguarding activity compared with previous years. A range of concerns were identified these related to Domestic Abuse, concern raised relating to a residential setting, issues related to care provided by VCC and one child at risk report.

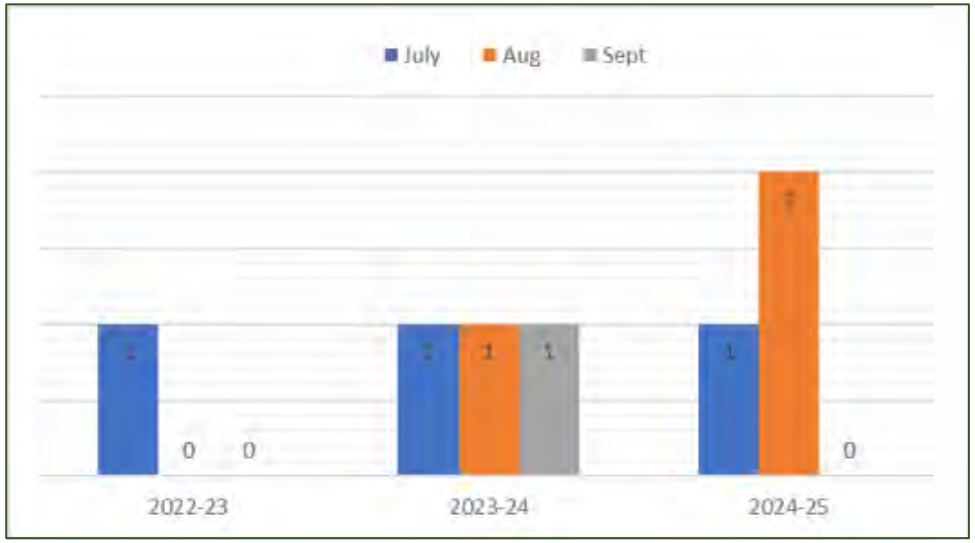
The concern regarding care provided at VCC related to a patient who had developed a suspected deep tissue injury (pressure) to heel whilst an inpatient. The patient had several co-morbidities which placed them at risk of developing pressure areas. This was not considered on admission and the correct pressure relieving regime was not implemented. A safeguarding report was submitted to Cardiff Adult Safeguarding team, and all learning identified during an investigation by the Trust's tissue viability nurse has been shared with the adult safeguarding team, with no further action taken.

Section 5: Allegations against a Person in A Position of Trust

No new professional concerns were received during this quarter.

Deprivation of Liberty Safeguards (DoLs)

Graph 46



3 applications for Deprivation of Liberty Safeguards (DoLs) were made during Quarter 1. This is an improvement on the figure from the same reporting period last year.

No extensions were required as either the patients had improved and discharged, or they had sadly passed away.

Training has continued to be delivered, with compliance at 70% (an 18% increase when compared with the same period in 2023-24). During this quarter, the Practice Educator for MCA/DOLS has delivered the first session to WBS Southeast collection staff with more sessions planned for the WBS teams pan-Wales.

14. SAFEGUARDING AND VULNERABLE GROUPS CONT.

Supporting Vulnerable Groups Workplan

- A dementia standards workplan has been developed to monitor progress of the **6** out of **20** *All Wales Dementia Care Pathway of Standards* applicable to the Trust.
- 5 staff have successfully completed the tier 3 champion/influencer training. The training consisted of staff experiencing what it is like to live with dementia, equipping staff with the knowledge and tools to undertake environmental assessments within their areas, and a collaborative session with support from Lleisiau Cymru and Dementia UK which focused on lived experience. This session was also made available to other staff within VCC.
- Cognitive impairment symbol is continued to be used on first floor ward. Next step is to audit its use and effectiveness.
- Tier 2 dementia training continued to be delivered during this quarter. There has been a 5% increase on the training compliance compared to last quarter and an overall 15% increase since the end of quarter 4 of 2023-24.
- Continued representation on National Workstreams including Improvement Cymru Dementia Partners National Steering Group and All Wales AHP Dementia Network.
- Head of Safeguarding & Vulnerable Person Lead will represent Velindre on an Improvement Cymru led working group on the implementation of the revised Learning Disability Care Bundle. First meeting to be arranged.
- 4% increase (on the end of year total 2023-24) of the number of staff who have completed the Learning Disability Awareness module on ESR.

VUNHST HEALTH & SAFETY QUARTERLY UPDATE

Outcome

The Trust has launched the Health and Safety cultural survey.
The aim is to gather comprehensive feedback from all employees to identify areas where improvements can be made and to celebrate aspects that are already working well. The Trust is committed to creating a supportive and safe working environment where every voice matters.
By actively engaging in this process, the Trust hopes to build a more resilient and harmonious community that prioritises the health and safety of all its members.

Focus

Our main emphasis has been on applying the Health and Safety Impact Matrix. This strategy has enabled us to concentrate our efforts on particular areas that will enhance trust moving forward.

Themes

Incident themes remain linked to hand and finger injuries. We are collaborating with the division to determine if any further training is necessary.

Trends

Training compliance has improved within the corporate division as a whole. However, we are still facing challenges regarding patient manual handling. Discussions are ongoing about exploring additional methods to enhance compliance for the Trust.

Current Incidents for the year

1 x Riddor Event

Q2 - 29 incidents

16. REGULATORY QUALITY AND SAFETY TRACKER COMPLIANCE

During this quarter, 6 new improvement plans were added to the Tracker:

- 3 Duty of Candour incidents related to Total Parenteral Nutrition (TPN) feeding, delay in treating Metastatic Spinal Cord Compression (MSCC) & missed opportunity for chemotherapy dose reduction
- Medicines Management Internal Audit Report Aug 2024
- United Kingdom Accreditation Service (UKAS) inspection (Welsh Blood Service laboratories)
- Natural Resources Wales (NRW) High Activity Sealed Sources (HASS) inspection (Velindre Cancer Centre Radiation Services)

The Tracker currently contains improvement plans related to the following:

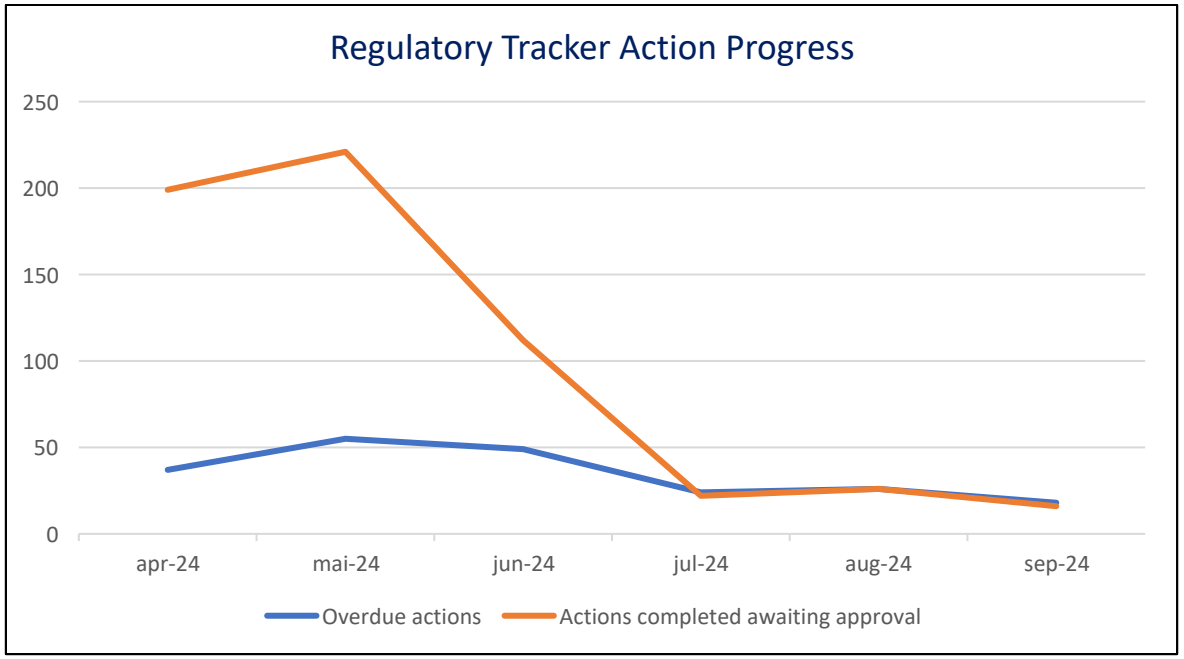
- 5 moderate (Duty of Candour) incidents
- 4 Nationally Reportable Incidents
- 3 external inspections
- 3 internal reviews
- 2 external peer reviews

As shown in **Graph 39** - significant progress has been made during Quarter 2 in:

- completing actions contained in the Regulatory Tracker
- Achieving final sign off for completed actions

This is due to concerted efforts by Divisional teams to address actions and engage with senior leadership to provide evidence of completion.

Graph 47

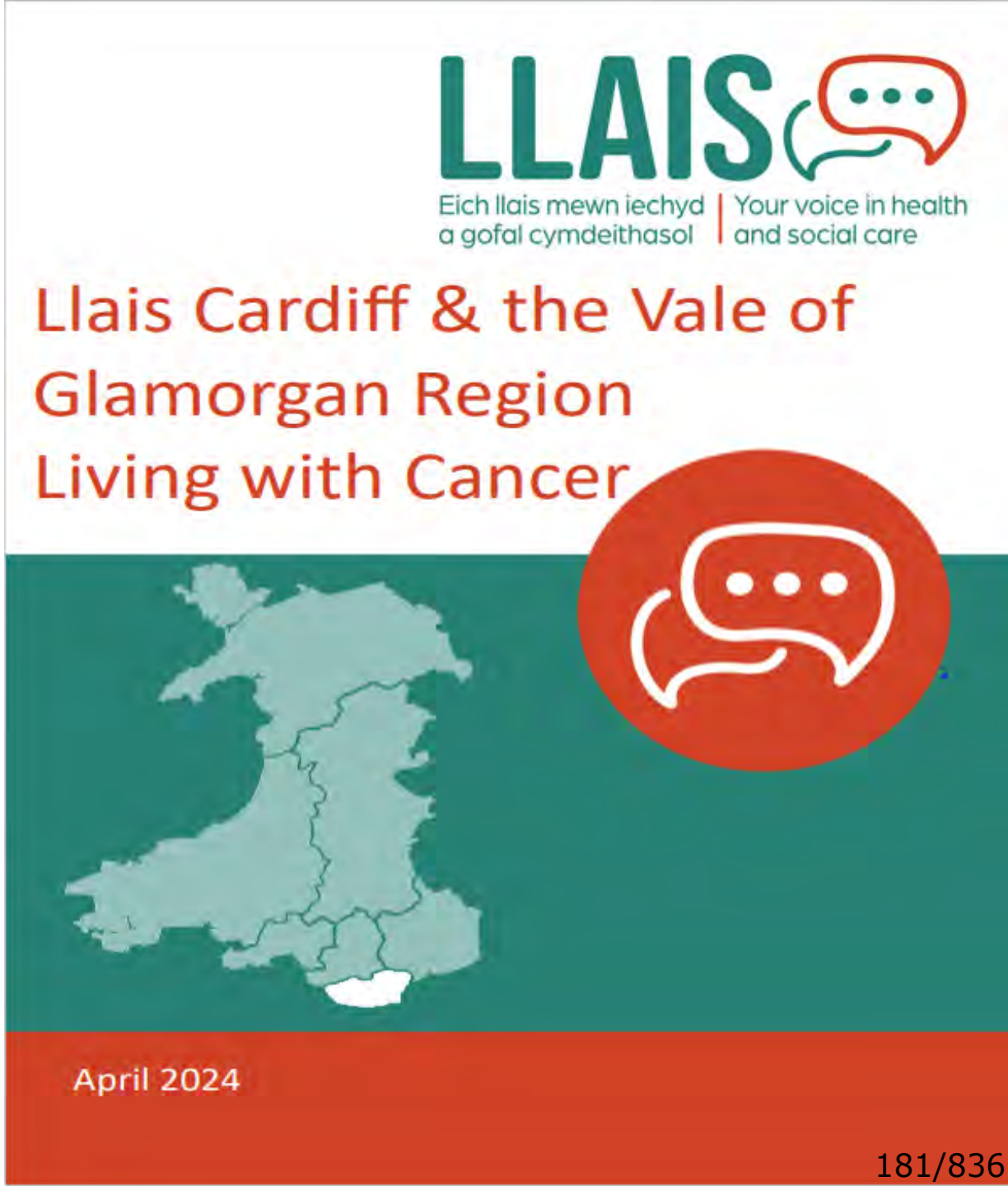


17. ASSURANCE VISITS & INSPECTIONS

As the new Citizens Voice Body for Health and Social Care in Wales, (Llais) it is crucial that they engage with the public so that we can undertake our role as the patient voice and help to improve the patient experiences of health and social care services.

As part of their ongoing engagement, they target specific areas in order to gather feedback around a particular theme or service.

On this occasion, they decided to look at Cancer Services, and hearing from people who have recently accessed these services, either recently being diagnosed or going through treatment currently



17. ASSURANCE VISITS & INSPECTIONS CONT.

Velindre Cancer Centre developed an improvement plan based on the recommendations within the report

This action plan will be monitored using our Trust Regulatory Tracker.

FEEDBACK FOR GOOD PRACTICE

Suggestions of good practice to Velindre Cancer Centre;

1. VCC to share the positive feedback received with staff within the relevant service areas.
2. It would be helpful for patients to understand how Velindre communicates with other healthcare services, such as GP's or other cancer hospitals.
3. Concerns were raised around lack of communications between patients and staff. Could you please clarify how VCC ensures that communication between staff and patients are reliable and consistent.
4. It would be helpful to understand how VCC share feedback with WAST around concerns raised about the transport services.
5. It would be helpful for patients to know what discussions have been held around having blood tests to be undertaken in their local area, rather than having to travel to VCC.
6. VCC to ensure food and drink facilities are working appropriately to avoid staff having to step away from providing care to patients.

18. QUALITY PRIORITIES 2024-25 UPDATE

Quality Priority:	Division	Update
To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.	VCS	Work continues around all 5 key areas highlighted. New appointment in to Head of Business Planning, Performance, and Operational Services role has this workstream as a priority and will be developing a robust and comprehensive action plan. Meeting planned with Q+S Manager to progress.
Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.	VCS	Mortality and Morbidity meetings are being held in 7 out of 11 SST's to date – these meetings are held quarterly and review the death within 30 days SACT and 30 and 90 days radiotherapy for the last quarter. 1 SST has their first meeting planned in September 2024, and the remaining 3 SST's are in the planning stage. Mortality data being added to the PMF.
To Integrate Clinical Audit within VCS Quality and Safety function	VCS	Clinical audit is now within the Q+S structure. 2 weekly meetings being held between Q+S and audit where themes from concerns and incidents are discussed, as well as learning and recommendations identified in audits. An "audit group" is in the early stages of planning which will see representation from all directorates/ departments where all potential audit projects can be discussed, proposed audit projects can be approved, and recommendations from completed audits can be shared and ensure actions developed. It will also be a forum for issues to be escalated – this ensures strong governance surrounding clinical audit and triangulation of quality safety, and audit.
Development of robust Site-Specific Quality Metrics	VCS	Q&S are working with Data and Insights team on developing a Quality Dashboard for SST's. Key metrics have been identified and D&I are working on building the dashboard. No implementation date as of yet. Q+S team working with CIVICA and Wales CIVICA Leads group to amend the national surveys to include patients' cancer diagnosis in the VCC survey to allow the SST's to view their patients experience across the cancer centre and show in the quality dashboard. Datix "Primary Service" codes have been updated to include all SST's which will allow incident and concerns be coded to the appropriate SST and shown in the quality dashboard.

18. QUALITY PRIORITIES 2024-25 UPDATE CONT.

Quality Priority:	Division	Update
To Improve incident and risk management.	TRUST	
Continue to review and update the WBS Quality Management Framework, including the deployment of a new electronic Quality Management System	WBS	Project to introduce new eQMS in progress – estimated go live October 2024
To Successfully Introduce West Nile Virus testing within Welsh Blood Service.	WBS	COMPLETE Implemented under Change Control PR000426. Live as of 1st May 2024.
Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.	WBS	Validation of new collection packs in progress. Progress is dependent on Welsh Government approval of funding for the Plasma for Medicines programme. Deadline for Parvovirus B19 and Hepatitis A testing has been extended to July 2025.
Review and improvement of donor selection and screening processes	WBS	Gap analysis complete List of suggested donor eligibility questions compiled and approved. WBS process flow for assessing travel risk via eProgesa is being reviewed to identify improvements that support correct assessment of donors and eligibility decision making.
Introduction of all Wales foetal D Screening for RhD negative pregnant women.	WBS	COMPLETE: Test platform (FEDIS) went live on 31/05/24. Test and system working as expected. Samples received from w/c 20th May onwards. 59 samples processed up to 10/07/24. T
Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT, which will reduce risk of manual transcription of results.	WBS	PAUSED: Awaiting engagement from NHSBT ODT regarding secure data transfer.

18. QUALITY PRIORITIES 2024-25 UPDATE CONT.

Quality Priority:	Division	Update
Achieve JACIE accreditation for the WBMDR	WBS	Audit expected to occur no later than September 2024; date to be confirmed by JACIE. Close out of audit findings and accreditation should be confirmed within 30 working days of audit date.
Commencing rollout of live connectivity of the BECS at community-based donation clinics,		Roll out of live connectivity has not yet commenced. This is reliant on the outcome of the pilot review. A pilot undertaken by one Collection team (West) has highlighted a number of issues that need to be addressed with Digital Services before the introduction to all Wales. Digital Services are unable to support roll out across all Teams at present due to the costs associated with the live connectivity equipment; this requires the purchase of appropriate protective equipment. Digital Services have suggested Collections push forward with the electronic completion of DAERs via 4G mobile dongle, however connectivity isn't always available.
Enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact.	WBS	As above (13.)
*TBC % increase in staff psychological safety scores within VUNHST Staff Survey results.	Trust	Incident and Learning Frameworks have been developed. A review of Trust values was undertaken. Annual staff survey results have been received and an analysis is being undertaken.

20. CONCLUSION

This is the second quarterly and fully integrated quality & safety report that has been co-produced by the three quality hubs. This has enhanced the ability to triangulate data. The triangulation of data this quarter has identified a theme of continued concerns and incidents relating to communication with Velindre Cancer Service.

Welsh Blood Service have also seen a trend in concerns related to appointments and communication.

Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain positive.

Compliance with Putting Things Right timescales for complaints responses is 93.6%. This is 18.6% above the national PTR target of 75%.

3 incidents in Velindre Cancer Service triggered the Duty of Candour, having been assessed as having potentially caused moderate harm to a patient. Investigations are underway to identify learning and opportunities for improvement. No Duty of Candour triggers occurred in Welsh Blood Service. No incidents met the criteria for National Reportable incidents across the Trust.

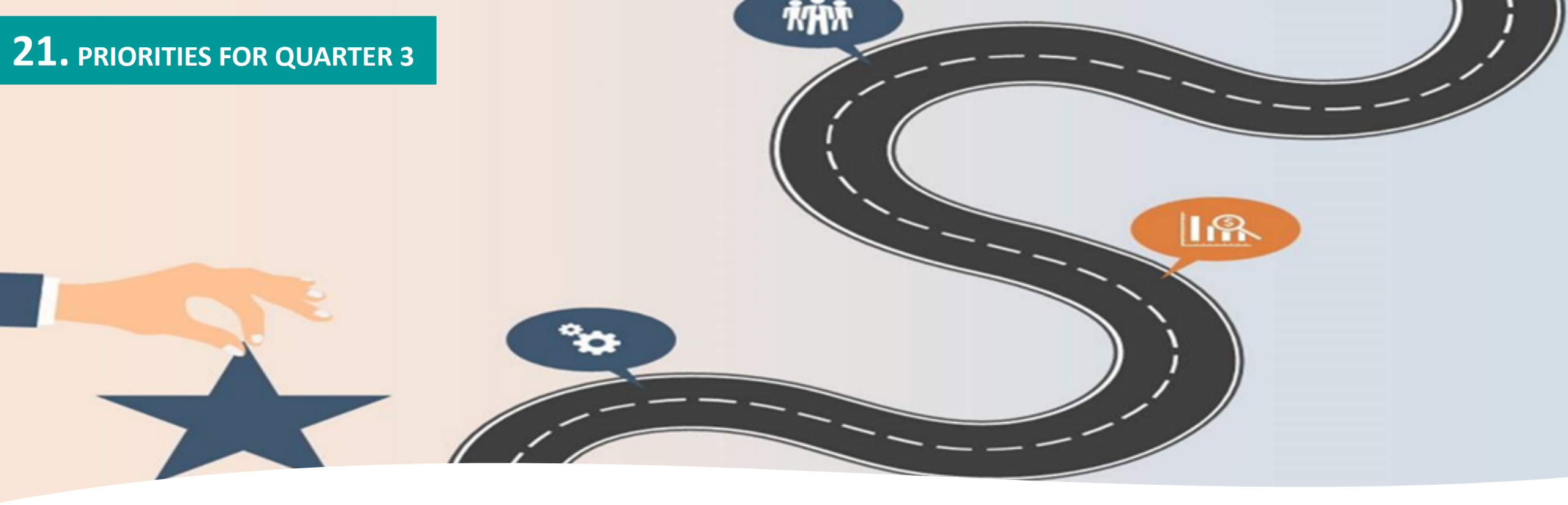
The Trust continues to comply with legislative safeguarding responsibilities and reporting.

Hospital Associated Infection rates remain low.

1 external review was undertaken in quarter 2 and improvement plans have been developed in the Cancer Centre.

Significant progress has been made during Quarter 2 to complete actions on the Regulatory Quality and Safety Tracker.

21. PRIORITIES FOR QUARTER 3



PRIORITIES FOR QUARTER 3, 2024-25

- The quality hubs will undertake focused work using the Yorkshire Contributory Factors to identify trend analysis learning from specific incident themes.
- To send patient and donor satisfaction survey to gather experience feedback following the concerns process.
- To further develop collaborative working opportunities through the quality hubs to optimise quality and safety outcomes and support learning and continuous improvement.
- To Explore further opportunities to gather patient and donor feedback to analysis for learning and improvement.

Inspection Code	Inspection Title	Recommendation	Reference Number
Local (Velindre Quality & Safety)/2022/15	Brachytherapy CCC Peer Review July 2022	ID63 Develop competency documents for all staff groups and method for ongoing competency updates	Local (Velindre Quality & Safety)/2022/15/MD21/1
National Reportable Incident/2022/11	Brachytherapy Significant Accidental and Unintended	NRI 2 Recommendation to use emergency off not interrupt when required to stop	National Reportable Incident/2022/11/MD1/1
National Reportable Incident/2022/11	Brachytherapy Significant Accidental and Unintended Exposures Aug 2023	NRI 4 Recommendation to record dwell position and time remaining before resuming if interrupt or emergency off pressed.	National Reportable Incident/2022/11/MD3/1
National Reportable Incident/2023/25	Document Management System	VCS to adopt the national standard of writing to patients by default, copying in GPs and/or other clinicians.	National Reportable Incident/2023/25/MD1/1
National Reportable Incident/2023/25	Document Management System	The SOP allowing the sending of unauthorized letters to be reviewed and it is recommended that this practice is ceased – rapid letter review process to be put in place instead of sending unauthorized letters. Delegated approval rights for secretaries to be revoked.	National Reportable Incident/2023/25/MD3/2

National Reportable Incident/2023/25	Document Management System	The SOP allowing the sending of unauthorized letters to be reviewed and it is recommended that this practice is ceased – rapid letter review process to be put in place instead of sending unauthorized letters. Delegated approval rights for secretaries to be revoked.	National Reportable Incident/2023/25/ MD3/3
National Reportable Incident/2023/25	Document Management System	Full review of VCS DMS SOPs to reduce the variation in letter-writing practices amongst clinicians and secretaries. To include how letters are dictated	National Reportable Incident/2023/25/ MD4/5
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	HIW – NATIONAL REVIEW OF DNACPR DECISIONS IN ADULTS The table below includes any other improvements identified during the review where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas. Health boards and trusts should ensure that clinicians completing the date section 'for review' within a DNACPR form, must clearly document all the required information including the date and their professional registration numbers, to ensure	Healthcare Inspectorate Wales (HIW)/2024/28/M D1/1

Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	The Advance and Future Care Planning Group (Wales) should consider how to further increase public awareness within health boards and trusts regarding the existing resources and the meaning and process for DNACPR decision making, to ensure people can appropriately engage in conversations about their preferences during the end of their lives.	Healthcare Inspectorate Wales (HIW)/2024/28/MD3/1
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	In line with the all-Wales Policy, health boards and trusts should ensure that clinicians fully engage in appropriate discussions with patients and family, to ensure an individual's life is respected and valued, and to make clear that a DNACPR decision does not prejudice any other aspect of care.	Healthcare Inspectorate Wales (HIW)/2024/28/MD6/1
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	Health boards and trusts should consider how staff can be supported with appropriate time to undertake training, and access the information resources available, to support them with considering people's spiritual needs, values, and	Healthcare Inspectorate Wales (HIW)/2024/28/MD7/1

Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	The all-Wales Advance and Future Care Planning Group should consider whether the current DNACPR and/or Advance and Future Care Plan policy and relevant documents can cater for individuals' spiritual needs, values, and beliefs, so this information can be more readily accessible and	Healthcare Inspectorate Wales (HIW)/2024/28/MD8/1
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	Health boards and trusts must ensure that clinicians clearly and succinctly record a patient's clinical summary within section 2, and the reasons why CPR would be inappropriate, in line with the all-Wales Policy.	Healthcare Inspectorate Wales (HIW)/2024/28/MD12/1
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	Health boards and trusts must ensure that section 6 of the DNACPR form is completed in a timely manner by the Senior Responsible Clinicians in line with the all-Wales Policy.	Healthcare Inspectorate Wales (HIW)/2024/28/MD13/1
Healthcare Inspectorate Wales (HIW)/2024/28	DNACPR Review - Improvement Plan- Velindre NHS Trust 1	Health boards and trusts must ensure that communication of a DNACPR decision is improved across to the relevant clinical teams involved in the care of patients, and these within section 8 of the DNACPR form, such as their GP, care home	Healthcare Inspectorate Wales (HIW)/2024/28/MD14/1
Local (Velindre Quality & Safety)/2024/37	NRW HASS Inspection	CTSA and NRW have provided some advice in the report around requirements for housing a brachy unit within a bunker. Since the meeting, MT has been provided with the updated security guidance	Local (Velindre Quality & Safety)/2024/37/MD1/1

Local (Velindre Quality & Safety)/2024/37	NRW HASS Inspection	Confirm security rating for research sources.	Local (Velindre Quality & Safety)/2024/37/MD4/1
National Reportable Incident/2023/13	SACT NRI steps 1-7	NRI step 4 Development of one active, live digitally generated report that reflect a patient's place in relation to target treatment	National Reportable Incident/2023/13/MD4/1

Action	Site	Service	Date Raised	Original Due
ID63 Theatres: Competency framework will be developed RT: All training documentation and competency assessments provided to KF to incorporate into exempplar training plans Physics Checker/MPE training for review April 23	Velindre Cancer Centre	Radiotherapy	27.09.2023	31.03.2023
RT Radiographers in process of updating working instructions to include this.	Velindre Cancer Centre	Radiotherapy	27.09.2023	31.10.2023
Physics checker is always on site during any brachytherapy treatment. Physics and RT to work together to establish process for ensuring RT radiographers know which physics checker is available and how they can be contacted if required. Rota of routine cover to be issued to RT so that contact can be made when required.	Velindre Cancer Centre	Radiotherapy	27.09.2023	31.10.2023
Review the guidance around writing to patients and provide guidance for clinicians on what letters should be sent to the patient and which letters may not be sent to the patient	Velindre Cancer Centre	Medical Services	20.03.2024	30.09.2024
Review the requirement for medical secretaries to have delegated rights to send letters without authorisation particularly in the case of letters that need to be sent out at short notice. Where G2 dictation is used there is a reduced risk of error in sending of letters without clinician authorisation compared to when letters are produced from the body of an OON as that requires medical secretaries to copy and paste. Update the SOP to reflect this	Velindre Cancer Centre	Medical Services	20.03.2024	30.08.2024

Review signing off process for urgent letters if delegated approval rights are revoked. Where G2 dictation is used there is a reduced risk of error in sending of letters without clinician authorisation compared to when letters are produced from the body of an OON as that requires medical secretaries to copy and paste. Update the SOP to reflect this	Velindre Cancer Centre	Medical Services	20.03.2024	30.08.2024
Review dictation software, voice recognition software and other digital solutions to aid letter writing and reduce the variation.	Velindre Cancer Centre	Medical Services	20.03.2024	31.10.2025
The importance of comprehensive completion of the DNACPR form is included in the training and during staff induction. Action = The Trust undertakes a comprehensive two-yearly DNACPR audit, gathering evidence has commenced. The above recommendation is included in the audit. Audit findings will be reported through the governance structure and an improvement plan developed based on the findings.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024

The Advance and Future Care Planning Group (Wales) should consider how to further increase public awareness within health boards and trusts regarding the existing resources and the meaning and process for DNACPR decision making, to ensure people can appropriately engage in conversations about their preferences during the end of their lives. Action = The Trust will continue to provide representation to this group. The representatives will ensure that updates from this group are brought back to the Trust.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Training delivered in the Trust includes the treatment ladder and is in line with the ethos of recommendation 6. Action = The Trust undertakes a comprehensive two-yearly DNACPR audit, and gathering evidence has commenced. The above recommendation is included in the audit. Audit findings will be reported through the governance structure and an improvement plan developed based on the findings.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Action = To submit a paper to the Trust Training and Education Group, for consideration of DNACPR training to be made mandatory for regulated professionals involved in the DNACPR process.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	31.08.2024

Action = The Trust will continue to provide representation to this group. The representatives will ensure that updates from this group are brought back to the Trust.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Action = The Trust undertakes a comprehensive two yearly DNACPR audit, gathering evidence has commenced. The above recommendation is included in the audit. Audit findings will be reported through the governance structure and an improvement plan developed based on the findings.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Action = The Trust undertakes a comprehensive two-yearly DNACPR audit, gathering evidence has commenced. The above recommendation is included in the audit. Audit findings will be reported through the governance structure and an improvement plan developed based on the findings.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Action = The Trust undertakes a comprehensive two yearly DNACPR audit, gathering evidence has commenced. The above recommendation is included in the audit. Audit findings will be reported through the governance structure and an improvement plan developed based on the findings.	Velindre Cancer Centre	Palliative Care SST	24.06.2024	30.09.2024
Formal advice from the RWA to the employer is required to meet the new guidance for existing and new installations.	Velindre Cancer Centre	Radiation Services	26.09.2024	09.10.2024

Research irradiator, confirmation that the entrance door conforms to the security guidance in terms of classification.	Velindre Cancer Centre	Radiation Services	26.09.2024	01.10.2024
Improve/revise/update the current report due to BI restrictions	Velindre Cancer Centre	SACT	27.09.2023	31.03.2024

Current Due Date	Date Last Upd	Action	Progress Status
29.09.2024	25.07.2024	Red	Overdue
31.08.2024	25.07.2024	Red	Overdue
31.08.2024	25.07.2024	Red	Overdue
30.09.2024	05.07.2024	Red	Overdue
30.09.2024	02.10.2024	Red	Overdue

30.09.2024	02.10.2024	Red	Overdue
30.09.2024	03.07.2024	Red	Overdue
30.09.2024	24.06.2024	Red	Overdue

30.09.2024	24.06.2024	Red	Overdue
30.09.2024	24.06.2024	Red	Overdue
31.08.2024	24.06.2024	Red	Overdue

30.09.2024	24.06.2024	Red	Overdue
30.09.2024	24.06.2024	Red	Overdue
30.09.2024	24.06.2024	Red	Overdue
30.09.2024	24.06.2024	Red	Overdue
09.10.2024	08.10.2024	Green	Overdue

01.10.2024	10.10.2024	Green	Overdue
04.10.2024	17.09.2024	Red	Overdue

Inspection code	Inspection title	Inspection origins	Recommendation description	Reference numbers

Action description	Site	Services	Service filtering	Responsible person	Date raised from	Date raised to

Action ratings	Progress status	Priority types	Approval boards	Risks	Barriers	View my actions only
	Overdue					

Title	Date of Inspection
Brachytherapy CCC Peer Review July 2022	01/07/2022
Brachytherapy SAUE Aug 2022: Datix 7015	17/11/2022
Datix 13629 (DMS)	15/12/2023
Datix 15014 (Missed Dose Reduction)	20/10/2023
Datix 15153 (TPN Feeding)	08/08/2024
DNACPR Review - Improvement Plan- Velindre NHS Trust 1	03/06/2024
JACIE Initial Inspection for Welsh Bone Marrow Donor Registry	23/08/2024
Llais C&V Region Living with Cancer	01/04/2024
Loss to follow up NRI steps 1-9 INC 10502	09/06/2023
Medicines Management Internal Audit Report August 2024	01/08/2024
NRW HASS Inspection	05/06/2024
OFW 13221 (Colorectal Missed Referral)	05/04/2024
OFW13770 (SACT Bloods)	26/09/2023
OFW15555 (MESCC)	23/09/2024
Patient & Donor Experience	05/01/2023
SACT NRI steps 1-7	11/09/2023
SACT Treatment Helpline Peer Review March 2024	11/12/2023
SU3 Inspection (Surveillance visit) (July 2024)	11/07/2024

Next Review Date	Restricted	Recommendations	Actions	Open Actions
	No	133	133	19
	No	5	5	0
	No	9	17	12
	Yes	12	18	14
	No	7	7	6
	No	17	17	2
	Yes	39	28	28
	No	3	4	1
	No	6	7	0
	No	3	3	1
	Yes	4	4	2
06/06/2024	No	7	8	3
06/06/2024	Yes	3	3	1
	No	7	9	0
31/01/2024	No	4	4	1
	No	7	7	1
	No	6	7	2
	No	11	11	0

Overdue Actions	Closed Actions
1	113
2	3
5	0
4	0
1	0
8	7
0	0
1	2
0	7
0	2
1	1
0	5
0	2
3	6
0	3
0	6
0	5
0	11

Appendix 3:

1. BACKGROUND

Patient and Donor Feedback consists of views and opinions of patients and donors on the care they have experienced. Gathering and examining feedback will give insight into what is working well – and not so well across both divisions. Scoping was undertaken to review the current arrangements across both the Welsh Blood Service and Velindre Cancer Centre of how patient /donor experience is gathered, analysed, and shared in the Trust.

The Trust currently has a few mechanisms for capturing patient donor feedback.

Quantitative

Civica is utilised in both divisions to undertake surveys, this enables the gathering and analysis of many views.

Qualitative

- Compliments captured on Datix.
- Cards and letters
- Social media
- Patient /Donor stories
- Concerns

2. ASSESSMENT

3.1 Welsh Blood Service

Welsh Blood Service is forming a donor experience hub that meets quarterly, the chair will be the head of donor engagement and the group reports to the supply chain lead. The remit of the group is: Welsh Blood are working towards setting up this group.

a) Monitoring and identifying trends in donor experience

b) Leading the donor experience strategy across the Service

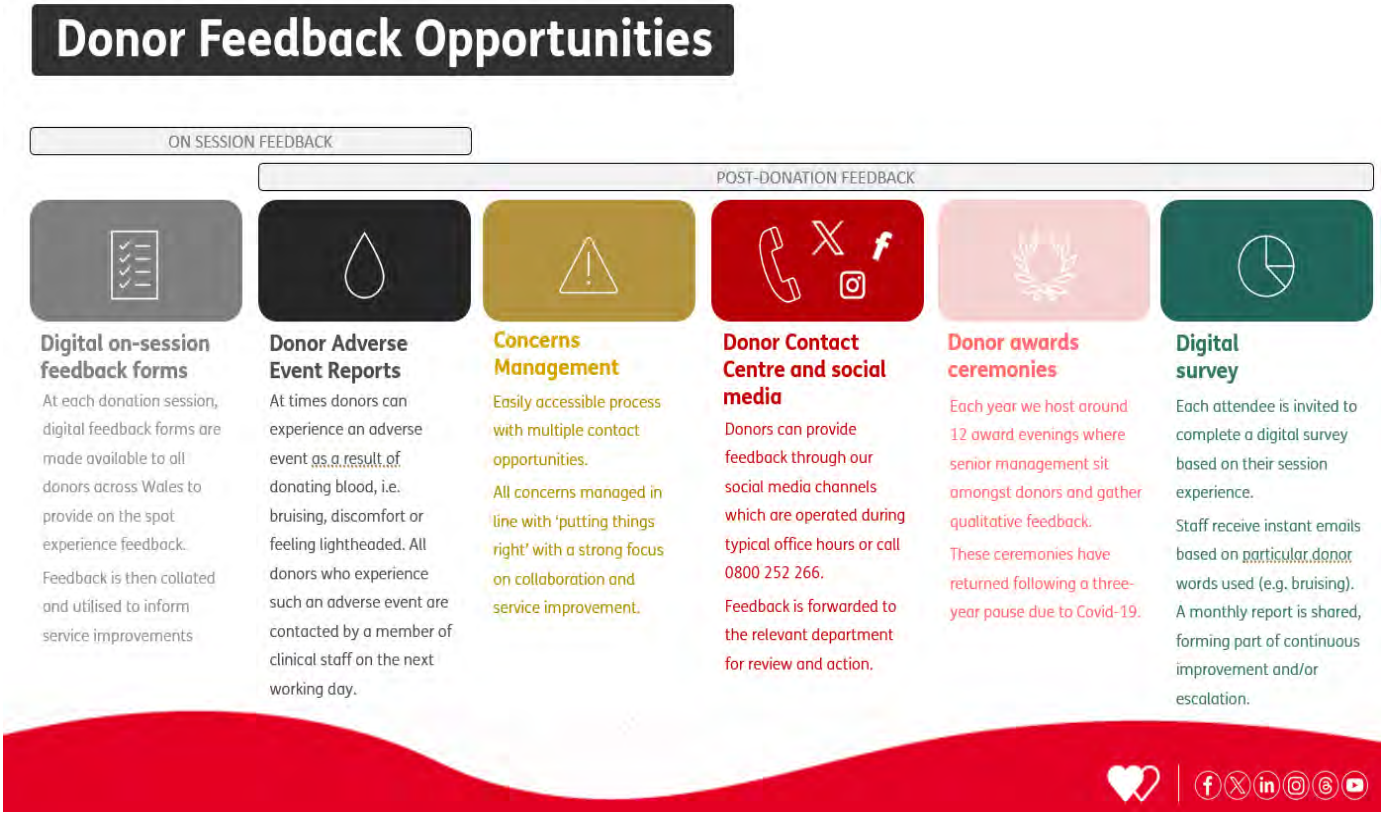
c) Involvement in identifying donor experience priorities

d) Agreeing on and monitor Performance Indicators (PIs)

e) Managing questions and interactions with the Donor and Advocate Panel

f) Enabling staff, advocates, and donors to work in collaboration to enhance the donor experience

g) Ensuring donors and advocates are encouraged to have a voice



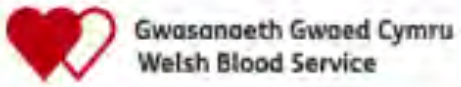
Welsh Blood Service utilises a variety of both qualitative and quantitative mechanisms to gather donor feedback. Datix is not used frequently as a mechanism to record donor compliments, as it is collected utilising surveys that have a high completion rate across the division.

Qualitative feedback is received and reported via the concerns process, most Welsh Blood Service concerns are managed through the early resolution process. Learning is shared with the teams involved and reported via the quality reporting governance arrangements.

Sharing Donor Feedback

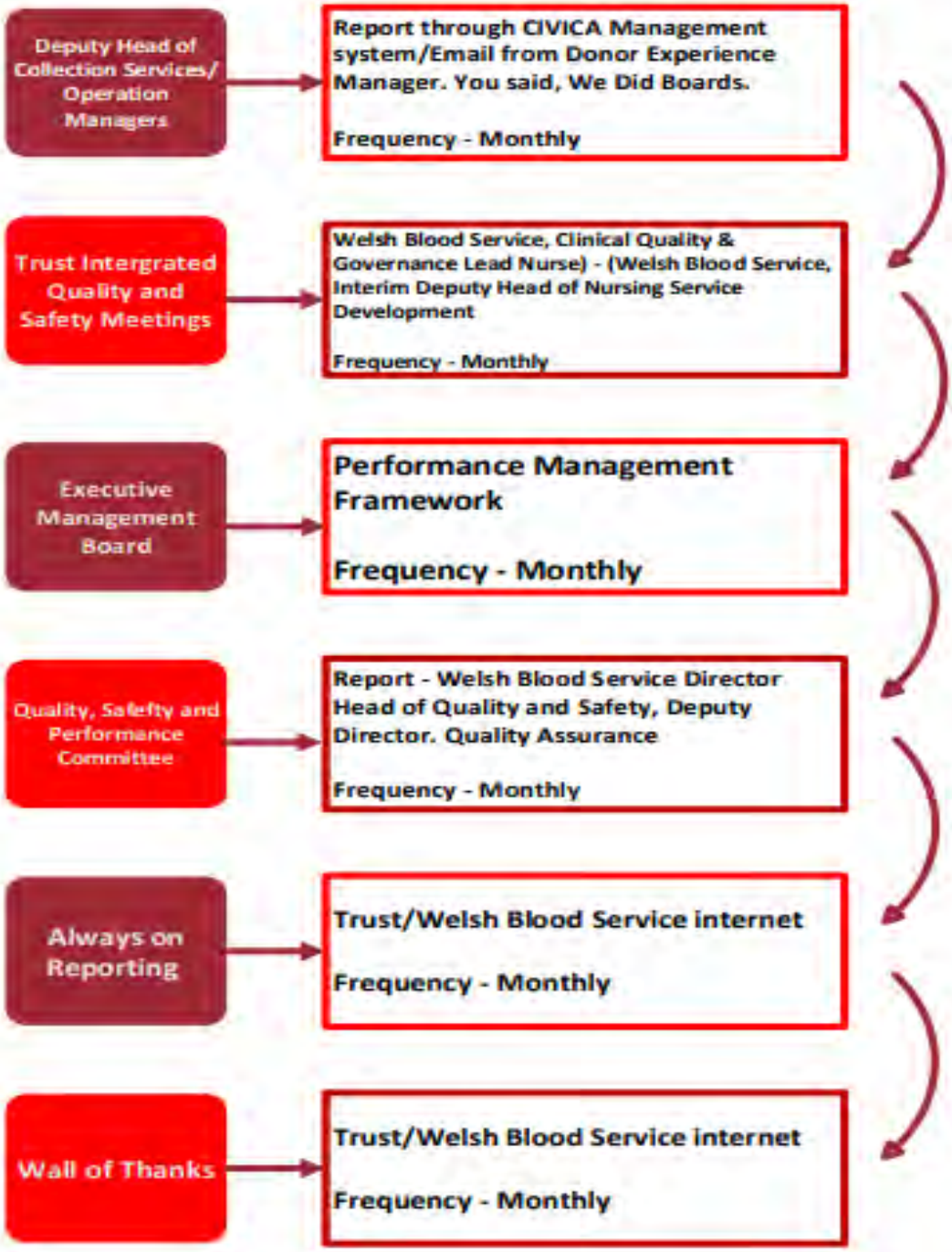
- Donor satisfaction scores are communicated throughout the organisation via the Trust performance management framework and are included in both quarterly and annual reports.
- The WBS share their monthly CIVICA reports through utilising the "push report" function of the system. Each department that uses CIVICA to capture

donor/service user experiences are responsible for sharing the positive's and are responsible for addressing the areas for improvement. We also use the website for always on reports and the wall of thanks for wider sharing.



WELSH BLOOD SERVICE CIVICA SURVEY'S

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



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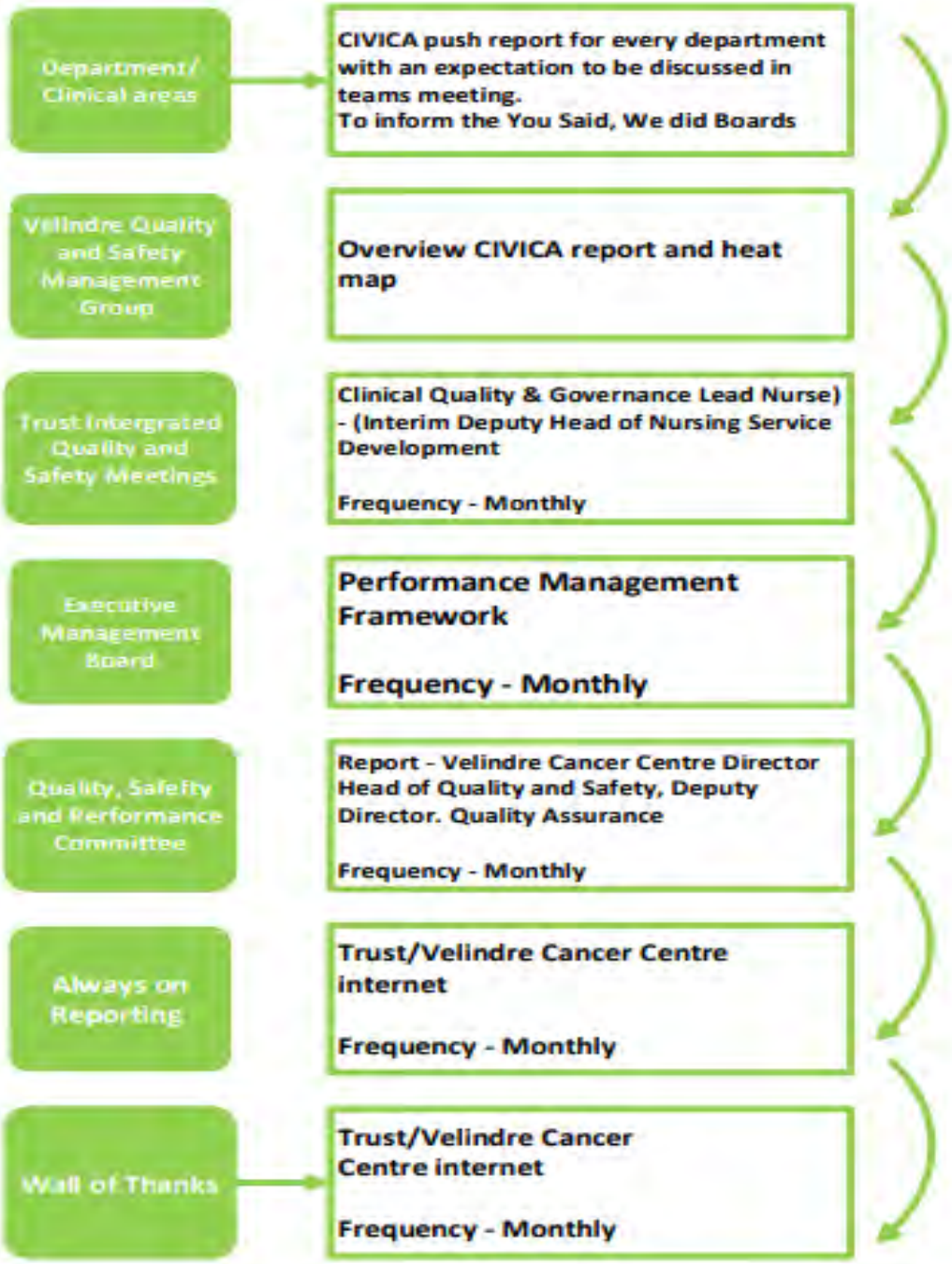
Velindre Cancer Centre

VELINDRE CIVICA SURVEY'S

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



Velindre Cancer Centre utilises a variety of both qualitative and quantitative mechanisms for donor feedback. Datix is used as opportunities for patient feedback and compliments.

Qualitative feedback is received and reported via the concerns process. Learning is shared with the teams involved and reported via the quality reporting governance arrangements.

Patient Stories are gathered intermittently, however there is not a consistent process or arrangements in place for stories to be captured, stored, and recorded.

Patient Engagement

Velindre University NHS Trust Patient Engagement Strategy

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

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

The feedback from the engagement activities helped define seven goals:

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

There are currently no formal mechanisms for sharing patient feedback from engagement opportunities for analysis and learning.

Further work is required to ensure that patent engagement and patient experience findings are shared and triangulated as an opportunity to improve the quality of our services.

3.3 Trust Communications and Social Media

There is currently no formal mechanism for sharing patient donor feedback from social media. Concerns that are identified are shared with concerns leads. Currently compliments shared on social media platforms are not routinely added onto to Datix due to resource issues.

3.4 The People Experience Framework

NHS Wales People's Experience Framework for Assuring Service User Experience has been renamed and refreshed to 'The People's Experience Framework' – this feels easier to understand and more inclusive and follows wide engagement with third sector organisations; Llais and NHS bodies. The shift in the language now also recognises that people use NHS Wales services beyond the traditional meaning associated with the term's patient or service user. The Framework includes a 'local self-assessment tool', empowering organisations to evaluate their current position and to develop an ambitious improvement plan. It covers all areas across people's experience umbrella including:

o Complaints
o Compliments
o Stories
o Incidents
o National and Local People's Experience surveys
o People's Experiences Survey (PES)
o Lived experience/People's groups
o Staff experiences
o Equality.

The People's Experience Framework also introduces a requirement to build experience measures into contractual arrangements such as commissioned services and introduces a People's Experience (Welsh People's Experience core set of questions), which is a Welsh version of the English Friends and Family Test, which will become a requirement within all people's experience and feedback questionnaires/surveys. The Framework is awaiting final design and publication pending endorsement.

The Patient Experience Framework includes a good practice local self-assessment tool. It is recommended that all NHS Wales bodies complete a local self-assessment rag rating score foreach element of the framework as a basis for local quality and improvements. The self-assessment consists of 5 main criteria:

- Leadership
- Capacity and capability to effectively collect feedback.
- Analysis and triangulation

- Using peoples feedback to drive quality improvement and learning.
- Reporting and publication.

The framework will be officially launched nationally in April 2025. Along with the National PREM Refresh.

3. NEXT STEPS

Following the scoping exercise there is an opportunity to utilise the self-assessment within the Peoples Experience Framework to develop an improvement plan for our patient donor experience mechanisms across the Trust. The Trust requires a joined approach to gather and analyse patient/donor feedback to ensure that it can be utilsed as an effective method of improving the quality of our services. The following will be undertaken:

1. **A working group will be established to complete the Self-Assessment and develop a plan for improvement,**
2. **The improvement plan will be monitored via the Trust Integrated Quality and Safety Group.**

Quality, Safety and Performance Committee

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK - SEPTEMBER 2024 / 2025

Date of meeting	**14TH NOVEMBER 2024**

PUBLIC OR PRIVATE REPORT	**Public**

IF PRIVATE PLEASE INDICATE REASON	**Not applicable Public Report**

REPORT PURPOSE	**INFORMATION / NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**

Prepared by	Peter Gorin, Head of Strategic Planning and Performance Rachel Hennessy, Acting Director of Velindre Cancer Services Sarah Richards, Head of Planning and Performance Services.
PRESENTED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital, Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance.
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital Anne Carey, Interim Chief Operating Officer.

EXECUTIVE SUMMARY	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW:** The report provides the Velindre University NHS Trust Executive Management Board approved analysis of the Performance Management Framework for the month of September 2024. The report focuses on the key issues to be raised and discussed. <u>Therefore, this report only provides detailed supporting data and analysis where Key Performance Indicators (KPIs) are not being achieved.</u>

The Trust's performance against the full range of PMF Key Performance Indicators (KPIs) targets is provided in the PMF Detailed Analysis report.

THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO SEPT 2024 / 2025 ARE SUMMARISED BELOW:

Velindre Cancer Service

SACT Performance:

- July – 100% for Emergency and 89% Non-emergency
- August – 100% for Emergency and 87%
- September – 100% Emergency and 65% 'unvalidated'. The expectation is that this will improve by 16-20% post- clinical validation.
- Non-emergency performance continues to be challenging. As a result, business continuity plans are still in place, with the Executive Director of Nursing chairing the biweekly SACT GOLD.

Radiotherapy Performance:

- September Scheduled - was 95% against 100% standard
- September Urgent –82% against 100% standard
- September Emergency – 100% against 100% standard
- September Elective delay - 97% against 100% standard.
- Performance continues to be challenging during the Linac replacement programme.

Welsh Blood Service

- All clinical demand was met, however this was supported by the implementation of pre-amber alerts for rare blood groups throughout the month (B- Group: until 12th September; AB- Group: until 3rd October; AB+ Group: 12th September until 26th September).
- Donor satisfaction reached an impressive 99% (against a target of 95%). A total of 7,341 donors were registered at donation clinics. Among them, 3 informal concerns were addressed within 2 days, and 1 formal concern was acknowledged within 5 days.
- One adverse event was reported to the Medicines and Healthcare products Regulatory Agency (MHRA). An incorrect donor travel risk assessment led to a lookback and product recalls. The Root Cause Analysis found the staff process too complex. A Corrective and Preventive Action Plan aims to simplify the process to ensure accurate assessments and prevent future issues.
- New whole blood donors did not meet target for the quarter (3210 against a target of 5500), further details provided below. The service continues to prioritise known blood groups to better match supply with demand, which affects target achievement. When stock stabilise recruitment effort can re-focus on recruiting new donors.

	• Transplant Centre demand for Stem Cell collections was met but failed to meet the collection target (2 against a target of 7), further details provided below. Strong performance in recruiting stem cell donors is expected to further enhance performance. • Performance of Reference Serology Turnaround times decreased this month compared to the previous two months (65% against a target of 80%) due to workforce issues, further details provided below. Addressing turnover through retention strategies, succession planning, and effective onboarding, with two new staff members expected to complete their training by April 2025, is anticipated to positively impact future performance.

RECOMMENDATION / ACTIONS	**The Quality, Safety and Performance Committee is asked to:** • **NOTE and DISCUSS the September 2024 Performance Management Framework**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**16 October 2024**
VCS SLT / Performance Review	**23 October 2024**
Executive Management Board - Run	**29 October 2024**

Summary and outcome of previous governance discussions
The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB and is presented to the QSP Committee for information and noting. In particular:

- The Velindre University NHS Trust Executive Management Board noted the continued development of the Trust Performance Management Framework.
- The Interim Director of Strategic Transformation, Planning and Digital highlighted that the section regarding PMF developments and associated work packages needed to be refined and this would be done in advance of the Velindre University NHS Trust Quality, Safety and Performance meeting on 14th November 2024.
- Assurance was provided that an implementation plan, with agreed timescales, has been developed and is delivery is being managed though the Trust planning team.
- Further assurance was provided a number of these work packages have already been delivered e.g. reporting on compliance metrics.
- The Trust Executive Management Board were supportive of the development of the approach and format of the executive summary of the report for the Velindre Cancer Service and the Welsh Blood Service. It was agreed that the approach provided far greater clarity on the progress since the previous reporting period and the expected outcome of the agreed actions.
- The Interim Chief Operating Officer also provided assurance that there was ongoing work to improve the format and presentation of the PMF in advance of the QSP meeting on 14th November 2024.

The Velindre University NHS Trust Executive Management Board noted the Performance Management Report for September 2024.

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

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 AND INITIALISM	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts
SMART	Relating to goal setting – “Specific, Measureable, Achievable, Relevant, Time-based”

1. SITUATION AND BACKGROUND:

1.1 PMF Development Overview

The following work packages were presented to the Committee in September and progress since is summarised below.

In addition, the executive summary for the core service performance for Velindre Cancer Services and the Welsh Blood Service has been presented in a new way in this version of the report. Instead of the narrative summary, there are slides showing the key data, updates from last month, action and expected impact of actions. The Interim Chief Operating Officer has led on this development with the Divisional Leadership Teams. The remainder of the executive summary will be developed in the same way for the next report, based on the Committee's feedback.

PMF Work Packages – Progress since last reporting period

1 - Level of Statutory Compliance:

As reported in the September report, going forwards, there will continue to be a summary of performance measures (KPIs) across statutory/mandatory, best practice/benchmarks and locally determined stretch targets.

2 - Wider inclusion of Quality Metrics into the PMF and 'Always On' Reporting:

The Trust is required to report against Duty of Quality & Always On reporting targets. There is now agreement on the implementation plan for the Quality metric development, in sprints of three weeks over 20 weeks.

The reporting of these Quality metrics will then start from Q2 2025, in line with the Always On reporting requirements.

Ensuring Data and Insight capacity for work packages two and three, in particular, continues to be an issue and is being escalated to Executive team for collective prioritisation recommendations and will be considered in Executive Management Board on 11th November.

3 - Single Source of the Truth for Data, Mapped to Pathways:

It is agreed that regionally this is an important priority and links to actions in the Cancer Improvement Plan 2023-6.

Extract from Cancer Improvement Plan:

"In Wales, data on cancer patients is fragmented and is collected and held by a number of different organisations with varying roles and responsibilities. There is no single organisation that has ownership of the responsibility to use data for patient benefit. This accounts for the high levels of frustration, built up over many years, from a wide range of stakeholders, about the lack of a cancer intelligence function in Wales with responsibility for analysing data at cancer site, population and provider level with sufficient granularity to actually enable service change. The development of innovative digital solutions must be a key component of the recovery of Cancer Services. Minimal progress has been made on delivering the actions set out in the Cancer Information and Intelligence Framework; A Digital Health Strategy for Cancer in Wales 2017-2020. A key component of this strategy was improved data sharing and collection to benefit patients, professionals and the system. Direct patient access or held summaries of their treatment will help enable the balancing of healthcare pathways, activity and decision making between the professional and patient: a key component of the quadruple aim in A Healthier Wales (Welsh Government, 2019)15. Wales urgently needs to make progress in taking forward the actions set out in the Framework and address the deficit in the availability of cancer intelligence to improve care and outcomes. The Wales Cancer Network will lead development of a refreshed Digital Cancer Plan deriving this from the refreshed National Digital Healthcare Plan."

Since September, there has been development of the structure of the Regional Cancer Programme Board, which includes the consideration later in November of the regional approach to the development of a Regional Minimum Data Set and Patient Transfer List.

In addition, the Trust is pursuing its own requirements for a Patient Transfer list locally.

Ensuring Data and Insight capacity for work packages two and three, in particular, continues to be an issue and is being escalated to Executive team for collective prioritisation recommendations and will be considered in Executive Management Board on 11th November.

4 - Inclusion of all Targets:

Work is now complete to ensure that all performance metrics, without a set target, will include a target, and / or, a date by which the target will be agreed as well as a clear rationale for delay.

5 - Exception/ Threshold Reporting:

An approach has been agreed to include exception reporting data only for the Executive Management Board and the Quality, Safety and Performance Committee from this report period onwards.

6 - Future PMF Development Plans:

All VCS and WBS Directorates and Trust-wide functions are reviewing their metrics to discuss proposed changes with the Trust Board. This to include any further additional Quality metrics. Any changes to the PMF would then be governed via Executive Management Board and Strategic Development Committee into Trust Board.

7 - PMF Automation:

Work is also progressing to ‘automate’ the production of the PMF performance report to reduce the current level of manual interactions in the current process. This work, with the support of Business Information colleagues plus associated transition training, will be completed by February 2025.

1.2 Velindre Cancer Service

Radiotherapy Waiting Times

Canolfan Ganser Felindre
Velindre Cancer Centre

September 2024

All Wales COSC Standards		June 24 partial validation	July 24 partial validation	August 24 partial validation	Sept 24 partial validation
Scheduled	% within 21 days (target 100%)	76%	82%	91%	95%
	Longest wait	46 days	38 days	42 days	34 days
Emergency	% within 1 day (target 80%)	85%	100%	90%	100%

Updates on Last Month:

- Pre-treatment CT remained constant at 17 hrs a day.
- Planned Linac availability increased from 76.5 to 78 hrs per day.
- Linac utilisation increased from 97% to 98% on Elekta machines but decreased from 99% to 97% on Varian machines due to technical issues.
- Longest wait for Scheduled patients reduced from 42 days to 34 days, due to focus on pathway delays.
- Scheduled performance improved from 91% to 95%, Urgent SC from 78% to 82% and Emergency from 90% to 100%.

Key Issues / Risks:

- Resilience of the fleet and Linac replacement programme a risk to delivery.
- Alignment of consultant job plans with Radiotherapy pathway timings results in non-capacity related breaches. Our ability to forecast and manage this will increase once Aria and Insightive are in place, early 2025

Action / Mitigation Underway:

- Short term capacity has been offered prior to confirmation of extending life of LA1 to May 2025. This has given an additional 7.5 hours a day.
- Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.
- All failures to meet waiting times targets are investigated at pathway level to identify delay reasons, and have a clinical review. Themes are logged and mitigations developed to offset as far as possible before full fleet replacement.

Forecast / Next Month:

- Performance will continue to recover and stabilise due to the capacity gained from extending LA1.
- Actual performance improvements may be more evident in the medium to long term, linked to improvement in pathway management as well as Linac capacity.

Radiotherapy Trends

Canolfan Ganser Felindre
Velindre Cancer Centre

Urgent Treatment Standard

Target: 80% within 2 Days and 100% within 7 days

Current Performance against Target or Standard

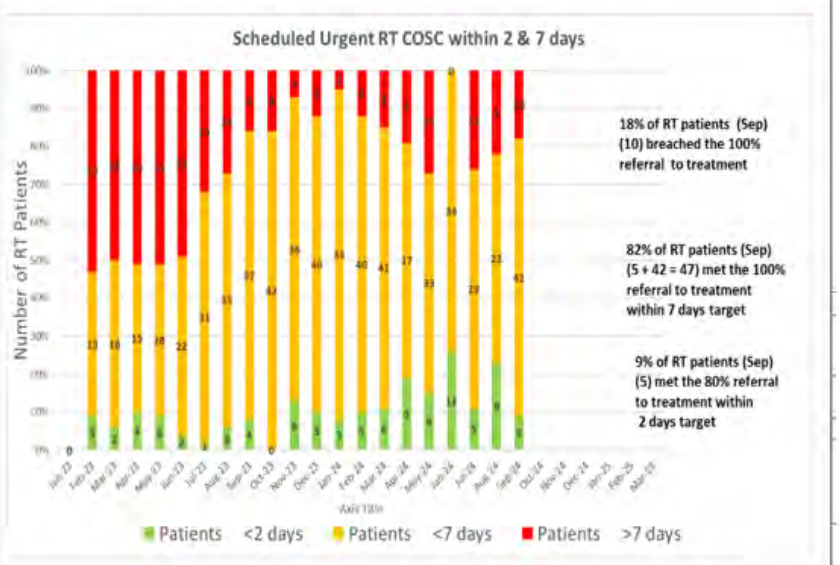


Chart Analysis

The above chart represents the spread of Urgent RT performance against the 2 and 7 day targets with a significant improvement in >7 day breaches over the last 6 months but some recent reduced performance.

Elective Treatment Standard

Target: 80% within 14 Days and 100% within 21 Days

Current Performance against Target or Standard

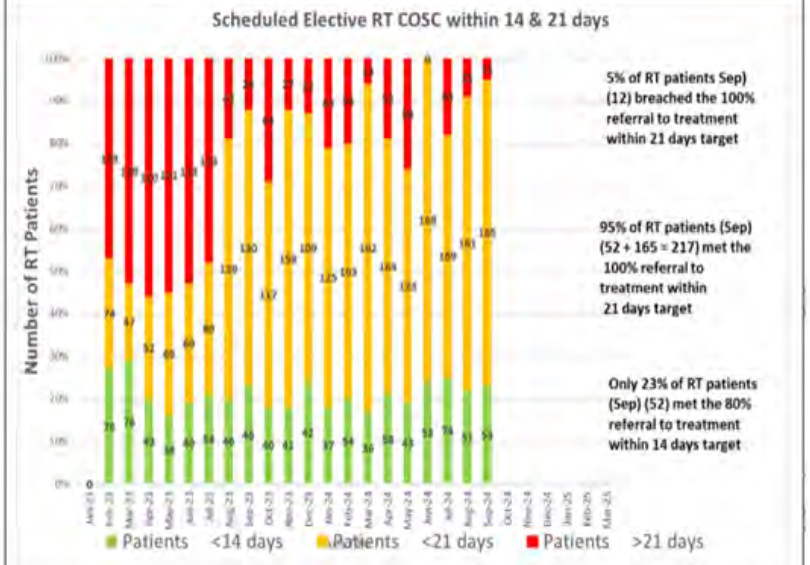


Chart Analysis

The above chart represents the spread of Scheduled RT performance against the 14 and 21 day targets with a significant improvement in >21 day breaches over the last 6 months.

Radiotherapy - Breach data

Canolfan Ganser Felindre
Velindre Cancer Centre

September 2024

Theme	No	Action
Late delineation/ approval	1	Highlighted to consultant, failsafe systems in place to enhance visibility prior to fully integrated system
Replan	4	Individual reasons for each replan, investigated and improvements highlighted
Complex plan required	3	Due to the clinical complexities of the physics plan required senior physics workforce input did not have sufficient capacity to support
Process failure	2	Fed back into service and management group to understand improvement required
Pathway	1	Feed into pathway improvement workplan
Capacity	12	• all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken and are thus booked according to clinical priority • Approval to bring LA1 back into operation service, will increase capacity and is part of the mitigation during the Linac fleet replacement • Planned Linac availability in October - up to 75 hours per day across 8 Linacs

Urgent Radiotherapy Breaches – 10 patients >7days

- 3 due to LINAC capacity
- 2 due to requirement for complex management
- 1 due to need to replan
- 1 due to a process failure
- 1 due to CT capacity
- 1 due to RTQA capacity
- 1 due to clinician capacity

Scheduled Radiotherapy Breaches – 13 patients>21days

- 5 due to LINAC capacity
- 3 due to need to replan
- 1 due to requirement for complex management
- 1 due to a process failure
- 1 due to pathway management
- 1 due to clinician capacity
- 1 due to late delineation

SACT Non-Emergency Waiting Times

Canolfan Ganser Felindre
Velindre Cancer Centre

September 2024

Month	Unvalidated Performance*	Validated Performance
June 2024	64.24%	88%
July 2024	65%	89%
August 2024	60.45%	87%
September 2024	65.44% as at 30/09	
October 2024	73.25% as at 10/10	

**We typically see a 16-20% increase in position following Breach Validation.*

Action / Mitigation Underway:

- Further work with BI & Digital to visualise pathways and create a 'single source of the truth'
- As part of the Phase 1 SACT Pre-assessment service review and shift of model of care recruitment is underway for - SAS Dr/Advanced Clinical Practitioner – Independent prescribers
- Business case is being written to expand the Pre-SACT and VAPP Services
- Negotiations with Lloyds Pharmacy regarding Nantgarw support unit in progress.
- Pathway coordinators now engaged in clinical validation to support timely reporting and free up clinical resource.

Updates on Last Month:

- Improved booking utilisation of Medicine at Home for week commencing 21st October, with some slots still to book for week commencing 28th October 2024. Up from average of 50 to 60.
- Current October utilisation rate for Tuesday treatments reflects 99%, highest to date this year, linked to the decoupling of bloods project.
- On going work via SACT Gold to further increase capacity
- Work started to review the Model of Care for SACT pre-assessment from Consultant delivered to Consultant led (phase 1)

Key Issues / Risks:

- Referral rate up in line with projections, however it is not linear, and spikes are challenging for the all aspects of the SACT treatment pathway.
- Work underway with HBs to forecast demands
- Internal daily sitrep in response to operational pressure under development
- Lack of a Patient Tracking List to visualise patients and drive pathway improvements
- On-going capacity across key Teams Nursing, Pharmacy and Digital & Insight Recruitment Pharmacy staff

Forecast / Next Month:

- A further 55 treatments per week from the Pharmacy expansion plan remains to be implemented. This step up is linked to the recruitment of additional staff.
- Gradual improved performance expected Aug-Sept-Oct.
- Update on-going initiatives (under SACT Gold) and outcomes

Breach data

September 2024

Canolfan Ganser Felindre
Velindre Cancer Centre

SACT Gold – Key actions

- Expansion of Medicine at Home provision between April and September 2024 - an increase of 40 patient treatments per week.
- Increasing outsourced pharmaceutical product capacity.
- Piloting pathway improvements to improve booking flexibility, ensuring we maximise the utilisation of all our available capacity,
- A senior SACT Improvement Lead in place to support rapid SACT improvement delivery and a comprehensive improvement plan is in place.
- Additional capacity across key 'bottlenecks' in the pathway
- Escalation process in place that reviews and prioritises patient to minimise patient impact and harm

	Jul-24			Aug-24	
Number of days waiting	Referrals	Percentage of referrals treated within time frame		Referrals	Percentage of referrals treated within time frame
0-7 days	151	37.8%		167	39.8%
8-14 days	74	18.5%		85	18.9%
15-21 days	132	33.0%		113	25.1%
22 - 28 days	39	9.8%		48	10.7%
29 - 35 days	2	0.5%		6	1.3%
36 - 42 days	1	0.3%		1	0.2%
43-49 days	1	0.3%			
Total	400			420	

1.3 Welsh Blood Service

Red Cell Stock Level (below 3 days) – O, A & B+

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2024

Updates on Last Month:

- All clinical demand was met however this was supported by the implementation of pre-amber alerts for rare blood groups throughout the month (see below).

(B- Group: until 12th September; AB- Group: until 3rd October; AB+ Group: 12th September until 26th September).

Key Issues / Risks:

- Challenges in blood group imbalances and maintaining an adequate number of donors for less common blood types.
- Variance in issuing.

Action / Mitigation Underway:

- Continued daily Resilience Group meetings to ensure immediate operational responses.
- Established a Task & Finish Group to review whole blood collection capacity and identify actions to increase collections by expanding donor recruitment.
- Resourcing plan in development to better align supply and demand – will enable more capacity to attract new donors.

Forecast / Next Month:

- Expanding donor recruitment and reviewing collection capacity are expected to show improvements.
- October may see similar issues.
- The operational adjustments currently underway should help mitigate these risks in the medium term.

Ymddiriedolaeth GIG Prifysgol Felindre
Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

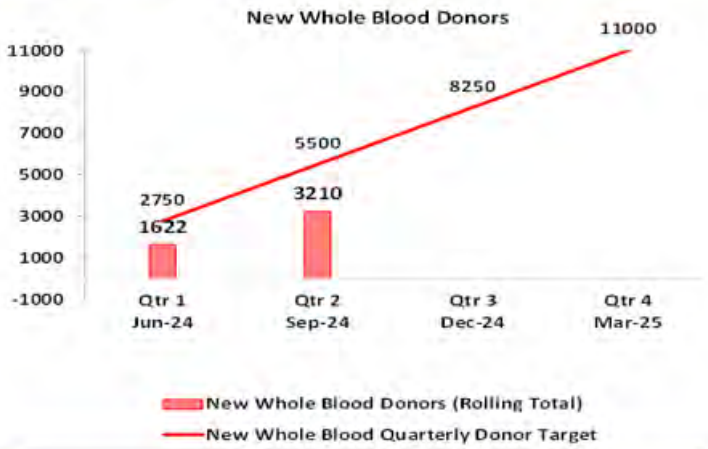
GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

Velindre University NHS Trust
Excellent care, inspirational learning, healthier people

New Whole Blood Donors (per quarter)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2024



Updates on Last Month:

- With 1,498 new donors recruited, the target for the quarter was not met. However, this number is higher than the same period in 2023 (1,262), supported by a 90% appointment uptake rate.

Key Issues / Risks:

- The service continues to prioritise the known blood groups to better align supply with demand, which reduces appointment availability for new donors and impacts achieving target.

Action / Mitigation Underway:

- The new donor strategy is being implemented which aims to increase opportunities for both young donors and ethnic minority donors to give blood.
- A new automated system guides potential donors by sending one of six personalised emails based on their specific situation, such as booking a blood donation or being eligible for stem cell donation. Each email offers tailored next steps, supporting recruitment of new donors.
- Resourcing plan in development to better align supply and demand – will enable more capacity to attract new donors.

Forecast / Next Quarter:

- If blood stocks stabilise, recruitment efforts can focus on recruiting new donors, which will improve the performance of this metric.
- KPI currently under review.

Stem Cell Collections

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2024

Updates on Last Month:

- Transplant Centre demand for Stem Cell collections was met but failed to meet the collection target of 7 Peripheral Blood Stem Cell collections (PBSC) per month.
- The total cell provision for the service was 6 (2 stem cell collections from Welsh donors, and 4 cell imports for the University Hospital of Wales).

Key Issues / Risks:

- A reduction in recruiting new Bone Marrow donors poses a significant risk to maintaining the stem cell collection target.
- After falling below target in August for the first time since February, recruitment of new stem cell donors has rebounded and is now back above target this month.

Action / Mitigation Underway:

- The launch of the buccal swab drives has considerably improved recruitment of new donors which, over time, will increase the number of collections.
- The Welsh Bone Marrow Donor Registry five-year strategy in development as part of WBS Futures.
- Business Case for Welsh Government / Commissioners in development to support uplift in funding given the new buccal swab pathway.

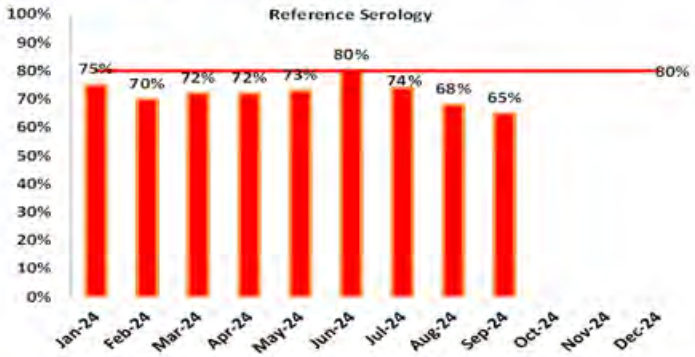
Forecast / Next Month:

- Future performance is anticipated to increase as the Welsh Bone Marrow Donor Registry has a possible 9 stem cell collections booked during the October/November period.
- The strong performance in recruiting stem cell donors is expected to further enhance overall performance.

Reference Serology Turnaround Times (2 working days)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2024



Updates on Last Month:

- Performance decreased this month compared to previous two months due to workforce issues. Ongoing training and development of junior staff continues to affect this metric.
- Compatibility testing (39% of referrals) continues to meet clinical need with 'time critical' tests prioritised and completed within required timeframe, maintaining safety of clinical care.

Key Issues / Risks:

- Staff turnover and replacement of key roles is hampering performance.

Action / Mitigation Underway:

- Addressing turnover through retention strategies, succession planning and effective onboarding.
- Two new staff members are expected to complete their training by April 2025, which is anticipated to positively impact future performance.
- Recommendations from the report of the RCI independent review are being prioritised and an action plan formulated.
- This metric is under active review to align with the RCI User Guide, i.e. 90% of results within 5 working days.

Forecast / Next Month:

- The immediate impact of staff training for next month will be minimal in terms of performance improvements.
- Actual performance improvements may be more evident in the medium to long term following review of KPI.

1.4 Workforce and Wellbeing:

- ***Sickness – c***urrent rolling sickness absence is 5.22% to September 2024, which is above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. A number of interventions to manage sickness are in place to mitigate the risk to staff wellbeing and there has been a downwards trend in sickness absence over the last 12 months. Work is ongoing with service managers to support staff.
- ***PADR's (staff appraisals)* –** Trust wide PADRs this month is 73% (target 85%). This is continued improved performance over the last three months.
- ***Statutory & Mandatory Training* –** remains above target at 85% (target 85%) and has been consecutively on target for the whole year to date.

1.5 Digital Services:

- Steady performance in September 2024, with some improvements observed. Generally improved performance in respect of Digital Service Desk metrics - new Halo ITSM platform deployed late-September. As new service embeds, may be some variation in performance over coming months, but in the medium to long-term, it is anticipated that this new platform will help facilitate permanent improvement in Digital Service Desk performance and ongoing attainment of performance targets.
- Target (95%) for user satisfaction with Digital Service Desk met in September 2024 – deployment of Halo ITSM expected to facilitate attainment of this target over time.
- Slight improvement in respect of the rolling 12-month number of significant business continuity incidents – 12 in September 2024 (down from 13 in the previous month). The major of incidents relate to outages associated with national, DHCW-managed IT systems.
- Incidents are reviewed via the relevant national Service Management Boards, to identify opportunities to prevent re-occurrence.
- Annually reported metrics re: % of Trust investment in digital now being reported, as a percentage of overall Trust spend (capital and revenue). 2023/24 investment reported at 2.6% against a target of 4%, outlining need for further investment in digital services (staff and technologies), to ensure the Trust can deliver its digital ambitions and achieve the objectives of the Trust and Digital Strategies.
- Work underway to improve the delivery of the IG and cyber security statutory and mandatory training, with a view to improve overall compliance – currently reported at 82% against a target of 85%. E-learning package being re-written (due to be completed in Q4 2024/25) and additional classroom-based sessions being put on by Head of Information Governance to increase opportunities for staff to attend training.

1.6 Estates Infrastructure and Sustainability:

Estates Compliance:

Over the past two months, Velindre Cancer Centre has seen a temporary drop in estates compliance due to challenges with the migration to the new Computer-Aided Facilities Management System (CAFMS), Synbiotix. Issues with system development have affected the ability to track and report Planned Preventative Maintenance (PPM), but the estates team has implemented a manual checklist to ensure all critical PPMs are being completed and logged.

A development plan is in place to address the system issues and the team is working closely with Synbiotix to resolve them.

An assurance meeting, supported by the Digital Director, will take place in October 2024 to request further clarification of the project plan. Compliance remains high at Welsh Blood Service (WBS) sites, which are due to migrate to Synbiotix in October 2024, with lessons from Velindre experience being applied to mitigate risks.

Sustainability:
Energy prices have decreased following the energy crisis. Team Sigma provide billing & consumption verification for the Trust, alongside comprehensive reporting. Gas and electricity consumption across VUNHST Estate during 23/24 has been lower than baseline 18/19 year. The Trust continues to manage energy consumption with constant monitoring via the Building Management System. Water consumption during 23/24 has increased at VCC.

The water consumption increase against the baseline at VCC is due is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures. This action has resulted in an external audit awarding "Substantial Assurance" for water safety, for the first time on site.

Fire:
The KPIs for fire safety training remain below target figure of 85%. The Trust fire safety manager continues to work with both the ESR and WOD teams to review the current provision of fire safety training and to review and streamline the delivery of fire safety training down to five [5] competency levels and remove duplicate competencies which have been agreed. The Head of Health & Safety is also working with the ESR team around the content of the monthly reports with the aim of focusing on staff directly employed by the Trust and currently in work to gain more exact compliance figures.

The fire safety manager has also continued to work with SLT leads and staff supervisors across the Trust to emphasise the importance of prioritising attendance at future training events and has run additional sessions through the coming quarter [October to December] to improve this area of compliance.

Following request from the Trust Health, Safety and Fire Management Board, the divisions have developed schedules for emergency drills and exercise; these are currently being implemented with both WBS and VCC running evacuation drills in the coming quarter [October to December 2024]. In addition, work is underway to ensure that sites have appropriate arrangements in place for security-related incidents which will also be included in the emergency drill and exercise schedules.

Health & Safety:
This month, the Trust has experienced fewer events; however, we regret to report that we have one Riddor Recordable incident, in which an employee twisted their knee and missed more than seven days of work. WBS = 5, VCC = 1 V&A case, and Corporate = 1 make up our total. We have received another late-reported occurrence this month, which we have added to our statistics in retrospect.
Additional talks are being held between the safety department and the divisions to make sure that any events are reported as soon as possible. If the incident is substantial enough, this could lead to a delayed report to the HSE.

Since we are unable to provide the training at this time, we must emphasise once more the reduction in patient manual handling. Discussions will shortly address this.

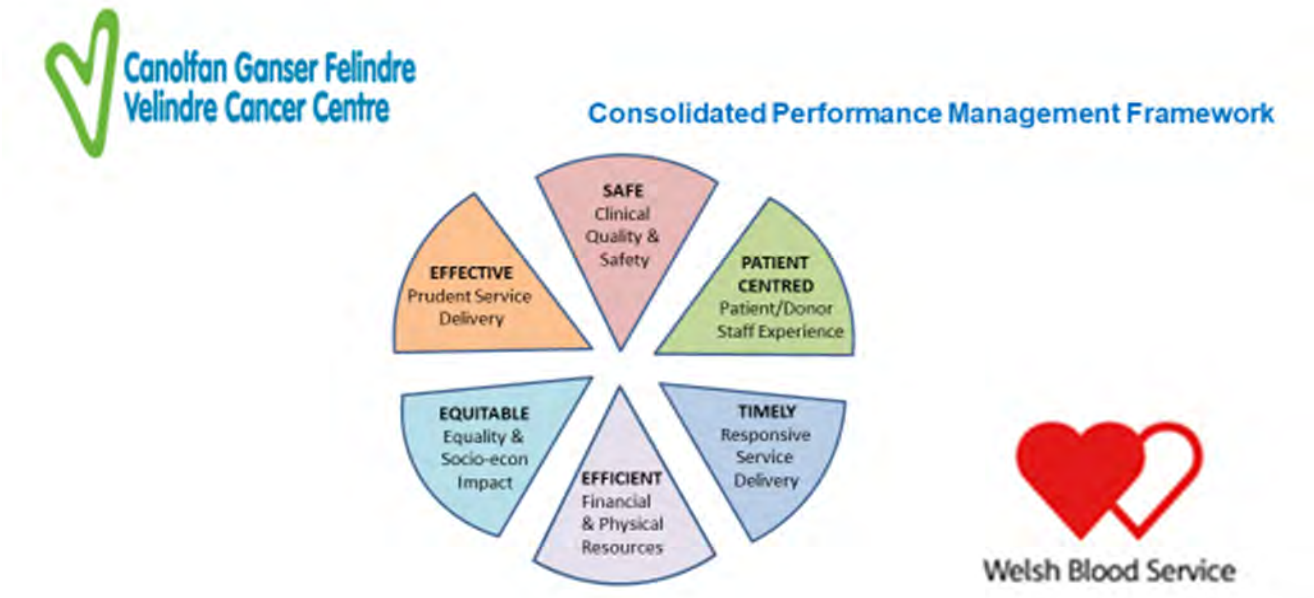
I would also want to draw attention to the launch of the Health and Safety Culture Survey. The employees will have access to this to complete for the quarter, and the results will be released in the upcoming year.

1.7 Finance:

- The overall position against the profiled revenue budget to the end of September 2024 is underspent by £0.018m and at this stage is currently expecting to achieve an outturn forecast of Breakeven.
- Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values in line with 30th June deadline which has led to a financial impact to the Trust for 2024-25 as follows:
- £318k Reduction in recurrent baseline uplift income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. Hywel Dda UHB has given notice that the £483k funding will be removed recurrently in 2025-26 together with activity baseline funding of c£360k. Their argument for this is that since 2018 they have re-directed patient's flows from Velindre Trust to the Swansea Bay cancer centre to receive treatment.
- However, the activity that Velindre has undertaken for Hywel Dda residents over the past five years hasn't significantly reduced and the Velindre cancer service teams are not aware of any significant changes to patient flows. Furthermore, Hywel Dda has now stated that they will not support the cost neutral re-basing of the Velindre LTA to reflect the current activity and cost that each commissioner consumes, previously agreed by DoF in 2020-21.
- The agreement reached by DoFs was that the re-basing would be matched by an allocation adjustment between commissioners to neutralize the impact on each commissioner's current consumption cost compared to historic baseline cost shares. This issue is likely to lead to a dispute between Velindre and Hywel Dda UHB in the 2025-25 IMTP LTA process.
- The shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions and mitigating cost pressures.
- In conjunction with the overall financial plan an in-depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.
- In order to achieve a balanced financial position, the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves. The overall Trust savings performance as of September'24 is an underachievement against plan of £(0.074)m, however at this stage are expected to deliver to target by the end of the Financial year.
- The approved Capital Expenditure Limit (CEL) as of September 2024 is £19.600m. This represents all Wales Capital funding of £17.689m, and Discretionary funding of £1.911m. The Trust reported Capital spend to September'24 of £8.153m and is forecasting to remain within the CEL of £19.600m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.
- During September'24 the Trust (core) achieved a compliance level of **98.1%** (August 96.6%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.1%** at the end of month 6, and a Trust position (including hosted) of **97.5%** compared to the target of 95%.

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION - PERFORMANCE FOR SEPTEMBER 2024:

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



2.2 Navigating our PMF Performance Report

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

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

2.3 For the purposes of this Executive level report, KPIs that are achieving their targets ✓ are not supported by detailed analysis templates, this analysis is only given for KPIs that are outside standard' ✗ against any particular target.

2.4 Cancer Services Scorecard as at September (month 06) 2024/25.

QSF Domain	Cancer Services Safety Scorecard			Performance as at Month 06 (September)			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	Number of Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	➔	
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	➔	
	% Patients with a Sepsis NEWS score >or= 3 receiving all 6 treatment elements within 1 hour	National	Monthly	100%	100%	100%	✓	➔	
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	➔	
	Number of Healthcare acquired Infections (HAIs) MRSA bacteraemia **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	<1 24/25	0 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) MSSA bacteraemia **(WHC 2024 (38) target**	National	Monthly	23/24 Base	<1 24/25	0 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) P. aeruginosa bact. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	0 24/25	0 24/25	✓	➔	
	Number Healthcare acquired Infections (HAIs) Klebsiella spp bact. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	4 24/25	1 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) C Difficile. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	<3 24/25	1 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) E Coli bacteraemia **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	3 24/25	1 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	23/24 Base	<13 24/25	2 24/25	✓	➔	
	Total Antimicrobial (AMR) Usage **(WHC 2024 (38) target) reduction by 2029/30**	National	Monthly	2019 Base	5% reduction	TBA	✓	➔	
	Proportion of total AMR usage WHO 'Access' category **(WHC 2024 (38) target) by 2029/30**	National	Monthly	2019 Base	reduction to 70%	TBA	✓	➔	
	% Compliance with World Health Organisation 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99%	✓	➔	
	Number of Health and Safety Incidents recorded	Local	Monthly	9	9	1	✓	➓	
	Number of National VCS Reportable Incidents	National	Monthly	0	0	0	✓	➔	

	Number of Duty of Candour Incidents recorded	**National**	**Monthly**	**0**	**0**	**1**	✗	➔	KPV.63
	Number of 'Never Events' recorded	**National**	**Monthly**	**0**	**0**	**0**	✓	➔	
	% compliance for staff who have completed the Core Skills and Training Framework Level 1.	**National**	**Monthly**	**85%**	**85%**	**81%**	✗	➔	KPV.59
	Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents	**Local**	**Monthly**	**0**	**0**	**0**	✓	🡻	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	**Cancer Services Effectiveness Scorecard**			**Performance as at Month 06 (September)**			**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	Radiotherapy (RT) 30 Day Mortality Benchmark	**Curative**	**Monthly**	**TBA**	**TBA**	**TBA**	✓	➔	
		Palliative	**Monthly**	**TBA**	**TBA**	**TBA**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Curative**	**Monthly**	**TBA**	**TBA**	**0.01%**	✓	➔	
		Palliative	**Monthly**	**TBA**	**TBA**	**1.14%**	✓	➔	
	Inpatient Mortality	**Inpatient**	**Monthly**	**TBA**	**TBA**	**2**	✓	➔	
	Number of Pathway of Care Delays	**National**	**Monthly**	**1**	**0**	**0**	✓	➔	
	% Personal Appraisal Development Reviews (PADR) Compliance	**National**	**Monthly**	**72%**	**85%**	**71%**	✗	🡻	KPV.56
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.43%**	**3.54% 4.70%**	**5.18%**	✗	🡹	KPV.57
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Cancer Services Experience Scorecard			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95	85%	95% 88%	✓	➔	
	% of 'formal' concerns responded to within 30 working days	Local	Monthly	100	85%	100%	✓	➔	
	Number of Incidents of violence and aggression to staff	Local	Monthly	7	0	1	✗	↑↓	KPV.53
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Cancer Services Timeliness Scorecard			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	23% 95%	✗	↓	Slides on p.8-10
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	9% 82%	✗	➔	Slides on p.8-10
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 100%	✓	↑	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	97% 97%	✓	↑	
	% Patients Beginning Non-Emergency SACT within 21 days August **Position**	National	Monthly	98%	98%	87% Aug	✗	↑↓	Slides on p.11-12
	% Patients Beginning Emergency SACT within 5 days August Position	National	Monthly	100%	98%	100% Aug	✓	↑	
	% Outpatients seen within 30 minutes of scheduled time	Local	Monthly	paused	100%	paused	N/A	N/A	
	% Patients receiving equitable and timely access to Therapy Services	Local	Monthly	100%	100%	98%	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Cancer Services Efficient Scorecard			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% Outpatient Did Not Attend (DNA) rates	National	Monthly	3%	5%	nda	N/A	N/A	
	Electricity performance in kilowatt hours (kWh)against target consumption budget profile	National	Monthly	N/A	255k	269k	✗	↑↓	KPV.62
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Monthly	N/A	17k	40k	✗	↑↓	KPV.62
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	1750m3 May	1800m3 May	✗	↑	KPV.67
	Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£0k	✓	→	
	VCC expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£156k	£119k	£243k	✗	→	KPV.72
	Cost Improvement Programme – VCC achievement of savings (£k) in line with profile	National	Monthly	£939k	£389k	£382k	✗	↓	KPV.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

2.5 Blood and Transplant Scorecard as at September (month 06) 2024/25.

QSF Domain	Blood and Transplant Safety Scorecard			Performance as at Month 06 (September)			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	Number of Health and Safety Incidents recorded	Local	Monthly	5	N/A	5	N/A	→	
	Quality Incidents closed within 30 days	Local	Monthly	96%	90%	98%	✓	→	
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	→	KPI.30
	Number of Duty of Candour Incidents recorded	National	Monthly	0	0	0	N/A	N/A	

	Number of 'Never Events' recorded	**National**	**Monthly**	0	**0**	**0**	N/A	N/A	
	Numbers of critical and major non-conformances through external audits or inspections	**Best practice**	**Monthly**	**0**	**0**	**0**	✓	➔	
	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	**National**	**Monthly**	**95%**	**85%**	**92%**	✓	🡻	
	Number of Staff RIDDOR Incidents, injuries, and work-related accidents.	**Local**	**Monthly**	**0**	**0**	**1**	✗	🡻	KPI.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	**Blood and Transplant Effectiveness Scorecard**			**Performance as at Month 06 (September)**			**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	New Whole Blood Donors	**Local**	**Quarterly**	**1660**	**2750**	**1498**	✗	🡻	**Slide on p.14**
	% Demand for Red Blood Cells Met	**Best practice**	**Monthly**	**104%**	**100%**	**107%**	✓	🡹	
	% Demand for Platelet Supply Met	**Best practice**	**Monthly**	**133%**	**100%**	**116%**	✓	🡻	
	Red Blood Cell Stock Level (below 3 days)	**Local**	**Monthly**	**0**	**0**	**0**	✓	🡹	
	% Time Expired Platelets (adult)	**Local**	**Monthly**	**20%**	**Max 10%**	**10%**	✓	🡹	
	% Time Expired Red Blood Cells (adult)	**Local**	**Monthly**	**0.02%**	**Max 1%**	**0%**	✓	➔	
	New Apheresis Donors	**Local**	**Quarterly**	**21**	**14**	**25**	✓	🡹	
	Number of Stem Cell Collections per month	**Local**	**Monthly**	**6**	**7**	**2**	✗	🡻	**Slide on p.15**
	New Bone Marrow Donors	**National**	**Monthly**	**3341**	**333/month 4000/year**	**3256**	✓	🡹	
	Enhance the Impact of RD&I & Celebrate Success Number of Conference Presentations	**Local**	**Monthly**	**N/A**	**5 per year**	**10 Year to date**	✓	🡹	

	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	**National**	**Monthly**	**86%**	**85%**	**82%**	✗	↓	KPI.56
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.8%**	**3.54% 4.70%**	**6.33%**	✗	↓	KPI.58
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Blood and Transplant Experience Scorecard**			**Performance as at Month 06 (September)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Donor/ Staff Experience	% Unsuccessful Venepuncture	**Best practice**	**Monthly**	**1.7%**	**2.0%**	**1.5%**	✓	↑	
	% Part Blood Bags collected	**Best practice**	**Monthly**	**2.7%**	**3.0%**	**2.7%**	✓	↓	
	% Donor Satisfaction	**Local**	**Monthly**	**95%**	**95%**	**97%**	✓	↑	
	Number of Concerns	**Local**	**Monthly**	**9**	**0**	**4**	✗	↓	KPI.28
	% Responses to informal concerns within required 2-day timescale	**Local**	**Monthly**	**100%**	**100%**	**100%**	✓	→	
	% Responses to formal concerns within 30 working days	**Local**	**Monthly**	**100%**	**100%**	**N/A**	✓	→	
	Number of incidents of violence and aggression to staff	**Local**	**Monthly**	**1**	**N/A**	**0**	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Blood and Transplant Timeliness Scorecard			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	93%	✓	↑	
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	92%	✓	↓	
	% Reference Serology Turnaround Times (2 working days)	Best practice	Monthly	70%	80%	65%	✗	↓	Slide on p.16
	% Turnaround Time (Deceased Donors Typing / Cross matching)	Best practice	Quarterly	84%	80%	95%	✓	↑	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Blood and Transplant Efficient Scorecard			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Whole Blood Collection Productivity	Best practice	Monthly	1.12	1.25	1.17	✗	↓	KPI .08
	Manufacturing Productivity	Best practice	Monthly	418	392	354	✗	↑	KPI.10
	% Controllable Manufacturing Losses	Best practice	Monthly	0.06%	0.5%	0.11%	✓	↓	
	Electricity performance kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	126k	123k	✓	→	
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	10k	9k	✓	↑↓	
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	295m3 Apr	291m3 Aug	✓	↑	
	Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£(3)k	✗	↓	KPI.71
	WBS expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£0k	£0k	£22k	✗	→	KPI.72
	Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	National	Monthly	£569K	£368k	£300k	✗	↓	KPI.74

Symbols Key: In Month = Compliant ✓ Non-compliant ✗	Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

Trust-wide Services Scorecards as at September (month 06) 2024/25.

Estates Services:

QSF Domain	Estates Safety Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗	Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓								

QSF Domain	Estates Effectiveness Scorecard – Trust-wide position			Performance as at Month 06 (September)			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	Compliance with Sustainable Development Assessment Tool (SDAT)	Local	Annually	TBA	TBA	TBA	N/A	N/A	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗	Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓								

QSF Domain	Estates Timeliness Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% PPM undertaken completed against plan	Local	Quarterly	90%	95%	87%	✗	↑	EST.54

	% Reactive maintenance achieved within agreed days/hours	Local	Quarterly	80%	95%	85%	✗	↑	EST.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Efficient Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Trust HQ Electricity performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	1789	1870 July	✗	↑	EST.64
	Trust HQ Gas performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	228	1378 July	✗	↑	EST.64
	Trust Waste Recycling performance by weight (Kg)	Local	Monthly	4500Kg	4500Kg	4800Kg	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

Health and Safety Services

QSF Domain	Health and Safety Scorecard – Trust-wide position			Performance as at Month 06 (September)			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	RIDDOR reportable incidents of workforce	Local	Quarterly	0	0	0	✓	→	
	% Fire Action Plan actions implemented	Local	Quarterly	78%	100%	97%	✓	↑	
	Number of Health and safety incidents recorded	Local	Monthly	14	14	7	✓	↑↓	
	% Fire Drills completed accordance with schedule	Local	Quarterly	paused	100%	6 Jun	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									
QSF Domain	Health and Safety Effectiveness Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		

	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	Data Link
Effectiveness	% staff overall compliance with Level 1 (Essential) Level 2 (fire Warden) & Level 3 Fire safety training	Local	Monthly	89%	85%	80%	✗	➔	H&S.27
	% Training compliance – Manual Handling (level 1 and 2), Health & Safety, Violence and Aggression (module A and B) and Display Screen Equipment	Local	Monthly	80%	85%	82%	✗	↓	H&S.26
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Health and Safety Experience Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	Number of Incidents of violence and aggression to staff	Local	Monthly	7	0	1	✗	↓	H&S.43
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Workforce and Organisational Development

QSF Domain	Workforce and OD Safety Scorecard – Trust-wide position			Performance as at Month 06 (September)			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	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	87%	85%	85%	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									
QSF Domain	Workforce and OD Effectiveness Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		

	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	Data Link
Effectiveness	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	73%	✗	↑↓	WOD. 36
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.22%	✗	↑	WOD. 37

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Workforce and OD Experience Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	March 23	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% staff who would recommend the Trust as a place to work	National	Annually	65%	85%	65%	✗	→	WOD. 13

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Workforce and OD Equitable Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	5%	13.85% (Mar 24)	N/A	N/A	
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	6.16%	✓	→	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	6.43%	↑	→	WOD.80
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	93.90%	↑	↑	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

Digital Services

QSF Domain	Digital Safety Scorecard – Trust-wide position			Performance as at Month 06 (September)			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 against NCSC "10 Steps to Cyber Security" best practice standards	Local	Bi-annual	88%	90%	87%	✗	🡻	DIG.62
	% compliance with cyber security statutory & mandatory training	Local	Monthly	TBA	85%	82%	✗	🡹	DIG.72
	% of Trust expenditure in digital	Local	Annually	TBA	4%	2.6%	✗	🡹	DIG.73
	Number of significant IT business continuity incidents	Local	Monthly (rolling 12 months)	12	6	12	🡹	🡹	DIG.61
	Cyber Security - % of employees clicking on internal phishing campaigns	Local	Quarterly	TBA	<10%	10.6% July	TBD	n/a	DIG.63

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻

QSF Domain	Digital Experience Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline Oct 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% User satisfaction with Digital Service Desk	Local	Quarterly	87%	95%	95%	✓	➔	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻

QSF Domain	Digital Timeliness Scorecard – Trust-wide position	Performance as at Month 06 (September)	Compliance against Target or Standard	Data

	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	Link
Timeliness	% Digital Service Desk requests resolved within agreed (SLA) timescales	Local	Monthly	81%	85%	88%	✓	↑	
	% Digital Service Desk incidents resolved within agreed (SLA) timescales	Local	Monthly	80%	85%	84%	✗	→	DIG.59

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Digital Efficient Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	TBA	99%	TBA	N/A	N/A	
	% of outpatients consultations performed virtually	Local	Monthly	32.9%*	TBA	31%	TBD	→	
	% of donors booking online	Local	Monthly	82.2%*	TBA	84%	TBD	↑	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

Finance Services

QSF Domain	Finance Timeliness Scorecard – Trust-wide position			Performance as at Month 06 (September)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	97%	✓	→	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Finance Efficient Scorecard – Trust-wide position	Performance as at Month 06 (September)	Compliance against Target or Standard	Data

	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	Link
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	**National**	**Monthly**	**0**	**0**	**£0.015 m**	✓	➔	
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	**National**	**Monthly**	**N/A**	**£0.159 m**	**£0.299 m**	✗	➔	FIN.72
	Financial Capital spend (£m) position against forecast expenditure profile	**National**	**Monthly**	**0**	**£7.419 m**	**£7.419m**	✓	➔	
	Cost Improvement Programme £2.6M achievement of savings (£k) in line with profile	**National**	**Monthly**	**N/A**	**£1.147 m**	**£1.0941**	✗	🡻	FIN.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
	Not required

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A 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: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
	The Performance Management Framework reports the performance of the organisation across a number of areas but is not the mechanism for managing risks identified within the report.
WHAT IS THE 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

Performance Management Framework Data Graphics and Analysis for KPIs not achieved

APPENDIX 1: CANCER SERVICES

SAFETY

KPI Indicator KPV.63

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Number of Duty of Candour (DoC) Incidents recorded with Welsh Government in a calendar month

Target: NIL and as a % of Overall Activity (to be agreed)

Current Performance against Target or Standard

	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual DoC Recorded								0	0	0	0	1	0	2	1
% DoC over VCS Activity															
Target DoC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target % D0C						TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA

SLT Lead:

Performance

Assessment of current performance, set out key points:

- One incident being managed in line with duty of candour regarding the management of patient temperature on the treatment helpline.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Management of temperature on the treatment helpline has been clarified and the process updated and shared with the helpline staff. A speedy cascade has been shared with all staff via the intranet and emails.	Complete	

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPV.59

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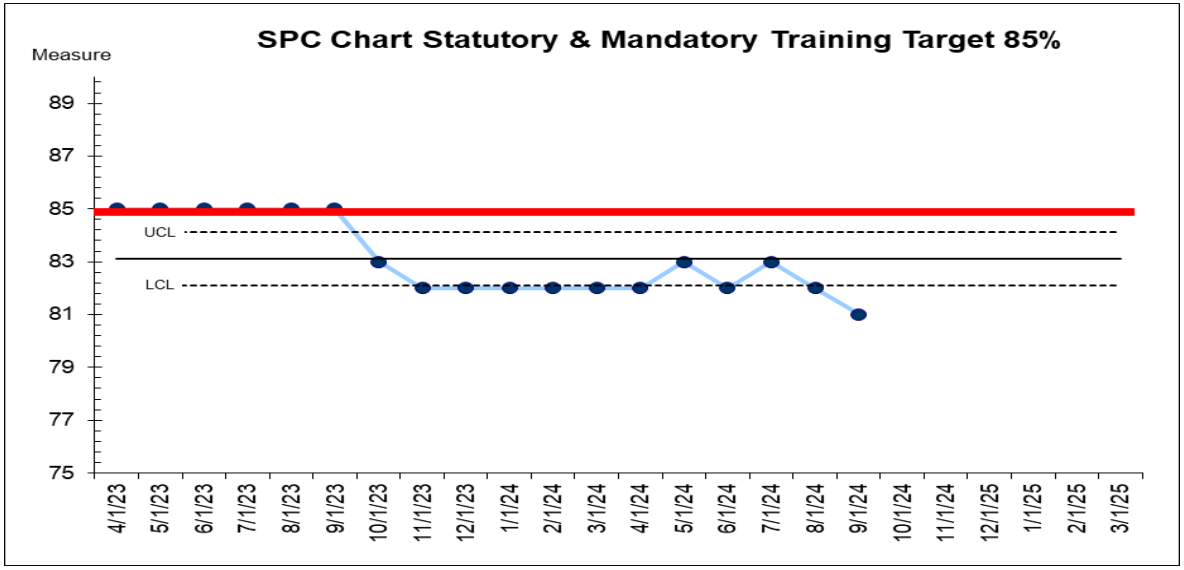
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	June 24	July 24	Aug 24	Sep 24
Actual %	85	85	85	83	82	82	82	82	82	82	83	82	83	82	81
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 dip against the 85% target, with the target being missed marginally for the last six months.

Performance

Assessment of current performance, set out key points:

Statutory and Mandatory compliance for this month has decreased to 81.48% and remains under the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Monthly compliance rates are shared with the SLT. Managers in Medical Staffing (42.33%), Palliative/Chronic Pain (51.85%) and Operational Services (68.94%) are asked to review their compliance, and ensure staff complete all statutory and mandatory modules. As VCC (as a division) remain under target compliance, all areas are asked to review their Statutory and Mandatory compliance rates and complete any outstanding training.	31/10/24	All managers in the division

Expected Performance gain – immediate:

To improve compliance for statutory and mandatory training, so that the target is met or comfortably exceeded, and maintained.

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. & M and compliance framework in the All Wales network	Continuous	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.	Continuous	

Expected Performance gain – longer-term

Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.

Risks to future performance

Set out risks which could affect future performance

- Future predicated wave of COVID and Flu may affect staffing levels and ability to release staff to undertake training.

EFFECTIVENESS

KPI Indicator KPV.56

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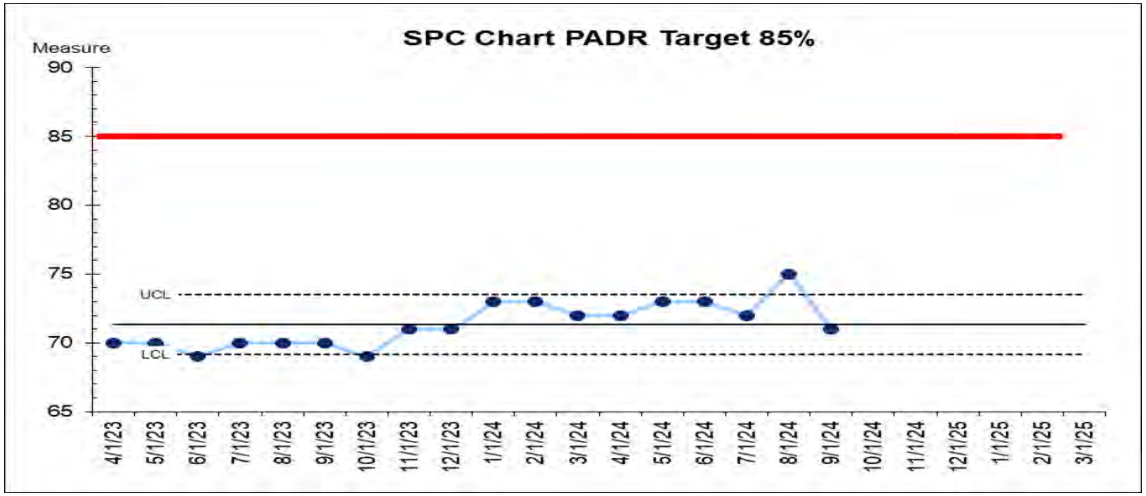
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

VCC Position	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual %	70	70	70	69	71	71	73	73	72	72	72	73	72	75	71
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows some improvement for the last 15 months but returning to averaging 72%, and consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

PADR Compliance has decreased this month and is reporting as 71.47%. Compliance remains below the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale	Lead:
Monthly compliance rates are shared with the SLT. The SLT is liaising with their managers, particularly in areas where compliance has been consistently low, with the ask that an action plan is developed to increase PADR compliance rates across the service. All areas are asked to understand (from BI) who hasn't received their PADR and to ensure these are scheduled to take place as a priority. Review will be built into monthly formal 1:1s with the SLT.	30/11/24	Various line managers depending on the area

Expected Performance gain – immediate:

Action plans outlining plans to ensure compliance increases. Hope to see an improvement in overall compliance across the VCC.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	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 KPV.57

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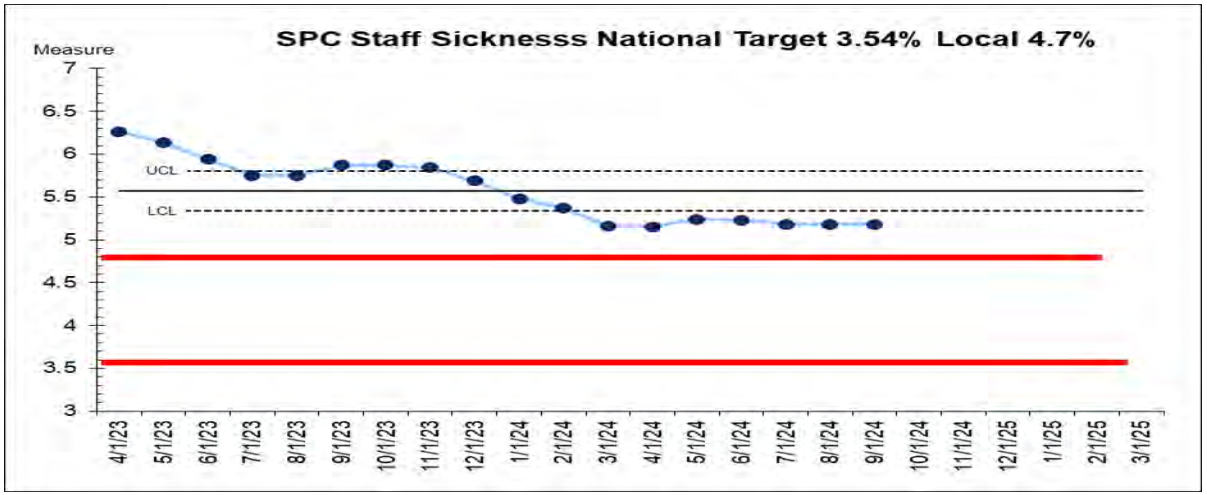
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Business Partner.

Current Performance against Target or Standard

VCC Position	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual %	5.75	5.75	5.87	5.87	5.84	5.69	5.48	5.37	5.16	5.15	5.24	5.23	5.18	5.18	5.18
Local Target 4.7%	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 6 months. However, the overall average of 5.7% sickness level remaining higher than the National 3.54% target and our new Local Target of 4.70%

Performance

Assessment of current performance, set out key points:

In month sickness has decreased slightly this month to 5.58% and remains over the Trust target of 4.70%. Short-term absence has decreased to 1.76% and long-term absence has increased slightly to 3.82%.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:
Monthly compliance rates are shared with the SLT. Managers in Information Section (9.09%), Nursing (6.34%), Radiation Services (5.06%), Therapies (16.90%), Outpatients (11.10%) and Operational Services (7.04%) to review sickness absence cases in their areas and discuss any actions necessary with the People Team, ensuring that the absences are being managed under the MAAW Policy. All areas to continue with absence management processes/practices.	31/10/24	Various line managers depending on the area

Expected Performance gain – immediate:

Reassurance that all sickness absence cases are being managed in line with policy. Monthly KPI meetings with People Advisors to support sickness absence management continue to take place.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

PATIENT EXPERIENCE.

KPI Indicator KPV.53

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Graph title - Incidents of Violence and Aggression

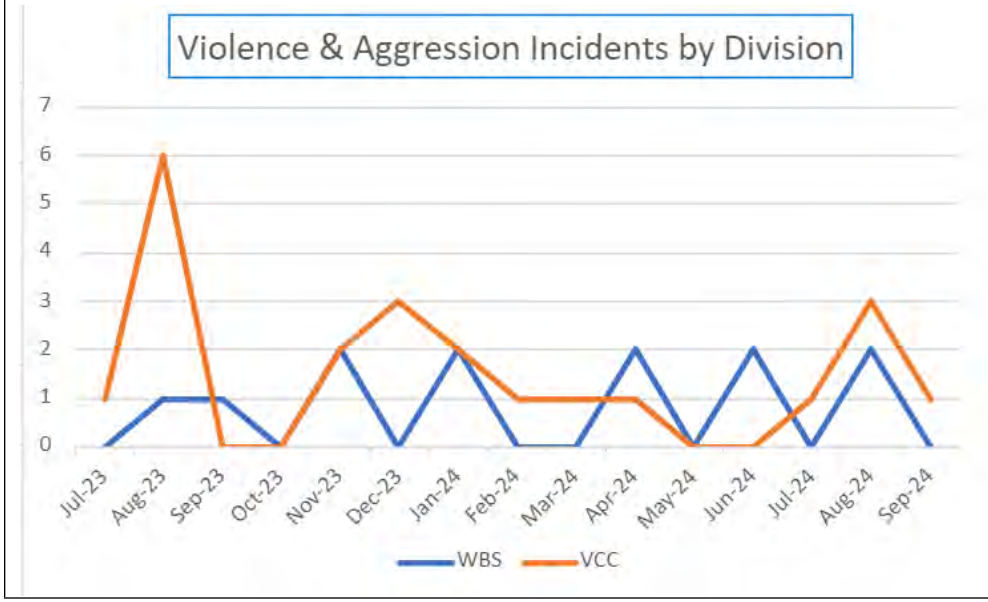
Target: 0

SLT Lead: Lauren Fear

Current Performance against Target or Standard –

Performance – Decreased

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	Jun e 24	Jul 24	Aug 24	Sep 24	Tot al
WBS	1	1	0	2	0	2	2	0	0	2	0	2	0	2	0	18
VCC	1	6	0	0	2	3	2	1	1	1	0	0	1	3	1	22



Service Improvement Actions – Immediate (0 to 3 months)

All recorded incidents are being monitored

Expected Performance gain – immediate Actions: Ongoing:Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. There are an increased number of offerings, which has deceased our compliance figures
Monitoring through PMF monthly data

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme.	H&S Team Timescale Q4 2024

Expected Performance gain – longer-term

Risks to future performance

EFFICIENCY

KPI Indicator KPV.62

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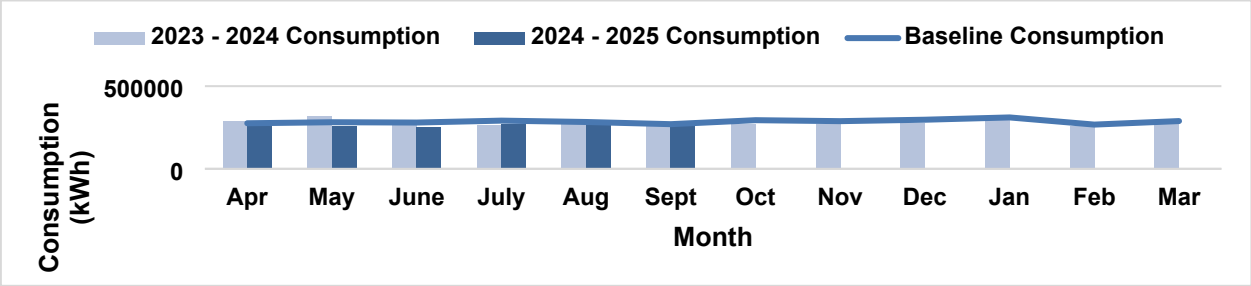
VCC - Energy (Gas and Elect) performance consumption

Target: -2% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard

Electricity



Trust	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual (kWh	256,978.87	257,672.70	251,464.90	268,714.90	268,014.70	258,174.60	-	-	-	-	-	-
Target previous year	280,510.13	307,952.69	260,983.54	256,536.19	263,561.42	257,266.12	259,202.75	260,675.31	266,962.36	283,215.36	251,091.78	259,769.98
Carbon Emissions	53.21	53.36	52.07	55.64	55.50	53.46	-	-	-	-	-	-
Carbon Emissions Target (-3%	58.09	63.77	54.04	53.12	54.58	53.27	53.67	53.98	55.28	58.65	51.99	53.79

Performance

Assessment of current performance, set out key points:
Currently, Electricity and Gas both below 2018/19 baseline consumption target and following similar pattern to previous year but with generally lower consumption.

Planned energy management audits are due in November to stocktake a selected departments energy usage. Actions to follow that align with the SIP's to ensure Sustainability Objectives achieved.

Gas data continues to decrease due to energy optimisation on ward areas. Enhanced BMS monitoring and active management

Increase in gas also due to a mild summer period. In addition, the summer period May-August has been cooler than previous years and a decrease in outside air temperature.

The carbon conversion figures are taken from DEFRA. The conversion factors are changed every financial year. This is reflected in the calculations.

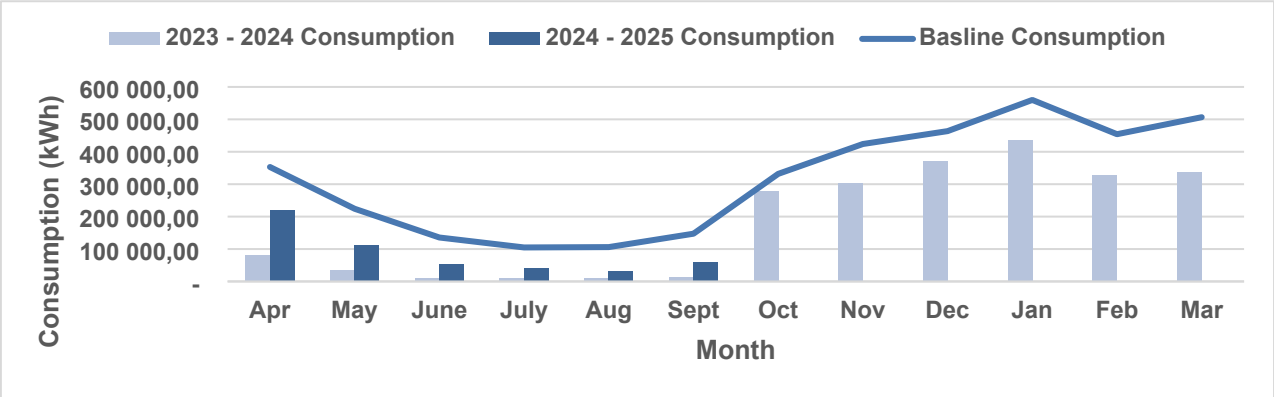
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed and integration of energy performane software (Sigma) to BMS Gas - Integration of energy performance software (Sigma) to BMS Onboarding of Bureau	3 month **3 months**	Jonathan Fear Milburn Mounter

Expected Performance gain - immediate
Continue to monitor energy performance
Promote ways to reduce electricity usage
Appointment of team sigma to monitor bills charges.

Service Improvement Actions – tactical (12 months +)

Gas



Trust	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual (kWh)	216,143.70	109,184.30	-55,125.70	39,988.40	31,256.50	60,531.70	-	-	-	-	-	-
Target previous year	78,836.57	37,765.94	23,731.93	17,230.35	15,453.57	27,518.19	280,543.27	292,780.57	384,134.75	425,525.43	74,377.83	75,133.26
Carbon Emissions	41.62	21.02	10.60	7.68	6.00	11.65	-	-	-	-	-	-
Carbon Emissions Target (-3%	15.28501775	6.369738406	1.780759276	2.115838997	2.054966704	2.350437 18	51.84320212	56.5761886	69.463178	81.0325589	13.4819688	12.3524723

Actions: what we are doing to improve	Timescale: 12 months	Lead:
Metering strategy Updating SIGMA – to monitor energy usage & billing more actively		Jonathan Fear

Expected Performance gain – longer-term
Continue to monitor consumption, increase metering.
Further engagement with departments to understand clinical operational timings in order to rationalise running of estate assets anticipated electricity and gas reduction in the upcoming months

Risks to future performance

Set out risks which could affect future performance
Increase to electricity & gas usage due to cold weather and heating being manually turned on and left on in some buildings.

KPI Indicator KPV.67

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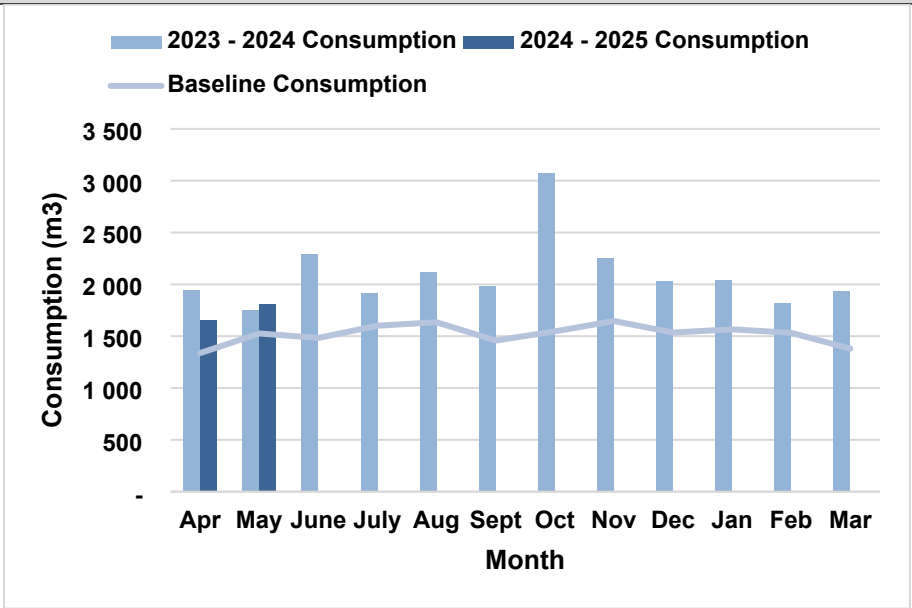
Graph title -Water

Target: Continued monitoring to identify and mitigate trends

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



Awaiting some final invoices for certain sites which has meant incomplete data.

If performance is not at required level, set out what the main causes are:
There has been a significant increase in water consumption across VCC during December. The Estates Department have been informed and are investigating this spike.

Consumption otherwise has generally followed a similar pattern to previous years. Some figures are higher than in previous years due to increase flushing regimes.

- There has been an increase in water consumption at VCC compared to previous year consumption and compared to the baseline data due to an increased flushing regime to comply with water safety regulations
- Across all sites there has also been Increased hygiene requirements to comply with IP & C guidance

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Integrating the water consumption to the BMS at VCC	6 months	Milburn Mounter

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

• Increased metering across all sites • Dedicated resource to capture the metering	**12 months**	Jonathan Fear

Expected Performance gain – longer-term
Continue to monitor consumption resulting in targeted initiatives and improvements reducing consumption.

Risks to future performance
Increased flushing regimes to adhere to water safety regulations
Water on bypass

KPI Indicator KPV.72

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Usage of Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

VCC Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cumm £k	698	27	65	**103**	140	198	243						
Target per IMTP £0.156M Forecast		34	67	101	119	138	156	0	0	0	0	0	

Agency Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	3	4	0	0	0	(1)	0	0	0	0	0	0	6	6
2	Medical & Dental	1	6	11	7	25	20	0	0	0	0	0	0	70	70
3	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Prof Scientific & Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Additional Clinical Services	3	9	3	2	1	1	1	1	1	1	1	1	19	24
6	Allied Health Professionals	7	13	18	21	25	25	20	27	21	21	7	0	109	205
7	Healthcare Scientists	9	7	6	7	7	0	0	0	0	0	0	0	36	36
8	Estates & Ancillary	4	0	0	0	0	0	0	0	0	0	0	0	4	4
9	Students													0	0
10	TOTAL AGENCY	27	38	38	37	58	45	21	28	22	22	8	1	243	345

Performance

The spend on agency for September'24 was **£0.045m** (August £0.058m) with gives cumulative year to date position of **£0243m** and a current forecast outturn spend of circa **£0.345m.** The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies.

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

The use of Medical Agency ceased in September.

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Radiotherapy Workforce Plan addressing substantive employment	September 2023	Kathy Ikin

Expected Performance gain - immediate

Reduced agency premium

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Sustainable workforce modelling and deployment	Dec 2023	Rachel Hennessey

Expected Performance gain – longer-term

Reduced reliance on agency via sustainable workforce

Risks to future performance

Set out risks which could affect future performance

- Workforce market, demand, significant change programmes

KPI Indicator KPV.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cumm £k	950	35	69	126	199	286	382						
Target £939k Forecast		35	69	126	199	300	389	475	568	661	753	846	939

VCS Cost Improvement Programme 2024-25 – Target £939k

Scheme Type	Recrrent / Non-Recurrent	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes								
Radiation Services - Agency Reduction	NR	Green	50	25	50	25	50	0
Establishment Control	R & N/R	Green	234	107	115	8	234	0
Service Workforce Redesign	R & N/R	Red	0	0	0	0	0	0
Procurement - Supply Chain	R	Green	50	17	17	0	50	0
Productivity Efficiencies	R & NR	Green	35	12	12	0	35	0
SACT Provision	R	Green	150	60	60	0	150	0
Total Saving Schemes			**519**	220	253	33	519	0
Income Generation								
Private Patients - Recovery of Debt	NR	Green	150	75	48	(27)	150	0
Private Patients - Contract Renewal	R	Amber	150	50	38	(12)	150	0
Productivity Efficiencies	R	Red	0	0	0	0	0	0
Private Patients	NR	Green	70	23	23	0	70	0
Maximising Income	R	Green	50	20	20	0	50	0
Total Income Generation			**420**	168	129	(39)	420	0
TRUST TOTAL SAVINGS			**939**	**389**	**382**	**(7)**	**939**	**0**
					98%		**100%**	

Performance

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system. In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The VCS savings performance as of September'24 is a small underachievement against plan of £0.007m, however at this stage expected to deliver to target by the end of the financial year.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Extraordinary Savings meetings with SLT for alternative delivery should targets not be met	31/03/24	Paul Wilkins

Expected Performance gain - immediate

Delivery of current savings and planned savings for 23/24 financial year

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	Dec 2023	Rachel Hennessey

Expected Performance gain – longer-term

Delivery of efficiencies

Risks to future performance

Set out risks which could affect future performance

- Balance of organisational capacity, demand, and available workforce.

APPENDIX 2: BLOOD AND TRANSPLANT SERVICES

SAFETY

KPI Indicator KPI.30

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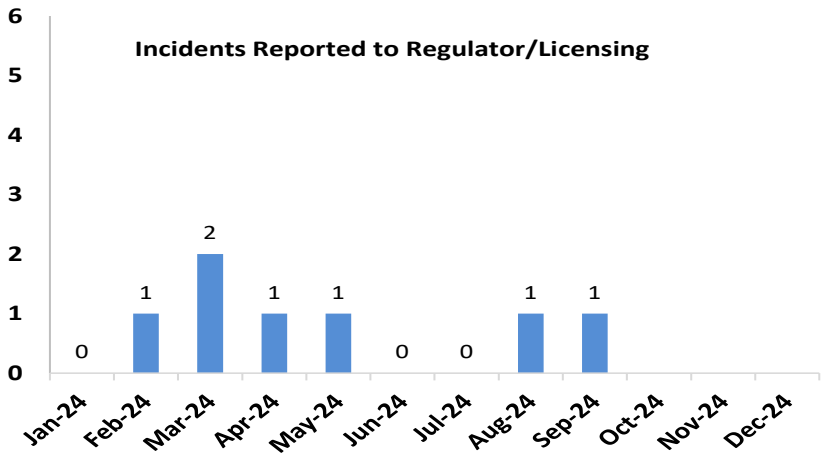
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual	1	2	1	0	4	1	0	1	2	1	1	0	0	1	1
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:
One adverse event was submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in September reporting an incorrect assessment of a donor travel risk at previous attendances. Lookback and product recalls have taken place with the Root Cause Analysis (RCA) investigation identifying a complex process for staff to complete. The Corrective and Preventive Action Plan assigned is awaiting approval.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead:
The completion of Corrective Actions and Preventative Actions (CAPA), for SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Managers continue to explore opportunities to share learning through formal staff engagement sessions, and a Task & Finish group (reporting to the WBS Integrated Quality & Safety Hub) is working on removal of complexity from the donor eligibility assessment process.	Peter Richardson **Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Actions have been/will be introduced as outcome of Root Cause Analysis of these incidents is known.		

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

KPI Indicator KPI.54

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Number of Staff RIDDOR Incidents, injuries and work-related accidents

Target: NIL

SLT Lead: Sarah Richards

Current Performance against Target or Standard

WBS Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

1 RIDDOR reportable incident occurred during Sept 2024.
1 manual handling injury where a member of the Transport team twisted their leg while maneuvering a roll cage – this was a RIDDOR reportable incident as the injured person was off for more than 7 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
Ongoing monitoring, investigation and mitigation of incidents.	Ongoing **Lead:** WBS H S & Env Compliance Magr

Expected Performance gain - immediate.
Continue without H&S incidents and report RDDOR related incidents.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	
Continue to monitor RIDDOR incidents. Training for staff to identify and therefore flag potential RIDDORS. Improvements to Datix reporting (mentioned in incidents) process will help to highlight RIDDORs as soon as they occur	**Lead:** WBS H S & Env Compliance Manager **Timescale:** Ongoing

Expected Performance gain – longer-term.
Continue with low numbers of RIDDOR incidents. H&S inspections on WBS sites and venues to identify hazards that may cause incidents of near misses. Ensure that these are mitigated.

Risks to future performance

Set out risks which could affect future performance.
Delays in reporting incidents that are potential RIDDORS. Addressed through looking at the reporting process.

KPI Indicator KPI.56

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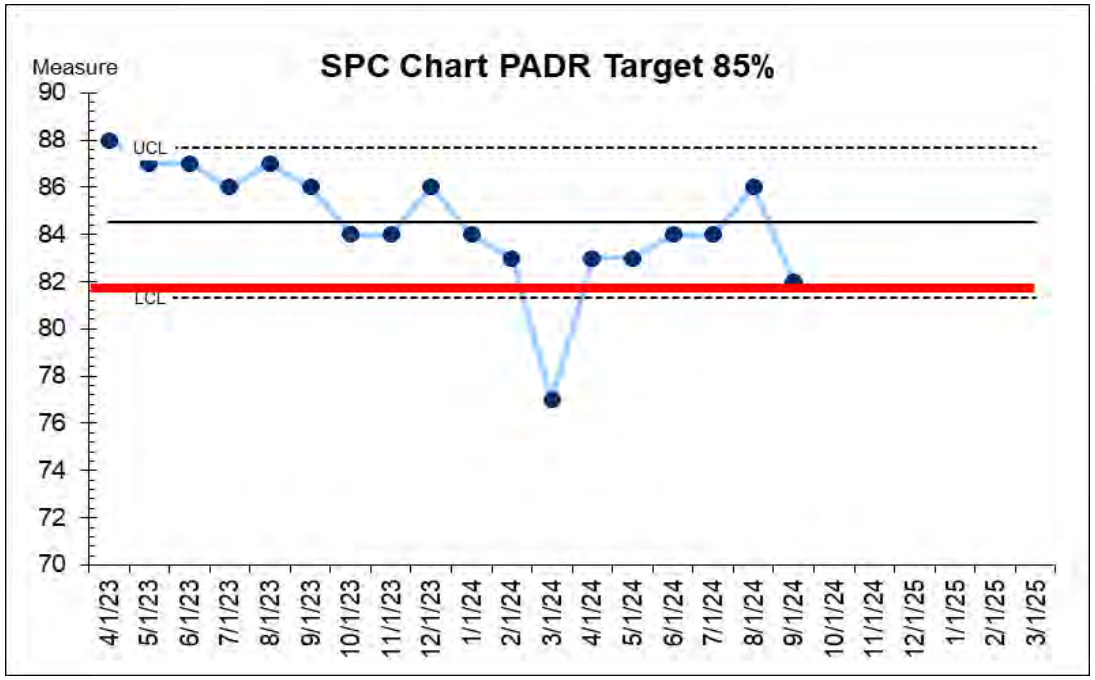
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual %	86	87	86	84	84	86	84	83	77	83	83	83	84	86	82
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 variation for the last 12 months averaging 85% but with a 'special cause variation' in March. Data shows that May performance is stabilising to previous levels but remains just below target.

Performance

PADR Compliance performance decreased at 82.11 for September. Performance is attributed to low numbers of staff falling out of compliance across WBS departments.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
WBS is provided with monthly reports to identify which staff are due their PADR. Each team continues to book in PADR meetings in advance of the deadlines.	Monthly ongoing	ESR Manager Service Managers

Expected Performance gain - immediate.

Staff that are due incremental pay increases will receive these on time when PADR meetings are undertaken in a timely manner.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Current measures are working well. Regulatory compliance has now been met and will be monitored for compliance ongoing.

Risks to future performance

Set out risks which could affect future performance.

Further strike action would impact upon compliance for this measure.

KPI Indicator KPI.58

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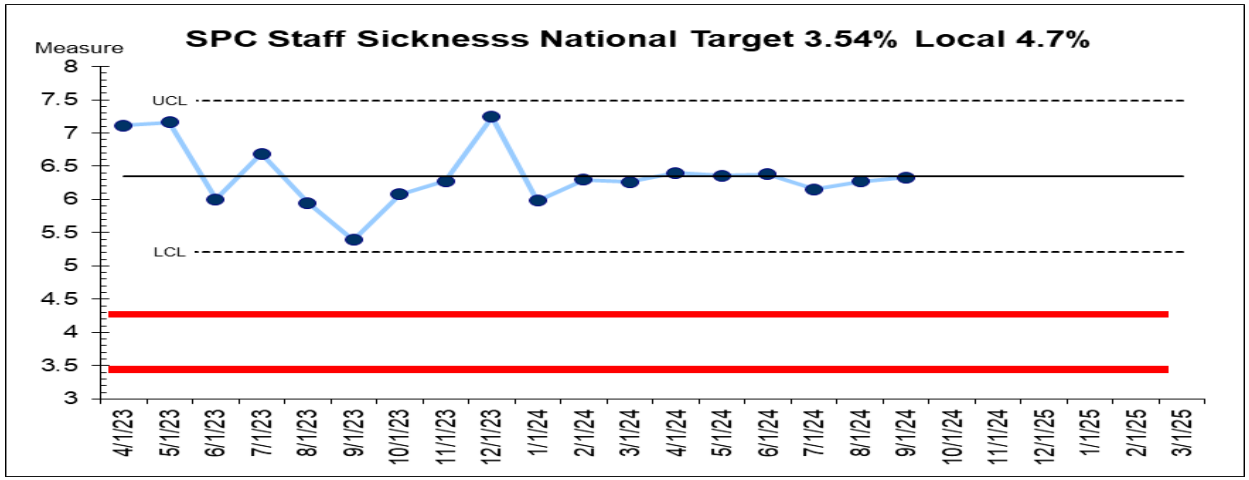
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual %	6.6	5.95	5.39	6.08	6.28	7.24	5.98	6.40	6.41	6.4	6.36	6.26	6.15	4.93	6.33
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 (WG) 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.5	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend to September 2023, with improvement in October and November and December 2023, but stabilising in 2024. Overall sickness level remains higher than the National 3.54% target and our new Local Target of 4.70%

Performance

Assessment of current performance, set out key points:

Sickness absence increased in September reporting at 6.33% compared with the large decrease to (4.93%) in August and 6.15%, in July.

Short-term sickness absence is reported at 2.54% an increase on the 2.10% reported in august. Long-term sickness is reported at 3.59% which is a noticeable increase on the 2.83% in August.

Whilst short and long-term sickness increased long term sickness is attributed as the main reason for absence performance in September.

NB: WG sickness target is 3.54% whilst VUHNST sickness absence target is set at 4.70%.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:
Ongoing analysis to identify the causes of sickness. Identification of ways to improve in month sickness rate performance.	Ongoing/Monthly **Lead:** Director of WOD People and Relationship Advisors

Expected Performance gain - immediate.

WBS continue to implement any recommended measures aimed to address and positively affect sickness absence rates.

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve Accessible staff wellbeing initiatives continue to take place. Regular reminders promoting the available Wellbeing support are issued.	**Timescale** Ongoing **Lead:** Head of OD
	Expected Performance gain – longer-term. An reduction in staff sickness rates.	
	Risks to future performance	
	Set out risks which could affect future performance. Strikes and Recruitment pressures remain concerns which influence sickness rate absence.	

DONOR & STAFF EXPERIENCE

KPI Indicator KPI.28

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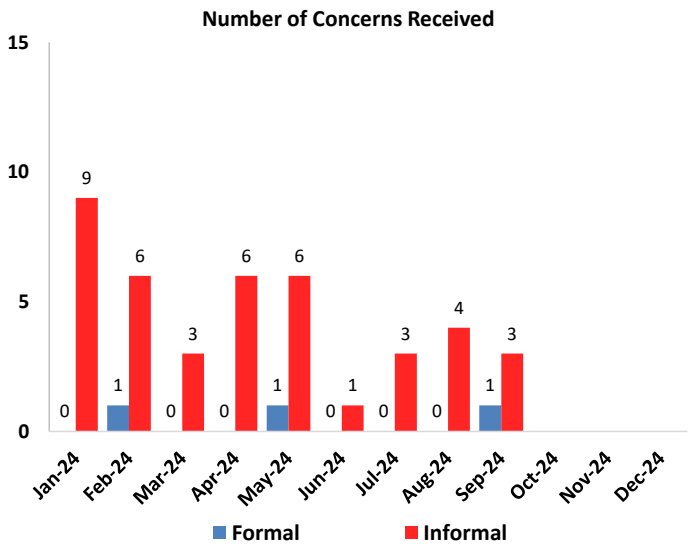
Number of WBS "Formal" and "Informal" concerns received from blood donors

Target: NIL

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Formal	0	0	0	1	0	0	0	1	0	0	1	0	0	0	1
Actual Informal	4	7	2	5	5	1	9	6	3	6	6	1	3	4	3
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:

During September 1 formal and 3 informal concerns were received. 7,341, donors were registered at donation clinics and the volume of concerns represents 0.05% of all donors registered.

The 1 formal concern was managed within 5-working day timeline, correspondence has been sent and the concern is being investigated.

All 3 informal concerns were managed within the 2-day timeline.

Concerns recorded in September relate to access to the collection service, communication & appointments.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Time scale
Continuous oversight and management of concerns in line with Putting Things Right Regulations. Review of all concerns received to ensure learning and improvement opportunities are addressed.	Ongoing **Lead:** **Edwin Massey**

Expected Performance gain – immediate.
Improved performance, improved donor experience and satisfaction.

Service Improvement Actions – tactical (12 months +)

Actions:	Timescale
Continued review of current practices to reduce concerns following donor feedback.	On-going **Lead:** Julie Reynish/Julie Curry

Expected Performance gain – longer-term.
Improved service provision, donor experience and satisfaction.

Risks to future performance

EFFICIENCY

KPI Indicator KPI.08

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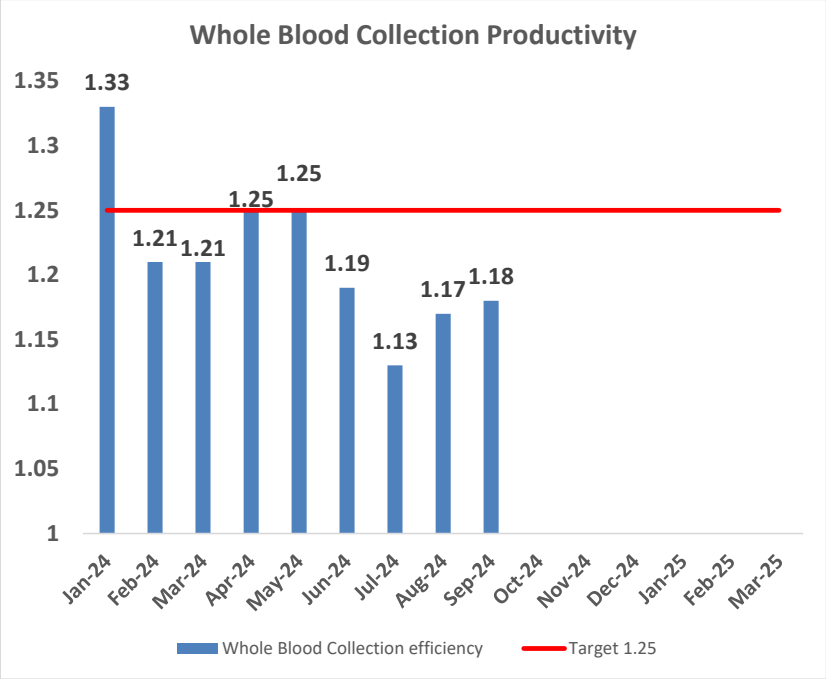
Whole Blood Collection Productivity – number of Blood Components Collected per Standardised Full Time Equivalent Staff Member

Target: 1.25 Weighted Factor | **SLT Lead: Jayne Davey**

Current Performance against Target or Standard

	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
Actual FTE	1.18	1.16	1.14	1.13	1.22	1.24	1.33	1.21	1.21	1.25	1.25	1.19	1.13	1.17	1.18
Target 1.25 FTE	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25



Performance

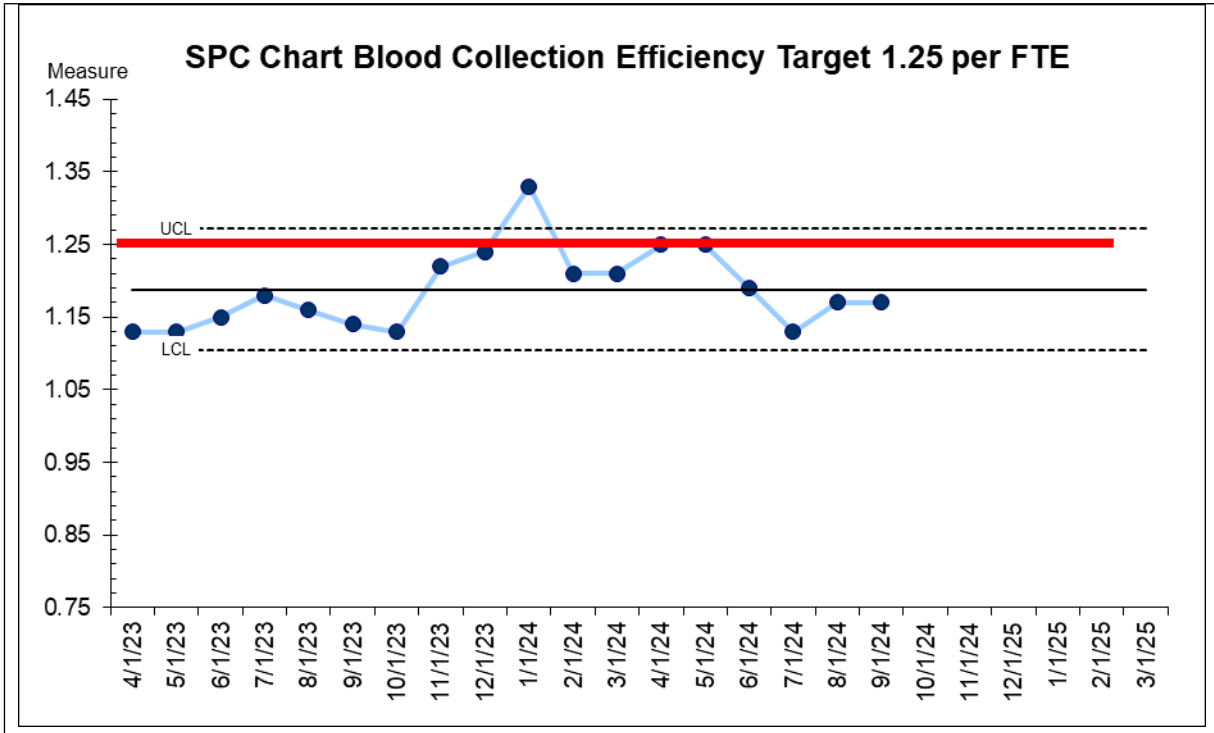
Assessment of current performance, set out key points:

At 1.18 collection efficiency performance increased slightly in September and was just below target.

September performance can be attributed to.

1. Sickness resulting in reduced clinic capacity on the day.
2. Staffing pressures in the West & Wrexham Collection Team
3. A stable performance (95.64%) of the no. of donors providing a complete donation at clinic, exceeding the 95% target.
4. Donor appointment performance was below the target at 88.76%.

NB: staffing continues to be challenging with 7 collections assistants in training and 6 due to commence employment in October. During the training period, the staff are not utilised, reducing the ability to book donors to the full capacity of each session.



Actions: what we are doing to improve	Timescale:
• Daily meetings with WBS departments to review stock levels in line with hospital demand are staged. • Continue to focus on staff training to safely reduce the amount of time in training • Recruitment completed across Wales to increase staffing levels to support an increase in donor chair capacity. • 7 CCA's progressing with training, until signed as competent will not be included in the staffing figures • 2 Registered Nurses progressing with training, until signed as competent will not be included in the staffing figures	Ongoing – daily **Lead:** Jayne Davey
Risks to future performance	**Timescale:**
• Increase in staff absence. • Increase in staff leaving the organisation or reducing hours. • Increase in hospital demand. • Ageing blood mobile trailers that have to be serviced regularly and therefore unavailable to Collection plan.	Quarter 2 Quarter 2 **Lead:** Jayne Davey

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. The average performance of 1.19% fails to meet the target of 1.25%,

KPI Indicator KPI.10

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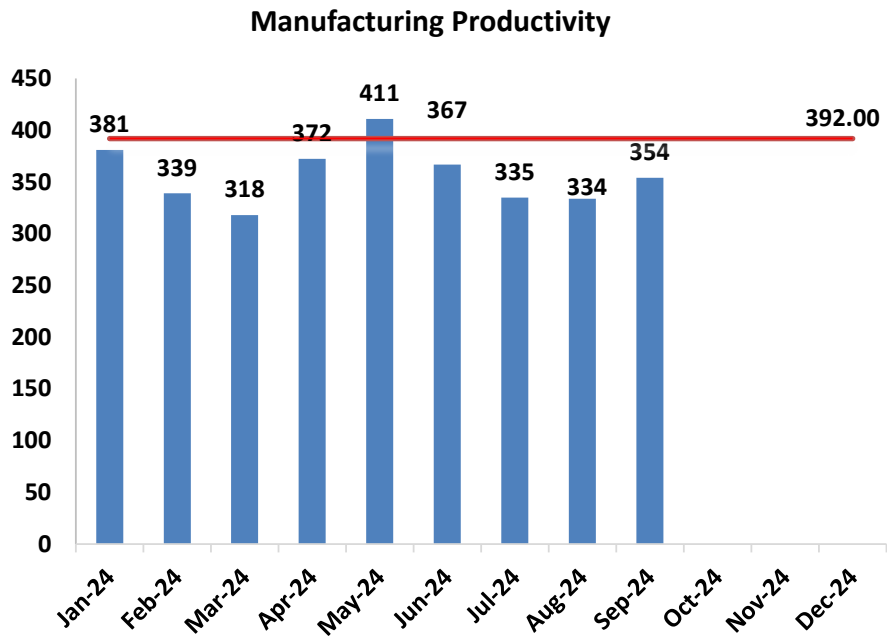
Blood Product Manufacturing Productivity

Target: 392 per month

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24
Actual	369	414	377	396	389	335	381	339	318	372	411	367	335	334	354
Target 392	392	392	392	392	392	392	392	392	392	392	392	392	392	392	392



NB: Manufacturing Efficiency is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.

Performance

Assessment of current performance, set out key points:
September blood product manufacturing productivity is slightly below the target value but remains within the expected range. The value reflects work coming into the department as staffing levels have not changed.

NB. This metric is under active review.

Service Improvement Actions – Immediate (0 to 3 months)

This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework. Identifying the acceptable fluctuation range will improve interpretation and monitoring of this standard.	Timescale **Lead:** Georgia Stephens

Expected Performance gain - immediate.
None

Service Improvement Actions – tactical (12 months +)

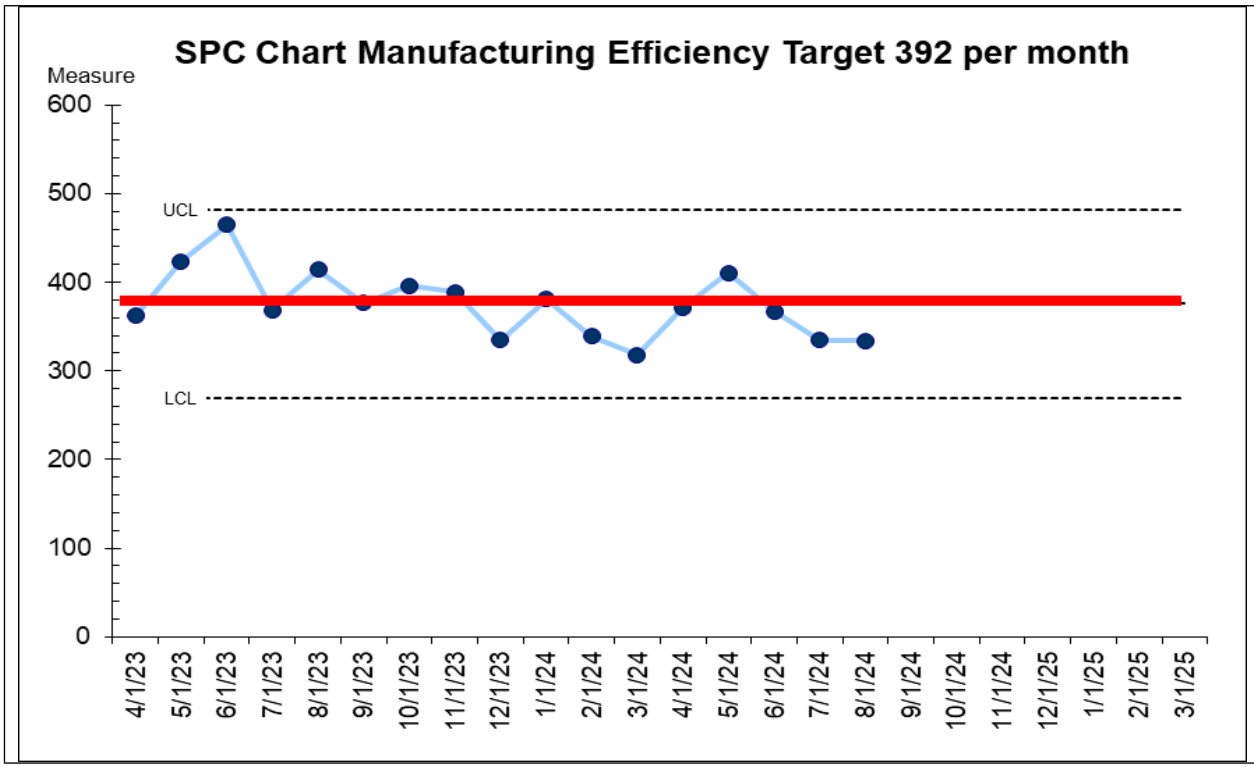
As Above	Timescale Lead: Georgia Stephens

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. With the average performance of 400, just above and close to the target.

KPI Indicator KPI.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory | **SLT Lead: WBS Divisional Director**

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

WBS Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual £k	0	0	0	3	2	1	(3)						
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

WBS Revenue Position as at September' 24

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**17.218**	**17.215**	**(0.002)**	**31.536**	**31.536**	**0.000**
Expenditure						
Staff	8.968	9.100	(0.133)	17.543	17.543	0.000
Non Staff	19.224	19.092	0.132	35.801	35.801	0.000
Sub Total	**28.191**	**28.192**	**(0.001)**	**53.344**	**53.344**	**0.000**
Total	**(10.974)**	**(10.977)**	(0.003)	**(21.808)**	**(21.808)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of September 2024 was a small overspend of **£(0.003)m** with an outturn forecast position of **breakeven** currently expected.

A small income underachievement of **£(0.002)m** due to underperformance on bone marrow (currently achieving 50% of target year to date), partly offset by increased activity on plasma sales.

Whilst Plasma Sales activity has been increasing deliveries to Randox (main supplier) were suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year which has now been settled. The current year debt stands at £0.289m and a re-payment plan has been agreed, with three instalments expected to be paid over the final quarter of the calendar year. Due to the suspension of deliveries to Randox WBS are currently holding 18 pallets of plasma in storage and are currently looking for a new supplier to purchase the plasma, initial indications is that WBS will not be able to recover the full selling price which will impact on the Divisions income position.

There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, however, is starting to show signs of recovery with significantly more swab tests having taken place over the last couple of months. The payback from the additional swabs should start to be realised later in this financial year. WBS continue to run campaigns in order to try and grow the panel in sites such as schools and universities, and also raise awareness through advertising on platforms such as social media.

Staff overspend of **£(0.133)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team are currently creating an unfunded post

analysis to determine the in year and recurrent cost pressure taking into account any funding provided via the Trust IMTP.

Non-Staff reported an underspend of **£0.132m** as at month 6. There are overspends in areas such as room hire costs which are no longer funded by WHSSC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits and the Divisional non pay CIP. Expectation is that security at the site is currently committed until 31st August and is currently under review with a view to remove in the short term. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone Marrow which is a direct correlation with income under performance

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve • Quarterly Performance Reviews • WTAIL Bone Marrow Business Plan	**Timescale:** Qtr 1 2024/25	**Lead:** Alan Prosser
Expected Performance gain - immediate Identification of recovery trajectory for Bone Marrow. Financial opportunities and challenges understood.		

Service Improvement Actions – tactical (12 months +)		
	Timescale: 3	**Lead:** Alan Prosser
Expected Performance gain – longer-term		

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

KPI Indicator KPI.72

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Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

WBS Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (cumm)	126	(3)	8	17	24	28	22						
Target Per IMTP £0k Opening Forecast		0	0	0	0	0	0	0	0	0	0	0	

Agency Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	1	3	3	2	0	(2)	0	0	0	0	0	0	8	8
2	Medical & Dental													0	0
3	Nursing & Midwifery Registered													0	0
4	Prof Scientific & Technical	(7)	0	0	0	0	0	0	0	0	0	0	0	(7)	(7)
5	Additional Clinical Services													0	0
6	Allied Health Professionals													0	0
7	Healthcare Scientists													0	0
8	Estates & Ancillary	4	7	5	5	4	(4)	0	0	0	0	0	0	21	21
9	Students													0	0
10	TOTAL AGENCY	(1)	10	8	7	4	(6)	0	0	0	0	0	0	22	22

Performance

The spend on agency for WBS during August was minus £0.006m (August'24 £0.004m) giving a year to date cumulative position of £0.022m and an expected outturn forecast of c£0.022m

Agency spend within facilities is being targeted with the aim of removing use in the short term.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Facilities review of operating model and remove reliance on temporary support • Departmental planned removal of usage into vacancies	2024	Sarah Richards

Expected Performance gain - immediate

Planned reduction of agency use

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Implement model • Departmental planned removal of usage into vacancies	2024	Sarah Richards/SMT

Expected Performance gain – longer-term

Sustainable operating model.

Risks to future performance

Set out risks which could affect future performance

- Workforce constraints

KPI Indicator KPI.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cummulative £k	700	43	82	82	223	279	300						
Target £650k Forecast		43	82	82	223	318	368	390	405	441	486	528	569

WBS Cost Improvement Programme for 2024-25 - Target £569k (previously £650k)

Scheme Type	Recrrent / Non-Recurrent	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes								
Establishment Control	R	Green	54	50	67	17	54	0
Stock Control - Scan for Safety Enabled	NR	Green	150	75	0	(75)	150	0
WBS Demand Planning	R	Red	0	0	0	0	0	0
WBS Demand Planning	NR	Green	75	50	25	(25)	75	0
WBS Productivity Efficiencies	NR	Red	0	0	0	0	0	0
Procurement - Supply Chain	R	Green	50	17	2	(15)	50	0
Service Workforce Redesign	R	Red	0	0	0	0	0	0
Creditor Review	NR	Green	100	100	100	0	100	0
Budget Efficiences	NR	Green	40	13	27	14	40	0
Total Saving Schemes			**469**	305	220	(85)	469	0
Income Generation								
Sales of Plasma	R	Green	100	63	80	0	100	0
WBS Productivity Efficiencies	R	Red	0	0	0	0	0	0
Total Income Generation			**100**	63	80	0	100	0
TRUST WBS SAVINGS			**569**	**368**	**300**	**(68)**	**569**	**0**
					82%		**100%**	

Performance

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.875m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, most of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2024-25.

As of September WBS have achieved £0.300m of savings against a tar4get of £0.368 resulting in a year to date underachievement of £0.068m

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve • Extraordinary Savings meetings with SLT for year delivery should targets not be met	**Timescale:** 31/03/24	**Lead:** Alan Prosser
	Expected Performance gain - immediate Delivery of current savings and planned savings for 23/24 financial year		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	**Timescale:** Dec 2023	**Lead:** Alan Prosser
	Expected Performance gain – longer-term Delivery of efficiencies		
	Risks to future performance		
	Set out risks which could affect future performance • Competing demand and implementation of operating models		

APPENDIX 3: TRUST-WIDE SERVICES

SAFETY

KPI Indicator DIG.61

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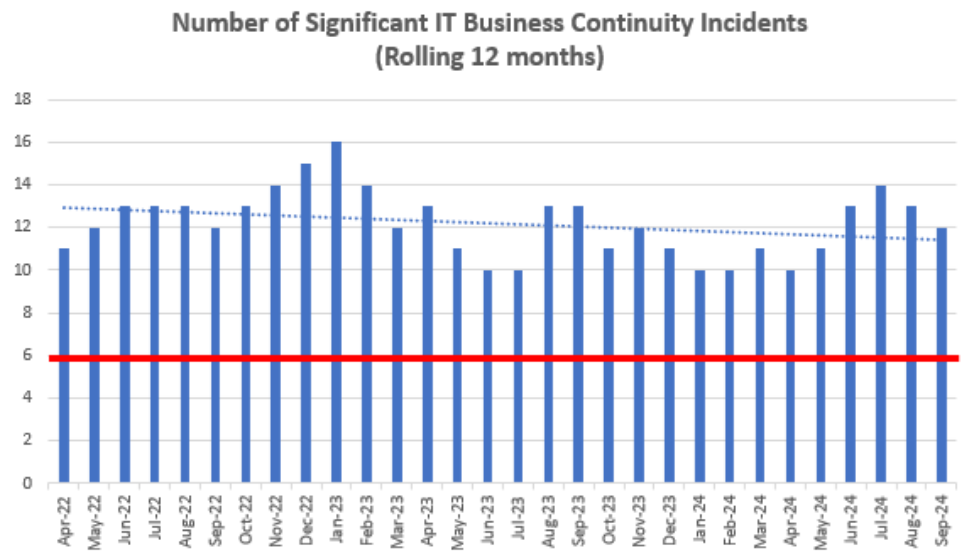
Digital Infrastructure: Number of Significant IT Business Continuity Incidents (Rolling 12 Months)

Target: 6 Incidents (Rolling 12 Months)

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual	10	13	13	11	12	11	10	10	11	10	11	13	14	13	12
Target	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6



Performance

Assessment of current performance, set out key points:

- Marginal improvement in September 2024 – overall slight downward trend. Majority of incidents continue to be associated with national (DHCW-managed) systems.
- One major business continuity incident in September 2024, relating to a service outage that impacted VCC Radiotherapy services (>100 patients cancelled & rebooked).
- Ongoing engagement with DHCW to ensure improved service management approach in respect of national IT systems.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Capital procurement to replace legacy / end of life IT equipment.	31/03/2025 (Ongoing)	DMH

Expected Performance gain – immediate

Reduced number of service outages, improved resilience and performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Full telephony upgrade, as part of Trust-wide telephony platform	2024/25 (In Progress)	DMH
• Deploy new HPE Aruba network infrastructure – first install in Nevill Hall Radiotherapy Satellite Centre (due October 2024)	24/25 – 2027 (In Progress)	DMH
• Removal of 'end of life' / legacy IT infrastructure	31/03/2025 (Ongoing)	DMH

Expected Performance gain – longer-term

Reduced number of service outages, improved resilience and performance.

Risks to future performance

	Set out risks which could affect future performance • Number of 'end of life' IT equipment in operational use in VCC – replacement being expedited as part of ongoing technology refresh programme. • Additional resources / capacity enabled within Digital Services team to deal with technical debt.

KPI Indicator DIG.59

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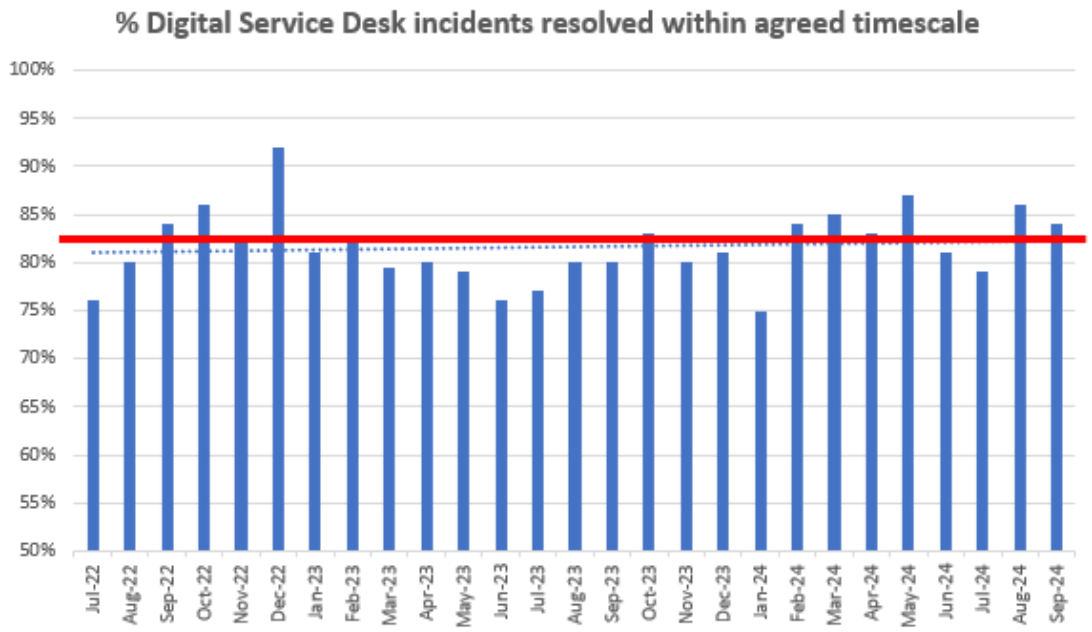
Digital Services: % Incidents resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	Jun24	July 24	Aug 24	Sep 24
Actual %	77	80	80	83	80	81	81	84	85	83	87	81	79	86	84
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points:
Performance relatively stable at approx. 81/82% over last 12 months – marginal improvement observed in August and September 2024, though target not achieved in September (84%).

Further improvements anticipated through Q3 and Q4 2024/25 as improved Digital Service Desk procedures are enabled and new IT Service Management Tool is deployed (service went live in late-September 2024).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution. • Increase volume of calls that can be managed directly by 1st line support.	30/09/2024 **ONGOING**	Digital Ops Manager

Expected Performance gain – immediate
Aim to routinely achieve 85% target by start of Q4 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Improve efficiency through adoption of new ITSM platform (Halo).	31/03/2025	Digital Ops Manager

Expected Performance gain – longer-term
Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance
Deployment of new IT Service Management (ITSM) completed – service went live in late-September 2024. This new tool should significantly improve service desk performance, increased automation etc.

KPI Indicator DIG.62

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% compliance against NCSC "10 Steps to Cyber Security" best practice standards

Target: 90%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual (%)	-	-	-	-	-	-	-	-	-	-	-	87 %	-	-	
Target (90%)	-	-	-	-	-	-	-	-	-	-	-	90 %	-	-	

Performance

Assessment of current performance, set out key points:

- Annual measure, reported via Quality, Safety & Performance Committee
- Most recent annual review completed in June 2024, 87% performance – down 1% from March 2023.
- Next update June 2025, to align with revised cycle of business for Quality, Safety & Performance Committee.
- Work plan established, Cyber Assurance Framework audit completed in early 2024, further audit planned for Sep 2024.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy various IT infrastructure (e.g. new firewalls) to enhance cyber security posture)	Ongoing	DMH

Expected Performance gain - immediate

Original performance target aimed to achieve target compliance (90%) by 31/03/2023 – achievement largely delayed due to challenges in recruiting Cyber Security Manager. Work will continue with the aim of achieving this target by June 2025.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy various IT infrastructure, further vulnerability monitoring etc. to enhance cyber security posture.	Ongoing	DMH

Expected Performance gain – longer-term

Aim to achieve target by end of 2024/25 financial year – to be reported in June 2025.

Risks to future performance

Set out risks which could affect future performance

- Limited cyber security capacity / expertise within Digital Services team. Cyber Security Manager now appointed, commenced in post December 2023.

KPI Indicator DIG.63

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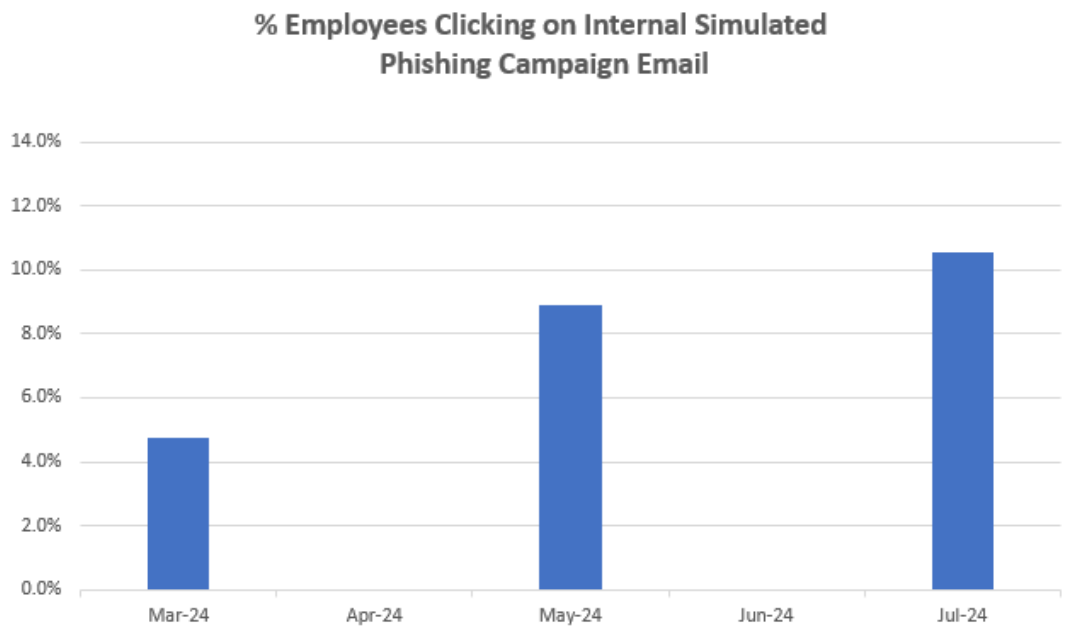
Cyber Security – % of employees clicking on internal phishing campaigns

Target: TBA

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4.8	-	8.9	-	10%	-	-
Target TBA	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	



Performance

Assessment of current performance, set out key points:
Simulated phishing campaigns re-started in March 2024, repeated in July 2024. Next campaign due to be reported in October 2024.

Increase in number of staff clicking on an internal phishing campaign email – email made out to look more genuine than in previous campaigns. Increase in number of staff correctly reporting email via Digital Service Desk.

Campaigns scheduled to run bi-monthly. Net update – September 2024.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Establish communications and re-training plan to respond to findings from simulated phishing campaigns.	30/06/2024 **(COMPLETED)**	Head of Digital Delivery

Expected Performance gain - immediate
Improved performance through 2024/25.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• n/a	n/a	n/a

Expected Performance gain – longer-term
n/a

Risks to future performance

Set out risks which could affect future performance

- Cyber Security Manager commenced in post December 2024 – risk re: inability to progress with attainment of Cyber Security Strategic Plan now decreased.

EFFECTIVENESS

KPI Indicator WOD.36

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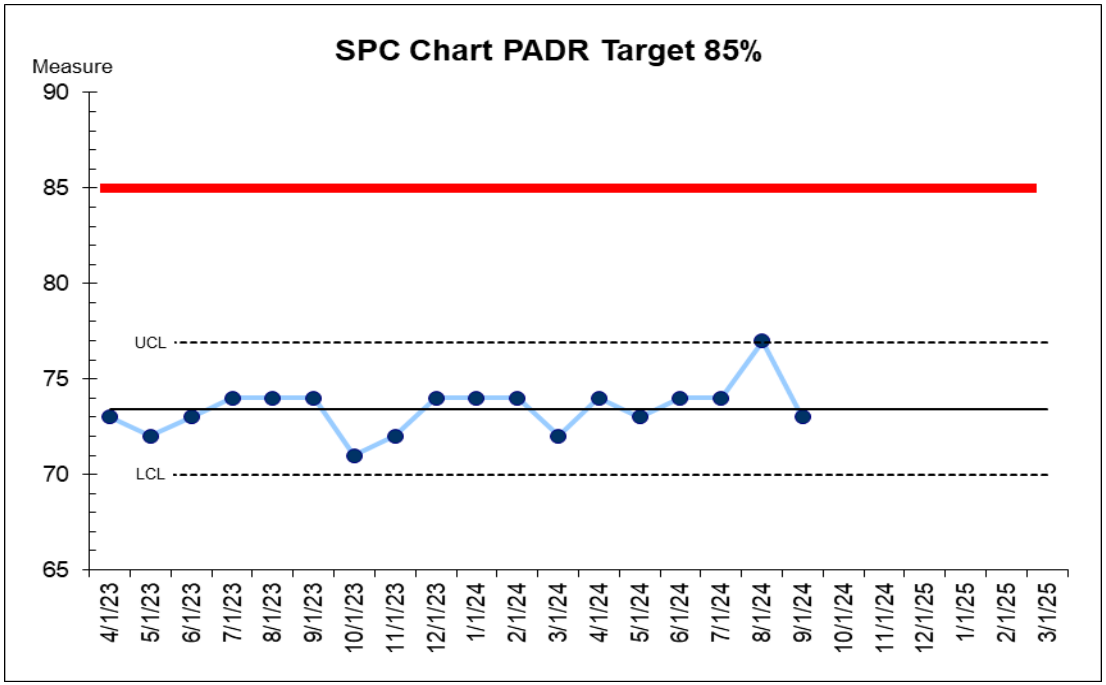
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual %	74	74	74	71	72	74	74	74	72	74	73	74	74	77	73
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 12 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:
Regular monthly monitoring and action plans are in place for hotspot areas.	Monthly	People and Relationship Team
PADR training for managers who undertake the process.	Quarterly	People and Development Trainers
SLT at all divisions are regularly reported to on compliance against targets, with action plans drawn up for hotspot areas	Monthly	POD Senior Business Partners

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

KPI Indicator WOD.37

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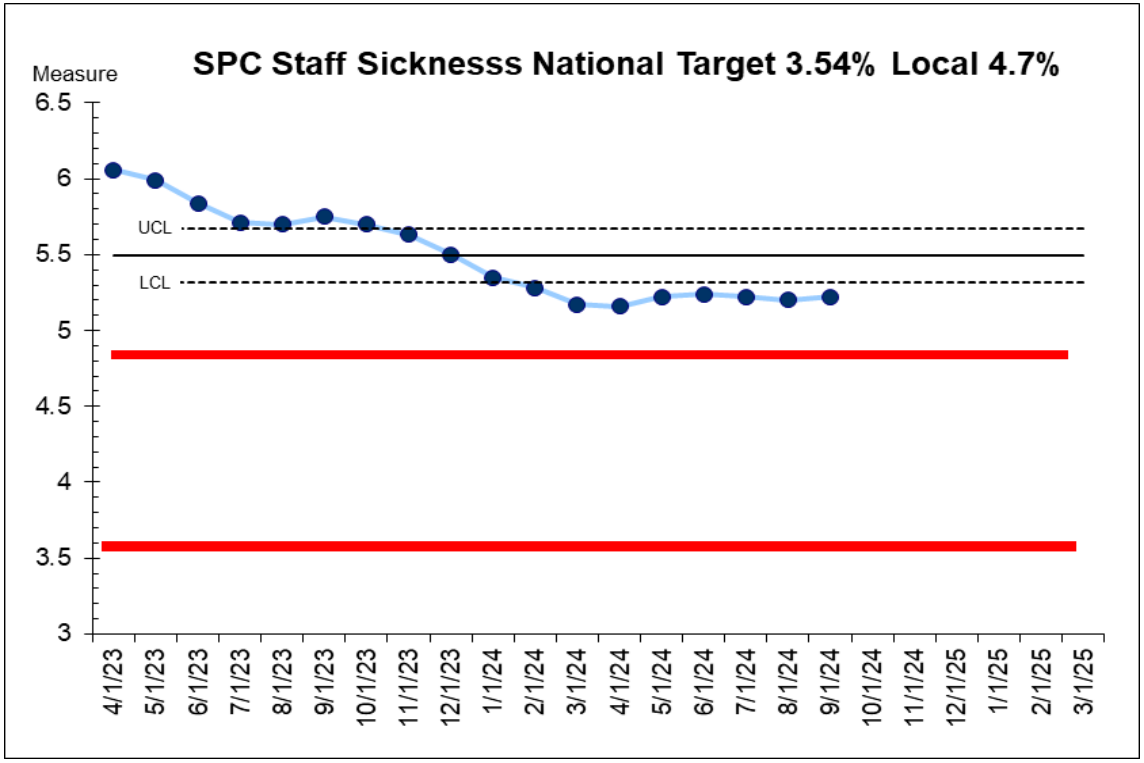
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual %	5.71	5.70	5.75	5.70	5.63	5.50	5.35	5.28	5.17	5.16	5.22	5.24	5.22	5.20	5.22
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



Performance

Assessment of current performance, set out key points:

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

Short-term absence remains relatively low across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months	30/04/2025	Head of OD
• Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan	Ongoing	Head of OD and Trust Board

SPC Chart Analysis The SPC chart shows an improving trend over the last 12 months. However, the overall average 5.7% sickness level remains higher than the 4.7% Local target and the 3.54% National target	Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

KPI Indicator WOD.13

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% staff who rate us as a good employer in Annual Staff Survey

Target: 85% Annual Taeget

SLT Lead: Carl James

Current Performance against Target or Standard

Trust	Jan 24	Feb 24	Mar 24	Apr 24	My 24	Jun 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual %			65%												
Target 90%			90												

% of staff who rate Trust as a good employer in the staff survey – we had 65% respondents Agree/Strongly Agree with Q138 which says 'I would recommend my organisation as a place to work'

This will be updated in March 2025.

SPC Analysis

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

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
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator H&S.27

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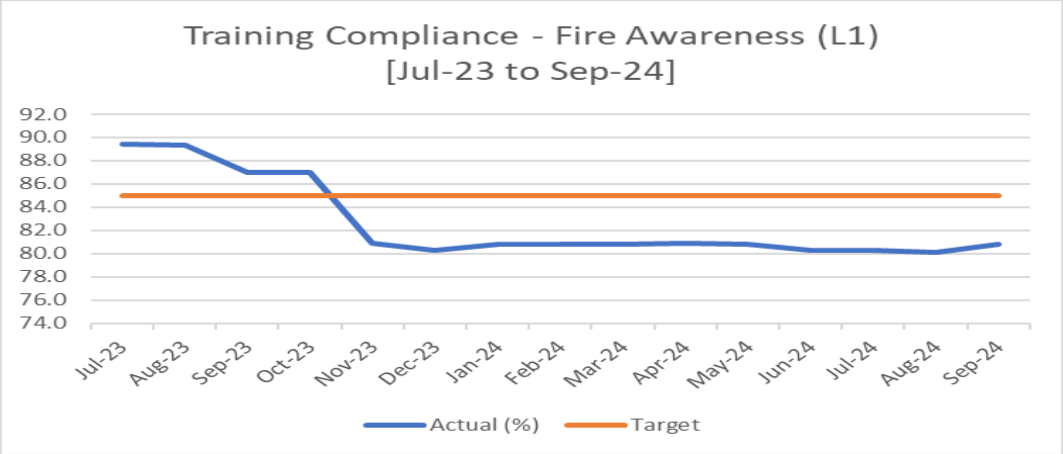
KPI 7 – Compliance with fire safety training need analysis (TNA): ***Basic Awareness*** [Level 1]

Target: 85%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

MONTH	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual (%)	89	89	87	87	81	80	81	81	81	81	81	80	80	80	80
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



nda – No Data Available

NB: KPI previously set to quarterly reporting at Trust Estates Compliance meetings prior to new Performance Management Framework arrangements in 2022.

Analysis

Compliance has risen slightly from 80.1% (August 2024) to 80.8% to end of September 2024.

As noted, further sessions scheduled and pblicised for coming quarter [October to December 2024].

Review of ESR data and reporting also underway with WOD and ESR teams.

Performance

If performance is not at required level, set out what the main causes are:

- Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e., agile/hybrid working.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training.	COMPLETE Q1	Trust FSM Trust FSM

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	Trust FSM

Expected Performance gain – longer-term

- Staff have wider access to training which can be delivered at a time and place to suit their needs.
- Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

a) Failure of Trust and staff to comply with statutory and mandatory duties.

b) Insufficient training has the potential to result in fire incident.

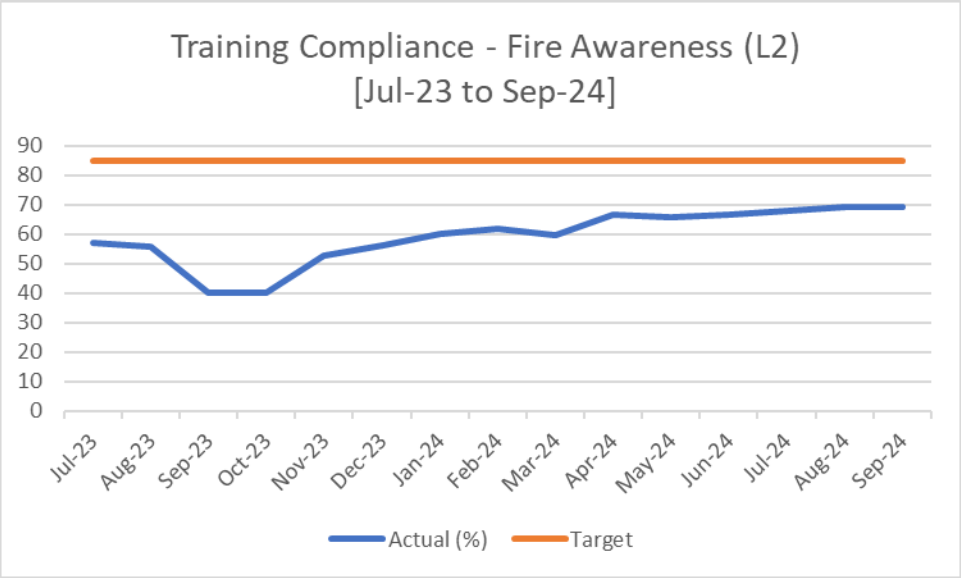
KPI 8 – Compliance with fire safety training need analysis (TNA): ***Operational Response*** [Level 2]

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

ONTH	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Actual (%)	57	56	40	40	53	56	60	62	60	67	66	67	68	69	69
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Analysis

Compliance has remained static with slight fall (-0.1%) compared to previous month [August 2024]

Performance

Despite marginal rise in training compliance, figures still below Trust benchmark due to service needs and resurgence of the pandemic, some training for staff has been restricted; both the FSM and Trust Ed & Dev team are actively working with departments to identify alternative approaches to the delivery of fire training.

Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e. agile/hybrid working.

49.0

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training. Training needs analysis for fire safety training to be reviewed to make sure that staff competency matrices are correct.	Q1	Trust FSM

Expected Performance gain - immediate

Divisions and managers accept some ownership of training and advise how staff can receive training to fit in with current ways of working and other barriers.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	As KPI 7

Expected Performance gain – longer-term

Staff have wider access to training which can be delivered at a time and place to suit their needs. Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties.
Insufficient training has the potential to result in fire incident.

KPI 9 - Compliance with fire safety training need analysis (TNA): ***Tactical Response*** [Level

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q2 2023 – 2024			Q3 2023 – 2024			Q4 2023-2924			Q1 2024 – 2025			Q2 2024 – 2025		
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 234	Sep 24
Actual %	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Analysis

As noted under KPI 7, a paper was submitted to the Trust Education Steering Group in July to rationalize fire training into three distinct levels including fire [Tactical] response.

Performance

If performance is not at required level, set out what the main causes are:

- Lack of clarity on training criteria

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Adopt more structured TNA for fire safety as outlined in paper to the trust's Education Steering group	Q2	Trust FSM Trust Ed & Dev team

Expected Performance gain - immediate

a) Managers and staff have clearer idea of the training they need to complete.

b) Training can be more focused around staff groups / departments

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
n/a	n/a	n/a

Expected Performance gain – longer-term

n/a

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties. Insufficient training has the potential to result in fire incident.

KPI Indicator H&S.26

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Graph title - Trust Health and Safety Training Compliance by Course

Target: 85%

SLT Lead: Lauren Fear

Current Performance against Target or Standard – below 85% in 4 out of 9 areas

Performance - Level below target

	Health Safety and Welfare	Moving & Handling module A	Moving & Handling Inanimate load	Moving &Handling People Handling (VCC)	Moving and Handling People Handling (WBS)	Display Screen Equipment	Violence and Aggression module A	Violence and Aggression module B	Violence and Aggression module C
Jul-23	85%	78%	85%	73%	90%	78%	93%	79%	14%
Aug-23	85%	78%	81%	72%	59%	77%	93%	79%	16%
Sep-23	86%	76%	77%	70%	83%	77%	92%	79%	17%
Oct-23	85%	75%	76%	69%	81%	76%	92%	79%	16%
Nov-23	84%	76%	76%	69%	81%	76%	92%	79%	16%
Dec-23	85%	77%	78%	68%	93%	77%	91%	74%	21%
Jan-24	85%	77%	82%	78%	86%	77%	92%	76%	20%
Feb-24	85%	76%	85%	76%	88%	78%	91%	78%	25%
Mar-24	86%	78%	86%	66%	91%	86%	98%	81%	30%
Apr - 24	86.4	78.6	88.9	70.6	93.8	78.1	92.0	81.0	30.7

Service Improvement Actions – Immediate (0 to 3 months)

Training figures are consolidated against previous months Maintaining or increased improvement across the board.	**Timescale and Lead**

Expected Performance gain – V&A module C has a slight decrease due to the increase in assignments.

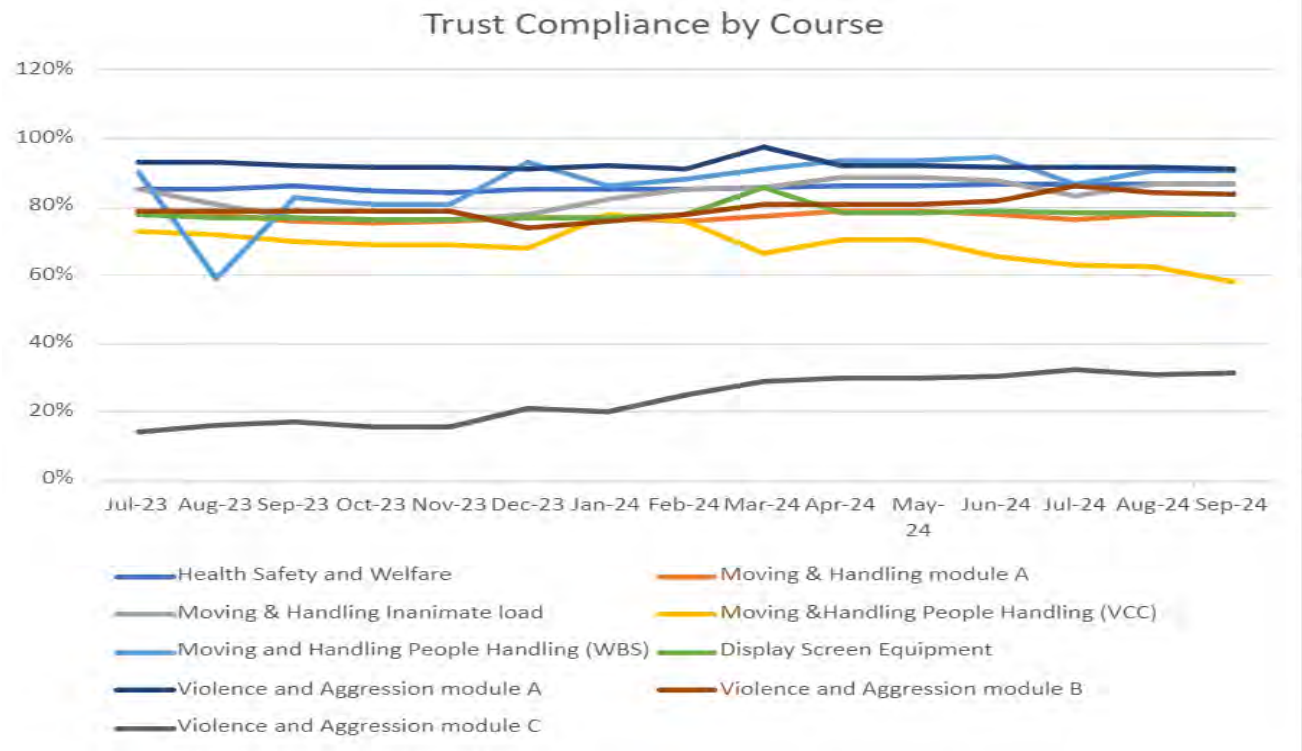
Service Improvement Actions – We shall continue to offer training course to suit the needs of the departments. Via teams or out of hours

Actions: As above	**Timescale:** **Lead:** Departmental Heads

Expected Performance gain – We have personally contacted all the managers within corporate to advise which training courses remain **outstanding and we have provided onsite training for Fire Safety, However the uptake remains low. All training dashboards are circulated through the divisions.**

Risks to future performance

May - 24	86.8	78.6	89.9	71%	94.5	78.6	92.2	81.4	30.2
June-24	87%	78%	85%	66%	95%	79%	92%	82%	31%
July-24	87%	77%	83%	63%	87%	78%	92%	86%	32%
Aug - 24	87%	78%	87%	62%	90%	79%	92%	84%	31%
Sep - 24	87%	78%	87%	59%	90%	78%	91%	84%	31%



Lack of onsite delivery for patient manual handling. We are expected to see a decline in performance. Although there is an SLA in place, there seems to be reluctance to travel. Availability has improved with C&V

Graph title - Trust Health and Safety Training Compliance by Division

Target: 85%

SLT Lead: Lauren Fear

Current Performance against Target or Standard – Below 85% I 5 out of 5 areas

Performance - Level below target

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24
Corporate Division	85%	85%	83%	81%	81%	83%	83%	84%	85%	84.3	86.3	87.0	86.4	89.3%	89.2%
RD&I	81%	81%	83%	86%	88%	89%	87%	90%	89%	88.5	87.	86.6	87.0	88.4%	87.7%
TCS	83%	83%	82%	81%	82%	85%	84%	84%	84%	83.6	83.6	83.6	84.2	81.5%	81.5%
VCC	77%	77%	76%	75%	74%	75%	76%	75%	77%	77.4	77.4	77.1	77.9	77.4%	77.1%
WBS	92%	92%	89%	89%	91%	90%	92%	92%	93%	93.5	93.7	92.7	90.9	91.9	91.4%
Trust Compliance	82%	82%	84%	83%	82%	80%	80%	81%	81%	82%	82.9	82.6	82.5	82.6%	82.4%

On the back of actions listed last month the overall picture has been consolidated. Continue to manage.

There is sufficient capacity in terms of training places offered, the challenge remains releasing staff to attend face-to-face training and staff completing mandatory online training. Volume of Statutory and mandatory training required.

Timescale Q4 2024/25 Lead: Departmental Managers

Expected Performance gain – steady improvement in compliance

Service Improvement Actions – tactical (12 months +)

Actions: As above

Timescale: Lead: Departmental Managers

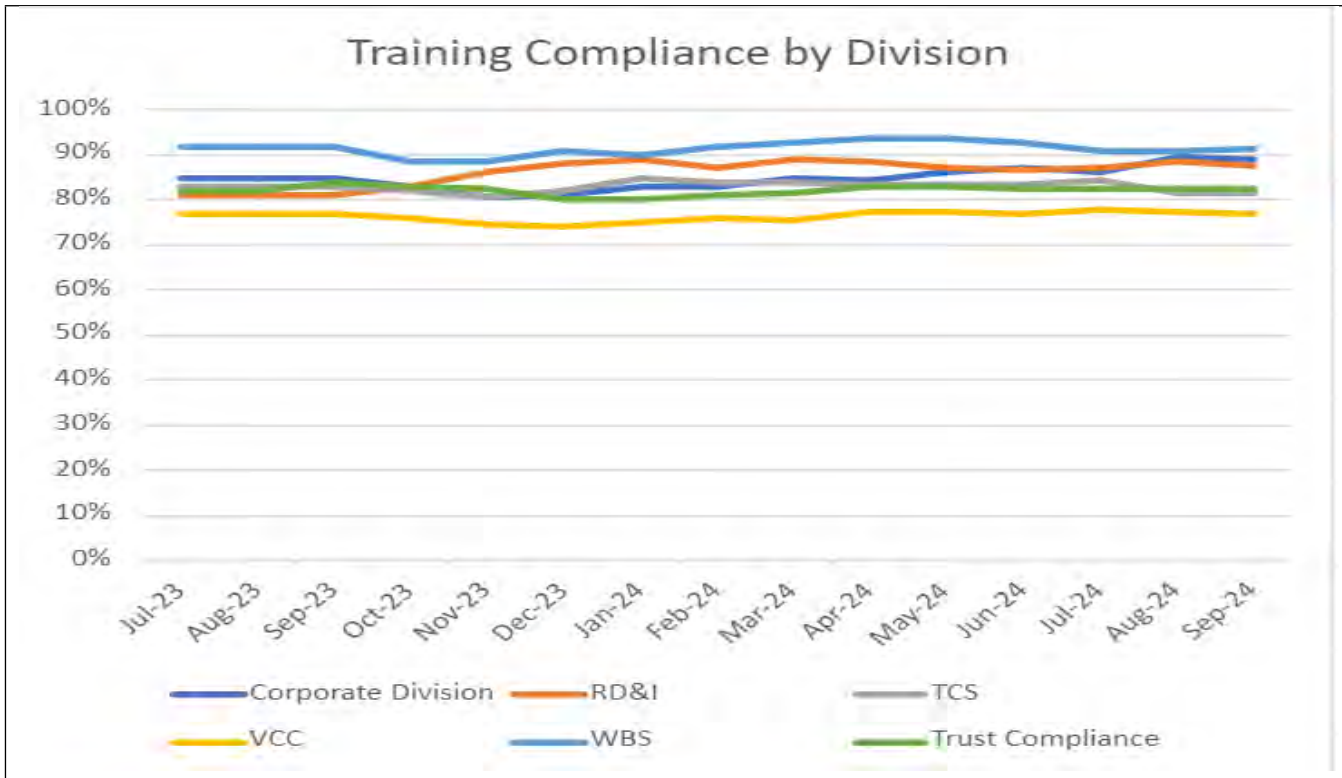
Expected Performance gain – longer-term Compliance with WG 85% target

Risks to future performance

Staff unable to be released due to operational pressures. –

Staff unable to be released due to operational pressures.

Volume of Statutory and Mandatory training which staff have to complete on line


Training Compliance by Division
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Corporate Division
RD&I
TCS
VCC
WBS
Trust Compliance

KPI Indicator H&S.43

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Graph title - Incidents of Violence and Aggression

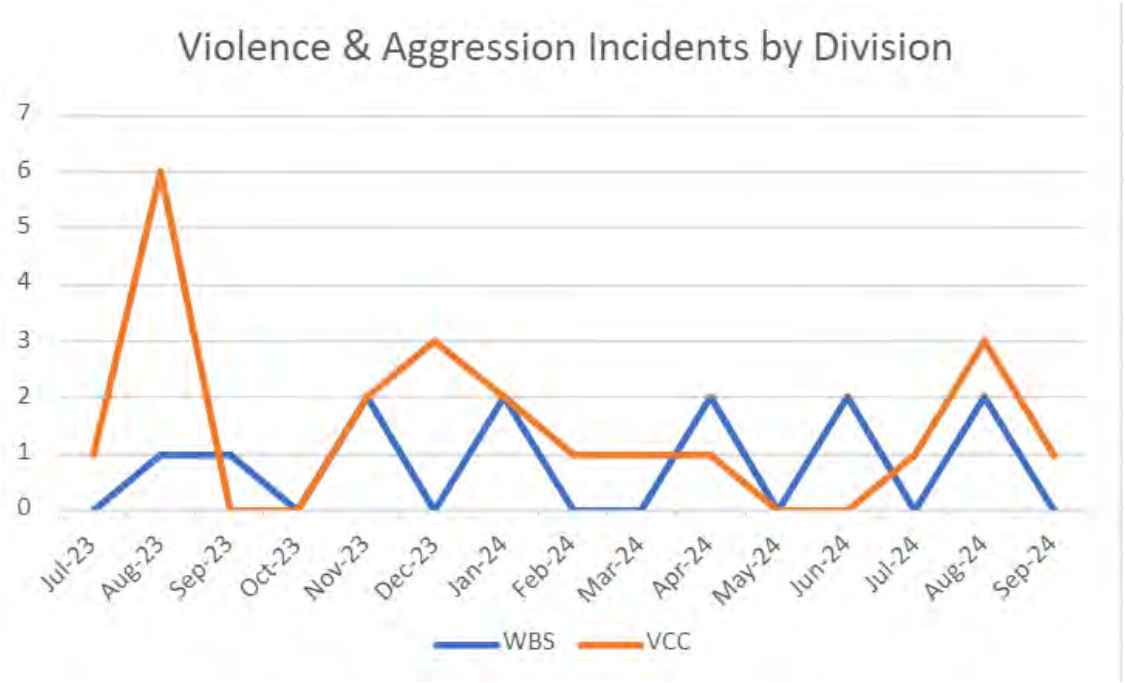
Target: 0

SLT Lead: Lauren Fear

Current Performance against Target or Standard –

Performance - Stable

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	June 24	July 24	Aug 24	Sep 24	Total
WBS	1	1	0	2	0	2	2	0	0	2	0	2	0	2	0	14
VCC	1	6	0	0	2	3	2	1	1	1	0	0	1	3	1	22



Service Improvement Actions – Immediate (0 to 3 months)

All recorded incidents are being monitored

Expected Performance gain – immediate Actions: Trust wide Bespoke training in targeted areas in addition to a V&A Passport Scheme. This has resulted in an increased range of options for staff and we are expecting a continued improvement in terms of performance.

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit	H&S Team Timescale Q4 2024

Expected Performance gain – longer-term

Risks to future performance

STAFF EXPERIENCE

KPI Indicator DIG.51

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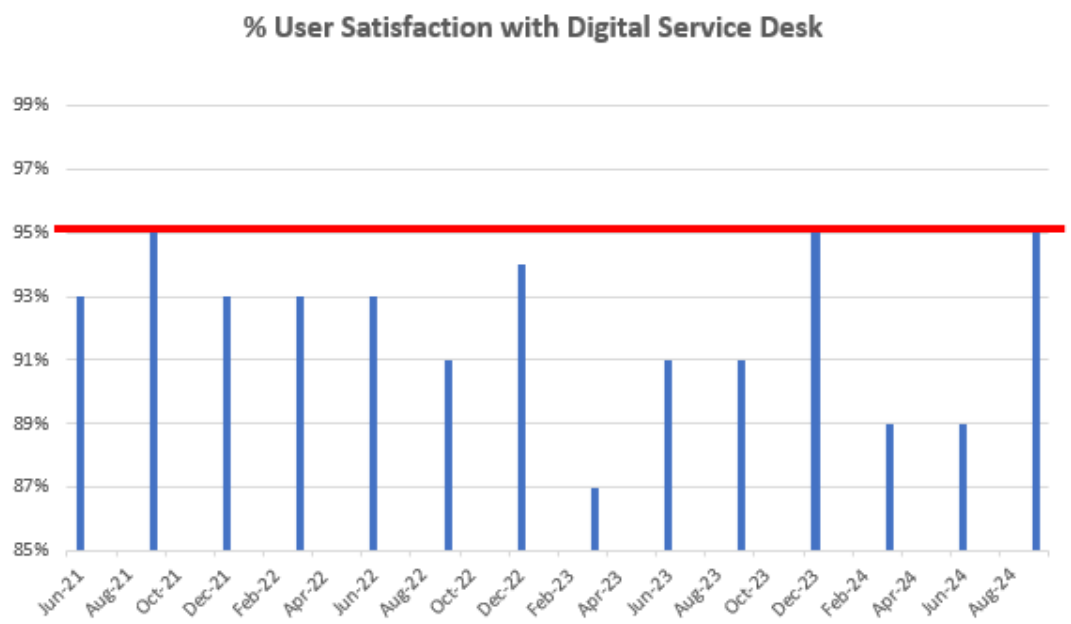
Digital Service Desk % User Satisfaction with Digital Service Desk

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	Jul 23	Aug 23	Sep 23	Oct 23	Nov23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 23	Aug 23	Sep 23
Actual %	91%			95%			89%			89%			95%		
Target 95%	95%			95%			95%			95%			95%		



Performance

Assessment of current performance, set out key points:
Significant improvement reported in Q2 2024/25 – 95% target achieved.

Work ongoing to transition fully remotely-managed calls to 1st Line Support. Digital Support Service Improvement Plan drafted and work to further improve efficiency, automation etc. commenced.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Routine review of performance and associated feedback within Digital Services Infrastructure Team meetings to identify areas for improvement.	Ongoing	Digital Ops Manager

Expected Performance gain - immediate
Aiming to achieve and subsequently maintain 95% target by Q1 2024.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy new IT Service Management (ITSM) tool, to support improved ways of working across Digital Service Desk.	30/09/2024 **COMPLETE**	Digital Ops Manager
• Automation of Service Desk activities – improved turnaround time to resolution.	30/09/2024 **ONGOING**	
• Increase volume of calls that can be managed directly by 1st line support.	30/09/2024 **ONGOING**	

Expected Performance gain – longer-term
Improved customer experience, to ensure 95% target is maintained.

Risks to future performance

Set out risks which could affect future performance

- No current risks

TIMELINESS

KPI Indicator DIG.58

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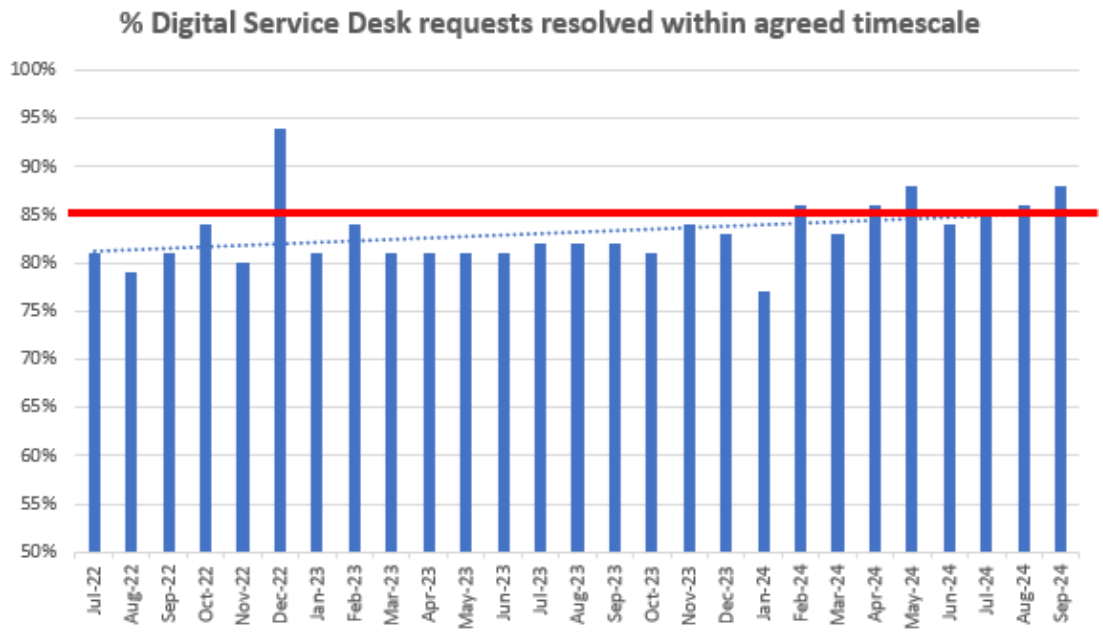
Digital Services: % Service Requests resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	Jun24	July 24	Aug 24	Sep 24
Actual %	82	82	82	81	84	83	82	86	83	86	88	84	85	86	88
Target 95%	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 achieved again in September 2024 – target achieved in each of last 3 months.

Work ongoing to increase volume of calls managed by 1st line support and increase use of automation to speed up call resolution.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution. • Increase volume of calls that can be managed directly by 1st line support.	30/09/2024 **ONGOING**	Digital Ops Manager

Expected Performance gain – immediate
Aim to routinely achieve 85% target by start of Q4 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Improve efficiency through adoption of new ITSM platform (Halo).	31/03/2025	Digital Ops Manager

Expected Performance gain – longer-term
Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance
Deployment of new IT Service Management (ITSM) completed – service went line in late-September 2024. This new tool should further improve service desk performance, increased automation etc.

KPI Indicator DIG.59

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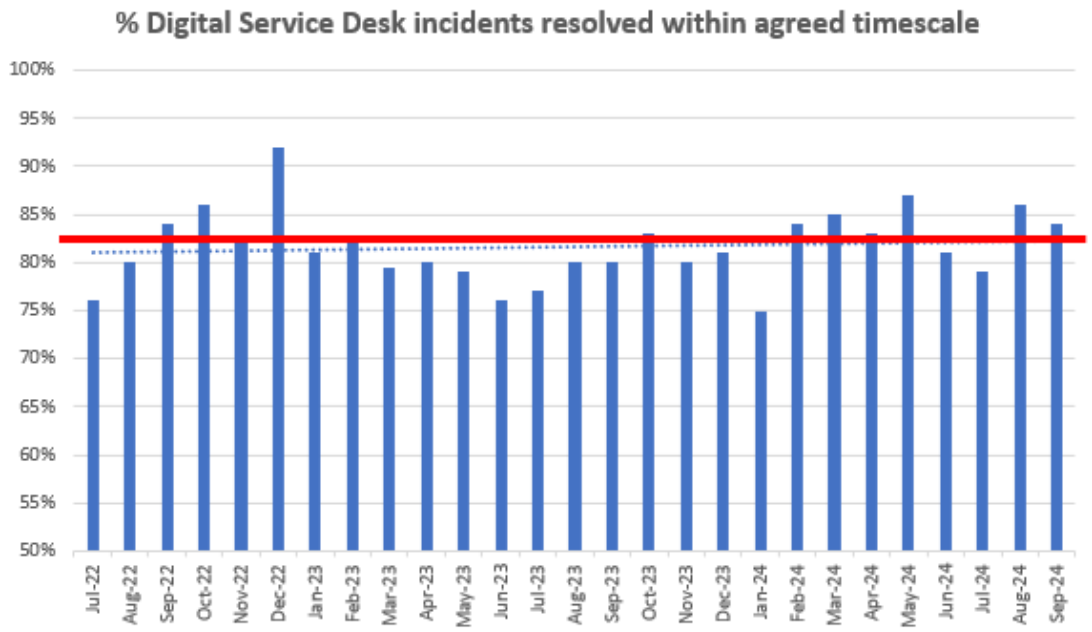
Digital Services: % Incidents resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	My 24	Jun24	July 24	Aug 24	Sep 24
Actual %	77	80	80	83	80	81	81	84	85	83	87	81	79	86	84
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points:
Performance relatively stable at approx. 81/82% over last 12 months – marginal improvement observed in August and September 2024, though target not achieved in September (84%).

Further improvements anticipated through Q3 and Q4 2024/25 as improved Digital Service Desk procedures are enabled and new IT Service Management Tool is deployed (service went live in late-September 2024).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution. • Increase volume of calls that can be managed directly by 1st line support.	30/09/2024 **ONGOING**	Digital Ops Manager

Expected Performance gain – immediate
Aim to routinely achieve 85% target by start of Q4 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Improve efficiency through adoption of new ITSM platform (Halo).	31/03/2025	Digital Ops Manager

Expected Performance gain – longer-term
Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance
Deployment of new IT Service Management (ITSM) completed – service went live in late-September 2024. This new tool should significantly improve service desk performance, increased automation etc.

EFFICIENT

KPI Indicator FIN.72

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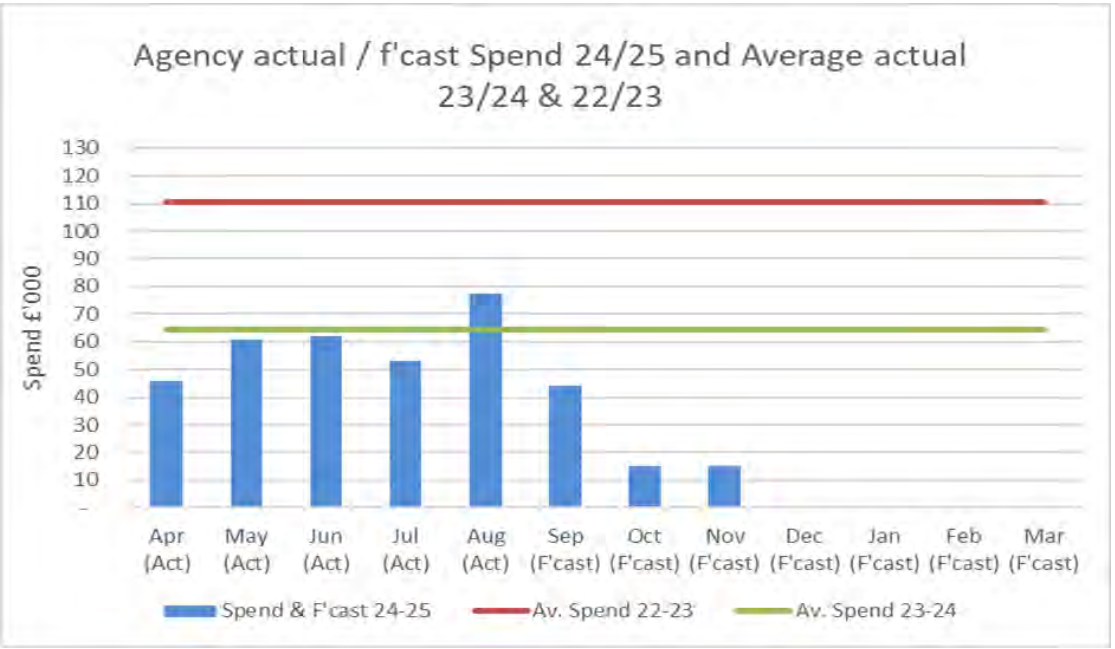
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget | **SLT Lead: Finance Director**

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

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual £k	1.323	46	107	169	222	299							
Target (per IMTP) £0.179m Forecast		39	78	117	138	159	179	0	0	0	0	0	0



The spend on agency for August'24 was **£0.077m** (July £0.053m) which gives a cumulative year to date position of **£0.299m** and a current forecast outturn spend of circa **£0.373m** (£0.775m 2023/24).

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

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

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

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

Service Improvement Actions – Immediate (0 to 3 months)

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

KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP | **SLT Lead: Finance Director**

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cumm	1.800	0.162m	0.324m	0.497m	0.831m	1.094m							
Target £2.875m Forecast		0.162m	0.324m	0.497m	0.831m	1.147m	1.334m	1.591m	1.848m	2.105m	2.362m	2.619m	2.875m

Overall VUNHST Cost Improvement Programme £2.875m (previously £2.6M)

Performance

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

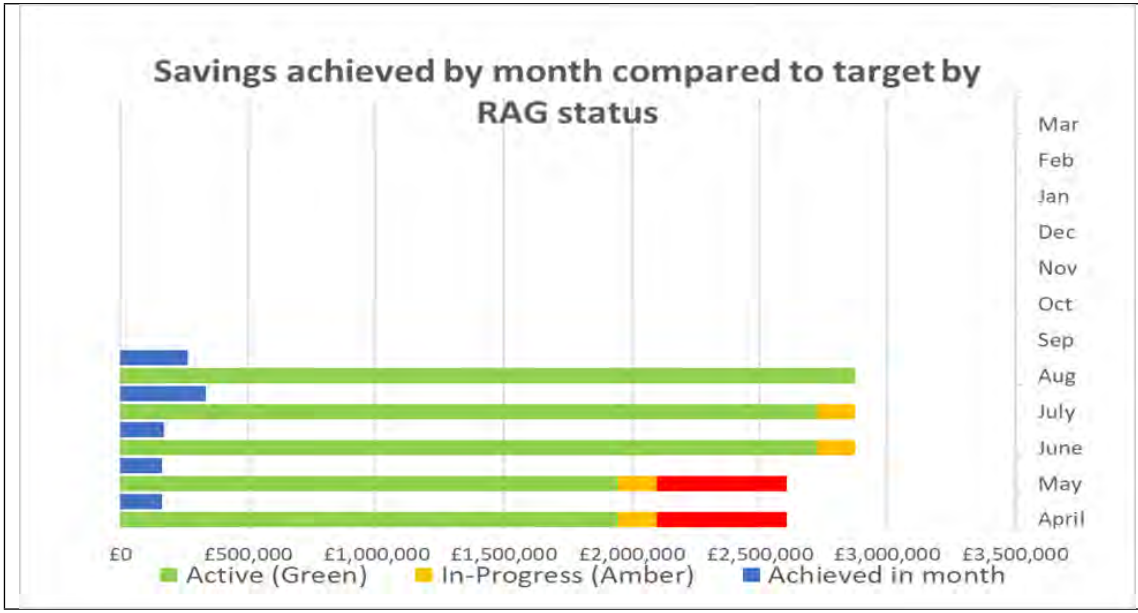
In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2025-26.

Performance



The overall Trust savings performance as of August'24 is a small underachievement against plan of £(0.053m), however at this stage is expected to deliver to target by the end of the financial year. Whilst some savings schemes are overachieving against the target, there are some schemes within VCS and WBS such as the demand planning, procurement efficiencies and private patients which are underperforming against the original plan. The WBS stock control has yet to realise and savings and will need to be monitored closely to ensure the target can be met during 2024-25.

It is extremely important that divisions continually review their current savings savings, and where delivery may not be achieved, alternative schemes are implemented to ensure the savings target is met for 2024-25.

KPI Indicator EST.64

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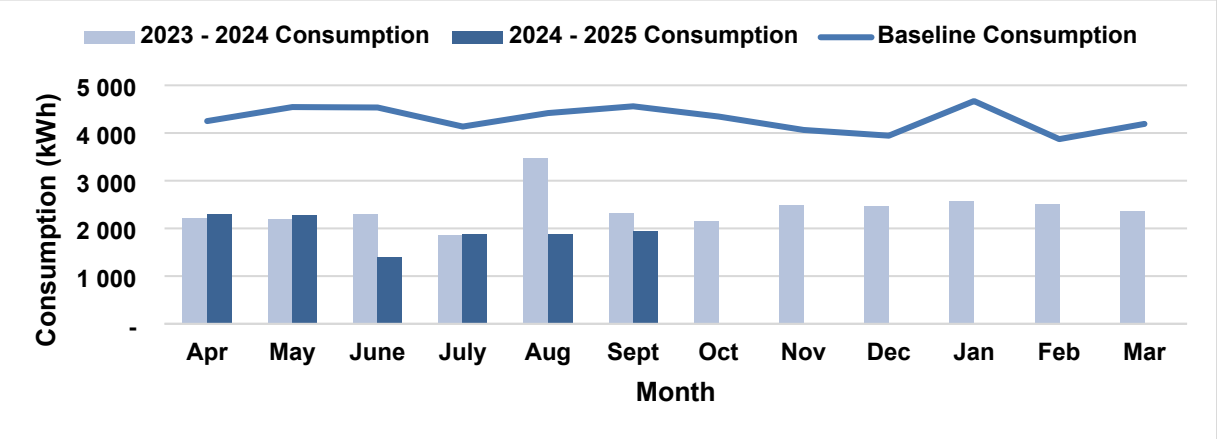
Trust HQ - Energy (Gas and Elect) performance consumption

Target: -2%

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Electricity

Trust	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual (kWh)	2,297.00	2,281.00	1,389.80	1,870.00	1,883.00	1,934.00	-	-	-	-	-	-
Target previous year (-2%)	2,136.91	2,134.97	2,225.18	1,789.65	3,372.69	2,254.28	2,086.47	2,412.39	2,390.08	2,482.23	2,426.94	2,278.53
Carbon Emissions	0.48	0.47	0.29	0.39	0.39	0.40	-	-	-	-	-	-
Carbon Emissions Target (-3%)	0.44	0.44	0.46	0.37	0.39	0.47	0.43	0.50	0.49	0.51	0.50	0.47

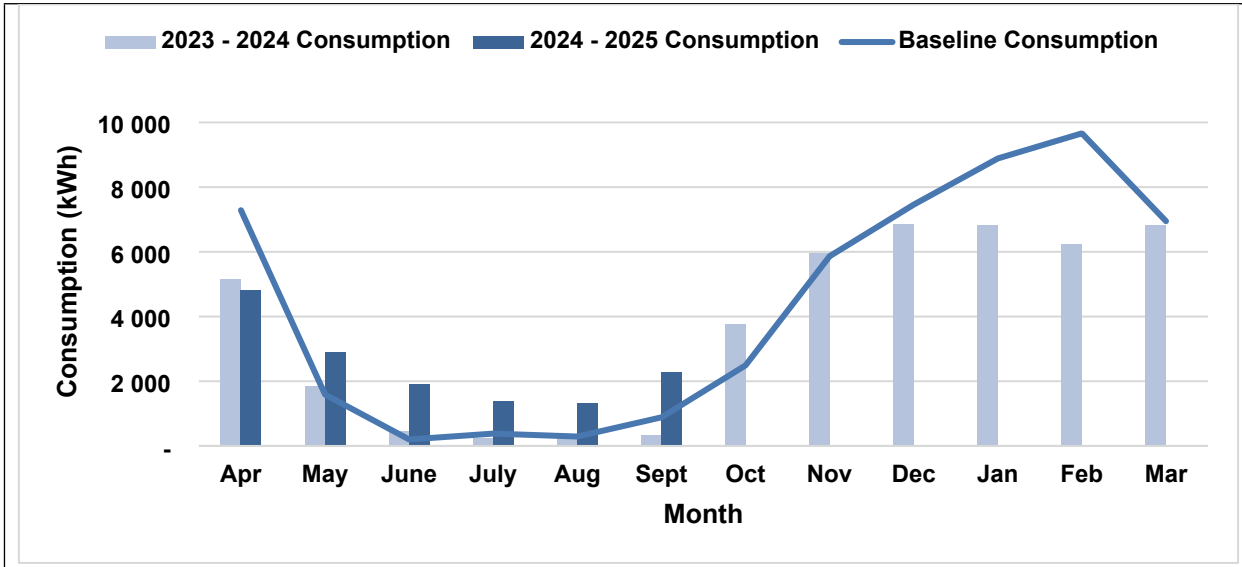
Performance

Estates Optimization work is being explored for Trust HQ to reduce energy consumption and cost. This includes rationalization of the Estate through closing offices and enhancing BMS monitoring and effectiveness. These upgrade works will form part of a series of energy audits to be undertaken in November; with actions aligned with the SIP's.

Meetings have been held with Estates Colleagues to account for the rise in gas usage at Trust HQ. This is down to Outside air temperature; a cold and wet May-August compared to the previous year. The summer period has also been milder than previously.

Electricity is higher than in previous years but is lower than the baseline year.

The carbon conversion figures are taken from DEFRA. The conversion factors are changed every financial year, and this is reflected in the calculations.



GAS

Trust	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual (kWh)	4,791.70	2,887.00	1,908.50	1,377.80	1,304.40	2,275.90	-	-	-	-	-	-
Target previous year (-3%)	4,993.79	1,790.02	428.75	228.56	283.70	307.06	3,653.02	5,761.99	6,627.43	6,599.20	6,052.22	6,608.13
Carbon Figure	0.92	0.56	0.37	0.27	0.25	0.44	-	-	-	-	-	-
Carbon Target (-3%)	0.96	0.34	0.08	0.04	0.05	0.06	0.70	1.11	1.28	1.27	1.17	1.27

KPI Indicator EST.54

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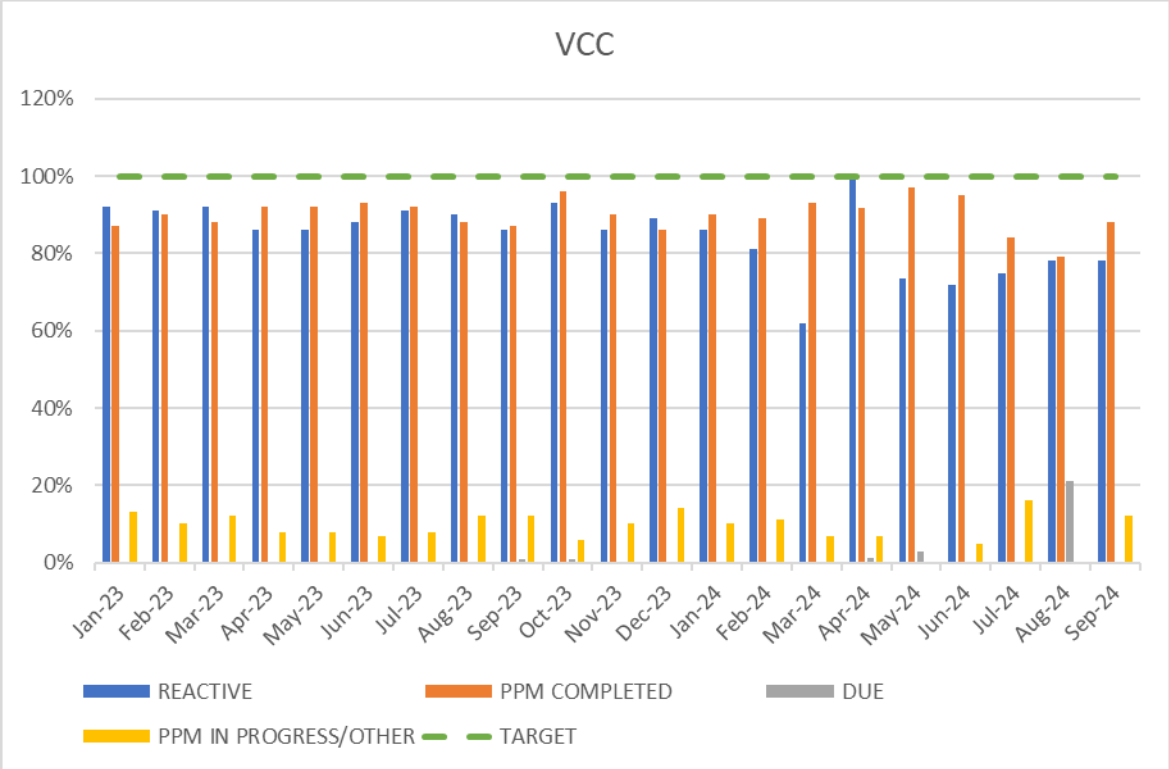
Graph title – 15 month Data PPM & Reactive Work Orders Velindre Cancer Centre

Target: 95% compliance of completion of PPM & Reactive tasks

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:

Long-term Sickness Absences:

- Estates recruited into 2 new positions in Electrical & Fire Safety
- Impacts staff workload, morale, and operational efficiency.

Transition of Facility Management Systems:

- Estates is transitioning to Symbiotic, a new Computer-Aided Facility Management (CAFM) system.
- The current and new systems will run concurrently for 6 months to ensure a smooth transition.
- Welsh Blood Service Assets are planned to be integrated into new CAFm system in October 2024.

Focus on Statutory Compliance: Despite these challenges, Estates staff are prioritising statutory compliance to maintain a safe and high-quality e

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Short Term Estates staff continuing to work with CAFm provider to resolve development issues.	0-3 months	Jonathan Fear

Planned Tasks – 78% In Progress – 22%
Reactive Tasks – 88% In Progress Jobs – 22%
Cancelled Jobs – 0% Planned & Reactive

Under benchmark level of compliance this month on PPM & reactive tasks due to staff vacancies and transition of CAFm systems that identified issue – deadline dates. This has now been understood and the team are now working towards new deadlines.

Service Improvement Actions – tactical (12 months +)

Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency. Improved levels of PPM compliance to meet benchmark of 95%	recruitment 6 months CAFM Improvements ongoing	Jonathan Fear

Expected Performance gain – longer-term

Continue to improve compliance levels at VCC and across the Trust and continue to work with CAFm provider with development list to resolve issues listed on plan.

Risks to future performance

Works are being prioritised to ensure high risk and statutory activities are completed. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

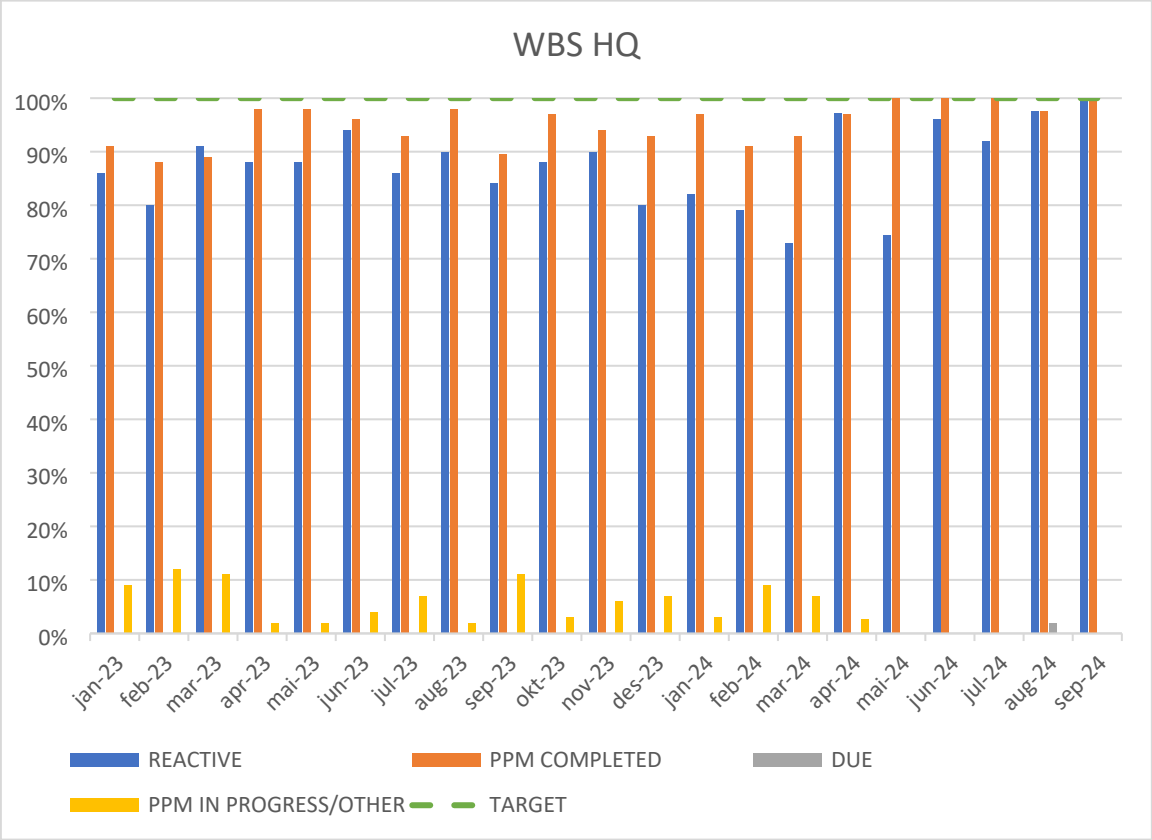
Graph title – 15 month Data PPM & Reactive Work Orders WBS HQ

Target: 95% compliance of completion of PPM & Reactive tasks WBS HQ

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:
Long-Term Sickness Absences:
Estates has experienced two long-term sickness absences recently.
Transition of Facility Management Systems:
Estates is transitioning to Synbiotix, a new Computer-Aided Facility Management (CAFM) system.
The current and new systems will run concurrently for 6 months to ensure a smooth transition.
Focus on Statutory Compliance: Despite these challenges, Estates staff are prioritising statutory compliance to maintain a safe and high-quality environment.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term • Planning to integrate systems in October 2024 for WBS all sites.	**0-6 months**	**Jonathan Fear**

Planned Tasks – 100% Planned In Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Improved levels of PPM & Reactive compliance to meet benchmark of 95%.

Service Improvement Actions – tactical (12 months +)

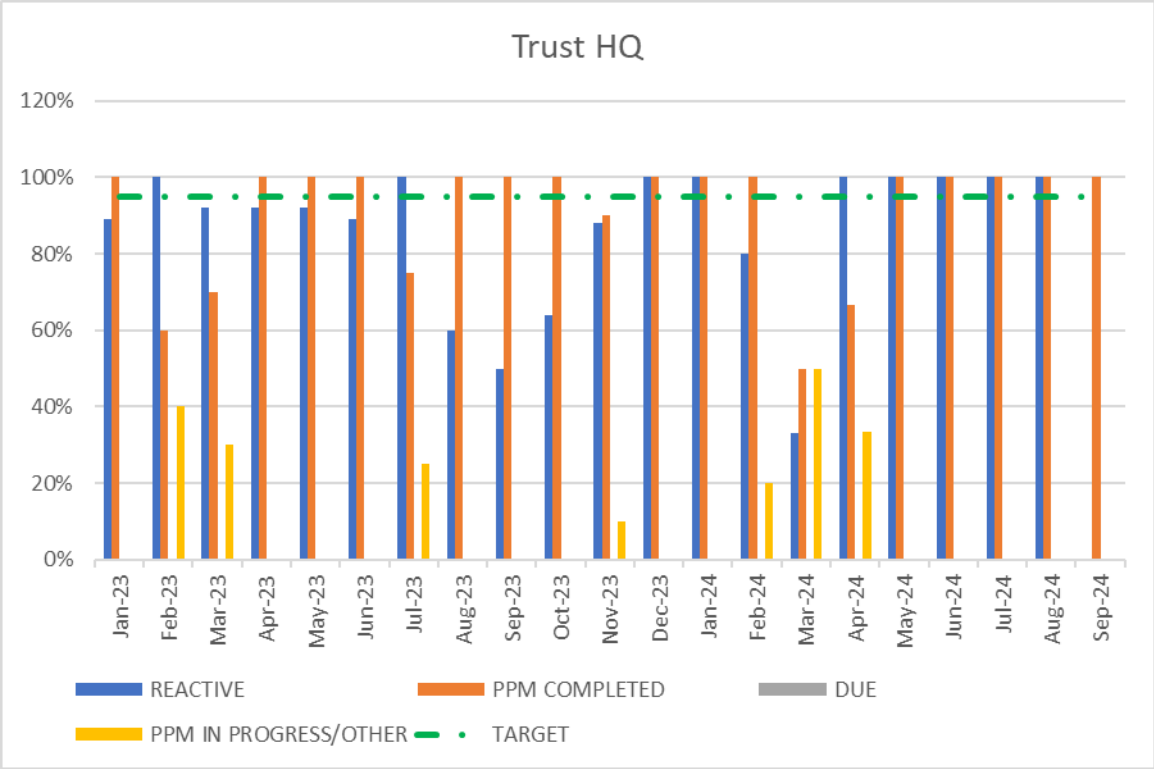
Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jonathan Fear**

Expected Performance gain – longer-term
Decreased number of late/cancelled jobs as there will be an adequate workforce. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Works are being prioritised to ensure high risk and statutory activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders Headquarters Nantgarw	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable Trust HQ	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:

Benchmark met for PPM & Reactive maintenance. Continue to manage.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency. • Plans to integrate Trust HQ into new CAFm system December 2024	**0-3 months**	**Jonathan Fear**

Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Benchmark achieved on PPM and Reactive tasks.

Service Improvement Actions – tactical (12 months +)

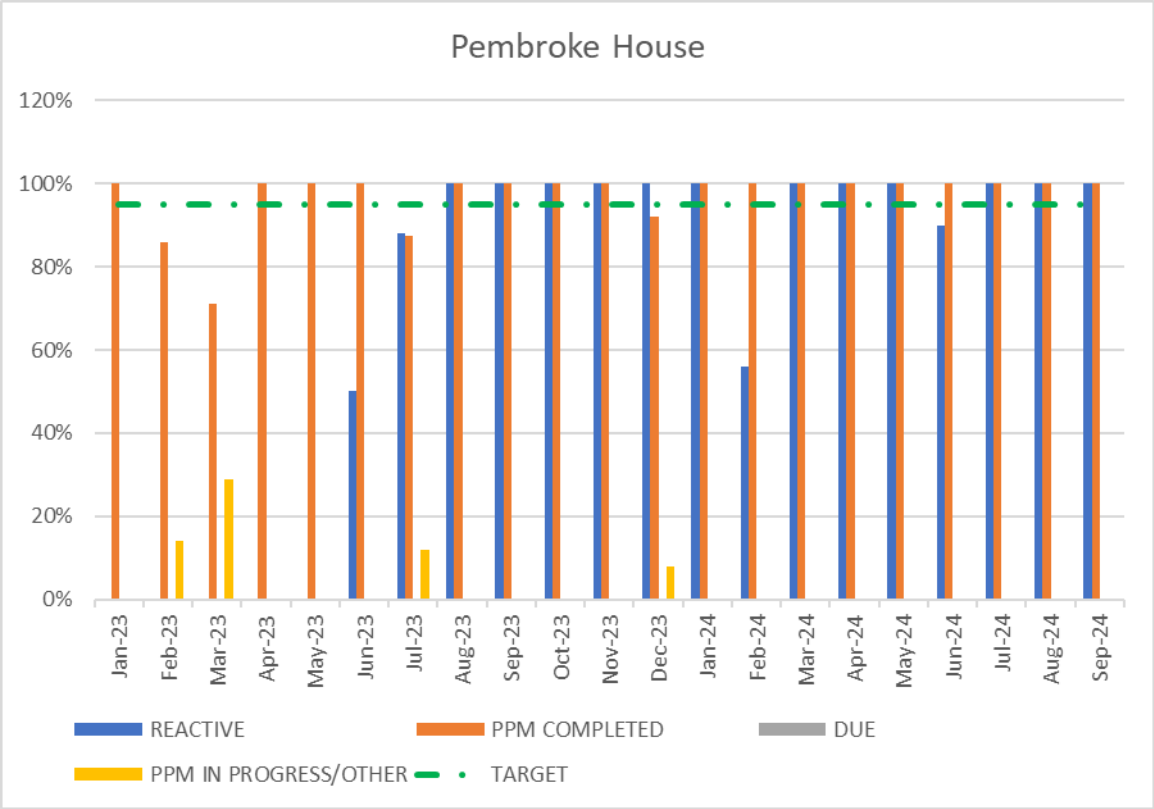
Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
Continue to meet benchmark of 95%

Risks to future performance

Continue to manage compliance at Trust HQ.

Graph title – 15 month Data PPM & Reactive Work Orders WBS Wrexham	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable Pembroke House	**Performance - no discernible trends available**



Benchmark met on PPM & Reactive tasks Pembroke House.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Ensure monthly PPM tasks are scheduled in a timely manner in line with the monthly North Wales Visit. • Plans to integrate Trust HQ into new CAFm system December 2024	**0-3 months**	**Jonathan Fear**

Expected Performance gain - immediate
Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Maintain High Standards of compliance to meet benchmark of 95%.
Improve Reactive levels of compliance. Reactive tasks under benchmark as site is visited once a month.

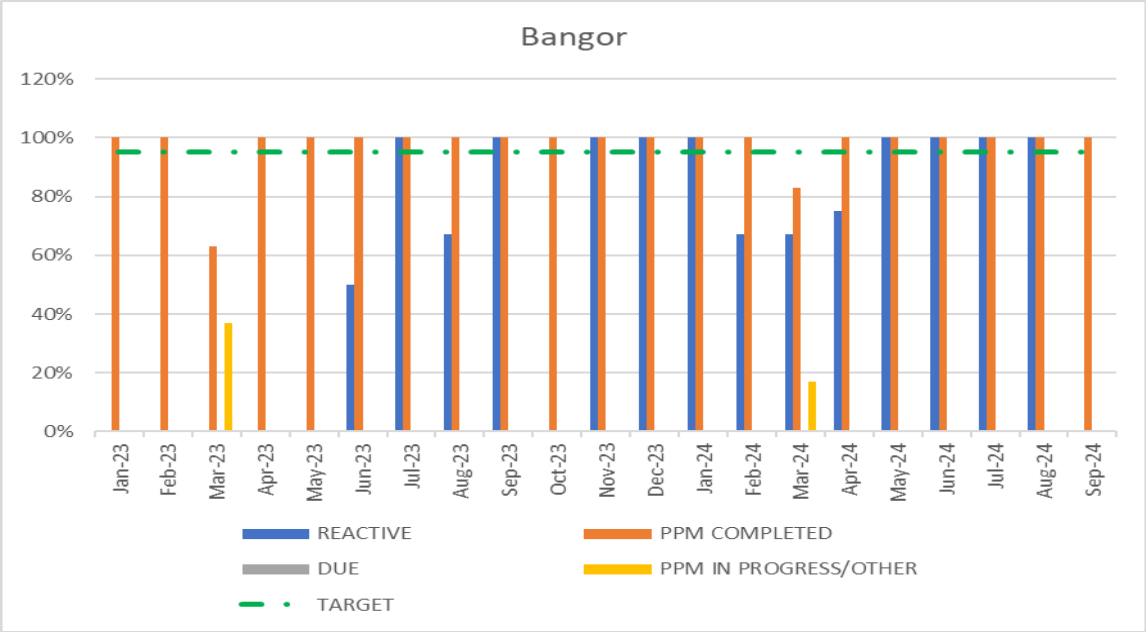
Service Improvement Actions – tactical (12 months +)

Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jonathan Fear**

Expected Performance gain – longer-term
0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance
Maintain High Levels of Compliance

Graph title – 15 month Data PPM & Reactive Work Orders Bangor	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
Benchmark met on PPM & Reactive tasks Pembroke House.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale: 0-3 months	Lead: Jonathan Fear
• Plans to integrate Trust HQ into new CAFm system October 2024 Planned Tasks – 100% Planned in Progress – 0% Reactive Tasks – 100% In Progress Jobs – 0% Cancelled Jobs – 0% Planned & Reactive		

Expected Performance gain - immediate
Maintain High Levels of Compliance in planned tasks. Benchmark under target due to site being visited once a month at North Wales site on reactive tasks.

Service Improvement Actions – tactical (12 months +)

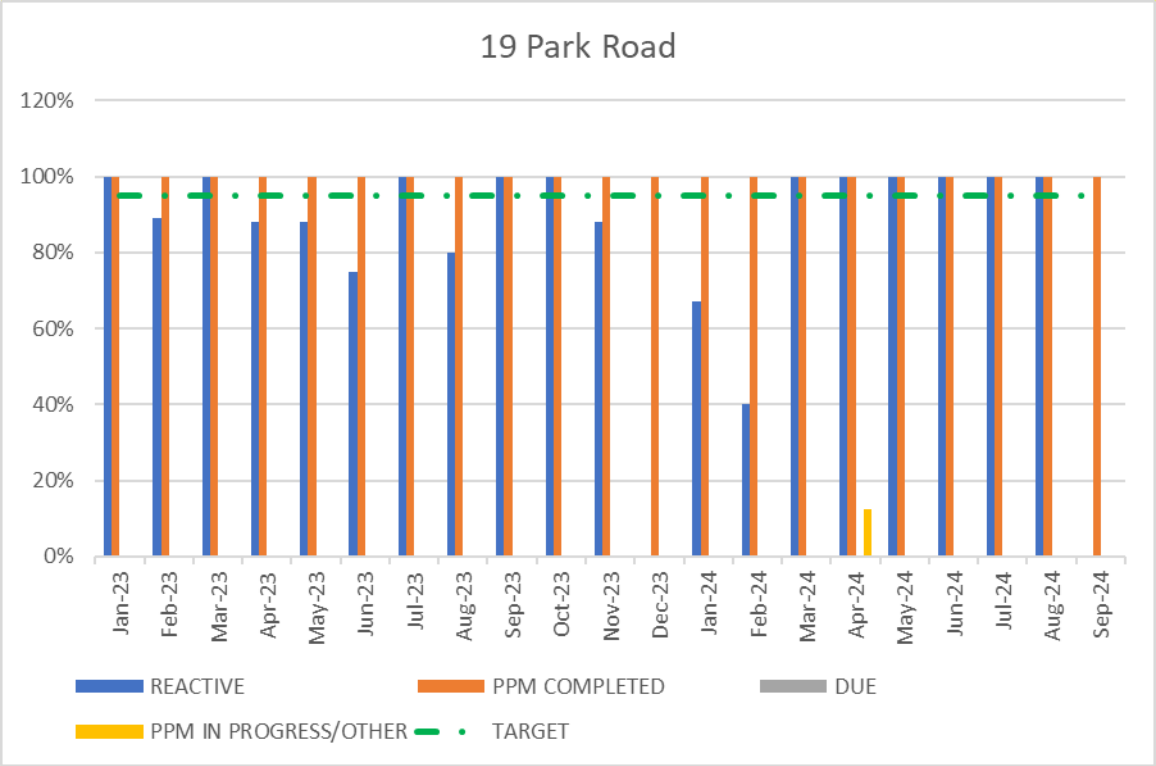
Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**6 months CAFM Improvements ongoing**	**Jonathan Fear**

Expected Performance gain – longer-term
0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Maintain High Levels of Compliance.

Graph title – 15 month Data PPM & Reactive Work Orders 19 Park Road	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable 19 Park Road	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
Benchmark met in PPM and Reactive tasks

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Short Term Continue to meet benchmark. • Plans to integrate Trust HQ into new CAFm system December 2024	**0-3 months**	**Jonathan Fear**

Expected Performance gain - immediate.
Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Benchmark achieved on PPM. Reactive tasks under benchmark due to a number of staff on sickness during this period.

Service Improvement Actions – tactical (12 months +)

Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
0% of late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards
Improve reactive task compliance.

Risks to future performance

KPI Indicator DIG.69

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Digital Service % uptime of critical systems (% availability by service, excl. planned maintenance windows)

Target: 99%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sep 24
Actual (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Target 99%	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99

Performance

Assessment of current performance, set out key points:

- Currently unable to report performance.
- Initial list of critical systems identified
  - eProgesa
  - WBS Appts. System (client & public-facing service)
  - WTAIL IT Systems
  - Prometheus (WBS).
  - WPAS
  - WCP
  - WNCR
  - ChemoCare
  - WellSky (Careflow)
  - RADIS / RISP & Synapse

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Establish 'proxy reporting of 'availability for critical systems	31/05/2024 **(delayed)**	Head of Digital Infrastructure

Expected Performance gain – immediate
Establish PMF reporting capability.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy IT system monitoring platform, to ensure accurate reporting of service availability.	31/03/2025	Head of Digital Infrastructure

Expected Performance gain – longer-term
Establish PMF reporting capability.

Risks to future performance

Set out risks which could affect future performance

- Insufficient funding available to enable permanent deployment of required monitoring solution. PoC not progressed due to funding constraints and desire to explore alternative options via new ITSM tool.

KPI Indicator DIG.70

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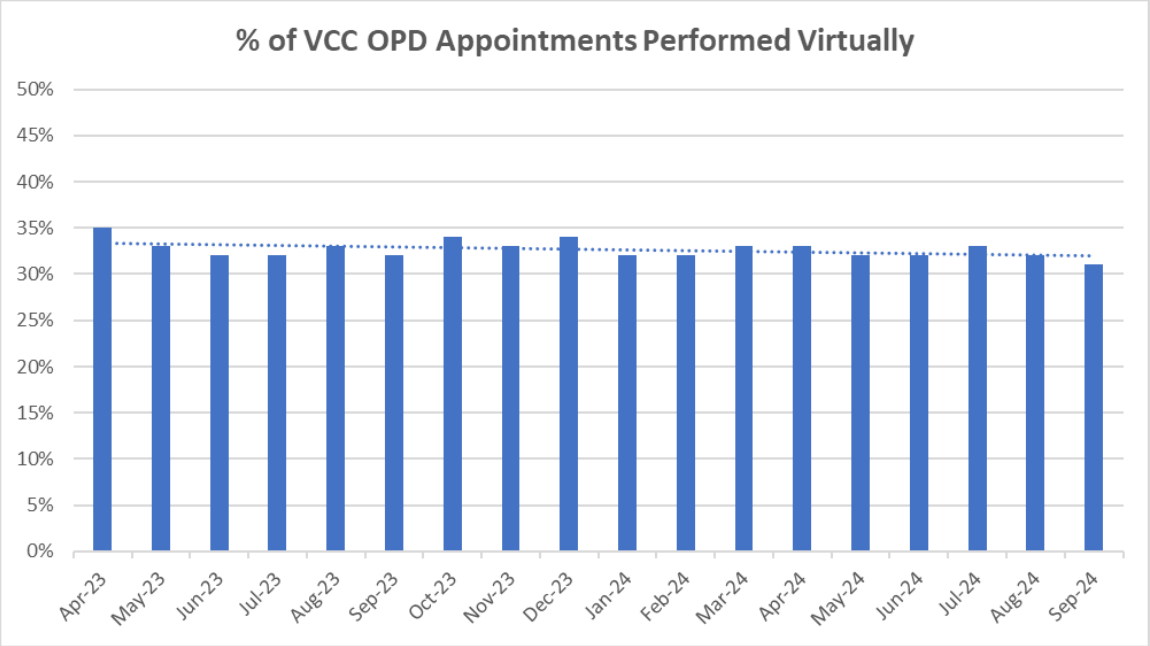
Digital Service % of Outpatient consultations performed virtually

Target: TBA %

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24	Aug 24	Sep 24
Actual (%)	32%	33%	32%	34%	33%	34%	32%	32%	33%	33%	32%	32%	33%	32%	31%
Target TBA %	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD



Performance

Assessment of current performance, set out key points:

- Welsh Government policy to increase utilisation of virtual (video & telephone) consultations for OPD consultation.
- Majority of current VCC virtual consultations performed over the telephone.
- Very limited utilisation of video consultations at present.
- PMF target to be agreed with VCC SLT.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Participating in national discussion to refresh video consultations platform.	Sep 2024 **(COMPLETED)**	Head of Digital Programmes
• Deploy improved working environment for VAP clinic.	Q1 2024/25 **(COMPLETED)**	
• Support expansion plan for VAP service.	31/12/2024	Head of Digital Delivery
• Deploy "Keep Me Safe" app.	30/09/2024 **(DELAYED)**	Head of Digital Programmes

Expected Performance gain – immediate

Increased utilisation of telephone and video consultations in VCC.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Refresh of VCC telephony infrastructure	Q4 2024/25	Head of Digital Infrastructure

Expected Performance gain – longer-term

Increased utilisation of telephone consultations in VCC.

Risks to future performance

Set out risks which could affect future performance

- Failure to agree approach for deployment of national (NHS Wales) video consultation platform.
- Inability to deploy video consultation due to either (i) insufficient functionality and/or (ii) IG / IT security concerns across potential suppliers.

KPI Indicator DIG.71

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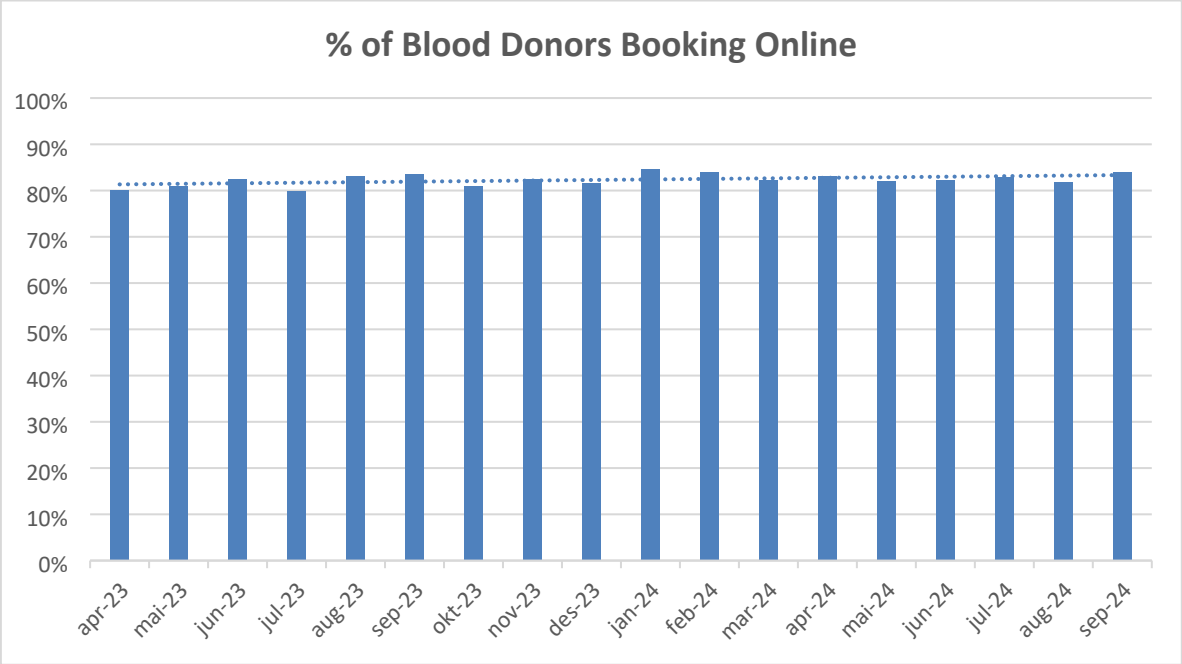
Digital Service % of Donors booking online

Target: TBA %

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24	Aug 24	Sep 24
Actual (%)	80%	83%	84%	81%	82%	82%	85%	84%	82%	83%	82%	82%	83%	82%	84%
Target TBA %	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD



Performance

Assessment of current performance, set out key points:

- Approx 8,000 blood donation appointments made each month.
- Online Appts. System deployed in 2016 – initial utilisation approx. 50-60%.
- Utilisation currently averaging approx. 82% per month.
- PMF target to be agreed with WBS SLT.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Re-platform of WBS Appts. System	June 2024 (delayed to October 24)	Head of Digital Applications (WBS)

Expected Performance gain – immediate

Increased online bookings through improved donor experience and accessibility.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Reviewing requirements for Donor mobile app and 'omnichannel' (CRM) solution as part of BECS procurement.	Q4 2024/25	WBS Director Chief Digital Officer

Expected Performance gain – longer-term

Increased online bookings through improved donor experience and accessibility.

Risks to future performance

Set out risks which could affect future performance

- Unable to deliver mobile app / CRM solution, thus limiting opportunity for WBS to enhance its online offering to donors.

KPI Indicator DIG.72

Return to Top

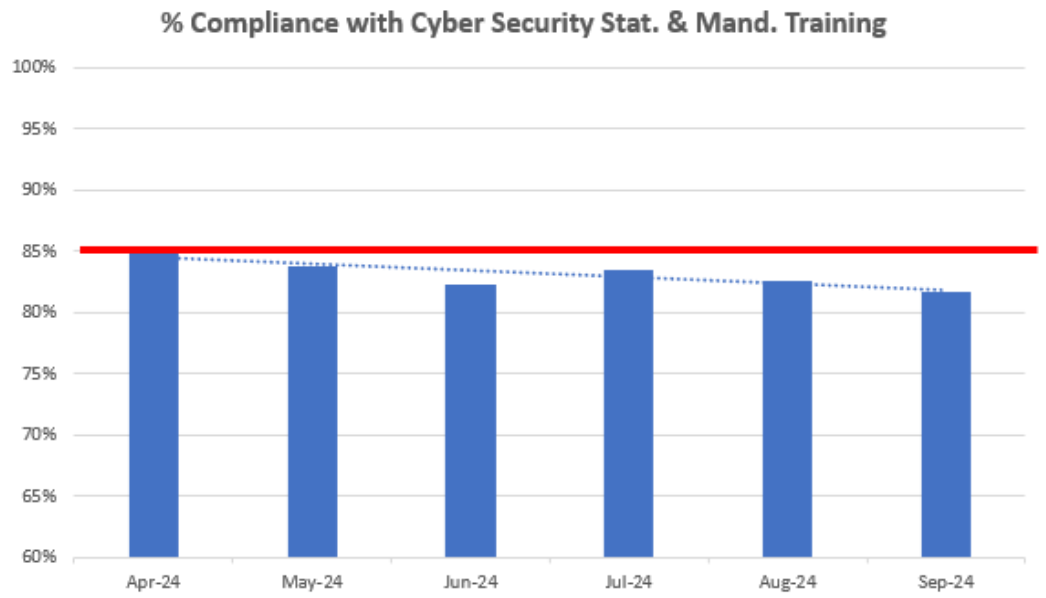
% compliance with cyber security statutory & mandatory training

Target: 85%

Lead: Digital

Current Performance against Target or Standard

Trust Position	July 23	Aug 23	Sep23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar24	Apr 24	May 24	Jun24	July 24	Aug 24	Sep 24
Actual %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	85	84	82	84	83	82
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 85%, achieved in April 2024 – performance has fallen away in subsequent months.
- Comms being issued into the service to encourage completion of current statutory & mandatory training module.
- E-learning module due to be re-written by end of 2024/25.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Regular phishing simulation campaigns to raise staff awareness (re-established early 2024).	**COMPLETED**	Cyber Security Manager
• Staff training / awareness sessions.	Q2/Q3 2024/25	
• Re-write of current IG / cyber security e-learning module.	31/03/2025	

Expected Performance gain – immediate
Improved performance, ongoing achievement of target.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
As per above.		

Expected Performance gain – longer-term
Improved performance, ongoing achievement of target.

Risks to future performance

Set out risks which could affect future performance
Limited Cyber Security resources within Digital Services team. Options being explored to strengthen resilience / increase capacity.

KPI Indicator DIG.73

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Trust-wide % Expenditure on Digital

Target: TBA

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24	Aug 24	Sep 24
Actual	3.7%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2.6%	n/a	n/a	n/a	n/a	n/a	n/a
Target TBA	4%	-	-	-	-	-	-	-	-	4%	-	-	-	-	-	-

Chart to be developed

Performance

KPI definition agreed – Finance have now provided data for 2023/24 and 2024/25 financial years.

- 2022/23 = 3.7%
- 2023/24 = 2.6%

Target of 4% agreed.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Work with EMB / Board to consider options to grow investment in digital services	2025/26	Chief Digital Officer

Expected Performance gain - immediate

TBC

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

TBC

Risks to future performance

Set out risks which could affect future performance

TBC

EQUITABLE

KPI Indicator WOD.80

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Diversity of Workforce – % People with a Disability within workforce

Target: TBA% Quarterly

Current Performance against Target or Standard

Trust Position	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Ma y 24	Jun 24	July 24	Aug 24
Actual %	-	4.9	-	-	4.9	-		5.33			5.74			5.79		
Target TBA%	-	TBA	-	-	TBA	-										

Trust
Disability
30-Sep-24

Disability	Headcount	%
No	1490	82.64%
Not Declared	44	2.44%
Prefer Not To Answer	16	0.89%
Unspecified	137	7.60%
Yes	116	6.43%
Grand Total	**1803**	**100%**

SLT Lead: Director of Workforce and OD

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
-

KPI Indicator WOD.81

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% of Workforce who have declared Welsh Language Listening/Speaking capability

Target: 100% Quarterly

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Ma y 24	Jun 24	July 24	Aug 24
Actual %	89.70	-	-	90.19	-		90.59			92.50			93.53		
Target %	100 %	-	-	100 %	-		100 %			100 %			100 %		

Trust

Welsh Language (Listening/Speaking)

30-Sep-24

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1216	1803	67.44%
1 - Entry/ Mynediad	239	1803	13.26%
2 - Foundation / Sylfaen	73	1803	4.05%
3 - Intermediate / Canolradd	44	1803	2.44%
4 - Higher / Uwch	56	1803	3.11%
5 - Proficiency / Hyfedredd	65	1803	3.61%
Capability Stated	**1693**	**1803**	**93.90%**
Not Stated	110	1803	6.10%
Grand Total	**1803**	**1803**	**100%**

Performance

Assessment of current performance, set out key points:

- Welsh Language capability 'stated' recorded quarterly
- Target agreed as 100% where declaration has been made i.e. 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

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Health and Safety – Highlight Report [September 2024]

DATE OF MEETING	14th November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

REPORT PURPOSE	ASSURANCE
PREPARED BY	Steph Williams, Head of Health and Safety
PRESENTED BY	Steph Williams, Head of Health and Safety
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The report provides a snapshot of the current position of Health and Safety up to the end of September 2024.

RECOMMENDATION / ACTIONS	The Committee is requested to **NOTE** this report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Management Group Meeting	17/10/2024
Executive Management Board – RUN	29/10/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

1. The report was DISCUSSED and NOTED by the Estates Management Group.
2. The report was DISCUSSED and NOTED by the EMB-RUN meeting. Key points include escalating the Patient manual handling compliance to “Alert/ Escalate” and moving the overall training compliance from “Alert/ Escalate” to “Advise”, given the good progress made.

3. Workplace stress was also brought to EMB, following discussion at the Health and Safety Group that the Workforce team are leading on to ensure effective professional input and an approach was agreed.

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	NOT APPLICABLE

ACRONYMS	
ESR	Electronic Staff Record
WOD	Workforce & Organisational Development
C&VUHB	Cardiff & Vale University Health Board
ToR	Terms of Reference
FARS	NWSSP Fire Audit & Risk Assessment module
IRR17	The Ionising Radiation Regulations 2017
HSE	The Health & Safety Executive

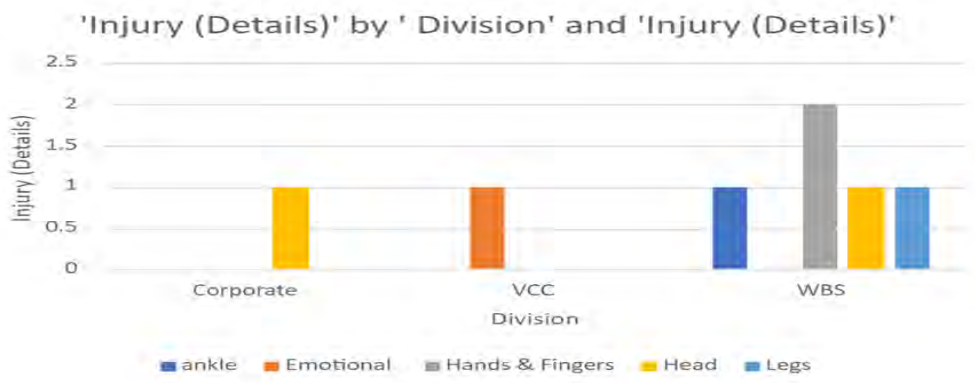
1. SITUATION

This report provides information to the VUNHST Quality, Safety and Performance Committee on fire safety issues up to the end of *SEPTEMBER 2024*.

The Committee is asked to **NOTE** the contents of the report and the actions which are being taken.

2. SUMMARY OF MATTERS FOR CONSIDERATION

ALERT / ESCALATE	**Patient Manual Handling Training** There has been a further decline in patient manual handling training due to lack of training courses at Velindre University NHS Trust also we have received communication from Cardiff and Vale UHB that they have no

	availability for training courses until February 2025. This has been mentioned and flagged in the Cynefin meetings. It was decided a few years ago to work with Cardiff and Vale UHB in an SLA. However, the compliance statistics show that this is not currently effective for the Trust. On November 7, the VCC risk register will be updated to include the risk of non-compliance. This will be reported through next cycle of risk governance as appropriate. This month there continues to be a decline in compliance. Current month is static at 58% which is a further drop. Since the September meeting, the following key actions have been taken: • The Estates function has progressed with the purchase of the necessary equipment to enable the training to be undertaken internally. • Estimates have been obtained from an outside contractor to provide the training. The approximate cost of this is £18,000. It was discussed and agreed in EMB that there is a commitment to ensure that there will be protected time for staff to complete the training. • This approach would be to ensure backlog of training completed by end March 2025. • In parallel, business case being progressed for an internal training post which would include manual handling training going forwards from April 2025.
ADVISE	**<u>Health and Safety Incidents in September</u>** There were 7 incidents across the Trust last month. 1 of these incidents was RIDDOR reportable due to a 7-day absence from work due to a strained knee whilst carrying out operational duties. Hands and Fingers has increased this month with several first aid cases involving needle stick injuries. The team is examining the cases to see if there are any further trends with these. 

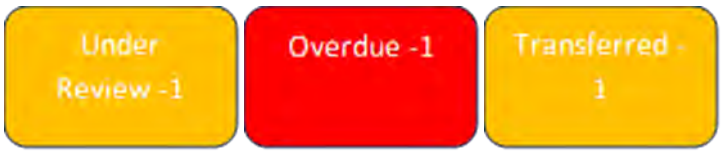
The number of incidents reported has increased from the previous month. Overall, we have had 63 incidents as a Trust.

Although the current trajectory has reduced marginally to 2.42, this will still push us over the set appetite of 110 incidents for the year. To achieve this, the run rate currently is 1.98 per week.

Outstanding Datix Investigations Over 90 days

Corporate - 0
WBS – 4
VCC – 2

Policies Under review



Policy	Version	Policy Lead (s)	Accountable Executive Lead (s)	EQIA rec	Date EQIA Completed	Approving Body	Policy Review Date	Link to policy	Policy Status	Policy Risk Assessment	Comments
QS09 Management of Latex and Latex Allergy Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS09	Policy in Date	Policy in date with no risk assessment required	
QS14 Safer Manual Handling Handling Policy	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS14	Policy in Date	Policy in date with no risk assessment required	
QS15 Management of Violence and Aggression	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS15	Policy in Date	Policy in date with no risk assessment required	
QS18 Health, Safey and Welfare Policy	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	23/12/2021	EMB - Endorsement QSP - Approval	Jul-25	QS18	Policy in Date	Policy in date with no risk assessment required	Policy was revised to align with legislation
QS24 Medical Devices and Equipment Management policy	Version 4.1	Medical Devices Officer	Director of Strategic Transformation, Planning & Digital	No	20/10/2020	EMB - Endorsement QSP - Approval	Jan-24	QS24	Policy review date lapsed - Action required	Policy risk assessment being completed	Look to transfer ownership
QS26 Safe Use of Display Screen Equipment	Version 6	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS26	Policy in Date	Policy in date with no risk assessment required	
QS30 Lone Working Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	May-18	EMB - Endorsement QSP - Approval	Mar-23	QS30	Policy review date lapsed - Action required	Policy risk assessment being completed	Needs to be reviewed
QS33 Control of Substances Hazardous to Health (COSHH)	Version 5	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS33	Policy in Date	Policy in date with no risk assessment required	
QS35 Sharps Policy	Version 4	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	Yes	05/10/2023	EMB - Endorsement QSP - Approval Trust Board - Policy update Noting	Oct-26	QS35	Policy in Date	Policy in date with no risk assessment required	
QS36 Workplace Equipment Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	18/05/2020	EMB - Endorsement QSP - Approval	May-23	QS36	Policy review date lapsed - Action required	Policy risk assessment being completed	Add in home working
QS37 Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids (Needlestick)	Version 4	Head of Infection Prevention and Control	Director of Strategic Transformation, Planning & Digital	No	12/11/2018	EMB - Endorsement QSP - Approval Trust Board - Policy update Noting	Sep-22		Policy review date lapsed - Action required	Policy review date passed with moderate risk	UPDATE 17/04/24 SW - Spoke to Hayley Jefferies and she advised that she worked on this with Helen and this was amalgamated with the sharps policy QS35. I have sent Kay Borrow an email advising that QS37 does not exist and should be removed from the list as its showing as outstanding and that is not a true reflection.

There is no change to the policy status this month as we will be completing an exercise to change our policies to procedures within the Trust.

IOSH Managing Safely
20 licenses have been received, and we are identifying people to complete the training.

Health and Safety Risk Register

This topic has moved on with meetings involving the new Trust Risk manager that took up post 1st October and the Interim Corporate

Governance Director. A task and finish group will be required to be set up to create framework surrounding the tolerable risks, training of this topic and an action plan to assign next step in moving this forward

Added to the Risk Register is the Compliance for the Patient manual handling training and this will be assessed through the November governance cycle.

Health and Safety Management System

The introduction of the Health and Safety Cultural Survey marks a crucial step in understanding how to enhance our management system. By pinpointing the issues, we can develop an annual plan aimed at improving the management system that will be presented to the organisation. This survey will remain open until December, after which the collected information will be compiled and included in the annual report.

Additionally, the survey serves as a valuable tool for engaging employees, encouraging them to share their insights and concerns. By fostering as open dialogue, the organisation can build a culture of trust and collaboration. It's essential to ensure that all voices are heard, and that the feedback collected leads to meaningful changes and improvements.

Once the annual report is completed, it will provide a comprehensive overview of the current health and safety culture within the organisation. This report will highlight key areas of success as well as opportunities for growth. The goal is to create a safe, more inclusive work environment where everyone feels valued and protected.

Moving forward, the insights gained from the survey will inform strategic decisions and help prioritise initiatives that align with the organisation's commitment to continuous improvement. By investing in the well-being of its employees, the Trust demonstrates its dedication to nurturing a thriving workplace where everyone can succeed.

Currently there are 13% of the target responses, communications continue to go out around the business to encourage people to complete the survey. Feedback currently indicates that an audit is required.

Health Technology Wales

We have engaged with HTW and provide support to align process with the Trusts. An introduction to the Impacts register has been welcomed

	and we have agreed to meet the directors of HTW to provide an awareness on their Health and Safety responsibilities.
ASSURE	• DSEAR Actions continued to be monitored, we have a monthly meeting to discuss progress and currently sit at 52% complete. • H&S technician post was now closed for the second time. Interviews to take place 8th November.
INFORM	**<u>Health & Safety Priorities</u>** Trust priorities in relation to fire and safety (quarter 2 - 2024 / 2025) are summarised below: • The development of the Health and Safety intranet page ongoing • Introduction and Production of Health and Safety Flashcards (These will be bite sized information supporting the Health and Safety topics for the quarter) • Engaging with divisions • Promoting anti-violence collaborative campaign • Continue to cleanse Bank and Agency staff to improve our training figures.

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 ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required – not a strategic decision
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: NO	
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
	Covered by EQIA as developed as part of the Health and Safety Policy
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

Refer to commentary in the ALERT/ESCALATE and ADVISE sections of the report.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Compliance for a number of statutory and mandatory training subjects including fire safety are regularly below the 85% benchmark set by Welsh Government*
WHAT IS THE CURRENT RISK SCORE	Scoring to be assessed through November governance cycle
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Risk added to the risk register in relation to low compliance of the patient manual handling training

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

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Velindre Cancer Centre Backlog Maintenance

DATE OF MEETING	14/11/2024

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	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Velindre Cancer Centre recently had a comprehensive condition survey of its estate to assess both the current backlog of maintenance and the overall condition of its infrastructure. The survey was designed to identify critical areas needing immediate attention, prioritise ongoing maintenance requirements and guide future investment decisions in light of the nVCC being operational in 2027. The goal is to ensure the facility remains capable of delivering quality services for our Staff, Patients, and visitors.

	The Building Backlog Paper was presented to the VCC SLT and EMB RUN, receiving their approval. Following this, a funding request was made to EMB, which approved £51,000 in Capital. EMB supported the £175k in principle but is subject to review of most appropriate funding routes.

Funding Source	Total Funding £k
EMB Reserves Revenue	175
Capital Discretionary (Approved)	51
Total	**226**

RECOMMENDATION / ACTIONS	**This paper is for noting for assurance purposes only by the Committee, given Executive Management Board's approval of the next steps.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Monthly Group Meeting	12/09/2014
VCC SLT Meeting	23/10/2024
Executive Management Board RUN	29/10/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

23/10/2024 SLT VCC
SLT received full documents of condition backlog and supported the proposed approach for the proposed work and associated risk position. The most appropriate funding routes were discussed and agreed to work through further with Executive Management Board.

29/10/2024 EMB RUN
EMB Approved the 51k capital request, and approved the principle of how the remaining £175k has been prioritised. It was agreed that the funding route for the £175k was to be determined. Assurance was provided by finance colleagues that remaining reserves are likely to be available pending further review of position following the meeting.

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

APPENDICES	
1	Appendix 1 – Risk Implementation Plan

1. SITUATION

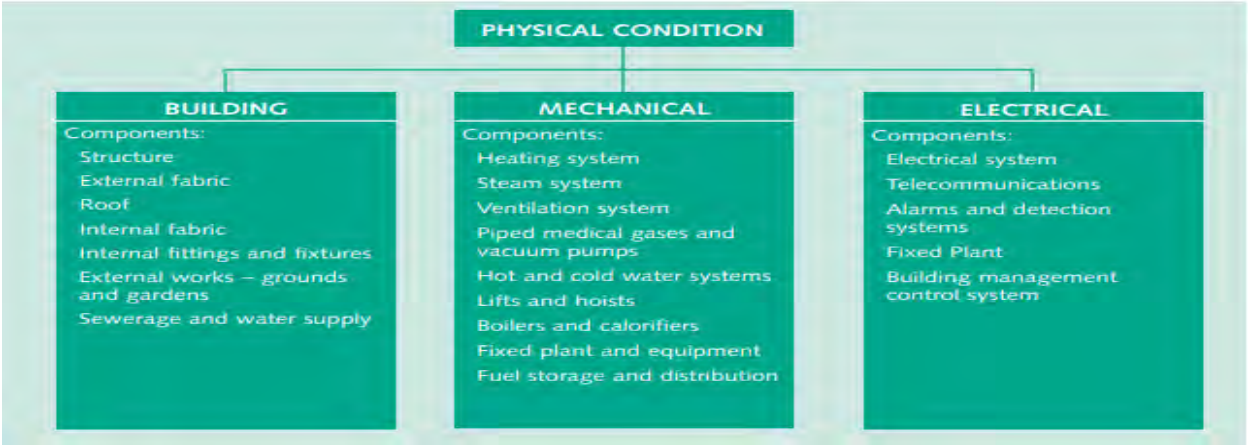
The Estates department has recently appointed an external contractor to conduct a Building Condition Survey at Velindre Cancer Centre in line with Estates Code HBN 00-08, covering the following:

Facet 1: Physical Condition Survey (Fabric & M&E)

Facet 2: Statutory Compliance Audit (including Fire Safety)

The recent condition survey of the Velindre Cancer Centre (VCC) revealed a significant backlog in maintenance, amounting to £11.22 million. This is required to bring the facility up to Condition B status, defined as a building in sound operational condition with only minor deterioration. This backlog poses a considerable risk to the safety and efficiency of the facility's operations over the next three years if not addressed, and until the new Velindre Cancer Centre (nVCC) project is commissioned.

The condition survey covers the following areas.



Definitions of categories A,B,C,D.

A very satisfactory, no change needed;

B satisfactory, minor change needed;

C not satisfactory, major change needed;

D unacceptable in its present condition;

The proposed maintenance strategy for addressing the Building Condition Trust Risk (ID 3506) aims to reduce the risk score from 16 to 12 by focusing on urgent repairs, targeted investments, and enhanced monitoring. This approach will prioritise immediate repairs of critical infrastructure, especially the building's external components, which are most vulnerable to wear and deterioration. By strategically investing in these essential elements and conducting regular inspections, this plan will ensure ongoing oversight and address potential issues before they escalate, thus supporting the building's safety, integrity, and operational efficiency.

Furthermore, the Interim Assistant Director Estates and estates team has reviewed all asset conditions presented in paper and has implemented target maintenance works to the highest risk areas. A request for funding totalling £226k has been requested to focus on keys areas of the building infrastructure on:

- Roofs £90k
- Skylights £31k **Capital**
- Cooling plant and equipment £35K

- Masonry £20k
- Windows (pending regulation 14 audit report for safety) TBC
- Roof Guttering Downpipes Facias £20K **Capital**
- Flooring in clinical spaces £30k

Other associated recommendations will be continued to be manged by optimising Estates Staffing resources and carefully managing maintenance schedules, with the aim of mitigating the impact of aging infrastructure and maintaining high-quality healthcare services until the nVCC project becomes operational in three years' time.

2. BACKGROUND

Velindre Cancer Centre (VCC) was originally constructed in the 1950s and has undergone numerous ad-hoc developments over the years, resulting in a facility with structures of varying ages. Despite these piecemeal upgrades, the building still faces significant infrastructure challenges. VCC has carried out targeted refurbishments, such as upgrades to the Linac Bunkers and several smaller operational projects to improve clinical spaces. The Capital Estates team has overseen key building and mechanical infrastructure projects, including ventilation system installation for the first-floor ward and various heating and hot water boiler replacements to ensure the site's critical services remain operational. Additionally, significant fire safety improvements have been made through a large-scale project to upgrade fire stopping and fire doors throughout the site, addressing essential statutory compliance requirements.

To further support operations, the Estates team has recently expanded its maintenance workforce and reviewed the maintenance needs of on-site assets in line with industry standards such as SFG20 and Welsh Health Technical Memoranda (WHTM). This SBAR outlines the strategy in managing VCC's aging infrastructure and the measures being implemented to mitigate risks while awaiting the completion of the new Velindre Cancer Centre (nVCC).

3. ASSESSMENT

The recent building condition survey covers areas under Facet 1 & 2 with a risk matrix being provided by the contractor based on their professional knowledge.

The assessment is listed below in categories with assurance on how the Trust will manage the risk over the next three years and implement critical risks works where required.

Statutory Compliance

Asbestos.

Currently, the management of asbestos at VCC is compliant, with the Trust maintaining an asbestos management survey that is reviewed annually.

The report outlines the need for Refurbishment and Development (R&D) asbestos surveys to facilitate the full refurbishment of VCC at a cost of £2,895k. This recommendation will be implemented as part of the disposal strategy for VCC after the site is vacated and operations move to the new Velindre Cancer Centre (nVCC).

Summary of agreed position:

- **This will be actioned through the disposal strategy through the decommissioning of Velindre Cancer Centre 2027.**

Mechanical

Cooling Plant & equipment.

The report highlights two assets requiring lifecycle replacement at a cost of £64k, with the Linac 4 York Chiller classified as high risk. It is currently maintained under a robust service schedule conducted four times a year. Estates are also exploring rental agreements for assets approaching the end of their life cycle and critical failure. This will be a more cost-effective option and transfers the responsibility for maintenance and potential failures to external providers until the new Velindre Cancer Centre (nVCC) is operational. Meeting has been scheduled with rental providers for costs to provide this service and to gain assurance that this asset can be delivered within a short timeframe.

Summary of agreed position:

- **Not required at present, this service SLA is set up with rental providers in-case of Asset Failure and can be implemented within 24 hours not to impact clinical service.**

Lifts

The survey recommends the lifecycle replacement of the first-floor ward lift £220kk. Whilst all lifts on-site currently demonstrate good reliability and are not subjected to the excessive use as seen in other hospitals, the replacement is advised for long-term sustainability. The lift is covered under a maintenance agreement with Otis, which includes bimonthly service visits and an annual British engineering

maintenance inspection. Any recommendations from service reports are promptly addressed in accordance with the specialist contractor's guidance. Critical spares have also been purchased for this asset in case of common breakdowns to prevent down time of the service.

Summary of agreed position:

- **Continue to manage Lift Asset over 3-year period.**

Pipework

The report highlights the need for lifecycle replacement of all heating and domestic hot and cold-water pipework at a cost £3,128k. Currently, the strategy for managing the heating pipework includes quarterly duct inspections to monitor for signs of corrosion or leaks. Domestic hot and cold-water services are managed through a rigorous water safety sampling regime, approved by the Trust's water safety group, which has so far shown no signs of elevated microorganisms in the system. If contamination is detected at the Velindre site, a risk assessment is conducted in collaboration with Infection Prevention and Control (IPAC), followed by the implementation of action plans to address the issue. In cases where clear samples cannot be obtained, pipework replacement may be necessary. Over the past two years, the estates team has updated the pipework system drawings to accurately identify key lines and critical isolation points, aiding in the identification of areas that may require attention during such incidents. This proactive approach ensures efficient management of contamination risks and supports timely interventions. The inspection strategy adopted by the Estates team is designed to provide early warnings of any potential leaks in the pipework. In the event of an unforeseen leak, the Estates team will engage external contractors from the Maintenance Framework to attend the site promptly and resolve the issue within a short timeframe, minimising any potential impact on the site.

Summary of agreed position:

- **Estates Procedure currently in place.**

Air Handling Units (AHU's)

Condition survey recommends lifecycle replacement of 2 x AHU's in Linac bunker 6 and general space £345k.Reccomendation is to continue to manage assets until the transition to nVCC.

For assurance these assets have recently undergone a basic overhaul and is subject to an annual verification by NWSSP authorising engineer for Ventilation. Annual verifications are undertaken for a few reasons:

- The system is still required.

- The plant conforms to the minimum standard.
- The fire containment has not been breached.
- The general condition of the system is adequate for purpose.
- The system overall is operating in a satisfactory manner.

The latest report was undertaken on June 26th 2024 and has 4 recommendations, and all have been addressed by the estates team. Performance of the AHU is generally very reliable and is subject to a robust maintenance schedule and a stock of critical spares for both units.

Summary of agreed position:

- **Continue to manage assets and undertake Critical Annual Plant Verifications.**

Heat Emitters (Radiators)

The report identifies 10 areas to replace all heat emitters across the site requiring lifecycle replacement at £410k, though they currently function adequately. Heating is closely monitored by the Building Management System (BMS), which will flag any performance issues. Given the current performance and ongoing BMS monitoring, the risk is low. Continuous performance tracking and routine maintenance will ensure heating remains effective, with rapid response measures in place should a radiator fail before replacement.

Summary of agreed position:

- **Estates Procedure currently in place.**

Local Water Heater

New water heaters have been purchased and installed in the Medical Physics building, resolving the issue. This risk can be updated and removed from the register as works have been completed.

Summary of agreed position:

- **Estates Procedure currently in place.**

Sanitary Fittings

Several areas across the site have been identified for refurbishment, including sink replacements and full toilet refurbishments, with an estimated total cost of £122k. Currently, the Trust addresses these areas through basic painting and flooring programmes to enhance operational appearance and maintain infection control standards. It is recommended that this strategy continue over a 3-year period, until

the new nVCC becomes operational, pending approval from the Senior Leadership Team (SLT). Any items identified as posing a health and safety risk will be addressed by the Operational Estates team. In addition, IPAC conducts site audits, which are submitted to the Estates team for action to ensure that standards remain acceptable.

Summary of agreed position:

- **Estates Procedure currently in place.**

Airconditioning

The air conditioning system in the Zone 10 non-clinical offices is listed for lifecycle replacement 38k. While the asset remains operational, it is a critical component of the environment and is covered by a servicing contract that mandates maintenance four times a year. During this interim period, the primary strategy is to manage risk by maintaining a robust service schedule by the servicing provider and estates staff, aiming to extend the asset's life until the current VCC site closes and transitions to the nVCC. In the event of a critical failure, replacement will be considered.

Summary of agreed position:

- **Estates Procedure currently in place.**

Electrical

Lighting Installation

The Trust has received a report recommending an LED lighting upgrade across 28 areas of the site due to the obsolescence of fluorescent lighting. The proposed upgrade, with a total cost of £865k, aims to enhance energy efficiency, lower maintenance costs, and provide a future-proof lighting solution. Currently, the estates team is replacing failed fluorescent fixtures with LEDs as they reach end-of-life. However, a full upgrade is not considered viable due to the site's limited life expectancy until 2027 and the return on investment will not be achieved.

Additionally, the estates department follows a rigorous Planned Preventive Maintenance (PPM) programme, and all areas have valid testing and inspection certificates from NICEIC-approved contractors, ensuring the electrical installation meets satisfactory standards.

Summary of agreed position:

- **Estates Procedure currently in place.**

Outside Lighting

The Trust has received a report recommending outside LED lighting upgrade across 4 areas of the site. The proposed upgrade, with a total cost of £38k, aims to enhance energy efficiency, lower maintenance costs, and provide a future-proof lighting solution. Currently there are no site safety issues with external lighting and the estates team is replacing failed outside fixtures with LEDs as they reach end-of-life. However, a full upgrade is not considered viable due to the site's limited life expectancy until 2027. Additionally, the estates department follows a rigorous Planned Preventive Maintenance (PPM) programme, and all areas have valid testing and inspection certificates from NICEIC-approved contractors, ensuring the electrical installation meets satisfactory standard.

Summary of agreed position:

- **Estates Procedure currently in place.**

Emergency Lighting

The emergency lighting system in Zone 11 has been identified for lifecycle replacement due to its age and the need to future-proof the system. Although the lights are currently part of a Monthly Planned Preventive Maintenance (PPM) program and regular testing confirms they are fully functional, lifecycle replacement is recommended to prevent unexpected failures and ensure long-term compliance with safety regulations. This work will be addressed through the estates maintenance program to mitigate the risk as part of the PPM process, with an estimated cost of £8k

Summary of agreed position:

- **Estates to complete within 3 months.**

LV Switchgear & Distribution Boards Wiring Sockets and switches

A recent condition survey of the Distribution Board, Mains Switchgear and wiring sockets has recommended the lifecycle replacement of 52 assets due to their aging condition and the need for long-term reliability, with an estimated cost of £1527k. While these assets are currently operational, they are part of a 6-monthly Planned Preventive Maintenance (PPM) program, which includes regular inspections and functional switching operations. They also undergo rigorous testing and inspections managed by an external contractor registered with the

NICEIC (National Inspection Council for Electrical Installation Contracting). Any failures of the Distribution Boards critical spares are readily available for replacement. Any recommendations from these tests are addressed by the in-house estates team.

Summary of agreed position:

- **Estates Procedure currently in place.**

Fire Call Points

The Trust Fire Safety Manager has reviewed the fire call point recommendation and advised improvements to fire detection in an adjacent building in Zone 13 electrical stores. This risk is currently being addressed, and once the work is completed, the risk will be eliminated.
The estimated time for completion of these works is four weeks. Estimated costs £2k.

Summary of agreed position:

- **On track for completion of risk mitigation.**

Controls Ventilation and Fans

The AHU and Extract control circuit panel are recommended for lifecycle replacement at a cost of £32k in Zone 4. These units are part of a planned preventive maintenance (PPM) program and are currently fully functional with no faults. Essential spares are held on-site, and additional spares are readily available off the shelf if needed. Any faults with the system can be easily rectified on the same day.

Summary of agreed position:

- **Estates Procedure currently in place.**

Building

Ceilings

A recommendation has been made to replace ceiling tiles across various zones at an estimated cost of £39k. The Estates team will ensure that the identified areas, particularly in clinical spaces, meet IPAC standards and will replace ceiling tiles as necessary to maintain compliance and safety.

Summary of agreed position:

- **Estates Procedure currently in place.**

Roof Coverings

A lifecycle replacement has been recommended for the roof over Zone 8 at VCC, covering areas of CT Sim 1 and 2, with an estimated cost of £231k. Given VCC's short remaining lifespan of 3 years and no current roof leaks posing risks on these locations, it is advised to conduct a roof leak detection test to identify any penetrations in the Trocol roof system. A less invasive and more cost-effective repair strategy will then be implemented for the roof coating. In addition to Zone 8, the test will include all flat roof areas, such as Zones 10, 7, 6, and 5, to identify any defects. These areas will also undergo a repair strategy and will be included in a Planned Preventive Maintenance (PPM) program to ensure that drains and gullies are free from moss and debris that could lead to roof flooding. The roof condition will be closely monitored over the next 3 years, with a reactive strategy in place to address any signs of water ingress. Currently, any leaks identified on-site have been addressed.

Summary of agreed position:

- **Funding request submitted £90k – work to be completed 2-4 months.**

Masonry

Building condition survey has identified signs of subsidence in the Medical Physics Building, Zone 13 and repointing in zones 10,11 at a cost of £33k,. A structural engineer has been requested to conduct a site visit and provide a detailed report with recommendations and assurance measures.

Summary of agreed position:

- **Funding request submitted £20k, works to be completed 2-3 months**

Windows

A recommendation has been made to replace all steel single-glazed windows in Zones 8 and 9 at an estimated cost of £879
k. The estates team is currently replacing windows in the Zone 9 offices due to water ingress causing damp conditions in staff workspaces at a cost of around 3.5k. The remaining single-glazed units will undergo inspection to assess safety, and necessary actions will be taken if health and safety risks are identified. A competent contractor will conduct the window assessments to provide assurance. Given the 3-year lifespan of the facility, it is advisable to continue to manage.

Summary of agreed position:

- **Regulation 14 audit to be undertaken by external contractor 1 month assess report and implement actions for safety risks.**
- **Funding requirement to be confirmed.**

Walls (site grounds)

A condition survey has identified two walls across the site damaged by large vehicles exiting the premises, as well as one retaining wall requiring attention at a cost of £9k. These issues have been included in the estates program of works for rectification. A structural engineer will assess the retaining wall, and the necessary repairs will be addressed accordingly. The entrance wall will be repaired as planned, and the risk associated with the retaining wall will be reviewed once the structural engineer's report is received.

Summary of agreed position:

- **Funding request TBC once assessment report has been received.**

Roof Guttering & Downpipes – Facias Soffits Downpipes

The roof guttering and downpipes around Zone 8 has been identified for replacement at a cost of £47k. This component is crucial in preventing water ingress and protecting the building. A scheme of works will be developed to replace the guttering & downpipes in this area, and the project will also include cleaning gutters in other areas and targeting pitched roof cleans.

Summary of agreed position:

- **Funding request of £20K, work to be completed 2-4 months.**

Paths

Defects identified in the condition survey have been estimated to cost £6k for repairs to the affected area at the rear of Zone 10. VCC is currently subject to a quarterly site inspection involving operational services, estates, and health and safety staff. Any health and safety defects identified during these inspections are addressed collaboratively by estates and operational services. Further investigate on of the area will be conducted to evaluate whether targeted repairs are sufficient, rather than proceeding with a full replacement.

Summary of agreed position:

- **Estates & Operational services procedure currently in place.**

Skylights

Skylights in Zone 8 have been identified for replacement following the condition survey, with an estimated cost of £31k. As part of the roofing assessment, the skylights will be inspected to determine if they are adequately preventing water ingress into the departments. A general cleaning and inspection of the skylights will be incorporated into the Planned Preventive Maintenance (PPM) schedule to ensure they remain functional for the remaining 3-year period until the transition to the nVCC.

Summary of agreed position:

- **Funding request submitted £31k, works to be completed 2-4 months.**

Signs of Water Ingress

Condition survey identified signs of water ingress in Zone 2 Ambulatory Care at a cost of £2k, this action has been identified and remedial works have been completed.

Summary of agreed position:

- **This risk has been mitigated.**

Fire Stopping

Fire stopping was identified in the condition survey report and promptly inspected by the Estates Team and the Fire Safety Manager upon receipt at a cost of £2k. The inspection confirmed that the fire stopping had already been installed on the opposite side of the masonry wall, and no further action is required at this time.

Summary of agreed position:

- **This Risk has been mitigated.**

Flooring

Flooring has been identified for lifecycle replacement in 13 areas throughout the site 103k. Flooring has been addressed consistently in clinical spaces to meet IPAC and health and safety requirements. Estates will action target areas in collaboration with clinicians and IPAC to action target spaces.

Summary of agreed position:

- **Funding request submitted £30k, works to be completed 1-3 months in clinical areas demonstrating the highest priority.**

4. SUMMARY OF MATTERS FOR CONSIDERATION

Please see sight implementation plan (Appendix 1) with risk scores and associated costs. The plan will also demonstrate the timeline for task completion.

5. IMPACT ASSESSMENT

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Trust Reserves And Capital Discretionary Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact:

	£175k from Revenue and £51k from Capital Discretionary funding **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
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Building Failure Risk id 3506
WHAT IS THE CURRENT RISK SCORE	16
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*Some investment £226k in to the highest risks associated in paper to safe guard the outer of the building from the elements of weather. Estates robust maintenance has then been implemented on other assets.*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Listed in Table
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Budget - Financial
All risks must be evidenced and consistent with those recorded in Datix	

Building Condition	Risk Description	Score	Mitigation Actions	New Risk Scores	Timeline	Cost £k	Actual Cost Requirement £k	Funding Required	Funding Route / Notes	Urgency Timeline
Statutory Compliance										**Statutory**
Asbestos	Asbestos R&D Survey & Removal	10	Undertake as part of VCC Demolition	5	Apr-27	2,895	0	N	TBC	Not Required at Present will be completed through Velindre decommissioning post 2027
Mechanical										
1. Cooling Plant & Equipment	Cooling Plant and Equipment replacement	20	SLA agreement for rental Chillers	5	Chiller can be delivered to site in 24 hours during a critical failure.	65	35	Y	12k per year rental Plus £5k delivery / Recurrently £60k captial - (N/R request to Trust Reserves)	Funding required when asset fails to be called from NR Reserves 0-6 months
2. Lifts	Lift FF ward lifecycle replacement	15	Bimonthly Otis service visits & Critical spares in stock	9	In place currently	220	0	N	Not Required	Continue to manage
3. Pipework	Pipework lifecycle replacement	9	Regular inspections and contractor emergency response. Water safety sampling strategy	9	In Place Currently	3,128	0	N	Not Required / Estates revenue budgets funds inspections	Continue to manage
4. AHUs	Zone 15 Lifecycle Replacements AHU's	20	Critical Verifications & ongoing estates maintenance in line with SFG20 industry standards.	9	In place currently	345	0	N	Not Required	Continue to manage
5. Heat Emitters	Radiators Lifecycle replacement	10	BMS monitoring and estates regular inspections. Reactive teams available in case of any failures.	10	In place currently	410	0	N	Not Required	Continue to manage
6. Local Water Heater	Water Heater Lifecycle replacement	15	Completed	0	completed	0	0	N	Completed	Completed
7. Sanitary Fittings	12 areas identified for replacement	20 15 10	Ongoing strategy to ensure IPAC standards are met, estates undertake regular maintenance inspections.	10	In place Currently	122	0	N	Estates revenue – capital VCC	Continue to manage
8. Air Conditioning	Lifecycle replacement	10	Service contract quarterly, assessment to replace in case of failure staff areas.	10	In place Currently	38	0	N	Estates Revenue – Capital	Continue to manage
Electrical										
1. Lighting Installation	LED Lighting Upgrades	10	Replacement strategy on failed units all units currently functional & ppm in place.	10	Strategy in place	865	0	N	Estates Revenue - Replace as required	Continue to manage
2. Outside Lighting	Replacement Outside Lighting	10	Replacement strategy on failed units all units currently functional & ppm in place.	8	Strategy in place	38	0	N	Estates Revenue Replace as required	Continue to manage
3. Emergency Lighting	Life Cycle Replacement	20	Replacement strategy on failed units all units currently functional & ppm in place.	10	In place Currently	8	0	N	Estates Revenue Replace as required	Estates to implement inhouse 3 months
4. LV Switchgear & Distribution Boards	LV Switchgear Lifecycle replacement	15	PPM in place & Electrical Inspection Reports in date for compliance.	9	In place Currently	1,527	0	N	Estates Revenue Replace as required	Continue to manage
5. Fire Call Points	Fire Call Point Installation	20	Action completed	0	Action completed	2	0	N	N/A	Completed
6. Ventilation Controls and Fans	AHU control panel lifecycle replacement	15	Critical spares purchased and PPM in place regular inspections	8	In place Currently	32	0	N	Estates Revenue Replace as required	Continue to manage
Building										
1. Ceilings	Ceiling Tiles replacement	10	Replacement strategy where require	10	In place currently	39	0	N	Estates Revenue Replace as required	Not Required at Present
2. Roof Cover	Replacement Roofing VCC	15	Leak detection test to be undertaken PO raised, Capital works scheme to repair any leaks identified	9	Awaiting date for roof test, repair works 2-4 months	231	90	Y	Request to N/R Trust reserves	Urgent Immediatley Funding required to be completed 2-4 months
3. Masonary	Brick Cavity needs repointing and evidence of subsiding	15	Requires inspection - Structual Engineer visted site and funds required for repointing	15	2-3 Months	33	20	Y	Request to N/R Trust reserves	Urgent Immediatley Funding required 2-3 months
4. Windows	Lifecycle replacement Windows	15	Regulation 14 Audit to assess window safety, any action required will be implemented. Zone 9 completed due to damp funded from Estates discretionary	15	Regulation 14 audit scheduled for November 7th 2024. Will update SLT audit actions	879	TBC	TBC	Capital Discretionary / N/R Trust Reserves	3 MONTHS Funding requirement TBC
5. Walls	Wall damage and subsidence	15	Entrance Wall to be repaired, structural assessment completed on wall, awaiting report. Verbal update stated no immediate concerns to walls.	15	Awaiting report 2 weeks 7th November 2024	9	TBC	TBC	Estates Revenue	3 MONTHS Funding requirement TBC
6. Roof Guttering & Downpipes, Facias	Roof Guttering and Downpipes	15	PPM Maintenance undertaken and capital works to be completed.	9	Capital works 2-4 months. PPM already in place to maintain gutters and down pipes	47	20	Y	Capital Discretionary	Urgent Immediatley Funding required
7. Paths	Repairs required.	15	Full inspection completed no areas cause for concern. Site inspections take place quarterly	9	Inspection completed.	6	0	N	VCC Revenue for any repairs	Completed
8. Skylights	Lifecycle replacement	15	PPM in place and replacement assets identified for capital works scheme. No current signs of water ingress.	9	Capital works 2-4 months	31	31	Y	Capital Discretionary	Urgent Immediatley Funding required 2-4 months
9. Water Ingress	Leak Identified	10	Leak repaired	5	Continue to monitor	2	0	N		Completed
10. Render	Render Cladding Requires Replacement	10	Monitor Conndition	10	Continue to manage	69	0	N	Not Required / Estates revenue budgets funds inspections	Continue to manage
11. Decoration Internal and External	Decoration	5	Monitor Conndition work with IPAC teams action where required	5	Continue to manage	34	0	N	Estates Revenue	Continue to manage
12.External Doors	Door require lifecycle replacement	10	risk compelted	0	Completed	0	0	N	Completed	Completed
13. Fire Stopping	Fire Stopping recommendation	20	Assessment undertaken by Trust Fire safety Manager, confirmed all is ok.	0	Risk Removed	2	0	N	Not Required	Completed
14. Flooring	Flooring	10	Assessment undertaken and target areas where required posing risks to Health and Safety and IPAC.	10	3 months	102	30	N	Request to N/R Trust reserves	Urgent Immediatley Funding required 1-3 months
					Total	**11,179**	**226**			
					Capital	**0**	**51**			
					Revenue	**11,179**	**175**			

Funding Source	Total Funding £k
EMB Reserves Revenu	175
Capital Discretionary	51
Total	**226**

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER UPDATE

DATE OF MEETING	14 November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The main objectives of this report are to: • share the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains; • to allow the Executive Management Board to have effective oversight and assurance of the way in which risks are being managed across the Trust; • update the Executive Management Board with a summary of activity related to the status of the risks and associated movement.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. • **NOTE** the on-going development of the Trust's risk framework. • **NOTE** the work underway to improve organisational management of risk reporting.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
VCS SLT	09.10.2024
WBS SLT	10.10.2024
TCS Risk Meeting	23.10.2024
Executive Management Board – Run	29.10.2024
This paper takes into consideration the feedback from VCC and WBS leadership teams on their respective risks. Discussion with the TCS Team is reflected in the paper. This paper was considered by EMB on 29 October. At its meeting, EMB: - Agreed that a further review of the VCS risks was required; - Agreed to organise the thematic linking of risks, which is reflected in this paper	

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	Trust Risk Register – September (data validated in October 2024)

1. SITUATION

This report informs the Quality, Safety and Performance Committee of the status of reportable risks in line with the Board approved risk appetite levels and provides an update on progress to develop the Trust's risk framework.

The baseline information is drawn from Datix, with additional information provided by the Velindre Cancer Service (VCS) and Welsh Blood Service (WBS) monthly risk analysis reports, validated by their Senior Leadership Teams (SLT).

Risks reported in this paper are:
1. risks in the safety/quality domain with a risk level of 12 and above;
2. risks in the non-safety domain risk level of 15 and above.

2. ASSESSMENT

2.1 Trust Risk Register

For the reporting period, there is a total of 16 risks to report in line with the Trust's risk appetite. This includes:

- 6 risks with a current score of 12 or above, reported in the safety/quality domain. Five on the VCS register and one on the WBS register.
- 10 risks with a current score over 15 or above. Eight on the VCS register and two on WBS register.

Further detail on the risks escalated to the Trust Risk Register can be viewed in Appendix 1.

2.2 Velindre Cancer Service – based on September 2024 data and analysis by the VCS Senior Leadership Team on 9 October 2024

Key changes since the September reporting cycle, last reported to EMB Shape on 29 October 2024:

2.1 Reduced risk scores

One risk has been reduced during the reporting period:

VCS risk 3431 – "There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff."

The risk was reduced since the VAP is now reviewing and managing skin patients.

2.2 New risks to the Trust Risk Register
Five new risks have been accepted onto the Trust Risk Register since the September reporting cycle. They are all owned by the Velindre Cancer Service.

Two risks have been accepted to the Service and Trust Risk Registers. (3472, 3467)

Three risks have been escalated to the Trust Risk Register in line with the Trust's risk appetite policy. (3270, 3468, 3392)

The details are available in Appendix 1.

2.3 Risk Themes
There are two areas of work reporting multiple risks.

a. Systemic Anti-Cancer Treatment
The relevant risks in Appendix 1 are:

- 3338
- 3431
- 3270
- 3461

Due to multiple risks related to the SACT service, the Trust stood up Business Continuity arrangements in relation to SACT delivery in February 2024, establishing SACT Gold and a SACT Transformation resource allocated to support enhanced monitoring and capacity and demand modelling as well as delivering the required delivery improvements and efficiencies.

Bi- weekly SACT Gold meetings have continued to oversee the development and delivery of a SACT recovery plan, which has focused initially on increasing capacity for Pharmacy and SACT delivery.

This has now been extended to include the front end of the SACT Pathway in line with service risks identified, culminating in a business case which supports the transition from a consultant delivered to a consulted led model of care and expansion of the non-medical workforce. The business case will be presented EMB on the 11 November 2024.

b. Medical Staffing
The relevant risks in Appendix 1 are:

- 3247
- 3332
- 3468

Key to the management of these risks is the business case described above, which will create a multidisciplinary team to manage SACT patient care, meaning that care will be planned up front and protocol driven. This will significantly lessen the burden on

consultant colleagues. These models are being benchmarked with models in other specialist cancer centres.

The transition model set out in the business case provides capacity to enable the Royal College standards to be met, considering the current level of demand.

Concurrently, further work is underway with the site-specific teams to understand their specific speciality needs.

2.4 Welsh Blood Service, based on September 2024 data and analysis by the WBS Senior Leadership Team on 10 October 2024

All WBS risks on the Trust Risk Register are scoring consistently with the scores reported in the September cycle.

The WBS Director has indicated that there is one risk related to the funding of BECS currently positioned as 'new' on Datix and due to be discussed at WBS SLT on 13 November 2024.

2.5 Transforming Cancer Services

A long standing Datix risk owned by the TCS programme has been reviewed and closed by the Programme Director. The risk has been closed as it relates to the main design development prior to financial close, controlled by Capex.

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

3.1 All Wales Datix module

At the September meeting of the NHS Wales Directors of Corporate Governance, it was agreed that there was achieving a single functionality for risk was difficult, due to the varying levels of risk maturity across health bodies in NHS Wales. This position echoed the position reached by the workstream leading on the development of the new module, where few all-Wales fields were agreed by consensus.
Following the meeting, the Once For Wales Concerns Management System Programme Board team confirmed that:

- They would share a copy of the specification used in the programme which was distributed on 27 September;
- Confirmed that the contractual position allows for organisations who have DatixWeb functionality to continue use of the DatixWeb Risk Module for the life of the contract, currently 30 Nov 2027. This means that health bodies can use either DatixWeb or Datix Cymru risk modules as they prefer, but not both.

A paper to consider all options will be presented to the Executive Management Board in November.

3.2 Velindre Charity

Velindre Charity risks are now reporting on Datix as of 24 October 2024.

3.3 Project and programme risk reporting

New Velindre Cancer Centre project risk reporting was discussed at the Project Board meeting on 9 October. A meeting with the project team to align risk reporting arrangements has been requested.

Discussions regarding the capture, management and reporting of programme risks are ongoing.

The Transforming Cancer Services programme team is currently reviewing their risk profile on Datix. A meeting took place on 23.10.2024 to assist the review of data in order to ensure accurate reporting to the November Trust Board. The Risk and Assurance Manager is working with the Project Team to ensure all risks reportable to Trust Board are on Datix.

3.4 Reviewing the Trust's Risk Management Policy

Over the reporting period, we have met with the following internal teams to discuss risk management:

- The VCS Senior Leadership Team and members of the VCS Trust Quality Hub Quality Workshop on 3 October
- The VCS Senior Leadership Team meeting on 10 October
- A meeting of members of the Trust, WBS and VCS Quality Hubs on 10 October
- Chief Operating Officer, Director of VCS and Director of WBS on 10 October

The meetings were attended by the new Risk and Assurance Manager in post since 1 October. Key issues discussed include:

- The importance of logging the right information in the right place on Datix;
- The dependency between accurate logging and training;
- The need to agree a Trust wide approach for managing project and programme risks that complements good practice in place within programme teams whilst also respecting and complying with Trust wide policy;
- How we schedule meetings in a way that allows us to provide the Trust Committees/Board with an up-to-date picture of our organisational risk profile with a good governance wrap;
- How we present a view of associated risks to the Board and how this links to the presentation of operational risks in the Trust Assurance Framework.

The outcomes of these discussions will inform a review of the Trust Risk Management Policy.

The Manager is also planning to undertake a review of all risks under the risk appetite level as instructed by the Audit Committee.

The Manager is undertaking a benchmarking exercise comparing current and historic Trust risk reports against those compiled by other NHS Wales/England organisations.

All improvements are being captured in phase two of the Governance, Assurance and Risk Programme.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15.
- **NOTE** the on-going development of the Trust's risk framework.
- **NOTE** the work underway to improve organisational management of risk reporting.

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 & SAFETY06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒

	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail belowNo - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.There are no specific legal implications related to the activity outlined in this report.

3 RISKS

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

TRUST RISK REGISTER

Quality, Safety and Performance Committee

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER	RISK TITLE	INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Centre										
Risks Relating to SACT										
3338 13.02.24	VCS SACT & Medicines Management	Safety/ Quality	RH	There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	20	16	12	Risk score remains at 16 (score as noted in September reporting cycle).	1. Daily escalation meetings. *Ongoing.* 2. Outsourcing more product to support capacity within pharmacy.	12.09.2024 Recruitment according to Pharmacy expansion is progressing, challenges being experienced of recruiting into pharmacist role which is integral to plan success. This element of recruitment is also captured as a risk as part of the VCC SACT (silver) Capacity workstreams. MaH expansion plan on track. Outsourced product suppliers indicating challenges with delivery of national contracts; pharmacy reviewing/ monitoring. Service capacity has increased. Continued expansion required to meet forecast growth and routinely enable compliance with SACT waiting time targets. Continue to progress plan.
3431 24.07.24	VCS Medical	Safety/ Quality	CM	There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff.	20	16	4	Risk reduced from 20 (as noted in September reporting cycle.)	1. Options to increase capacity for skin/Melanoma have been identified and are aligned to the principle of developing non-medical workforce options. 2. Expedite access to VAP capacity for Skin/Melanoma Pre SACT Assessment (51 per month based for 4 regimens and based on 2 VAP appointments and then return to face to face clinic for 3rd Appointment). 3. Manage the demand for Pre SACT Assessments in the short term until a robust staffing model is in place which will require EMB level discussion	10.10.2024 Discussed in SLT 10.10.2024 - score reduced as VAP now reviewing / managing skin patients.

TRUST RISK REGISTER

Quality, Safety and Performance Committee

									4. Consider pausing accepting new patients with Stage 2 melanoma in the adjuvant setting (NICE approved in Oct 2022 and absorbed by the SST without additional workforce) until there is a robust staffing model. 5. Create a waiting list for Pre SACT Assessment for skin/melanoma which will extend waits to access SACT treatment. 6. Re-prioritise existing VAP capacity to highest risk SST in the short term until additional VAP capacity in place. This would need to be formally assessed to understand the risk rebalance implications. 7. Increase consultant sessions into Skin/Melanoma until sustainable additional capacity in place.	
3270 23.11.23 *New to Trust Risk Register for this reporting period.*	VCS	Performance and Sustainability /Workforce	NH	There is a risk to performance and service sustainability as a result of increased demand for SACT starting to exceed capacity in all clinics leading to the burnout of the medical and supporting workforce due to excessive workloads.	16	16	4	***New to Trust Risk Register for this reporting period.*	1. Independent prescribing roles out to advert. 2. 4 x speciality doctor roles out to advert.	Update 17.10.2024 SACT GOLD established, service improvement manager appointed to oversee SACT service challenges, capacity and demand reviews being undertaken for all SSTs to understand the gap. Inherent risk score was reviewed during November and has increased from 12 to 16 due to inability to recruit to SAS doctors.
3461 30.08.24	VCS Phamacy	Performance & Sustainability	BT	There is a risk that VCC Pharmacy will not be able to undertake aseptic dispensing of parenteral SACT as a result of the current ChemoCare module which supports this process no longer being supported by the supplier. This may lead to a failure of the module and increased cyber vulnerabilities and thus the inability to aseptically dispense parenteral SACT.	15	15	5	Risk score remains at 15 (score as noted in September reporting cycle).	1. Pharmacy QA input to develop product specifications, an exercise is being undertaken to prioritise QA activities to release these documents by end of September 2024 (@71% in draft as of 31st July). 2. Suite of user defined worksheets to be developed and validated by the end of October 2024. 3. Discussion to be taken to EMB in Nov recommending option to prioritise upgrade of SACT e-PMA.	15.10.24 Upgrade to new version will not incur a charge. Upgrade included on Digital Services Team workplan, resource and timescales not yet planned. To note that there are a number of potential urgent requirements on the resource of the digital pharmacy team (support of de-coupling roll out, implementation of general meds -EPMA and this upgrade, with BAU).

TRUST RISK REGISTER

Quality, Safety and Performance Committee

Risks Relating to Medical Staffing										
3247 08.11.23	VCS Medical	Workforce	AMS	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	16	16	9	Risk score remains at 16 (score as noted in September reporting cycle).	1. Clinic templates to be reviewed to manage patient flow 2. Business case to be developed to obtain funding to convert accommodation to deliver an additional four consultation rooms.	25.09.24 Two additional clinical rooms funded from capital funds building works to be completed 1st week of December to be operational same week. Plan to reduce risk score once additional romms are operational. Full review of demand and utilisation of capacity within OPD completed 18.10.2024
3332 02.09.24	VCS Medical	Workforce	NH	There is a risk to staff wellbeing as a result of consultants having insufficient time to prescribe and complete OONs (Outpatient Oncology note) in working hours due to increase in patient clinic numbers, leading to increased email traffic and potential treatment delays	16	16	4	Risk score remains at 16 (score as noted in September reporting cycle).	1. Recruitment of SAS doctors and independent prescribers to support the demand in all disease sites. 2. Being discussed at SACT Business Continuity meetings.	31.10.2024 Inherent risk score reviewed and increased from score of 12 when risk identified in February 2024 to 16 due to increase in vacancies.
3468 12.09.24 **new to Trust Risk Register for this reporting period*	VCS Medical	Workforce	NH	There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	20	16	2	***New to Trust Risk Register for this reporting period*	1. Development of an Advanced Nurse practitioner (ANP) role in sarcoma- this role would support and map patients through complex pathway. Develop skill set and expertise in managing young people with cancer and develop strong working links and cross site working with the ANP led TCTU. Develop expertise in sarcoma management and protocols. 2. Appointment of a permanent CNS in sarcoma to provide a key worker as per CNS review. 3. Continue national / international recruitment for medical oncology consultant and look at opportunities to entice/encourage Velindre trainees to develop this interest. Consider combining with a consultant sarcoma role with Advanced Therapies, Immunotherapy or Research depending on candidate interest. 4. Continue dialogue with Paediatric oncology colleagues at CAV regarding	**Risk accepted onto Datix Divisional Register by SLT in September.** **New risk on Trust Risk Register for the reporting period.** Expression of Interest on BMJ and social media platforms Linked In and Twitter/X. Contacted international recruitment agencies asking for clinical/medical oncologist. Will continue to pay on session to academic to support the SACT clinic once a week.

TRUST RISK REGISTER

Quality, Safety and Performance Committee

									the young adult 16-18 patient group regarding where these patients are best managed and consider option of transfer of care to paediatric services until the age of 18. 5. Work with Swansea Bay to develop stronger links and a pan- South Wales expertise.	
12+ Risks in the Quality and Safety domains										
2465 05.11.21	VCS Medical	Quality/ Safety	RH	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	16	12	4	Risk score remains at 16 (score as noted in September reporting cycle).	1. Internal audit of the underlying causes of this risk 2. Reporting to VCC SLT to provide assurance that the issue is being addressed.	25.09.2024 Risk transferred to Heads of Ops, Clinical lead engaged to attend SMSC Oct 2024. Action plan has been developed - email etiquette documentation being reviewed by SLT, completion by end of September. When agreed, will be shared within division for implementation.
3472 19.09.24 **new to Trust Risk Register for this reporting period*	VCS Medical	Safety	NH	There is a risk to patient safety as a result of the DHCR system not allowing outpatient oncology notes to be rapidly identified. This leads to – missing key information relevant for outpatient clinics - a lack of visibility for oncology information (e.g. prognosis/ intent) for acute teams (VCC and HB) and primary care which is affecting patient management. – an impact on patient experience due to slower clinics and increased waiting times – an increase in staff stress; finding the relevant information can be time consuming and stressful	16	16	2	***New to Trust Risk Register for this reporting period*	1. The Senior Management Staff Committee have brought the risks posed by this formally to the attention of the CEO and the attention of the Board and have asked for this request to be given the necessary priority for changes within DHCW.	**Risk accepted onto Datix Divisional Register by SLT in October.** **New risk on Trust Risk Register for the reporting period.** Risk being being picked up by COO with DHCW and outstanding actions from the DHCR implementation plan is going to EMB.

TRUST RISK REGISTER

Quality, Safety and Performance Committee

2187 14.09.20	VCS Radiation Service	Quality/Safety	RW	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	25	12	8	Risk score remains at 12 (score as noted in September reporting cycle).	1. Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC.	29.10.24 Scrutiny case agreed to recruit 2 x engineers prior to pending retirements. 16.09.2024 Overall the SRU recruitment is progressing well with 9 of 13 physics posts appointed The Engineering section remains the section with the highest risk across both sites due to: - A recent retirement and subsequent promotion leaving a vacancy - Multiple retirements anticipated within the next 12 months - The requirement to fill the engineering lead at the satellite - A national shortage of staff with specialist skillset and extensive on the job training required. Workforce planning is active with the new Head of Engineering inputting to the future plans and direction for the section. A scrutiny business case is to be submitted following these discussions. 1 of 2 engineers at the satellite is already in post and training up in Varian systems whilst contributing to team at VCC
15+ Risks in other domains										
3392 16.05.24 **new to Trust Risk Register for this reporting period*	VCS	Workforce	SP	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	20	20	6	***New to Trust Risk Register for this reporting period*	1. Proactive recruitment into vacant posts 2. Timetable review to ensure appropriate skill mix and expertise to cross cover head and neck service 3. Clear prioritisation being utilised within the Dietetic service Regular team meetings and communication with staff to prevent stress and burnout 4. To close drop-in telephone clinic from end of play 17/05/2024 to work through backlog, release staff for cross cover and explore	**New risk on Trust Risk Register for the reporting period.** 03.11.2024 Risk rating reviewed, control measures minimal, carrying x4 vacancies and x1 LTS and awaiting further Locum to start. 14.10.2024 Scrutiny approval of band 8a Professional Lead for DT. Awaiting job matching prior to advertising. 10.10.24 Risk increased from 12 to 15.

TRUST RISK REGISTER

Quality, Safety and Performance Committee

									sustainable model that can be utilised once recruitment gaps filled. 5.. Communication with MDTs, SSTs & local Health board teams re: any potential service changes	
3448 14.08.24	VCS	Performance & Sustainability	BT	There is a risk to patient safety as a result of the VCC Cancer Associated Thrombosis (CAT) service not continuing due to inability to recruit to key posts following the pending retirement of key individual 2025 leading to patients diagnosed with CAT unable access specialised services and therefore may lead to sub optimal treatment, delays in their cancer treatments	16	16	4	Risk score remains at 16 (score as noted in September reporting cycle).	1. Director of Cancer Service to link with Clinical Director of Palliative Medicine to formally confirm intentions for Directorate ongoing provision of the CAT service. 2. Baseline review to be undertaken. Benchmarking against other cancer centre by 29 November.	VCC Planning and Service Development Manager has initiated piece of work to understand provision of CAT services across SE Wales.
3467 09.09.24 **new to Trust Risk Register for this reporting period*	VCS	Sustainability /Performance /Quality/Work force.	SP	There is a risk to clinical service delivery as a result of reduced staffing within the outpatient Physiotherapy service, leading to reduced patient care, experience and outcomes.	20	12	6	***New to Trust Risk Register for this reporting period*	1. Scrutiny case to request 0.4wte Locum Physiotherapist for 13 weeks, this will allow the continuation of a service albeit at a reduced level. Awaiting scrutiny approval.	**Risk accepted onto Datix Divisional Register by SLT in September.** **New risk on Trust Risk Register for the reporting period.** 03.11.2024 Risk reviewed – decreased to score of 12. - All 3 local Health Boards (Heads of Physiotherapy) have been contacted and all in agreement to receive outpatient referrals in own outpatient settings = care closer to home for an agreed 2 month period. - Intranet information updated to inform of referrals routes into each HB. - Deputy Head of Therapies to review all urgent breast patients at VCC - Scrutiny panel has agreed locum back fill for 13 weeks 0.4wte. Individual locum sourced to start December 2024.
Welsh Blood Service										
12+ Risks in the Quality and Safety domains										

TRUST RISK REGISTER

Quality, Safety and Performance Committee

2774 27.10.22	WBS	Quality/ Safety	AP	There is a risk to **quality and safety** as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16	12	4	Risk score remains at 12 (score as noted in September reporting cycle).	1. Discovery and planning Transformation Workstream: process redesign and system configuration 2. Data workstream: migration of legacy data 3. Application workstream: build of environments, database and interfaces.	All activity on track for planned go live 30.06.2025.
15+ Risks in other domains										
3350 04.03.24	WBS	Service Sustainability	AP	There is a risk to **performance and service sustainability** due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	15	15	12	Risk score remains at 15 (score as noted in September reporting cycle).	1. Review of risk assessment required by 25/12/2024.	26.09.2024 Business case, covering document and QIA documentation completed. BJC signed off by SLT. BJC endorsed by SDC 22.10.24 for Trust Board approval in November.
3306 15.01.24	WBS	Performance and Sustainability	AP	There is a risk of **loss of performance and sustainability**, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	20	15	5	Risk score remains at 15 (score as noted in September reporting cycle).	1. Review of risk assessment required by 27/01/2025.	Tender exercise completed for WBS electrical resilience (ACB replacement). Currently working with departments to complete critical list of equipment to produce end to end plan. This information will support a robust risk assessment for identified works. Work estimated for completion Dec/ Jan 24/25 pending WBS operational requirements.

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	14 November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	To provide the Quality, Safety and Performance Committee with the opportunity to review the updates to the Trust Assurance Framework and the actions planned for the next period.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the current status and on-going development of the Trust Assurance Framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
EMB Shape	14.10.2024
Strategic Development Committee	22.10.2024

Discussion took place at EMB Shape:

- The review process for the TAF is being strengthened with regular update meetings being undertaken to ensure a monthly review cycle from the end of October.
- The move to a new format combining the IMTP and TAF was discussed and will be available from April 2025.
- The need to strengthen the operational risks feeding into the TAF will be implemented through the review cycle supported by the Risk and Assurance Manager.

Discussion at Strategic Development Committee focused on typographical amendments including choice of words for describing ongoing review of TAF 08.

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

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

APPENDICES	
1	Strategic Risks
2	Trust, Assurance and Risk Framework August 2024

1. SITUATION

1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020.

The Trust Assurance Framework template was reviewed and updated further in consultation with the Audit Committee in early 2025. A refreshed Trust Assurance Framework, detailing eight strategic risks, was approved by Trust Board in March 2024.

The eight strategic risks are included as Appendix 1 for ease of reference.

2. ASSESSMENT

2.1 The table below has been developed to record movement within the TAF:

Number	Risk Title	Movement since last reporting period
All TAF risks	Relevant to all risks.	We are mapping the key risks from the Trust Risk Register across to the TAF.
TAF 1	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.	• Owner of actions for 01.01-01.03 has moved to Alan Prosser. SMART actions which relate to the Infected Blood Inquiry have been updated with progress updates. • A deep dive into the actions to mitigate against key Velindre Cancer Service risks will be led by the Chief Operating Officer over the next month.
TAF 2	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.	• Action 02.02 updates that a Value Based Healthcare programme has been established and staff on boarded. Progress has been made on provision outcome. • Action 02.04 updates that NHS Executive is in place. Initial accountability review report has been received by the Trust and observations were returned to the Cabinet Secretary for Health on 30.09.2024. Final report and recommendations are awaited.

TAF 3	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.	• Action 03.06 Short and medium term action plans have been agreed in respect of the Trust Workforce Plan. • Action 03.07 details the approval of the Nurse Retention Plan which will pass through the governance cycle. • Six new actions have been added to TAF03: • 03.08 – Embed workforce planning progress • 03.09 - Establish train the trainer in respect of workforce planning • 03.10 – Embed Hybrid Working Principles • 03.11 – Implement Attraction and Retention Project • 03.12 – Implement Nurse Retention Plan • 03.13 – Utilise learning from Nurse Retention implementation.
TAF 4	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and bahaviours, systems and processes	Four actions 04.04 – 04.04 were marked as complete; • Working groups to implement working together. • Triangulation of data to understand the culture climate in the organisation. • Staff engagement has taken place to review. • Trust values and the Speaking up Safely Framework has been promoted, and communication and governance processes are in place. Six new actions have been added, relating to: • 04.05 – Employee voice mechanisms • 04.06 Embedding of Values and Behaviours Framework • 04.07 – Embedding principles of Social Partnership Duty

		• 04.08 – Implement Compassionate Leadership Pledge • 04.09 – Develop measures and monitoring around Health and Wellbeing • 04.10 - Implement actions against the Trust Strategic Equality Plan.
TAF 5	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	• Updates against actions 05.01, 05.02, 05.03 and 05.04 which are on target in respect of due dates. • Action 05.05 was closed as the scope for a Change Advisory Board (CAB) has been established.
TAF 6	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.	• Inclusion of new actions in the context of the development of phase two of the Governance, Risk and Assurance programme and review of Trust Risk Policy. • First and second lines of defence were updated in respect of C1. • Owners of key controls have been updated. • 06.07 Phase 2 of the GAR programme is being considered in October 2024. • 06.08 is a new action to Review the Trust Risk Policy • 06.04 was closed regarding the establishment of the Governance, Assurance and Risk programme
TAF 7	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant	Closed actions: • 07.02 Action complete, AmAT tracker is fully rolled out across both divisions. • 07.15 Action complete October 2024, work concluded revised pathways and risk stratification processes in place - An

	service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	assurance external Peer review being arranged Updates against actions; • 07.01 completion date for the action was updated from September 2024 to January 2025 with Q-Pulse being procured, an options appraisal underway and ongoing discussions taking place. • 07.03 expected completion date has been updated to March 2025 from August 2024. An initial quality, safety and outcome metrics plan has been agreed and commenced. • 07.04 Implementation workgroup has been established. A business case is expected for Digital PROMS in quarter 3 of 2024/25. • 07.05 standard pro forma to support electronic referral agreed. Pilot with CAVUHB in progress. • 07.06 revised processes implemented as part of SACT GOLD work plan. • 07.07 SACT telephone helpline report received and action plan in place. • 07.11 Project group being established, project leads identified. Trust wide Q-Pulse system procured. work progressing to implement QPulse. • 07.13 expected completion date reviewed and updated to March 2025. Clinical and Scientific Board has been established and strategy approved by Trust Board. • 07.14 Once Clinical & Scientific Manager in post - implementation plan will be drafted
TAF 8	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient	Updates have been made to all open actions: • 08.01 – Value Based Healthcare Programme is underway

	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.	• 08.02 – Pharmacy review has been completed • 08.03 – Capital finance control procedures have been approved by Audit Committee • 08.04 – Investment opportunities presentation took place at EMB Shape • 08.05 – Cardiff Cancer Research Hub Market engagement is complete • 08.06 – Scheme of Delegation and Governance Framework was Approved by Trust Board.

All changes within the TAF since the 26 September Trust Board meeting have been marked in red in Appendix 2.

2.2 The mapping of the IMTP and the Trust Assurance Framework has been reviewed and considered as part of the template. The tracking of the performance against these objectives, in line with the standard IMTP quarterly reporting, will be included in the next reporting cycle. The presentation of the IMTP and TAF will change in April 2025. The template and approach for this will be outlined and considered by the Governance, Assurance and Risk group in December to allow the development of the 2025-2028 Integrated Medium-Term Plan and Trust Assurance Framework to progress on this basis.

2.3 A regular review cycle has been established to support the ongoing management of the Trust Assurance Framework. The Interim Director of Corporate Governance and the Risk and Assurance Manager are meeting with the leads for each TAF risk to discuss and clarify movements and Executive Board members are updating the document regularly. The initial meetings are also considering and capturing the requirements for ongoing management and support to capture movement within the TAF.

2.4 A summary of further actions Taken/ In Plan are noted in the table below:

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Populate refreshed TAF on Power BI template	Risk and Assurance Manager to review position to date work.	Digital support for this work will be reviewed to reach a consolidated position on the work required to deliver

			a Power BI template by end of November 2024. Awaiting confirmation of a link in the digital team to resume the work to automate the TAF.
2	Tracked changes	The systematic capture of in month changes within the TAF will partly depend on the development of the Power BI template. For now, and from October 2024, tracked changes will be highlighted in red In addition to this, the cover paper will be developed to include clearer commentary of key movement,	To be confirmed in alignment with the development of the Power BI template.
3	Risk Score Trend	Approach to managing updated on overall Risk Score Trend and supporting narrative to be reviewed by Executive Management Board.	Approach to be agreed by Executive Management Board in November.
4	Establish Risk and Assurance Manager support required by Executive leads as part of regular review cycle	1-2-1 meetings with Executive leads to be undertaken	Meetings in diary for October to confirm arrangements for November cycle.
5	Include TAF improvements in the wider Governance, Assurance and Risk Programme	Ongoing.	Ongoing until Audit Committee approval of the GAR phase two plan in December 2024

3 SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The Quality Safety and Performance Committee is asked to **NOTE** the current status and on-going development of the Trust Assurance Framework.

4 IMPACT ASSESSMENT

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

	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	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Consideration of the impact of the actions outlined in this paper on the current scoring of the strategic risks will be managed by the Executive Management Board at its monthly Run meetings.
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Trust Strategic Risks

01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.
02	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.
03	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.
04	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes
05	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
06	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
07	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.
08	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.

SECTION 1

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	WBS position is stable VCS has been under additional pressure due to the increase in SACT referrals and the downtime in radiotherapy, resulting in loss of capacity.
RISK LEADS	Anne Carey	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 Service Level Agreement meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government. NICE Guidelines re Cancer drugs	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/
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND

3270	There is a risk to performance and service sustainability as a result of increased demand for SACT starting to exceed capacity in all clinics leading to the burnout of the medical and supporting workforce due to excessive workloads.	16	Risk increasing
3338	There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	16	Risk decreasing
3306	There is a risk of Loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	15	Stable
3350	There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	15	Stable
3431	There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff.	16	Risk decreasing
3461	There is a risk that VCC Pharmacy will not be able to undertake aseptic dispensing of parenteral SACT as a result of the current ChemoCare module which supports this process no longer being supported by the supplier. This may lead to a failure of the module and increased cyber vulnerabilities and thus the inability to aseptically dispense parenteral SACT.	15	New risk

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
01.01	The Infected Blood Inquiry (IBI) report was published in May 2024. Recommendation 7 (in part) outlines the need to improve patient outcomes post transfusion. Mapping work is ongoing with DHCW to understand how best to record the fating of blood products at the patient bedside, and will consider the opportunity of including this with the implementation of the Laboratory Information Management System (LIMS) 2.0. This will be reported into the Welsh Government IBI next steps working group. The fating of blood at the patient bedside in turn will enable	Alan Prosser	IA	Dec-24	Work is ongoing with WBS and DHCW to understand the digital requirements of fating blood components at the patient bedside. Paper to due for completion by December 24.	08.10.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
01.02	Following publication of the Infected Blood Inquiry Report in May 2024 the Blood Health National Oversight Group has produced a paper for consideration by the Welsh government IBI next steps working group to help align the inquiry recommendations against the National Blood Health plan which should in turn improve prudent use of blood across Wales which in turn supports demand and supply for the Welsh Blood Service.	Alan Prosser	IA	Oct-24	Paper has been endorsed by National Blood Oversight Group on October 8th and will be presented to Welsh Government IBI next steps working Group for consideration.	08.10.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
01.03	Collection capacity within the Welsh Blood Service has struggled for a number of months due to a number of operational variables. A resourcing plan to improve this position is being completed by the service for consideration of commissioners to sustain the sufficiency of supply of blood for the patients of Wales	Alan Prosser	PA	Nov-24	Commissioners business case being produced to consider funding uplift to support improved collection of blood throughout Wales.	18.4.24	All Wales programmes which will ensure equity of care for patients.	
01.04	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	Rachel Hennessey			Progress against action and further actions to be undertaken in month to provide updated position for November EMB reporting.			
01.05	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	Rachel Henneseey			Progress against action and further actions to be undertaken in month to provide updated position for November EMB reporting.			

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE
Strategic Goal 1 Outstanding for quality, safety and experience	1. Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27 3. Implementation of Outreach Programme by 2025-26 4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services 5. Implementation of Regional Acute Oncology Delivery Model and Network Structure 6. Implementation of ePMA for Use by Velindre Cancer Services 7. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services 8. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC) 9. Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes 10. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables 11. Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25 12. Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy 13. Ensure the Viability of the Neuro- Oncology Service 14. Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping). Define Recommendati ons, Develop and Deliver Improvement Plan	1. Project close and Radiotherapy Satellite Unit to 'go-live'. 2. Progress phase 3 objectives 3. Complete 4. Develop contingency plan to address scenario in which national implementation on of the TrAMs model is delayed beyond the opening of nVCC. 5. Complete 6. Project close following successful implementation. 7. Project close following successful implementation. 8. Develop plan to facilitate transition of brachytherap y service to nVCC. Develop interim business case for radiotherapy as part of contingency planning to address potential delays to wider infrastructure project to include commissioni ng a fourth linear accelerator, outsourcing,7-day working,etc. 9. Complete 10. Full programme implemented. Undertake post- implementation on programme review 11. Complete 12. Complete 13. Complete 14. Complete	1. Complete 2. Project close 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Deploy workforce plan for operational and facilities services. Draw down identified funding from FBC to enable recruitment to necessary posts. 9. Complete 10. Complete 11. Complete 12. Complete 13. Complete 14. Complete

	15. Implement Recommendations from Peer Review of SACT Treatment Helpline 16. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics 17. Implement New Molecular Radiotherapy Treatments at VCS 18. Review the Radiation Protection Service Resource to Enable Dynamic Response to National, Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources 19. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme 20. Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services 21. Develop and Implement Model for Clinical Leadership and Supporting Governance Structure 22. Design, Commission and Deploy Revised Patient Transport Model 23. Implement Pathway Improvement Programme 24. Undertake Digitisation of Medical Records 25. Implementation of New Services / Delivery Models 26. Implement DHCR Phase 2 by 2024/25 27. Implementation of Consolidated Document Management System Across VCS 28. Respond to Low / Limited Audit Assurance Findings 29. Implementation of Centre for Collaborative Learning and Innovation	15. Complete 16. Complete 17. Determine resource implications of the introduction of new Molecular Radiotherapy treatments at VCS in anticipation of NICE approval. Actively engage with commissioners. 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Undertake evaluation of new models. 24. Establish project group. Identify service improvement s / opportunities for change. Identify additional resource requirements Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 25. Develop solutions for, develop service model for delivery of, identify resource implications and develop business cases to secure funding, where appropriate, to facilitate: Implementation on of new Internal Mammary Node (IMN) service, axillary radiotherapy service and partial breast radiotherapy service Implementation on no new extreme hypofractionation for prostate / SABR prostate service. Implement SABR treatments for new indications. Expansion of stereotactic radiosurgery (SRS) service. Palliative radiotherapy service. 26. Complete 27. Complete 28. Complete 29. Phased implementation on work to commence (initial proposals aligned to nVCC Full Business Case agreed).	15. Complete 16. Complete 17. Complete 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Complete 24. Undertake post-project evaluatio 25. Complete 26. Complete 27. Complete 28. Complete 29. Complete
	WELSH BLOOD SERVICE	**WELSH BLOOD SERVICE**	**WELSH BLOOD SERVICE**
Strategic Goal 1 Outstanding for quality, safety and experience	1. Implement improved donor interaction by 2026/27. 2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27. 3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) 4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 5. Revised blood collection clinic portfolio by 2025/26. 6. Introduce clinically led collection team model by 2024/25 7. Develop and implement a platelet strategy by 2025/26. 8. To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system. 9. Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26 10. Procure new Blood Establishment Computer System (BECS) contract. 11. Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25. 12. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26. 13. Implementation of Foetal DNA typing by 2024/25. 14. Review and Develop strategy for Nucleic Acid Testing (NAT).	1. Complete introduction of a donor experience hub. Complete implementation on of a Customer Relationship Management t (CRM) System. Implement omni- channel software 2. Implement recommended strategies for maintaining growth of the registry such as collecting 3rd party cellular products or ATMP Starting materials. Continue to progress with the WBMDR replacement software project 3. Begin to implement new strategy 4. Complete 5. Complete development of options for introduction of a new fixed donation venue/complete review of existing blood donation venues 6. Complete 7. Development of the collection strategy for apheresis and whole blood platelet collection Development of the Horizon Scanning for fluctuations for optimal platelets supply. Development of the strategy to improve the on-shelf availability of all platelet types: Including expanding donor panel. Research and development of new components 8. Complete deployment (Q1) 9. Complete Data Migration (Q1).Training (Q1). Go Live (end of Q1) 10. New Contract Award (Q1).New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECs solution 11. Part of standard activity post implementation. 12. Implement Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) strategy (Qtr 1). Substances of Human Origin (SoHo) Regulations – develop strategy for WBS. 13. Scope expansion of service. 14. Implement new NAT strategy.	1. Implement tailored pathways for donors and advocates. New donor app implementation and create content. 2. Continue to implement recommended strategies for the expansion of stem cell collection services. Implement new WBMDR software. 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Complete 9. Complete 10. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28). Continue supporting existing BECS solution. 11. Part of standard activity post implementation. 12. Substances of Human Origin (SoHo) Regulations – WBS Strategy to be in place 13. Complete 14. Complete
	15. Introduction of West Nile Virus (WNV) Testing. 16. Assess and implement the recommendations of the Infected Blood Inquiry (IBI). 17. Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. 18. Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. 19. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	15. Complete 16. Complete 17. Commence supply of frozen recovered plasma for fractionation from Q1 Receipt of first fractionated product from Q3. 18. Develop Full Business Case (FBC). 19. Implement recommend actions of review of workforce planning across WBS. 20. Implementation recommendations from the Inependent Blood Inquiry	15. Complete 16. Complete 17. Source Plasma TBC depending on policy decision and business case support. 18. Construction commence s - three- year programme 19. TBC

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SECTION 1

RISK ID	02	RISK TITLE	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	STRATEGIC GOAL	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	No change to risk score since previous reporting period.
RISK LEADS	Lauren Fear	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: 7 Levels of Assurance(see definitions tab)	RATING	PE	Overall Trend in Assurance	THIS WILL HAVE A GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	E	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of	E	Strategic Development Committee/ Quality Safety and Performance Committeee; introduction of	PA	Regulatory scope re MHRA tbc; clear stanadards for services understood and suppported by commissioning arrangements across NHS Wales	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office	E
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region			X		PE	Agreed to model for next phase	NE	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	E
5.2	Partnerhsip with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	QSP	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety		Wales Audit Office/Welsh Government	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent	1.9; 1.7; 1.8
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commsissioning and specialsit cancer commissioning	Replace of CCLG not in place yet so no regioanl assurance regarding strategic alignment etc	1.9
Agreement of need for improved regionsal cancer commissiong (core services)		1.6; 1.8
Need for improved data/quality metrics to track perforamance	Provision of improved metrics to EMB; QSP and Trust Board	1.3; 1.4

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
02.01	Phase 1 complete. Development of Phase 2 of PMF with additionalperfromance measures/quality metrics commenced - delivery dates require firming up. Phase 2 elements commenced with a range of new quality indicators proposed for WBS and wider quality dimensions - approved by EMB in May 2024 - for consideration by SDC in May 2024. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (may 2024)	Lauren Fear	~~01/03/2024~~ Nov 2024	Previous timescale not met however the PMF packages of work are defined and set out in September 2024 QSP and Trust Board papers.	18/09/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
02.02	Value Based Healthcare programme in place to provide a range of outcome measures and data insight to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded. Progress being made on a number of projects (Food mission; cancer dashboards etc. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (may 2024)	13/10/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
02.03	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Lauren Fear	Nov-24	First Regional Cancer Programme Board held in September 2024. Actions agreed by all partners to progress with forming core scope and approach by November 2024.	18/09/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
02.04	WG review of NHS Wales strategic management / accountability arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	April/May 2024	Update 15/10/2024 - NHS Executive in place. Initial accountability review report has been received by the Trust and observations returned to the Cabinet Secretary for Health (30/09/2024). Awaiting receipt of final report and recommendations. Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage. No further update received on the findings of the national review	15-Oct-24	Unknown at this state	The level of assurance should increase

02.05	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Lauren Fear	Nov-24	Review completed in August 2024 of all regional governance and alignement to Trust. Feedback from key partners is a posistive improvement in engagement across the regional scope.	18/09/2024	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
02.06	Establishment of new national commissioning body (bringing WHSSC/EASC together)	Welsh Government	01-Apr-24	Implementation of new commissioing body well progressed. New Commissioning Body established and LIVE	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	Action complete: increased level of assurance increased as national body with clear commissioning scope and powers

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	Working with our Health Partners: The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our Agreed Programmes of Work: We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most. 1. Delivering the Fundamental Cornerstones of Healthcare Provision: • Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality • Delivering services that meet the national clinical quality and safety standards and provide an excellent experience • Treating patients as quickly as possible • Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales • Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services • Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years • Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working		
	2. Improving Population Outcomes and Reducing Inequalities: • Improving access to our services to increase uptake and reduce inequalities and ill-health • Strengthening our decision-making to consciously address poor outcomes and inequalities in the communities we serve • Working with our health partners where it is clear and compelling that we can add value and make a difference		
	3. Regional Working, Partnerships and Collaboration to Improve Outcomes • Work with Local Health Board partners to strengthen our support the delivery lead of improved cancer outcomes for patients in South East Wales • Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales • Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales 4. Delivery of Transformation Programmes Non-surgical Tertiary Oncology Services: • Implementing the final phase of the Acute Oncology Service regional model • Continue to improve pathways for unscheduled care patients • Delivery of the Cardiff Cancer Research Hub • Implementation of the Integrated Radiotherapy Solution in 2025 • Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff in 2027 • Construction and opening of the Radiotherapy Satellite Centre, at Nevill Hall Hospital in Abergavenny, in 2025		
	Blood and Transplant Services • Laboratory Modernisation programme: • Refurbishment of the Talbot Green facility by 2027 • Plasma for Fractionation: developing the case for change and delivery of the Programme		

SECTION 1

RISK ID	03	RISK TITLE	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	No change to risk score since previous reporting period.
RISK LEADS	Sarah Morley			RISK THEME	Workforce Supply and Shape		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Approved Workforce Planning Methodology aligned to Trust Values and Beahviours	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			E
C5	Educational pathways in place to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE
C6	Widening Access Programme to support development of new skills and roles	Susan Thomas	X			PE
C7	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X			E
C8	Hybrid Working Principles established to support workforce planning methodology	Sarah Morley			X	E
C9	Consistent recruitment and selection process	Sarah Morley	X			PE

SOURCES OF ASSURANCE

ID	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Monthly Divisional Senior Leadership Team feedback	IA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	PA
C4	Evaluation sheets	PA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	PA
C5	People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	PA
C6	People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	PA
C7	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA
C8	Flexible Working Policy	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit	NA
C9	Recruitment and Selection Policy	IA	Dashboards on recruitment and selection reported monthly to divisional SLTs. Supply and Shape paper to EMB then QSP	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		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	Current Risk Rating	RISK TREND
3467	There is a risk to clinical service delivery as a result of reduced staffing within the outpatient Physiotherapy service, leading to reduced patient care, experience and outcomes.	20	new risk
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	20	Increasing risk

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
03.06	Development of a Trust workforce plan	Susan Thomas	IA	Sep-25	Initial plan was presented to EMB in Septemeber 2024, where Short and medium term actions were agreed. These actions will be reflected in Workforce Supply and Shape paper in November QSP.	18.09.2024	The impact will be reduced once the short and medium term actions are completed	
03.07	Development of a Nurse Retention Plan	Susan Thomas	IA	Sep-24	Nurse Retention Plan was approved by EMB in June 2024.	18.09.2024		
03.08	Embed workforce planning progress into monthly Divisional Senior Leadership Team Workforce reports	Amanda Jenkins	NA	Oct-24	New action	18.09.2024		
03.09	Staff educators to undertake HEIW train the trainer on workforce planning	Amanda Jenkins	NA	Jan-25	New action	18.09.2024		
03.10	Embed Hybrid working principles in training and reporting	Amanda Jenkins	NA	Jan-25	New action	18.09.2024		
03.11	Implementation of the Attraction and Retention Project	Amanda Jenkins	NA	Mar-25	New action	18.09.2024		
03.12	Implemention of the Nurse Retention Plan through the Professional Nursing Forum	Nicola Williams	NA	Apr-25	New action	18.09.2024		
03.13	Utilise the learning from implementation of the Nurse Retention to develop a Trust Retentaion Plan	Amanda Jenkins	NA	Oct-24	New action	18.09.2024		
					CLOSED ACTIONS			
03.01	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	PA	COMPLETE	The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024. The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.
03.02	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	
03.03	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
03.04	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	
03.05	Review Exit Interview Process	Susan Thomas	IA	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	Planned ans Sustained Workforce Right people right place right time 1. Implement the Education Strategy Implementation Plan 24/25 2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model 3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism 4. Attraction and Retention 5. Agree a plan for the Widening Access Programme 6. Ongoing recruitment Marketing Campaigns for hard to fill roles 7. Working with Comms Trust wide recruitment campaign in place 8. Evaluate the International nurse Recruitment Programme 9. Develop a Nurse retention plan		

	Skilled and Developed Workforce Achieving Excellence through our staff 1. Component caring and capable workforce Deliver the Trust Training Plan 24/25 – clear KPIs to support evaluation 2. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model 3. Developing our academic profile Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre for Learning and Innovation 4. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology 5. Working with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology		

SECTION 1

RISK ID	04	RISK TITLE	There is a risk of failure to meet or exceed service expectations without the prevelance of a positive working environment, which is characterised by effective values and bahaviours, systems and processes	STRATEGIC GOAL	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	No change to risk score since previous reporting period.
RISK LEADS	Sarah Morley			RISK THEME	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness 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
C2	Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			E
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Susan Thomas	X			PE
C4	Trust Values and Behaviour Framework	Susan Thomas	X			PE
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE
C6	Health and Wellbeing infustructure for the Trust to support physical and psychological wellbeing of staff	Susan Thomas	X			E
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE
C9	Clear safe, effective and efficient services models to support role clarity aligned to compassionate leadership principles	Anne Carey	X			PE
C10	Operational workforce plans developed to support agreed service models	Anne Carey	X			PE
C11	Employee Voice Framework	Sarah Morley	x			PE
C12	Avoidable employee harm prinicples are embedded into the management of beahviours within the Trust	Sarah Morley	X			PE

SOURCES OF ASSURANCE

ID	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	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	People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	PA
C3	People Development and Education Steering Group	PA	Reporting though relevant Trust goverence processes and Trust Board cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports	NA
C4	Healthy and Engaged Steering Group NHS Staff Survey	PA	Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports	NA
C5	Healthy and Engaged Steering Group	PA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Healthy and Engaged Steering Group Trust Polices and Proceedures to support health and wellbeing	PA	Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports - Evalution of wellbeing activites, MAWW Audit	PA
C7	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Perfromance Managment Framework Report	PA	Exucutive Management Board	PA	Internal Audit Reports	IA
C9	Monthly Divisional Senior Leadership Meetings	IA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	NA
C10	SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	NA
C11	Healthy and Engaged streerting group and Local Partenship Forum	PA	Reporting though various Trust goverence processes	PA	Internal Audit Reports	NA
C12	Healthy and Engaged streerting group and Local Partenship Forum	PA	Reporting though various Trust goverence processes	PA	Internal Audit Reports	NA

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 RATING	RISK TREND
3332	There is a risk to the health and wellbeing of the medical workforce due to increasing demand resulting in prescribing and the completion of Outpatient Oncology Notes being done outside of job plan hours	16	New risk
3247	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	16	Stable
3468	There is a risk to the sarcoma service as a result of the single handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	16	Stable

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
04.05	Undertake analysis of current employee voice mechanisms and develop an engagment action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	Claire Budgen	IA	Mar-25	New Action	18.09.24		
04.06	Embed the Values and Behaviours Framework into Trust communications, policies and processes	Claire Budgen	IA	Dec-24	New Action	18.09.24		
04.07	Embed the prinicples of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Amanda Jenkins	IA	Apr-25	New Action	18.09.24		
04.08	Implement the Compassionate Leadership Pledge and action plan within the Trust	Claire Budgen	IA	Mar-25	New Action	18.09.24		
04.09	Develop outcome measures for the monitoring and analysis of Health and Wellbeing activies within the Trust	Claire Budgen	IA	Dec-24	New Action	18.09.24		
04.10	Implement the actions of the Trust Strategic Equality Plan, incuding embedding the Anti-Racist Wales Action Plan in the Trust	Claire Budgen	IA	Mar-25	New Action	18.09.24		
CLOSED ACTIONS								
04.01	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley	PA	COMPLETE	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in May 2024. This paper also proposes that the conversations continue as routine in person and virtually.	20/06/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	Identification of the needs for an Employee Voice Framework
04.02	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley	PA	COMPLETE	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	20/06/2024	We received the Trust level data from the 2023 staff survey with the more detailed dahsboards following in May. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream.	This will encompased I nthe revised BOFT approach in the Trust way of working.

04.03	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	PA	COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
04.04	Promotion of the Speaking Up Safely Framework	Sarah Morley	PA	COMPLETE	The initial task and finish group to establishe the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place.	14/05/2024	Initial programme completed - ongoing work to trianguate with wider cultural work	

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	Healthy and Engaged Workforce Our staff will feel valued and supported and promote a culture of true inclusivity, fairness and equity across the workforce. 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence 2. Implement the Values and Behaviour framework project 3. Triangulate culture work, staff feedback themes and leadership work to deliver an aligned Culture Programme of work that addresses Organisational issues reflects our values and allows staff to speak up freely 4. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working 5. Deliver an action plan 24/25 commitment in the Trust Anti- Racist Action plan 6. Monitor Welsh Language Standards, working with Divisions on improvement plans 7. Implement the WL Culture plan 8. Update all WOD related policies and procedures 9. Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA		
	People Function Cultural Development – People and Relationships Model 1. Develop an engagement plan for the function to support the engagement and alignment with service development 2. Implementation of the holistic People and Relationships model 3. Engagement and Commitment from EMB 4. Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback		

SECTION 1

RISK ID	5	RISK TITLE	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	STRATEGIC GOAL	ALL	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Lauren Fear	Carl Taylor		RISK THEME	Digital Transformation		

SECTION 2

RISK SCORE (see definitions tab)

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

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	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape / National Programme Boards	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback Trust Digital Inclusion Plan	IA	EMB Shape / Digital Communities Wales	IA	Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP Trust Capital Programme Digital Spend included in PMF (Current 2.6%)	IA	EMB Shape / EMB Run	IA	Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	PA	Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales Accreditation	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		E	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Assurance Arrangements for Digital Architecture will need to be established -	
C9 - Change Advisory Board - is formed and has now met twice	Data and Insight prioritisation as this becomes part of the Digital Services team -	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3472	There is a risk to patient safety as a result of thge DHCR system not allowing outpatient oncology notes to be rapidly identified. This leads to missing key information relevant for outpatient clinics. - a lack of visibility for oncology information (e.g prognosis/intent) for acute teams (VCC and HB) and primary care which is affecting patient management - an impact on patient experience due to slower clinics and increased waiting times - an increase in staff stress; funding the relevant information can be time consuming and stressful	16	New risk

2774	There is a risk to **quality and safety** as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	12	Stable

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
05.01	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Oct-24	Terms of reference drafted for approval at Aug Digital Programme Board	Oct-24	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of being stood up in Q3 24/25. Digital Design Authority is still to formally meet.	The level of asurance should increase.
05.02	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Oct-24	Strategic Development Committee Data and Insight incuded as part of the Change Advisory Board for C9	Oct-24	Will contribute to reduction in likelihood of risk	C9 would move to Effective
05.03	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer	IA	Oct-24	Digital Strategy was reviewed in August Digital Programme Board	Oct-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
05.04	Reviewing control framework with Head of Information Governance for cross-check and alignment	Chief Digital Officer	IA	Nov-24	Initial review undertaken and updates will be made for Nov TAF	Oct-24	Will contribute to reduction likelihood of risk	Assitional assurance for C11 and C13
					CLOSED ACTIONS			
5.05	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer	IA	Complete	Scope fror CAB has been established CAB is now meeting regularly	Oct-24	Will contribute to reduction likelihood of risk	Assurance controls better represent best practice, around C9

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 5 **A sustainable organisation that plays it part in creating a better future for people across the globe**	**2. "Agile" Delivery Squads introduced to Digital target operating model** **3. "Agile" Delivery Squads introduced to Digital target operating model** **4. New Patient Reported Outcome Measures (PROMS) system for Value Based**	**1. ongoing development of call centre solution and support** **2. Scale model to new areas** **3. Complete** **4. Further PROMS development by Value Intelligence Centre**	**1. Transition to nVCC** **2. Complete** **3. Complete** **4. Ongoing**
	13. Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre **14. Performance Management Framework (Quality Measures) dashboard** **16. National Data Resource roadmap** **17. Trust wide Data and Insight plan** **18. New Velindre Cancer Centre (nVCC) digital enablement** **19. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services** **20. Digital enablement of the integrated Radiotherapy Solution Programme by 2026/27** **21. Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services** **22. Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)** **24. Upgrade Video Consultation platform to support Pathway Improvement Programme**	**13. WBS Donor system** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems delivered by Velindre Scrutiny of ProjectCo Digital systems** **19. Project close following successful implementation.** **20. Progress phase 3 objectives.** **21. Project close following successful implementation.** **22. Project close and Radiotherapy Satellite Unit to 'go-live'** **23. Complete** **24. Complete**	**13. Complete** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems &Transition of digital into nVCC** **19. Complete** **20. Complete** **21. Complete** **22. Complete** **23. Complete** **24. Complete**
	25. Undertake Digitisation of Medical Records **26. Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure** **27. Electronic Patient Record – Phase 2** **28. VCS Service Changes – Other digital activities in support of the VCS plan** **29. WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.** **30. WBMDR Digital: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27** **31. BECS Procure new Blood Establishment Computer System (BECS) contract and implement digital system.** **32. NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS).** **33. WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system** **34. Plasma for Medicines: Digitally enable the Plasma for Medicines programme** **36. Foetal D: Digital enablement of Foetal DNA typing.** **37. Live Connectivity: Introduce live connectivity for the blood collection teams** **38. Donor Interaction and Appointments: Digitally enable improved donor interaction by 2026/27.**	**25. Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project.** **26. Complete** **27. Complete** **28. Complete** **29. Complete Data Migration (Q1).Training (Q1).Go-Live (end of Q1).** **30. Continue to progress with the WBMDR replacement software project.** **31. New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution.** **32. Go Live with new NEQAS system. Close Project.** **33. Final deployment activity (Q3)** **34. Adapt digital systems (BECS) to work with the Plasma for Medicines model once agreed** **35. Close down DHCW service** **36. Scope expansion of service.** **37. Complete** **38. Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software**	**25. Undertake post-project evaluation** **26. Complete** **27. Complete** **28. Complete** **29. Complete** **30. Implement new WBMDR software.** **31. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28) Continue supporting existing BECS solution.** **32. Complete** **33. Complete** **34. Complete** **35. Complete** **36. Complete** **37. Complete** **38. Implement tailored pathways for donors and advocates. New donor app implementation and create content.**
	25. Undertake Digitisation of Medical Records 26. Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure 27. Electronic Patient Record – Phase 2 28. VCS Service Changes – Other digital activities in support of the VCS plan 29. WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26. 30. WBMDR Digital: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27 31. BECS Procure new Blood Establishment Computer System (BECS) contract and implement digital system. 32. NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS). 33. WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system 34. Plasma for Medicines: Digitally enable the Plasma for Medicines programme 36. Foetal D: Digital enablement of Foetal DNA typing. 37. Live Connectivity: Introduce live connectivity for the blood collection teams 38. Donor Interaction and Appointments: Digitally enable improved donor interaction by 2026/27.	25. Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 26. Complete 27. Complete 28. Complete 29. Complete Data Migration (Q1).Training (Q1).Go-Live (end of Q1). 30. Continue to progress with the WBMDR replacement software project. 31. New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution. 32. Go Live with new NEQAS system. Close Project. 33. Final deployment activity (Q3) 34. Adapt digital systems (BECS) to work with the Plasma for Medicines model once agreed 35. Close down DHCW service 36. Scope expansion of service. 37. Complete 38. Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software	25. Undertake post-project evaluation 26. Complete 27. Complete 28. Complete 29. Complete 30. Implement new WBMDR software. 31. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28) Continue supporting existing BECS solution. 32. Complete 33. Complete 34. Complete 35. Complete 36. Complete 37. Complete 38. Implement tailored pathways for donors and advocates. New donor app implementation and create content.

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	Currently static. Actions planned accociated to the GAR programme, as described below, should result in further movement from January 2025.
RISK LEADS	Non Gwilym			RISK THEME	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: Refer to 7 Levels of Assurance (see definitions tab)	RATING	E	Overall Trend in Assurance Refer to 7 Levels of Assurance (see definitions tab)	Currently static. Actions planned accociated to the GAR programme, as described below, should result in further movement from January 2025.

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

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

06.05	Revised reporting mechanism to be developed	Non Gwilym	4	Oct-24	Progress delayed - Refresh of Phase 2 of GAR underway to be defined and agreed by mid Octover 2024, to include revised reporting mechanisms as per below: *Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to*	23.08.24	Impact to be asseessed when delivered. No risks identified currently.	
06.06	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	4	Nov-24	Dates amended to reflect benchmarking exercise underway but to be progressed by newly appointed Risk and Assrnace Manager from 1 October 2024.	22.08.24	Impact to be asseessed when programme delivered.	
06.07	Develop new plan for phase 2 GAR programme	Non Gwilym	2	Dec-24	Phase two of the GAR programme being considered by Governance, Risk and Assurance Group on 22 October. Timetable for process as noted by Audit Committee (September) as follows: 1. GAR Programme Steering Group meeting 22 October 2. Independent Members Group consideration of draft GAR Phase 2 Plan 5 November 3. EMB consideration and endorsement of GAR Phase 2 Plan with SMART actions26 November 4. GAR Programme Steering Group meeting18 November 5. Audit Committee consideration and approval of GAR Phase 2 Plan 12 December	03.10.24	Impact to be asseessed when programme delivered.	In itself, the development of the GAR phase 2 programme will not impact on the risk score. It will however provide a blueprint that should, upon implementation, impact on the overall assurance. Further to this, we will implement any "quick wins", with the appropriate governance wrap, as we develop the plan. 1. Phase 2 plan to be informed by output of 2023/24 Board and Committee effectiveness surveys (C2/3). 2. Programme of work to include consideration of refresh of Trust Risk Policy (C5). 3. Benchmarking being undertaken by Risk and Assurance Manager. (C6) 4. IMTP presentation has been reconsidered for next iteration of TAF.
06.08	Review Trust Risk Policy	Non Gwilym	3	Mar-25	1. Trust wide risk group discussion to scope policy review. 2. Discussion with VCS Quality, Safety Group at Quality workshop 3. Meetings in diary to discuss policy review	11.09.24	Impact to be asseessed when programme delivered.	1. Reviewed policy incorporating learning from GAR phase 2 actions on risk. 2. Training programme established. 3. Updated learning aids available for all Trust staff. Assurance level will increase when action has been delivered.
CLOSED ACTIONS								
06.01	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.24	Requirement for C7 to be put in place	
06.02	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.24	Requirement for C7 to be put in place	
06.03	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	6	Complete	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.24	Impact to be asseessed when delviered	
06.04	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Non Gwilym	4	Complete	Phase 2 GAR programme in development for EMB consideration in October 2024 following endorsement of GAR Steering Group. August 2024 update: Phase 2 GAR refresh underway. Initial thoughts captured at GAR group meeting in August. Refreshed phase two for GAR group consideration in October 2024	21-Oct-24	Impact to be asseessed when delviered	The Governance, Assurance and Risk programme was established as part of the wider Building our Future Toghether organistaional programme in October 2023. The action is effecitvely complete, and I suggest that we reword with the draft proposed as 06.07.

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Our Strategic Delivery Framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation** **Trust Purpose and Vision, aligned to** **• Trust Strategic Goals** **• VCS Strategy and Priorities and Service Plans** **• WBS Strategy and Priorities and Service Plans** **• Support Functions Strategies and Plans**		
	Building our Future Together 'Destination 2033' BOFT is an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be. **BOFT Programme** **1. Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread** **2. Provide a way of working and shape to the organisation which enables us to maintain focus** **3. Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future** **4. Draw together our organisational developments with a common sense of purpose** **5. Improve our effectiveness, efficiency and value based approach** **6. Develop the mechanisms which enable us to prioritise where and when we focus our efforts** **7. Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition** **8. Support realistic, authentic and compassionate leadership**		

	9. Re-assessing inter-related areas of work to ensure that together they provide the mechanisms to achieve our objectives **• Prioritisation & Co-ordination Arrangements** **• Values & Culture** **• Internal Staff Communication & Staff Engagement** **• Governance Risk and Assurance** **• Performance Management** **• Leadership Development** **• Value Based Healthcare** **• Quality Framework** **• Ways of Working** **• Clinical & Scientific Arrangements**		

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RISK SCORE (see definitions tab)

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

SECTION 3

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

RATING PE

Overall Trend in Assurance

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effective	1st Line of Defence (Operational Management)	Assurance Rating	2nd Line of Defence (Executive Management)	Assurance Rating	3rd Line of Defence (Board Management)	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO	As per TAF 01 C12									
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Performance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Performance Committee	NE
C5	Pathway driven programmes for improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Performance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Performance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Performance Committee	IA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Performance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		PE	VOA Implementation Group	IA	Executive Management Board	IA	Strategic Development Committee	IA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Performance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	E	VCS Quality & Safety Group / VCS SLT	PE	Integrated Quality & Saefty Group / Executive Management Board	PE	Quality, Safety and Performance Committee	PE

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3230	REFERRAL PROCESS - There is a risk to patient safety, as a result of variation and multiple access routes for new referrals in 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.	8	Risk decreasing - Current risk score adjusted based on actions put in place to manage referrals received via e-mail. Pilot being progressed with CAVUHB
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.	12	Stable
3448	There is a risk to patient safety as a result of the VCC Cancer Associated Thrombosis (CAT) service not continuing due to inability to recruit to key posts following the pending retirement of key individual 2025 leading to patients diagnosed with CAT unable access specialised services and therefore may lead to sub optimal treatment, delays in their cancer treatments	16	new risk
3461	this process no longer being supported by the supplier. This may lead to a failure of the module and increased cyber vulnerabilities and thus the inability to aseptically dispense parenteral SACT.	15	new risk
3467	There is a risk to clinical service delivery as a result of reduced staffing within the outpatient Physiotherapy service, leading to reduced patient care, experience and outcomes.	12	new risk
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.	12	Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
7.01	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	~~01/09/2024~~ Jan-25	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 Oct 24- Discussions remain underway with VCC	05.11.24	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
7.03	Intergrated Quality and Safety dashboards to be developed that align with PMF	Exec Director Transofrmation, planning, performance and digital	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed Oct 24- development commenced - 12 week development programme	05.11.24	Should reduce risk	Enhanced control and assurance
7.04	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Implementation Working Sub-Group established within VCS, Lead by the Value Intelligence Centre Business Case for digital PROMS approved. Procurement expected in Q3 of 24/25. Preparatory work ongoing with Prostate and Lung team for phase 1 implementation. Work underway with clinical teams to agree SST specific PROM sets where national PROMS have not been set. The programme is collaborating with WCN on this. Breast national set newly agreed. Triggers to be defined. When PROMS data is collected digitally it will be available within the data warehouse for analytical and reporting purposes, including at Board level. This is expected in Q4 24/25 for the areas which will have PROMS deployed	09/10/2024	Should long term reduce risk	Enhanced assurance
7.05	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	standard pro forma to support slectronic referral agreed. Pilot with CAVUHB in progress. Longer term solution H2H referral which will require support from DHCW.	05/11/2024	Reduce risk	Enhanced control
7.06	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24	revised processes implemented as part of SACT GOLD work plan	05/11/2024	Reduce risk	Enhanced control
7.07	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan in place. continuing to work through implementation	05/11/2024	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control
7.08	Transformational multi professional workforce plans across all areas of the cancer service	Rachel Hennessey	1	Mar-26	team job planning currently taking place.	05/11/2024	Reduce risk	Enhanced control
7.09	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
7.1	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process have been reviewed based on benchmarking outcomes and review of national standards	15.5.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
7.11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured. work progressing to implement QPulse in phases with priority given to business continuity documents and medical physics where existing systems are required to be updated	05/11/2024	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
7.12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
7.13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Director / Exec Director Nursing, AHP & HCS	2	Aug-24	Clinical & Scientific Board established. Clinical and Scientific Strategy has been approved by Trust Board (September 2024) Clinical & Scientific Manager appointed	05.11.2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making.	Enhanced control
7.14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	As above - once Clinical & Scientific Manager in post - implementation plan will be drafted	05.11.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
CLOSED ACTIONS								
07.02	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	COMPLETE	Mar-24	Oct 24- AmAT Quality & Regulatory Tracker fully rolled out across both divisons	05.11.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
7.15	Undertake a review of the management of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	COMPLETE	Aug-24	Oct 24 - Work concluded revised pathways and risk stratefication processes in place - An assurance external Peer review being aranged	05.11.2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27

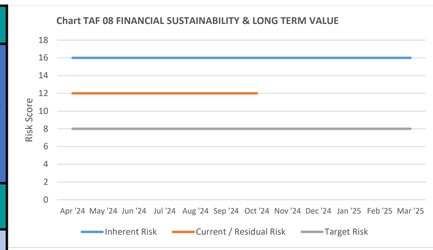
Strategic Goal 1 Outstanding for quality, safety and experience	**Clinical Quality and safety Priorities:** **1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.** **2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.** **3. To Integrate Clinical Audit within VCS Quality and Safety function** **4. Development of robust Site- Specific Quality Metrics** **5. To improve incident and risk management.** **6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System** **7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.** **8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.** **9. Review and improvement of donor selection and screening processes** **10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.** **11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results.** **12. Achieve JACIE accreditation for the WBMDR** **13. Commencing rollout of live connectivity of the BECS at community- based donation clinics** **14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact** **15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.** **16. Implement an outcome recording system for patients (digital PROMS)**		
	The Quality Impact Assessment (QIA) focuses on Three Main Areas: **1. Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care.** **2. Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients.** **3. Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care**		
	Strategic Equality Plan and Equality Impact Assessments (EQIA) **• Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps** **• Objective 2: Engage with the community** **• Objective 3: Communicate with people in ways that meet their needs** **• Objective 4: Ensure service delivery reflects individual need**		

SECTION 1

RISK ID	08	RISK TITLE	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe	RISK SCORE TREND	No change to risk score since previous reporting period.
RISK LEADS	Matthew Bunce			RISK THEME	Financial Sustainability and Long-Term Value		

RISK SCORE (see definitions tab)

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



	Apr '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25
Inherent Risk	16	16	16	16	16	16	16	16	16	16	16	16
Current / Residual Risk	12	12	12	12	12	12	12					
Target Risk	8	8	8	8	8	8	8	8	8	8	8	8

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING	E	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
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; 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, Strategic Development Committee	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; 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; 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	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

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
08.01	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Delivery over 2024/25 to 2026/27	"VBH Programme of work for 2024-25 - 2025-26 agreed by Trust Board overseen by the VBH Steering Group. Assurnace provided through review at SDC and QS& P Committees. 2024-25 Objectives: • Digital PROMS platform Business Case approved by Trust Board and procurement complete. Currently commencing implementation. • PROMS Questionnaires agreed for use in Prostate, Lung and Neurology. Good progress with national questionnaires for CUP and Breast • SST Data Insights Dashboard launched in March 2023 with development improvements made during 2024 through development group to ensure benefits maximised • Data quality group mobilised focussing on improving data quality in arease of clinical and financial risk • Training, communication & engagement - communication strategy in place, x14 traing & engagement sessions undertaken in past 12 momths; x4 members of staff undertaken Swansea University Value in Health course" Digital PROMS Business Case approved by Trust Board	13.10.2024	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	Control 11 - VBHC effectiveness will improve from PE to E and assurance will be enhanced further

08.02	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	Delivery over 2024/25 to 2026/27	"Savngs / Efficiencies opportunity Pipeline presented at April 2024 EMB Shape identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit suppy (underway) & furthe rareas to be identified through Medicnes Strategy Group, Workforce re-design - service divisions to identofy all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and porductivty imporvement, Procurement reviews of non pay spend to identifiy opprotunities for cost improvement ir income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery. Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance. Medicines Strategy Group established by SRO (Medical Director) for Medicines Group with first meeitng to be held Nov / Dec '24. "	13.10.2024	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability and reduce risk	Control 6 - Finance & Investment enhanced monitoring will improve from PE to E and assurance will be enhanced further
08.03	Development and review of Financial Control Procedures	EDoF / DDoF	6	OngoingDelivery in 2024/25 and annually as part of IA programme	"Capital financial control procedure approved by Audit Committee. Financial Control Procedure update plan and pipeline for review in development. Internal Audit scope of review for Key Financial Controls has been agreed. The indicative timeline suggests that fieldwork will commence in September and the report will be presented to Audit Committee in December 2024. "	13.10.2024	Strengthened control procedures will support risk mitigation	Control 10 - Scheme of Delegation and Delegated Financial Authority will improve form PE to E and assurance will be enhanced further
08.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Investment appraisal process & prioritosation framework developed by April 2025	"Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria and an evaluation process aligned to the 3 areas identified. Progress delayed due to lack of finance resource, but aim to have agreed criteria and process for investment appraisal and prioritisation by April 2025 . "	13.10.2024	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	Control 6 - Finance & Investment enhanced monitoring and Control 8 - Investment Appraisal effectiveness will improve from PE to E and assurance will change from IA to PA
08.05	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-25	"Cardiff Cancer Research Hub market engagement exercise completed. Programme plan drafted and in the process of being reviewed. Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection. "	13.10.2024	Attracting external / alternative sources of income will decrease pressure on reliance on exchequer income thereby supporting financial sustainability and reducing overall finanical risk	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial asurance
08.06	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Nov-24	"Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. A draft Scheme of Delegation and Governance Framework has been developed for nVCC, which has cross refernecd findings from PwC and Gateway reviews as well IA reviews. Draft Scheme of Delegation considered by Scrutiny Committee and Trust Board in Sep '24 with some improvement ammendments recommended which are being made. Updated version to be presnted to November Board for approval. nVCC FBC expected to be approved by WG in Oct '24 therefore SoD will be approced by Trust Board once FBC is approved and financial sums can be finalised. "	13.10.2024	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 **Outstanding for quality, safety and experience**	Value & Sustainability In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements through EMB Shape. The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include: • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre 1. Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).		

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

MEDICAL DEVICES ANNUAL REPORT 2023/24

DATE OF MEETING	14/11/2024

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	Jignesh Raiyani, Medical Devices Officer Tony Millin, Head of Radiotherapy Physics
PRESENTED BY	Anne Carey, Interim Chief Operating Officer
APPROVED BY	Anne Carey, Interim Chief Operating Officer

EXECUTIVE SUMMARY	This report provides a summary of the activities for the previous 12 months, and an outline of the key priorities for the Medical Devices Group for the next financial year.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **APPROVE** the Medical Devices Annual Report for 2023/24.

	• **NOTE** the update on the Medical Device Regulations and support the key priorities of the Medical Devices Group to: 1. Comply with the Best-practice guidance for the in-house manufacture of medical devices and non-medical devices, (IPEM2021) in anticipation of the incorporation of this requirement into the future updates of UK Medical Device Regulations (MDR). *2.* Embed the utilisation of the RAM medical device database at VCC / WBS.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC SLT	4/11/2024
WBS SLT	1/11/2024
Executive Management Board VIA Chair's Urgent Action	5/11/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

This report has been reviewed by WBS and VCS SLT and the contents have been 'NOTED'

The Executive Management Board via Chair's Urgent Action:
endorsed the Medical Devices Annual Report 2023/24 for

- **ENDORSED** the Medical Devices Annual Report for submission to the Quality, Safety & Performance Committee for approval..
- **NOTE** the update on the Medical Device Regulations and support the key priorities of the Medical Devices Group to:
  1. Comply with the Best-practice guidance for the in-house manufacture of medical devices and non-medical devices, (IPEM2021) in anticipation of the incorporation of this requirement into the future updates of UK Medical Device Regulations (MDR)
  2. Embed the utilisation of the RAM medical device database at VCC / WBS

7 LEVELS OF ASSURANCE
NOT APPLICABLE

APPENDICES	
Appendix 1	Further information on the work of the Medical Devices Group

1. SITUATION

The Trust Medical Devices Group (MDG) provides the governance framework for the management of Medical Devices ensures that risks associated with the lifecycle of non-radiation related 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 Medicines and Healthcare products Regulatory Agency (MHRA) or manufacturer alerts and keeping the Board, via the Chief Operating Officer, informed of specific issues that require action within the Trust.

2. BACKGROUND

This report summarises the work programme for the management of non-radiation based Medical Devices throughout Velindre Cancer Services, and the development and management of Reagent Kits and Medical Device Software in the Welsh Blood Service.

At Velindre Cancer Services, devices are managed by the engineering section within Radiotherapy Physics. The service and maintenance requirements are mostly completed through a service support local agreement, with the Clinical Engineering department at Cardiff and Vale University Health Board. The remaining devices are managed under individual contracts usually with the manufacturer of the device.

At Welsh Blood Service the development of Reagent Kits and Medical Device Software is currently managed by the Welsh Blood Service Laboratories and Digital Services, respectively.

The work of the group is summarised in ***Appendix 1***.

3. ASSESSMENT

The MHRA are reviewing the regulation for in-house manufacturing to determine optimum future changes. From publications by the MHRA to date, there is an expectation within the Medical Device community that the New and Updated UK Regulation will align as closely as possible and reasonable; to the EU 2017 Medical Devices Regulations.

Welsh Government have implemented a Medical Devices Planning Forum, at which VUNHST both Welsh Blood Service and Velindre Cancer Service are represented to ensure developments for the new legislation are planned and implemented effectively.

Existing Medical Device management activity is reported in detail in Appendix 1, which confirms all relevant Trust Devices are managed appropriately within the current regulations, including the application of relevant FSNs (Field Safety Notices).

4. SUMMARY OF MATTERS FOR CONSIDERATION

The national review of the Medical Devices legislation related to in-house manufacturing of devices, does not yet have a target completion date. The Welsh Government planning group has advised services to develop plans to: -

1. Comply with the Best-practice guidance for the in-house manufacture of medical devices and non-medical devices, (IPEM2021) in anticipation of the incorporation of this requirement into the future updates of UK Medical Device Regulations (MDR).

https://www.ipem.ac.uk/media/0cjfijnf/ipem-best-practiceguidance-on-ihmu-v2-2_final.pdf

This is therefore recommended as the key priority for the Medical Devices Group.

2. Embed the utilisation of the RAM medical device database at VCC / WBS.

   This will support improved efficient and effectiveness of planning and scheduling of device maintenance, and support optimisation of device availability.

These priorities will ensure VUNHST is prepared to implement the revised Medical Device Regulations when they are published and be well positioned to realise the benefits provided by the new technology.

5. IMPACT ASSESSMENT

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

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	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 implementation of the Medical Devices Database will improve availability of non-radiation medical devices. This will in turn support improvement in routine device monitoring and maintenance and ensure quality of products available for service.
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
	Improved Technical Controls for Medical device Management – no impact to Equality factors
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Improved Technical Controls for Medical device Management – no impact to Socio Economic factors

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Not applicable
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	The recommendations will ensure is best placed to meet anticipated regulatory changes.

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Appendix 1 – Further information

Regulation update

The MHRA are reviewing the regulation for in-house manufacturing to determine optimum future changes. From publications by the MHRA to date, there is an expectation within the Medical Device community that the new and updated UK regulation will align as closely as possible and reasonable; to the EU 2017 Medical Devices Regulations (MDR). In the Wales NHS, Welsh Government (WG) has implemented a national planning forum to develop readiness for the new regulations, and representatives of Velindre UNHST are engaged in the planning meetings.

The most recent UK publication (Jan 2024) confirms the Department of Health will continue to accept CE marked devices under the EU Medical Devices Regulation; within UK markets until June 2030. The key new requirement for in the revised MDR, is that in house manufacture or in-house modifications, must be completed within a formal quality management system.

VCC Radiotherapy Physics Engineering section will revise the scope of the existing Quality Management System (ISO 9001) that is in place, to incorporate all aspects of in-house manufacturing and proposed medical device regulations (IPEM2021). It is anticipated this will be completed in October 2025.

The VUNHST Medical Device Group

The Trust has a Medical Devices Group (MDG), which provides the governance framework for the management of medical devices. The purpose of which is to ensure that risks of all categories associated with the lifecycle of non-radiation related medical devices (including acquisition, in-house manufacture or development, de-contamination, 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.

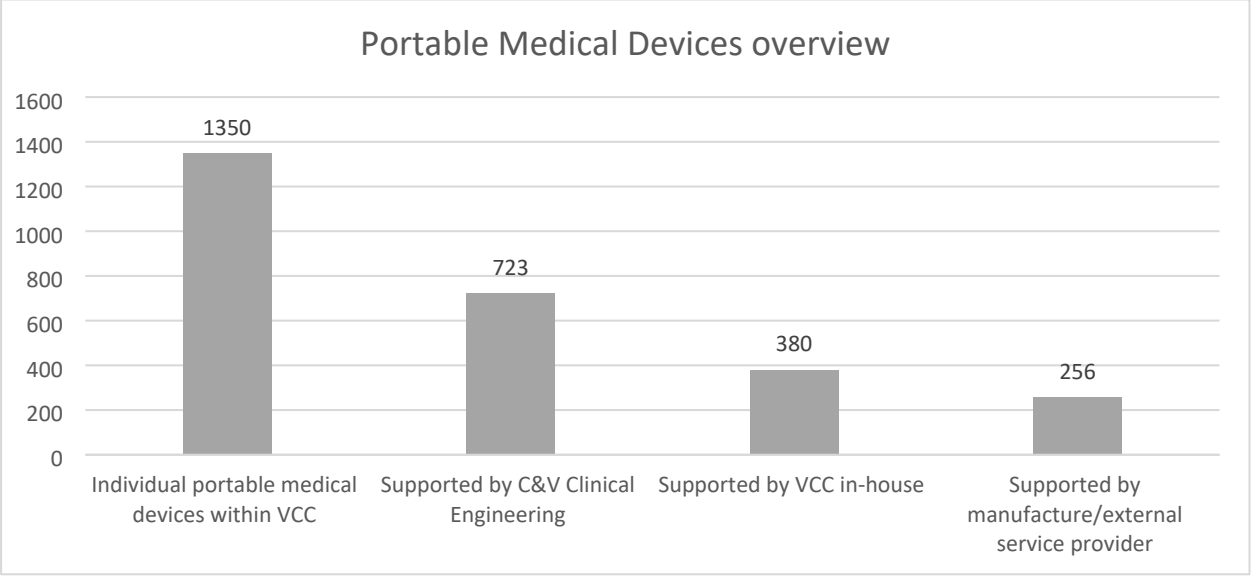
The governance route for assurance and escalation is via highlight reports to EMB and via discussions with the Chief Operating Officer. Currents issues are contained in a Master Actions Log (e.g. Medical Devices Database) with target dates and progress information, these are discussed at each MDG meeting, the only current outstanding issue is with the implementation of the equipment database management. Following a protracted set of IT issues the database became functional in June 2024, and a programme of work is in place to transfer all information for existing devices to the new database by the end of December 2024. Following this transfer, a plan will be devised to de-commission the current Access Based Database.

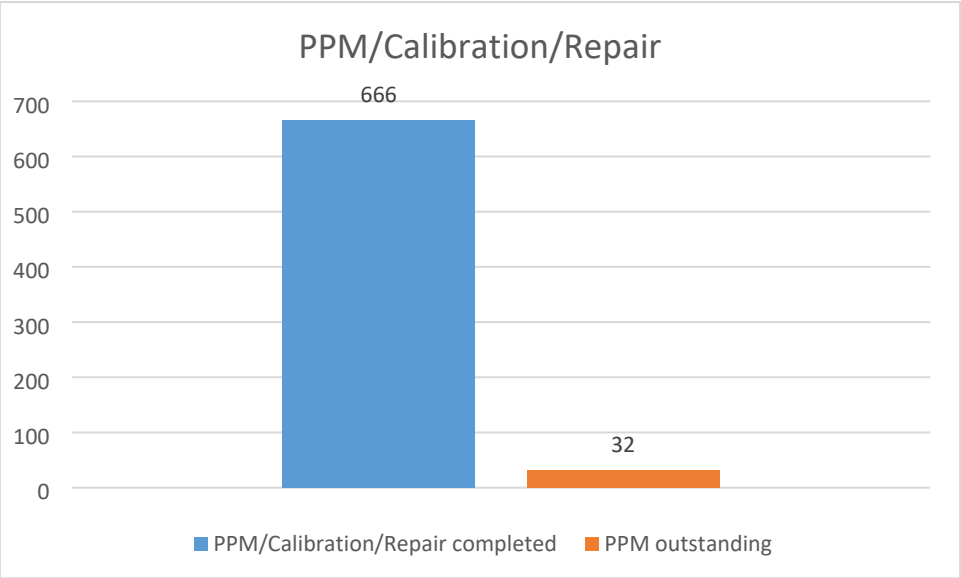
Once the database is completed, it is intended to carry out a maintenance rationalisation exercise to improve efficiency and reduce costs.

VCC update

There is a full cycle of maintenance for Medical Devices within VCC. The majority of VCC's portable powered medical equipment (including wall mounted oxygen flow meters and suction) are maintained by Cardiff and Vale University Health Board's (C&V UHB) Clinical engineering department. This is provided via a Service Level Agreement (SLA), which includes Point of Care Testing Services, for relevant Point of Care Devices. Point of Care Testing (POCT) is defined as any diagnostic test undertaken by staff other than a laboratory healthcare scientist and usually carried out near the patient.

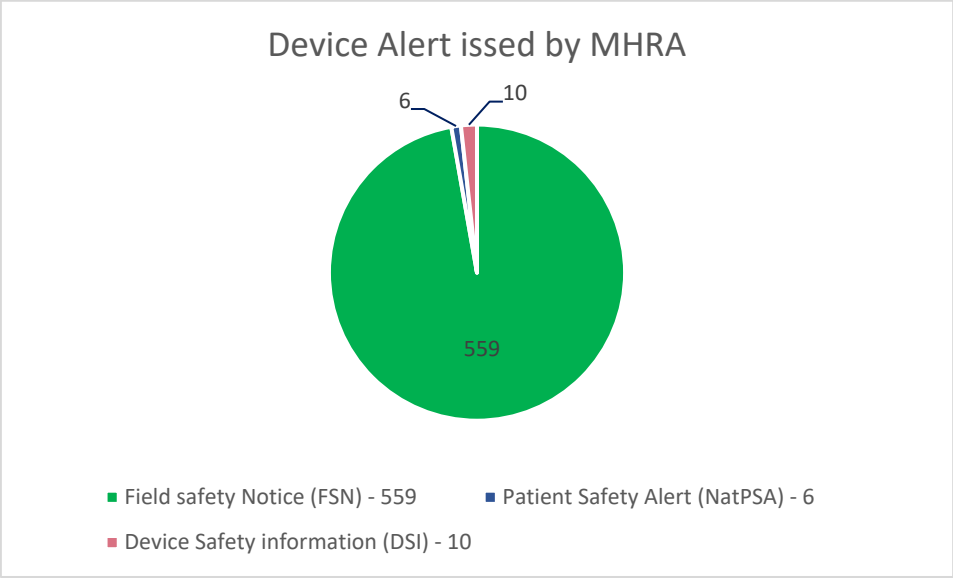
There are more than 100 different types of devices in operation in VCS, which equates to over 1350 individual portable medical devices. 723 devices are supported and maintained within an SLA with C&V UHB, 380 devices are maintained by VUNHST and 256 devices are maintained by the manufacturer or contractually with another 3rd party supplier. A rolling program of like for like device replacement has been instigated. In the period April 2023 to March 2024, 666 Planned and Preventative Maintenance actions (PPM's)/Calibrations/repairs were carried out. There are 32 PPMs outstanding, which are currently in progress and completion anticipated by the end of December 2024. Outstanding planned maintenance may occur when a device is in use at the relevant time, with maintenance ordinarily carried out within the relevant quarter.

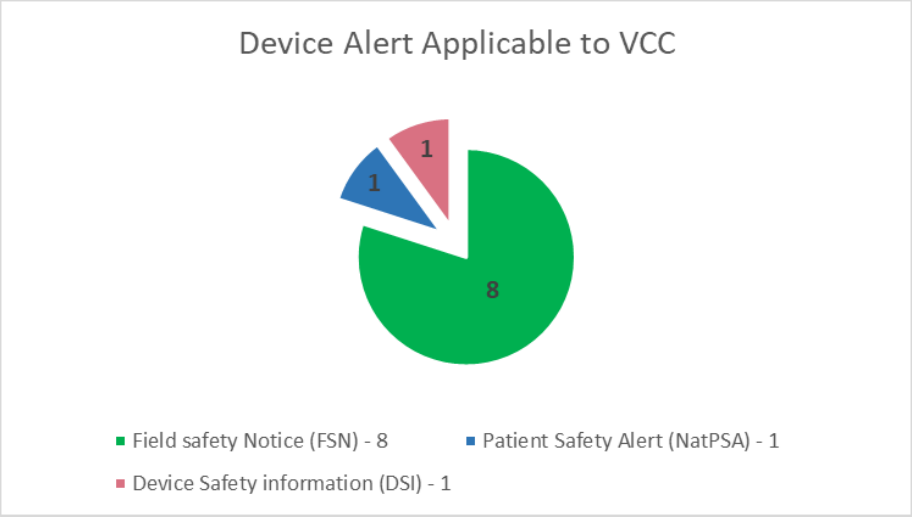




In this reporting period, there have been 559 Field Safety Notices (FSN), 6 Patient Safety Alerts (NatPSA) and 10 Device Safety Information (DSI) have been issued by MHRA. Out of these 8 FSN, 1 NatPSA and 1 DSI notices were applicable to VCC and have been dealt or being dealt within an appropriate timeframe dependant on the course of action required. The appropriate timescale for action of the Safety Alert Notice is variable. This may be specified within the Alert itself, can vary by the severity of the Alert, some may be subject to a manufacturer's system change and some require remediation work in a planned and justifiable timescale. This is the case when for example availability of manufacturer's parts or changes are required to complete the Safety Alert Notice. The timescales are monitored and reported at the Medical Devices Management Group.

There have been five Freedom of Information (FOI) requests relating to medical devices from April 2023 to March 2024, all have been dealt with in the specified timeline.



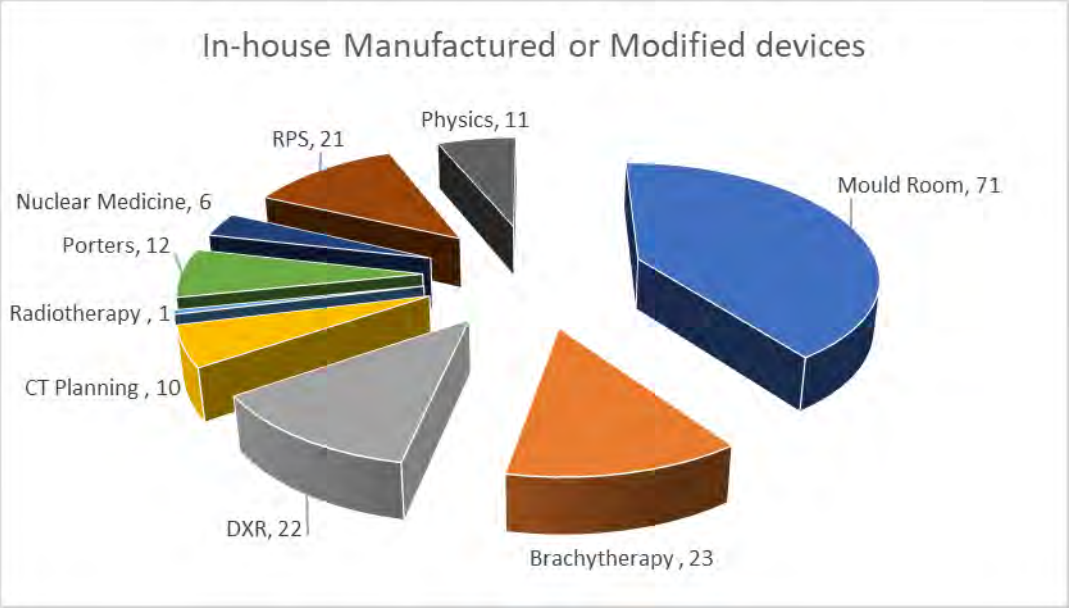


The equipment workstream of the nVCC project includes the procurement and commissioning of the medical devices for the new hospital. Work is underway to scope the detail of the work plan and the associated requirements for meeting regulatory compliance. This will also be an opportunity to develop new approaches. A significant improvement planned for the management of medical devices is to procure and commission an asset tracking system for medical devices e.g. RFID tracking for the new hospital. This will enable hospital wide visibility of all portable powered medical devices and can be useful when locating critical equipment. The new tracking system will be linked to the VCC medical devices database. This will subsequently provide additional service benefits in staff efficiency by eliminating time spent searching for devices, increasing clinical and medical productivity, and delivering prompt and effective patient care.

VCC In-house Manufacturing and Modification

There were 177 Medical and Quality Assurance Devices that were manufactured or modified in-house by VCC Engineering Workshop for internal departments.

The devices manufactured or modified are well within the competencies of the Workshop Engineers. Even if any device falls outside the definition of the Medical Devices and is used within the clinical area, as a good practice, the same level of principle is used for the manufacturing process as Manufacturing Medical Devices. As required, training courses are considered to ensure that competency is established.



WBS update

In preparation for the new UK MDR 2025, the WBS is re-reviewing its medical device classifications for in-house developed Medical Devices, Medical Device Software and Reagents to ascertain what their cost would be if purchased from the marketplace. Under the EU MDR/IVDR there is a requirement in the Health Institution Exemption (HIE) (Article 5.5) that the development of in-house Medical Devices is justified, with cost not being an adequate reason. There is an expectation that the new UK MDR may also implement the same stringent criteria.

For those Medical Devices that will need to be developed in-house there will be resource cost to ensure that the development complies with the legislation.

From the previous classification meetings, it was identified that it is unlikely that certain Reagent Kits can be purchased, and development of bespoke Medical Device Software will 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 health institutions will be required to meet many of regulatory requirements that apply to commercial manufacturers but will be exempt 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. The WBS is in the process of developing a new Management Procedure (MP-061) that will outline a Product Development Process (PDP) for the in-house development of In-vitro Diagnostic Medical Devices (IVDs) and Medical Device Software.

This PDP will aim to ensure that any 'in-house' manufacture or modified IVDs or Medical Device Software meets the relevant essential requirements of the UK Medical Devices Regulations. The procedure will also ensure that good engineering practice is employed which meets the intent of the product realisation aspects of ISO 13485 and ISO 62304.

As outlined in the Government response on medical devices *"the government intends to introduce a requirement for health institutions to **register** medical devices that have been manufactured or modified 'in-house.' The MHRA will provide further guidance on these requirements to accompany the regulatory changes."* To comply with expected legislation in these areas, training on the registration process will be required to ensure submissions meet all the regulatory expectations of a medical device technical file.

Glossary:

FSN	Field Safety Notice (FSN) is an important communication about the safety of a Medical Device that is sent to customers by a Device Manufacturer, or their representative. FSNs tell you what you need to do to reduce the specified risks of using the Medical Device.
NatPSA	National Patient Safety Alerts (NatPSAs) are official notices giving instructions to NHS bodies on how to prevent risks which might cause serious harm or death. NatPSAs are only issued for safety-critical reasons that will impact on patient safety, with strict criteria.
DSI	Device Safety Information (DSI), a type of guidance on Medical Device safety. It is usually intended for healthcare professionals but may also be relevant to patients.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST MEDICAL EDUCATION ANNUAL REPORT

DATE OF MEETING	14/11/2024

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	Dr Louise Hanna, AMD Medical Education Elizabeth Eddie, Executive Medical Business Manager
PRESENTED BY	Dr Louise Hanna, AMD Medical Education
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The purpose of the report is to provide oversight of the Medical Education programmes and activities over the past academic year. This is the third annual report for medical education governance for VUNHST and details the activities and performance for the reporting period August 2023 to August 2024 for both WBS and VCC.

	Key deliverables/messages: • Increased 38 'Above Outlier' (positive) scores in the GMC National Training Survey (NTS), This is an increase from 7 'Above Outlier' scores in 2023. This has resulted in the closure of one risk, and reduction of one risk on the HEIW risk register'. • Time for training remains an issue due to heavy clinical workloads and service pressures. • A VUNHST strategy for undergraduate and postgraduate Medical Education is currently being developed. An underpinning workplan will then be agreed to ensure delivery.

RECOMMENDATION / ACTIONS	The QS&P Committee is asked to note the contents of the Medical Education Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Medical Education Team	23/10/2024
EMB RUN	29/10/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been prepared by members of the Medical Education Board and has been reviewed within the core Medical Education Team.	

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	HEIW Faculty Team Appraisal 2024 – full report
2	Results of GMC NTS 2024
3	Annual Teaching Review (Undergraduate) Report 2024

1. BACKGROUND

In 2015, the General Medical Council published Promoting excellence: standards for medical education and training. In response, the VUNHST Medical Education Governance Framework was developed, which outlines the requirement of an annual report to be submitted to the Executive Management Board and the Quality, Safety & Performance Committee, to include:

- Results of commissioner reviews/visits, with particular focus on areas of exception
- Results of the GMC National Training Surveys (Trainers and Doctors in Training)
- Any items relating to VUNHST that appear on the Health Education and Improvement Wales (HEIW) Risk Register
- Any other points considered important to highlight

2. ASSESSMENT

2023/24 saw a number of notable successes within Medical Education, including (but not limited to) the following:

- Continuing to deliver wide-ranging, high-quality medical education activities and initiatives, despite increasing clinical workloads and service pressures.
- Achieving 38 'Above Outlier' scores in the GMC National Training Survey (NTS) 2024. This is an increase from 7 'Above Outlier' scores in 2023.
- Closure of HEIW risk TP618 – Medical Oncology and Clinical Oncology Velindre Cancer Centre, following the results of the GMC NTS 2024.
- Reduced HEIW risk TP565 – Medical Oncology (Trainer), Velindre Cancer Centre.

Challenges include:

- Time for training, due to heavy clinical workloads and service pressures.
- Vulnerability in the resilience of the administrative support available as it relies heavily on a single individual.
- Lack of a Medical Education Manager to provide oversight and assurance.
- HEIW risk TP565 – Medical Oncology Trainer – remains on HEIW risk register despite nil below average in recent GMC survey.
- HEIW risk TP617 – Clinical Oncology specialty – below outlier for local teaching and lower quartiles for feedback and study leave.

Key actions to address the challenges are outlined in the Medical Educational Annual Report 2023/24. They include the work currently underway on developing a strategic plan for Medical Education, with SMART objectives to be tracked, and a review of the administrative support structure to bolster resilience and effectiveness.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Overall, 2023/24 was a successful year for medical education at VUNST. Both undergraduate and postgraduate programs have continued to be delivered effectively, providing high-quality clinical training and support to our students and trainees.

In order to address the challenges that remain, particularly around time for training due to high clinical workloads and service pressures, and the need to secure a more resilient administration support structure, a piece of work is being undertaken by the Medical Education and Finance teams to understand the resource required to fulfil our commissioning obligations both in the undergraduate and postgraduate settings. This activity and requirement will be costed and shared for discussion and further action.

There is a continued commitment within the medical education function to improve and maintain our reputation for excellence in medical education and the strategic workplan will facilitate this.

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 ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

YES - Select Relevant Goals below

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐
- A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐
- 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. ☐
- Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐

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

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	

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Trust Medical Education Annual Report (Postgraduate & Undergraduate) 2023/2024

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Appendix 2 – Results of GMC NTS 2024 ..... **Error! Bookmark not defined.**

Appendix 3 – Annual Teaching Review (Undergraduate) report **Error! Bookmark not defined.**

1. Purpose

This paper provides an annual report on Medical Education activities at Velindre University NHS Trust over the past academic year. These encompass postgraduate medical education, undergraduate medical education (student placements within the Trust), and a small number of (student) placements for physician associate students.

The report highlights key achievements, challenges, and developments, as well as future priorities aimed at enhancing the quality of medical education at the Trust. We continue to align our activities with the General Medical Council (GMC) standards and focus on delivering high-quality education that equips students, trainees, locally-employed doctors and physician associates with the skills required to deliver high-quality, safe, and effective care.

2. Background

In 2015, the General Medical Council published Promoting excellence: standards for medical education and training. The standards came into effect on 1 January 2016 and are grouped within 5 themes:

1. Learning environment and culture
2. Educational governance and leadership
3. Supporting learners
4. Supporting educators
5. Developing and implementing curricula and assessments

In response, the VUNHST Medical Education Governance Framework was developed, which outlines the requirement of an annual report to be submitted to the Executive Management Board and the Quality, Safety & Performance Committee, to include:

- Results of commissioner reviews/visits, with particular focus on areas of exception
- Results of the GMC National Training Surveys (Trainers and Doctors in Training)
- Any items relating to VUNHST that appear on the Health Education and Improvement Wales (HEIW) Risk Register
- Any other points considered important to highlight

3. Administration and Governance arrangements

3.1 Key roles within the Medical Education function include the AMD – Medical Education & Training, Postgraduate Leads, College Tutors, Faculty Lead, Named Educational Supervisors, and Oncology Project Lead.

3.2 The Medical Education function sits between the VCS Medical Services directorate and the VUNHST Corporate Medical Business Service, supported by 1WTE Medical Education Co-ordinator who reports to the Executive Medical Business Manager.

3.3 There is currently no Medical Education Manager post in place at VUNHST. This is anomalous to most NHS Trusts and all NHS Wales Health Boards. The role of a Medical Education Manager is widely considered to be vital for quality assurance, improvement, governance ,and service delivery within medical education departments/functions.

3.4 Teaching and training is delivered in a hybrid model of virtual (MS Teams) and face-to-face sessions.

3.5 The AMD – Medical Education & Training, supported by the other key medical education roles, monitors issues arising from local processes and intelligence, as well as the GMC and HEIW training surveys, and undergraduate survey feedback. They work together with Trust teams and with HEIW, Training Programme Directors, University partners, and local tutors to manage concerns and issues as they arise.

3.6 A quarterly Medical Education Board is chaired by the College Tutor & Faculty Lead, although, because of reduced administrative capacity due to extended absence, this group has not met formally since September 2023. Informal meetings between key members of the medical education function are held frequently, however, and medical education issues have been discussed at the Medical Workforce Group, which meets quarterly. The Medical Education Board will resume its quarterly cycle in January 2025.

3.7 The results from the GMC National Training Survey (NTS) of doctors in training and trainers are reviewed by the Trust and HEIW and any risks are recorded on the HEIW NTS risk register, which is reviewed periodically throughout the academic year. See Section 5 for more details.

3.8 The Trust is visited by its medical education commissioners, as follows:

- HEIW
  - Annual Faculty Team Appraisal
  - Annual Education and Training Commissioning and Quality meeting
  - GMC NTS Survey results – Risk Management Review meeting
- Cardiff University
  - Annual Teaching Review meeting

4. Postgraduate medical education

Overview

4.1 Postgraduate medical education is commissioned by Health Education and Improvement Wales (HEIW), which was formed in 2018 by amalgamating the Wales Deanery, NHS Wales's Workforce Education and Development Services (WEDS) and the Wales Centre for Pharmacy Professional Education (WCPPE).

4.2 The Trust hosts doctors in training on formal HEIW training numbers on their rotational placements, although these doctors are employed by the Single Lead Employer, i.e. NHS Wales Shared Services Partnership.

4.3 There are two main doctors in training cohorts at VUNHST, which can broadly be described as follows:

- 'Registrar' level
  - Specialty Trainees (ST3+) with HEIW Training number – SLE employees
  - Specialty Doctors – locally-employed by the Trust to support outpatient activity
- 'SHO' level
  - Foundation, Core/IMT/GP Trainees with HEIW Training number – SLE employees
  - SHOs/Clinical Fellows – locally-employed by the Trust to support inpatient activity

HEIW Commissioned Training Programmes

4.4 Trainees on the following formal training programmes rotated through VUNHST as part of their training between 1 Aug 2023 – 31 Jul 2024:

Specialty	Programme Grade	No. Trainee	Rotation duration	Site
Clinical Oncology	Specialty Trainee	36	3-12 months	VCC
	Internal Medicine Trainee	16	3 months	
	GP Specialty Trainee	5	6 months	VCC
Medical Oncology	Specialty Trainee	10	3-12 months	VCC
	Foundation Y2	6	4 months	VCC
Clinical Radiology	Specialty Trainee	2	3-12 months	VCC
Palliative Medicine	Specialty Trainee	12	3-12 months	VCC (1), Marie Curie Hospice (11)
	Foundation Y2	3	4 months	Marie Curie Hospice
	Internal Medicine Trainee	6	3 months	Marie Curie Hospice
	GP Specialty Trainee	2	6 months	City Hospice
	TOTAL:	**98**		

Locally-Employed 'SHO Level' Doctors

4.5 The following doctors were in post between 1 Aug 2023 – 31 Jul 2024:

Specialty	Grade	No. Doctors	Post Duration	Site
Clinical Oncology	Clinical Fellow	10	5-12 months	VCC
	Clinical Research Fellow	4	12 months	VCC
Clinical Radiology	Clinical Research Fellow	1	2 months	VCC
Palliative Medicine	Clinical Fellow	1	7 months	Marie Curie Hospice
	Clinical Research Fellow	2	8-26 months	VCC
	TOTAL:	**18**		

Induction

4.6 All doctors in training (both formal trainees, and locally-employed doctors) receive a comprehensive induction, the content of which is regularly reviewed to ensure it meets the recommendations set out in the *HEIW Departmental Induction – Best Practice guide*. They are also provided with the following:

- The *Velindre Junior Doctor Handbook*
- Access to the 'Doctors in Training' share-drive containing teaching and training resources and recordings.
- The 'SHO' level doctors are also provided with *A Practical Guide to being an SHO at Velindre*.

Teaching

4.7 The weekly 'SHO teaching' programme was well attended in 2023/24 and received positive feedback. The sessions are delivered within 'protected time' with the Registrars covering the ward bleep to promote attendance. Where possible, sessions are recorded for those unable to attend or who want to revisit content.

4.8 The Specialty Trainee teaching programme was reinstated in early 2024 with each session driven by and SST team, with the last . Consultants are aware to release Specialty Trainees on teaching days.

Supervision

4.9 All doctors in training (both formal trainees, and locally-employed doctors) have an Educational Supervisor to support them with their progress through their programme curriculum and Personal Development Plan (PDP) activities.

4.10 All doctors in training (both formal trainees, and locally-employed doctors) conduct their duties under the clinical supervision of their senior medical colleagues.

Welsh Blood Service (VCS)

4.11 The Welsh Blood Service undertakes an extensive programme of training throughout Wales. This includes teaching specialty registrars, nurses, clinical scientists, and medical students. All the consultants are involved in teaching and two consultants are RCPath examiners. The medics together with nurses are responsible for cascading learning to WBS staff, including on adverse events management.

4.12 WBS has been hosting a national Clinical Leadership Fellow since August 2024.

HEIW Faculty Team Appraisal – 14 May 2024

4.13 Faculty Team Appraisal is a key component of HEIW activity to ensure standards for training are upheld by Local Education Providers (i.e. VUNHST), particularly standards reflecting the characteristics of a 'good learning environment and culture' which is underpinned in Local Education Providers by Faculty Teams and structures. It aims to support Faculty Teams' development and provide opportunities for identifying good practice for sharing across Teams.

4.14 The HEIW Faculty Team Appraisers noted the following:

- That the VUNHST Faculty team were *"very engaged and proactive in providing comprehensive management of education and training, as well as support for trainees".*
- That issues with trainer capacity are *"linked to the issue of 'time for training' as it is not uncommon for DCC activity to encroach on SPA time"* but that the VUNHST Faculty team had *"reported positive ways in which the Trust is considering ways of making clinical service delivery more efficient, for example, decoupling bloods from chemotherapy clinics and upskilling staff in decision-making".*
- That *"Trainees receive good learning opportunities and experience including access to clinics and wider activity as well as excellent library support."*

4.15 The summary of collective actions agreed is as follows:

- Capturing all the current education and training activity and initiatives to inform a future piece of work on demand and capacity.
- Seeking funding for a post with responsibility for oversight and governance of education and training activity.
- Engaging with the development of the new Velindre Cancer Centre to ensure that appropriate infrastructure and planning for education and training support, management and delivery are incorporated.
- Engaging with external partners including University Hospital of Wales (UHW) to maximise opportunities for learning from other specialists, to underpin development of multiprofessional learning e.g. establishing a reciprocal arrangement for participation in in Grand Rounds.

4.16 The full HEIW Faculty Team Appraisal 2024 report is available at Appendix 1.

HEIW Education and Training Commissioning and Quality meeting – 17 June 2024

4.17 The annual Education and Training Commissioning and Quality meetings between the Trust and HEIW are intended to provide an opportunity for a two-way conversation about the planning, management, delivery and support of education and training across the organisation as a Local Education Provider (LEP).

4.18 These meetings help HEIW understand the strategic direction for service delivery in our organisation and represent an important mechanism for HEIW to ensure good educational governance across the system, support delivery of high-quality training and inform future workforce planning and trainee and learner allocation.

4.19 Although historically these meetings were focused only on medical training, in recent years HEIW has widened the scope of these meetings to ensure a multi-professional focus. This is in keeping with the national trend of an increasing emphasis on multidisciplinary and multi-professional teaching and training.

4.20 The agenda of the meeting covered the following:

- Overview of the Expectations Agreement
- Overview of HEIW and VUNHST strategic priorities
- Learning environments
- Exception report (following the 2023 GMC NTS results)
- Future considerations

4.21 The HEIW team noted the following in the Exception Report (following the 2023 GMC NTS results):

- That *"Palliative Medicine at Velindre Hospital received particularly positive feedback in the 2023 GMC National Training Survey with seven above outliers reported, (Overall Satisfaction, Reporting Systems, Handover, Supportive Environment, Induction, Local Teaching and Rota Design)."*
- That *"the Trust does not have any issues in Enhanced Monitoring status with the GMC and no high-risk training concerns have been identified."*

4.22 The full HEIW Education and Training Commissioning and Quality Meeting Report 2023/34 (which is prepared by HEIW), has not yet been made available.

5. GMC National Training Survey (NTS) 2024 results

Background and summary results

5.1 The GMC NTS services as a critical tool for assessing the quality of postgraduate medical education and training across the UK. Conducted annually by the GMC, the survey collects feedback from doctors in training, and their trainers, to evaluate the educational environment, identify areas for improvement, and ensure training standards are being met.

5.2 The NTS helps the GMC to monitor compliance with its standards for medical education, highlighting both positive aspects and any concerns regarding the support, supervision, workload, and learning opportunities available to trainees.

5.3 The survey results provide valuable data that can be used by organisations to improve the quality of medical training. It enables comparison between training programmes and specialties, helping to drive improvements where needed. The feedback from the NTS also contributes to ensuring that doctors receive the education and support they need to progress safely and effectively in their careers.

5.4 The GMC survey considers 'Velindre NHS Trust' to have two training locations – 'Velindre Hospital' and 'Holme Tower Marie Curie Hospice'. Although these are separate organisations, there are strong links between the Velindre Cancer Service and the Cardiff Hospices and the training teams meet regularly.

5.5 The Trust's 2024 GMC NTS results can be summarised as follows:

- Very good results for:
  - Palliative Medicine (trainers and trainees)
  - Holme Tower (trainees)
  - IMT trainees (VCS)
  - F2 trainees (VCS)
  - Workload, teamwork, and handover (VCS trainees)
  - Many other areas
- No longer below outlier status for:
  - VCS Clinical Oncology induction (all training grades)
  - VCS regional teaching
  - IMT local and regional teaching
  - Workload (Clinical Oncology Specialty Trainees)
  - Support for training (VCS trainers)
- Areas for development
  - Time for training – Holme Tower
  - Local teaching – Velindre Cancer Centre – all trainees. All trainees working within clinical oncology (StR, IMT, GP, F2 combined) Velindre Cancer Centre, clinical oncology registrars and IMT. (No data on GP)
  - Feedback – all trainees working within clinical oncology (StR, IMT, GP, F2) clinical oncology registrars
  - Regional teaching – medical oncology registrars
  - Study leave – all trainees working within clinical oncology (StR, IMT, GP, F2 combined)
  - GP training – multiple below outlier in 2023 but insufficient results in 2024

5.6 A more detailed presentation of the Trust's 2024 GMC NTS results, collated by the AMD – Medical Education & Training, is available at Appendix 2.

5.7 The full detail of the 2024 NTS responses can be explored using the online tool: National training surveys - GMC (gmc-uk.org). This gives access to data about individual trusts and placements and can be searched in different ways, e.g., by site, speciality, and programme.

HEIW Risk Management Review

5.8 Each year following the results of the GMC NTS, HEIW reviews the risks for each Trust/Health Board and updates their risk register accordingly. A review meeting is held between VUNHST and HEIW (usually in November) to review these risks and mitigations/actions.

5.9 Following the 2023 NTS, there were 4 risks on the HEIW risk register for VUNHST:

- TP565 – Medical Oncology (Trainer) – risk rating 6
- TP618 – Medical Oncology & Clinical Oncology (VCS) – risk rating 4
- TP617 – Clinical Oncology Specialty Training (VCS) – risk rating 4

5.10 Following the 2024 NTS:

- Risk TP565 has reduced from a risk rating of 6 to 4
- Risk TP618 has been removed
- There are no new risks

5.11 The next risk review meeting with HEIW is scheduled for 18 November 2024.

6. Undergraduate Medical Education

Background and summary of activities

6.1 Velindre University NHS Trust provides undergraduate training and education by agreement with the Cardiff University Medical School and Swansea University Medical School.

6.2 Teaching and training activities include the following:

- Oncology Project
- Student Selected Components (SSC)
- Palliative Medicine teaching
- Year 3 Bookend tutorials
- Senior Student Assistantship (SSA)
- Physician Associate elective placements (Swansea)

Annual Teaching Review (Cardiff University)

6.3 The next Annual Teaching Review meeting with Cardiff University is scheduled for 4 November 2024.

6.4 Ahead of the meeting, VUNHST has submitted preparatory report to Cardiff University, which provides a detailed overview of the undergraduate medical education activities and developments over the academic year 2023/24. This report is available at Appendix 3.

7. Library

7.1 The Trust's Library Service serves all members of the Trust at all sites. This includes the Welsh Blood Service, Trust HQ and the Velindre Cancer Centre which is where the library is physically based. The service is funded by the Trust but managed by, and a full member of, Cardiff University Library Services via an SLA.

7.2 A summary of library service activities and issues has been provided as follows:

- Positives
  - 1:50 plans for the library facilities in the new Velindre Cancer Centre have been agreed and represent a definite improvement on our current facilities and include a silent reading room meaning we can support our educational provision going forwards.
  - A 3-year contract for UpToDate has been confirmed – this is a vital resource for clinical staff, particularly doctors in training.
- Challenges
  - Changes to the library management structures and funding model within the Trust has been put on hold until the admin process for the new VCC have been clarified.
  - The library staff Cardiff University NHS team leader (overseeing both Velindre and C&V Library services) retired in September 2024 so there will be a period of establishing new relationships.
- Actions
  - To take part in the NHS Wales Library & Knowledge Services Quality and Improvement Framework (QIO) project. This is a national project led by HEIW's Dean's Library Advisor.
  - To investigate and engage with generative AI in specific relation to developments in education and the areas of information skills and knowledge management.

8. Other education and training activities

8.1 A summary of some of other education and training and training activities the Trust delivers, is listed below:

- Annual Intensive FRCR 2B revision Course. Oral presentation at ESTRO 2024; winner of VUNHST Employee Excellence Award (Education Category 2024)
- Sixth Form work experience
- Taster weeks – undergrad/postgrad
- ANP education, development, and supervision
- Primary Care oncology teaching and study days
- Grand Round
- New Consultant Development Programme
- Senior Medical Leaders Development Programme (with FMLM)

- Numerous examples of multi-professional training – supervision of non-medical outliners (NMO) in radiotherapy; non-medical prescribers (NMP), expert practice modules, paramedics.
- Other professional groups have role in training medics – e.g. paracentesis, radiotherapy planning.
- Educational sessions at the Senior Medical Staffing Committee (SMSC)

9. Successes and challenges

9.1 2023/24 saw a number of notable successes within Medical Education, including (but not limited to) the following:

- Continuing to deliver wide-ranging, high-quality medical education activities and initiatives, despite increasing clinical workloads and service pressures.
- Achieving 38 'Above Outlier' scores in the GMC National Training Survey (NTS) 2024. This is an increase from 7 'Above Outlier' scores in 2023.
- Closure of HEIW risk TP618 – Medical Oncology and Clinical Oncology Velindre Cancer Centre, following the results of the GMC NTS 2024.
- Reduced HEIW risk TP565 – Medical Oncology (Trainer), Velindre Cancer Centre.

9.2 Challenges include:

- Time for training, due to heave clinical workloads and service pressures.
- Vulnerability in the resilience of the administrative support available as it relies heavily on a single individual.
- Lack of a Medical Education Manager to provide oversight and assurance
- HEIW risk TP565 – Medical Oncology Trainer – remains on HEIW risk register despite nil below average in recent GMC survey.
- HEIW risk TP617 – Clinical Oncology specialty – below outlier for local teaching and lower quartiles for feedback and study leave.

10. Actions for 2024/25

The following actions (not exhaustive) have been agreed for 2024/25:

- Finalise a strategic plan for postgraduate and undergraduate Medical Education
- Agree a work plan to deliver the Medical Education strategy
- Adopt the AMAT tool for recording and reviewing all actions relating to Medical Education
- Continue the implementation of the e-Job Planning system to provide oversight of all Medical Education delivery by Consultant and SAS doctors
- Review the administrative support structure to bolster resilience and decrease reliance on sole individuals
- Development of a dedicated SharePoint space for all Medical Education teaching and education materials, including session recordings and the full calendar of teaching and training

- Review Y3 Bookend tutorial content
- Continue to strengthen links between medical education function and Velindre Oncology Academy
- Develop plans for future education delivery through the Collaborative Centre for Learning, Research, and Innovation (opening 2027), including internal and external engagement
- Finalise the Physician Associate SOP/Governance Framework
- Explore funding options for mandatory teaching

11. Contributors

11.1 Contributions to this report have been gratefully received from members of the Velindre Medical Education Board and others involved in medical and multi-professional education across the Trust.

12. Conclusion

12.1 Overall, 2023/24 was a successful year for medical education at VUNST. Both undergraduate and postgraduate programs have continued to be delivered effectively, providing high-quality clinical training and support to our students and trainees.

12.2 While challenges remain, particularly around capacity and workload, time for training, and the need to secure a more resilient administration support structure, there is a commitment within the medical education function to improve and maintain our reputation for excellence in medical education.

Ref: FTA/24/V

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Faculty Team Appraisal 2024

Velindre University NHS Trust (14th May 2024)

Attended by:
Health Education and Improvement Wales (HEIW)
Jane Gwilliam, Associate Dean (Postgraduate Education Support and Improvement)
Tom Yapp, Foundation School Director
Glyn Cardew-Richardson, Postgraduate Education Support and Development Officer
Caroline Groves, Lead for Quality Unit and Quality and Postgraduate Education Support Manager
Kaye Walters, Postgraduate Education Support and Development Manager
Jonathan Gamble, Co-Chair of Trainee Think Tank/Trainee Representative
Meg Gorman, NHS Libraries Partnerships Leader & Dean's Library Adviser

Velindre University NHS Trust
Louise Hanna – Associate Medical Director (Education and Training)
Ricky Frazer – Faculty Lead (Quality, Trainers and Trainees)
Nikki Pease – SAS Advocate
Audrey Yong – Radiology Training Lead and TPD
Margred Capel – Palliative Medicine TPD (shared role with Dr Anthony Williams, Swansea)
Bernadette Coles, NHS Wales Library and Knowledge Service Librarian
Elizabeth Eddie – Executive Medical Business Manager
Nicola Hughes- Head of Medical Services
Kate Belbin – Medical Education Coordinator

Faculty Team Appraisal

Background
Faculty Team Appraisal is a key component of HEIW activity to ensure standards for training are upheld by Local Education Providers, particularly standards reflecting the characteristics of a 'good learning environment and culture' which is underpinned in Local Education Providers by Faculty Teams and structures. It is therefore pivotal to the delivery of HEIW's Multiprofessional Quality Framework, having implications for educational governance and all Framework components. It also aims to support Faculty Teams' development and provide opportunities for identifying good practice for sharing across Teams.

Team Appraisals also consider Faculty Team effectiveness in line with a Donabedian conceptual model as a framework for evaluating team effectiveness in context, with a focus on how Teams plan for the essential elements constituting quality, that is structure, process, and outcome (Donabedian, 1988).

Context
This year, activity in advance of the Team Appraisal aimed to provide opportunity for the Faculty Team to collectively reflect and set their direction in relation to planning to deliver the Team's remit to support healthcare education and training. HEIW is therefore grateful to the Velindre Faculty team for the extremely comprehensive work undertaken in preparation for the appraisal and for the open and inclusive appraisal discussion.

1. Faculty Team Structures

Team Structures
There have been changes to composition of the Faculty team in the past year – both changes to existing team members' roles and the introduction of new team members. The Assistant Medical Director for Education and Training has taken up a role in the Royal College of Radiologists (RCR) as its Medical Director for Education and Training, Clinical Oncology. However, the team does not anticipate any changes to the Faculty team structure which has been in since establishment of the Faculty team as subgroup of the Trust's Medical Education Board.

The high concentration of secondary care trainers in the Trust is also beneficial to the work of the Faculty team.

Planning for the Future
The team is undertaking a significant amount of planning in preparation for the new Velindre Cancer Centre, which will support the co-location of space and resources for education and training. For example, the team is seeking support in plans for breakout rooms that will enable one-to-one meetings with trainees, small group learning or 'role-play' communication skills training following larger group teaching.

The team is keen for plans to recognise that space for training at the new Cancer Centre location requires more than just clinical environments and demands appropriate spaces for innovative educational activities and discussion.

The Trust's hosting of a Foundation Year 2 (F2) trainee cohort represents a new development. The development of opportunities for their attendance at a weekly clinic is a simple yet innovative change that has been valuable in providing early exposure to clinic activity.

The team has adopted a more strategic approach to education and training oversight since the introduction of Foundation training to the Trust, for example in relation to the identification of time for training. This cohesiveness has been enabled by the work of the Medical Business Manager and Medical Education Co-ordinator who, for example, have been developing mechanisms for oversight of Consultant job planning including the procurement of an e-job planning system, which it is anticipated will be accompanied by supporting documentation and processes including a 'tariff' and overarching descriptors for different roles for implementation in job planning.

The introduction of the Velindre Oncology Academy which will support existing activity is a further example of building system resilience to support delivery of high-quality multi professional education, training and professional development.

2. Faculty Team Processes

Organisation of Work
The Faculty team is very engaged and proactive in providing comprehensive management of education and training, as well as support for trainees.

Although the team can struggle to meet as a group due to heavy workloads there is regular informal communication among members (and many work very closely together in the clinical context). The Faculty Leads conduct monthly 'touch points' to ensure alignment and meet virtually. Medical Education Board meeting are also considered by the team to provide useful regular opportunities to come together.

The team operates an 'open door' policy for trainees to discuss any concerns or raise issues relating to training. The co-location of registrars facilitates this and although IMT, GP Registrar and Foundation doctors are based further away they actively participate in induction and other training-related discussion.

All doctors in training attend morning meetings with multidisciplinary colleagues which provides extremely valuable opportunities to be part of conversations around education and training. Additionally there is a trainee representative on the Consultants' Committee and the Joint Local Negotiating Committee (JLNC), doctors in training have own committee and there is direct access to Training Programme Directors to raise any issues relating to training.

3. Faculty Team Outcomes

Progress against Previous Objectives
The Faculty Team agreed the following objectives to work towards at their 2023 appraisal (held 2023):

1. Time for training: The Medical Business Team was planning to engage with the Trust's Clinical Director and the newly appointed Executive Medical Business Manager to improve the issue of appropriate time for training being built into trainers' job plans and ensuring that individuals were actually able to use this time.

2. Develop understanding of the training workload across the Trust: The Faculty Team were to continue to have ongoing discussions with the newly appointed Executive Medical Business Manager to develop the Executive Board's understanding of the increasing training activity taking place across the Trust and to highlight the need for additional resources, in particular the appointment of a Medical Education Manager, in order to

continue to develop training opportunities and to coordinate training activity across the Trust.

Objectives 1. and 2. are linked and were therefore considered together in appraisal discussion. The team has secured agreement in principle from the Executive Board to the procurement of an e-job planning system as well as the 'tariff' allocation for delivery of specific roles to inform Consultant job planning. It was reported that the Executive Board recognises the need for change in this area, is supportive, and is planning accordingly for the 'hidden' DCC and SPA commitments it is anticipated the work will identify.

3. Stabilisation of rotas: The Trust had worked hard to appoint Clinical Fellows and Specialty Doctors to help stabilise rotas and more funding for some of these roles was secured from August 2023. The Trust was keen to consider how its FY2 and PA offering could be developed in order to enable trainees to undertake additional training and be released to attend teaching sessions, etc.

The team suggested issues with trainer capacity are linked to the issue of 'time for training' as it is not uncommon for DCC activity (particularly email handling) to encroach on SPA time. Although outside the remit of the Faculty team, they reported positive ways in which the Trust is considering ways of making clinical service delivery more efficient, for example, decoupling bloods from chemotherapy clinics and upskilling staff in decision-making. However, the team recognises its role in contributing to such activity to ensure that training can be accommodated in the development of any new care models.

4. Training in Blood Transfusion: The Medical Director for the Welsh Blood Service was to work with the AMD (Education and Training) at Velindre NHS Trust to put together a business case for the potential introduction of a transfusion training post into the haematology rotation in Wales.

This objective was not covered in appraisal discussion.

5. Development of Radiology Training Posts: There is a single funded post for subspecialty ST4/5 training that has been well utilised in the past but is now challenging to fill due to the lack of out of hours on call; Velindre has been reliant on other Trusts providing the on-call element but this is no longer possible due to the rapid expansion in Radiology training numbers. The Trust is keen to work with the South Wales Radiology Training Scheme to consider the potential for hybrid radiology training with another Trust and this will be easier to establish with the new PACS/RIS programme.

This objective was not covered in appraisal discussion.

Achievements in the Past Year

The Faculty team considers its recruitment of Clinical Fellows to be incredibly valuable to the Trust, particularly in making rotas more resilient and adding value as the workforce of the future. Many are individuals who have past experience in Velindre NHS Trust or who welcome the excellent opportunity the Trust provides to experience training and working in Oncology and Palliative Medicine.

The Trust upholds a principle of Fellows receiving the same opportunities and teaching as trainees so that they feel valued by the organisation, and weekly protected teaching time with release from the wards has been reinstated. Wider support for the Fellows is also very comprehensive with opportunities early in their appointments to explore individual development needs and provision of networks to support them in areas including leadership and teaching.

It is evident from the amount of training activity undertaken by a small hospital and Faculty team, that there is a shared enthusiasm for medical education and emphasis on developing individuals to be the trainers and educational leaders of the future. For many, training in Velindre is the first opportunity to experience Oncology and Palliative Care delivery and placements in the organisation are relatively short, so the proportion of trainees who remain in the Trust to train and work is testimony to the level of support provided. Trainees receive good learning opportunities and experience including access to clinics and wider activity as well as excellent library support. The team cited examples of particularly good opportunities afforded to students and trainees –

- Opportunities are provided across the education continuum from work experience schemes through to Foundation, General Practice and Secondary Care postgraduate medical training programmes.
- The undergraduate Oncology Project provides a good introduction to activity, with excellent support provided by the Trust's Audit Department.
- There are multiple ways in which training at Velindre Hospital is showcased at a national level including its high exam success rate, multiple staff with national roles and recently Cardiff's Fellowship of the Royal College of Radiologists (FRCR) course was presented at a European Society of Radiology Conference.

- Lots of multiprofessional training is delivered by the Welsh Blood Service on an all-Wales basis and there is a regular teaching session for Specialist Registrars. There has been local discussion regarding the potential for the Service to host a trainee.

The team highlighted the following as areas of good practice for sharing with other Faculty teams and that represent potential case studies for consideration in future Faculty team development activity:

- Investment in a supportive learning environment and the opportunities that make trainees want to come back to the Trust and work in Oncology and Palliative Medicine including robust rotas, opportunities for publication etc., as well as access to personalised support and development opportunities. The Trust is particularly proud of outcomes including increases in numbers of quality improvement projects and publications and upskilling of professional groups, for example Advanced Nursing Practitioners trained as independent prescribers. This is attributed to the dedication and commitment of Faculty team members which helps individuals feel valued and grow in confidence.

Challenges in the Past Year

The Wales Radiology training programme is strong but Velindre Hospital is limited in the opportunities it can offer in the specialty as it does not have on-call provision to accommodate the needs of senior trainees. Consideration is being given to 'quasi' on-call delivery, but this is in very early planning stages. Additionally, there is no unified reporting system across South Wales; reporting licences are linked to each Health Board. The Training Programme Director anticipates that from 2026 licences should be linked to the individual rather than an organisation which could increase the number of trainees coming to Velindre to train.

Areas for Development

Educational Development Time (EDT) is incorporated into weekly timetables in Oncology. Trainees' supervisors are aware of its importance and trainees welcome the model, although the team acknowledged that service pressures can present a challenge in accessing EDT but this is monitored. EDT is a current focus of HEIW's Trainee Think Tank which is seeking to empower trainees to work with LEPs on its implementation.

ACTION HEIW's Associate Dean for Postgraduate Education Support and Improvement will explore with the Deputy Director of Secondary Care and Director of Medic Professional Support and Development ways in which the Velindre Faculty team could be supported in the implementation of Educational Development Time. **(FTA/24/V/A1)**

Support and Resourcing

Concern was expressed by the HEIW representatives about the capacity of the Trust's model for future training delivery (and job planning) given trainees' focus on maintaining work/life balance, increasing demand for LTFT (Less Than Full Time) and potential long-term impact of the pandemic on the future learning needs of students and trainees. It was confirmed by the Assistant Medical director (Education and Training) that consideration is being given to mechanisms to make it sustainable without increasing the already high workload demands on Faculty team members and trainers.

The Faculty team highlighted the lack of local administrative support for postgraduate medical training as a potential risk to delivery with limited resilience and governance around activity. They highlighted a need for more robust structures to support sustainability of training and provide oversight of training roles and activity. A need for administrative support was also highlighted in relation to use of the TRAC e-recruitment system. As a small organisation Velindre NHS Trust has the ability to be agile, recruit quickly and attract many applicants for posts, however use of TRAC for recruitment was deemed hugely time consuming.

Although there are increasing numbers of Specialty doctors working in the Trust it does not have its own SAS Doctor Tutor (unlike other Health Boards in Wales). However, the Trust's SAS Doctor Advocate has worked with HEIW's Director of Medic Professional Support and Development to establish a link with the SAS Doctor Tutor in Cardiff and Vale University Health Board and share learning opportunities for SAS doctors . The Trust is also encouraging specialty doctors (including Consultants who have returned following retirement) in education, for example in undertaking appraiser roles.

Although only employing a team of two, the Trust's library service has an international profile in providing expert-level information specialist searching and peer review for the Cochrane Library Systematic Reviews. This is enabled by the library's link to the Cardiff University library service, but the team are also actively encouraged by the Trust.

The library is able to provide high-level support to all service users, although it is considered the infrastructure model (with management by Cardiff University and the uncertain sourcing of funding from within the Trust) could present a risk in not being aware of the full scope of Trust service and training activity. A recent intern developed an options appraisal relating to the position of the library in organisational administrative structures but this has been put on hold pending the

development of the new Velindre Cancer Centre. The library staff have been involved in planning processes for the Centre for Learning within the Cancer Centre and will have improved space in the new build.

Objectives for the Coming Year

The Faculty team collectively agreed the following objectives to work towards in the coming year:

1. Capturing all the current education and training activity and initiatives to inform a future piece of work on demand and capacity. The team is keen to establish a database or library of education activity that will quantify it, make it visible within the Trust, support access to opportunities for trainees and specialty doctors, and potentially enable others to learn from it. The team is also keen to run a 'showcase' event with similar aims. **(FTA/24/V/O1)**

2. Seeking funding for a post with responsibility for oversight and governance of education and training activity. This post is required to co-ordinate current disparate activity and ensure training delivery is sustainable. In turn, this will inform Trust job planning activity. The Faculty team considers current efforts to demonstrate the extent of education and training will assist in raising the profile of this activity and support development of the business case for additional administrative support. **(FTA/24/V/O2)**

3. Engaging with the development of the new Velindre Cancer Centre to ensure that appropriate infrastructure and planning for education and training support, management and delivery are incorporated. **(FTA/24/V/O3)**

4. Engaging with external partners including University Hospital of Wales (UHW) to maximise opportunities for learning from other specialists, to underpin development of multiprofessional learning for example establishing a reciprocal arrangement for participation in in Grand Rounds. **(FTA/24/V/O4)**

GMC National Training Survey results 2024

Collated by Louise Hanna

July 2024

Velindre University NHS Trust

- Doctors in training:
  - Velindre Cancer Centre
  - Marie Curie Holme Tower
  - City Hospice

- Trainers:
  - All those with Velindre Contract

Key to looking at the tables

Type	Colour code
Green flag (above outlier)	
Upper quartile	
Within interquartile range	
Lower quartile	
Red flag (below outlier)	
Insufficient responses for results	

The numerical scores are out of 100 and are calculated by the GMC using responses to questions.

VUNHST all trainers

	Survey Year	2023		2024	
Trust/Board	Indicator	Score	Outcome	Score	Outcome
Velindre NHS Trust	Supportive Environment	70.83	Within IQR	71.67	Within IQR
	Educational Governance	66.40	Within IQR	70.28	Within IQR
	Professional Development	70.51	Within IQR	70.83	Within IQR
	Appraisal	53.91	Within IQR	48.75	Within IQR
	Support for Training	64.97	Within IQR	70.14	Within IQR
	Time to Train	47.27	Within IQR	49.17	Within IQR
	Rota Issues	58.06	Within IQR	66.67	Within IQR
	Handover	75.83	Above	78.70	Above
	Resources to Train	71.09	Within IQR	73.33	Within IQR

VUNHST Trainees

	Survey Year	2021		2022		2023		2024	
Trust/board	Indicator	Sc...	Outcome	Sc...	Outcome	Sc...	Outcome	Sc...	Outcome
Velindre NHS Trust	Overall Satisfaction	86.79	Within IQR	84.00	Within IQR	75.42	Within IQR	86.55	Within IQR
	Clinical Supervision	96.25	Within IQR	92.00	Within IQR	86.35	Within IQR	93.49	Within IQR
	Clinical Supervision out of hours	93.00	Within IQR	90.36	Within IQR	86.59	Within IQR	89.58	Within IQR
	Reporting Systems	73.50	Within IQR	77.62	Within IQR	76.09	Within IQR	79.32	Within IQR
	Work Load	59.08	Within IQR	59.50	Within IQR	50.09	Within IQR	64.37	Above
	Teamwork	85.12	Above	86.59	Above	84.28	Above	85.19	Above
	Handover	81.33	Above	79.71	Above	80.02	Within IQR	81.62	Above
	Supportive Environment	81.79	Above	81.60	Within IQR	74.38	Within IQR	85.69	Within IQR
	Induction	85.32	Within IQR	78.60	Within IQR	78.65	Within IQR	88.53	Within IQR
	Adequate Experience	80.80	Within IQR	79.00	Within IQR	69.79	Q1 but not below	82.33	Within IQR
	Curriculum Coverage	79.02	Within IQR						
	Educational Governance	81.85	Within IQR	79.33	Within IQR	73.61	Within IQR	81.32	Within IQR
	Educational Supervision	84.60	Within IQR	83.25	Within IQR	82.55	Within IQR	88.79	Within IQR
	Feedback	77.08	Within IQR	76.60	Within IQR	69.01	Within IQR	80.56	Within IQR
	Local Teaching	77.74	Within IQR	76.40	Within IQR	53.61	Below	65.39	Within IQR
	Regional Teaching	66.07	Within IQR	64.50	Within IQR	48.96	Below	63.14	Within IQR
	Study Leave	69.60	Within IQR	71.83	Within IQR	66.49	Within IQR	81.47	Within IQR
	Rota Design	73.56	Within IQR	69.97	Within IQR	55.98	Within IQR	74.55	Within IQR
	Facilities	75.69	Above	71.60	Within IQR	69.88	Within IQR	69.75	Within IQR

VUNHST – trainers palliative medicine

		Survey Year	2023		2024	
Trainer Specialty	Trust/Board	Indicator	Score	Outcome	Score	Outcome
Palliative medicine	Velindre NHS Trust	Supportive Environment	79.17	In Q4 but not an above outlier	83.33	Above
		Educational Governance	81.25	Above	83.33	Above
		Professional Development	78.13	In Q4 but not an above outlier	81.25	Within IQR
		Appraisal	78.13	Above	68.75	Within IQR
		Support for Training	77.08	Within IQR	83.33	Above
		Time to Train	62.50	Within IQR	61.11	Within IQR
		Rota Issues	75.00	Within IQR	79.17	Above
		Handover	62.50	Within IQR	79.17	In Q4 but not an above outlier
		Resources to Train	87.50	Above	91.67	Above

Holme Tower all trainees

		Survey Year	2021		2022		2023		2024	
Trust/board	Site	Indicator	Sc…	Outcome	Sc…	Outcome	Sc…	Outcome	Sc…	Outcome
Velindre NHS Trust - RQF	Holme Tower Marie Curie Hospice - W0715	Overall Satisfaction	88.33	Within IQR		N less than 3	96.67	Above	99.00	Above
		Clinical Supervision	98.33	Within IQR		N less than 3	95.00	Within IQR	100.00	Within IQR
		Clinical Supervision out of hours		N less than 3		N less than 3	91.67	Within IQR	96.36	Above
		Reporting Systems		N less than 3		N less than 3	85.00	Within IQR	90.00	Above
		Work Load	54.17	Within IQR		N less than 3	54.17	Within IQR	65.83	Above
		Teamwork	86.11	Q4 but not above		N less than 3		N less than 3	97.92	Above
		Handover	80.56	Q4 but not above		N less than 3	94.44	Above	84.17	Q4 but not above
		Supportive Environment	90.00	Above		N less than 3	91.67	Above	97.00	Above
		Induction	90.00	Within IQR		N less than 3	93.33	Within IQR	98.00	Above
		Adequate Experience	75.00	Within IQR		N less than 3	87.50	Within IQR	90.00	Within IQR
		Curriculum Coverage	68.05	Within IQR						
		Educational Governance	77.78	Within IQR		N less than 3	69.44	Within IQR	95.00	Above
		Educational Supervision	93.75	Within IQR		N less than 3	93.75	Within IQR	97.50	Within IQR
		Feedback	76.39	Within IQR		N less than 3		N less than 3	88.54	Within IQR
		Local Teaching	87.22	Above		N less than 3	87.22	Within IQR	94.58	Above
		Regional Teaching	72.22	Within IQR		N less than 3	62.50	Within IQR	81.25	Within IQR
		Study Leave		N less than 3		N less than 3	64.58	Within IQR	92.50	Within IQR
		Rota Design	62.50	Within IQR		N less than 3	89.58	Above	88.75	Above
		Facilities		N less than 3		N less than 3	69.58	Within IQR	85.00	Above

VCC – clinical oncology registrars

			Survey Year	2021		2022		2023		2024	
Programme Group	Trust/Board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Clinical oncology	Velindre NHS Trust	Velindre Cancer Centre - RQFH5	Overall Satisfaction	91.92	Within IQR	90.00	Within IQR	86.88	Within IQR	80.91	Within IQR
			Clinical Supervision	97.69	Within IQR	94.55	Within IQR	95.31	Within IQR	92.05	Within IQR
			Clinical Supervision out of hours	93.75	Within IQR	90.63	Within IQR	92.19	Within IQR	89.96	Within IQR
			Reporting Systems	74.17	Within IQR	80.50	Q4 but not above	73.75	Within IQR	75.56	Within IQR
			Work Load	59.46	Within IQR	48.30	Below	49.48	Below	58.52	Within IQR
			Teamwork	83.97	Above	87.88	Above	79.69	Within IQR	81.06	Within IQR
			Handover	85.74	Above	82.95	Above	80.47	Above	77.27	Q4 but not above
			Supportive Environment	85.38	Above	85.91	Above	77.50	Within IQR	83.18	Within IQR
			Induction	85.73	Within IQR	80.00	Within IQR	74.38	Q1 but not below	81.59	Within IQR
			Adequate Experience	87.50	Within IQR	87.50	Within IQR	87.50	Within IQR	78.41	Within IQR
			Curriculum Coverage	86.54	Within IQR						
			Educational Governance	87.18	Above	81.82	Within IQR	76.04	Within IQR	75.00	Within IQR
			Educational Supervision	87.02	Within IQR	85.23	Within IQR	83.59	Within IQR	82.95	Within IQR
			Feedback	85.94	Within IQR	84.90	Within IQR	91.67	Within IQR	75.00	Q1 but not below
			Local Teaching	79.62	Within IQR	79.09	Within IQR	66.04	Q1 but not below	63.33	Q1 but not below
			Regional Teaching	70.19	Within IQR	71.97	Within IQR	61.46	Within IQR	63.64	Within IQR
			Study Leave	80.45	Within IQR	69.32	Within IQR	75.52	Within IQR	82.95	Within IQR
			Rota Design	79.17	Above	71.40	Within IQR	65.63	Within IQR	73.86	Within IQR
			Facilities	77.31	Above	68.50	Within IQR	60.47	Within IQR	56.00	Within IQR

VCC medical oncology registrars

			Survey Year	2021		2022		2023		2024	
Programme Group	Trust/Board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Medical oncology	Velindre NHS Trust	Velindre Cancer Centre - RQFH5	Overall Satisfaction		N less than 3		N less than 3	65.00	Q1 but not below	97.50	Above
			Clinical Supervision		N less than 3		N less than 3	90.00	Within IQR	100.00	Within IQR
			Clinical Supervision out of hours		N less than 3		N less than 3	91.67	Within IQR	91.67	Within IQR
			Reporting Systems		N less than 3		N less than 3	76.67	Within IQR	80.00	Within IQR
			Work Load		N less than 3		N less than 3	47.92	Within IQR	62.50	Within IQR
			Teamwork		N less than 3		N less than 3	83.33	Q4 but not above	85.42	Q4 but not abov
			Handover		N less than 3		N less than 3	70.14	Within IQR	87.50	Above
			Supportive Environment		N less than 3		N less than 3	73.33	Within IQR	90.00	Within IQR
			Induction		N less than 3		N less than 3	80.00	Within IQR	87.50	Within IQR
			Adequate Experience		N less than 3		N less than 3	62.50	Below	100.00	Within IQR
			Curriculum Coverage		N less than 3						
			Educational Governance		N less than 3		N less than 3	75.00	Within IQR	93.75	Above
			Educational Supervision		N less than 3		N less than 3	75.00	Q1 but not below	96.88	Within IQR
			Feedback		N less than 3		N less than 3		N less than 3		N less than 3
			Local Teaching		N less than 3		N less than 3	64.45	Within IQR	65.42	Within IQR
			Regional Teaching		N less than 3		N less than 3	58.33	Q1 but not below	62.50	Q1 but not belov
			Study Leave		N less than 3		N less than 3	75.00	Within IQR	96.88	Within IQR
			Rota Design		N less than 3		N less than 3	66.67	Within IQR	75.00	Within IQR
			Facilities		N less than 3		N less than 3		N less than 3	73.44	Within IQR

VCC IMT trainees

			Survey Year	2021		2022		2023		2024	
Programme Group	Trust/Board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Internal Medicine Training Stage One	Velindre NHS Trust	Velindre Cancer Centre - RQFH5	Overall Satisfaction	78.33	Within IQR	75.00	Within IQR	68.75	Within IQR	77.50	Within IQR
			Clinical Supervision	95.00	Within IQR	88.33	Within IQR	75.00	Q1 but not below	86.25	Within IQR
			Clinical Supervision out of hours	93.75	Within IQR	83.33	Within IQR	76.04	Within IQR	85.94	Within IQR
			Reporting Systems		N less than 3		N less than 3	75.00	Within IQR	80.00	Q4 but not above
			Work Load	60.42	Q4 but not above	72.92	Above	48.44	Within IQR	73.44	Above
			Teamwork	83.33	Q4 but not above		N less than 3	75.00	Within IQR	87.50	Above
			Handover	80.56	Above	82.64	Above	85.42	Above	79.17	Above
			Supportive Environment	75.00	Within IQR	73.33	Within IQR	62.50	Within IQR	83.75	Q4 but not above
			Induction	83.33	Within IQR	75.00	Within IQR	77.50	Within IQR	93.75	Above
			Adequate Experience	75.00	Within IQR	62.50	Within IQR	56.25	Within IQR	71.88	Within IQR
			Curriculum Coverage	69.45	Within IQR						
			Educational Governance	75.00	Within IQR	80.56	Q4 but not above	79.17	Above	68.75	Within IQR
			Educational Supervision	75.00	Within IQR	83.33	Within IQR	93.75	Within IQR	79.69	Within IQR
			Feedback		N less than 3		N less than 3	36.11	Q1 but not below	65.28	Within IQR
			Local Teaching	72.22	Within IQR	67.22	Within IQR	35.42	Below	48.33	Q1 but not below
			Regional Teaching	66.67	Within IQR	51.39	Within IQR	29.17	Below	56.25	Within IQR
			Study Leave	46.53	Within IQR	74.31	Q4 but not above	51.56	Within IQR	68.75	Within IQR
			Rota Design	72.92	Above	58.33	Within IQR	35.94	Within IQR	65.63	Within IQR
			Facilities		N less than 3		N less than 3	87.50	Above	80.00	Above

VCC GP trainees

			Survey Year	2021		2022		2023		2024	
Programme Group	Trust/Board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
GP Prog - Radiology	Velindre NHS Trust	Velindre Cancer Centre - RQFH5	Overall Satisfaction	84.00	Within IQR	76.00	Within IQR	43.75	Below		N less than 3
			Clinical Supervision	92.00	Within IQR	85.00	Within IQR	63.75	Below		N less than 3
			Clinical Supervision out of hours	89.06	Within IQR	91.25	Within IQR	75.00	Below		N less than 3
			Reporting Systems		N less than 3	73.75	Within IQR	76.25	Q4 but not above		N less than 3
			Work Load	58.75	Within IQR	78.75	Above	45.31	Within IQR		N less than 3
			Teamwork	91.67	Above	85.00	Q4 but not above	91.67	Above		N less than 3
			Handover	74.58	Within IQR	76.25	Within IQR	70.31	Within IQR		N less than 3
			Supportive Environment	78.00	Q4 but not above	75.00	Within IQR	62.50	Q1 but not below		N less than 3
			Induction	84.00	Within IQR	71.00	Within IQR	71.25	Within IQR		N less than 3
			Adequate Experience	77.50	Within IQR	70.00	Within IQR	37.50	Below		N less than 3
			Curriculum Coverage	78.33	Within IQR						
			Educational Governance	78.33	Q4 but not above	73.33	Within IQR	64.58	Within IQR		N less than 3
			Educational Supervision	80.00	Within IQR	85.00	Within IQR	65.63	Q1 but not below		N less than 3
			Feedback		N less than 3		N less than 3	33.33	Q1 but not below		N less than 3
			Local Teaching	73.00	Within IQR	72.67	Within IQR	19.17	Below		N less than 3
			Regional Teaching	53.33	Within IQR	51.67	Within IQR	20.84	Below		N less than 3
			Study Leave	42.50	Within IQR	73.75	Above	50.00	Within IQR		N less than 3
			Rota Design	66.25	Within IQR	70.00	Within IQR	14.06	Below		N less than 3
			Facilities		N less than 3		N less than 3		N less than 3		N less than 3

VCC clinical radiology registrars

			Survey Year	2021		2022		2023		2024	
Programme Group	Trust/Board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Clinical radiology	Velindre NHS Trust	Velindre Cancer Centre - RQFH5	Overall Satisfaction				N less than 3		N less than 3		N less than 3
			Clinical Supervision				N less than 3		N less than 3		N less than 3
			Clinical Supervision out of hours				N less than 3				
			Reporting Systems				N less than 3				N less than 3
			Work Load				N less than 3		N less than 3		N less than 3
			Teamwork				N less than 3		N less than 3		N less than 3
			Supportive Environment				N less than 3		N less than 3		N less than 3
			Induction				N less than 3		N less than 3		N less than 3
			Adequate Experience				N less than 3		N less than 3		N less than 3
			Educational Governance				N less than 3		N less than 3		N less than 3
			Educational Supervision				N less than 3		N less than 3		N less than 3
			Feedback						N less than 3		N less than 3
			Local Teaching				N less than 3		N less than 3		N less than 3
			Regional Teaching				N less than 3		N less than 3		N less than 3
			Study Leave				N less than 3		N less than 3		N less than 3

VUNHST – trainees F2

		Survey Year	2024	
Programme Group	Trust/board	Indicator	Score	Outcome
Medicine F2	Velindre NHS Trust	Overall Satisfaction	93.33	Above
		Clinical Supervision	91.25	Within IQR
		Reporting Systems		N less than 3
		Work Load	80.55	Above
		Teamwork		N less than 3
		Handover	93.06	Above
		Supportive Environment	83.33	Within IQR
		Induction	91.67	Within IQR
		Adequate Experience	91.67	Within IQR
		Educational Governance	91.67	Above
		Educational Supervision	100.00	Within IQR
		Feedback	88.89	Within IQR
		Study Leave	91.67	Above
		Rota Design	81.25	Above
		Facilities		N less than 3

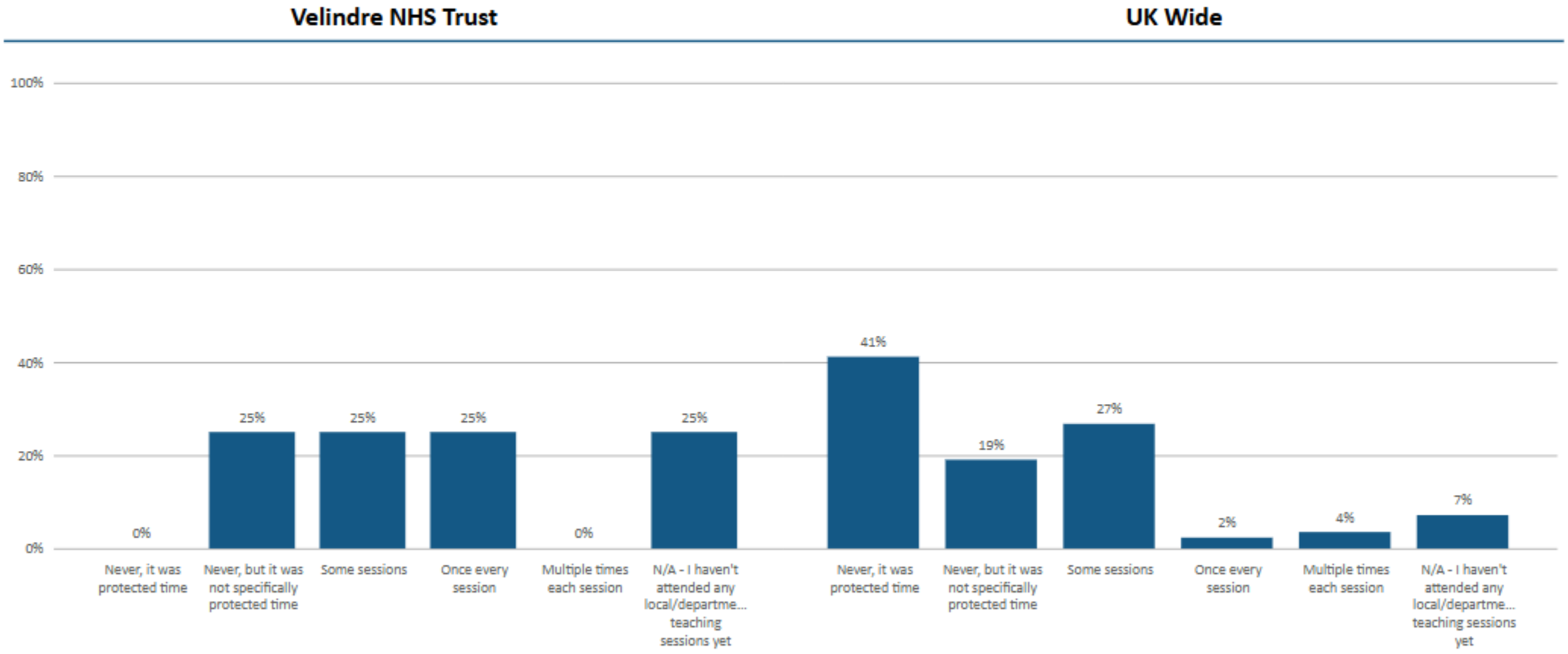
VUNHST – trainees clinical oncology specialty

		Survey Year	2021		2022		2023		2024	
Post specialty	Trust/board	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Clinical oncology	Velindre NHS Trust	Overall Satisfaction	88.10	Within IQR	83.95	Within IQR	71.56	Q1 but not below	79.12	Within IQR
		Clinical Supervision	95.95	Within IQR	91.05	Within IQR	82.34	Q1 but not below	90.44	Within IQR
		Clinical Supervision out of hours	92.76	Within IQR	89.58	Within IQR	83.85	Within IQR	87.62	Within IQR
		Reporting Systems	73.13	Within IQR	78.13	Q4 but not above	74.69	Within IQR	76.54	Within IQR
		Work Load	59.42	Within IQR	60.20	Within IQR	48.18	Within IQR	62.50	Within IQR
		Teamwork	85.71	Above	87.96	Above	81.95	Within IQR	82.35	Within IQR
		Handover	82.34	Above	81.14	Above	79.17	Above	78.55	Within IQR
		Supportive Environment	82.14	Above	81.05	Within IQR	70.00	Within IQR	82.06	Within IQR
		Induction	84.94	Within IQR	76.84	Within IQR	74.38	Below	85.74	Within IQR
		Adequate Experience	83.33	Within IQR	78.95	Within IQR	67.19	Q1 but not below	75.74	Within IQR
		Curriculum Coverage	82.14	Within IQR						
		Educational Governance	83.33	Above	79.39	Within IQR	73.96	Within IQR	72.55	Within IQR
		Educational Supervision	83.63	Within IQR	84.87	Within IQR	81.64	Within IQR	82.35	Within IQR
		Feedback	73.27	Q1 but not below	74.62	Q1 but not below	60.61	Q1 but not below	73.75	Q1 but not below
		Local Teaching	76.98	Within IQR	75.53	Within IQR	46.67	Below	56.47	Below
		Regional Teaching	65.68	Within IQR	63.38	Within IQR	43.23	Below	59.80	Within IQR
		Study Leave	66.57	Within IQR	71.27	Within IQR	63.15	Within IQR	72.79	Q1 but not below
		Rota Design	75.00	Within IQR	68.97	Within IQR	45.31	Within IQR	70.59	Within IQR
		Facilities	78.67	Above	72.23	Within IQR	71.34	Within IQR	63.00	Within IQR

2024 - Local Teaching - Internal Medicine Training Stage One - Velindre NHS Trust - Velindre Cancer Centre - RQFH5

GENHQ13 - When attending these local/departmental sessions, in this post, how often did you have to leave a teaching session to answer a clinical call?

Table | Chart | Return to: Year on year



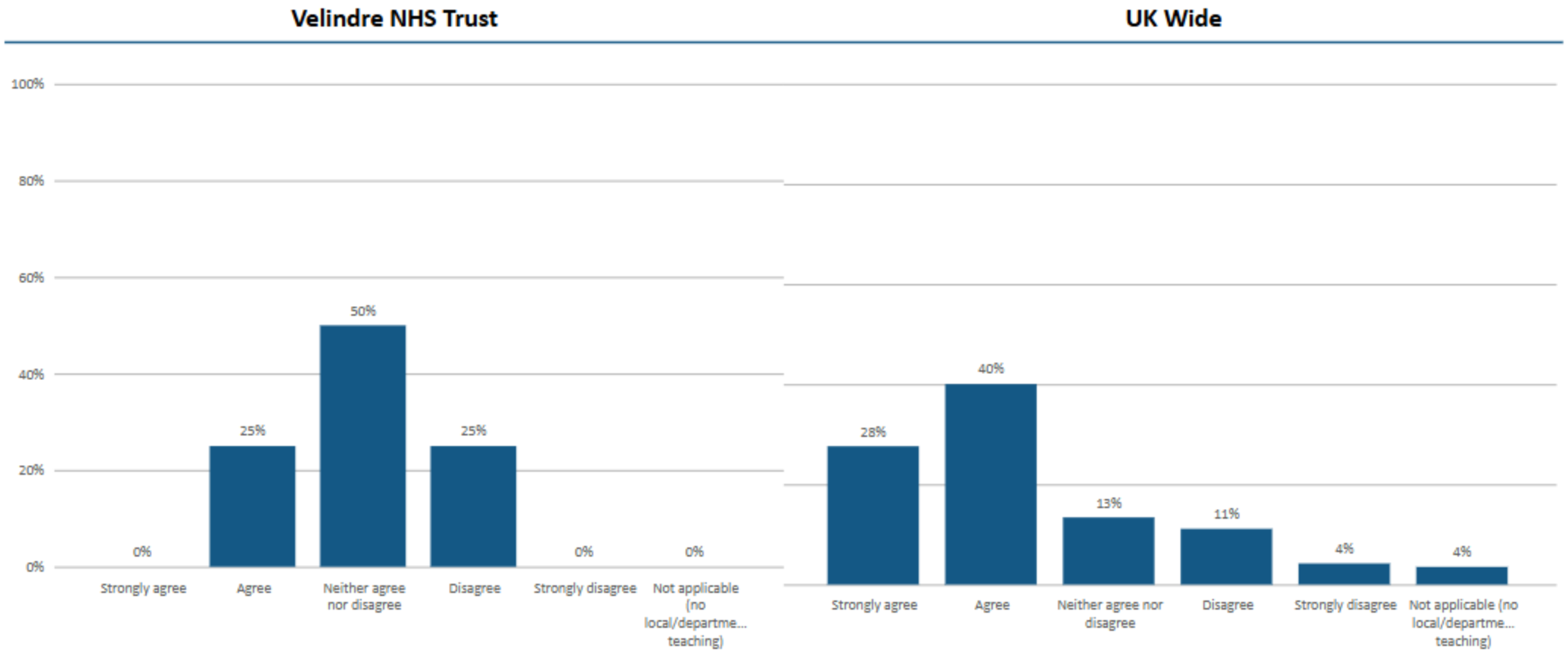
N = 3 to 5

N = 38381 to 38385

2024 - Local Teaching - Internal Medicine Training Stage One - Velindre NHS Trust - Velindre Cancer Centre - RQFH5

GENHQ173 - To what extent do you agree or disagree with the following statement?
I have enough protected time to attend all the local/departmental teaching I need to in this post.

Table | Chart | Return to: Year on year



N = 3 to 5

N = 52161 to 52165

Summary 1- highlights

- Exceptionally good results for:
  - Palliative Medicine (trainers and trainees)
  - Holme Tower (trainees)
  - IMT (VUNHST)
  - F2 (VUNHST)
  - Workload, teamwork and handover (VUNHST - trainees)
  - Many other areas
- No longer below outlier status for:
  - VCC -clinical oncology induction (all training grades)
  - VCC -regional teaching
  - IMT -training (local teaching and regional teaching)
  - Clinical oncology trainee - workload
  - VCC trainers - support for training

Summary 2

- Areas for development
  - Time for training – Holme Tower
  - Local teaching – Velindre Cancer Centre – all trainees. All trainees working within clinical oncology (StR, IMT, GP, F2 combined) Velindre Cancer Centre, clinical oncology registrars and IMT. (No data on GP)
  - Feedback – all trainees working within clinical oncology (StR, IMT, GP, F2) clinical oncology registrars
  - Regional teaching – medical oncology registrars
  - Study leave – all trainees working within clinical oncology (StR, IMT, GP, F2 combined)
  - GP training – multiple below outlier in 2023 but insufficient results in 2024

HEIW correspondence

Reduced Risks

I am pleased to confirm that following the survey results we have been able to reduce the risk rating of the following risks:

TP565, Medical Oncology (Trainer), Velindre cancer Centre

Closed risks

Following improved results on the 2024 survey and/or other evidence we are pleased to confirm that we have been able to close the below risks:

TP618, Medical Oncology & Clinical Oncology, Velindre Cancer Centre

HEIW risk register

HEIW Medical Training Concerns Risk Report

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GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Health Board: Velindre NHS Trust
Site: All Sites
Year: All Years

Specialty Group: All Specialty Groups
Specialty: All Specialties

High Risk: Not Filtered
Foundation: Not Filtered
Enhanced Monitoring: Not Filtered

Case Ref	Specialty	Programme Specialty	Grade	Health Board	Site	Concern Raised Via	Summary of Issues	Risk Report Update	Next Steps	Risk Rating
TP565	Oncology	Medical Oncology;	Trainer;	Velindre NHS Trust	Velindre Cancer Centre	2022 NTS	24/06/2024 2024 NTS results show nothing below average. 2022: Survey results show Medical Oncology Trainers - below outliers for Overall Satisfaction, Support and Appraisal and Time and Training Resources. 2023 Survey Results - Trainer - Nothing below average. ABOVE outlier for Supportive Environment. Programme Group - Below Outlier for Adequate Experience; lower quartiles for Overall Satisfaction, Educational Supervision, Regional Teaching.	11/03/2024 update via meeting with AMD and MEM - Trainers are committed. Issues reflect a service under pressure. There is a lot of work being undertaken to alter ways of working, especially in relation to the Chemotherapy service to improve the flow of work. There is no up to date feedback from Trainers but they have been successful in getting more funding for consultant posts. An electronic job planning system is also being roiled out which will break down SPA time more efficiently. Two new prescribers have been appointed and one more to come. Recent updates: 17/02/2023 - Update via AMD - The issue relating to time for training is related to the increase in service demand that has taken place gradually over time and particularly with the pandemic. New clinical information system in the last six months that was developed in conjunction with DHCR and that has impacted on clinical time. The medical business team is actively recruiting new staff within oncology and has appointed to new consultant and specialty doctor posts. Within job planning, additional clinical sessions are being identified and remunerated, and educational roles such as educational and clinical supervisor and undergraduate oncology project tutor are being noted. Future plans that are being explored include development of a multi-professional workforce plan, work to move job planning onto a formal system such as 'Allocate' and a review of SPA time in line with work done in neighbouring health boards. 27/10/2023 - Update from Trust - 24 Feb 2023 met with Med Onc trainers - main issues raised were around job planning and medical	Update on progress and timeline required.	4

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High Risk: Not Filtered
Foundation: Not Filtered
Enhanced Monitoring: Not Filtered

Risk Report Update	Next Steps	Risk Rating
education admin/management support. It was also raised that cover on the Assessment Unit/AOS is well developed but less so on wards - subsequent work increase cover supported by PAs and Specialty Doctor recruitment and development. Oct 2023 met with Med Onc trainers - noted that job plan recognition for roles is key, the Trust are about to commence a number of changes to job planning processes, which will include recognition with sessional allocation and clear objectives for for ES, CS, teaching etc. Oct 2023 met with Med Onc Trainees - no reports of lack of clinical exposure. Reports of good exposure to tumour site specific and acute oncology aspects of the curriculum, and ability to attend clinics despite acute oncology duties at CAV, on-calls, study etc. Registrar teaching programme also to be reinstated.		

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HEIW risk register

HEIW Medical Training Concerns Risk Report

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GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Health Board: Velindre NHS Trust
Site: All Sites
Year: All Years

Specialty Group: All Specialty Groups
Specialty: All Specialties

High Risk: Not Filtered
Foundation: Not Filtered
Enhanced Monitoring: Not Filtered

Case Ref	Specialty	Programme Specialty	Grade	Health Board	Site	Concern Raised Via	Summary of Issues	Risk Report Update	Next Steps	Risk Rating
TP617	Medicine	Clinical Oncology;	Specialty Training;	Velindre NHS Trust	Velindre Cancer Centre	2023 Survey results	24/06/2024 2024 NTS results show: Clinical Oncology Post Below Outlier: - Local Teaching Lower Quartiles: - Feedback - Study Leave Programme: Lower Quartiles: - Feedback - Local Teaching 2023: NEW RISK - programme - Below Outlier for Workload; lower quartile for Induction and Local Teaching. Post - Below Outliers for Induction, Local Teaching, Regional Teaching; lower quartiles for Overall Satisfaction, Clinical Supervision, Adequate Experience, Feedback.	2023: NEW RISK - programme - Below Outlier for Workload; lower quartile for Induction and Local Teaching. Post - Below Outliers for Induction, Local Teaching, Regional Teaching; lower quartiles for Overall Satisfaction, Clinical Supervision, Adequate Experience, Feedback. 27/10/2023 - Update from Trust - QIP undertaken Jun-Aug to create a trainee centred medical induction at VCC, trainee led project with medical directorate and clinical director support incorporating extensive trainee and trainer/stakeholder feedback sought to inform the improvements. To reduce the workload for future inductions and also to allow for new starters outside of the main changeover schedule, the sessions were recorded and uploaded to the share point drive. This also acted as a reference point for anyone wanting to revisit a session or topic. Cycle 1 feedback has been very positive with 90% sessions rated 82% or above for 'usefulness'. Feedback and debrief notes to further improve for Cycle 2. Oct 2023 met with Registrars - regular teaching programme to be reinstated, programme being developed to commence Jan 2024, each session driven by an SST team, with last hour dedicated to radiotherapy. Consultants aware to release trainees on teaching days. Also reinforced strategy and process for taking time back if have to work beyond usual hours. 25/07/2024 Update via meeting with AMD and MEM - Induction programme has been set up for anyone new to Velindre and the Education Centre have worked with Registrars to confirm what they need.	Update required	4

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ANNUAL UNDERGRADUATE MEDICAL EDUCATION REPORT
For academic year 2023 – 2024

Report completed 21 October 2024
Meeting to be held on 4 November 2024

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1. Introduction

The Service Increment for Teaching (SIFT) in Wales is distributed to Trusts/Health Boards to cover the additional costs associated with delivering clinical teaching in a service setting, i.e. the time and resources spent by healthcare professionals in teaching and supervising students. The allocation of SIFT is based on the number of students placed within each organisation, the length of their placements, and the level of support required to deliver high-quality teaching environments.

Monitoring of SIFT funds is conducted through a combination of financial oversight and educational quality assurance. Annual review visits are conducted to ensure that SIFT funding is being used effectively to support the education of undergraduate students, maintaining the standards set by the General Medical Council (GMC) and discuss any other relevant issues.

To support the Annual Medical Undergraduate Teaching Review meeting due to take place on 4 November 2024, this report provides an overview of the undergraduate medical and clinical education activities and developments at Velindre University NHS Trust (VUNHST) during the past academic year. It highlights the achievements, challenges, student feedback evaluation, and future actions and priorities for the administration and deliver of undergraduate medical education at VUNHST.

2. Organisation

Velindre University NHS Trust provides undergraduate medical education through its two clinical divisions, the Velindre Cancer Service and the Welsh Blood Service. An Associate Medical Director of Medical Education has been in post since 2021.

The Medical Education function sits between the VCS Medical Services directorate and the VUNHST Corporate Medical Business Service, supported by a Medical Education Co-ordinator.

2.1 Velindre Cancer Service (VCS)

VCS's main location is the Velindre Cancer Centre situated in Whitchurch, Cardiff. It provides non-surgical oncology services to the population of Southeast Wales, together with some supra-regional services e.g. brachytherapy.

The core undergraduate medical education activities delivered within VCS are as follows:

- Oncology Project
- Student Selected Components (SSC)

- Palliative Medicine teaching
- Year 3 Undergraduate Bookend Tutorials

Further detail on each of these programmes can be found in Sections 3.

2.2 Welsh Blood Service (WBS)

Welsh Blood Service is situated in Talbot Green. It provides a national blood transfusion service and typing services for donors and recipients of stem cell and organ transplants in Wales. It also provides an unrelated stem cell donor registry as part of an international network.

The Welsh Blood Service provide all medical students in Wales with senior studentship training and competency assessment prior to qualification and starting work as junior doctors. The Senior Student Assistantship (SSA) is a well-established educational transfusion programme delivered by Transfusion Practitioners (TPs) to final year medical students across Wales. Further detail can be found in Section 3.5.

3. Overview of Clinical Placement Activity and Student/Tutor Feedback

3.1 Oncology Project

Most of the undergraduate activity at Velindre involves third year medical students who attend Velindre during their oncology project. This amounted to 288 students for the academic year 2023-2024, including 20 students who are undertaking their course through the medium of Welsh. The latter student group submitted their project in the Welsh Language. Due to a lack of Welsh-speaking tutors in North Wales, our tutors also marked the Welsh language projects submitted in North Wales.

The Oncology Project is led by Dr Rhiannon Evans, Consultant Clinical Oncologist (Senior Honorary Lecturer), supported by Dr Claire Bartholomew, Senior Specialty Trainee – Clinical Oncology. Dr Evans also has the specific oversight of the Coleg Cymraeg students and is the Welsh language lead for the Oncology Project.

Students are encouraged to meet their patients face to face in the outpatient setting when possible, and to observe both clinic and treatment appointments. Tutorials have been held mainly virtually since the COVID pandemic, as tutors and students find this easier to arrange, and it avoids the need for a student to leave a clinical placement for a meeting.

The current challenges surrounding the project include obtaining adequate number of tutors and timely patient recruitment. We introduced an online marking system in 2022-2023 to streamline the marking process for tutors and administrative team and feedback has been

positive. For the current academic year, we held a new tutors meeting in early October – there was good attendance and a number of new tutors have been recruited. A new initiative was introduced last year to recruit some patients from nurse-led clinics – this was successful, and we plan to continue this this year.

Student feedback for 2023-2024 was generally very positive (table 1 & 2), although there has been decline in response rate over recent years. It would be good to discuss this further and explore whether this is specific to the oncology project and if there are any particular barriers to completing it. Students were all reminded of the importance of feedback and completing the questionnaire in their recent introductory lecture.

There was a noticeable improvement in the "opportunities to witness patient's social situation and impact of disease" and "opportunities to increase understanding of role of multi-disciplinary team and support services", which may be a reflection of more face-to-face interactions than previous years.

Whilst the score for 'organisation of placement' has increased from 80% to 84%, we hope to improve this further by increasing communication with students and quicker allocation of tutors and patients. Unfortunately, we have seen a decrease in the score for students feeling "more confident in approaching patients with life threatening illness" and "more confident in dealing with a patient's symptoms and distress". This is likely to be multi-factorial, and we will look into ways of improving this for future years.

Table 1: Student Evaluation

Core Question	2023-24 Positive Percentage	2022-23 Positive Percentage	2021-22 Positive Percentage	2020-21 Positive Percentage
Student Responses	121 out of 285 (42%)	194 out of 295 (65%)	211 out of 262 (81%)	234 out of 302 (77%)
Learning Outcomes identified	94	96	97	96
Learning Outcomes useful	94	93	94	91
Organisation of placement	84	80	77	85
Opportunities to learn (Overall)	94	95	94	95
Opportunities to increase knowledge of patient with cancer	97	96	91	92
Opportunities to witness patient's social situation and impact of disease	97	90	79	64
Opportunities to increase understanding of role of multi-disciplinary team and support services	93	89	89	77
Quality of learning opportunities	97	95	95	94
Level of confidence increasing	97	95	94	94
Communication skills improving	98	97	95	96
Achieved Learning Outcomes	93	91	88	99
Overall (Core Questions)	94	93	89	89
Overall (Project Specific Questions)	90	91	90	96
Overall (All questions)	92	92	90	92

Table 2: Student Evaluation

Oncology Project Specific Questions:	2023-24 Positive Percentage	2022-23 Positive Percentage	2021-22 Positive Percentage	2020-21 Positive Percentage
Student Responses	121 out of 285 (42%)	194 out of 295 (65%)	211 out of 262 (81%)	234 out of 302 (77%)
Patient allocation was appropriate	97	96	98	97
Patient enabled fulfilment of Project aims	96	96	95	98
Tutor was accessible	95	95	93	97
Tutor provided opportunities to discuss patient problems	93	96	94	97
The students experienced no difficulties in attending tutor or Project sessions	87	86	89	88
The written project is a fair way to assess learning	90	92	89	89
Adequately supported during difficult stages of patients illness (N/A included in Positive Percentage)	90	89	92	94
More confident in approaching patients with a life threatening illness	78	83	82	100
More confident in dealing with a patients symptoms and distress	81	82	80	100
Overall (Project specific questions)	90	91	90	96

3.2 Student Selected Components (SSC)

The Clinical Audit team led by Sara Walters has a significant role in coordinating and supporting SSC projects. The SSC projects are also supervised and hosted by the Velindre Palliative Care team, and also Velindre employed palliative care consultants in the community, hospice and hospitals.

A notable project by medical student Becca Roberts was entitled: “Impact of sharing patients’ Treatment Escalation Plans via Electronic Discharge Advice Letters” and won second prize at the FRCR Research, Improvement and Innovation Award 2024 competition.

Year 3 – 19 students:

1. An audit of rates of interstitial lung disease in patients with HER-2 positive secondary breast cancer on second and later line treatment with Enhertu (Trastuzumab deruxtecan).
2. Evaluation of the impact of radiological involvement and tertiary imaging review in a newly established complex melanoma multidisciplinary team meeting.
3. Evaluation of the benefits of the Day 8 call back for patients receiving SACT capecitabine.
4. Outcomes of post-treatment MRI scans after chemoradiotherapy for cervical cancer.
5. Patient information leaflets and Royal College of Radiologists radiotherapy consent forms: how well do they match, and can they be harmonised?
6. Treatment outcomes following image-guided brachytherapy in cervical cancer.
7. A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales
8. An evaluation of the IO toxicity Service
9. An audit into the recurrence of oropharyngeal cancer on contralateral side to original cancer after being treated with radiotherapy to lymph nodes on ipsilateral side only.
10. An audit to evaluate the outcomes of Neo-Adjuvant SACT in use of HER2 positive breast cancer patients at VCC Jan 2021-2024
11. Evaluation of 'The Immunobuddies' podcast and The IO Toxicity forum.
12. Predicting radiotherapy doses to the dentoalveolar structures: A service review of estimated and actual radiation dosimetric distribution to the maxilla and mandible for patients receiving radiotherapy for tumours of the parotid gland in Velindre Cancer Centre (VCC).
13. An audit of the use of palliative and curative radiotherapy for patients with breast cancer with brain metastases
14. An audit of Velindre Cancer Centre cancer care targets with relation to the Well-Being of Future Generations Act
15. A service evaluation of patients in South East Wales who complete a full 2 year course of palliative immunotherapy for advanced lung cancer (current knowledge gap regarding best practice)
16. A study of Cancer Patients and their families for Considerations of the interior design of a cancer centre (with relation to the nVCC).
17. Assessing Post-Metastatic Resection Care: Evaluating the Impact of Revised NICE Guidelines on Treatment Strategies, Patient Recurrence, and Outcomes in University Hospital Wales and Velindre Cancer Centre.
18. An audit of the clinical effectiveness of Cemiplimab for advanced squamous cell carcinoma of the skin and of Avelumab for advanced Merkel cell cancer
19. How do post operative CT scans change the management of stage 3 endometrial cancer

Year 4 – 15 students:

1. Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions?
2. To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?
3. Evaluating the toxicities and outcomes of Pembrolizumab, a newly approved immunotherapy, for triple negative breast cancer Treatment outcomes in patients who developed adrenal insufficiency on immunotherapy and evaluating the adrenal education workshop.
4. Measuring the Impact of Carcinoma of Unknown Primary (CUP) Service Intervention in Terms of Patient Experience
5. Review of outcomes for definitive, non-surgical treatment of muscle invasive bladder cancer
6. Treatment Response of Patients with Advanced Epithelial Ovarian Cancer to Maintenance Chemotherapy Based on Mutation Status
7. An Audit of unilateral radiotherapy in contrast to bilateral radiotherapy, in terms of survival and local recurrence rate and risk of contra-lateral disease recurrence
8. A service evaluation of the oesophageal and gastric cancer referral pathway
9. An audit of patient outcomes (with regards to survival and toxicity) after treatment with Sotorasib for KRAS G12C mutated non-small cell lung cancer at Velindre Cancer Centre
10. Anal Cancer Morphology Significantly Predicts Patient Survival and Response to Treatment: A Single Centre Retrospective Study
11. An Audit of DPYD Testing in Velindre Cancer Centre

Virtual Event:

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

Teaching Sessions:

- We provide the medical students with the opportunity to attend a number of interesting short virtual sessions on key oncological topics including immunotherapy, radiotherapy and clinical trials. These sessions are provided by the junior doctors and have received excellent feedback from the students.
- Session 1:
    - Careers in Oncology
    - Clinical Trials

    - Radiotherapy
    - Oncological emergencies – Part 1: Neutropenic Sepsis and SVCO
- Session 2:
    - Genomics
    - Oncological emergencies – Part 2: Cord Compression and Hypercalcemia
    - Chemotherapy
    - Immunotherapy

Learning/Impact of the projects:

- A decision was made based on the evidence provided from the project that 8-day call backs are no longer required and therefore have been stopped. This frees up staff time/resource. The project findings were discussed at the ICOG and the Site-Specific Team (SST) Leads meeting. They will also be presented for information at the Medicines Management Group.
- A number of projects have been accepted as abstracts and/or presented at national conferences.

3.3 Palliative Medicine teaching

Prof Mark Taubert, Clinical Director – Palliative Medicine, leads the undergraduate teaching programme within the department, with 3-4 medical students every Tuesday. The following is an example of the tutorials and experience of the students whilst with the Palliative Medicine Team.

- Attendance of medical students for the palliative medicine consultant ward round
- Online medical student tutorials
- QR code link to resources including 360-degree Virtual Reality learning accessible in non-clinical areas:

- Hosting prospective medical school applicants for clinical placements
- Mini-CEX and Case-based Discussions for medical students following ward rounds.
- Acute Oncology/Palliative Assessment rounds
- Involvement in various teaching activities including Oncology Project
- Hosting elective and placement medical students.
- 30-minute tutorials after Acute Oncology meetings with Dr Ricky Frazer, Honorary Lecturer, on Tuesday afternoons – discussion and questions
- Cardiff and Vale Palliative Care webinar series: 5 live webinars delivered via Zoom. Sessions were 1.5 hours, 1 hour of main presentations and a 30-minute optional patient

discussion section. Recordings of the sessions are continuously available on Cardiff University MSC/Diploma CPD YouTube channels to those who registered.

Achievements:

- Examples of Block 3 Velindre Medical Student Teaching Feedback (July 2023):
    - Very well organised teaching. Really helpful week.
    - Lots of good teaching.
    - I found this week really insightful into a specialty I haven't observed before.
    - Excellent experience and great to see different parts of Cardiff.
    - Excellent teaching, very good learning opportunities and abilities to talk to palliative care patients.
    - Excellent variety – wards, hospice, clinics, teaching and MDT meetings, home visits.
    - The teaching was really good and provided a helpful insigt on palliative care. Professor Mark Taubert was also great.
    - Good teaching and good and varied exposure.
    - It was nice to see palliative care in a range of settings.
    - Really well organised, felt like they knew I was supposed to be there.
    - Great timetable with a whole range of clinical activities and teaching hospice days and Velindre day added a lot to the week.
    - Great, friendly staff.
    - Really good week of placement. Extremely well structured, always felt they were ready to teach us.
- Palliative Care SSC med student Becca Roberts project: "Impact of sharing patients' Treatment Escalation Plans via Electronic Discharge Advice Letters" and won second prize at the FRCR Research, Improvement and Innovation Award 2024 competition.
- A further project on QR codes in palliative care published in BMJ SPCare Forum: https://blogs.bmj.com/spcare/2023/11/01/quick-response-palliative-care-are-wearable-medical-identification-with-qr-code-technology-acceptable-to-palliative-care-patients-by-e-harding-m-thomas-and-n-pease/
- Mark Taubert received a commendation award for his teaching and campaigning work in end of life care at the inaugural national palliative care awards , with an award ceremony hosted by Kate Garraway in London https://blogs.bmj.com/spcare/2024/07/05/news-inaugural-palliative-and-end-of-life-care-awards/
- Letter from Prof Goodfellow regarding palliative teaching at Velindre which had been singled out by medical students for special recognition:

Is there a member of staff who deserves recognition?
Dr Mark Taubert (palliative care consultant)! I thought he was absolutely amazing on the day we had at Velindre, he really stood out for me. He even sent us an email with more information which included an amazing soundcloud episode where he spoke about important topics. He even gave myself and my placement partners a free ticket to a life after death virtual event where there were lectures all day. It really felt as though he was keen to teach us and he gave us a tour, did teaching & got us to speak to some patients. Lovely experience.
Prof Mark Taubert from Velindre Cancer Centre went above and beyond for us whilst on our day visit. I wish we had more time there!
The consultant at velindre Mark Taubert

- Publication in BMJ Leader with our 4th year Medical Student Emma Wardle on what makes 'Top Doctors': https://bmjleader.bmj.com/content/early/2023/07/08/leader-2022-000735.abstract
- SSC student Grace Fry presentation at Velindre SSC presentation event on POS-S symptom scoring in palliative care.
- Collaboration with undergraduate programme of Radboud University Medical School, Netherlands to provide a binaural podcast of a real palliative care ward round https://blogs.bmj.com/spcare/2021/04/20/the-sound-of-covid-19-binaural-recordings-of-a-palliative-care-ward-round-in-a-cancer-hospital/
- Surgam 2023 Awards Cardiff University: C4ME Nomination – Palliative Medicine Outstanding medical student support
- Awarded ESMO Integrated Oncology & Palliative Care Centre Accreditation Award
- Careers- Why Palliative Care? A conversation with Dr Rachel Clarke https://compassionate.cymru/2023/04/17/in-conversation-with-dr-rachel-clarke/

Future Plans:

- Palliative Medicine will continue to host 3rd year SSC students and fourth year SSC students next year (at Velindre, hospitals, the hospice and in the community).
- We have interest from ESMO students in joining us as on electives. One elective this year was published as a blog.
- Students continue to have the opportunity to experience radiotherapy treatment first hand with the aid of the virtual reality experience in palliative care.
- Feedback from placements and from Tuesday rounds in palliative care is consistently very high, as demonstrated by the Surgam Awards (2021 and 2023) and feedback forms. The interface Acute Oncology/Palliative Care is particularly popular.

3.4 Year 3 Undergraduate Bookend tutorials

Tutorials run throughout the year on four of the more common oncological emergencies, including neutropenic sepsis, superior vena caval obstruction, malignant spinal cord compression and immunotherapy-induced colitis. These are held as small-group tutorials in a clinical question format.

The tutorials are run by registrars and clinical fellows with an interest in education and moved back to a face-to-face format post-pandemic in 2022/23. This continues to generate positive feedback as students had reported online lectures to be less helpful and interactive, with them appreciating the opportunity to be able to discuss oncological issues more broadly in a small group format.

The main challenge of the bookend tutorials is in obtaining tutors, due to the tutorial dates clashing with dates of clinical rotations and the FRCR Part 2a Cardiff course for StRs. It would be helpful to explore the possibility of rescheduling these to better allow the adequate provision of teaching staff.

Plenary lectures are also delivered by Dr Ricky Frazer in the bookend weeks of the Oncology and Surgery Block. Dr Ricky Frazer and Dr Jo Ocen also provide lectures for the Year 2 case 16 and were involved in the inception of this to support early grounding for undergraduate students in oncological concepts and terminology.

Future plans:

- Set up a conversation between VUNHST and Cardiff University to consider a review of the content of the Acute Oncology presentations due to the significant developments and changes to Acute Oncology treatment/care. This would also allow us to consider whether the Bookends is the most appropriate place to deliver this teaching.
- Review administration processes to ensure students receive preparatory materials with sufficient time to prepare ahead of the sessions.

3.5 Senior Student Assistantship (SSA)

As part of Senior Student Assistantship (SSA) for final year medical students at Cardiff and Swansea University Medical Schools, a transfusion training half-day programme is delivered for every final year student in Wales.

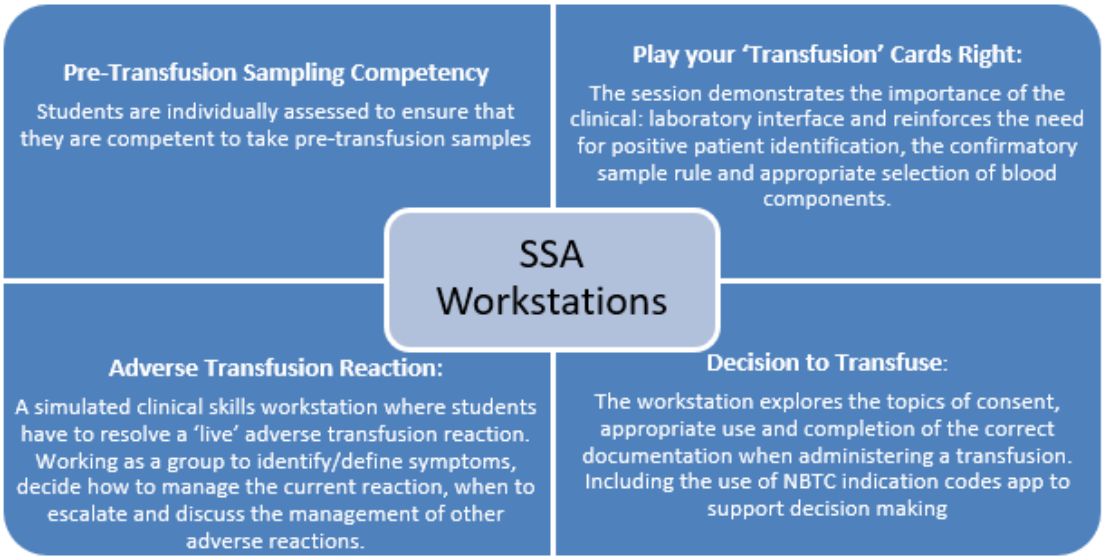
This standardised training and assessment programme is maintained, facilitated and delivered by the All-Wales Transfusion Practitioner Group in conjunction with the Welsh Blood Service Blood Health Team, and support from the undergraduate medical education and clinical skills departments within each Health Board in Wales.

It has been designed to prepare the students for key challenges in transfusion practice when starting work in their foundation training programme, by providing the knowledge and understanding to support students to safely, appropriately and effectively manage patients at various points in the transfusion process, using scenario based interactive learning stations and pre-learning package.

Pre-learning includes:

- Blood Transfusion Training e-Learning packages:
    - Safe Transfusion Practice
    - Blood components and Indications for Use
    - Consent for Transfusion
- Penny Allison video to highlight the: '*3 Fundamental Principles for Safe Transfusion Practice.'*

The SSA session involves 4 key workstations:



In 2024, Microsoft Forms application was piloted to capture student feedback which resulted in improved level of response from 2023 (Table 1). QR codes linked to feedback surveys were embedded in the introduction and debrief sessions to capture feedback 'live'.

Survey Title	2024	2023
Pre Knowledge	362/424 = 84%	222/424 = 54%
Post Knowledge	312/424 = 74%	222/424 = 54%
Evaluation	301/424 = 71%	260/424 = 61%

Table 1 – Session feedback response 2024 vs 2023.

Students evaluated each of the four key workstations grading them as either poor, average, good or excellent (Chart 1):

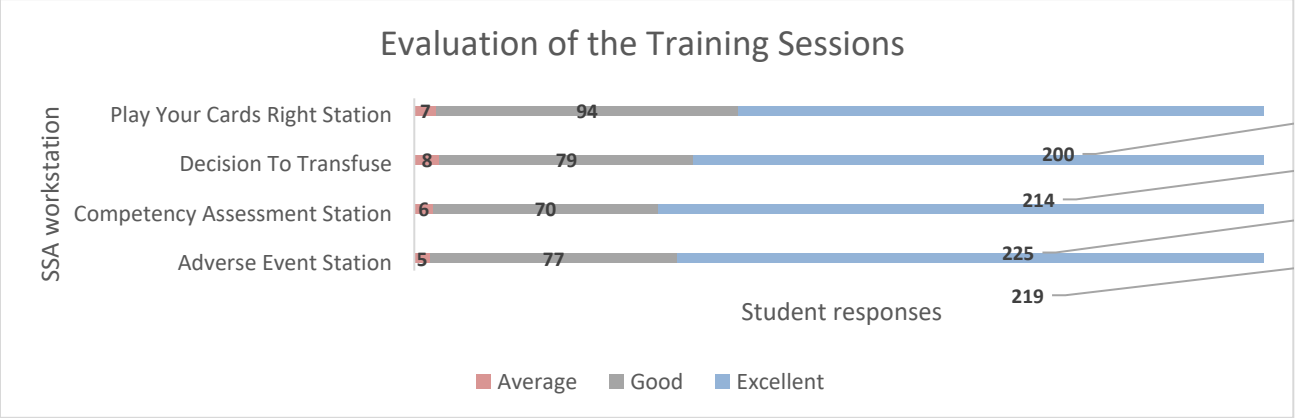


Chart 1 – Summary of Training Stations:

The session feedback has seen significant improvement in all sessions in 2024 compared to 2023 (Table 2):

	2024				2023			
	Poor	Average	Good	Excellent	Poor	Average	Good	Excellent
Adverse Event	0	2%	25%	73%	0%	5%	42%	53%
Competency Assessment	0	2%	23%	75%	0%	4%	43%	53%
Decision To Transfuse	0	3%	26%	71%	0%	5%	40%	55%
Play Your Cards Right	0	2%	31%	66%	2%	14%	41%	43%

Table 2: Evaluation of training for 2023 vs 2024

Delivery of Training: Key aspects of the delivery of the transfusion training session were defined in 6 statements which the students rated with 'disagree, agree or strongly agree' as shown in Chart 2 below:

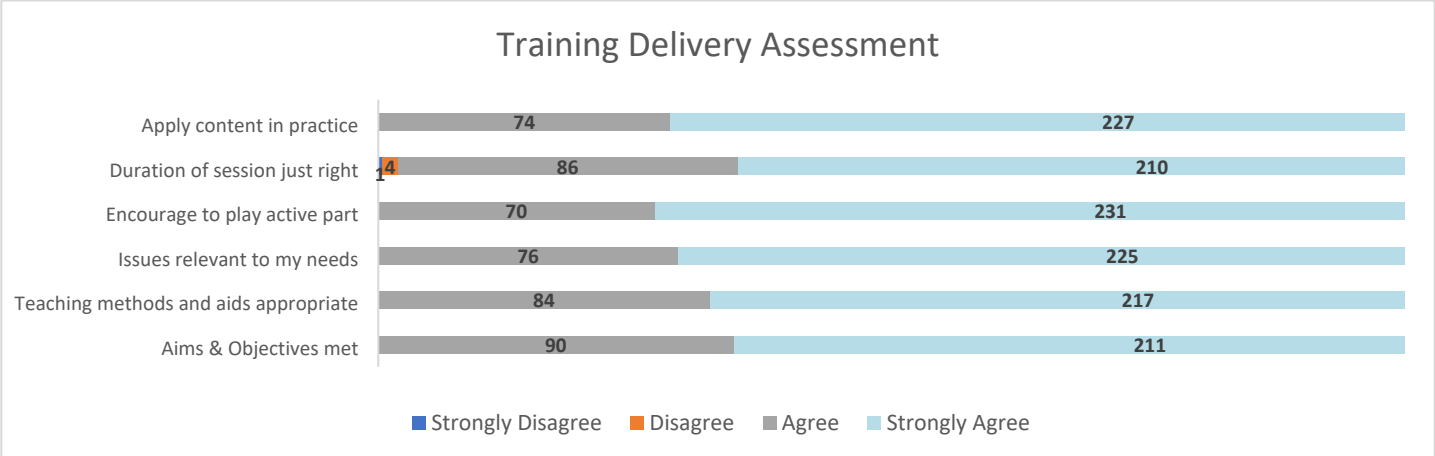


Table 3 shows the results as a percentage of response for 2024 vs 2023 and again demonstrates improved positive feedback.

	2024				2023		
	Strongly Disagree	Disagree	Agree	Strongly Agree	Disagree	Agree	Strongly Agree
Aims & Objectives met	0%	0%	30%	70%	0%	44%	56%
Teaching methods and aids appropriate	0%	0%	28%	72%	0%	42%	58%
Issues relevant to my needs	0%	0%	25%	75%	0%	39%	61%
Encourage to play active part	0%	0%	23%	77%	0%*	33%	66%
Duration of session just right	0%*	1%	29%	71%	3%	39%	58%
Apply content in practice	0%	0%	25%	75%	0%*	44%	56%

Table 3:
**These percentages are 0.03% but rounded down to 0%*

4. Administration

The undergraduate education programme is supported by the Medical Education Co-ordinator who reports to the Executive Medical Business Manager within Corporate Medical Business.

Roles, responsibilities and objectives are currently under review as part of a wider Medical Education strategy refresh. Appendix 1 contains a list of key roles involved in the delivery and administration of undergraduate medical education across the Trust.

5. Assessment

The purpose of this report is to assure Cardiff University that undergraduate education at VUNHST is at an acceptable standard, and that the SIFT funding allocated to VUNHST is being utilised appropriately. It also seeks to assure Cardiff University that VUNHST is abreast of developments in education and continually striving for excellence and improvement to ensure our students receive the best possible education.

APPENDIX 1 – List of key roles 2022/24

AMD Medical Education & Training	Dr Louise Hanna Consultant Clinical Oncologist
College Tutor & Faculty Lead *(Honorary Lecturer)*	Dr Ricky Frazer Consultant Medical Oncologist
Oncology Project Lead *(Senior Honorary Lecturer)*	Dr Rhiannon Evans Consultant Clinical Oncologist
Oncology Project *(Honorary Lecturer)*	Dr Claire Bartholomew Specialty Trainee – Clinical Oncology
SSC Co-Lead	Dr Elin Evans Consultant Clinical Oncologist
SSC Co-Lead	Sara Walters Clinical Audit Manager
Clinical Director – Palliative Medicine	Professor Mark Taubert Consultant in Palliative Medicine
Y3 Undergraduate Bookends Lead	Dr Ruth Stone Specialty Trainee – Clinical Oncology
SSA Lead	Stephanie Ditcham Head of National Blood Health Advisory Team
Library Lead	Bernadette Coles Librarian
Administration	Kate Belbin Medical Education Co-ordinator
Administration	Elizabeth Eddie Executive Medical Business Manager

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD

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

APPENDIX 2 – VUNHST & Cardiff University Library Service Report

Velindre University NHS Trust's Library Service serves all members of the Trust at all sites. This includes the Welsh Blood Service, Trust HQ and the Velindre Cancer Centre which is where we are physically based. The library at the Cancer Centre is Wales' only cancer specialist library. The service is funded by the Trust but managed by, and a full member of, Cardiff University Library Services via an SLA.

The physical library is available on a 24-hour basis to all Velindre staff and students by prior arrangement. Instructions on how to access the library are included in the student library induction pack.

1. Services to undergraduate students.

A full range of library services is available to all undergraduate students whether visiting or on placement at the Velindre site. We also support all the medical students for the duration of their oncology project wherever they or their tutor are based.

Face to face inductions for student groups are now available but most are still be done via Teams. All medical students are sent an email at the beginning of their oncology project explaining who we are, the level of support they can expect from us and how to go about obtaining a Velindre NHS Wales Athens password.

In addition to this, the library and its staff and services are flagged in the introductory lecture given to the year 3 undergraduates prior to starting the oncology project.

We take part in both the year 3 and year 4 SSC induction (via Teams) – these students have access to all our specialist resources and are offered training and support for their projects.

We also have a specialist Trust e-resource collection which is available to students via the NHS Wales Athens password system during their oncology project or while they are on placement.

(This is available to all oncology project students not just those with tutors at the Velindre site.)

It includes a specialist collection of cancer/palliative care titles, access to UpToDate, and the TNM manual online includes a selection of oncology e-textbooks although this has been limited due the expensive/complicated licensing nature of e-books.

Undergraduate level courses are not a huge part of our remit on this site and while this meeting is focused on medical students, we are involved in supporting undergrads on a variety of courses.

As well as Cardiff medical students (Y3 – Oncology Project, and Y4 & Y5 – Student-Selected Component), we support radiotherapy students (Cardiff) and nursing students from various HEIs. We also support pre-registration pharmacy technicians (online diploma level), a few medical physicists (Swansea Uni), physician associate masters and occasional individuals from therapy students on placement.

2. Developments 2023-2024

Library Review and Action Plan
Completed actions on the 2024 action plan include the signing of the SLA with Cardiff to March 2025, the production of an annual report, the completion of an eBooks survey and the national space survey run by NHSWLKS. A new action plan to March 2025 has been put on place.

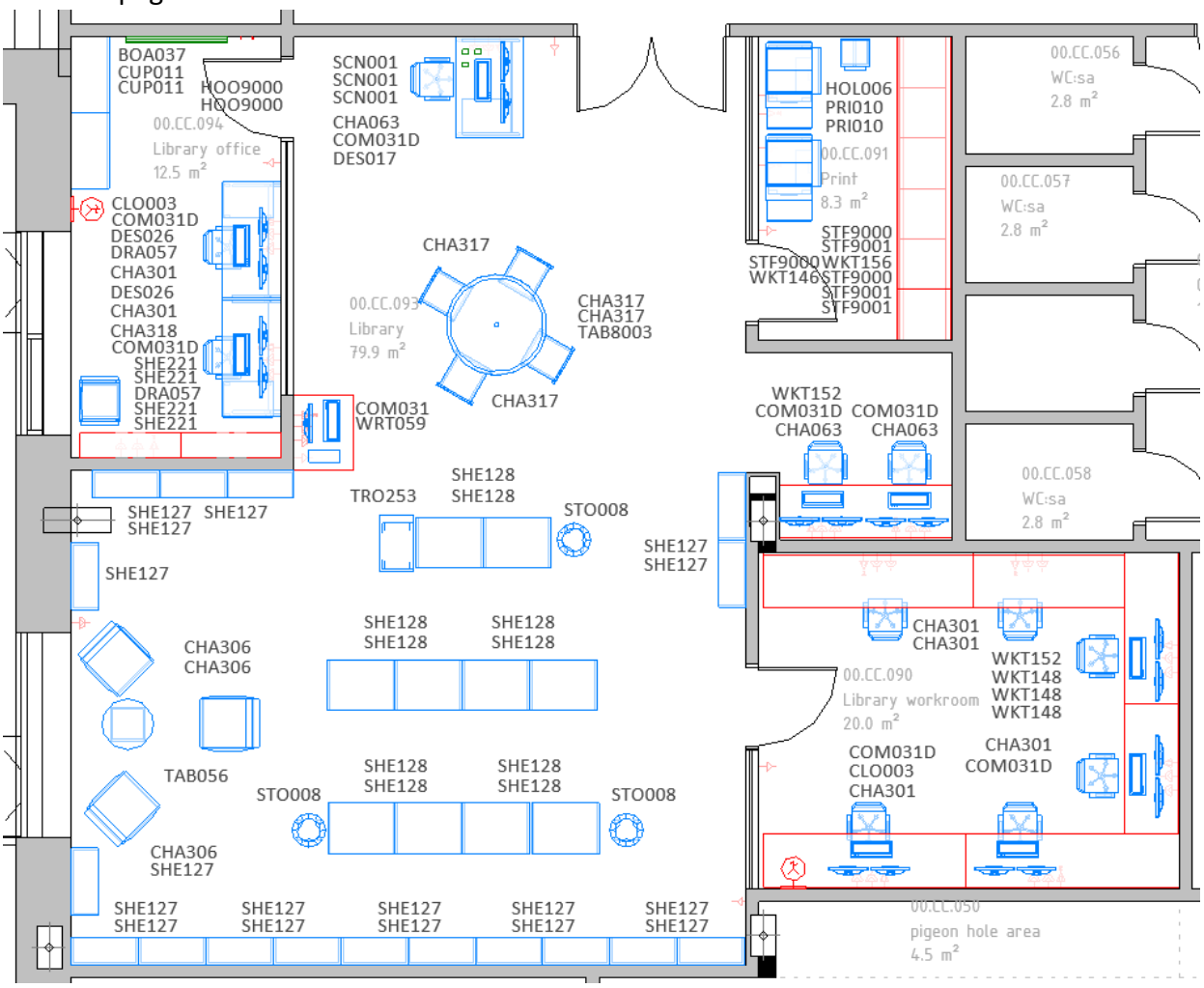
Funding
The current SLA runs until March 2025, and we have begun the process for the 2025/26 renewal. The Trust have commented that they are reviewing all SLAs held by the Trust and we are part of this process – we are waiting to hear the result of those discussions.

Eduroam
It has been agreed that Velindre IT will begin transmitting Eduroam throughout the site via the Velindre infrastructure. It has already been switched on at WBS and has been tested and works at VCC. Cardiff and Velindre IT are co-ordinating a date where the CU access can be switched off in the main VCC areas so the Trust version can be switched on. This will benefit all students and academic staff member as the current Eduroam coverage is limited to small specific areas of the site while the new Trust access will be everywhere. IT are also in discussions with CU IT to change the method of access for the Cardiff wired PCs which will mean that a separate CU infrastructure will not be needed on site. This has implications for the new VCC hospital build and will hopefully make things simpler (and cheaper) going forward.

Improved facilities in nVCC
The new library design for nVCC is still not the largest library in NHS Wales but includes a library office and a separate silent study space. It is also located in the centre of the new hospital adjacent to all the other educational facilities. This will give all UG students improved access to our resources.

Planned library space in the new Velindre Cancer Centre

See over page.



The next phase moves on to a more detailed discussion of equipment and decoration.

BM Coles
VUNST Librarian
October 2024

Schools of Medicine, Cardiff and Swansea Universities:
Minimum Library and IT Standards for Undergraduate Students on placement (hospital practice) in:
NHS Wales University Health Board/Trust Libraries 2024

Standard	**Yes/No**	**Comments – please quantify provision in each site if multi-site library service and any concerns or difficulties in achieving the standard.**
Induction		
Library staff contribute to the induction process for new undergraduate students on placement.	Yes	Library is included in all SSC induction sessions and offers all other UG student groups induction on request
Provision of an induction/welcome "pack" in hard copy or online and/or via dedicated pages on the website (internet and/or intranet).	Yes	Student specific library induction pack plus presence on student web pages
Library Space & Facilities		
Access to library and quiet study facilities with safe 24-hour access (please list safety procedures, and if 24-hour access not achievable please indicate why).	Yes	24 hours access is available on request. The library is in a secure building and the student must sign in and out of the library at the main hospital reception to be given a key. Security patrols the site after normal working hours.
Features promoting accessibility and inclusion. *Examples may include space between desks for wheelchair users to move around, adjustable desks and seating, dimmable lighting, colour-coded floor plans, use of tranquil colours such as greens and blues in furniture or on walls.*	Yes	The library space is on the ground floor and is accessible for wheelchair access.
A range of adequate study areas for students available including quiet study spaces.	Yes	Limited study spaces available due to small physical size of the library Desks, carrells and casual seating available
If library space permits, bookable room(s) to allow for private or group study, or online tutorials/meetings (if not available	No	Bookable rooms are not available in the library

please indicate why, e.g. no space, rooms available elsewhere etc.).		
PCs / WiFi / IT Facilities		
Access to Health Board/Trust networked/standalone PCs (which are no older than five years) with provision to access University email, internet, and a range of appropriate Office software with safe 24-hour access (please list safety procedures, and if 24-hour access not achievable please indicate why).	Yes	Wired access to CU network Wired access to Velindre network Available within the library on a 24-hour basis (see safety above)
Access to a WiFi network which enables students to access the internet. (Adoption of the JISC eduroam service by Health Board/Trusts is encouraged which enables all students to access a secure WiFi network.)	Yes	Eduroam access in Library building (soon to be extended across the site) Velindre WiFi in Library building Cloud WiFi in Library building
Access to plug sockets or charging stations to allow users to work on their personal devices.	Yes	Sockets are available in the library
Access to printing, scanning and photocopying facilities.	Yes	All available in the library
Collections		
Access to the NHS Wales LibrarySearch resource discovery tool (online catalogue).	Yes	
Access to NHS Wales local and national digital library resources e.g. journals, evidence summaries, databases, guidelines etc.	Yes	
Access to an up-to-date collection of recommended materials	Yes	

(including wellbeing titles) in print and online.		
Access to an interlibrary supply service to obtain books and journal articles from other sources when not held in the local library.	Yes	
Library space and collections are well signposted, and web pages on the Health Board /Trust website advertise library services and facilities, with access to electronic resources on and off site.	Yes	Links to the library are on the main Trust pages as well as the VCC pages.
Using library resources		
Access to an enquiry service.	Yes	
Training in use of print and online information resources.	Yes	All students are offered training sessions on demand if required
Out of staffed hours services e.g. borrowing and returning items.	Yes	
Library staffing		
The library is managed by an appropriately qualified librarian and the staffing infrastructure is adequate to support the workload and provision of a quality service.	Yes	2 full time professional members of staff 1 librarian and 1 assistant librarian post
Knowledgeable, well trained library staff.	Yes	Both postholders have an MSc in health information management and both attend regular training via Cardiff ULS and NHS Wales Library & Knowledge Service
Identification of a member of library staff with specific responsibilities as the 'Undergraduate Liaison Librarian'.	Yes	Librarian
	Yes	

Clearly displayed methods of contacting the library.		Information online and on site – staff can be contacted through email or through Teams as well as by telephone.
Consultation with users		
Library provides regular opportunities for users to give feedback on services.	Yes	We carry out occasional user surveys and have a suggestions box on site
Signage		
Signage to be well displayed and in line with accessibility and Welsh Language regulations.	Yes	
Signage clearly displaying the opening times of the library.	Yes	
Evaluation		
Library and information support is included in formal student evaluation and feedback.	Unsure	
SIFT funding		
There is a formal process, at least annually, for reviewing SIFT-based funding and re-negotiating this as required.	Unsure	The library is not involved in this process

***To note*:** Library and IT provision to support medical students on clinical placement are referenced in the following:
i) GMC Promoting excellence: standards for medical education and training 2015 https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-2109_pdf-61939165.pdf
ii) Clinical Placement Agreement between the Medical Schools of Cardiff and Swansea Universities and the University Health Boards/Trusts
***See also*:** i) Learning Space within NHS Knowledge and Library Services in England 2020 and 2023 https://library.nhs.uk/wp-content/uploads/sites/4/2024/01/HEE-Policy-for-NHS-Library-Learning-Space.pdf
ii) PD ISO/TR11219:2012 Information and documentation – qualitative conditions and basic statistics for library buildings – space, function and design

BM Coles
VUNST Librarian

October 2024

APPENDIX 3 – VUNHST SIFT Expenditure Schedule 2023-24

2023-24 VUNHST
SIFT Expenditure Sche

ANNUAL REPORT 2023/24

START

Technoleg Iechyd Cymru
Health Technology Wales

Mae'r ddogfen hon hefyd ar gael yn Gymraeg
This document is available in Welsh

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Our partners:

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

Ariennir gan Lywodraeth Cymru | Funded by Welsh Government

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FOREWORD

Welcome to the Health Technology Wales (HTW) Annual Report which describes the work that we have done during 2023-24.

This year we have balanced our commitments to selecting, appraising and promoting the adoption of novel, evidence-based, non-drug technologies, with taking on new roles to support the innovation and medtech ecosystem in Wales and beyond.

During 2023-24, we considered 66 new topic referrals and published 11 new HTW national guidance documents, which addressed topics that ranged from digital assessment tools to robot-assisted surgery and intensive family preservation programmes. Since 2017, HTW has published 44 pieces of evidence-based guidance and 245 Topic Exploration Reports. The 2022-23 audit report indicates that there is a high level of awareness of HTW guidance within NHS Wales and that HTW guidance is having a significant impact on decision-making.

To support the delivery in NHS Wales of the six ministerial priorities, HTW evolved its topic identification and prioritisation processes during 2023-24 and focused on searching for technology topics that are being addressed by HTA organisations internationally and may be relevant and of interest to the Welsh health and care sectors. Through engagement with clinical networks and policy leads, we have identified those most relevant to the ministerial Priorities and will now pursue more detailed selection and assessment of these.

During 2023-24, HTW contributed, as a collaborating partner, to the development and implementation of the Innovative Devices Access Pathway (IDAP) pilot, a national venture that aims to promote transformative medical technologies that address unmet clinical needs in the NHS.

In order to support decision-making around the full lifecycle of medical technologies, HTW engaged with the newly formed All-Wales Clinical Effectiveness Group (AWCEG). AWGEG is tasked with identifying interventions that are undertaken in Wales but which, evidence suggests, are low value interventions in terms of clinical and cost effectiveness. HTW provides evidence reviews and summaries to the group to ensure that they have access to the most robust and up-to-date published information on which to base their decisions.

Public and Patient Involvement (PPI) is central to all aspects of our work. During 2023-24, 13 non-drug technology topics were considered by the HTW PPI Standing Group. Meanwhile, the impact of the HTW PPI Group continues to spread beyond Wales through its involvement in the work of the International Network of Agencies for Health Technology Assessment (INAHTA).

Engaging with local, national and international stakeholders remained key to the success of HTW during 2023-24. Local engagement through the HTW Stakeholder Forum helped to guide the work of HTW to ensure that it continues to be of greatest relevance and value to the communities it serves. We have continued to work closely with partners in the Health and Care Research Wales (HCRW) Evidence Centre to ensure that the decisions made by NHS and social care leaders and Ministers are supported by the best available evidence. We have continued to build on already established links with the life sciences industry through the work of our Industry User Group and collaborations with the Life sciences Hub Wales and the Bevan Commission.

During 2023-24, HTW was able to successfully deliver the objectives outlined in the five-year Strategic Plan published in 2021 and continued to develop its vision to become a world class HTA organisation. We hope that you enjoy reading this annual report and we look forward to continuing to work with you in realising our vision.

Professor Peter Groves
Chair
Health Technology Wales

Dr Susan Myles
Director
Health Technology Wales

STRATEGIC PLAN 2021-2025

Better Health - Evidence Driven

The HTW Strategic Plan 2021-2025 sets out the organisation's immediate, medium and long-term strategic goals and objectives.

VISION: To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health technologies that offer most promise to deliver improved health outcomes and value for the people of Wales.

MISSION: To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies in Wales.

Key achievements in delivering our 2023/24 priority objectives are set out below:

Expand HTW's topic identification, prioritisation and selection efforts

- Reviewed the International HTA Database to identify health technologies which align with Welsh Government's six ministerial health and social care priorities
- Shortlisted 10 relevant publications from the INAHTA database which were classified into ministerial priority areas
- Worked in close partnership with clinical and policy networks across Wales to identify new topics for evidence appraisal

Maintain increased HTW evidence appraisal and guidance output

- 11 pieces of guidance published in 2023/24
- 10 topics progressed to evidence appraisals
- 30 Topic Exploration Reports (TERs) published

Support time-critical health and social care policy decision making

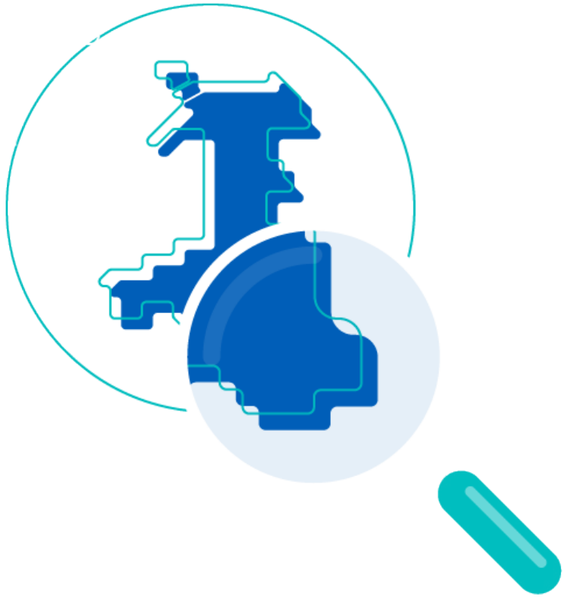
- Continued to conduct rapid evidence reviews as a Collaborating Partner of the Health and Care Research Wales Evidence Centre
- Participated as part of a Technology Specific Evaluation Team (TSET) in the NHS Artificial Intelligence Award evaluating research for two AI technology projects
- Provided a key evidence support role to the All-Wales Clinical Effectiveness Group (AWCEG) in reviewing current Interventions Not Normally Undertaken (INNU) policies held by Welsh health boards

Roll-out technology adoption audit function and pilot the adoption audit process for NICE medical technologies guidance

- 11 pieces of HTW guidance and three pieces of NICE guidance audited as part of the 2022/23 HTW Adoption Audit
- Encouraging response rates with participation by 6 local health boards and the Welsh Health Specalised Services Committee
- Responses indicate that awareness of HTW guidance is high (70%), clarity of HTW guidance recommendations is good (83%), and HTW guidance is having some form of impact in the majority of cases (72%)

Improve and publish HTW's methods and processes

Publication of HTW Appraisal Process Guide and summary document

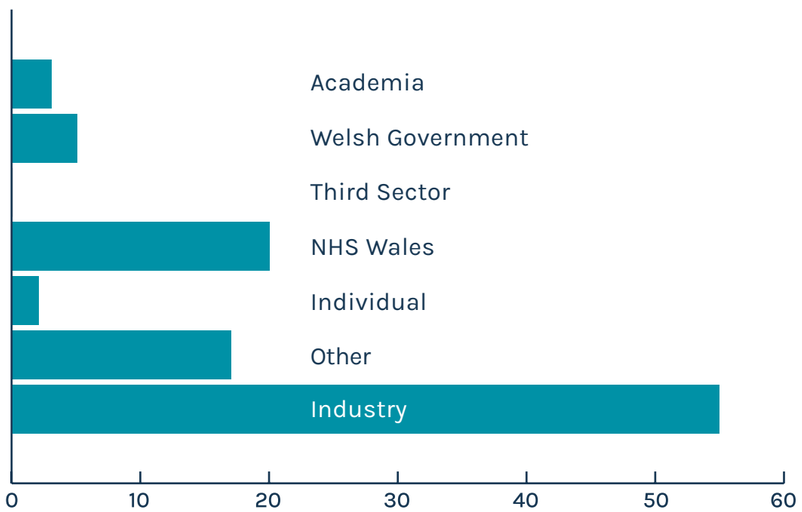


TOPIC IDENTIFICATION

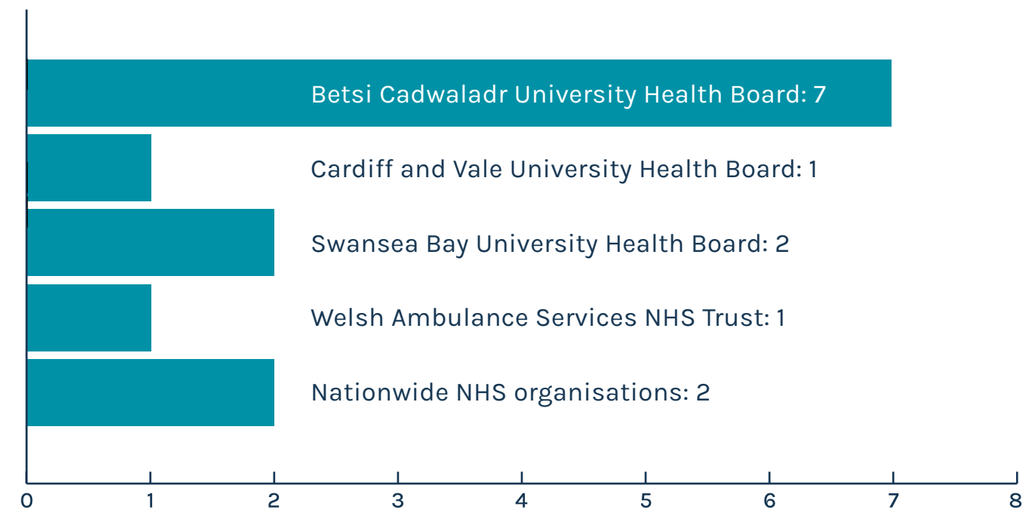
66
Topics proposed to HTW in 2023/24

493
Topics proposed to HTW since 2017

Source of topic referrals in 2023/24



Breakdown of topics referred from the NHS in 2023/24



We have produced an animation to explain the criteria required for submitting a topic for appraisal. To find out more watch our animation **here.**

A ROADMAP FOR INNOVATION

The Innovative Devices Access Pathway (IDAP) aims to bring transformative medical technologies to market to address unmet clinical needs within the NHS.

It has been delivered by a UK-wide collaboration of partner organisations that includes Health Technology Wales, the Department of Health and Social Care, Medicines and Healthcare products Regulatory Agency, NHS England, Office for Life Sciences, National Institute for Health and Care Excellence and Scottish Health Technologies Group.

The aim of IDAP is to create a roadmap to support innovators in generating the evidence they need to achieve regulatory approval, health technology assessment and facilitate patient access.

In September 2023, the IDAP pilot initiative was launched and innovators were invited to submit expressions of interest for access into the pathway. The pilot attracted strong interest receiving 81 applications.

All eligible applicants were evaluated by the partner organisations alongside NHS clinicians and patient and public representatives. In assessing the applications multiple factors were considered including the potential to fulfil an unmet clinical need and address one of the Life Sciences Vision Healthcare Missions, the transformational and innovative nature of the device and the likelihood of it delivering a solution that will be widely adopted.

Eight technologies were invited to join the IDAP pathway, ranging from a device that aims to identify and destroy liver cancer tumours using focused ultrasound waves, to a blood test for Alzheimer's Disease and a Multiple Sclerosis fatigue app.

IDAP partners will now work with the companies to develop a Target Development Profile which provides a bespoke pre-market roadmap for the technology including engagement with other IDAP support tools.

You can find out more about the eight technologies selected to join IDAP here.

The aim of the IDAP pilot was to test the main elements of the pathway and to provide informative learning and feedback that will be used to help build the future IDAP.

Insights gained during the pilot phase will be crucial in shaping the future direction of the new IDAP pathway.

> This provides a game changing opportunity for health technologies to reach patients and clinicians faster. I look forward to seeing the impact these technologies will have as they address unmet clinical needs in Wales and across the UK.
>
> We believe Wales has a key role to play in supporting this new pathway and I hope this forward-thinking project will pave the way for the adoption of more innovative technologies to the benefit of the people of Wales.
>
> Llywodraeth Cymru
> Welsh Government
>
> **Eluned Morgan MS**
> Minister for Health and Social Services in Wales

DRIVING INNOVATION IN ARTIFICIAL INTELLIGENCE

HTW is working in collaboration with partners across the health, social care and innovation sectors to support the development of innovative AI technologies for use in Wales.

It is at the forefront of developing frameworks for the appraisal of AI health and care technologies and is working on several projects aimed at identifying the challenges and opportunities the AI technology presents.

These include:

The AI in Welsh Health and Social Care Commission

The newly formed commission was set up by Welsh Government with the following aims:

- Deepen our understanding of AI needs
- Improve the organisational understanding of the requirements that exist across the health and social care sector in Wales so that we are using AI as a tool to answer the right questions:
  - What has prevented greater adoption of AI?
  - What can we deliver that supports effective adoption of AI?
  - What are the big issues than need solving?
- Map the current ecosystem

  Develop a better understanding of the wider architecture that can support and enable the delivery of ethical AI.
- Enable safe and ethical AI

  Ensuring the safe and ethical adoption of AI is core to the purpose of the commission.

HTW was invited to join the commission in 2023 and is part of a technical working group that supports its work. We are currently working with Welsh Government and other partners on the assessment and adoption of AI in health and care in Wales.

AI rapid review

As part of a Public Health Wales Evidence Service project, HTW's Principal Researcher Dr David Jarrom collaborated with the Public Health Wales Evidence Review to carry out research entitled: "A rapid review exploring the effectiveness of artificial intelligence for cancer diagnosis". Dr Jarrom and his team peer-reviewed the evidence review and worked with PHW's reviewers to develop methods for evaluating research specifically on AI.

AI Appraisals

HTW is due to undertake two pilot appraisals of AI technology. As part of this work, we have developed an internal checklist on AI-specific considerations for HTA. This has generated interest from other HTA bodies and this work will be presented at the HTAi 2024 Annual Meeting in Seville.

IDENTIFICATION CASE STUDY

EVALUATION FOR AI IN HEALTH AND CARE AWARD

What did we do?

In 2021 HTW joined a consortium supporting the testing and evaluation of artificial intelligence technologies in health and care, to support the work of the Evaluation for Artificial Intelligence (AI) in Health and Care Award (known as the AI Award). The AI Award aimed to accelerate the testing and evaluation of promising AI technologies that could be used in health and care. Over two years, we have supported and evaluated evidence generation on two specific AI technologies as part of this work.

Who with?

We joined a consortium with academic researchers from Swansea University Computational Foundry and research staff at TEC Cymru, and applied to join the AI Award's Evaluation Partner Group. This group works with AI technology developers to deliver robust empirical evaluations of their technologies, and assist with further research. There are 15 Evaluation Partner Group members, of which this consortium is the only one based in Wales.

Throughout 2022 and 2023, we worked with two AI technology developers on separate projects. One, known as a 'Phase 3' evaluation, involved peer reviewing existing evidence and advising on ongoing evidence collection. A second, more in-depth 'Phase 4' evaluation, has involved advising on rollout of the technology to a number of test sites, where a pilot study was carried out. The consortium then evaluated the results and made recommendations for further research.

What were the reactions?

Dr Matthew Roach, Senior Lecturer in Computer Science at Swansea University, said: "Health Technology Wales have been a vital part of our consortium. Their work on evidence evaluation and health economics has been essential, and they have helped us understand the needs and expectations of AI adopters in the health and care."

What did people learn?

The consortium includes expertise in computational science, AI safety and user-centred research on digital technologies. HTW staff were involved in advising on developing and evaluating evidence on the effectiveness and cost effectiveness of AI technologies and how these need to be adapted for AI specifically. We have also learned about the work conducted by other members of the Evaluation Partner Group, allowing us to share innovative solutions and learnings with each other.

What difference has this made?

Dr David Jarrom, Principal Researcher, said: "Working on the AI Award has put us at the cutting edge of research on using AI technologies in health and care, and best-practice methods of evaluating this research, as part of a truly multi-disciplinary project. We have learned a lot that can be applied to our own appraisals of artificial intelligence, and we are already putting these learnings into practice."

IDENTIFICATION CASE STUDY

TOPIC IDENTIFICATION USING AN INTERNATIONAL DATABASE

What did we do?

On February 7, 2023, the Minister for Health and Social Services outlined six priorities for care services in Wales, aimed at addressing immediate pressures and building a sustainable service. HTW reviewed the International HTA Database to identify suitable health technologies being appraised internationally which align with ministerial priorities.

The database provides free access to information about ongoing and published health technology assessments commissioned or undertaken by health technology assessment organisations internationally. We concluded that a review of the database would provide a streamlined route to identify suitable topics for consideration.

The initial work focussed on reviewing publications of complete health technology assessments published in the last two years. We filtered publications according to the following criteria:

- At least an abstract in English
- A technology not recently reviewed by the National Institute for Health and Care Excellence (NICE). Older topics reviewed by NICE were included if the NICE review made research recommendations
- The publication included a rapid or systematic evidence synthesis that compared the technology to a comparator
- The publication included consideration of health economics
- The publication included evidence-based recommendations, or the agency involved in the work has a clear process for how evidence is used in decision making

This process produced a shortlist of 10 relevant HTA publications which were classified into Welsh ministerial priority areas:

Ministerial Priority	Number of Topics
A closer relationship between the NHS and local government	0
Improving access to general practice, dentistry, optometry and pharmacy	1
Urgent and emergency care	0
Planned care and recovery	5
Cancer services	3
Mental health and child and adolescent mental health services	0
None	1
TOTAL	10

We needed support from subject experts who could give us advice about whether the topic was likely to be of importance in Wales. We classified the identified topics into 'speciality areas' which assisted us in finding relevant subject experts.

Who with?

We consulted with Welsh Government on all 10 of the relevant topics identified. We also consulted with clinical networks for seven of the topics, including the Cancer Clinical Network, Mental Health Network, Social Care Network, and Women's Health Network.

What were the reactions?

Welsh Government and experts from the clinical networks suggested that all 10 of the topics should be subject to further exploration in the form of a HTW Topic Exploration Report.

What did people learn?

Using resources to identify international reviews that other HTA organisations have prioritised and conducted, may result in topics that are potentially relevant to NHS Wales that we would not have otherwise considered.

APPRAISAL

10 Topics progressed to evidence appraisals in 2023/24

11 Pieces of HTW guidance published in 2023/24

44 Pieces of HTW guidance published since 2017

Find out more

Would you like to find out more about the Health Technology Wales topic appraisal process? To raise awareness about how the process works we have created an animated video: https://www.youtube.com/watch?v=38OuhQp0S04&t=5s

GET INVOLVED

Do you know about a technology or model of care and support in health or social care that Health Technology Wales could appraise?

Anyone can suggest a topic and we are keen to receive suggestions from people with a wide range of backgrounds, including the general public.

To suggest a topic complete our online form here.

> It was really helpful to see HTW's processes in moving from an initial research question, to a comprehensive evidence synthesis, to the development of guidance.
>
> **Patricia Harrington, Deputy Director, Health Technology Assessment, Health Information and Quality Authority (HIQA)**

> As a junior doctor interested in the evaluation of healthcare technologies, I joined the assessment group meeting to observe the discussions on evidence assessment. The meeting was insightful hearing from various experts from HTW and independent advisors on the technology. I enjoyed listening to experts' thoughts on the evidence available from a cost-effective point of view and clinical effectiveness, giving me a deeper understanding of how health technologies we use in practice are scrutinised before their recommendation for NHS wide use.
>
> **Alexander Coombs, Foundation Year 2 Doctor**

> I just wanted to say a huge thank you for letting me observe today's meeting. It was an excellent opportunity to understand the process, key discussion points, expert feedback, and the importance of patient involvement/experience – as well as the breadth of topics covered. It has really helped me move from a theoretical understanding of the theory of how health technology is implemented into the NHS, to a much more practical understanding, which is helpful for me as I progress in my public health training.
>
> **Dr Emily Clark, Specialist registrar in Public Health, Public Health Wales**

DEMYSTIFYING TOPIC APPRAISAL: THE HTW APPRAISAL PROCESS GUIDE

One of our core aims is to ensure that our work can be clearly understood by our stakeholders. This includes; clinicians, health and care providers, people receiving health and social care, technology manufacturers and members of the public.

To achieve this, we have created a range of tools and resources, including guides and animations, that are available in accessible formats which can be clearly understood by a wide audience.

In 2023 we published an Appraisal Process Guide which describes how we carry out health and social care appraisals.

The aim of the guide is to provide a summary of our methods and processes in an accessible format, for anyone who is interested in our work.

It explains the process we use for appraisals including:

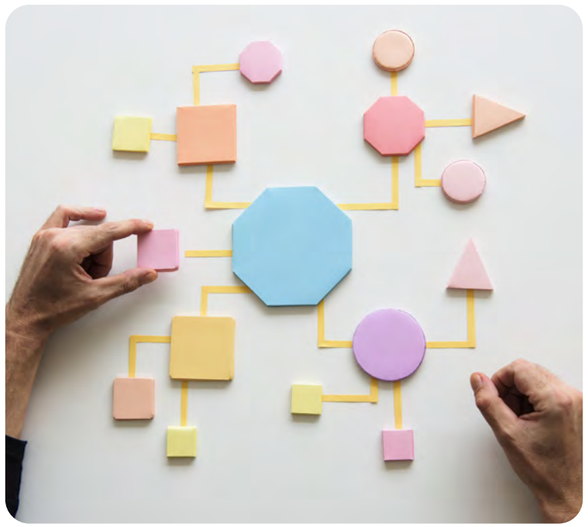
- Initial topic submission and selection
- Production of a Topic Exploration Report
- Selection of topics for further work, in the form of an Evidence Appraisal Report
- Production of an Evidence Appraisal Report
- Production of guidance

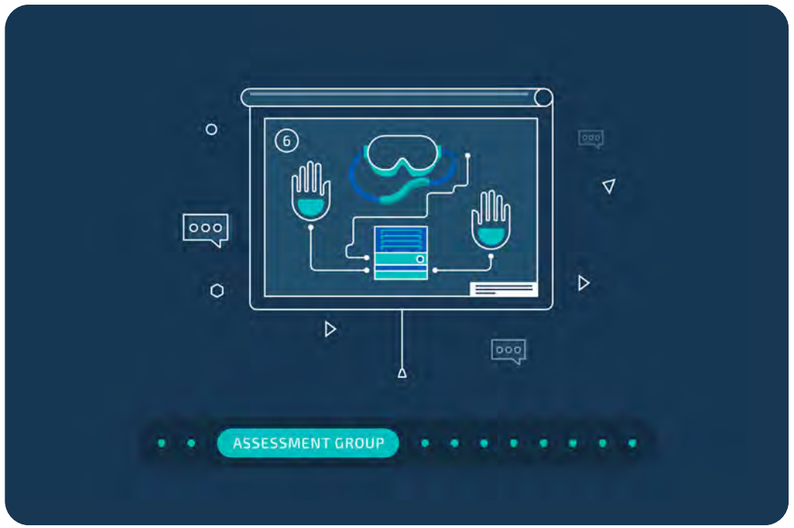
The guide also describes what happens after an appraisal has taken place, how we monitor the impact and adoption of our guidance and the circumstances under which we might change or update guidance.

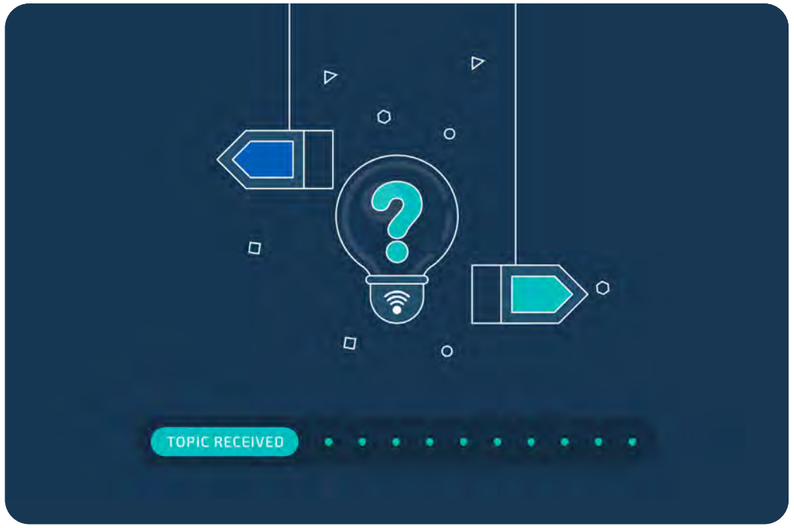
Before publishing the guide, we carried out a consultation survey and invited stakeholders to provide feedback on the draft version of the guide which we then incorporated into the final version.

A shorter plain language summary of our appraisal process can also be found on our website.

For more information about our health technology appraisal process watch our topic appraisal animation video here.







GUIDANCE IMPACT

493
Topics proposed to HTW since 2017

65
Topics progressed to evidence appraisal

44
Pieces of national guidance published

OUR RECOMMENDATIONS

Our national guidance recommendations fall into three main categories:

Routine adoption:

The evidence supports the adoption of that technology for a general population.

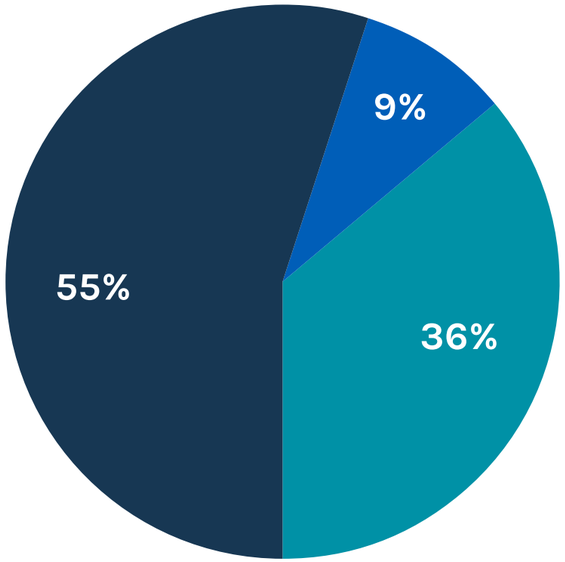
Selective adoption:

The evidence supports the adoption of that technology in a specific subset of the general population.

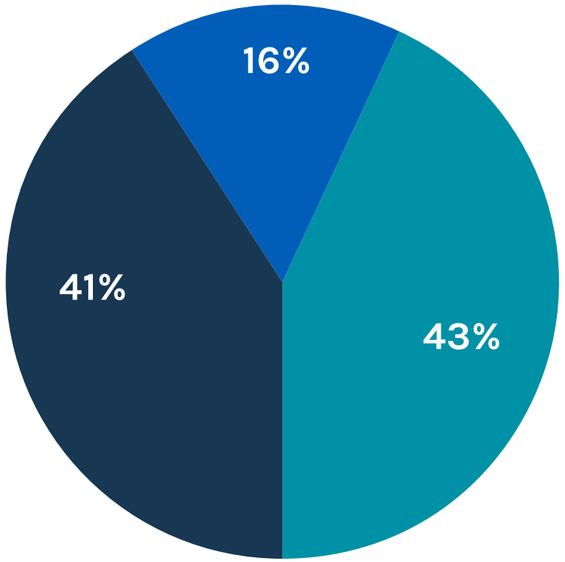
Insufficient evidence to support adoption:

There is not enough evidence to support the adoption of that technology.

2023/24



2017-2024



OUR GUIDANCE

MARCH 2024 | LIPOSUCTION FOR THE TREATMENT OF CHRONIC LYMPHOEDEMA

The use of liposuction for the treatment of chronic lymphoedema is promising, however current evidence does not support its routine adoption in Wales.

MARCH 2024 | VIDEO FEEDBACK INTERVENTIONS

The evidence supports the adoption of video feedback interventions to support children and their families who are at risk of or suffering from harm. Improvements in parental sensitivity, parent-child interaction and attachment have been identified using video feedback interventions.

MARCH 2024 | INTENSIVE FAMILY PRESERVATION PROGRAMMES (IFPP)

The evidence supports the adoption of intensive family preservation programmes for families in crisis. The use of intensive family preservation programmes reduces the risk of out of home child placement.

JANUARY 2024 | DIGITAL WOUND MANAGEMENT TOOLS

The current evidence suggests that some integrated digital wound management systems can accurately measure surface area, but not depth or volume, for some but not all wounds. There is, however, insufficient evidence on how these technologies impact on clinical management and patient outcomes.

JANUARY 2024 | LOW ENERGY CONTACT X-RAY BRACHYTHERAPY

The evidence supports the routine adoption of contact x-ray brachytherapy (CXB) in addition to chemoradiotherapy for people with early-stage rectal cancer who are suitable for surgery. The use of CXB boost increases treatment response rates and organ preservation and reduces the need for subsequent surgery compared with external beam radiotherapy boost.

JANUARY 2024 | ROBOT-ASSISTED THORACIC SURGERY

The evidence does not support the routine adoption of robot-assisted thoracic surgery. The current evidence suggests equivalent clinical outcomes but uncertainty about any improvement in short and long term clinical effectiveness of robotic thoracic surgery as compared to standard of care (open or video-assisted thoracic surgery).

OUR GUIDANCE

DECEMBER 2023 | SOLUTION-FOCUSED ASSESSMENT TOOLS (DIALOG+)

The evidence supports the routine adoption of DIALOG+ for people receiving treatment for psychosis and schizophrenia in a secondary mental health setting. The use of DIALOG+ is shown to improve overall quality of life when compared with standard care but its impact on psychological symptoms, treatment satisfaction and addressing health and social needs remain uncertain.

DECEMBER 2023 | PERCUTANEOUS IMPLANTATION OF PULMONARY ARTERY SENSORS

The evidence supports the routine adoption of percutaneously implanted pulmonary artery pressure sensors to monitor the treatment of people with New York Heart Association class III chronic heart failure and/or a hospitalisation for heart failure within the previous 12 months.

NOVEMBER 2023 | MULTI-GRIP UPPER LIMB PROSTHETICS

The evidence on the use of multi-grip myoelectric upper limb prosthetics by people with upper limb difference remains insufficient to support their routine adoption. The benefits of multi-grip myoelectric upper limb prosthetics compared with other types of prosthetics for upper limb difference is uncertain, and their current use should be determined by individual patient requirements.

SEPTEMBER 2023 | MYOPIA-CONTROL CONTACT LENSES AND SPECTACLES

The evidence supports the routine adoption of orthokeratology and multifocal soft contact lenses to slow the progression of myopia in children and adolescents. Evidence shows that orthokeratology and multifocal soft contact lenses significantly reduce spherical equivalent refraction progression and axial length elongation over at least two years of follow up.

JUNE 2023 | WEARABLE CARDIOVERTER DEFIBRILLATORS

The evidence supports the adoption of wearable cardioverter-defibrillators, in some but not all, adult patients at high risk of sudden cardiac death. For patients who require an implantable cardioverter-defibrillator to be explanted and there is a delay to re-implantation, the use of wearable cardioverter-defibrillators is considered clinically and cost effective, and HTW supports their use for this indication.

EVIDENCE APPRAISAL ON MYOPIA-CONTROL SPECTACLES AND CONTACT LENSES TO SLOW THE PROGRESSION OF SHORT-SIGHTEDNESS IN CHILDREN AND ADOLESCENTS

What did we do?

HTW considered the use of myopia-control spectacles and contact lenses to slow the progression of short-sightedness in children and adolescents. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report, and published HTW Guidance in September 2023.

Who with?

This topic was proposed by a clinical advisor to the NHS. We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from Welsh Government, numerous optometrists, and national clinical advisors for optometry.

What were the reactions?

Stakeholders believed the review to be of high quality. They felt that the appropriate evidence had been reviewed and conclusions reflected the evidence. The College of Optometrists welcomed HTW's guidance. Experts involved in the appraisal process subsequently co-developed a scientific journal article with HTW describing the health economic analysis.

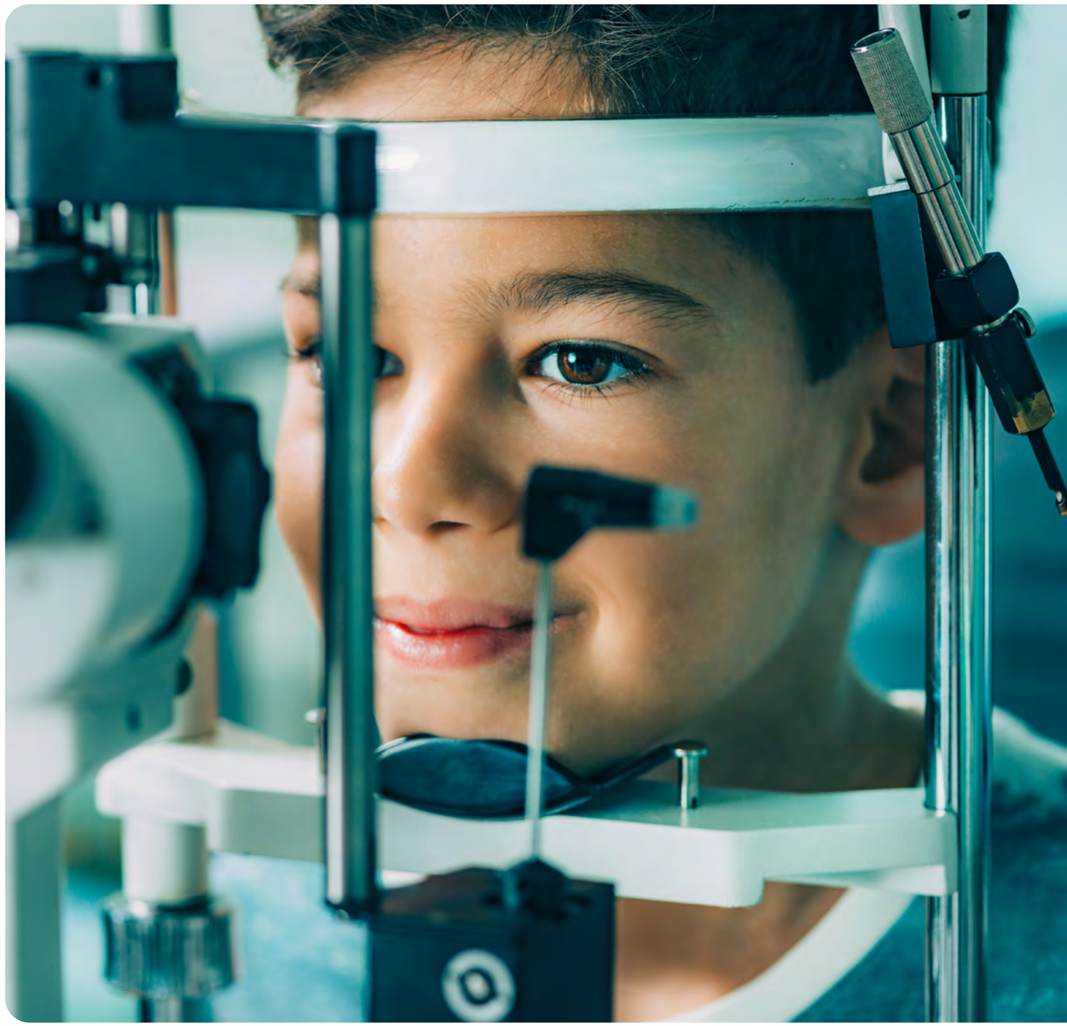
Andy Britton, a Specialist Optometrist who provided expert clinical input into the appraisal, reported that *"The Health Technology Wales process on Myopia Control was a robust appraisal of the current evidence regarding the effectiveness of the various interventions. As someone who was involved in the initial paper that gave rise to this report, it was rewarding to see the whole process performed so diligently and professionally. The opportunity to be involved as an expert witness towards the end of the process was also valuable... all-in-all a great process delivering a great conclusion that will ultimately benefit the children of Wales."*

What did people learn?

Orthokeratology and multifocal soft contact lenses may reduce spherical equivalent refraction progression and axial length elongation over at least two years of follow up. Economic modelling estimates that orthokeratology and multifocal soft contact lenses may be cost-effective compared with single-vision correction, driven by the assumption of quality-of-life gains from a reduction in long-term progression of short-sightedness and its complications.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of two types of lenses, orthokeratology and multifocal soft contact lenses, to slow the progression of short-sightedness in children and adolescents.



EVIDENCE APPRAISAL ON PERCUTANEOUSLY IMPLANTED PULMONARY ARTERY PRESSURE SENSORS TO MONITOR TREATMENT OF PEOPLE WITH CHRONIC HEART FAILURE

What did we do?

HTW considered the use of percutaneously implanted pulmonary artery pressure sensors to monitor treatment of people with chronic heart failure. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report, and HTW Guidance in October 2023.

Who with?

This topic was identified following a search of National Institute for Health and Care Excellence (NICE) interventional procedures guidance. We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from consultant cardiologists working in NHS Wales.

What were the reactions?

Ross Wardle, Head of Market Access UK and Ireland for Abbott Medical, stated that *"Our experience of working with HTW on the development of the guidance on percutaneous implantation of pulmonary artery pressure sensors has been a very positive one. Regular and transparent communication from the outset enabled us to seamlessly feed into the process where necessary and ensure all relevant information was considered."*

What did people learn?

Percutaneously implanted pulmonary artery pressure sensors may reduce hospitalisations for heart failure and the length of stay in hospital, and may improve quality of life. Experts suggested that the baseline rate of hospitalisations in Wales may have been underestimated in the HTW cost-utility analysis, and it is therefore plausible that percutaneously implanted pulmonary artery pressure sensors are cost effective in NHS Wales.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of percutaneously implanted pulmonary artery pressure sensors to monitor the treatment of people with New York Heart Association class III chronic heart failure and/or a hospitalisation for heart failure within the previous 12 months. The Appraisal Panel also advised that the use of percutaneously implanted pulmonary artery pressure sensors in NHS Wales should be associated with the gathering of real-world evidence of clinical and cost effectiveness.

EVIDENCE APPRAISAL ON SOLUTION-FOCUSED ASSESSMENT TOOLS (DIALOG+) FOR IMPROVING THE TREATMENT OF PEOPLE WITH PSYCHOSIS AND SCHIZOPHRENIA WITHIN SECONDARY MENTAL HEALTH SERVICES

What did we do?

HTW considered solution-focused assessment tools to improve the treatment of people with psychosis and schizophrenia in secondary mental health services. We appraised the clinical and economic evidence on the topic, produced an Evidence Appraisal Report, and published HTW Guidance in December 2023.

Who with?

This topic was proposed by a consultant nurse at Cardiff and Vale University Health Board. We engaged with several stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from nurses and clinical psychologists, the manager of the Royal College of Psychiatrists Wales and a health economist with experience in this area.

What were the reactions?

Stakeholders believed the review to be of high quality and had confidence in the HTW appraisal method. Stakeholders felt the appropriate evidence had been reviewed and that the process was robust.

The topic proposer, Norman Young, Nurse Consultant, Clinical Service Lead for Early Intervention in Psychosis, Headroom said: *"DIALOG+ is a tool that effortlessly merges patient-reported experiences and outcomes with a solution-focused therapeutic approach. Developed over two decades, DIALOG+ not only has robust psychometric properties but also demonstrates enhanced clinical outcomes when utilised in routine practice. Recognising its potential, I put forward DIALOG+ for an independent evaluation when Health Technology Wales (HTW) invited topics. The HTW team agreed and carried out a comprehensive economic and clinical appraisal. As a topic proposer, I was actively involved in all key stages and in reviewing the final report. I wholeheartedly recommend that anyone with a suitable topic should take the opportunity to put it forward."*

What did people learn?

The evidence review showed that the use of a particular solution-focused assessment tool, DIALOG+, can improve subjective quality of life compared with standard care. The economic evidence also indicated that DIALOG+ is unlikely to increase overall health and social care costs compared to standard care.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of DIALOG+ for people receiving treatment for psychosis and schizophrenia in a secondary mental health setting.

EVIDENCE APPRAISAL ON LOW ENERGY CONTACT X-RAY BRACHYTHERAPY (CXB) FOR THE TREATMENT OF EARLY-STAGE RECTAL CANCER

What did we do?

HTW considered the use of contact x-ray brachytherapy (CXB) for the treatment of early-stage rectal cancer. CXB is a form of radiotherapy boost, given alongside standard radiotherapy or chemoradiotherapy. It is locally delivered via a tube inserted into the rectum. It aims to improve quality of life and reduce the need for surgery and stoma. We appraised the clinical and economic evidence on the topic, publishing an Evidence Appraisal Report and HTW Guidance in January 2024.

Who with?

This topic was proposed by a Consultant Clinical Oncologist at Swansea Bay University Health Board. We engaged with the Papillon Patient Support group, Tenovus and the All-Wales Cancer Network to explore patient perspectives on the diagnosis of rectal cancer and available treatments. During the consultation period, we received feedback from clinical oncologists, surgeons and radiotherapy physics professionals. The topic proposer stated the process was *'very diligent and thorough'* and that they found *'communication excellent throughout'*.

We joined forces with experts who took part in our appraisal of low energy contact X-ray brachytherapy (CXB) to develop an academic journal article which can be read here.

What were the reactions?

Stakeholders believed the review to be of high quality and felt that the appropriate evidence had been reviewed and conclusions drawn. Clinical experts involved in the appraisal process welcomed the guidance and developed a journal article with HTW to present the appraisal findings to a wider audience. They also plan to share the guidance with clinical colleagues at international meetings in 2024.

What did people learn?

The evidence review showed that the use of CXB boost increases treatment response rates and organ preservation compared with external beam boost for people with rectal cancer who are suitable for surgery. Economic modelling suggested that CXB boost is also cost-effective compared with external beam boost in this population.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of CXB in addition to chemoradiotherapy for people with early-stage rectal cancer who are suitable for surgery. Dr Craig Barrington, Consultant Clinical Oncologist at Swansea Bay UHB said *"I feel the conclusions of the report to be practise changing for the population of Wales and I hope it enables our patients to have access to all potential opportunities for treating their rectal cancer"*.

APPRAISAL CASE STUDY

EVIDENCE APPRAISAL ON MULTI-GRIP UPPER LIMB PROSTHETICS

What did we do?

We carried out an appraisal of multi-grip upper limb prosthetics. HTW originally produced guidance on this technology in 2019. The topic was proposed by the Welsh Health Specialised Services Committee, which has now become the NHS Wales Joint Commissioning Committee. We appraised the clinical and economic evidence on the use of multi-grip myoelectric upper limb prosthetics for people with upper limb difference, published an Evidence Appraisal Report, and re-issued HTW guidance in September 2023.

There was a lot of new evidence available since we first appraised this topic, with evidence comparing multi-grip prosthetics to other types now available.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from clinicians involved in prosthetics and rehabilitation from across Wales and from Scotland, as well as prosthetics researchers.

What were the reactions?

Dr Rachel Gemine, Assistant Director of Evidence, Evaluation and Effectiveness, Welsh Health Specialised Services Committee, said *"The report from HTW provided a comprehensive evidence review which enabled us to prioritise resources and ensure the best outcomes and experiences for the people of Wales who are requiring upper limb prosthetics. This guidance supported the decision to continue to individually assess those who would potentially benefit from multi-grip myoelectric."*

What did people learn?

The HTW Appraisal Panel recommended that the evidence remains insufficient to support the routine adoption of multi-grip myoelectric upper limb prosthetics. The benefits of multi-grip myoelectric upper limb prosthetics compared with other types of prosthetics are uncertain, as there is often little difference in reported outcomes, and their current use should be determined by individual patient requirements.

Evidence on cost-effectiveness was limited and we were unable to perform our own economic modelling. However, economic evidence from the Netherlands suggested multi-grip myoelectric upper limb prosthetics are unlikely to meet NHS cost-effectiveness thresholds.

EVIDENCE APPRAISAL ON INTENSIVE FAMILY PRESERVATION PROGRAMMES

What did we do?

HTW considered the evidence on intensive family preservation programmes (IFPP) for families in crisis where there is an imminent risk of children entering care. These programmes are short-term intensive interventions where a social worker works directly with families to resolve crises and provide support to improve skills and resilience. They also provide connections to available services in Wales, with the ultimate aim of preventing children from being taken into care.

We appraised the effectiveness and economic evidence on this topic, published an Evidence Appraisal Report, and published HTW guidance in March 2024.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal including representatives from the College of Arts, Humanities and Society Sciences in Cardiff.

During the consultation period, we received feedback from academics in social care research, educational psychologists, research fellows, and early years practitioners.

What did people learn?

The HTW Appraisal Panel concluded that the evidence supports the adoption of IFPP for families in crisis. The use of IFPP reduces the risk of out-of-home child placement. Parent and children's perspectives support the view that IFPP are beneficial and can address crises that may risk a child's entry to care. While the evidence leaves some uncertainty about the impact of this on child emotional and behavioural wellbeing, there seems to be no evidence of harm. The economic analysis was associated with uncertainty but indicates the potential for cost savings of up to £12,171 per child through the use of IFPP, largely due to the avoidance of out-of-home placement.

What difference will this make?

Families at the point of crisis should be offered IFPP, which findings suggest are associated with reductions in out-of-home placement and can keep children within the family unit. Evidence also suggests that IFPP could be associated with a reduction in distress and substance misuse in parents. Parents and children's perspectives support the idea that IFPP are beneficial and can help address crises that may risk a child's entry to care. However, parents do raise concerns about the coercive nature of IFPP and question why more intensive services could not be provided prior to crises occurring. It is also recognised that there are capacity constraints in social services and that this is a potential barrier to the implementation of the intervention.

APPRAISAL CASE STUDY

EVIDENCE APPRAISAL ON VIDEO FEEDBACK INTERVENTIONS

What did we do?

Health Technology Wales appraised the evidence and produced guidance supporting the adoption of video feedback interventions (VFI) to support children and their families who are at risk of, or suffering from, harm. Child maltreatment has a profound impact on children's wellbeing and a potentially lifelong effect on the child's social, emotional, and cognitive development. Parental home visiting programmes, including VFI for families at risk may decrease the prevalence and risk of maltreatment. VFI is an umbrella term that refers to the use of recorded video feedback during several sessions. The intervention has other names, including but not limited to Video Interaction Guidance (VIG) and Video Feedback Intervention to Promote Positive Parenting (VIPP).

We appraised the effectiveness and economic evidence on this topic, published an Evidence Appraisal Report (EAR), and issued HTW guidance in March 2024.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal including representatives from the Swansea Bay University Health Board, CASCADE and Cardiff Council.

During the consultation period, we received feedback from academics in social care research, educational psychologists, research fellows, and early years practitioners.

What did people learn?

The HTW Appraisal Panel recommended that the evidence supports the adoption of video feedback interventions to support children and their families who are at risk of, or suffering from, harm. Improvements in parental sensitivity, parent-child interaction and attachment have been identified using video feedback interventions. The impact of video feedback interventions on out of home placement and longer-term outcomes are uncertain. Parents who used video feedback interventions report improvements in family relationships and parental confidence. Uncertainty in the effect of video feedback interventions on out of home placement translates into uncertainty in the costs of video feedback interventions compared with standard care. The Appraisal Panel concluded, however, that the evidence to support the benefits of video feedback interventions justifies any possible increase in costs, and that the economic evidence does not preclude adoption.

What difference will this make?

Early interventions in the form of parenting home visiting programmes that are aimed at improving outcomes for children and preventing the escalation of risk, are highlighted in national safeguarding guidance across the UK. Identifying and addressing a family's needs early on can decrease risk factors that may be impacting a child's life negatively. The adoption of VFI in social care can have a positive impact on parental sensitivity, parent-child interaction, attachment, and child placement decisions. VFI could also potentially contribute to the reduction in out of home placements, although HTW appraisal panel would encourage further data accumulation to support this intervention.

"It's important that we understand the most effective ways of supporting children and families who are at risk of harm, so I was delighted to be invited to contribute to the appraisal of Video Feedback Interventions in social care. In many ways Health Technology Wales adopt the central tenets of Video Feedback Interventions as working with them is a strengths-based, rewarding experience. I hope their appraisal will lead to increased use of Video Feedback Interventions, especially as children, families and professionals like this strengths-based approach."

Nina Maxwell Speciality Co-Lead for Social Care, Assistant Director and Principal Research Fellow, CASCADE, Cardiff University

AUDITING THE ADOPTION OF HTW GUIDANCE

We carry out an annual adoption audit to find out whether adoption of our national guidance recommendations has taken place across Wales.

The adoption audit is carried out in collaboration with partners across health and social care and focuses on HTW and NICE Medical Technologies Evaluation Programme (MTEP) guidance.

Each adoption report summarises how HTW guidance has been used and any facilitators and barriers to adoption.

Our 2023 audit revealed that awareness and impact of HTW guidance is high and that is having an impact across Wales.

The audit focused on 11 pieces of HTW guidance and three pieces of NICE MTEP guidance.

Response rates to the audit were encouraging with responses from six of the seven health boards and from the Welsh Health Specialised Services Committee (WHSSC).

Key findings from the Adoption Audit Report 2022/23 included:

- Responses from organisations where the guidance is relevant indicate that awareness of HTW guidance is high (70%), clarity of HTW guidance recommendations is good (83%), and HTW guidance is having some form of impact in the majority of cases (72%).
- In some cases, responses clearly show that HTW guidance was adopted and had a clear impact on decision-making.
- For guidance recommending the routine adoption of a technology, this was most evident for FreeStyle Libre flash glucose monitoring.
- There were some cases where HTW guidance appears not to have been adopted. For guidance recommending the use of a technology, this was most evident for ClearGuard™.
- Adoption of guidance was hindered in some cases by resource limitations (positive HTW guidance is not accompanied by additional funding) and other factors such as small patient numbers, the capabilities of existing technology and the current use of other products.

The audit report concluded that local health boards, WHSCC and the specialist health boards should continue to work with HTW to support future adoption audit reports and that Welsh Government should continue to encourage participation in the process. It also suggests that HTW should consider how the adoption audit process can be extended to cover social care guidance.

Professor Peter Groves, Chairman of HTW, said:
"I would like to take this opportunity to thank the local health boards, commissioners, and specialist health boards for engaging with us so closely throughout the audit process."

Dr Susan Myles, Director of HTW, added:
"We are proud to be leading the way in the UK and internationally in the way we monitor the impact of our national guidance.

"This important work will enable us to support the ambitions set out in the health and social care agenda for Wales."

Collaborating with partners on topic selection:

As part of the 2023 adoption audit we included three pieces of NICE MTEP guidance.

For the 2024 adoption audit we have further developed our process for selecting the NICE guidance to be audited in partnership with Wales NICE Health Network (WNHN) members.

The selection process has involved the WNHN members selecting three pieces of guidance from a shortlist of six pieces of NICE medtech and diagnostic guidance.

ADOPTION CASE STUDY

SHOWCASING THE USE OF AMaT SOFTWARE TO AUDIT GUIDANCE

What did we do?

In 2021 we provided funding that enabled local health boards across Wales to access the AMaT (Audit Management and Tracking) system. The software can be used by health boards to disseminate and monitor the adoption of Health Technology Wales and NICE guidance. This enables the health boards to provide information on the adoption of that guidance for the annual HTW adoption audit.

Who with?

Hywel Dda University Health Board (HDUHB) is one of seven health boards in Wales to use AMaT . As HDUHB covers three counties, Pembrokeshire, Carmarthenshire, and Ceredigion, it was particularly important to ensure that there was equality of access to the best available care across the health board area. We worked closely with HDUBH's clinical effectiveness team for two years to support the implementation of AMaT.

To find out more about how HDUHB used AMaT to monitor the adoption of HTW and NICE guidance watch our video case study here.

What did people learn?

The use of AMaT by HDUHB's clinical effectiveness team has enabled the health board to ensure compliance with HTW and NICE guidance. Donna Edwards, Clinical Effectiveness Co-ordinator at HDUBH said this means they can be *"reassured as a health board that the patients and the people we serve are receiving the best evidence-based care"*.

She went on to say that AMaT enabled the health board to: *"Provide safe and effective care in each of the counties, with limited variation."*

The health board now hopes to develop its use of AMaT so that it is better able to understand which health boards have implemented HTW and NICE guidance. It is also planning to enable clinicians to input information directly into the system.

What difference has this made?

By working in collaboration with HDUBH we have gained greater insight into the health board's user experience. This has enabled us to further develop the audit process to ensure it meets the needs of those taking part.

HTW EVIDENCE SUPPORT FOR NATIONAL GROUPS

Individual Patient Funding Requests (IPFR)

HTW aims to support the IPFR process across Wales by developing evidence summaries for non-medicine IPFR treatment requests. The evidence summaries provide a high-level overview of the clinical evidence available to support the use of the intervention requested and contain a summary of the economic considerations. The production of evidence summaries ensures that best practice is consistently considered when IPFR panels across Wales are considering the clinical and cost effectiveness of IPFR applications for the funding of non-medicine interventions.

> It's great that individuals are now recognising how IPFR, INNU (Interventions not normally undertaken) and prior approval requests link in with the work of Health Technology Wales and the All Wales Therapeutics and Toxicology Centre. Sophie's input to the IPFR group, and the wider work such as quality assurance and the annual training event, has been extremely valued.
>
> **Ann-Marie Matthews,**
> ***Lead for Clinical Commissioning, Aneurin Bevan University Health Board***

All Wales Clinical Effectiveness Group (AWCEG)

AWCEG was established in November 2023 to ensure that a national approach to quality improvement takes place across Wales. It aims for best practice to be spread across the healthcare system and to ensure equity of access to evidence-based procedures.

AWCEG bases its work on the concept of value-based healthcare which promotes co-production, equity and reducing unwarranted variation through evidence-based practice.

The group draws on expertise from HTW who provide rapid evidence reviews to support decision-making by the national group.

Part of this work involves reviewing current Interventions Not Normally Undertaken (INNU) policies held by Health Boards across Wales and the NHS England Evidence Based Interventions (EBI) list with the aim of developing an All-Wales list.

HTW is providing a key evidence support role during this process, evaluating the best available evidence, to inform AWCEG recommendations on procedures to be added or removed from the new national list.

It is hoped that removing access to inappropriate or unnecessary interventions will free up valuable resources which can be put to better use in the NHS.

> It is great to see that we now have a clinically led group in Wales that seeks to reduce unwarranted variation in care using the most up-to-date evidence base. HTW play a pivotal role in supporting this work through evidence synthesis, ensuring that there is an All-Wales approach.
>
> **Dr Sally Lewis, *Director of the Welsh Value in Health Centre***

2023/24 PPI HIGHLIGHTS

HTW's Patient and Public Involvement (PPI) work continues to grow. This year has seen HTW engage with new patient networks and organisations, undertake original events, lead with partners in PPI activities across the UK and internationally and grow and expand HTW's PPI remit. Current tools and processes continue to prove to be effective and relevant and we continue to gather feedback and improve.

Summary of PPI work undertaken:

- PPI undertaken for 13 topics
- Six literature reviews, one patient submission, two patient surveys, one patient testimonial and two focus groups
- PPISG meetings held to determine PPI mechanisms, oversight of ongoing PPI activities, plain language summaries and evolving PPI processes and tools
- HTW continue to input into INAHTA's (International Network of Agencies for Health Technology Assessment) Patient and Citizen Interest Group (PCIG) sessions. Current work involves the creation of a checklist for organisations looking to start PPI
- HTW's PPI Manager has contributed expertise to IDAP's (Innovative Devices Access Pathway) patient engagement on the trial of their pathway for innovative technologies
- Presentation of PPI work as posters at the virtual HTAi conference 2023
- Engagement with Cardiff University presenting a panel on how to conduct good patient engagement in research

This year four of our longstanding PPI members left the PPI Standing Group group, Kiana Collins, Alan Meudell, Catherine Evans-O'Brien and Louise Baker. We would like to take this opportunity to thank them for their invaluable contributions to our PPI work and for the commitment they have shown to championing and developing our processes further.

HTW AND VELINDRE CANCER CENTRE PPI FOCUS GROUPS ON THE USE OF AI IN HEALTHCARE

What did we do?

HTW partnered with the Velindre Cancer Centre to run focus groups for two appraisals in which the health technology incorporated Artificial Intelligence (AI). Two focus groups were held, one virtual and one in-person at the Velindre Cancer Centre. Attendees were current or former cancer patients of varying ages, ethnicities and backgrounds. The focus groups had two aims; to establish a baseline understanding of patients' views, experiences and expectations around the use of AI in healthcare and to gather patient feedback on the two technologies being appraised.

Who with?

Velindre Voices patient network and Velindre's Patient Experiences team.

What were the reactions?

The focus groups proved popular and were well attended. Participants informed HTW that they enjoyed the sessions and were keen to partake in feedback sessions upon completion of the relevant evidence appraisals. The sessions were positively received and have helped to strengthen relationships between HTW and Velindre, educate patients on health technology assessment and HTW and encourage patient participation in ongoing and future appraisals.

What did people learn?

HTW gained valuable insights from patients which were used to inform the PPI reports in the evidence appraisal reviews for both topics. We were able to establish that patients have vastly different ideas of what constitutes AI in healthcare. Patients expect to be informed of, and consent to, innovations such as AI being used in procedures, tests, processes and structures that they will be subject to during any course of treatment. Good communication is of particular importance as the majority of patient fears and concerns around the use of AI in healthcare can be alleviated if time is taken to explain how it functions, where responsibilities lie and what they can expect. Many patients are unaware of encountering AI and where AI technologies are currently being used in healthcare services. All participants expressed that they would be happy to have both technologies in questions used during their treatments once the technologies and the role of the AI was adequately explained to them.

What difference has this made?

HTW were able to gain patient experiences and evidence for the two appraisals that otherwise would have been difficult to obtain. It has ensured that patient voices, opinions, experiences and concerns inform decision making in healthcare in Wales.

> Working with Health Technology Wales in hosting patient focus groups was an efficient and enjoyable process throughout. This was our first time in partnership with an external organisation for a project like this and we are pleased to say it was a huge success. With clarity on roles and expectations from the outset, we thoroughly enjoyed working alongside Alice and her team to deliver two engaging, thought provoking and efficient focus groups.
>
> Our patients felt valued through both sessions and were encouraged to share their views, questions and challenges freely. We would love to work with the HTW team again in the future and welcomed the opportunity to offer our patients such an exciting and interesting topic to review.
>
> **Lucesca Walters, Patient Engagement and Volunteer Support Officer, Velindre University NHS Trust**

PPI PUBLICATIONS

In 2023/24 HTW's PPI team contributed to the following publications:

- The role of HTW's Patient and Public Involvement Standing Group (PPISG) and Public Partners was featured in an article looking at how HTA bodies across the globe include patient representatives at the organisational level. HTW's PPI manager and a public partner were interviewed and provided written oversight of the role of the PPISG and public partners in HTW's core work program, including the running of Assessment Group and Appraisal Panel. The article was published with the International Journal of Technology Assessment in Health Care and can be located here. Karen Facey, PPI Advisor, HTW PPI Standing Group said: *"This paper has generated much interest in the HTA community which shows that HTW's work is again world leading."*
- An article written as poster presentations for the HTAi 2023 conference on HTW's PPI work has been published in the International Journal of Technology Assessment entitled: *"The Importance Of Flexible PPI Approaches: Case Study On Flash Glucose Monitoring"*. The article can be located here.
- HTW's PPI Manager contributed to the production of INAHTA'S (International Network of Agencies for Health Technology Assessment) position statement on patient and public involvement. The position statement was published and can be viewed here. An article on the international production of this position statement through the work of the PCIG is due for publication with the International Journal of Technology Assessment.
- HTW were invited to write a chapter for the second book on conducting PPI in HTA which is due for publication in the summer of 2025. Covering HTW's unique approaches to undertaking PPI, the chapter will look at the role of the PPISG in conducting a PPI mechanism tool for every topic, HTW's flexible and responsive process for adapting PPI activities during the course of an appraisal and HTW's model for evaluation and implementing changes from feedback. The chapter will be one of several jurisdictional chapters featuring PPI approaches from across the globe.

COLLABORATING WITH PARTNERS IN 2023/24

We engage with stakeholders across health, social care, innovation and academia to identify and appraise topics that address key health and care priorities in Wales.

Throughout 2023/24 we continued to work in collaboration with regional, national, and international partners to raise awareness about health technology innovation and appraisal.

Projects we engaged with our partners on included:

IDAP

HTW is part of the UK-wide partnership that launched IDAP – the Innovative Devices Access Pathway - in September 2023.

The project, which received £10million of government funding, is run by HTW, the Medicines and Healthcare products Regulatory Agency (MHRA), the National Institute for Health and Care Excellence (NICE), NHS England and the Scottish Health Technologies Group.

We worked in collaboration with our IDAP partners to launch the IDAP pilot, sharing content across our website, social media channels and with Welsh stakeholders. Once eight technologies had been chosen to join the pilot, we issued a joint press release and agreed content for social media posts.

Learn 2 Innovate

As part of our ongoing HTA capacity building work, we worked in collaboration with the Learn 2 Innovate student health care innovation programme to deliver training on health technology appraisal.

Alexander Coombs, founder and programme director of Learn 2 Innovate Programme said: "At Learn 2 Innovate we collaborated with Health Technology Wales to deliver an interactive workshop on validation of health technologies. The programme is designed to support and inspire students to become future innovators in healthcare. The session from HTW provided students the understanding that new technologies should aim to improve patient outcomes and be cost-effective, both of which ought to be considered in the early phases of a health technology idea. The students enjoyed the session with excellent feedback, and we hope to continue our relationship with HTW in the future."

Health and Care Research Wales Evidence Centre

We have continued to produce rapid evidence reviews on priority health and care topics as a collaborating partner of the Health and Care Research Wales Evidence Centre. HTW was appointed a collaborating partner of the centre, having previously worked as a collaborating partner of the Wales COVID-19 Evidence Centre.

Spreading the word

As part of our ongoing work to increase understanding about our role and the health technology assessment process, we produced a series of resources aimed at explaining what we do and why.

These have included:

- A series of animations explaining the topic appraisal process and the criteria for submitting a topic for appraisal
- Case study videos about guidance we have published
- A Frequently Asked Questions document about our work and the criteria for submitting a topic
- An Appraisal Process Guide that is also available in a plain language format

Advisory committee meetings hosted

6	Appraisal Panels
13	Assessment Groups
2	Stakeholder Forums
1	Industry User Group
4	Executive Groups
4	PPI Standing Groups

Website

15132	Webpage views
9334	Visitors

Social media

2736	Followers
208	LinkedIn posts and tweets
1307	Engagements
42,616	Impressions
365	Link clicks
489	Likes and retweets

OUR ROLE AS COLLABORATING PARTNER OF THE HEALTH AND CARE RESEARCH WALES EVIDENCE CENTRE

Throughout 2023/24 we have continued to conduct rapid evidence reviews as a Collaborating Partner of the Health and Care Research Wales (HCRW) Evidence Centre.

The centre, which is funded by Welsh Government, was set up to ensure that decisions about health and social care policies in Wales are made using findings from the most up to date research.

Its aim is to focus on the following priorities:

- Identifying information gaps relating to health and social care policy and practice in Wales
- Answering research questions that address the information gaps quickly and with robust methodology
- Establishing a network between the Centre and key policy and practice organisations such as Welsh Government, Social Care Wales and the NHS
- Working closely with the Welsh public
- Reviewing available research evidence where possible
- Conducting new research where evidence is lacking

As a Collaborating Partner, HTW conducts rapid evidence reviews on a wide range of health and social care topics on behalf of the Evidence Centre. In 2023/2024 HTW worked on the following rapid evidence reviews in collaboration with the Wales Evidence Centre:

- **Prognostic factors for a change in eye health or vision: A rapid review**
- **Measuring mental health in a cost-of-living crisis: A rapid review**
- **Factors associated with childhood obesity or overweight in children under five years old: A Rapid Review**

  The team were working on the Childhood Obesity Report at the time of publication. Over one-quarter of children in Wales aged four-to-five years old are either overweight or obese. Children who are overweight or obese may experience health issues during childhood or adolescence. They are also more likely to be overweight or obese through to adulthood, which can cause associated health problems. The aim of this work is to inform future policy decisions relating to the factors associated with obesity or overweight in children under five years old.

Collaborating partners work in close collaboration with leaders in Welsh Government, the NHS and social care to ensure that the Evidence Centre addresses key evidence gaps and priorities for health and social care in Wales.

The centre builds on the success of the Wales COVID-19 Evidence Centre which was vital in informing pandemic management and recovery and showed how essential research evidence is to supporting decision making about health and social care. It draws on the skills, networks and methods developed by the Wales COVID-19 Evidence Centre to carry out its work.

The latest Evidence Centre work programme can be seen here.

The latest information about the Health and Care Research Wales Evidence Centre can be found by signing up to the Health and Care Research Wales bulletin.

> As a Centre, we provide research evidence to NHS and Social Care Wales leaders and to Ministers to tackle health and social care challenges in Wales. Health Technology Wales, as a collaborating partner, has a fundamental role in delivering this research to inform policy and practice needs in Wales.
>
> **Professor Edwards,**
> ***Director of the Health and Care Research Wales Evidence Centre***

RAISING OUR PROFILE

We exhibited at conferences and events throughout the UK and internationally in 2023/24, meeting with stakeholders and potential topic proposers and spreading the word about our work.

Events we have taken part in during 2023/24 include:

June 2023: Social Care Roadshow

We exhibited at the Social Care Research Roadshow which was organised by Social Care Wales in partnership with Health and Care Research Wales. The event focused on care and support of older people and it was an important opportunity to raise awareness of our work in appraising non-medicine care technologies among social care professionals.

June 2023: HTAi

Our Health Services Researcher Charlotte Bowles attended HTAi 2023 in Adelaide, Australia, where she presented a paper on HTA Adaptation: Pharyngolaryngeal Biopsies (OLB) for People with Suspected Head and Neck Cancer in the Outpatient Setting.

June 2023: MediWales Connects 2023

HTW hosted an exhibition stand at the event and Principal Researcher Matthew Prettyjohns gave a presentation. MediWales Connects, an all-Wales NHS collaboration conference, featured a key note speech by Judith Paget CBE, Chief Executive of the NHS in Wales and Director of Health and Social Services. NHS colleagues from across Wales met with industry sector representatives to share ideas on clinical innovation.

July 2023: Bevan Commission Conference - Transforming the Future of Health and Care Together

This event run by Bevan Commission, which was held to mark the 75th anniversary of the NHS, focussed on creating a sustainable model for health and care and featured talks from eminent national and international speakers. We exhibited at the event alongside health and social care organisations from across Wales.

October 2023: MediWales Showcase

We exhibited at the annual MediWales Showcase where members of Wales' thriving life sciences sector gathered to share news of their latest projects.

October 2023: ABHI UK HealthTech Conference

We were delighted to take part in the Association of British Health Tech Industries annual conference. During the event we met with health tech manufacturers and potential topic proposers and took the opportunity to raise awareness about the Scientific Advice Service offered by HTW.

November 2023: NICE Conference

The one-day National Institute for Health and Care Excellence (NICE) conference brought together frontline staff and leaders from health and social care together with the life sciences, health tech and digital sectors. It focused on revealing how NICE is transforming to deliver more relevant, timely and usable guidance.

March 2024:

The Wales Health Science Conference, organised by the Welsh Scientific Advisory Committee provided us with a chance to showcase our work to a diverse audience of health science experts, practitioners, professors and students.

A GLOBAL PERSPECTIVE

Throughout 2023/24 we have continued to collaborate with our international partners to share knowledge and insights on health technology assessment and the identification of topics for appraisal.

EXPANSION OF INTERNATIONAL HTA COLLABORATION

In September 2023 we announced the expansion of a collaboration between six HTA bodies from across the UK, Australia, and Canada.

Institut national d'excellence en santé et en services sociaux (INESSS), Quebec and Pharmac, New Zealand joined the collaboration which now includes:

- National Institute for Health and Care Excellence (NICE)
- Canadian Agency for Drugs and Technologies in Health (CADTH)
- Australian Government Department of Health and Aged Care
- Healthcare Improvement Scotland , Scottish Medicines Consortium (SMC) and Scottish Health Technologies Group (SHTG)
- Health Technology Wales (HTW)
- All Wales Therapeutics & Toxicology Centre (AWTTC)
- Institut National D'Excellence En Santé Et En Services Sociaux (INESSS)
- Pharmac, New Zealand

It is estimated that the collaboration could benefit more than 134 million people worldwide. Together the partner organisations focus on three key areas of work:

Work sharing: Exploring the feasibility of work sharing to support HTA decision making

Horizon scanning: Identifying and preparing for the opportunities and challenges of the future

Sciences and methods development: Collaborating on sciences and methods to make best use of skills and expertise within the partner organisations.

INISA

In October we were pleased to announce that our Director Dr Susan Myles had been appointed to join the board of directors of INSIA (International Network for Social Intervention Assessment). This reinforces HTW's commitment to identifying and appraising innovative technologies and models of care to support the social care sector in Wales. As part of our partnership with INISA we have joined a group of international colleagues which will plan INSIA's communications strategy and activities.

OUR TEAM

The work in this annual report has been delivered by the Health Technology Wales team.

Our team comprises of 28 people including health services researchers, health economists, information specialists, communication specialists, project managers and administrators.

During the 2023/24 financial year we were pleased to welcome two new Senior Health Services Researchers and a Senior Health Economist to our team.

We come from a broad range of backgrounds and skillsets and collectively have extensive experience in both the public and private sectors.

The team is supported by the invaluable contributions of our external committee members who continue to ensure our work meets the needs of the health and social care sectors in Wales.

Professor Peter Groves
Chair

Dr Susan Myles
Director

Lisa King
Senior Programme Manager

June Price
Business Operations Manager

Katie McDermott
Project Manager

Rebecca Shepherd
Project Support Manager

Alice Evans
Patient and Public Involvement Manager

Elise Hasler
Information Specialist

Jenni Washington
Information Specialist

Matthew Prettyjohns
Principal Researcher, Health Economics

Dr David Jarrom
Principal Researcher, Health Services Research

Jessica Williams
Health Services Researcher

Dr Claire Davis
Health Services Researcher

Dr Clare England
Health Services Researcher

Leona Batten
Health Services Researcher

Hayley Bennet
Health Economist

Sophie Hughes
Senior Health Economist

Mafalda Gordo
Business Support and Communications Assistant

Dr Greg Hammond
Health Services Researcher

Antonia Needham
Health Services Researcher

Charlotte Bowles
Health Services Researcher

Rebecca Boyce
Health Economist

Diana Milne
Communications Manager

Llinos Jones
Welsh Language Translator

Caron Potter
Executive Assistant

Dr Sian Cousins
Senior Health Services Researcher

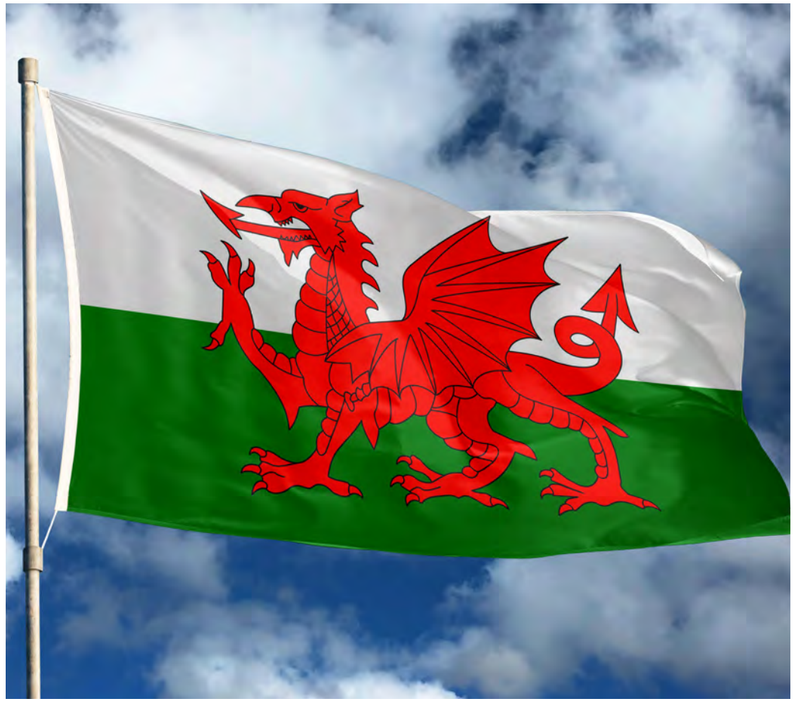
Ryan Miller
Senior Health Economist

Nathan Bromham
Senior Health Services Researcher

BUDGET DELIVERY

HTW is successfully delivering against its Strategic Plan for 2021–2025 which sets out our immediate and medium-term strategic goals and objectives.

The Welsh Government awarded us £1.5million for 2023-2024 to fund our core work. HTW secured additional income of £130,000 to fund it's work as a collaborating partner of the Health and Care Research Wales Evidence Centre and two years of grant funding to support its involvement in an NHS Artificial Intelligence Award as part of a Technology Specific Evaluation Team (TSET).



Reporting modest underspend to date, due to recruitment delays. On target to deliver within budget during FY 24/25.

Supporting **25.3** full-time equivalent posts and a headcount of **28**.

Allocating our budget to **87%** staff costs and **13%** non-staff costs.

A **five-year award** secured in FY23/24 to act as a collaborator in the new Welsh Evidence Centre.

Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our website.

Technoleg Iechyd Cymru
Health Technology Wales

healthtechnology.wales

Health Technology Wales (HTW), Velindre University NHS Trust Headquarters, Unit 2 Charnwood Court, Park Nantgarw, CF15 7QZ, United Kingdom

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Transforming Access to Medicines / Clinical Pharmacy Technical Services Update

DATE OF MEETING	November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	Gareth Tyrrell, Pharmacist (NWSSP)
PRESENTED BY	Gareth Tyrrell, Pharmacist (NWSSP)
APPROVED BY	Gareth Tyrrell, Pharmacist (NWSSP)

EXECUTIVE SUMMARY	The Pharmacy Technical Services continues to provide ready-to-administer products to organisations across NHS Wales under the MHRA “Specials” licence, whilst also maximising the resource utilisation opportunities through the Wholesale Dealer License. The TrAMS programme is currently not operational however progress in relation to the programme is reported through the NWSSP Partnership Committee

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee are asked to **NOTE** the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Managing Director / Director of Pharmacy / Clinical Director	11/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

1.1 The aim of this report is to provide assurance on the current performance of the Pharmacy Division within NHS Wales Shared Services Partnership, and report to the board any matters of exception that increase the risks of service delivery.

2. BACKGROUND

2.1 The Pharmacy Division provided several Pharmacy Technical Services to partners across NHS Wales under agreed Service Level and Technical agreements. These services are heavily regulated under Medicines and Healthcare products Regulatory Agency (MHRA), Home Office and General Pharmaceutical Council (GPhC) licences. These services include:

- Manufacture and supply of ready-to-administer injectable medicines under an MHRA “Specials” Licence.
- Purchase, storage, and supply of licenced and unlicenced products, including vaccines, under an MHRA Wholesale Dealer Authorisation.
- Purchase, storage, and distribution of controlled drugs under Home Office Licence.

2.2 Staff within NWSSP who are named on the licences are legally responsible for implementing the regulatory requirements under The Human Medicines Regulations 2012.

2.3 All services adhere to European and UK Good Manufacturing and Distribution practices as set out within the licences and are subject to risk-based compliance inspections by the regulator intervals determined by service risk.

2.4 The service is currently deemed “low risk” and has a 24-month inspection interval.

2.5 Monthly performance reports are presented to the NWSSP Service Board for governance.

2.6 Products supplied from the NWSSP Pharmacy Division are detailed below:

- Potassium Chloride 50mmol in 50mL syringe
- Rituximab 600mg in 250mL 0.9% Sodium Chloride
- Rituximab 700mg in 250mL 0.9% Sodium Chloride
- Rituximab 800mg in 250mL 0.9% Sodium Chloride
- Nivolumab 480mg in 250mL 0.9% Sodium Chloride

3. ASSESSMENT

3.1 NWSSP aim to comply fully with the licencing requirements for MHRA Specials Manufacturing and Wholesaler Dealing, and the regulatory standards of Good Manufacturing Practice.

3.2 The service is currently undergoing a full gap analysis and implementation programme for compliance with the updated Annex 1 – Manufacture of Sterile Products.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The purpose of this paper is to highlight current exceptions to service adherence of Good Manufacturing and Distribution Practice and any significant changes to service model or provision within the NWSSP Medicines Unit.

4.2 There are no exceptions to the Pharmaceutical Quality System or performance to report to the committee.

4.3 As of April1st 2024, NWSSP Pharmacy are now utilising CareFlow Pharmacy system as a location under the Velindre Software Licence. Ongoing work between

NWSSP and Velindre continues to minimise impact and ensure joint use of procedures and financial reporting mechanisms. The implementation has met all information governance requirements and has been documented on the NWSSP PQS under the change control management process. There have been no issues to report.

4.4 NWSSP has recently added the Picketston site to its Home Office and MHRA Wholesale Dealer Licences to undertake Medicines Contingency and Stockpile activities.

4.5 Medicines Unit are working with other NWSSP divisions and Welsh Government policy leads on the National Influenza Programme.

4.6 Medicines Unit currently engaged in supporting Calcium Folinate shortages impacting cancer patients within Wales, requiring initiation of new product: Calcium Folinate 250mg in 250mL Glucose 5%. This will improve resource utilisation of available stock.

4.7 Medicines Value Unit continues to contract manage the outsourced Aseptic contracts with commercial suppliers, managing supply issues and shortages.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Working / Stakeholder Engagement

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The implications outlined in this report as exceptions risk the ability of the service to prepare medicines within a times and efficient manner
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

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

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Mobile Phone Policy

DATE OF MEETING	14/11/2024
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	David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	Carl Taylor, Chief Digital Officer
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Trust Mobile Phone Policy has been reviewed and updated.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **APPROVE** the Trust Mobile Phone Policy.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	26/06/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED** the Mobile Phone Policy subject to the completion of an Equality Impact Assessment

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	Mobile Phone Policy
Appendix 2	Equality Impact Assessment

1. SITUATION

The Trust mobile phone policy is due for review as part of the routine cycle of business for the maintenance of Trust policies and procedures.

The updated policy, attached as appendix 1, is presented to the Executive Management Board to **endorse for approval**.

2. BACKGROUND

The Velindre University NHS Trust mobile phone policy provides the framework for effective communication, enhances productivity, maintains data security, and ensures the responsible use and management of mobile phones within the Trust.

3. ASSESSMENT

The current mobile phone policy has been fully updated to reflect current and future utilisation of mobile phones across VUNHST. The updated policy includes new guidance for staff on appropriate use, as well as confirmation of the new arrangements that have been established by the Digital Services team for the procurement and ongoing management of mobile phone contracts.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The report is presented to the Executive Management Board, requesting it is endorsed for approval ahead of submission to the Quality, Safety & Performance Committee for full approval.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	05 – Digital Transformation | Failure to Embrace New Technology
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	Mobile technologies play a crucial role in the delivery of safe and effective patient and donor care. As such, a robust policy is required, to ensure appropriate use of such services across the Trust
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
	The Digital Services team now manage the mobile phone estate for the whole Trust. Recent changes include a consolidation of the (previously two) separate contractual arrangements in place across VCC/HQ and the Welsh Blood Service, into a new, single contract with 'EE'. This will result in the reduction in monthly bills and the avoidance of a significant amount of cost on an annual basis.
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
	Any impact has been considered in the review of the policy. Bespoke devices can be provided if needed.

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

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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

Ref: IG10

MOBILE PHONE POLICY

Executive Sponsor & Function:	Chief Digital Officer
Document Author:	Head of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	TBC
Date of Equality Impact Assessment:	7 November 2024
Equality Impact Assessment Outcome:	Any impact has been considered in the review of the policy
Review Date:	November 2027
Version:	2

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Trust Mobile Phone Policy

1. Aim

1.1 The aim of this policy is to establish clear arrangements for the management of mobile phones within the Trust and outline the responsibilities of both managers and staff / personnel. The policy covers the usage of both Trust-owned mobile phones and personal mobile phones used for work purposes.

2. Policy Statement and Objectives

2.1 The Velindre University NHS Trust mobile phone policy facilitates effective communication, enhances productivity, maintains data security, and ensures the responsible use and management of mobile phones within the Trust.

2.2 The key objectives of the policy are:

2.2.1 **Clear Guidelines**: To provide staff / personnel with clear guidelines and expectations regarding the appropriate use of mobile phones within the Trust, ensuring consistency and compliance across the organisation.

2.2.2 **Asset Management**: To provide guidelines and procedures for the procurement, distribution and management of Trust owned mobile phones, including controls for joiners, movers and leavers, to ensure efficient utilisation of mobile phone assets.

2.2.3 **Eligibility Criteria**: To define the criteria for issuing Trust mobile phones, ensuring that they are provided only to staff / personnel members who genuinely require them for their work responsibilities.

2.2.4 **Data Security and Confidentiality**: To outline the responsibilities of staff / personnel in protecting patient information and sensitive data when using mobile phones, ensuring compliance with data protection regulations and maintaining the confidentiality and integrity of sensitive information.

2.2.5 **Responsible usage**: To promote responsible and professional use of mobile phones.

2.2.6 **Incident reporting**: To establish procedures for reporting incidents, loss, theft or damaged mobile phones, ensuing prompt action and appropriate follow-up.

3. Scope of the Policy

3.1 This is a Trust-wide policy and applies to all staff and personnel operating under the auspices of the Trust, including but not limited to employees, locums, contractors, temporary staff, students, service user representatives, volunteers and partner agency staff. Velindre University NHS Trust is committed to ensuring that adequate communication facilities are available to staff to help them carry out their normal day-to-day tasks, which includes the use of mobile phones.

3.2 The Policy seeks to ensure that adequate procedures exist for:

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3.2.1 Management and use of mobile phone equipment

3.2.2 Finance and procurement requirements

3.2.3 Security of communication and equipment

3.2.4 Ensuring that health and safety issues are addressed.

3.3 This policy does not cover the use of mobile phones by patients, donors or visitors.

4. Criteria for Issue of Trust Mobile Phones

4.1 Trust mobile phones will only be provided to staff / personnel who have obtained the approval of their line manager and from the Digital Services department.

4.2 To be eligible for a Trust mobile phone, the requester must meet one or more of the following criteria:

4.2.1 The requestor responsibilities necessitate regular time spent away from their normal place of work, which may include travel for work purposes.

4.2.2 The requester is required to remain reachable while off-site or outside regular working hours, which may include fieldwork or site visits.

4.2.3 The requestor is involved in the delivery "on call" services outside normal business hours.

4.3 The above criteria also encompass other work-related activities that require staff/ personnel to be outside of their normal place of work.

4.4 It is important to note that routine working from home does not constitute being away from the office as per the criteria set out above.

4.5 Trust mobile phones may be issued on an individual basis or shared among multiple staff / personnel, such as when an on-call phone is made available for a group of staff/ personnel participating in an on-call rotation.

5. Management Responsibilities

5.1 The Digital Services department is responsible for the procurement, distribution and asset management of Trust mobile phones. The Digital Services department are responsible for ensuring the regular, periodic review of this policy and to ensure that all individuals in scope of the policy are aware of the policy.

5.2 **Approval and Authorisation**

5.2.1 Authorised department managers have the responsibility to approve the issuing of Trust mobile phones to their staff based on the eligibility criteria outlined in the policy. They should assess the needs and requirements of their team members and ensure that mobile phones are provided only to those who meet the criteria.

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5.2.2 New users

a. For new staff / personnel who meet the criteria for a Trust-owned mobile phone, the line manager is responsible for assessing the need and submitting an authorised request to the Digital Services department. This principle also applies to existing staff for whom it has been identified there is a requirement for a mobile phone.

b. The Digital Services department will assess the request, procure and provision a Trust mobile phone for the new staff member based on the approved request.

c. The new staff member / personnel will sign an agreement upon receipt of the Trust mobile phone, acknowledge their responsibilities for its care, authorised use and compliance with the mobile phone policy.

5.2.3 Movers

a. In cases where a member of staff / personnel changes their position or department within the Trust, the new line manager will assess whether the existing Trust mobile phones is still required for their new role.

b. If the mobile phone is still necessary, the line manager will coordinate with the Digital Services department to update any necessary asset database, configuration, or access permissions.

c. If the mobile phone is no longer required, the line manager will request the mobile phone and inform the Digital Services department, who will reclaim the mobile phone and update asset records accordingly. It is the responsibility of the individual member of staff to remove all personal information from the mobile phone before returning it to their line manager and the Digital services department. The phone will then be cleared down by Digital Services before being reused.

5.2.4 Leavers

a. When a member of staff / personnel leaves the Trust, the line manager or the People and OD department must ensure that the Trust mobile phone is returned.

b. The staff member and/or their line manager are responsible for returning the mobile phone to the Digital Services department. It is the responsibility of the staff member to remove all personal information from the mobile phone before returning it to their line manager and the Digital services department.

c. Once the device has been retrieved, the Digital Services department will clear down the device before being reused.

5.3 The Digital Services will coordinate an annual review of mobile phone contracts with departmental / line managers, to ensure ongoing provision of mobile phones is appropriate.

5.4 **Communication and awareness**

Managers should support the communication of this policy to their team members, ensuring that staff / personnel understand the guidelines, expectations, and limitations regarding mobile phone use. They should address any questions or concerns raised by their staff / personnel and provide necessary clarifications.

5.5 **Monitoring and compliance**

The Digital Services department are responsible for monitoring the appropriate use of trust owned mobile phones via a Mobile Device Management solution. They will regularly review and observe mobile phone usage to ensure compliance with policy. They will also address any instance of non-compliance and promptly raise these issues with the line manager. In some instances, the line manager is responsible for taking appropriate disciplinary action, if necessary.

5.6 **Budgetary Considerations**

Managers may need to provide input and justification for the allocation of resources, including budget, for the procurement, distribution, and management of Trust mobile phones. They should work closely with the Digital Services department to ensure that resources are allocated efficiently and in accordance with operational needs.

5.7 **Performance and Productivity**

Managers should monitor the impact of mobile phone usage on staff / personnel performance and productivity. They should address any concerns related to excessive or inappropriate use of mobile phones that may hinder staff / personnel effectiveness or the smooth functioning of the team.

5.8 **Training and support**

Managers should support their team members by providing appropriate training and guidance on the responsible use of mobile phones. They should ensure that staff / personnel are aware of data security measures, patient confidentiality requirements, and other relevant policies.

5.9 **Reporting and Incident Management**

The Digital Services department have standard procedures in place for reporting lost, stolen, or damaged mobile phones. The managers should ensure their team members are aware of these procedures. They should also guide staff / personnel in reporting any incidents or breaches related to the mobile phones use and collaborate with the relevant departments, such as the Digital Services Department, to address such incidents appropriately.

6. Staff / Personnel Responsibilities for Trust-owned mobile phones

6.1 **Care and Safekeeping**

Staff / Personnel who have been issued a Trust-owned mobile phone have the following responsibilities:

a. Safeguard the mobile phone from loss, theft, or damage.

b. Keep the mobile phone in good working condition and report any malfunctions or damage to the Digital Services department.

c. Not driving whilst using a mobile phone

6.2 **Authorised use**

a. Use the Trust-owned mobile phone for work-related purposes and in accordance with the mobile phone policy. Please refer to fair usage policy below.
b. Adhere to all applicable laws, regulations, and policies regarding data protection, patient confidentiality, and workplace guidelines.
c. Refrain from using the mobile phone for personal purposes during working hours, except in emergencies or situations requiring immediate attention. Please refer to fair usage policy below.
d. Under no circumstances must the device be used to send inappropriate messages or view inappropriate content. Any breaches of this will be reported to your line manager.

6.3 **Fair Usage Policy**

6.3.1 **Data Usage:** The Trust provides various services that involve data usage, such as internet access, mobile applications and cloud storage. Users are expected to adhere to reasonable data usage limits.

6.3.2 **Bandwidth management:** In shared network environments within the Trust, such as offices, hospitals, or clinics, bandwidth is a shared resource. To ensure fair access and optimal performance for all users, the Trust implements bandwidth management measures. This may include the use of bandwidth caps, traffic prioritisation, or other techniques to manage network congestion and maintain service quality.

6.3.3 **Data Resource Allocation:** The Trust mobile data bundle will be a shared resource. Users are expected to utilise these resources in a responsible manner, avoiding excessive or disproportionate usage that may hinder the availability or performance of the service for others.

6.3.4 **Abusive or excessive usage:** The Trust strictly prohibits any abusive or excessive usage of the mobile phone service. Users must refrain from activities that may disrupt the service or compromise the security, privacy or integrity of the service.

6.3.5 **Reasonable use:** Specific usage limits will apply. Users are expected to exercise reasonable use of the Trust mobile service. The means utilising the service for their intended purposes and refraining from excessive or unfair utilization that may impact the experience and performance of other users.

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6.3.6 **Policy and Enforcement:** The Trust reserves the right to monitor usage patterns and enforce this Fair Usage Policy. In case of non-compliance, the Trust may issue warnings, impose temporary restrictions, or, depending on the severity or recurrence of the violation, take further disciplinary actions.

6.3.7 The Trust provides mobile devices for fulfilling business responsibilities. Velindre Trust has an allocated 'pool' of data, which is shared across all mobile phone users – as such, no data should be used for personal use. Staff / personnel will be required to repay any charges to the Trust should abuse be identified.

If mobile devices, accessory and/or service fees or charges result from personal use of this equipment and exceed the shared data bundle.

6.3.8 Each user has unlimited calls and texts which are designed for normal use only to UK mobile and landline numbers. Premium rate / special numbers are excluded and will be charged to the user, unless it is identified that the number was for a designated business use. A full list of chargeable numbers will be published on the Digital Services intranet website.

6.4 **Confidentiality and Data Protection**

6.4.1 Ensure that any patient information or other sensitive data is handled securely and in compliance with privacy laws and regulations.

6.4.2 Refrain from capturing, storing or transmitting any patient related information or sensitive data without explicit authorisation.

6.4.3 Any data stored on the mobile phone is the property of the Trust.

6.4.4 Refrain from taking photos, videos, or audio recording of patients / donors, staff, or sensitive areas without proper authorisation.

6.5 **Professional conduct**

6.5.1 Use the mobile phone in a professional and respectful manner, avoiding any activities that may disrupt workflow or compromise patient care.

6.5.2 Maintain a courteous and respectful tone in all communications made through the mobile phone.

6.6 **Compliance and reporting**

6.6.1 Comply with the mobile phone policy and any other relevant policies and procedures of the Trust.

6.6.2 Sign an agreement upon receipt of the Trust-owned mobile phone, acknowledging, understanding and acceptance of the mobile phone policy and related responsibilities.

6.6.3 Promptly report any lost, stolen, or damaged mobile phones to the Digital Services department, following the established procedures.

6.6.4 Promptly report any incidents or data breaches related to the mobile phone to the Digital Services department who will in turn report it to the Information Governance department.

6.7 **Training and Awareness**

6.7.1 Participate in any training or awareness programs provided by the Trust regarding responsible use of mobile phones. Stay informed about updates or changes to the mobile phone policy and ensure compliance with the latest guidelines.

7. Use of Personal Mobile Phones for Work Purposes

7.1 While this policy primarily covers the use of Trust-owned mobile phones, it also acknowledges that staff / personnel may use their personal mobile phones to access work-related applications and services. This includes but is not limited to accessing Microsoft 365 applications and the Microsoft Authenticator for multi-factor authentication.

7.2 Staff / personnel using personal mobile phones for work purposes must adhere to the following guidelines:

7.2.1 **Data Security:** Staff must ensure that their personal mobile phones are secure and have appropriate security measures in place, such as PINs, passwords, biometric locks, and up-to-date security software.

7.2.2 **Data Protection:** Staff must ensure that any work-related data accessed or stored on their personal mobile phones is protected in accordance with data protection regulations and Trust policies.

7.2.3 **Confidentiality**: Staff must maintain the confidentiality of patient information and other sensitive data when accessing work-related applications on their personal mobile phones.

7.2.4 **Compliance:** Staff must comply with all Trust policies regarding the use of mobile phones, including but not limited to policies on data protection, patient confidentiality, and acceptable use.

7.2.5 **Incident Reporting:** Staff must promptly report any loss, theft, or security incidents involving their Trust-owned mobile phones to their line manager and the Digital Services department.

7.3 Support and Reimbursement

The Trust may provide limited support for personal mobile phones used for work purposes, primarily focusing on assisting with the configuration and access to Trust applications such as Microsoft 365 and Microsoft Authenticator. However, the Trust will not reimburse staff / personnel for any costs associated with the use of their personal mobile phones, including data plans or any hardware-related expenses.

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7.4 Limitation of Use

Personal mobile phones used for work purposes should primarily be used to access essential work-related applications and services. Staff / Personnel are encouraged to limit their use of personal devices for work purposes to avoid potential security risks and to ensure a clear separation between work and personal activities.

By following these guidelines, staff / personnel can ensure that they use their personal mobile phones responsibly and securely when accessing work-related applications and services, while maintaining compliance with Trust policies and protecting sensitive information.

8. Mobile Phones & Medical Equipment

Staff / personnel should be aware that mobile phones (even when not in use) can disrupt the functioning of some medical and other electronic equipment if in close proximity to this equipment. Staff / personnel should adhere to any specific rules affecting certain areas within their division or other NHS premises.

9. Mobile Phones and Driving

It is illegal to use a mobile phone whilst driving if the phone is held in the hand during any part of the operation. The Trust also recommends that it is best not to use a hands-free mobile phone while driving, as users can also be prosecuted for using hands-free mobile phones if they fail to have proper control over the vehicle. Therefore, staff / personnel should avoid taking calls on the hands-free device whilst driving. If necessary (and only using a hands-free device), staff / personnel should inform the caller that they are driving and end the conversation quickly. For your own safety and that of other road users, use voicemail or divert calls so that messages can be left for you while your phone is switched off.

10. Mobile Phones with Integrated Cameras / Video

Personal and Trust mobile phones with integral cameras or video are subject to the **Trust Procedure for Filming/Recording and Photography in the Trust**

The following extract is from the above procedure:

Use of Mobile Phones & Personal Cameras for Medical Photography

Photographs or videos must not be taken with mobile phones or personal cameras under any circumstances. This is unacceptable and disciplinary action will be taken by the Trust if this is discovered

If staff are regularly required to record images, then a request for the purchase of a camera should be considered via the Divisional Director/Deputy Director.

The accepted policy for medical photography is that it is done by a designated photographer with the appropriate consent of the patient and their knowledge as to what the pictures will be used for. If staff have any concerns, please contact your line manager in the first instance or the Divisional Director/Deputy Director

11. Ordering, Purchasing & Receipt of Mobile Phones

11.1 Completed and authorised mobile phone application forms must be submitted via the Digital Service Desk portal (see Appendix 1).

11.2 Where an individual requests a mobile phone specification above the standard mobile phone specification the individual will be responsible for paying 100% of the excess cost.

11.3 The applicant should receive their mobile phone within 10 working days of Digital Services department receiving the application form. The applicant will be required to complete a “Mobile Phone User Agreement” (see Appendix 2) before they are issued with their mobile phone.

11.4 The mobile phone will always remain the property of the Trust.

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Appendix 1 | Mobile Phone Request Procedure

Requesting a New Mobile Phone

Staff / Personnel needing a new mobile phone must follow the outlined procedure to ensure efficient processing and approval:

1) Complete the online Mobile Phone Application Form:

- Access the Digital Services portal – **vunhst.wales/digitalservices**
- Navigate to the 'mobile phone request' section.
- Fill in all required fields in the mobile phone application form with accurate and up-to-date information.

2) The submitted form will automatically enter the approval workflow.

- The request will be reviewed by the appropriate departments and personnel.
- You will receive notifications at each stage of the approval process, including final approval or denial.

3) Collection/Delivery:

- Upon approval, the Digital Services department will arrange for the issuance of the new mobile phone.
- You will be informed about the collection or delivery details.

Appendix 2 | Mobile Phone User Agreement Form

Mobile Phone User Agreement	
Name:	
Job Title:	
Directorate:	
Ward / Department / Team:	
Mobile Number:	
Network:	
Contract Number:	

Declaration

- I have read, understood and will comply with the Trust's Mobile Phone Policy. I understand that if I fail to adhere to the Trust's policy, I will be subject to the Trust's disciplinary procedures.
- I understand that I am responsible for looking after the mobile phone issued to me and will take reasonable precautions to ensure that the phone is not damaged, lost or stolen.
- I understand that I am liable for the cost of any personal calls made on the Trust mobile phone issued to me and I will identify and pay for any personal calls made.
- I agree to return the mobile phone to the Trust when leaving the Trust's employment. I understand that the Trust will seek to recover any subsequent costs (e.g. handset not returned, personal calls not paid) as a consequence.

Signed:	**Date:**

EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	Mobile Phone Policy		
Manager	David Mason-Hawes		
Date of meeting with OD Manager – ED&I			
Date of submission			
Date of next review			
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	Mobile Phone Policy
1.2	Who owns it?	Carl Taylor – Chief Digital Officer
1.3	What is the aim of the change(s)?	Complete update of the mobile phone policy
1.4	Who is affected most by the change?	VUNHST Staff
1.5	How does this topic fit into the wider context of the organisation?	Supporting staff use of mobile devices forms part of the Digital Strategy. The updated policy is designed to ensure clearer rules and processes are in place in respect of the use and ongoing management for mobile devices within the Trust.
1.6	Who is undertaking the EQIA	David Mason-Hawes, Head of Digital Delivery
1.7	When will you start and end the EQIA?	August 2024
2.1	What data is available to help inform the EQIA?	Information on current mobile phone utilisation across the Trust – approx. 110 users
2.2	What information is still needed?	n/a
2.3	How will missing data be collected?	n/a
2.4	What is considered relevant information and data?	

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle-aged people* *Older people* *Other…*	✓			Policy updates and revised processes for management of Trust mobile devices would support the offering of bespoke devices to accommodate diverse needs, to include training if required.	None
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*	✓			Policy updates and revised processes for management of Trust mobile devices would support the offering of bespoke devices to accommodate diverse needs, to include training if required.	None
Gender re-assignment *Would this affect those in/post-transition differently?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Marriage or civil partnership *Are single people affected differently?* *Are married people or civil partners treated differently?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Sex/Gender *Does it only apply to men / women?* *Could this affect one group more than the other?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*			✓	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?* *1. Does the subject treat the Welsh language less favourably than the English language?* *2. Have you considered the Cultural opportunities / Promotion of the project? E.g. literature / Visual art representing Welsh artists* *3. Are you assured that all aspects of this project / policy etc has considered the needs of Welsh speakers?* *If yes, identify the specifics If no, state*			☑	Policy updates and revised processes for management of Trust mobile devices does not impact on any protected characteristic group.	None

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
what should be included.					

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	1. As no impact on any protected characteristics are anticipated, no further changes to the updated policy are proposed.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	n/a – no negative impacts identified.
4.3	Could be policy be implemented in a different way to avoid negative impact?	n/a – no negative impacts identified.
4.4	How will this change promote equality of access and equality of opportunity?	The application for a Trust-provisioned mobile phone is open to all VUNHST staff. Whilst approval of an application is based on business need and is subject to the review of the line manager, the availability of mobile devices is designed to ensure all staff have access to a range of tools to be able to perform their duties effectively.
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	n/a – no negative impacts identified.
5.1	What do you have so far?	n/a
5.2	Have any themes emerged?	No

5.3	What do people have to say about our work?	n/a
5.4	How will you consult widely on your topic?	Draft policy already shared across Executive Management Board and SLTs.
5.5	Who will you consult with?	See 5.4.
5.6	How long will the consultation stage last?	See 5.4 – two week period allowed for comments following discussion at EMB.
6.1	The action plan must appropriately evidence the decision for one of the following policy options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	2. The policy will be updated to reflect any feedback received as part of the consultation.
6.2	What will you do with the comments or information you have gathered from your consultations?	Consider any feedback and update policy as required.
6.3	How did the consultation help guide new policy?	No major updates. Some cosmetic changes made to policy and changes made to the procedures for issuing new mobile phones made following feedback.
6.4	Will you make any changes to the draft report you produced?	Yes – policy updated to reflect feedback.
7.1	Confirm actions	Policy updated – no further action required.
8.1	Establish timetable for reviewing actions and refreshing the assessment	n/a

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
2				
3				

Strategic Alignment

	Future Generations Act Wellbeing Objectives	Links to Objective
1	A prosperous Wales	☐
2	A resilient Wales	☐
3	A healthier Wales	☐
4	A more equal Wales	☐
5	A Wales of more cohesive communities	☐
6	A Wales of vibrant culture and thriving Welsh language	☐
7	A globally responsible Wales	☐

Double-click to add your signature below:	Double-click to add signature below:
X Lead Officer	07/11/2024 X Michelle Fowler Equality & Diversity Manager Signed by: Michelle Fowler (mi120281)

Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

Last updated: 8th January 2024

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

People and OD Policies and Processes

DATE OF MEETING	14th November 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	Amanda Jenkins, Acting Assistant Director of Workforce
PRESENTED BY	Amanda Jenkins, Acting Assistant Director of Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

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

RECOMMENDATION / ACTIONS	QSP are asked to endorse these amendments / new polices for approval by Trust Board.

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

Executive Management Board	29/10/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Paper endorsed for QSP	

APPENDICES	
1	Reviewed – Welsh Language Policy
2	Amendment to Manging Attendance at Work Policy
3	NHS Wales Flexible Pensions Policy
4	NHS Wales Respect and Resolution at Work 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. BACKGROUND

The new systematic review process is in place within the Trust and the following have been reviewed by the People and OD Policy Group on 22nd October 2024, for legislative and best practice compliance.

3. ASSESSMENT

3.1 The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that QSP are asked to endorse for Trust Board approval:

3.1.1 Welsh Language Policy

- Review completed minor amendments made

3.2 The following are new or amended All Wales Polices to be endorsed by QSP for adoption by the Trust:

3.2.1 Addendum to Managing Attendance at Work Policy

- Update to the paragraph on sickness during annual leave, stating normal sickness certification to apply in cases where an employee is sick during a period of annual leave
- Changes to be applied to the NHS Policy when the new version is released but changes to take effect immediately

3.2.2 All Wales Flexible Pensions Policy

- Newly Developed National Policy

3.2.3 Respect and Resolution Policy at Work

- Minor amendments to policy and updated FAQs

4. SUMMARY OF MATTERS FOR CONSIDERATION

QSP are asked to accept these changes and endorse the polices for escalation to Trust Board for approval and adoption.

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

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *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
	Each policy has undergone an EQIA in line with the statutory requirements of assessing policy impact on Protected Characteristics. None of the polices outlined in this paper required further action.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having well designed people polices could result in further challenge through employment tribunals.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	TAF 01 - There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources. TAF 03 - There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives. TAF 04 - There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes. TAF 06 - There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate

	mechanisms and culture to achieve our medium to long term objectives.
WHAT IS THE CURRENT RISK SCORE	Various as outlined on the Trust Assurance Framework
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	NA – Specific risks aligned to the strategic Trust risks and reviews as part of the Trust Assurance Framework
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Ensuing the right people are able to review and comment on the policy development. This will hopefully be mitigated by a new systematic review process that will commence in September 2024.
All risks must be evidenced and consistent with those recorded in Datix	

VELINDRE UNIVERSITY NHS TRUST

WF 16

WELSH LANGUAGE POLICY

Executive Sponsor and Function: Executive Director of Workforce and OD

Document Author: Welsh Language Manager

Approved by: Trust Board

Approval Date: TBC

Date of Equality Impact Assessment: Original assessment April 2019 / updated assessment July 2024

Equality Impact Assessment Outcome: Accepted

Version: 5

1. Policy Statement

This policy meets the requirements of the Welsh language (Wales) measure 2011. It is a directive set out within the Trust's Welsh language Standards Compliance notice received in November 2018 with its aim is to promote and facilitate the use of the Welsh language.

The Trust's Welsh Language mission statement is:

"Velindre University NHS Trust celebrates the Welsh Language and its cultural importance to Wales. As a caring organisation that promotes and understands the value of meeting communication needs, we will provide person centred services and take a planned approach to all that we do."

2. Scope of Policy

This policy applies to ALL Staff

When implementing the Welsh language standards and this policy it is important that the Trust is self-regulating as it is the Trust that has ultimate duties placed upon them to comply with the regulations of the Welsh language Standards.

Failure to comply with this policy and the Welsh language Standards could result in reputational and financial penalties being placed upon the Trust.

3. Aims and Objectives

Our aims for the delivery of the Welsh language Standards through this policy are:

1. The Trust will prioritise the delivery of patient and donor services
2. The Welsh Language will not be treated less favourably than the English Language
3. Staff will be supported to deliver the Welsh Language Standards
4. Hosted organisations (NWSSP, NWIS and HTW) will have local arrangements in place to deliver the Standards and the Trust will work with them to ensure compliance is monitored.

4. Responsibilities

Ultimately it is the responsibility of ALL staff to deliver the aims and objectives of this policy, however oversight of the policy lies with the Chief Executive and the Trust Board.

Managers must ensure that the policy is disseminated and understood by staff and any requests for training opportunities must be supported by managers to increase the language skills available across the Trust.

5. Definitions

- NWSSP – NHS Wales Shared Services partnership
- HTW – Health Technology Wales

For ease of reference in the interpretation of the Welsh Language Standards http://www.legislation.gov.uk/wsi/2018/441/pdfs/wsi_20180441_mi.pdf

Please note the following definitions:

- Person – A colleague from another Health Board, Trust, Welsh Government or Local Authority and including a patient, donor or citizen of Wales.
- Individual – A patient, donor or citizen of Wales.
- The Public – The Public in its entirety, a member of the public who is not interacting with Velindre University NHS Trust in an 'individual' capacity.

6. Implementation and Compliance

Reflecting the identified areas within the Welsh language Standards the Trust will focus on five main areas:

1. **Service Delivery**: Standards 1-64 (Primary Care Standards are not relevant)
2. **Policy Making**: 69-77 (Primary Care Standards are not relevant)
3. **Operational Standards**: Standards 79-114
4. **Record Keeping**: Standards 115-117
5. **Supplementary Standards**: 118-121

Appendix 1 of the Policy demonstrates how the Trust will work within these five areas and ultimately the requirements of the Welsh language Standards.

7. Equality Impact Assessment

An Equality Impact Assessment was completed in April 2019 and did not highlight any additional areas of action.

Appendix 1:

1. Service Delivery

Written Communication

- The public are entitled to communicate with the Trust in Welsh and English. Should the Trust receive written correspondence in Welsh from a member of the public the Trust will respond in Welsh unless the correspondent has stated otherwise.
- The Trust has included a foot note on its paperwork stating that correspondence is welcomed in Welsh and will advise staff to recognise this statement as part of its direct communication.
- Should a person contact the Trust for the first time, via email, staff will include an email signature requesting the language preference of the person and use the information received to communicate from that point on in the preferred language of that person.

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn hapus i dderbyn gohebiaeth yn Gymraeg neu'r Saesneg. Ni fydd derbyn gohebiaeth yn Gymraeg yn achosi unrhyw oedi.

A fyddech cystal â gwneud eich anghenion Iaith yn glir i ni ar ôl derbyn yr e-bost hwn a gallwn gynllunio ein Cyfathrebu yn unol â hynny.

Velindre University NHS Trust is happy to receive communication in Welsh or English. Receiving Welsh language Communication will not lead to any delay.

Please make your language preference clear to us upon receipt of this email and we can plan our communication accordingly.

Telephone Communication from a main telephone line

- Staff answering the telephone on a main line e.g. the telephone line advertised externally, will answer the phone bilingually at all times using
- 'Bore da' or 'Prynhawn da' as necessary followed by the name of the Trust (staff can access information on this via an internal guidance document)
- Should a caller request a Welsh language service staff will explain that one is available and if they are not able to communicate in Welsh inform the caller that they may use a translation service to continue the call or continue the call in English if a discussion on a specific subject matter is required.
- When we advertise telephone numbers we will advertise the Welsh and English lines available and provide this information as part of our publicity.

Telephone Communication from a direct line to a member of staff

- For calls made to direct lines at the Trust, again, staff will answer the phone bilingually making a greeting to the caller and follow the same protocol as stated for main telephone lines.
- Staff will be encouraged to use their Welsh language skills whatever their level or ability in order to support caller's language preference.
- Should staff hold a telephone answer service then the message will be bilingual and staff will be informed of the process in order to record and collect a bilingual message using an internal guidance document.

Telephone calls initiated by the Trust

- Staff who communicate with a person for the first time will ask whether they wish to use the Welsh language in future correspondence. A record of that wish will be kept and used to inform the language of future calls with that person.

Meetings Organised by the Trust

- When inviting one person to a meeting we will ask that person whether they wish to use the Welsh language to communicate. If they wish to do so and others at that meeting are unable to communicate in Welsh then we will arrange simultaneous translation for that person. Likewise if 10% of the people who are invited to that meeting wish to communicate in Welsh and staff at that meeting are unable to facilitate that wish, again, translation services will be used.
- Staff will be advised that they must always ask the language preference of a person prior to a meeting.
- When inviting only one person to a meeting, we will ask that person whether they wish to use the Welsh language to communicate at the meeting. If they wish to do so, the meeting will be conducted in Welsh or if necessary, we will arrange for translation services to be provided.
- When inviting more than one person to a meeting, we will ask every person whether they wish to use Welsh language to communicate at the meeting. If at least 10% (but less than 100%) of the invited persons inform us that they wish to use welsh language, we will arrange for translation services to be provided.

Public events

- The Trust will advertise public events bilingually and all materials for the event will be available bilingually.
- Staff will ensure that language preference is asked prior to the event and should public participation be welcomed, staff will ensure that simultaneous translation will be available at that event. Attendees will be asked prior to the event to identify their language preference and communication needs in the Welsh language will not be treated less favourably than English language communication needs.

- Should the Trust fund at least 50% of a public event we will ensure that the Welsh language is not treated less favourably than the English language.
- Speakers at the public event will be asked if they wish to present in Welsh and if so Staff will ensure that this is possible and translation for attendees is organised.

Publications and Forms including patient and donor materials

- All documents and forms that are to be completed by an individual (e.g a consent form for treatment) or available to one or more individual will be available in Welsh and English.
- The Welsh language will not be treated less favourably in terms of clarity or size and we will not differentiate between the Welsh and English version in relation to any requirements that are relevant to the document or form e.g. a deadline for submitting a form or a time scale for response.
- When designing a form or document staff will be made aware of the Bilingual Design Guidelines published by the Welsh language Commissioner:

http://www.comisiynyddygymraeg.cymru/hybu/en/guidelines/Pages/guidelines.aspx

- All notices in public areas will be produced bilingually or a separate Welsh and English language version created.

Websites, Social media accounts and Apps

- Trust websites will be available in English and Welsh and will be as accessible to the user in both language.
- Trust websites will not treat the Welsh language less favourably than the English language.
- Corporate Social media accounts will be available in English and Welsh and should a question be raised in Welsh a response will be given in Welsh.
- All Apps that the Trust publishes will be fully functional in Welsh as well as English other than clinical apps intended for staff.

Signage

- All newly erected signs (as of May 2019) including temporary signs or display notices will convey the same information in Welsh and English.
- Welsh language text on signs and notices will be accurate in terms of meaning and expression.

Reception

- Welsh speaking staff will identify themselves as such by wearing a Welsh lanyard or pin badge. Staff members learning Welsh will also identify themselves in order to support patients or donors requiring a Welsh language service.

- Staff able to communicate in Welsh will support patients and donors requiring a Welsh language service and should a Welsh speaking member of staff be unavailable staff will be aware that they can access language support via 'language line', a translation support service.
- Information on 'language line' is available to staff via an all staff guidance document.
- Every reception area will display a sign stating that patients or donors are welcome to use the Welsh language at the reception.

Tendering

- Should the subject matter of a contract dictate that it should be published in Welsh then the Trust will ensure that the Welsh language will not be treated less favourably than the English language.
- When an invitation for a tender is published the Trust will state that tenders may be submitted in Welsh. If such a tender is submitted then it will not be treated less favourably than a tender in the English language. E.g timescales for receiving tenders and for informing tenderers of decisions.

Promoting the Welsh language

- The promotion of the Welsh language will be visual as part of the Trust's identity and any service that we provide.
- Publicity materials relating to the promotion of the Welsh language will be made available in Welsh.
- Should the Trust publicise an English language service that corresponds to a Welsh language service we will state on the English language promotional materials that a Welsh language service is available.
- The Trust will continue to promote events such as St David's Day, Diwrnod - Santes Dwynwen etc.

2. Policy Making Standards

Policy Development

- Any new policy formulated, reviewed or revised (As of 30th May 2019) the Trust will consider the effects that policy has on:

a) Opportunities for persons to use the Welsh language and
b) Treating the Welsh language no less favourably than the English language

- When the Trust publishes a consultation document relating to a policy decision the Trust will consider and seek views on a) and b) above and c) how the policy can be formulated or revised so that it would not have an adverse effect on the use of the Welsh language
- This will be part of the Equality Impact assessment process.

When research is commissioned or undertaken in order to assist the development of a policy decision the Trust will ensure that it considers how it would have positive effects on a) and b) above.

Operational Standards

- Should a post be offered to an individual the Trust will ask whether a Welsh language contract of employment is required and if that is the individuals preference then the Trust will supply that contract in Welsh.
- The Trust will state on its internal correspondence with staff, that should staff wish to receive any paper correspondence that relates to their employment in Welsh the Trust will make this available. All other employment related documentation will be available via ESR
- Should the Trust publish any of the following policies we will publish them in Welsh and in English:

    1. Behaviour in the Workplace
    2. Health and Wellbeing at work
    3. Salaries and Workplace benefits
    4. Performance management
    5. Absence from Work
    6. Working Conditions
    7. Work Patterns

Complaints and Disciplinary matters

- Staff wishing to make a complaint may do so in Welsh and should a complaint be made in Welsh a response will be given in Welsh
- Trust documentation setting out the complaints and disciplinary procedures will state that a Welsh speaking member of staff may make a complaint or hold a disciplinary in Welsh
- Should a meeting be required with a member of staff in relation to a complaint the Trust will make it known that a Welsh speaker has the right to conduct that meeting in Welsh. The Trust will provide this by using a simultaneous translator if a Welsh speaking member of staff is not available or specifically skilled to deal with that complaint.
- Should a decision be made on a complaint or a disciplinary process then the Trust will produce this in Welsh if the process has been conducted in Welsh
- The Trust will keep a record of each complaint received against compliance with the Standards

PLEASE REFER TO TRUST CONCERNS AND COMPLAINTS PROCESS 'Putting things right'

Any complaint may be given directly to the Welsh Language Commissioner in tandem with any internal complaint.

Trust Intranet

- The Trust will provide a dedicated Intranet page for staff in order to promote and facilitate the use of the Welsh language
- The Home page of the Trust intranet will be available in Welsh and dedicated pages relating to Workforce and OD provision will also be available in Welsh
- Should a Welsh speaking member of staff require the spell checking and grammar facility, this will be available to download on the Intranet site or via a service point call.

Training and Development

- Staff Welsh language skills are assessed via the competency levels within ESR and these skills can be updated according to staff training and development
- Opportunities for staff to receive Welsh language training during working hours will be given either via on-line training or dedicated classroom attendance courses.
- Staff are provided with opportunities to receive Welsh language awareness sessions as part of the statutory and mandatory training programmes
- Email wording for staff is provided as part of a guidance written to support staff in providing a bilingual service
- Staff are encouraged to identify themselves as Welsh speakers or Welsh learners and given a method of identification, either using a lanyard or a badge, in order to support patients and donors.

Recruitment

- Using the Trust's Bilingual Skills Strategy staff will assess the language requirements of new posts and categorise posts as follows:

1. Welsh speaking Essential
2. Welsh speaking Desirable
3. Welsh skills need to be learnt or
4. Welsh skills are not necessary

- Where posts are identified as essential, desirable of need to be learnt the Trust will specify that as part of the advertisement.
- Posts will be advertised in Welsh and English and a response will be given in Welsh should an application be submitted in Welsh
- Applications for posts will be clear that an applicant may conduct their interview in Welsh should they require to do so
- Application forms for posts and subsequent materials, including job descriptions will be published in Welsh and the Welsh language versions will not be treated less favourably than the English language versions of those documents

- Posts will undertake the Welsh language assessment form and will complete this prior to advertisement and share it with Workforce and the Welsh language Manager

Clinical Consultations

- The Trust will publish a plan for each 5 year period setting out the extent to which we are able to carry out clinical consultations in Welsh.
- The plan will detail the actions the Trust intends to take in order to increase the ability to offer this service and a timetable for its actions.
- An assessment of the success of this plan will be published, three years after its development and the assessment will be published

Signage

- New signs in the workplace including temporary signs will convey the same information equally in Welsh and English and the Welsh will be positioned so it is likely to be read first
- The Trust will use the guidance in the Welsh language Commissioner's design document in order to inform its signage and displays http://www.comisiynyddygymraeg.cymru/hybu/en/guidelines/Pages/guidelines.aspx

Record Keeping and Supplementary Matters

- The Trust will keep a record of:
  1. The number of employees who have Welsh language skills and their skills level
  2. The number of employees who attend a training course and their levels of achievement
  3. The number of new and vacant posts where Welsh language skills are essential, desirable or need to be learnt
- Will ensure that it records and publishes the Welsh language Standards it has a duty to comply with
- Will publish the complaints section relevant to compliance with the Standards
- Will report annually to the Welsh language Commissioner on its Compliance against the Standards
- Will provide any additional information the Welsh language Commissioner requires in order to assess the Trust's compliance against the Welsh language Standards

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: WF08.1

Policy Addendum

The following addendum has been made to the Managing Attendance at Work Policy paragraph titled 'Sickness during period of annual leave' on page 20 of the Policy. Agreed at Welsh Partnership Forum on 16th October 2024.

Sickness during period of annual leave:

When an employee falls sick during annual leave, they will be required to report that illness in line with normal notification procedures. In such cases the employee will be deemed to have been on sickness absence rather than annual leave from the date of the notification (this includes leave booked that falls on a Bank Holiday).

In the majority of situations, normal sickness certification requirements will apply. However, where a requirement for Fit Notes for all absences is in place as part of a managing attendance process, or in cases where managers can evidence concerns regarding the individual's health and wellbeing and/or pattern of absence, Fit Notes can be requested from Day 1 of absence. This should only be in exceptional cases with evidence to support the requirement provided.

Where an employee's sickness absence falls on a Bank Holiday (which wasn't a rostered workday, booked as leave), there is no entitlement to an additional day off.

With regard to shift workers and other staff working in the 24/7 environment, if an individual is sick on a Bank Holiday that was scheduled as a rest day, then the Bank Holiday will not be deducted from their annual leave entitlement. If an individual is sick on a Bank Holiday that they are scheduled to work, then the Bank Holiday will be deducted and paid as annual leave."

Flexible Pensions Policy

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

Approved September 2024
Welsh Partnership Forum
Medical and Dental Business Group

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Section 1

Policy scope, principles and benefits

1.Introduction

The definition of retirement is changing and broadening. Many employees are considering how they can gradually adjust their working patterns to achieve a healthy work-life balance and a smoother transition from their working life into retirement. This shift towards retiring flexibly leaves behind the expectation that retirement means permanently leaving the workplace and employment, or that full time work should immediately be replaced with full time retirement.

Flexible working is just as valuable for staff approaching the end of their careers, and for retired staff who are returning to the NHS, as it is for those joining the NHS for the first time or returning from parental leave.

Flexible working is key to retention, employee engagement and supporting staff to live healthy working lives, and NHS Wales is committed to offering more flexible, varied roles and opportunities to their employees.

To support employees to access flexible working later in their careers this policy has been developed to provide an overview of the options available to employees who are members of the NHS Pension Scheme to access their pension or part of it and/or plan for retirement through utilising the flexibilities available within the scheme which fit with employees' aspirations for flexible working and work/life balance.

2.Policy statement

NHS Wales is committed to developing and maintaining arrangements which make it a great place to work and learn, and to the delivery of a quality service, recognising that our staff are fundamental to our success, and that we need to attract new staff from a varied range of backgrounds. NHS Wales also understands that it is vital to retain the embodied investment in knowledge, skills and experience of staff over many years, which we commit to maintain both now and in the future.

Consistent with this commitment to ensuring all staff can access the benefits of flexible working, NHS Wales is committed to supporting and enabling staff to utilise the flexible pension provisions and benefits offered through membership of the NHS Pension Scheme.

3.Scope

To ensure promotion and consistent application of flexible pension options, this policy has been developed in partnership, for use within all NHS Wales organisations and supersedes/replaces any existing policies, guidance, minimum standards e.g. Retire & Return Policies at employer/organisation level.

This Policy:
✓ ***Will enable employees to understand the range of options available to access their pension and combine this with flexible working***
✓ ***Will enable employers to understand, promote and discuss flexible pension options with staff.***
✓ ***Sets out the expectations and requirements of employees and employers in pursuing and considering applications to access one of the options.***
✓ ***Seeks to ensure that employees later in their careers will feel valued, rewarded, and recognised by their employer for their experience, service and commitment.***
✓ ***Forms part of the contract of employment for staff working in NHS Wales.***

The aim of this policy is to enable employees and employers to make informed choices regarding the appropriate use of the flexible pensions available. The approach advocated by Welsh Government, employers and trade union partners is that these flexibilities are of mutual benefit with the expectation that conversations and applications will be progressed and approved.

This means that the default position will be that a request to access one of the pension flexibilities options, that meets the requirements of the Pension Regulations, will be approved, and every possible avenue explored to facilitate this. Requests will only be declined where there are clear business reasons in policy and law that prevent approval.

NHS Wales will not discriminate, either directly or indirectly, on the grounds of any of the characteristics protected by the Equality Act 2010 or any other personal characteristic in the implementation of this policy. We aspire to a diverse workforce and recognise that compassionate leadership does not mean treating everyone the same but treating them fairly and considering detailed knowledge of each individual staff members' needs, circumstances and background.

4.Principles

Flexible pension options support the following principles:

To support:	Through:
Work-life balance	➢ employees working flexibly later in their careers helping to achieve a healthy work-life balance
Retaining experience	➢ enabling experienced employees to stay in the NHS for longer and pass their valuable skills and knowledge to colleagues.
Health and Wellbeing	➢ supporting the health and wellbeing of employees who are later in their careers.
Financial Wellbeing	➢ supporting the financial wellbeing of employees through offering retired staff,

	the option to re-join the NHS Pension Scheme after full or partial retirement thereby enabling employees to build up further pension.
Managing work later in careers	➢ providing employees with flexible working options as a bridge between taking their NHS Pension and receiving their State Pension benefits.
Managing pension growth	➢ controlling pension growth to support staff affected by the annual allowance.

5.Benefits

The NHS Pension Scheme offers several flexible pensions options. These options can support employers attract and retain experienced staff whilst supporting employees, through a range of options, to access pension benefits whilst continuing to work for NHS Wales.

NHS Pensions and NHS Employers both provide further information on the NHS Pension scheme and the wider scheme design and contractual considerations of flexible retirement. Their resources can be accessed by following these links:

NHS Pensions

NHS Employers

Flexible pensions options support employees to:

- work flexibly towards the end of their careers
- to achieve a healthy work-life balance
- stay working in the NHS for longer and pass their valuable skills and knowledge to colleagues.
- maintain their experience within NHS Wales supporting the delivery of high-quality patient care.

By enabling employees to retire flexibly, employers can:

- Support the health and wellbeing of employees who are approaching the end of their careers.
- Develop working arrangements which fit with lifestyles and desired attendance patterns. Such arrangements support ongoing retention of employees and their productivity, while reducing rates of stress, fatigue and burnout.
- Offer retired employees the option to re-join the NHS Pension Scheme after full to supporting financial wellbeing, as it allows employees to build up further pension and may help to bridge any gap between taking their NHS Pension and State Pension benefits.
- Through partial retirement support employees who may be affected by the annual allowance, as the ability to take all or part of their pension whilst continuing to work may help some employees to control their pension growth.

Section 2

Flexible pensions guide and options

6. Pensions considerations

6.1 The NHS Pension Scheme - overview

There are 2 NHS Pension schemes. There's the 1995 / 2008 Scheme and the 2015 Scheme. From 1 April 2022, all active members of the NHS Pension Scheme are members of the 2015 Scheme.

The NHS Pensions website has extensive information on the schemes and sets out the benefits of membership withing the two member guides:

- The 1995/2008 Member Guide
- The 2015 Member Guide

6.2 How do I know what Pension Scheme an individual is in?

The NHS Pension Scheme has had several changes since 1995, and members may have service in more than one scheme. The Total Reward Statement, which can be accessed through ESR, provides information on an individual's NHS Pension Scheme membership.

An individual may have service in more than one scheme, particularly if they have been an NHS Pension Scheme member since before 1 April 2012, and if so, their service will be detailed in two separate parts in the Pension Statement e.g. there would be an Annual Benefit Statement for 2015 Scheme service and an Annual Benefit Statement for 1995 Scheme service.

6.3 Considering the impact of the McCloud remedy

The McCloud remedy has been put in place following a legal case ruling (McCloud) and is the process of removing age discrimination that was judged to have arisen in public service pension schemes, including the NHS Pension Scheme.

Employees who joined the NHS Pension Scheme on or before 31 March 2012 and who were still members of the scheme on 1 April 2015 are eligible for the McCloud remedy. If an individual is considering applying for one of the Flexible Pension options, it is important that they understand their position in respect of the McCloud remedy.

As part of the McCloud ruling, affected members have had their pensionable service for the McCloud remedy period - 1 April 2015 to 31 March 2022 - put back into the 1995/2008 Scheme.

If this affects the individual once, they will be contacted by NHSBSA in the 12 months after they have accessed all or part of their pension and asked to choose between keeping these benefits in the 1995/2008 Scheme or taking 2015 Scheme benefits for the remedy period instead.

When it comes to making this choice, the part of the Scheme that's better for them could be different depending on how long they continue to work after they've taken partial retirement. Their McCloud choice means there are other factors to consider when deciding what percentage of their pension to take at partial retirement, as it could affect their tax position, or their final salary link, if they have one. And if they later choose to take 2015 Scheme benefits for the remedy period, they may have lump sum overpayments to pay back.

Further information about the McCloud remedy is available on the public services pensions remedy – McCloud (NHSBSA) links to modelling tools to support the decision-making process.

6.4 Choosing when to retire

Each member of the NHS Pension Scheme has a normal pension age (NPA), at which they can retire and claim pension benefits. This age is defined by the scheme they are a member of (or additionally have preserved benefits in e.g. the 1995 scheme).

There is also a minimum pension age (MPA) which is the earliest age at which individuals are eligible to take their NHS pension.

Scheme	Normal pension age (NPA),	Minimum pension age (MPA)
1995	60 (55 for Special classes)	Age 50 if joined pre 06/04/2006 and not had a break of 5 years or more. Otherwise, age 55*
2008	65	55*
2015	State Pension Age	55*

* The minimum age that an individual can start taking their pension is changing from 55 to 57 from 6th April 2028.

The NHS Pension Scheme enables members to be flexible about the age at which they retire to suit their plans. This allows individuals to retire earlier or for the 2008 and 2015 schemes, later than their NPA.

If an individual is considering retirement:

- before their NPA, the pension they receive will be reduced because it is being taken earlier. This is because their pension will be paid for longer.
- later than their NPA, their pension benefits may increase by the application of late retirement factors. Late retirement enhancement is only available for membership of the 2008 scheme and 2015 scheme.

6.5 Early retirement

As noted, taking pension benefits before NPA will result in a reduction to the pension because it is being paid earlier. This is called an “actuarial reduction” and is based on the earlier age at which the individual is choosing to take their benefits compared with their NPA.

The term ‘actuarial reduction’ refers to the tables used to calculate the reduction to their benefits if they retire early. An individual incurs this reduction when their pension is paid earlier than normal and, therefore, potentially it will be in payment for longer. NHS Pensions have produced a factsheet which can be accessed here, setting out the early retirement percentage reductions across the different schemes.

Where an individual has membership in more than one NHS Pension scheme, then the actuarial reduction is applied to each specific period of membership in each scheme. For example, someone aged 58 (without Special Class Status) with a state pension age of 67 wishing to retire early would have any of their 1995 membership reduced by 2 years because they are retiring 2 years before age 60, however any membership they have in the 2015 scheme would be reduced by 9 years because their normal pension age (NPA) is the same as the state pension age i.e.67.

It is important to note that the pension paid to dependents will be based on their pension before actuarial reduction and further information is set out in their Total Reward Statement section on Adult Dependant’s Pension.

6.6 Early retirement reduction buy out (ERRBO)

Early Retirement Reduction Buy Out (ERRBO) is part of the 2015 scheme. If an individual claims their 2015 pension before their Normal Pension Age (NPA), it will be reduced, however they can plan to buy out one, two or three years of any reduction before their NPA but no earlier than age 65. Through purchasing an ERRBO this would enable the individual or the employer if they agree, to pay extra contributions so they can buy out the reduction that would apply to their 2015 Scheme benefits if they retired before their NPA.

NHS Pensions have produced a ERRBO Factsheet which provides more information regarding the scheme and the costs of additional contributions which are payable to buy out 1,2 or 3 years of reduction.

6.7 Employer pension contributions recycling/alternative payment

In certain circumstances an individual’s pensionable pay may result in a pension growing to a level which exceeds the annual allowance.

The arrangements set out in Section 7 Flexible Pensions provide mechanisms which can support members of the NHS Pension Scheme to manage their pension growth which enables individuals to manage their level of annual allowance.

However, individuals who are under the Normal Pension Age (NPA) are not able to manage their pension growth in this way and they may seek to reduce their pensionable pay through a reduction in their clinical activity as a way of managing any annual allowance liability/charge. Maintaining clinical activity is critical for NHS Wales services and a specific facility has been established on an All-Wales basis to support such individuals through a

scheme where they can apply, on an annual basis, to receive an alternative payment in place of their employer pension contributions whilst they are opted out of the NHS Pension Scheme.

This provision is open to staff who can demonstrate that their level of earnings in the NHS (which may be a projection of earnings) will result in their being impacted by the annual allowance in any financial year and who are unable to manage their pension growth through accessing the partial retirement provisions or reduce their level of pensionable pay without an impact on their activity.

To approve an alternative payment, employers are required to take legal considerations into account and to evidence whether there is an objective justification based on the risk to service delivery posed by an individual reducing hours or being reluctant to take on additional work.

Further details on the criteria and considerations regarding employer pension contributions recycling are included in the [1]Employer Pension Contributions - Model Alternative Payments Policy process which employers administer in line with the provisions at a local level.

6.8 What is abatement?

The Scheme regulations say a pensioner cannot receive more in pension and re-employed salary than the salary earned before retirement. This is known as an earnings margin.

If this earnings margin is exceeded, the annual pension will be reduced. This is known as abatement.

In March 2020, the Department of Health and Social Care (DHSC) suspended abatement for members who have Special Class (SC) and Mental Health Officer (MHO) status and claim age retirement pension benefits before age 60.

On 1 April 2024, abatement will be removed for these members if they retire and return.

Abatement is also the term used to describe the reduction or removal of pension payments if pensionable earnings have increased to pre partial retirement level within the first 12 months of partial retirement.

When will abatement apply?

Retire and return

If the individual is under their Normal Pension Age (NPA), abatement will apply if they retire on one of the following grounds and return to NHS work before their NPA:

- ill health under the previous ill health retirement arrangements
- ill health Tier 1 or Tier 2 under the current ill health retirement arrangements
- early payment of deferred benefits due to ill health
- redundancy if you retired before 1 October 2011
- early retirement in the interests of the efficiency of the service

[1] This Model Policy was previously issued by NHS Wales Employers as a guide for employing organisations. It is not an All Wales Policy agreed with BMA. Please contact your Workforce Department for the local policy/position.

Their pension being reduced depends on:

- their earnings while re-employed
- when they left the Scheme
- when they claimed their pension benefits
- the type of pension benefits claimed.

Abatement rules stop once they reach their NPA of the Section or Scheme which they've claimed their pension benefits from.

Individuals will not be subject to abatement if:

- they were over their NPA when they retired
- they are receiving redundancy benefits and retired after 30 September 2011
- they are receiving Actuarially Reduced Early Retirement (ARER) benefits.

Partial retirement

Partial retirement is a pension flexibility and requires employees to have a change in their terms of employment, and to reduce their pensionable pay by 10% or more for at least 12 months (based on the previous 12 months pensionable pay).

In the 12 months after partial retirement, if the member has a further change to their terms that increases their level of pensionable pay beyond the level required, they will no longer be eligible for the pension taken. Their pension payments will therefore be "abated".

Individuals will not be subject to abatement if there has been no change to their terms of employment, e.g. they have not been appointed to a new role at a higher rate of pay, not increased their substantive contracted hours.

7. Flexible pensions – the options

Summary of Flexibilities			
Flexibility	What is it?	What is the benefit	Considerations
Partial retirement	You can take between 20% and 100% of your pension benefits, without having to leave your current job. You can also continue to build your pension benefits in the 2015 Scheme.	Partial retirement enables you to claim all or some of your pension, whilst continuing to work, but without having to take a break and leave your job.	Whilst you won't need to take a break or change jobs, you will need to work with your employer to change your terms (such as by adjusting your hours) so your "pensionable pay" is reduced by 10% for the first year.
Retire and return/re-join	Accessing your full pension, then returning to work after a short break and, if you wish, re-joining the 2015 NHS Pension	If you're not ready to stop work altogether and you don't want to reduce your pensionable earnings, you can access your pension and re-	If you decide to re-join the NHS, you can work as many hours as you choose and in most cases your pension payments won't be reduced or

Summary of Flexibilities			
	Scheme to keep building your future pension benefits.	commence work in your current role after a 24-hour break.	stopped (known as 'abatement').
Step down	You may not be ready to retire but wish to step down to a different role, for example, to reduce the level of responsibility while remaining in NHS employment.	This option enables you to change the intensity or type of work on the approach to retirement whilst supporting the organisation to retain your skills and experience. You may wish to use this option where you wish to change role as you approach retirement, but you don't want to access your pension.	With this option you may be eligible to have your higher level of pensionable pay protected, which would mean that your final salary benefits are not affected when you do access your pension
Reduction in Hours/wind down	You may wish to reduce the number of hours or days that you work but remain in your current post	This option may support you to remain in work for a longer period before retirement through reducing the hours or days which you work. You may wish to use this option where you wish to reduce your hours as you approach retirement, but you don't wish to access your pension.	Reducing working commitments will reduce pensionable pay and there will be less pension building up each year compared to the previous higher number of hours worked. However, any final salary benefits built up in the 1995/2008 scheme will continue to be based on whole-time equivalent pensionable pay and protected from changes in working patterns.

7.1 Partial retirement

Partial retirement, sometimes referred to as draw down, enables active NHS Pension Scheme members who have reached minimum pension age to take all or part of their pension whilst continuing to work.

NHS Pensions have produced an Employers Factsheet and a Members Factsheet which should be read alongside this policy.

To be eligible for Partial Retirement an individual must:

- ✓ Have reached their minimum pension age.
- ✓ Be an active member of the Scheme (if they are not an active member, they would need to rejoin and be an active member for at least one month before taking Partial Retirement).

- ✓ Reduce their actual pensionable pay by at least 10% for the 12 months starting from the date they take Partial Retirement (for GP's, Dental Practitioners, Ophthalmic and non-GP Providers a 10% reduction in commitment is required).
- ✓ Make sure their 10% reduction in pensionable pay is calculated based on their previous level of pensionable pay for the 12 months before they take partial retirement.
- ✓ Have a change in their terms and conditions of employment to reflect their reduction in pensionable pay.
- ✓ Expect their new level of pensionable pay to last at least 12 months from the point partial retirement is taken.
- ✓ Not have already claimed partial retirement on two occasions.

Partial retirement is a pension flexibility and requires employees to have a change in their terms of employment, and to reduce their pensionable pay by 10% or more for at least 12 months (based on the previous 12 months pensionable pay). There is no need for the individual to end their contract of employment or have a break in service to take their pension benefits. Annual leave entitlements, salary and additional earnings such as clinical excellence awards will continue based on the new working pattern/revised terms and conditions.

For most staff, this reduction can be achieved via a reduction in working hours.

However, if an employee does not want to reduce their working hours, employers may consider alternative ways of meeting this requirement including split contracts (separate employment contracts/assignments) which would enable the employee to opt out of the NHS Pension Scheme for one of the contracts in order to reduce their pensionable pay by at least 10% for at least 12 months or work (non-pensionable) overtime to maintain their working hours. Further guidance on these options is set out in 7.1.1 – 7.1.3.

After taking partial retirement, individuals will continue to build up further pension in the 2015 Scheme unless they choose to opt out of the NHS Pension Scheme.

7.1.1 Achieving the 10 per cent reduction in pensionable pay

If an individual is considering partial retirement, they will need to have a conversation with their manager to agree a change to their terms and conditions of employment to achieve the required 10 per cent reduction in pensionable pay.

The 10% reduction in pensionable pay will be calculated based on their previous level of pensionable pay for the 12 months before they take partial retirement, ending on the day they take partial retirement.

In the 12 months after partial retirement, if the member has a further change to their terms that increases their level of pensionable pay beyond the level required, they will no longer be eligible for the pension taken. During this period, they may still be able to do additional work that doesn't count towards their pension, such as "overtime" or bank work (if opted out for the bank contract). If a member receives a nationally agreed pay award in the 12 months after taking partial retirement, they would still be eligible for their pension as their terms of employment would not have changed.

Agreement needs to be reached on how to reduce the individual's pensionable pay before they proceed with their application for partial retirement.

Open conversations between the individual and manager are key to understanding the circumstances, needs and preferences. These will need to be considered and balanced alongside the aims and priorities of the manager and employer, to agree a solution which suits both parties.

There are many ways of reducing pensionable pay and the most effective method will depend on the individual circumstances of the employee and the employer. There is no one size fits all solution to reducing pensionable pay and, in some cases, bespoke arrangements will need to be agreed.

Whilst individuals may be happy to maintain the reduction in pensionable pay following the end of the 12 months, they may specifically wish to agree that the change to terms and conditions of employment/the reduction in their pensionable pay is only for the 12-month period, with an agreement that at the end of that period, their working/contractual arrangements will return to normal.

Employers must not insist on permanent changes when the employee does not wish for the 12-month reduction in pensionable pay to be a permanent change to their contract. Reverting to previous arrangements/pay should be the default unless it has been agreed otherwise. However, this does not happen automatically and will require the Employer to notify payroll of the change. The individual will need to advise the payroll/pensions if they wish to rejoin the pension scheme.

7.1.2 Reducing hours and working overtime

To facilitate the reduction of hours whilst maintaining a similar level of activity to that which was previously worked, members could consider agreeing on a change of terms to reduce pensionable pay by 10% and working non-pensionable overtime for a 12-month period as part of a Flexible Pensions Agreement.

The NHS Pension Scheme regulations set out that overtime is non-pensionable. For members who have not taken partial retirement in the previous 12 months, overtime is defined as any period worked more than whole-time, according to the member's contract. This means that any hours worked beyond whole-time (by full-time or part-time staff) are non-pensionable, but hours worked up to whole time by part-time staff are pensionable.

However, for members who have taken partial retirement in the previous 12 months, any period worked more than their contract is overtime, regardless of whether or not this contract is full-time or part-time.

This means that if a member agrees to change their terms and reduce their pensionable pay to access partial retirement (for example, moving from full-time to 0.8 FTE), in the 12 months after they have taken partial retirement, they could do overtime to take them up to full-time equivalent. They would still be eligible for their partial retirement pension, as this overtime would not be pensionable, so it would not lead to an increase in their pensionable pay.

7.1.3 Combining partial retirement with an additional contract or bank agreement

To facilitate the reduction of hours whilst maintaining a similar level of activity to that which was previously worked, individuals may choose to be engaged on an additional (split) contract or bank agreement in addition to their substantive (normal) contract and as part of a Flexible Pensions Agreement.

Employees who are employed on an additional contract or engaged on a bank worker agreement may opt out of the NHS Pension Scheme in respect of the additional contract or bank agreement, whilst continuing to be a member of the NHS Pension Scheme in respect of their substantive (main) contract of employment.

To ensure the required 10% reduction in pensionable earnings level is met, opting out of the scheme from an additional (split) contract or bank agreement will need to be requested from the first day of partial retirement and within the first month of the arrangement commencing by employees completing the NHS Pensions Scheme form SD502.

This flexibility would enable the individual to reduce their hours and pensionable pay under their substantive contract of employment (as required to access partial retirement), whilst working additional capacity on a non-pensionable (opted out) basis under the terms of an additional (split) contract or bank agreement.

If contract splitting is being considered, then:

- The proposed contracts should be structured so that they are capable of being separately performed. This means that the roles under each contract should be distinguishable, and not “continuous” with the other. So, an employee could stop one job, but continue with the other; and

- The terms in the respective contracts need to be clearly defined and be capable of allowing proper maintenance of payroll records distinguishing between the two.

An example of this approach would be where clinical duties performed under a core contract which is pensioned under the NHS Pension Scheme, and management or clinical leadership role/additional NHS duties/external NHS duties under a second contract where the individual opts out of the NHS Pension Scheme.

Splitting contracts does not automatically require re writing of Job Descriptions or separate Job Evaluation as this can be set out and managed through the flexible pensions process for the 12-month period.
In addition, splitting contracts does not automatically require the use of a Bank worker agreement. However, if a Bank engagement is being considered, then:

- Individuals need to ensure that they opt out of the NHS Pension Scheme for any Bank agreement, and
- The different contractual relationship of a bank worker agreement should be recognised.

Where it is not possible for employers to agree to change of terms and a reduction in pensionable pay, but the employee wishes to claim 100% of their 1995 Scheme pension, using retire and return/re-join would offer a very similar outcome and so should be considered.

7.1.4 Monitoring the 10 per cent reduction in pensionable pay

Employers

Employers need to be confident that the agreed contractual change to working arrangements will lead to a reduction in pensionable pay of at least 10 per cent for the 12-month period. Employers should have a mechanism in place to ensure that the individuals pensionable earnings meet the requirements of partial retirement for the 12-month period. During the first 12 months of partial retirement, employers and individuals have a joint responsibility to notify NHSBSA if the individual has a change to terms and conditions that results in pensionable pay increasing to more than 90 per cent of the pensionable pay before partial retirement. If this does occur, then abatement may apply in full and the pension benefits in payment may be stopped.

Where pay does increase to more than is allowed and abatement occurs, the pension will only start to be paid again, once pensionable pay is reduced by a minimum of 10 per cent of the pay that the original partial retirement was based on.

At the end of the 12-month period, unless agreed otherwise when the individual submitted their request or in advance of the 12-month point, the terms will revert to those in place prior to the partial retirement.

Workforce & OD teams should give clear instructions to their pension and payroll colleagues to ensure that the agreed changes to working arrangements or pensionable pay are accurately processed and updated on the employee's pension and payroll records.

Employees

Employees should not agree any further changes to their contract of employment which would increase pensionable pay above 90 per cent of pensionable pay before partial retirement was agreed during the 12-month period.

Annual pay awards and pay increases members receive as they move through their pay band or pay scales do not count towards this, but any pay increase resulting from a contractual change to terms and conditions will. For example, if they decide to apply for a different job with a higher salary, increase substantive hours or increase commitments.

It is important that employers make members aware of the changes that could lead to abatement and overpayments which would need to be recovered.

7.1.5 What should be considered when deciding how much pension to take?

If an individual is applying for partial retirement, they should consider a number of factors when deciding how much of their pension they wish to take. The NHS Pensions Members Factsheet has more information regarding the decision making process and this should be read alongside the guidance in this policy.

A Partial Retirement Calculator has been developed by NHS Pensions and is available on the NHS Pensions scheme website. This will allow the individual and the employer to see how taking different percentages of their pension at partial retirement affects the amount of pension benefits they will get overall.

It is recommended that individuals use this calculator to work out the amount of pension they want to take and the change in working arrangement that's best for them before applying for partial retirement. In the event this calculator doesn't provide the information needed, they can contact NHSBSA for specific information

It is important that individuals know the whole picture regarding the impact of taking their pension whilst continuing to receive income from employment, for example the income tax

considerations and therefore accessing independent financial advice should be considered when determining whether it would be the right option for them. NHS Employers have compiled a list of organisations which are able to give advice and guidance on pension tax issues which can be accessed via this link. In addition, certain benefits will be impacted so it is important that employers share and communicate all relevant information to individuals and encourage them to take appropriate advice before making a final decision.

7.1.6 The impact of differing Normal Pension Ages (NPAs) when considering partial retirement.

If an individual takes their benefits before their normal pension age (NPA), their benefits will be reduced. As referenced in section 6, different NPAs apply in the 1995 scheme, 2008 scheme and 2015 scheme. This may affect their preferences around how much pension they may wish to take and when.

Members are not able to choose which scheme they take their benefits from. When a member chooses to take partial retirement, their chosen percentage is applied sequentially across all their benefits in the NHS Pension Scheme. This means that they would effectively take or use up their 1995/2008 Scheme benefits first, followed by their 2015 scheme benefits. Therefore, if they wish to take their 1995/2008 scheme benefits but not their 2015 scheme benefits (perhaps to avoid an early retirement reduction being applied to their 2015 scheme benefits) the individual and employer will need to indicate this on the application form provided by NWSSP Pensions Team.

NHS Pension Scheme members are not able to take their lump sum separately from their pension. Taking partial retirement involves claiming a proportion of their pension and any lump sum associated with that pension.

7.2 Retire and return/re-join

Retire and return is a way of retiring flexibly which works alongside the NHS Pension Scheme Regulations and can be used by employers as a tool to retain valuable and experienced staff and boost capacity. Individuals who have reached the minimum pension age may leave NHS employment, claim their pension benefits and later decide to return to NHS employment.

When employees retire and return, they must leave their employer, their existing contract of employment ends, and they must enter a new contract of employment with their employer.

Unless the individual requests otherwise (i.e. a longer break), the default position is that the only break in service required for retire and return is that prescribed by the pension rules (24 hours). All NHS Wales organisations will operate the break in contract on this basis, unless the individual requests a break of a different duration.

Illustration - to achieve the required break of 24 hours, an individual who finishes on 31st March with no annual leave outstanding must not return/re-join before 2nd April.

Individuals must be offered the right to return on the same contractual basis as they were pre-retirement. This means being engaged on a permanent contract and with the same terms and conditions, unless the individual requests a different working arrangement.

Individuals who have retired and returned prior to this policy being in place, and were appointed on a fixed term or locum contract, have the right to request for this contractual status to be reviewed in accordance with the terms of this policy.

Prior to taking retire and return, all annual leave should be taken to ensure that the last date of service and new date in service and as a result the pension payment is not impacted.

7.2.1 Specific retire and return considerations for medical & dental staff

- Retention of Clinical Excellence / Clinical Impact awards

  National award holders, who begin receiving their pension after 1 April 2023, will retain their award. This is subject to the standard scheme rules around job changes where any changes to working arrangements are made as a consequence of retire and return.

  As with any job change, award holders and employers should discuss job change plans with the Advisory Committee on Clinical Impact Awards (ACCIA) secretariat before the job change has been implemented to avoid losing the award or being required to re-apply early.

- Associate Specialists 2008 – the right to return to this grade

  An Associate Specialist on the 2008 Contract who retires, and returns will have the right to be re-engaged on the same Associate Specialist terms if they wish.

7.2.2 Retire and re-join

From 1 April 2023, all staff who choose to retire and return can join the 2015 scheme – this applies to staff who've retired from the 1995, 2008 and 2015 Schemes, so long as they are under age 75.

Employees who retire and return are contractually enrolled into the 2015 scheme on the first day of their employment, in the same way as any other new starter and if they do not wish to pay pension, they must opt out within the first month.

7.2.3 Differences between retire and return and partial retirement

The key distinction between retire and return and partial retirement is that with retire and return, as an NHS Pension Scheme member the individual must leave NHS employment, take their pension and be re-employed on a new contract of employment at a later date. With partial retirement, NHS Pension Scheme members can take their pension without leaving their job or taking a break in service and so their existing contract of employment continues to be in place.

Another important difference is that members who retire and return must take all their benefits from the 1995 Scheme at once, whereas partial retirement provides additional flexibility for members to take some or all of their pension in one or two payments.

Partial retirement provides a more seamless approach and is designed to provide an effective means for employees to access their pension if they already know that they plan to continue working after taking their pension.

Retire and return has specific provisions and under the NHS Pension Scheme regulations, members must take a 24-hour break before returning to employment to take their pension from the 1995 scheme.

There is no requirement to ensure an employee takes a longer break in service to achieve a break in continuous service and under this policy NHS Wales organisations must not insist on a longer break in service.

Employers must offer the same terms and conditions of employment to individuals upon their return. Through offering the same terms and conditions, including pay, annual leave and sick pay, it is the aim of this policy to support and encourage experienced staff who want to claim their pension to continue working, if they wish, as well as attracting staff who have recently retired back to work.

7.3 Step down

An individual may not be ready to retire but wish to step down to a different role, for example, to reduce the level of responsibility while remaining in NHS employment. This option enables them to change the intensity or type of work on the approach to retirement whilst supporting the organisation to retain their skills and experience.

If an individual has reached minimum pension age and choose to step down to a role where their new or remaining duties are less demanding and carry less responsibility than their previous duties, they may be able to apply for voluntary protection of the link to their higher level of pensionable pay if their pay reduces by 10% or more.

Voluntary protection of their previous pensionable pay level is part of the 1995 Scheme of the NHS Pension Scheme. This provision recognises that in the run up to retirement individuals may prefer, if possible, to remain in NHS employment, perhaps in a lesser capacity, while protecting, for the calculation of their final salary pension benefits, the previous salary level at which their benefits in the 1995 scheme were calculated.

Any ‘step down’ arrangement needs to be agreed between the individual and their employer and they will have to provide NHS Pensions with information that the step down has been agreed.

The provision is also intended for lasting, rather than trivial or short-term reductions in pay. It would normally be expected that the step down would occur with the same employer however, if a suitable role to ‘step down’ to cannot be provided by one employer, but can be arranged with another, this would be acceptable. In this case both employers will have to provide information that confirms a ‘step down’ arrangement has been agreed.

It is possible for an NHS Pension Scheme member to leave one employer and join another on a reduced rate of pay and to apply for voluntary protection of pensionable pay provided both employers agree to the step-down arrangement. The provision is not intended for situations where a member leaves one employer and joins another on a reduced rate of pay without an agreement between employers.

7.3.1 Eligibility criteria for voluntary protection of pensionable pay

To be eligible for voluntary protection of pay the individual must:

- have a final salary link to 1995 Scheme pension benefits

- have stepped down to a role where their new or remaining duties are less demanding and carry less responsibility than their previous duties (as confirmed by their employer(s))
- have a reduction in pensionable pay of at least 10% for a period of at least one year, beginning with the first pay day on which the reduced pensionable pay was paid (as verified by their employer(s))
- not have had any other reduction in pensionable pay in the 12-month period before they stepped down (as verified by their employer(s))
- have applied after 12 months, but within 15 months, of their pensionable pay being reduced
- have reached their minimum pension age in the 1995 Scheme
- have attained at least two years qualifying membership within the NHS Pension Scheme at the time they step down
- have not previously protected their pensionable pay under the voluntary protection of pay arrangements

7.3.2 Arrangements for 2008 Scheme and 2015 Scheme membership

The voluntary protection of pay arrangements is specifically for membership within the 1995 scheme of the NHS Pension Scheme.

The 1995 scheme uses best of the last three years when calculating an individual's pension, so the ability to protect the higher level of whole-time equivalent pay is important to retain the highest level of pay which is used to calculate their pension when they retire.

In the 2008 Scheme – Total Reckonable pay is the average of the best three consecutive years of pensionable pay in the last ten. Each year's pay in the last 10 years before retirement is increased by the cost of living to bring that pay figure up to what it would be worth on the day of leaving. The 2008 scheme therefore supports individuals "stepping down" in the last 10 years before retirement and so protection arrangements are not required.

In the 2015 Scheme – The amount of pension an individual earns each year is determined by what is known as the 'build up rate' which is shown as a fraction of their pensionable earnings. In the 2015 Scheme the build-up rate is 1/54th of pensionable pay. Therefore, they earn a pension of 1/54th of their pensionable earnings each year, or part year if they leave before the end of a financial year. Due to the way in which the 2015 scheme builds up each year any higher level of pension previously built up is secure in their overall pension record and any further pension which they build up is based on the stepped down role.

7.4 Reduction in hours/wind down

Individuals may wish to reduce the number of hours or days that they work but remain in their current post. This is called wind down.

Reducing working commitments will reduce pensionable pay and there will be less pension building up each year compared to the previous higher number of hours worked. However, any final salary benefits built up in the 1995 or 2008 schemes will continue to be based on whole-time equivalent pensionable pay and protected from changes in working patterns as noted in 7.3.2.

All employees working in NHS Wales are eligible to apply for flexible working through the All Wales Flexible Working Policy.

This option may support individuals to remain in work for a longer period before retirement through reducing the hours or days which they work. They may wish to use this option where they wish to reduce their hours as they approach retirement but don't wish to access their pension.

8. Flexible Pensions Option Request Process

8.1 Making a request

Where an individual wishes to access one of the flexible pensions options in Section 7 of this Policy, they should complete Part A of the Flexible Pension Request Form (Appendix 1). It is recommended that they have an informal discussion with their manager before submitting a formal request and managers are encouraged to facilitate this when requested to do so. However, the request will not be formally considered until it is put into writing.

If the manager refuses or is not receptive to an application at an informal discussion, they may still decide to proceed with a formal application. They may wish to seek advice and assistance from their workforce team or their trade union or a workplace colleague.

8.2 Responding to a request

Managers should be aware that there is a legal requirement to consider flexible working applications and inform their employees of the outcome within 2 months of the date the request and should take this into consideration to ensure they have an adequate time frame to give the request due consideration. Managers should also be aware that once agreed, there are steps that NWSSP Pension Team need to take prior to submission of any request to NHS Pension Scheme. Once submitted, NHS Pension scheme application timescales (at least 3 months) should also be factored in. Therefore, any discussions regarding the effective date of any change to contract, retirement etc. need to be cognisant of the work required by other agencies to progress and action the application.

Manager should arrange to discuss the application with the individual as soon as possible after receiving a request form (this can be in person, by telephone or via MS Teams). This will allow them to get a better understanding of the changes the individual is looking for and how they see things working in practice. The discussion should explore how the proposed working arrangement will work in practice, any potential positive and negative impacts it may have on service provision and how it may affect other team members. Employees have the right to be accompanied by a workplace colleague or a trade union representative at this meeting. If the manager intends to approve the request, this meeting is not a requirement, but it may still be helpful to discuss practical arrangements.

Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic. Employees are encouraged to identify where this is the case. Managers should also consider any health and safety issues that might result from the change and identify ways to mitigate them (e.g., if the working arrangements will mean the individual or their colleagues would become lone workers).

Advice can be sought from People Services/Human Resources/W&OD, Health and Safety and Occupational Health as appropriate.

8.3 Considering a request

All requests should be approached with a can-do attitude, with the presumption that they will be granted unless it is genuinely not possible to do so for one of the business reasons set out below. The request should be considered carefully and the benefits of implementing the change should be weighed against any costs. In considering the application line managers must ensure that they do not directly or indirectly discriminate against the employee. If there is any doubt about what that might entail, then advice can be sought from the local EDI or People Services/Human Resources/ W&OD team. Once a decision is made the manager should inform the individual in writing using Part B of the request form.

8.4 Decision making

If it is decided to approve the application, or accept it with modifications, a discussion should take place to determine how and when the changes might best be implemented. The line manager is responsible for ensuring that Payroll are notified of any changes to pay, and specific contractual changes must be clarified with the individual in advance of the new arrangements commencing. To start the NHS Pensions application process, the individual is responsible for contacting the NWSSP Pension Team to request a link to a form specifically generated for the member of staff...

Managers must make all endeavours to accommodate the request in full or in part, or by providing an alternative. If, after a discussion with and consideration of all alternatives available, the manager feels that they are unable to support a flexible pensions request in a particular post, they must discuss the application with People Services/Human Resources/ W&OD.

If following this conversation, they still do not feel able to approve the request and cannot find a mutually agreeable alternative they will meet with individual to explain this and will provide written, objectively justified reasons for the decision and give a clear operational reason why the proposed arrangements were not practicable. The manager must provide details/evidence of the business grounds for refusing the request and how they apply in the individual's case. Within the context of a manager being required to make all endeavours to accommodate a request, where it is determined this is not possible this can only be justified by one or more of the reasons included in the following list:

- Significant burden of additional cost
- Detrimental effect on ability to meet patient/customer needs
- Inability to re-organise work among existing employees and/or engaging/recruiting other staff.
- Detrimental impact on quality
- Detrimental impact on performance
- Detrimental impact on the ability to meet service demands
- Insufficient work for the periods during which you propose to work
- Planned structural changes to the department

8.5 Escalation

This stage should be used if the line manager has not been able to reach agreement on a solution in the exploratory/application stage. The purpose is to check for other possible solutions including whether the form of flexible pensions which the individual is seeking could be accommodated in a different team, location or role. If a request for flexible pensions has not been accommodated, and the individual would no longer feel able to continue to work in that department because they would be unable to balance their work / life responsibilities, then managers are expected to support employees in identifying any alternative roles within the organisation which may be more supportive of their circumstances and in line with their request.

Should an individual fail to attend a meeting to discuss their application and one further rearranged meeting without explanation, the manager can consider the application withdrawn. In these circumstances, the manager must inform the individual that the application has been withdrawn and provide a reasonable opportunity to respond.

8.6 Appeal

Where a flexible pensions request has been refused, the individual may lodge an appeal within 14 days of being notified of the refusal of their request by contacting their manager's line manager.

This must be in writing and clearly state the grounds on which they are appealing. These may be:

- Insufficient evidence has been provided to support the reason for refusal.
- Where the manager has incorrectly treated the application as withdrawn.
- Where new information is now available in relation to the request
- Where it is felt that the application was not handled in line with the policy
- Where there may be proposal that has not been fully considered or insufficient evidence has been provided in relation to a business reason for refusal.
- Where it is felt that the application was not dealt with in a reasonable manner or that the individual has been discriminated against.

An appeal meeting will be held, normally within one month of receipt of the written appeal. This will be dealt with impartially by a more senior person than the manager who made the original decision.

The individual should be given the opportunity to be accompanied by a trade union representative or work colleague at any appeal meeting. The outcome of the appeal will be communicated in writing within seven days of the appeal meeting. This is the end of the procedure and there is no further appeal, although further requests for flexible working/pensions can be submitted.

9. Monitoring and review

Employers will keep a record of all formal applications for Flexible Pensions arrangements in place and a record of any rejections and appeals.

Organisations should ensure that data relating to applications for flexible pensions and outcomes of decisions are recorded and regularly reported through the usual partnership and governance structures.

This information should be included in an organisation's published annual statutory public sector duty reports. The published information should demonstrate outcomes for flexible working applications disaggregated by each protected characteristic of the Equality Act 2010. In addition, organisations should consider reporting outcomes by occupational group and by department.

Appendix 1 – Flexible Pensions Request Form

Part A of the request form should be completed by the employee.

Part B of the form should be completed between the line manager following the review meeting.

When agreement has been reached the employee will be required to contact the NWSSP Pension Team to commence the Pension Scheme Application Process.

Part A: Request Details

Name of employee:	
Post:	
Band:	
Employee number:	
Email address:	
Department:	
Service Group:	
Line Manager:	

Flexible Pension Option requested:

Using the detail from the relevant section of the Policy as a guide, please provide information to be considered in support of your request against the relevant option below. Please note: Once the application is approved, the Manager and Individual will be required to access and complete the relevant Pensions/Payroll forms to action the requested changes.	
Partial Retirement (reducing my pensionable pay by at least 10% for first 12 months) *	
Retire, start receiving my pension and recommence employment (Retire and Return) *	

Step down (to a role with less responsibility/lower band)	
Reduction in Hours/wind down	

Employee Signature	**Date:**

Part B: Outcome Section

Managers decision (please tick to state one of the outcomes below):

Successful application

Request for flexible pensions option has been reviewed and accepted.	
Request has been accepted subject to certain amendments as outlined below	
Partial Retirement Confirm the NWSSP - Partial Retirement Supplementary Form has been completed for submission	
All Options Confirm the relevant change notifications have been submitted to Payroll	

Please note: Once the application is approved, the Manager and Individual will be required to access and complete the relevant Pensions/Payroll forms to action the requested changes.

Unsuccessful application

Application has not been successful.	
Rationale for rejecting application: This can only be justified by one or more of the reasons included in the following list: • Significant burden of additional cost • Detrimental effect on ability to meet patient/customer needs • Inability to re-organise work among existing employees and/or engaging/recruiting other staff. • Detrimental impact on quality • Detrimental impact on performance	

• Detrimental impact on the ability to meet service demands • Insufficient work for the periods during which you propose to work • Planned structural changes to the department	

New substantive employment arrangements – Flexible Pensions Agreement

Start date of change:	
Partial Retirement applications only: End date of change/ date due to revert to previous contractual terms. (this must be no earlier than 12 months from the date of partial retirement).	
Retire & Return applications only: Date due to return, following retirement (note there must be a 24-hour break following a retire and return application)	
Change in arrangements:	
Band:	
Hours:	
Salary and Incremental point:	
Any additional allowances to be continued/previously accrued (i.e. additional annual leave):	
Commencement of Bank Contract (if applicable)	

Signatures

Manager Signature	Signature: Date: - - /- -/ - - - -
Employee Signature I confirm that this flexible pension option request has been discussed with me and I agree to the adjustments to my working arrangements	Signature: Date: - - /- -/ - - -

Polisi Pensiynau Hyblyg

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

Cymeradwywyd Medi 2024
Fforwm Partneriaeth Cymru
Grŵp Busnes Meddygol a Deintyddol

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Cwmpas, egwyddorion a buddion y polisi

1. Cyflwyniad

Mae'r diffiniad o ymddeoliad yn newid ac yn ehangu. Mae llawer o gyflogeion yn ystyried sut y gallant addasu eu patrymau gwaith yn raddol i gael cydbwysedd iach rhwng bywyd a gwaith a sicrhau hwyluso'r trosglwyddiad o'u bywyd gwaith i ymddeoliad. Mae'r newid hwn tuag at ymddeol yn hyblyg yn troi cefn ar y disgwyliad bod ymddeoliad yn golygu gadael y gweithle a chyflogaeth yn barhaol, neu y dylid disodli gwaith llawn-amser ar unwaith gydag ymddeoliad llawn-amser.

Mae gweithio hyblyg yr un mor werthfawr i staff sy'n nesáu at ddiwedd eu gyrfaoedd, ac i staff wedi ymddeol sy'n dychwelyd i'r GIG, ag ydyw i'r rhai sy'n ymuno â'r GIG am y tro cyntaf neu'n dychwelyd o absenoldeb rhiant.

Mae gweithio hyblyg yn allweddol i gadw, ymgysylltu â chyflogeion a chefnogi staff i fyw bywydau gwaith iach, ac mae GIG Cymru wedi ymrwymo i gynnig rolau a chyfleoedd mwy hyblyg ac amrywiol i'w cyflogeion.

Er mwyn cefnogi cyflogeion i gael mynediad at weithio hyblyg yn ddiweddarach yn eu gyrfaoedd, mae'r polisi hwn wedi'i ddatblygu i roi trosolwg o'r opsiynau sydd ar gael i gyflogeion sy'n aelodau o Gynllun Pensiwn y GIG i gael mynediad at eu pensiwn neu ran ohono a/neu gynllunio ar gyfer ymddeoliad trwy ddefnyddio'r hyblygrwydd sydd ar gael o fewn y cynllun sy'n cyd-fynd â dyheadau cyflogeion ar gyfer gweithio hyblyg a chydbwysedd rhwng bywyd a gwaith.

2. Datganiad Polisi

Mae GIG Cymru wedi ymrwymo i ddatblygu a chynnal trefniadau sy'n ei wneud yn lle gwych i weithio a dysgu, ac i ddarparu gwasanaeth o safon, gan gydnabod bod ein staff yn hanfodol i'n llwyddiant, a bod angen i ni ddenu staff newydd o ystod amrywiol o gefndiroedd. Mae GIG Cymru hefyd yn deall ei bod yn hanfodol cadw'r buddsoddiad sydd wedi'i ymgorffori mewn gwybodaeth, sgiliau a phrofiad staff dros nifer o flynyddoedd, yr ydym wedi ymrwymo i'w gynnal nawr ac yn y dyfodol.

Yn gyson â'r ymrwymiad hwn i sicrhau bod yr holl staff yn gallu manteisio ar fuddion gweithio hyblyg, mae GIG Cymru wedi ymrwymo i gefnogi a galluogi staff i ddefnyddio'r darpariaethau pensiwn hyblyg a'r buddion a gynigir drwy aelodaeth o Gynllun Pensiwn y GIG.

3. Cwmpas

Er mwyn sicrhau bod opsiynau pensiwn hyblyg yn cael eu hyrwyddo a'u cymhwyso'n gyson, mae'r polisi hwn wedi'i ddatblygu mewn partneriaeth, i'w ddefnyddio yn holl sefydliadau GIG Cymru ac mae'n disodli unrhyw bolisïau, canllawiau, safonau gofynnol presennol e.e. Polisïau Ymddeol a Dychwelyd ar lefel cyflogwr/sefydliad.

Bydd y Polisi hwn:
✓ ***Yn galluogi cyflogeion i ddeall yr ystod o opsiynau sydd ar gael er mwyn cael mynediad at eu pensiwn a chyfuno hyn â gweithio hyblyg***
✓ ***Yn galluogi cyflogwyr i ddeall, hyrwyddo a thrafod opsiynau pensiwn hyblyg gyda staff.***
✓ ***Yn nodi disgwyliadau a gofynion cyflogeion a chyflogwyr wrth ddilyn ac ystyried ceisiadau i gael mynediad at un o'r opsiynau.***
✓ ***Yn ceisio sicrhau y bydd cyflogeion yn ddiweddarach yn eu gyrfaoedd yn teimlo eu bod yn cael eu gwerthfawrogi, eu gwobrwyo, a'u cydnabod gan eu cyflogwr am eu profiad, eu gwasanaeth a'u hymrwymiad.***
✓ ***Mae'n rhan o gontract cyflogaeth staff sy'n gweithio yn GIG Cymru.***

Nod y polisi hwn yw galluogi cyflogeion a chyflogwyr i wneud dewisiadau gwybodus ynghylch y defnydd priodol o'r pensiynau hyblyg sydd ar gael. Y dull a argymhellir gan Lywodraeth Cymru, cyflogwyr a phartneriaid undebau llafur yw bod yr hyblygrwydd hwn o fudd i'r ddwy ochr gyda'r disgwyliad y bydd sgyrsiau a cheisiadau yn cael eu datblygu a'u cymeradwyo.

Mae hyn yn golygu mai'r sefyllfa ddiofyn fydd y bydd cais i gael mynediad at un o'r opsiynau hyblygrwydd pensiwn, sy'n bodloni gofynion y Rheoliadau Pensiwn, yn cael ei gymeradwyo, ac y bydd pob llwybr posibl yn cael ei archwilio i hwyluso hyn. Bydd ceisiadau ond yn cael eu gwrthod pan fo rhesymau busnes clir mewn polisi a chyfraith sy'n atal cymeradwyaeth.

Ni fydd GIG Cymru yn gwahaniaethu, naill ai'n uniongyrchol nac yn anuniongyrchol, ar sail unrhyw un o'r nodweddion a warchodir gan Ddeddf Cydraddoldeb 2010 neu unrhyw nodwedd bersonol arall wrth weithredu'r polisi hwn. Rydym yn anelu at weithlu amrywiol ac yn cydnabod nad yw arweinyddiaeth dosturiol yn golygu trin pawb yr un fath ond yn hytrach eu trin yn deg ac ystyried gwybodaeth fanwl am anghenion, amgylchiadau a chefndir pob aelod o staff unigol.

4. Egwyddorion

Mae opsiynau pensiwn hyblyg yn cefnogi'r egwyddorion canlynol:

Cynorthwyo'r meysydd canlynol:	**Trwy:**
Cydbwysedd rhwng bywyd a gwaith	➢ cyflogeion sy'n gweithio'n hyblyg yn ddiweddarach yn eu gyrfaoedd yn helpu i sicrhau cydbwysedd iach rhwng bywyd a gwaith
Cadw profiad	➢ galluogi cyflogeion profiadol i aros yn y GIG yn hirach a throsglwyddo eu sgiliau a'u gwybodaeth werthfawr i gydweithwyr.

Iechyd a Llesiant	➢ cefnogi iechyd a llesiant cyflogeion yn ddiweddarach yn eu gyrfaoedd.
Llesiant Ariannol	➢ cefnogi llesiant ariannol cyflogeion trwy gynnig yr opsiwn i staff sydd wedi ymddeol i ailymuno â Chynllun Pensiwn y GIG ar ôl ymddeoliad llawn neu rannol a thrwy hynny alluogi cyflogeion i gronni pensiwn pellach.
Rheoli gwaith yn ddiweddarach mewn gyrfaoedd	➢ darparu opsiynau gweithio hyblyg i gyflogeion fel pont rhwng cymryd eu Pensiwn y GIG a derbyn eu buddiannau Pensiwn y Wladwriaeth.
Rheoli twf pensiwn	➢ rheoli twf pensiwn i gefnogi staff yr effeithir arnynt gan y lwfans blynyddol.

5. Buddion

Mae Cynllun Pensiwn y GIG yn cynnig nifer o opsiynau pensiwn hyblyg. Gall yr opsiynau hyn gefnogi cyflogwyr i ddenu a chadw staff profiadol wrth gefnogi cyflogeion, trwy ystod o opsiynau, i gael mynediad at fuddiannau pensiwn wrth barhau i weithio i GIG Cymru.

Mae Pensiynau'r GIG a Chyflogwyr y GIG ill dau yn darparu rhagor o wybodaeth am gynllun Pensiwn y GIG ac ystyriaethau cynllun ehangach ac ystyriaethau contractiol ymddeoliad hyblyg. Gellir cyrchu eu hadnoddau trwy ddilyn y dolenni hyn:

Pensiynau'r GIG

Cyflogwyr y GIG

Mae opsiynau pensiwn hyblyg yn cefnogi cyflogeion i wneud y canlynol:

- gweithio'n hyblyg tuag at ddiwedd eu gyrfaoedd
- sicrhau cydbwysedd iach rhwng bywyd a gwaith
- parhau i weithio yn y GIG am gyfnod hwy a throsglwyddo eu sgiliau a'u gwybodaeth werthfawr i gydweithwyr.
- cynnal eu profiad o fewn GIG Cymru cefnogi'r dasg o ddarparu gofal cleifion o ansawdd uchel.

Drwy alluogi cyflogeion i ymddeol yn hyblyg, gall cyflogwyr wneud y canlynol:

- Cefnogi iechyd a llesiant cyflogeion sy'n agosáu at ddiwedd eu gyrfaoedd.
- Datblygu trefniadau gweithio sy'n cyd-fynd â ffyrdd o fyw a phatrymau presenoldeb dymunol. Mae trefniadau o'r fath yn cefnogi cadw cyflogeion a'u cynhyrchiant yn barhaus, wrth leihau cyfraddau straen, blinder a gorflinder.
- Cynnig opsiwn i gyflogeion sydd wedi ymddeol ail-ymuno â Chynllun Pensiwn y GIG ar ôl cefnogi llesiant ariannol yn llawn, gan ei fod yn caniatáu i gyflogeion gronni pensiwn pellach a gallai helpu i bontio unrhyw fwlch rhwng cymryd eu buddiannau Pensiwn y GIG a buddiannau Pensiwn y Wladwriaeth.

- Trwy gymorth ymddeoliad rhannol, gall cyflogeion cyflogedig y gall y lwfans blynyddol effeithio arnynt, gallai'r gallu i gymryd y cyfan neu ran o'u pensiwn wrth barhau i weithio helpu rhai cyflogeion i reoli twf eu pensiwn.

Adran 2

Canllawiau ac opsiynau pensiynau hyblyg

6. Ystyriaethau pensiynau

6.1 Cynllun Pensiwn y GIG - trosolwg

Mae 2 gynllun Pensiwn y GIG. Mae yna Gynllun 1995 / 2008 a Chynllun 2015. O 1 Ebrill 2022, mae holl aelodau gweithredol Cynllun Pensiwn y GIG yn aelodau o Gynllun 2015.

Mae gan wefan Pensiynau'r GIG wybodaeth helaeth am y cynlluniau ac mae'n nodi manteision aelodaeth yn y ddau ganllaw i aelodau:

- Canllawiau i Aelodau Cynllun 1995/2008
- Canllawiau i Aelodau Cynllun 2015

6.2 Sut ydw i'n gwybod ym mha Gynllun Pensiwn y mae unigolyn?

Mae Cynllun Pensiwn y GIG wedi cael sawl newid ers 1995, a gall aelodau fod â chyflogaeth mewn mwy nag un cynllun. Mae'r Datganiad o'r Holl Fuddion, sydd ar gael drwy'r Cofnod Staff Electronig, yn rhoi gwybodaeth am aelodaeth Cynllun Pensiwn y GIG unigolyn.

Gall unigolyn fod â chyflogaeth mewn mwy nag un cynllun, yn enwedig os yw wedi bod yn aelod o Gynllun Pensiwn y GIG ers cyn 1 Ebrill 2012. Os felly, manylir ar ei gyflogaeth mewn dwy ran ar wahân yn y Datganiad Pensiwn e.e. bydd Datganiad Buddion Blynyddol ar gyfer cyflogaeth Cynllun 2015 a Datganiad Buddion Blynyddol ar gyfer cyflogaeth Cynllun 1995.

6.3 Ystyried effaith rhwymedi McCloud

Mae rhwymedi McCloud wedi'i roi ar waith yn dilyn dyfarniad achos cyfreithiol (McCloud) a dyma'r broses o ddileu gwahaniaethu ar sail oed y barnwyd ei fod wedi codi mewn cynlluniau pensiwn gwasanaeth cyhoeddus, gan gynnwys Cynllun Pensiwn y GIG.

Mae cyflogeion a ymunodd â Chynllun Pensiwn y GIG ar 31 Mawrth 2012 neu cyn hynny ac a oedd yn aelodau o'r cynllun ar 1 Ebrill 2015 yn dal i fod yn gymwys i gael rhwymedi McCloud. Os yw unigolyn yn ystyried gwneud cais am un o'r opsiynau Pensiwn Hyblyg, mae'n bwysig ei fod yn deall ei sefyllfa o ran rhwymedi McCloud.

Fel rhan o ddyfarniad McCloud, mae cyflogaeth bensiynadwy'r aelodau yr effeithiwyd arnynt ar gyfer cyfnod rhwymedi McCloud - 1 Ebrill 2015 i 31 Mawrth 2022 - wedi'i roi yn ôl yng Nghynllun 1995/2008.

Os yw hyn yn effeithio ar yr unigolyn unwaith, bydd NHSBSA yn cysylltu ag ef yn y 12 mis ar ôl iddo gael mynediad at y cyfan neu ran o'i bensiwn a gofynnir iddo ddewis rhwng cadw'r buddiannau hyn yng Nghynllun 1995/2008 neu gymryd buddiannau Cynllun 2015 am y cyfnod unioni yn lle hynny.

O ran gwneud y dewis hwn, gallai'r rhan o'r Cynllun sy'n well iddynt fod yn wahanol yn dibynnu ar ba mor hir y byddant yn parhau i weithio ar ôl iddynt ymddeol yn rhannol. Mae ei ddewis McCloud yn golygu bod ffactorau eraill i'w hystyried wrth benderfynu pa ganran o'i bensiwn i'w gymryd ar ymddeoliad rhannol, gan y gallai effeithio ar ei sefyllfa dreth, neu ei gysylltiad cyflog terfynol, os oes ganddynt un. Ac os bydd yn dewis cymryd buddion Cynllun 2015 yn ddiweddarach am y cyfnod unioni, efallai y bydd ganddo gyfandaliadau gordaliadau i'w talu'n ôl.

Mae rhagor o wybodaeth am rwymedi McCloud ar gael ar y dolenni rhwymedi pensiynau gwasanaethau cyhoeddus – McCloud (NHSBSA) i offer modelu i gefnogi'r broses o wneud penderfyniadau.

6.4 Dewis pryd i ymddeol

Mae gan bob aelod o Gynllun Pensiwn y GIG oedran pensiwn arferol (NPA), lle gallant ymddeol a hawlio buddiannau pensiwn. Diffinnir yr oedran hwn gan y cynllun y mae'n aelod ohono (neu y mae ganddo hefyd fuddion cadwedig ynddo e.e. cynllun 1995).

Mae yna hefyd isafswm oedran pensiwn (MPA), sef yr oedran cynharaf y mae unigolion yn gymwys i gymryd ei bensiwn y GIG.

Cynllun	Oedran pensiwn arferol (NPA),	Isafswm oedran pensiwn (MPA)
1995	60 (55 ar gyfer dosbarthiadau arbennig)	50 oed os ymunodd cyn 06/04/2006 ac nad yw wedi cael seibiant o 5 mlynedd neu fwy. Fel arall 55 oed*
2008	65	55*
2015	Oedran Pensiwn y Wladwriaeth	55*

* Mae'r isafswm oedran y gall unigolyn ddechrau cymryd ei bensiwn yn newid o 55 i 57 o 6 Ebrill 2028.

Mae Cynllun Pensiwn y GIG yn galluogi aelodau i fod yn hyblyg ynghylch yr oedran y maent yn ymddeol i weddu i'w cynlluniau. Mae hyn yn galluogi unigolion i ymddeol yn gynharach neu ar gyfer cynlluniau 2008 a 2015, yn hwyrach na'u NPA.

Os yw unigolyn yn ystyried ymddeoliad:

- cyn ei NPA, bydd y pensiwn a dderbyniant yn cael ei leihau oherwydd ei fod yn cael ei gymryd yn gynharach. Mae hyn oherwydd y bydd ei bensiwn yn cael ei dalu am gyfnod hirach.
- yn hwyrach na'i NPA, gall ei fuddiannau pensiwn gynyddu trwy gymhwyso ffactorau ymddeoliad hwyr. Dim ond ar gyfer aelodaeth o gynllun 2008 a chynllun 2015 y mae ychwanegiad ymddeoliad hwyr ar gael.

6.5 Ymddeoliad cynnar

Fel y nodwyd, bydd cymryd buddiannau pensiwn cyn NPA yn arwain at ostyngiad yn y pensiwn oherwydd ei fod yn cael ei dalu'n gynt. Gelwir hyn yn "ostyngiad actiwaraidd" ac mae'n seiliedig ar yr oedran cynharach y mae'r unigolyn yn dewis cymryd ei fudd-daliadau o'i gymharu â'i NPA.

Mae'r term 'gostyngiad actiwaraidd' yn cyfeirio at y tablau a ddefnyddir i gyfrifo'r gostyngiad yn ei fuddion os bydd yn ymddeol yn gynnar. Mae unigolyn yn ysgwyddo'r gostyngiad hwn pan fydd ei bensiwn yn cael ei dalu'n gynt na'r arfer ac, felly, mae'n bosibl y bydd yn cael ei dalu am gyfnod hwy. Mae Pensiynau'r GIG wedi cynhyrchu taflen ffeithiau y gellir ei gweld yma, sy'n nodi'r gostyngiadau canrannol ar gyfer ymddeoliad cynnar ar draws y gwahanol gynlluniau.

Pan fo unigolyn yn aelod o fwy nag un cynllun Pensiwn y GIG, yna bydd y gostyngiad actiwaraidd yn cael ei gymhwyso i bob cyfnod penodol o aelodaeth ym mhob cynllun. Er enghraifft, byddai rhywun 58 oed (heb Statws Dosbarth Arbennig) ag oedran pensiwn y wladwriaeth o 67 sy'n dymuno ymddeol yn gynnar yn cael gostyngiad o 2 flynedd yn aelodaeth 1995 oherwydd ei fod yn ymddeol 2 flynedd cyn 60 oed. Fodd bynnag mae unrhyw aelodaeth sydd ganddo yng nghynllun 2015 yn cael ei ostwng 9 mlynedd oherwydd bod ei oedran pensiwn arferol (NPA) yr un fath ag oedran pensiwn y wladwriaeth h.y. 67.

Mae'n bwysig nodi y bydd y pensiwn a delir i ddibynyddion yn seiliedig ar ei bensiwn cyn gostyngiad actiwaraidd ac mae rhagor o wybodaeth wedi'i nodi yn yr adran Datganiad Cyfanswm Gwobrwyo ar Bensiwn Oedolyn Dibynnol.

6.6 Swm gostyngol am Ymddeol yn Gynnar (ERRBO)

Mae Swm gostyngol am Ymddeol yn Gynnar (ERRBO) yn rhan o gynllun 2015. Os bydd unigolyn yn hawlio ei bensiwn yn 2015 cyn ei Oedran Pensiwn Arferol (NPA), bydd yn cael ei ostwng. Fodd bynnag gall gynllunio i brynu un, dwy neu dair blynedd o unrhyw ostyngiad cyn ei NPA ond heb fod yn gynharach na 65 oed. Drwy brynu ERRBO byddai hyn yn galluogi'r unigolyn, neu'r cyflogwr os yw'n cytuno, i dalu cyfraniadau ychwanegol fel y gall brynu'r gostyngiad a fyddai'n berthnasol i'w fuddion Cynllun 2015 pe bae'n ymddeol cyn ei NPA.

Mae Pensiynau'r GIG wedi cynhyrchu Taflen Ffeithiau ERRBO sy'n rhoi mwy o wybodaeth am y cynllun a chostau cyfraniadau ychwanegol sy'n daladwy i brynu allan 1, 2 neu 3 blynedd o ostyngiad.

6.7 Ailgylchu/taliadau amgen cyfraniadau pensiwn y cyflogwr

Mewn rhai amgylchiadau gall cyflog pensiynadwy unigolyn arwain at bensiwn yn tyfu i lefel sy'n uwch na'r lwfans blynyddol.

Mae'r trefniadau a nodir yn Adran 7 Pensiynau Hyblyg yn darparu mecanweithiau a all gefnogi aelodau Cynllun Pensiwn y GIG i reoli twf eu pensiynau sy'n galluogi unigolion i reoli lefel eu lwfans blynyddol.

Fodd bynnag, nid yw unigolion sydd o dan yr Oedran Pensiwn Arferol (NPA) yn gallu rheoli twf eu pensiynau yn y modd hwn ac efallai y byddant yn ceisio lleihau eu cyflog pensiynadwy trwy leihau eu gweithgaredd clinigol fel ffordd o reoli unrhyw rwymedigaeth lwfans blynyddol/ tâl. Mae cynnal gweithgarwch clinigol yn hollbwysig i wasanaethau GIG Cymru ac mae cyfleuster penodol wedi'i sefydlu ar sail Cymru gyfan i gefnogi unigolion o'r fath drwy gynllun lle gallant wneud cais, yn flynyddol, i gael taliad amgen yn lle cyfraniadau pensiwn eu cyflogwr tra byddant yn cael eu heithrio o Gynllun Pensiwn y GIG.

Mae'r ddarpariaeth hon yn agored i staff sy'n gallu dangos y bydd lefel eu henillion yn y GIG (a allai fod yn amcanestyniad o enillion) yn golygu y byddant yn cael eu heffeithio gan y lwfans blynyddol mewn unrhyw flwyddyn ariannol ac nad ydynt yn gallu rheoli eu twf pensiwn drwy gael mynediad at y darpariaethau ymddeoliad rhannol neu leihau lefel eu cyflog pensiynadwy heb effeithio ar eu gweithgaredd.

Er mwyn cymeradwyo taliad amgen, mae'n ofynnol i gyflogwyr ystyried ystyriaethau cyfreithiol a dangos a oes cyfiawnhad gwrthrychol yn seiliedig ar y risg i ddarpariaeth gwasanaeth a achosir gan unigolyn yn lleihau oriau neu'n amharod i gymryd gwaith ychwanegol.

Mae rhagor o fanylion am feini prawf ac ystyriaethau ailgylchu cyfraniadau pensiwn cyflogwyr wedi'u cynnwys yn y broses [1]Cyfraniadau Pensiwn y Cyflogwr - Polisi Taliadau Amgen Enghreifftiol y mae cyflogwyr yn ei gweithredu yn unol â'r darpariaethau ar lefel leol.

6.8 Beth yw gostyngiad?

Mae rheoliadau'r Cynllun yn dweud na all pensiynwr dderbyn mwy mewn pensiwn a chyflog ail-gyflogedig na'r cyflog a enillwyd cyn ymddeol. Gelwir hyn yn ffin enillion.

Os eir y tu hwnt i'r ffin enillion hon, bydd y pensiwn blynyddol yn cael ei leihau. Gelwir hyn yn ostyngiad.

Ym mis Mawrth 2020, ataliodd yr Adran Iechyd a Gofal Cymdeithasol (DHSC) ostyngiad ar gyfer aelodau sydd â statws Dosbarth Arbennig (SC) a Swyddog Iechyd Meddwl (MHO) ac sy'n hawlio buddiannau pensiwn ymddeoliad oedran cyn 60 oed.

Ar 1 Ebrill 2024, bydd gostyngiad yn cael ei ddileu ar gyfer yr aelodau hyn os byddant yn ymddeol ac yn dychwelyd.

Gostyngiad hefyd yw'r term a ddefnyddir i ddisgrifio lleihau neu ddileu taliadau pensiwn os yw enillion pensiynadwy wedi cynyddu i lefel cyn ymddeoliad rhannol o fewn 12 mis cyntaf ymddeoliad rhannol.

Pryd fydd gostyngiad yn berthnasol?

Ymddeol a dychwelyd

Os yw'r unigolyn o dan ei Oedran Pensiwn Arferol (NPA), bydd gostyngiad yn berthnasol os bydd yn ymddeol ar un o'r seiliau canlynol ac yn dychwelyd i waith yn y GIG cyn ei OPA:

- salwch o dan y trefniadau ymddeoliad afiechyd blaenorol

[1] Cyhoeddwyd y Polisi Enghreifftiol hwn yn flaenorol gan Gyflogwyr GIG Cymru fel canllaw i sefydliadau cyflogi. Nid yw'n Bolisi Cymru Gyfan y cytunwyd arno gyda BMA. Cysylltwch â'ch Adran Gweithlu i gael y polisi/safbwynt lleol.

- afiechyd Haen 1 neu Haen 2 o dan y trefniadau ymddeoliad afiechyd presennol
- talu buddion gohiriedig yn gynnar oherwydd afiechyd
- dileu swydd os gwnaethoch ymddeol cyn 1 Hydref 2011
- ymddeoliad cynnar er budd effeithlonrwydd y gwasanaeth

Mae lleihau eu pensiwn yn dibynnu ar:

- eu henillion wrth gael eu hailgyflogi
- pryd y gadawsant y Cynllun
- pryd y gwnaethant hawlio eu buddiannau pensiwn
- y math o fuddiannau pensiwn a hawlir.

Daw rheolau gostyngiad i ben unwaith y byddant yn cyrraedd eu NPA o'r Adran neu'r Cynllun y maent wedi hawlio eu buddiannau pensiwn ohoni.

Ni fydd unigolion yn destun gostyngiad os:

- oedd dros ei NPA pan wnaeth ymddeol
- yw'n derbyn buddiannau dileu swydd ac wedi ymddeol ar ôl 30 Medi 2011
- yw'n derbyn buddiannau Ymddeoliad Cynnar Gostyngol (ARER).

Ymddeoliad Rhannol

Mae ymddeoliad rhannol yn hyblygrwydd pensiwn ac mae'n ei gwneud yn ofynnol i gyflogeion newid eu telerau cyflogaeth, a lleihau eu cyflog pensiynadwy 10% neu fwy am o leiaf 12 mis (yn seiliedig ar y 12 mis blaenorol o gyflog pensiynadwy).

Yn y 12 mis ar ôl ymddeoliad rhannol, os bydd gan yr aelod newid pellach i'w delerau sy'n cynyddu lefel ei gyflog pensiynadwy y tu hwnt i'r lefel ofynnol, ni fydd bellach yn gymwys ar gyfer y pensiwn a gymerwyd. Bydd ei daliadau pensiwn felly yn cael eu "gostwng".

Ni fydd unigolion yn agored i ostyngiad os na fu unrhyw newid i'w telerau cyflogaeth, e.e. nid ydynt wedi'u penodi i rôl newydd ar gyfradd gyflog uwch, heb gynyddu eu horiau cytundebol parhaol.

7. Pensiynau hyblyg – yr opsiynau

Crynodeb o Hyblygrwydd			
Hyblygrwydd	Beth ydyw?	Beth yw'r fantais?	Ystyriaethau
Ymddeoliad Rhannol	Gallwch gymryd rhwng 20% a 100% o'ch buddiannau pensiwn, heb orfod gadael eich swydd bresennol. Gallwch hefyd barhau i adeiladu eich buddiannau pensiwn yng Nghynllun 2015.	Mae ymddeoliad rhannol yn eich galluogi i hawlio'ch pensiwn cyfan neu ran ohono, tra'n parhau i weithio, ond heb orfod cymryd seibiant a gadael eich swydd.	Er na fydd angen i chi gymryd seibiant neu newid swydd, bydd angen i chi weithio gyda'ch cyflogwr i newid eich telerau (megis trwy addasu eich oriau) fel bod eich "tâl pensiynadwy" yn cael ei ostwng 10% am y flwyddyn gyntaf.

Crynodeb o Hyblygrwydd			
Ymddeol a dychwelyd/ail-ymuno	Cael mynediad i'ch pensiwn llawn, yna dychwelyd i'r gwaith ar ôl seibiant byr ac, os dymunwch, ail-ymuno â Chynllun Pensiwn y GIG 2015 i barhau i adeiladu eich buddiannau pensiwn yn y dyfodol.	Os nad ydych yn barod i roi'r gorau i weithio yn gyfan gwbl ac nad ydych am leihau eich enillion pensiynadwy, gallwch gael mynediad at eich pensiwn ac ailddechrau gweithio yn eich rôl bresennol ar ôl seibiant o 24 awr.	Os byddwch yn penderfynu ail-ymuno â'r GIG, gallwch weithio cymaint o oriau ag y dymunwch ac yn y rhan fwyaf o achosion ni fydd eich taliadau pensiwn yn cael eu lleihau neu eu hatal (a elwir yn 'gostyngiad').
Camu i lawr	Efallai nad ydych yn barod i ymddeol ond yn dymuno camu i lawr i rôl wahanol, er enghraifft, i leihau lefel y cyfrifoldeb wrth barhau mewn cyflogaeth gyda'r GIG.	Mae'r opsiwn hwn yn eich galluogi i newid y dwyster neu'r math o waith wrth agosáu at ymddeoliad gan gefnogi'r sefydliad i gadw'ch sgiliau a'ch profiad. Efallai y byddwch am ddefnyddio'r opsiwn hwn pan fyddwch am newid rôl wrth i chi nesáu at eich ymddeoliad, ond nid ydych am gael mynediad i'ch pensiwn.	Gyda'r opsiwn hwn efallai y byddwch yn gymwys i ddiogelu eich lefel uwch o gyflog pensiynadwy, a fyddai'n golygu na fydd eich buddion cyflog terfynol yn cael eu heffeithio pan fyddwch yn cael mynediad i'ch pensiwn.
Gostyngiad mewn Oriau/dirwyn i ben	Mae'n bosibl y byddwch am leihau nifer yr oriau neu'r diwrnodau rydych yn eu gweithio ond rydych am barhau yn eich swydd bresennol	Gall yr opsiwn hwn eich cefnogi i aros mewn gwaith am gyfnod hirach cyn ymddeol trwy leihau'r oriau neu'r diwrnodau rydych yn eu gweithio. Efallai y byddwch am ddefnyddio'r opsiwn hwn os dymunwch leihau eich oriau wrth i chi nesáu at eich ymddeoliad, ond nid ydych am gael mynediad i'ch pensiwn.	Bydd lleihau ymrwymiadau gwaith yn lleihau cyflog pensiynadwy a bydd llai o bensiwn yn cronni bob blwyddyn o gymharu â'r nifer uwch o oriau a weithiwyd yn flaenorol. Fodd bynnag, bydd unrhyw fuddion cyflog terfynol a gronnir yng nghynllun 1995/2008 yn parhau i fod yn seiliedig ar gyflog pensiynadwy cyfwerth ag amser llawn ac wedi'u diogelu rhag newidiadau mewn patrymau gwaith.

7.1 Ymddeoliad rhannol

Mae ymddeoliad rhannol, y cyfeirir ato weithiau fel tynnu i lawr, yn galluogi aelodau gweithredol Cynllun Pensiwn y GIG sydd wedi cyrraedd isafswm oedran pensiwn i gymryd y cyfan neu ran o'u pensiwn wrth barhau i weithio.

Mae Pensiynau'r GIG wedi cynhyrchu Taflen Ffeithiau Cyflogwyr a Thaflen Ffeithiau i Aelodau y dylid eu darllen ochr yn ochr â'r polisi hwn.

I fod yn gymwys ar gyfer Ymddeoliad Rhannol rhaid i unigolyn fodloni'r canlynol:

- ✓ Bod wedi cyrraedd ei isafswm oedran pensiwn.
- ✓ Bod yn aelod gweithredol o'r Cynllun (os nad yw'n aelod gweithredol, byddai angen iddo ailymuno a bod yn aelod gweithredol am o leiaf mis cyn cymryd Ymddeoliad Rhannol).
- ✓ Gostwng o leiaf 10% ar ei gyflog pensiynadwy gwirioneddol am y 12 mis sy'n dechrau o'r dyddiad y mae'n cymryd Ymddeoliad Rhannol (ar gyfer Meddygon Teulu, Deintyddion, Darparwyr Offthalmig a Darparwyr nad ydynt yn Feddygon Teulu mae angen gostyngiad o 10% mewn ymrwymiad).
- ✓ Sicrhau bod ei ostyngiad o 10% mewn cyflog pensiynadwy yn cael ei gyfrifo ar sail ei lefel flaenorol o gyflog pensiynadwy am y 12 mis cyn iddo ymddeol yn rhannol.
- ✓ Yn cael newid yn ei delerau ac amodau cyflogaeth i adlewyrchu ei ostyngiad mewn cyflog pensiynadwy.
- ✓ Disgwyl i'w lefel newydd o gyflog pensiynadwy bara o leiaf 12 mis o'r adeg y cymerir ymddeoliad rhannol.
- ✓ Ddim wedi hawlio ymddeoliad rhannol eisoes ar ddau achlysur.

Mae ymddeoliad rhannol yn hyblygrwydd pensiwn ac mae'n ei gwneud yn ofynnol i gyflogeion newid eu telerau cyflogaeth, a lleihau eu cyflog pensiynadwy 10% neu fwy am o leiaf 12 mis (yn seiliedig ar y 12 mis blaenorol o gyflog pensiynadwy). Nid oes angen i'r unigolyn ddod â'i gontract cyflogaeth i ben na chael toriad mewn gwasanaeth i gymryd ei fuddiannau pensiwn. Bydd hawliau gwyliau blynyddol, cyflog ac enillion ychwanegol megis dyfarniadau rhagoriaeth glinigol yn parhau yn seiliedig ar y patrwm gwaith newydd/telerau ac amodau diwygiedig.

I'r rhan fwyaf o staff, gellir cyflawni'r gostyngiad hwn trwy leihau oriau gwaith.

Fodd bynnag, os nad yw cyflogai eisiau lleihau ei oriau gwaith, gall cyflogwyr ystyried ffyrdd eraill o fodloni'r gofyniad hwn gan gynnwys contractau wedi'u hollti (contractau cyflogaeth/aseiniadau ar wahân) a fyddai'n galluogi'r cyflogai i optio allan o Gynllun Pensiwn y GIG ar gyfer un o'r contractau er mwyn lleihau ei gyflog pensiynadwy o leiaf 10% am o leiaf 12 mis neu weithio goramser (amhensiynadwy) i gynnal eu horiau gwaith. Rhoddir arweiniad pellach ar yr opsiynau hyn yn 7.1.1 – 7.1.3.

Ar ôl cymryd ymddeoliad rhannol, bydd unigolion yn parhau i gronni pensiwn pellach yng Nghynllun 2015 oni bai eu bod yn dewis optio allan o Gynllun Pensiwn y GIG.

7.1.1 Sicrhau gostyngiad o 10 y cant mewn cyflog pensiynadwy

Os yw unigolyn yn ystyried ymddeoliad rhannol, bydd angen iddo gael sgwrs â'i reolwr i gytuno ar newid i'w delerau ac amodau cyflogaeth er mwyn cyflawni'r gostyngiad gofynnol o 10 y cant mewn cyflog pensiynadwy.

Bydd y gostyngiad o 10% mewn cyflog pensiynadwy yn cael ei gyfrifo ar sail ei lefel flaenorol o gyflog pensiynadwy am y 12 mis cyn iddo ymddeol yn rhannol, gan ddod i ben ar y diwrnod y maent yn cymryd ymddeoliad rhannol.

Yn y 12 mis ar ôl ymddeoliad rhannol, os bydd gan yr aelod newid pellach i'w delerau sy'n cynyddu lefel ei gyflog pensiynadwy y tu hwnt i'r lefel ofynnol, ni fydd bellach yn gymwys ar gyfer y pensiwn a gymerwyd. Yn ystod y cyfnod hwn, efallai y bydd yn dal yn gallu gwneud gwaith ychwanegol nad yw'n cyfrif tuag at ei bensiwn, megis "goramser" neu waith banc (os yw wedi optio allan ar gyfer y contract banc). Os bydd aelod yn derbyn dyfarniad cyflog y cytunwyd arno'n genedlaethol yn y 12 mis ar ôl iddo ymddeol yn rhannol, byddai'n dal i fod yn gymwys i gael ei bensiwn gan na fyddai ei delerau cyflogaeth wedi newid.

Mae angen dod i gytundeb ar sut i leihau cyflog pensiynadwy'r unigolyn cyn bwrw ymlaen â'i gais am ymddeoliad rhannol.

Mae sgyrsiau agored rhwng yr unigolyn a'r rheolwr yn allweddol i ddeall yr amgylchiadau, yr anghenion a'r dewisiadau. Bydd angen ystyried a chydbwyso'r rhain ochr yn ochr â nodau a blaenoriaethau'r rheolwr a'r cyflogwr, er mwyn cytuno ar ateb sy'n addas i'r ddau barti.

Mae sawl ffordd o leihau cyflog pensiynadwy a bydd y dull mwyaf effeithiol yn dibynnu ar amgylchiadau unigol y cyflogeion a'r cyflogwr. Nid oes un ateb sy'n addas i bawb ar gyfer lleihau cyflog pensiynadwy ac, mewn rhai achosion, bydd angen cytuno ar drefniadau pwrpasol.

Er y gallai unigolion fod yn hapus i gynnal y gostyngiad mewn cyflog pensiynadwy ar ôl diwedd y 12 mis, efallai y bydd yn dymuno cytuno'n benodol bod y newid i delerau ac amodau cyflogaeth/y gostyngiad yn ei gyflog pensiynadwy am y cyfnod 12 mis yn unig, gyda chytundeb y bydd ei drefniadau gwaith/contractiol yn dychwelyd i'r patrwm arferol ar ddiwedd y cyfnod hwnnw.

Rhaid i gyflogwyr beidio â mynnu newidiadau parhaol pan nad yw'r cyflogeion yn dymuno i'r gostyngiad 12 mis mewn cyflog pensiynadwy fod yn newid parhaol i'w gontract. Dylai dychwelyd i drefniadau/tâl blaenorol fod y dewis diofyn oni bai y cytunwyd fel arall. Fodd bynnag, nid yw hyn yn digwydd yn awtomatig a bydd angen i'r Cyflogwr hysbysu'r gyflogres o'r newid. Bydd angen i'r unigolyn hysbysu'r gyflogres/pensiynau os yw'n dymuno ailymuno â'r cynllun pensiwn.

7.1.2 Lleihau oriau a gweithio goramser

Er mwyn hwyluso lleihau oriau wrth gynnal lefel debyg o weithgaredd i'r hyn a weithiwyd yn flaenorol, gallai aelodau ystyried cytuno ar newid telerau i leihau cyflog pensiynadwy o 10% a gweithio goramser amhensiynadwy am gyfnod o 12 mis fel rhan o Gytundeb Pensiynau Hyblyg.

Mae rheoliadau Cynllun Pensiwn y GIG yn nodi nad yw goramser yn bensiynadwy. Ar gyfer aelodau nad ydynt wedi cymryd ymddeoliad rhannol yn ystod y 12 mis blaenorol, diffinnir goramser fel unrhyw gyfnod a weithiwyd yn fwy nag amser llawn, yn unol â chontract yr aelod. Mae hyn yn golygu bod unrhyw oriau a weithir y tu hwnt i amser llawn (gan staff amser llawn neu ran-amser) yn amhensiynadwy, ond mae oriau a weithir hyd at amser llawn gan staff rhan-amser yn bensiynadwy.

Fodd bynnag, ar gyfer aelodau sydd wedi cymryd ymddeoliad rhannol yn ystod y 12 mis blaenorol, mae unrhyw gyfnod a weithiwyd yn fwy na'u contract yn oramser, p'un a yw'r contract hwn yn llawn amser neu'n rhan-amser ai peidio.

Mae hyn yn golygu, os bydd aelod yn cytuno i newid ei delerau a lleihau ei gyflog pensiynadwy i gael mynediad i ymddeoliad rhannol (er enghraifft, symud o amser llawn i 0.8 FTE), yn y 12 mis ar ôl iddo gymryd ymddeoliad rhannol, gall wneud goramser i fynd â nhw hyd at gyfwerth ag amser llawn. Bydd yn parhau i fod yn gymwys ar gyfer ei bensiwn ymddeoliad rhannol, gan na fyddai'r goramser hwn yn bensiynadwy, felly ni fyddai'n arwain at gynnydd yn ei gyflog pensiynadwy.

7.1.3 Cyfuno ymddeoliad rhannol gyda chontract ychwanegol neu gytundeb banc

Er mwyn hwyluso lleihau oriau wrth gynnal lefel debyg o weithgaredd i'r hyn a weithiwyd yn flaenorol, gall unigolion ddewis cael eu cyflogi ar gontract ychwanegol (rhanedig) neu gytundeb banc yn ychwanegol at eu contract sylweddol (arferol) ac fel rhan o Gytundeb Pensiynau Hyblyg.

Caiff cyflogeion a gyflogir ar gontract ychwanegol neu a gyflogir ar gytundeb gweithiwr banc optio allan o Gynllun Pensiwn y GIG mewn perthynas â'r contract ychwanegol neu'r cytundeb banc, gan barhau i fod yn aelod o Gynllun Pensiwn y GIG mewn perthynas â'u contract cyflogaeth parhaol (prif gontract).

Er mwyn sicrhau y bodlonir y gostyngiad gofynnol o 10% yn lefel enillion pensiynadwy, bydd angen gwneud cais i optio allan o'r cynllun o gontract ychwanegol (rhanedig) neu gytundeb banc o ddiwrnod cyntaf yr ymddeoliad rhannol ac o fewn mis cyntaf i'r trefniant ddechrau gan gyflogeion trwy lenwi ffurflen Cynllun Pensiwn y GIG SD502.

Byddai'r hyblygrwydd hwn yn galluogi'r unigolyn i leihau ei oriau a'i gyflog pensiynadwy o dan ei gontract cyflogaeth sylweddol (yn ôl yr angen i gael mynediad i ymddeoliad rhannol), wrth weithio capasiti ychwanegol ar sail amhensiynadwy (optio allan) o dan delerau contract ychwanegol (rhanedig) neu gytundeb banc.

Os yw rhannu contract yn cael ei ystyried, yna:

- Dylai'r contractau arfaethedig gael eu strwythuro fel bod modd eu cyflawni ar wahân. Mae hyn yn golygu y dylai'r rolau o dan bob contract fod yn wahaniaethadwy, ac nid yn "barhaus" â'r llall. Felly, gallai cyflogai roi'r gorau i un swydd, ond parhau â'r llall; ac

- Mae angen i delerau'r contractau priodol gael eu diffinio'n glir a gallu caniatáu cynnal cofnodion cyflogres yn briodol gan wahaniaethu rhwng y ddau.

Enghraifft o'r dull hwn fyddai pan fo dyletswyddau clinigol yn cael eu cyflawni o dan gontract craidd sy'n bensiynadwy o dan Gynllun Pensiwn y GIG, a rôl rheoli neu arweinyddiaeth glinigol/dyletswyddau GIG ychwanegol/dyletswyddau GIG allanol o dan ail gontract pan fo'r unigolyn yn optio allan o Gynllun Pensiwn y GIG.

Nid oes angen ailysgrifennu Swydd-ddisgrifiadau na Gwerthuso Swydd ar wahân yn awtomatig i rannu contractau gan y gellir gosod hyn a'i reoli drwy'r broses pensiynau hyblyg am y cyfnod o 12 mis.

Yn ogystal, nid yw hollti contractau yn golygu bod angen defnyddio cytundeb gweithiwr Banc yn awtomatig. Fodd bynnag, os yw ymgysylltiad â'r Banc yn cael ei ystyried, yna:

- Mae angen i unigolion sicrhau eu bod yn optio allan o Gynllun Pensiwn y GIG ar gyfer unrhyw gytundeb Banc, a
- Dylid cydnabod perthynas gontractiol wahanol cytundeb gweithiwr Banc.

Lle nad yw'n bosibl i gyflogwyr gytuno i newid telerau a gostyngiad mewn cyflog pensiynadwy, ond bod y cyflogai yn dymuno hawlio 100% o'i bensiwn Cynllun 1995, byddai defnyddio ymddeoliad a dychwelyd/ail-ymuno yn cynnig canlyniad tebyg iawn ac felly dylid ei ystyried.

7.1.4 Monitro'r gostyngiad o 10 y cant mewn cyflog pensiynadwy

Cyflogwyr

Mae angen i gyflogwyr fod yn hyderus y bydd y newid contractiol y cytunwyd arno i drefniadau gweithio yn arwain at ostyngiad mewn cyflog pensiynadwy o 10 y cant o leiaf am y cyfnod o 12 mis. Dylai fod gan gyflogwyr fecanwaith ar waith i sicrhau bod enillion pensiynadwy'r unigolyn yn bodloni gofynion ymddeoliad rhannol am y cyfnod o 12 mis. Yn ystod 12 mis cyntaf ymddeoliad rhannol, mae gan gyflogwyr ac unigolion gyfrifoldeb ar y cyd i hysbysu NHSBSA os bydd yr unigolyn yn newid telerau ac amodau sy'n arwain at godi cyflog pensiynadwy i fwy na 90 y cant o'r cyflog pensiynadwy cyn ymddeoliad rhannol. Os bydd hyn yn digwydd, yna efallai y bydd gostyngiad yn berthnasol yn llawn ac efallai y bydd y buddiannau pensiwn sy'n cael eu talu yn cael eu hatal.

Pan fo cyflog yn cynyddu i fwy na'r hyn a ganiateir a bod gostyngiad yn digwydd, ni fydd y pensiwn yn dechrau cael ei dalu eto, unwaith y bydd cyflog pensiynadwy wedi'i ostwng gan isafswm o 10 y cant o'r tâl y seiliwyd yr ymddeoliad rhannol gwreiddiol arno.

Ar ddiwedd y cyfnod o 12 mis, oni bai y cytunir fel arall pan gyflwynodd yr unigolyn ei gais neu cyn y pwynt 12 mis, bydd y telerau'n dychwelyd i'r rhai a oedd yn weithredol cyn yr ymddeoliad rhannol.

Dylai timau'r Gweithlu a Datblygu Sefydliadol roi cyfarwyddiadau clir i'w cydweithwyr pensiwn a'r gyflogres i sicrhau bod y newidiadau y cytunwyd arnynt i drefniadau gwaith neu gyflog pensiynadwy yn cael eu prosesu'n gywir a'u diweddaru ar gofnodion pensiwn a chyflogres y cyflogai.

Cyflogeion

Ni ddylai cyflogeion gytuno ar unrhyw newidiadau pellach i'w contract cyflogaeth a fyddai'n cynyddu cyflog pensiynadwy uwchlaw 90 y cant o gyflog pensiynadwy cyn cytuno ar ymddeoliad rhannol yn ystod y cyfnod o 12 mis.

Nid yw dyfarniadau cyflog blynyddol a chodiadau cyflog a gaiff aelodau wrth iddynt symud drwy eu band cyflog neu eu graddfeydd cyflog yn cyfrif tuag at hyn, ond bydd unrhyw godiad cyflog sy'n deillio o newid contractiol i delerau ac amodau. Er enghraifft, os ydynt yn penderfynu gwneud cais am swydd wahanol gyda chyflog uwch, cynyddu oriau sylweddol neu gynyddu ymrwymiadau.

Mae'n bwysig bod cyflogwyr yn gwneud aelodau'n ymwybodol o'r newidiadau a allai arwain at ostyngiad a gordaliadau y byddai angen eu hadennill.

7.1.5 Beth ddylid ei ystyried wrth benderfynu faint o bensiwn i'w gymryd?

Os yw unigolyn yn gwneud cais am ymddeoliad rhannol, dylai ystyried nifer o ffactorau wrth benderfynu faint o'i bensiwn y mae'n dymuno ei gymryd. Mae Taflen Ffeithiau Aelodau Pensiynau'r GIG yn cynnwys rhagor o wybodaeth am y broses gwneud penderfyniadau a dylid ei darllen ochr yn ochr â'r canllawiau yn y polisi hwn.

Mae Cyfrifiannell Ymddeol Rhannol wedi'i datblygu gan Bensiynau'r GIG ac mae ar gael ar wefan cynllun Pensiynau'r GIG. Bydd hyn yn galluogi'r unigolyn a'r cyflogwr i weld sut mae cymryd canrannau gwahanol o'u pensiwn ar ymddeoliad rhannol yn effeithio ar gyfanswm y buddiannau pensiwn y byddant yn eu cael.

Argymhellir bod unigolion yn defnyddio'r gyfrifiannell hon i gyfrifo faint o bensiwn y maent am ei gymryd a'r newid yn y trefniadau gweithio sydd orau iddynt cyn gwneud cais am ymddeoliad rhannol. Os na fydd y gyfrifiannell hon yn darparu'r wybodaeth sydd ei hangen, gallant gysylltu â NHSBSA i gael gwybodaeth benodol

Mae'n bwysig bod unigolion yn gwybod y darlun cyfan o ran effaith cymryd eu pensiwn wrth barhau i dderbyn incwm o gyflogaeth, er enghraifft yr ystyriaethau treth incwm ac felly dylid ystyried cael mynediad at gyngor ariannol annibynnol wrth benderfynu ai dyna'r opsiwn cywir ar eu cyfer. Mae Cyflogwyr y GIG wedi llunio rhestr o sefydliadau sy'n gallu rhoi cyngor ac arweiniad ar faterion treth pensiwn y gellir ei chyrchu drwy'r ddolen hon. Yn ogystal, bydd rhai buddion yn cael eu heffeithio felly mae'n bwysig bod cyflogwyr yn rhannu ac yn cyfathrebu'r holl wybodaeth berthnasol i unigolion a'u hannog i gymryd cyngor priodol cyn gwneud penderfyniad terfynol.

7.1.6 Effaith gwahanol Oedrannau Pensiwn Arferol (NPAs) wrth ystyried ymddeoliad rhannol.

Os bydd unigolyn yn cymryd ei fuddion cyn ei oedran pensiwn arferol (NPA), bydd ei fuddion yn cael eu lleihau. Fel y cyfeirir ato yn adran 6, mae gwahanol NPAs yn gymwys yng nghynllun 1995, cynllun 2008 a chynllun 2015. Gall hyn effeithio ar ei ddewisiadau o ran faint o bensiwn y gall ddymuno ei gymryd a phryd.

Ni all aelodau ddewis o ba gynllun y maent yn cymryd eu buddion. Pan fydd aelod yn dewis cymryd ymddeoliad rhannol, caiff ei ganran ddewisol ei chymhwyso'n ddilyniannol ar draws ei holl fuddion yng Nghynllun Pensiwn y GIG. Mae hyn yn golygu y bydd, i bob pwrpas, yn cymryd neu'n defnyddio ei fuddion Cynllun 1995/2008 yn gyntaf, ac yna ei fuddion cynllun 2015. Felly, os ydyw'n dymuno cymryd ei fuddion cynllun 1995/2008 ond nid ei fuddion cynllun 2015 (efallai i osgoi gostyngiad ymddeoliad cynnar yn cael ei gymhwyso i fuddion cynllun 2015) bydd angen i'r unigolyn a'r cyflogwr nodi hyn ar y ffurflen gais a ddarperir gan Dîm Pensiynau PCGC.

Nid yw aelodau Cynllun Pensiwn y GIG yn gallu cymryd eu cyfandaliad ar wahân i'w pensiwn. Mae cymryd ymddeoliad rhannol yn golygu hawlio cyfran o'u pensiwn ac unrhyw gyfandaliad sy'n gysylltiedig â'r pensiwn hwnnw.

7.2 Ymddeol a dychwelyd/ail-ymuno

Mae ymddeol a dychwelyd yn ffordd o ymddeol yn hyblyg sy'n gweithio ochr yn ochr â Rheoliadau Cynllun Pensiwn y GIG a gellir ei ddefnyddio gan gyflogwyr fel dull o gadw staff gwerthfawr a phrofiadol a hybu capasiti. Gall unigolion sydd wedi cyrraedd yr isafswm

oedran pensiwn adael cyflogaeth y GIG, hawlio eu buddiannau pensiwn ac yn ddiweddarach benderfynu dychwelyd i gyflogaeth gyda'r GIG.

Pan fydd cyflogeion yn ymddeol ac yn dychwelyd, rhaid iddynt adael eu cyflogwr, daw eu contract cyflogaeth presennol i ben, a rhaid iddynt ymrwymo i gontract cyflogaeth newydd gyda'u cyflogwr.

Oni bai bod yr unigolyn yn gofyn fel arall (h.y. seibiant hwy), y sefyllfa ddiofyn yw mai'r unig doriad yn y gwasanaeth sydd ei angen ar gyfer ymddeol a dychwelyd yw'r hyn a ragnodir gan y rheolau pensiwn (24 awr). Bydd holl sefydliadau GIG Cymru yn gweithredu'r toriad yn y contract ar y sail hon, oni bai bod yr unigolyn yn gofyn am doriad o hyd gwahanol.

Enghraifft - i gyflawni'r toriad gofynnol o 24 awr, ni ddylai unigolyn sy'n gorffen ar 31 Mawrth heb unrhyw wyliau blynyddol yn weddill ddychwelyd/ail-ymuno cyn 2 Ebrill.

Rhaid cynnig yr hawl i unigolion ddychwelyd ar yr un sail gontractiol ag yr oeddent cyn ymddeol. Mae hyn yn golygu cael eu cyflogi ar gontract parhaol a chyda'r un telerau ac amodau, oni bai bod yr unigolyn yn gofyn am drefniant gwaith gwahanol.

Mae gan unigolion sydd wedi ymddeol ac wedi dychwelyd cyn i'r polisi hwn fod yn weithredol, ac a benodwyd ar gontract cyfnod penodol neu locwm, yr hawl i ofyn i'r statws contractiol hwn gael ei adolygu yn unol â thelerau'r polisi hwn.

Cyn cymryd ymddeoliad a dychwelyd, dylid cymryd unrhyw wyliau blynyddol sy'n weddill i sicrhau'r dyddiad gwasanaeth olaf a'r dyddiad cyflogaeth newydd, ac o ganlyniad nid yw'n effeithio ar y taliad pensiwn.

7.2.1 Ystyriaethau ymddeol a dychwelyd penodol ar gyfer staff meddygol a deintyddol

- Cadw dyfarniadau Rhagoriaeth Glinigol/Effaith Glinigol

  Bydd deiliaid dyfarniadau cenedlaethol, sy'n dechrau derbyn eu pensiwn ar ôl 1 Ebrill 2023 yn cadw eu dyfarniad. Mae hyn yn amodol ar reolau safonol y cynllun ynghylch newid swyddi lle gwneir unrhyw newidiadau i drefniadau gweithio o ganlyniad i ymddeol a dychwelyd.

  Fel gydag unrhyw newid swydd, dylai deiliaid dyfarniadau a chyflogwyr drafod cynlluniau newid swydd ag ysgrifenyddiaeth y Pwyllgor Cynghori ar Ddyfarniadau Effaith Clinigol (ACCIA) cyn i'r newid swydd gael ei roi ar waith er mwyn osgoi colli'r dyfarniad neu orfod ailymgeisio'n gynnar.

- Arbenigwyr Cyswllt 2008 – yr hawl i ddychwelyd i'r radd hon

  Bydd gan Arbenigwr Cyswllt ar Gontract 2008 sy'n ymddeol ac yn dychwelyd yr hawl i gael ei ail-gyflogi ar yr un telerau Arbenigwr Cyswllt os yw'n dymuno.

7.2.2 Ymddeol ac ail-ymuno

O 1 Ebrill 2023, gall yr holl staff sy'n dewis ymddeol a dychwelyd ymuno â chynllun 2015 – mae hyn yn berthnasol i staff sydd wedi ymddeol o Gynlluniau 1995, 2008 a 2015, cyn belled â'u bod o dan 75 oed.

Mae cyflogeion sy’n ymddeol ac yn dychwelyd wedi’u cofrestru’n gontractiol i gynllun 2015 ar ddiwrnod cyntaf eu cyflogaeth, yn yr un modd ag unrhyw ddechreuwr newydd arall ac os nad ydynt yn dymuno talu pensiwn, rhaid iddynt optio allan o fewn y mis cyntaf.

7.2.3 Gwahaniaethau rhwng ymddeol a dychwelyd ac ymddeoliad rhannol

Y gwahaniaeth allweddol rhwng ymddeol a dychwelyd ac ymddeoliad rhannol yw bod yn rhaid i’r unigolyn, wrth ymddeol a dychwelyd, fel aelod o Gynllun Pensiwn y GIG adael cyflogaeth y GIG, cymryd ei bensiwn a chael ei ail-gyflogi ar gontract cyflogaeth newydd yn ddiweddarach. Gydag ymddeoliad rhannol, gall aelodau Cynllun Pensiwn y GIG gymryd eu pensiwn heb adael eu swyddi na chymryd toriad mewn gwasanaeth ac felly mae eu contractau cyflogaeth presennol yn parhau i fod yn weithredol.

Gwahaniaeth pwysig arall yw bod yn rhaid i aelodau sy'n ymddeol ac yn dychwelyd gymryd eu holl fuddion o Gynllun 1995 ar unwaith, tra bod ymddeoliad rhannol yn rhoi hyblygrwydd ychwanegol i aelodau gymryd rhywfaint neu'r cyfan o'u pensiwn mewn un neu ddau daliad.

Mae ymddeoliad rhannol yn darparu dull mwy di-dor ac wedi'i gynllunio i ddarparu modd effeithiol i gyflogeion gael mynediad at eu pensiwn os ydynt eisoes yn gwybod eu bod yn bwriadu parhau i weithio ar ôl cymryd eu pensiwn.

Mae darpariaethau penodol ar gyfer ymddeol a dychwelyd, ac o dan reoliadau Cynllun Pensiwn y GIG, rhaid i aelodau gymryd egwyl o 24 awr cyn dychwelyd i gyflogaeth i dderbyn eu pensiwn o gynllun 1995.

Nid oes unrhyw ofyniad i sicrhau bod cyflogai yn cymryd seibiant hwy yn ei wasanaeth er mwyn cael toriad mewn gwasanaeth parhaus ac o dan y polisi hwn ni ddylai sefydliadau GIG Cymru fynnu toriad hirach mewn gwasanaeth.

Rhaid i gyflogwyr gynnig yr un telerau ac amodau cyflogaeth i unigolion ar ôl iddynt ddychwelyd. Trwy gynnig yr un telerau ac amodau, gan gynnwys tâl, gwyliau blynyddol a thâl salwch, nod y polisi hwn yw cefnogi ac annog staff profiadol sydd am hawlio eu pensiwn i barhau i weithio, os byddant yn dymuno gwneud, yn ogystal â denu staff sydd wedi ymddeol yn ddiweddar yn ôl i'r gwaith.

7.3 Camu i lawr

Efallai na fydd unigolyn yn barod i ymddeol ond yn dymuno camu i lawr i rôl wahanol, er enghraifft, i leihau lefel y cyfrifoldeb tra y bydd yn parhau mewn cyflogaeth gyda'r GIG. Mae'r opsiwn hwn yn ei alluogi i newid y dwyster neu'r math o waith ar yr ymagwedd at ymddeoliad wrth gefnogi'r sefydliad i gadw ei sgiliau a'i brofiad.

Os yw unigolyn wedi cyrraedd isafswm oedran pensiwn ac yn dewis camu i lawr i rôl pan fo ei ddyletswyddau newydd neu gyfrifoldebau sy’n weddill yn llai beichus ac yn llai o gyfrifoldeb na'i ddyletswyddau blaenorol, efallai y gall wneud cais am ddiogelu gwirfoddol o'r cyswllt i'w lefel uwch o gyflog pensiynadwy os yw ei gyflog yn gostwng 10% neu fwy.

Mae diogelu gwirfoddol o lefel ei gyflog pensiynadwy blaenorol yn rhan o Gynllun 1995 Cynllun Pensiwn y GIG. Mae’r ddarpariaeth hon yn cydnabod y gallai fod yn well gan unigolion yn y cyfnod cyn ymddeol, os yn bosibl, aros mewn cyflogaeth gyda’r GIG, efallai

mewn capasiti llai, gan ddiogelu lefel cyflog blaenorol eu buddiannau a gyfrifwyd yng nghynllun 1995, ar gyfer cyfrifo eu buddiannau pensiwn cyflog terfynol.

Mae angen cytuno ar unrhyw drefniant 'camu i lawr' rhwng yr unigolyn a'i gyflogwr a bydd yn rhaid iddynt roi gwybodaeth i Bensiynau'r GIG bod y cam i lawr wedi'i gytuno.

Mae'r ddarpariaeth hefyd wedi'i bwriadu ar gyfer gostyngiadau cyflog parhaol, yn hytrach na rhai dibwys neu dymor byr. Fel arfer byddai disgwyl i'r cam i lawr ddigwydd gyda'r un cyflogwr, fodd bynnag, os na all un cyflogwr ddarparu rôl addas i 'gamu i lawr' iddi, ond y gellir ei threfnu gydag un arall, byddai hyn yn dderbyniol. Yn yr achos hwn bydd yn rhaid i'r ddau gyflogwr ddarparu gwybodaeth sy'n cadarnhau bod trefniant 'camu i lawr' wedi'i gytuno.

Mae'n bosibl i aelod o Gynllun Pensiwn y GIG adael un cyflogwr ac ymuno ag un arall ar gyfradd gyflog is a gwneud cais am ddiogelu cyflog pensiynadwy yn wirfoddol ar yr amod bod y ddau gyflogwr yn cytuno i'r trefniant camu i lawr. Nid yw'r ddarpariaeth wedi'i bwriadu ar gyfer sefyllfaoedd pan fo aelod yn gadael un cyflogwr ac yn ymuno ag un arall ar gyfradd gyflog is heb gytundeb rhwng cyflogwyr.

7.3.1 Meini prawf cymhwyster ar gyfer diogelu cyflog pensiynadwy yn wirfoddol

I fod yn gymwys ar gyfer diogelu cyflog gwirfoddol rhaid i'r unigolyn fod:

- â chyswllt cyflog terfynol â buddiannau pensiwn Cynllun 1995
- wedi camu i lawr i rôl lle mae ei ddyletswyddau newydd neu ddyletswyddau sy'n weddill yn llai beichus ac yn llai o gyfrifoldeb na'i ddyletswyddau blaenorol (fel y cadarnhawyd gan ei gyflogwr(wyr))
- cael gostyngiad mewn cyflog pensiynadwy o 10% o leiaf am gyfnod o flwyddyn o leiaf, gan ddechrau gyda'r diwrnod cyflog cyntaf y talwyd y cyflog pensiynadwy gostyngol arno (fel y'i dilyswyd gan ei gyflogwr(wyr))
- heb gael unrhyw ostyngiad arall mewn cyflog pensiynadwy yn y cyfnod o 12 mis cyn iddo roi'r gorau iddi (fel y'i dilyswyd gan ei gyflogwr(wyr))
- wedi gwneud cais ar ôl 12 mis, ond o fewn 15 mis, i'w gyflog pensiynadwy gael ei ostwng
- wedi cyrraedd ei isafswm oedran pensiwn yng Nghynllun 1995
- wedi ennill o leiaf dwy flynedd o aelodaeth gymhwyso o Gynllun Pensiwn y GIG ar yr adeg y maent yn camu i lawr
- nad ydynt wedi diogelu ei gyflog pensiynadwy o'r blaen o dan y trefniadau diogelu cyflog gwirfoddol

7.3.2 Trefniadau ar gyfer aelodaeth Cynllun 2008 a Chynllun 2015

Mae'r trefniadau diogelu cyflog gwirfoddol yn benodol ar gyfer aelodaeth o fewn cynllun 1995 Cynllun Pensiwn y GIG.

Mae cynllun 1995 yn defnyddio'r gorau o'r tair blynedd diwethaf wrth gyfrifo pensiwn unigolyn, felly mae'r gallu i ddiogelu'r lefel uwch o gyflog cyfwerth ag amser llawn yn bwysig er mwyn cadw'r lefel uchaf o dâl a ddefnyddir i gyfrifo ei bensiwn pan fyddant yn ymddeol.

Yng Nghynllun 2008 – Cyfanswm y Tâl Cyfrifadwy yw cyfartaledd y tair blynedd olynol orau o gyflog pensiynadwy yn y deg diwethaf. Mae tâl pob blwyddyn yn y 10 mlynedd diwethaf cyn ymddeol yn cael ei gynyddu gan gostau byw i ddod â'r ffigur cyflog hwnnw i'r hyn y byddai'n werth ar y diwrnod gadael. Mae cynllun 2008 felly'n cefnogi unigolion sy'n "camu i lawr" yn y 10 mlynedd diwethaf cyn ymddeol ac felly nid oes angen trefniadau diogelu.

Yng Nghynllun 2015 – pennir swm y pensiwn y mae unigolyn yn ei ennill bob blwyddyn gan yr hyn a elwir yn 'gyfradd gronni' a ddangosir fel ffracsiwn o'i enillion pensiynadwy. Yng Nghynllun 2015 y gyfradd gronni yw 1/54 o'r cyflog pensiynadwy. Felly, mae'n ennill pensiwn o 1/54 o'i enillion pensiynadwy bob blwyddyn, neu ran o flwyddyn os bydd yn gadael cyn diwedd blwyddyn ariannol. Oherwydd y ffordd y mae cynllun 2015 yn cronni bob blwyddyn mae unrhyw lefel uwch o bensiwn a gronnwyd yn flaenorol yn ddiogel yn ei gofnod pensiwn cyffredinol ac mae unrhyw bensiwn pellach y mae'n ei gronni yn seiliedig ar y rôl camu i lawr.

7.4 Gostyngiad mewn oriau/dirwyn i ben

Mae'n bosibl y bydd unigolion yn dymuno lleihau nifer yr oriau neu'r diwrnodau y maent yn eu gweithio ond yn parhau yn eu swydd bresennol. Gelwir hyn yn dirwyn i ben.

Bydd lleihau ymrwymiadau gwaith yn lleihau cyflog pensiynadwy a bydd llai o bensiwn yn cronni bob blwyddyn o gymharu â'r nifer uwch o oriau a weithiwyd yn flaenorol. Fodd bynnag, bydd unrhyw fuddion cyflog terfynol a gronnwyd yng nghynlluniau 1995 neu 2008 yn parhau i fod yn seiliedig ar gyflog pensiynadwy cyfwerth ag amser llawn ac wedi'u diogelu rhag newidiadau mewn patrymau gwaith fel y nodir yn 7.3.2.

Mae pob cyflogai sy'n gweithio yn GIG Cymru yn gymwys i wneud cais am weithio hyblyg trwy Bolisi Gweithio Hyblyg Cymru Gyfan.

Gallai'r opsiwn hwn gefnogi unigolion i aros mewn gwaith am gyfnod hwy cyn ymddeol drwy leihau'r oriau neu'r diwrnodau y maent yn eu gweithio. Efallai y byddant yn dymuno defnyddio'r opsiwn hwn os ydynt yn dymuno lleihau eu horiau wrth agosáu at ymddeoliad ond nad ydynt yn dymuno cael mynediad i'w pensiwn.

8. Proses Cais Opsiwn Pensiynau Hyblyg

8.1 Gwneud cais

Pan fydd unigolyn yn dymuno cael mynediad at un o'r opsiynau pensiwn hyblyg yn Adran 7 y Polisi hwn, dylai lenwi Rhan A o'r Ffurflen Gais am Bensiwn Hyblyg (Atodiad 1). Argymhellir ei fod yn cael trafodaeth anffurfiol gyda'i reolwr cyn cyflwyno cais ffurfiol ac anogir rheolwyr i hwyluso hyn pan ofynnir iddynt wneud hynny. Fodd bynnag, ni fydd y cais yn cael ei ystyried yn ffurfiol hyd nes y caiff ei gyflwyno'n ysgrifenedig.

Os bydd y rheolwr yn gwrthod neu'n amharod i dderbyn cais mewn trafodaeth anffurfiol, efallai y bydd yn penderfynu bwrw ymlaen â chais ffurfiol o hyd. Efallai y bydd yn dymuno cael cyngor a chymorth gan ei dîm gweithlu neu ei undeb llafur neu gydweithiwr yn y gweithle.

8.2 Ymateb i gais

Dylai rheolwyr fod yn ymwybodol bod gofyniad cyfreithiol i ystyried ceisiadau gweithio hyblyg a hysbysu eu cyflogeion o'r canlyniad o fewn 2 fis i ddyddiad y cais a dylent ystyried hyn i

sicrhau bod ganddynt amserlen ddigonol i roi ystyriaeth ddyledus i'r cais. Dylai rheolwyr hefyd fod yn ymwybodol, unwaith y cytunir arnynt, fod camau y mae angen i Dîm Pensiwn PCGC eu cymryd cyn cyflwyno unrhyw gais i Gynllun Pensiwn y GIG. Unwaith y caiff ei gyflwyno, dylid hefyd ystyried amserlenni ceisiadau cynllun Pensiwn y GIG (o leiaf 3 mis). Felly, mae angen i unrhyw drafodaethau ynglŷn â dyddiad effeithiol unrhyw newid i gytundeb, ymddeoliad ac ati fod yn ymwybodol o'r gwaith sydd ei angen gan asiantaethau eraill i symud ymlaen a gweithredu'r cais.

Dylai'r rheolwr drefnu i drafod y cais gyda'r unigolyn cyn gynted â phosibl ar ôl derbyn ffurflen gais (gall hyn fod yn bersonol, dros y ffôn neu drwy MS Teams). Bydd hyn yn ei alluogi i gael gwell dealltwriaeth o'r newidiadau y mae'r unigolyn yn chwilio amdanynt a sut mae'n gweld pethau'n gweithio'n ymarferol. Dylai'r drafodaeth archwilio sut y bydd y trefniant gweithio arfaethedig yn gweithio'n ymarferol, unrhyw effeithiau cadarnhaol a negyddol posibl y gallai ei chael ar ddarparu gwasanaethau a sut y gallai effeithio ar aelodau eraill o'r tîm. Mae gan gyflogeion yr hawl i ddod i'r cyfarfod hwn gyda chydweithiwr yn y gweithle neu gynrychiolydd undeb llafur. Os yw'r rheolwr yn bwriadu cymeradwyo'r cais, nid yw'r cyfarfod hwn yn ofyniad, ond gall fod yn ddefnyddiol trafod trefniadau ymarferol o hyd.

Rhaid i reolwyr ystyried a yw'r cais mewn perthynas ag addasiad rhesymol sy'n gysylltiedig ag anabledd neu nodwedd warchodedig arall. Mae cyflogeion yn cael eu hannog i nodi pan fo hyn yn wir. Dylai rheolwyr hefyd ystyried unrhyw faterion iechyd a diogelwch a allai ddeillio o'r newid a nodi ffyrdd o'u lliniaru (e.e. os bydd y trefniadau gwaith yn golygu y byddai'r unigolyn neu ei gydweithwyr yn dod yn weithwyr unigol). Gellir gofyn am gyngor gan y Gwasanaethau Pobl/Adnoddau Dynol/Gweithlu a Datblygu Sefydliadol, Iechyd a Diogelwch ac Iechyd Galwedigaethol fel y bo'n briodol.

8.3 Ystyried cais

Dylid ymdrin â phob cais gydag agwedd 'gallu ei wneud', gyda'r rhagdybiaeth y bydd yn cael ei rhoi oni bai nad yw'n wirioneddol bosibl gwneud hynny am un o'r rhesymau busnes a nodir isod. Dylid ystyried y cais yn ofalus a dylid pwyso a mesur manteision gweithredu'r newid yn erbyn unrhyw gostau. Wrth ystyried y cais, rhaid i reolwyr llinell wneud yn siŵr nad ydynt yn gwahaniaethu'n uniongyrchol neu'n anuniongyrchol yn erbyn y cyflogai. Os oes unrhyw amheuaeth ynghylch yr hyn y gallai hynny ei olygu, yna gellir gofyn am gyngor gan y tîm Cydraddoldeb, Amrywiaeth a Chynhwysiant neu Gwasanaethau Pobl/Adnoddau Dynol/Gweithlu a Datblygu Sefydliadol lleol. Unwaith y gwneir penderfyniad, dylai'r rheolwr hysbysu'r unigolyn yn ysgrifenedig gan ddefnyddio Rhan B o'r ffurflen gais.

8.4 Gwneud penderfyniadau

Os penderfynir cymeradwyo'r cais, neu ei dderbyn gydag addasiadau, dylid cynnal trafodaeth i benderfynu sut a phryd y gellir gweithredu'r newidiadau orau. Mae'r rheolwr llinell yn gyfrifol am sicrhau bod y Gyflogres yn cael gwybod am unrhyw newidiadau i gyflogau, a rhaid egluro newidiadau contractiol penodol gyda'r unigolyn cyn i'r trefniadau newydd ddechrau. I gychwyn proses ymgeisio Pensiynau'r GIG, mae'r unigolyn yn gyfrifol am gysylltu â Thîm Pensiwn PCGC i ofyn am ddolen i ffurflen a gynhyrchwyd yn benodol ar gyfer yr aelod o staff.

Rhaid i reolwyr wneud pob ymdrech i ddarparu ar gyfer y cais yn llawn neu'n rhannol, neu drwy ddarparu dewis arall. Os bydd y rheolwr, ar ôl trafod ac ystyried yr holl ddewisiadau eraill sydd ar gael, yn teimlo na all gefnogi cais hyblyg am bensiwn mewn swydd benodol,

rhaid iddo drafod y cais gyda Gwasanaethau Pobl/Adnoddau Dynol/Gweithlu a Datblygu Sefydliadol.

Yn dilyn y sgwrs hon, os nad ydyw'n teimlo y gall gymeradwyo'r cais o hyd ac na all ddod o hyd i ddewis arall sy'n dderbyniol i'r ddwy ochr, bydd yn cyfarfod â'r unigolyn i egluro hyn a bydd yn darparu rhesymau ysgrifenedig y gellir eu cyfiawnhau'n wrthrychol dros y penderfyniad ac yn rhoi rheswm gweithredol clir dros y penderfyniad nad oedd y trefniadau yn ymarferol. Rhaid i'r rheolwr ddarparu manylion/tystiolaeth o'r seiliau busnes dros wrthod y cais a sut maent yn berthnasol yn achos yr unigolyn. Yng nghyd-destun ei gwneud yn ofynnol i reolwr wneud pob ymdrech i ddarparu ar gyfer cais, pan benderfynir nad yw hyn yn bosibl, dim ond oherwydd un neu fwy o'r rhesymau a nodir yn y rhestr ganlynol y gellir cyfiawnhau hyn:

- Baich sylweddol o gost ychwanegol
- Effaith andwyol ar y gallu i ddiwallu anghenion cleifion/cwsmeriaid
- Anallu i ad-drefnu gwaith ymhlith cyflogeion presennol a/neu ymgysylltu/recriwtio staff eraill.
- Effaith niweidiol ar ansawdd
- Effaith niweidiol ar berfformiad.
- Effaith niweidiol ar y gallu i gwrdd â gofynion y gwasanaeth.
- Dim digon o waith am y cyfnodau y bwriedir gweithio ynddynt
- Newidiadau strwythurol arfaethedig i'r adran

8.5 Uwchgyfeirio

Dylid defnyddio'r cam hwn os nad yw'r rheolwr llinell wedi gallu dod i gytundeb ar ddatrysiad yn y cam archwilio/cymhwyso. Y diben yw gwirio am atebion posibl eraill gan gynnwys a allai'r math o bensiynau hyblyg y mae'r unigolyn yn eu ceisio gael eu cynnwys mewn tîm, lleoliad neu rôl wahanol. Os nad yw cais am bensiynau hyblyg wedi'i gynnwys, ac na fyddai'r unigolyn yn teimlo y gallai barhau i weithio yn yr adran honno mwyach oherwydd na fyddai'n gallu cydbwyso ei gyfrifoldebau gwaith/bywyd, yna disgwylir i reolwyr gefnogi cyflogeion i nodi unrhyw rolau amgen o fewn y sefydliad a allai fod yn fwy cefnogol i'w hamgylchiadau ac yn unol â'u cais.

Os bydd unigolyn yn methu â mynd i gyfarfod i drafod ei gais ac un cyfarfod arall wedi'i aildrefnu heb esboniad, gall y rheolwr ystyried bod y cais wedi'i dynnu yn ôl. O dan yr amgylchiadau hyn, rhaid i'r rheolwr hysbysu'r unigolyn bod y cais wedi'i dynnu'n ôl a rhoi cyfle rhesymol i ymateb.

8.6 Apelio

Pan fo cais am bensiwn hyblyg wedi'i wrthod, gall yr unigolyn gyflwyno apêl o fewn 14 diwrnod o gael ei hysbysu bod ei gais wedi'i wrthod drwy gysylltu â rheolwr llinell ei reolwr.

Rhaid i hyn fod yn ysgrifenedig a datgan yn glir y sail y mae'n apelio arni. Gallai'r sail fod yn un o'r canlynol:

- Ni ddarparwyd digon o dystiolaeth i gefnogi'r rheswm dros wrthod.
- Pan fo'r rheolwr wedi trin y cais yn anghywir fel un a dynnwyd yn ôl.
- Pan fo gwybodaeth newydd bellach ar gael mewn perthynas â'r cais
- Pan fo'r gweithiwr yn teimlo na chafodd y cais ei drin yn unol â'r polisi

- Pan fo cynnig nad yw wedi'i ystyried yn llawn neu nad oes digon o dystiolaeth wedi'i darparu mewn perthynas â rheswm busnes dros wrthod.
- Pan fo gweithiwr yn teimlo nad ymdriniwyd â'r cais mewn modd rhesymol neu y gwahaniaethwyd yn erbyn yr unigolyn.

Cynhelir cyfarfod apêl, fel arfer o fewn mis i dderbyn yr apêl ysgrifenedig. Bydd hyn yn cael ei drin yn ddiduedd gan berson sy'n uwch na'r rheolwr a wnaeth y penderfyniad gwreiddiol.

Dylid rhoi cyfle i'r unigolyn ddod â chynrychiolydd undeb llafur neu gydweithiwr gydag ef i unrhyw gyfarfod apêl. Bydd canlyniad yr apêl yn cael ei gyfathrebu'n ysgrifenedig o fewn saith diwrnod i'r cyfarfod apêl. Dyma ddiwedd y drefn ac nid oes apêl bellach, er y gellir cyflwyno ceisiadau pellach am weithio hyblyg/pensiynau.

9. Monitro ac adolygu

Bydd cyflogwyr yn cadw cofnod o'r holl geisiadau ffurfiol am drefniadau Pensiynau Hyblyg sydd ar waith a chofnod o unrhyw wrthodiadau ac apeliadau.

Dylai sefydliadau sicrhau bod data sy'n ymwneud â cheisiadau am bensiynau hyblyg a chanlyniadau penderfyniadau yn cael eu cofnodi a'u hadrodd yn rheolaidd drwy'r strwythurau partneriaeth a llywodraethu arferol.

Dylai'r wybodaeth hon gael ei chynnwys yn adroddiadau dyletswydd y sector cyhoeddus blynyddol a gyhoeddir gan sefydliad. Dylai'r wybodaeth a gyhoeddir ddangos canlyniadau ar gyfer ceisiadau gweithio hyblyg sydd wedi'u ddadgyfuno fesul nodwedd warchodedig o Ddeddf Cydraddoldeb 2010. Yn ogystal, dylai sefydliadau ystyried adrodd ar ganlyniadau fesul grŵp galwedigaethol a fesul adran.

Atodiad 1 – Ffurflen Gais Pensiynau Hyblyg

Dylai Rhan A o'r ffurflen gais gael ei chwblhau gan y cyflogai.

Dylai Rhan B o'r ffurflen gael ei chwblhau gan y rheolwr llinell yn dilyn y cyfarfod adolygu.

Pan fydd cytundeb wedi'i wneud bydd angen i'r cyflogai gysylltu â Thîm Pensiwn PCGC i gychwyn Proses Ymgeisio'r Cynllun Pensiwn.

Rhan A: Manylion y Cais

Enw'r Cyflogai:	
Swydd:	
Band:	
Rhif y cyflogai:	
Cyfeiriad e-bost:	
Adran:	
Grŵp Gwasanaeth:	
Rheolwr llinell:	

Opsiwn Pensiwn Hyblyg y gwneir cais amdano:

Gan ddefnyddio'r manylion o'r adran berthnasol o'r Polisi fel canllaw, darparwch wybodaeth i'w hystyried i gefnogi'ch cais yn erbyn yr opsiwn perthnasol isod. Nodwch: Pan fydd y cais wedi'i gymeradwyo, bydd yn ofynnol i'r Rheolwr a'r Unigolyn gael mynediad i'r ffurflenni Pensiynau/Cyflogres perthnasol a'u llenwi er mwyn gweithredu'r newidiadau y gofynnir amdanynt.	
Ymddeoliad Rhannol (gostwng fy nghyflog pensiynadwy o leiaf 10% am y 12 mis cyntaf) *	
Ymddeol, dechrau derbyn fy mhensiwn ac ailddechrau cyflogaeth (Ymddeol a Dychwelyd) *	

Camu i lawr (i rôl â llai o gyfrifoldeb/band is)	
Gostyngiad mewn Oriau/dirwyn i ben	

Llofnod y Cyflogai	**Dyddiad:**

Rhan B: Adran Canlyniad

Penderfyniad y rheolwr (ticiwch i nodi un o’r canlyniadau isod):

Cais llwyddiannus

Mae'r cais am opsiwn pensiynau hyblyg wedi'i adolygu a'i dderbyn.	
Mae'r cais wedi'i dderbyn yn amodol ar rai diwygiadau fel yr amlinellir isod	
Ymddeoliad Rhannol Cadarnhewch fod Ffurflen Atodol Ymddeoliad Rhannol PCGC wedi'i chwblhau i'w chyflwyno	
Pob Dewis Cadarnhau bod yr hysbysiadau newid perthnasol wedi'u cyflwyno i'r Gyflogres	

Nodwch: Pan fydd y cais wedi'i gymeradwyo, bydd yn ofynnol i'r Rheolwr a'r Unigolyn gael mynediad i'r ffurflenni Pensiynau/Cyflogres perthnasol a'u llenwi er mwyn gweithredu'r newidiadau y gofynnir amdanynt.

Ceisiadau Aflwyddiannus

Nid yw'r cais wedi bod yn llwyddiannus.	
Rhesymeg dros wrthod y cais: Dim ond trwy un neu fwy o’r rhesymau sydd wedi’u cynnwys yn y rhestr ganlynol y gellir cyfiawnhau hyn: • Baich sylweddol o ganlyniad i gost ychwanegol • Effaith andwyol ar y gallu i ddiwallu anghenion cleifion/cwsmeriaid • Anallu i ad-drefnu gwaith ymhlith cyflogeion presennol a/neu ymgysylltu/recriwtio staff eraill. • Effaith niweidiol ar ansawdd • Effaith niweidiol ar berfformiad.	

• Effaith niweidiol ar y gallu i gwrdd â gofynion y gwasanaeth. • Dim digon o waith am y cyfnodau y bwriadwch weithio ynddynt • Newidiadau strwythurol arfaethedig i'r adran	

Trefniadau cyflogaeth parhaol newydd – Cytundeb Pensiynau Hyblyg

Dyddiad dechrau newid:	
Ceisiadau Ymddeoliad Rhannol yn unig: Dyddiad gorffen newid/ dyddiad dychwelyd disgwyliedig i delerau contractiol blaenorol. (ni ddylai hyn fod yn gynharach na 12 mis o ddyddiad yr ymddeoliad rhannol).	
Ceisiadau Ymddeol a Dychwelyd yn unig: Dyddiad dychwelyd disgwyliedig, yn dilyn ymddeoliad (sylwch fod yn rhaid cael egwyl o 24 awr yn dilyn cais ymddeol a dychwelyd)	
Newid trefniadau:	
Band:	
Oriau:	
Cyflog a Phwynt Cynyddrannol:	
Unrhyw lwfansau ychwanegol i'w parhau/cronni'n flaenorol (h.y. gwyliau blynyddol ychwanegol):	
Cychwyn Contract Banc (os yw'n berthnasol)	

Llofnodion

Llofnod y Rheolwr	Llofnod: Dyddiad: - - /- -/ - - - -
Llofnod y Cyflogai Cadarnhaf fod y cais opsiwn pensiwn hyblyg hwn wedi'i drafod â mi a chytunaf i'r addasiadau i'm trefniadau gweithio	Llofnod: Dyddiad: - - /- -/ - - -

Respect and Resolution Policy

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

Approved September 2024
Welsh Partnership Forum
Medical and Dental Business Group

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1. ABOUT THIS POLICY

1.1 We seek to ensure that all employees have access to a policy to help deal with any requests for resolution relating to their employment fairly, constructively and without unreasonable delay.

1.2 We aim to encourage fairness and positive relationships within the workplace. We aim to prevent bullying, harassment and any form of unacceptable behaviour.

1.3 We recognise that a positive working environment and good working relationships have a beneficial impact on employee wellbeing, engagement and patient experience. A positive working environment can also lead to better performance, improved employee retention and reduced stress related sickness absence. Focusing on resolution is good for our organisation, it is good for you and it is good for our patients and service users.

1.4 We recognise conflict and disagreements in the workplace happens but should not always be viewed negatively. When conflict is managed well it leads to healthy, resilient and positive working relationships. We strive for a workplace where everyone can engage with each other constructively and use the toolkit available to seek their own resolution as far as possible.

1.5 If this happens, we will support employees and managers to work together to resolve any issues and conflict constructively and quickly.

1.6 We commit to resolving issues at the earliest opportunity without resorting to a formal policy. As a last resort it may be necessary to use the formal part of this policy to resolve disputes or issues. This policy sets out our commitment to helping you seek a resolution.

1.7 This policy applies to all employees.

1.8 This policy has been agreed by the Wales Partnership Forum.

1.9 This policy constitutes the formal grievance policy.

1.10 The Core Principles of NHS Wales are central to this policy and apply throughout.

2. USING THIS POLICY

2.1 This Resolution Policy is aimed at securing constructive and lasting solutions to workplace disagreements, conflicts and complaints. Issues that could cause disagreements, conflicts or complaints may include but are not limited to:

(a) terms and conditions of employment;
(b) health and safety;
(c) work relations;

(d) bullying and harassment;
(e) new working practices;
(f) working environment;
(g) organisational change; and
(h) discrimination.

2.2 The status quo at the time you make your request for resolution will normally remain in place throughout the policy.

The status quo will continue until the request for resolution has been resolved or the formal procedure has been exhausted, other than in exceptional circumstances where it would be a breach of legal requirements or safety issues which may impact upon the status quo.

2.3 Everyone should ensure that issues are dealt with in a fair and consistent way and dealt with quickly and supportively.

2.4 Every workplace in the NHS in Wales should be free from bullying and harassment. We are committed to ensure all staff are treated, and treat others, with dignity and respect. This policy covers harassment or bullying which occurs at work and out of the workplace, such as on business trips, at work-related events, social functions or online. It covers bullying and harassment by staff (which may include contractors and agency workers) and also by third parties such as patients and visitors to our premises.

Conversely, staff who have experienced bullying, harassment or discrimination (such as racism) may have experiences not being believed, not taken seriously, or not having issues addressed. They may feel discouraged from raising issues, poorly treated or revictimized through the process, resulting in significant detrimental mental health impacts on individuals. Such allegations should come in at the formal stage of the respect and resolution process, where appropriate, and if there was evidence in line with initial assessment we would move to disciplinary or capability processes.

Whilst it would not be appropriate for an employee to specify a pre-determined sanction (such as disciplinary action) as a potential resolution, staff must be given a reasonable expectation that their concerns will be taken seriously, and that behaviour inconsistent with NHS Wales values will be actively identified and addressed, particularly in situations where there is evidence of repeated patterns of behaviour or causing relationship breakdown, balancing confidentiality with the need to keep the individual updated.

Compassionate leadership principles and approaches should be applied throughout, supported by training in applying the policy in an anti-discriminatory and culturally competent manner.

In particular, the culture of blaming those who have raised experiences of racism, whilst denying NHS Wales organisations are systemically racist, needs to be actively acknowledged and addressed.

3. INFORMAL RESOLUTION

3.1 It is our aim that we each take ownership of our relationships so that they are as healthy as possible. To help this, a toolkit has been developed which includes these useful approaches:

(a) Reflecting Tips on how we can have healthy relationships

(b) Having a Cuppa Conversation

(c) Discussing with an appropriate leader/manager

(d) Taking part in an independently Facilitated Conversation

(e) Accessing accredited Mediation.

3.2 It is expected that the variety of tools and resources available are used to help resolve the issue(s) prior to raising a formal request for resolution. This can be done with the support of your line manager though this may not always be necessary.

3.3 Most disagreements can be resolved quickly and informally through discussion with your colleagues or line manager. If you feel unable to speak to your manager, for example, because the issue involves them, then you should speak informally to a more senior manager, your Trade Union Representative or a member of Human Resources. If this does not resolve the issue, you should follow the formal part of the policy below.

4. FORMAL REQUEST FOR RESOLUTION

4.1 This step of the policy constitutes a formal grievance.

4.2 If your issues cannot be resolved informally by using the resources outlined in the toolkit, you should put your request for resolution in writing and submit it to your line manager (or a more senior manager if the issue involves your line manager) or a member of Human Resources.

4.3 Human Resources will appoint someone impartial, of sufficient seniority to consider the request. This appointment usually takes place within seven days of receiving the request. This person will be known as the Chair and will decide on the outcome of your request.

4.4 Your written request for resolution should contain a description of the nature of your issue, including any relevant facts, dates, names of individuals involved and the desired resolution you hope to achieve. In some situations, we may ask you to provide more information.

4.5 An employee may make a complaint or raise an issue in Welsh and may also respond in Welsh to any allegations made against them and they should be advised of this at the beginning of any proceedings. Any subsequent proceedings should be conducted in Welsh or a simultaneous translation service provided.

5. FORMAL RESOLUTION MEETINGS

5.1 The Chair will meet with you to discuss your request for resolution. This should happen within 14 days of the chair being appointed. The purpose of this meeting is to allow you to explain your issue, explain how you think it should be resolved, enabling a decision to be reached based on the available evidence and representations you have made. The focus of this meeting will be seeking a resolution.

5.2 Depending on the detail included within your request for resolution the Chair will either explore the issues with you at this meeting and decide on an outcome or will initiate an investigation to enable your request to be considered further.

5.3 If a detailed investigation is necessary, the Chair will appoint an investigator. This will normally be an employee of the organisation who is impartial. At this stage, the terms of reference and the timescales will be agreed.

5.4 The level of any investigation required will depend on the nature of the issues involved and will vary from case to case. It may involve interviewing and taking statements from you and any witnesses, and/or reviewing relevant documents.

5.5 The Chair will make a decision based on the information gathered at the formal resolution meeting(s) and with reference to any investigation, if appropriate.

5.6 If it is possible the Chair will provide you with a verbal decision at the end of the meeting. In any event, we will write to you, usually within seven days of the formal resolution meeting, to inform you of the outcome and any further action that is intended to resolve the issues. We will also remind you of your right of appeal.

5.7 An accurate record of the meeting will be made and will be available upon request.

6. APPEALS

6.1 If your issue has not been resolved to your satisfaction you may appeal in writing within 14 days of the date on which the decision was communicated to you in writing.

6.2 We will hold an appeal meeting, normally within one month of receiving your written appeal. This will be dealt with impartially by a more senior person than the Chair who has not previously been involved in the case (although they may ask anyone previously involved to be present where relevant for points of clarification).

6.3 This person will be known as the Appeal Chair. The Appeal Chair will be appointed by Human Resources and will usually be appointed within seven days of the appeal being received. The focus of this meeting, again, will be on seeking a resolution.

6.4 We will confirm our final decision in writing within seven days of the appeal meeting. This is the end of the procedure and there is no further appeal.

7. RIGHT TO BE ACCOMPANIED

7.1 You may bring a companion to any investigatory meeting, resolution meeting or appeal meeting to help and support you. The companion may be either a Trade Union Representative or a work colleague.

7.2 At the resolution and appeal meetings your companion may address the meeting to put and sum up your case, respond on your behalf to any views expressed, ask questions and confer with you during the meeting. Your companion should not answer questions on your behalf. You may adjourn and talk privately with them at any time during the meeting.

7.3 All witnesses will also have the right to be accompanied.

8. COLLECTIVE REQUEST FOR RESOLUTION

8.1 This part of the policy applies where more than one employee wishes to invoke the policy on the same issue. This would constitute a formal collective grievance.

8.2 If resolution is required for a collective issue the stages of this policy will be followed in accordance with sections 3 to 7 above. All employees who are in support of the collective request for resolution will need to be identified on the submission.

8.3 The number of employees attending the formal meeting to represent the collective group will be agreed at the outset (but should not normally exceed three employees plus their companion).

8.4 Where this policy fails to reach a resolution to the collective issue, either side may refer the matter to the Advisory Conciliation & Arbitration Service (ACAS) for advice or conciliation.

9. OVERLAPPING REQUESTS FOR RESOLUTION AND DISCIPLINARY PROCESSES

9.1 Where you raise a request for resolution during a disciplinary process, the manager will discuss with you and your representative before a decision is made on whether the disciplinary policy should be temporarily suspended in order to deal with the request for resolution. Where the request for resolution and disciplinary cases are related it may be appropriate to deal with both issues concurrently.

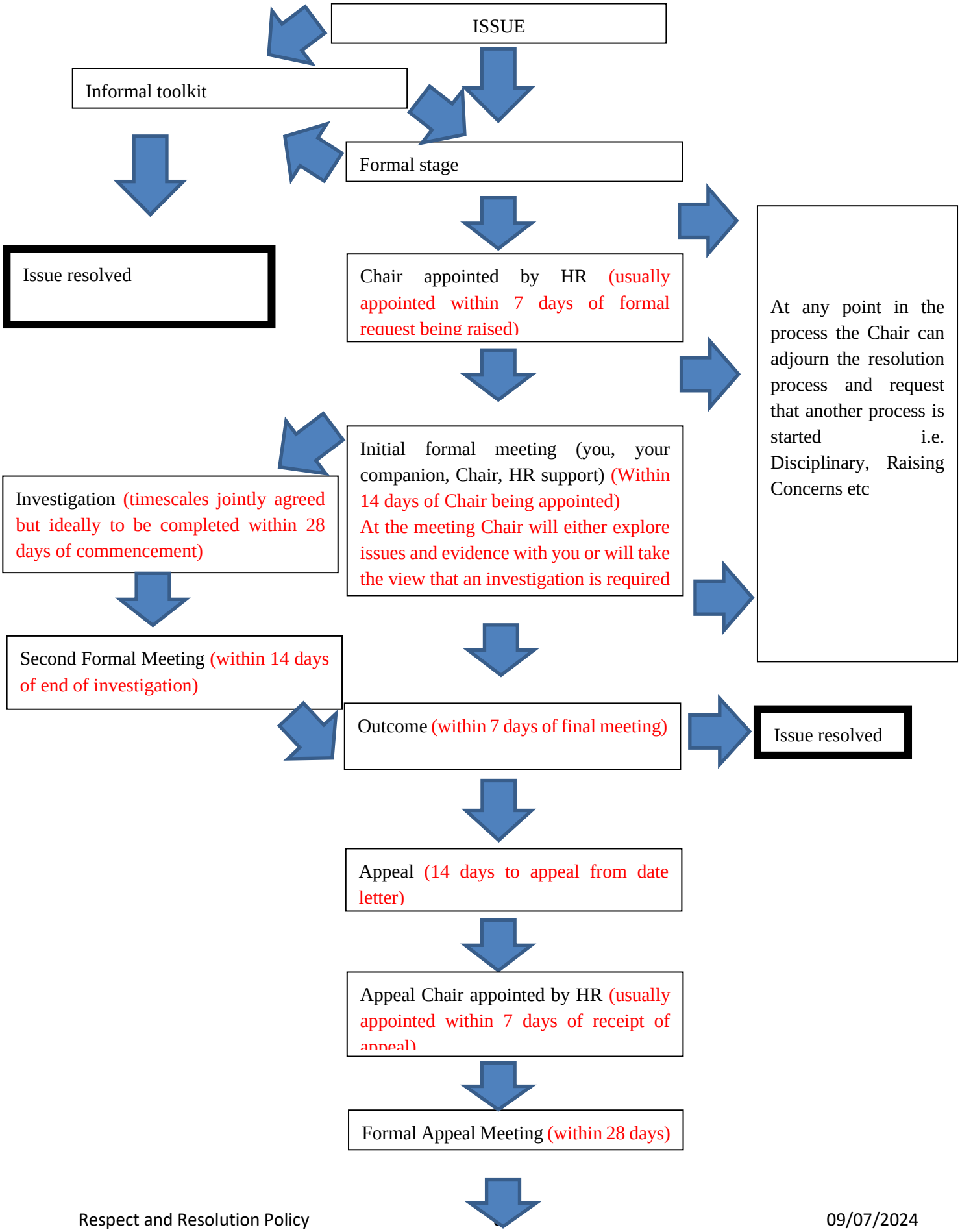
9.2 There may be occasions when disagreements or conflict have been resolved using the toolkit however the organisation may feel that a disciplinary process is required where core values or standards have been breached.

9.3 In some circumstances, such as in cases of harassment or discrimination, it may be decided by the Chair that it is more appropriate to suspend the resolution process and progress the matter under the appropriate disciplinary policy.

10. LEARNING FROM EVENTS

10.1 Where appropriate we will reflect and learn from the resolution process. This stage is not a requirement but is encouraged and may be useful in helping develop healthier working environments and relationships.

10.2 This review should be conducted in partnership where appropriate, with a view to developing and supporting a healthy working culture. These discussions should be focused on positive outcomes and change (see toolkit).


ISSUE
Informal toolkit
Formal stage
Issue resolved
Chair appointed by HR (usually appointed within 7 days of formal request being raised)
At any point in the process the Chair can adjourn the resolution process and request that another process is started i.e. Disciplinary, Raising Concerns etc
Initial formal meeting (you, your companion, Chair, HR support) (Within 14 days of Chair being appointed)
At the meeting Chair will either explore issues and evidence with you or will take the view that an investigation is required
Investigation (timescales jointly agreed but ideally to be completed within 28 days of commencement)
Second Formal Meeting (within 14 days of end of investigation)
Outcome (within 7 days of final meeting)
Issue resolved
Appeal (14 days to appeal from date letter)
Appeal Chair appointed by HR (usually appointed within 7 days of receipt of appeal)
Formal Appeal Meeting (within 28 days)
Appeal Outcome (within 7 days of meeting)

Polisi Parch a Datrys

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

Cymeradwywyd Medi 2024
Fforwm Partneriaeth Cymru
Grŵp Busnes Meddygol a Deintyddol

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1. YNGLŶN Â'R POLISI HWN

1.1 Rydym yn ceisio sicrhau bod gan bob cyflogai fynediad at bolisi i helpu i ymdrin ag unrhyw geisiadau am ddatrysiad yn ymwneud â'i gyflogaeth yn deg, yn adeiladol a heb oedi afresymol.

1.2 Ein nod yw annog tegwch a pherthnasoedd cadarnhaol yn y gweithle. Ein nod yw atal bwlio, aflonyddu ac unrhyw fath o ymddygiad annerbyniol.

1.3 Rydym yn cydnabod bod amgylchedd gwaith cadarnhaol a pherthnasoedd gwaith da yn cael effaith gadarnhaol ar lesiant ac ymgysylltiad y cyflogai ac ar brofiad cleifion. Gall amgylchedd gwaith cadarnhaol hefyd arwain at berfformiad gwell, cadw mwy o gyflogai a llai o absenoldeb salwch sy'n gysylltiedig â straen. Mae canolbwyntio ar ddatrys yn dda i'n sefydliad, mae'n dda i chi ac mae'n dda i'n cleifion a'n defnyddwyr gwasanaeth.

1.4 Rydym yn cydnabod bod gwrthdaro ac anghydfodau yn digwydd yn y gweithle, ond ni ddylid eu hystyried yn negyddol bob amser. Pan fydd gwrthdaro yn cael ei reoli'n dda, mae'n creu perthnasoedd gwaith iach, cydnerth a chadarnhaol. Rydym yn ymdrechu i gael gweithle lle gall pawb ymwneud â'i gilydd yn adeiladol a defnyddio'r pecyn cymorth sydd ar gael i ddod o hyd i'w datrysiadau eu hunain cyn belled ag y bo modd.

1.5 Os bydd hyn yn digwydd, byddwn yn cefnogi cyflogeion a rheolwyr i gydweithio i ddatrys unrhyw faterion a gwrthdaro yn adeiladol ac yn gyflym.

1.6 Rydym yn ymrwymo i ddatrys materion ar y cyfle cyntaf heb ddefnyddio polisi ffurfiol. Os bydd popeth arall yn methu, efallai y bydd angen defnyddio rhan ffurfiol y polisi hwn i ddatrys anghydfodau neu faterion. Mae'r polisi hwn yn amlinellu ein hymrwymiad i'ch helpu chi i ddod o hyd i ddatrysiad.

1.7 Mae'r polisi hwn yn berthnasol i'r holl gyflogeion.

1.8 Mae Fforwm Partneriaeth Cymru wedi cytuno ar y polisi hwn.

1.9 Mae'r polisi hwn yn ffurfio'r polisi cwynion ffurfiol.

1.10 Mae Egwyddorion Craidd GIG Cymru yn ganolog i'r polisi hwn ac maent yn berthnasol drwyddi draw.

2. DEFNYDDIO'R POLISI HWN

2.1 Nod y Polisi Datrys hwn yw sicrhau datrysiadau adeiladol a pharhaol i anghytundebau, gwrthdaro a chwynion yn y gweithle. Gall materion sy'n achosi anghytundebau, gwrthdaro a chwynion gynnwys, ond nid ydynt yn gyfyngedig i'r canlynol:

(a) telerau ac amodau cyflogaeth;
(b) iechyd a diogelwch;
(c) perthnasoedd gwaith;
(d) bwlio ac aflonyddu;
(e) arferion gwaith newydd;
(f) amgylchedd gwaith;
(g) newid sefydliadol; a
(h) gwahaniaethu.

2.2 Bydd y status quo ar yr adeg y byddwch yn gwneud eich cais am ddatrysiad fel arfer yn parhau ar waith trwy gydol y polisi.

Bydd y *status quo* yn parhau hyd nes y bydd y cais am benderfyniad wedi'i ddatrys neu hyd nes y bydd y weithdrefn ffurfiol wedi'i dihysbyddu, ac eithrio mewn amgylchiadau eithriadol lle byddai'n torri gofynion cyfreithiol neu faterion diogelwch a allai effeithio ar y *status quo*.

2.3 Dylai pawb sicrhau yr ymdrinnir â materion mewn ffordd deg a chyson a hynny'n gyflym a chyda chefnogaeth.

2.4 Dylai pob gweithle yn GIG Cymru fod yn rhydd rhag bwlio ac aflonyddu. Rydym wedi ymrwymo i sicrhau bod yr holl staff yn cael eu trin, ac yn trin pobl eraill, ag urddas a pharch. Mae'r polisi hwn yn cynnwys aflonyddu a bwlio sy'n digwydd yn y gwaith a'r tu allan i'r gweithle, megis ar dripiau gwaith, mewn digwyddiadau sy'n gysylltiedig â'r gwaith, digwyddiadau cymdeithasol neu ar-lein. Mae'n cynnwys bwlio ac aflonyddu gan staff (a all gynnwys contractwyr a gweithwyr asiantaeth) a hefyd gan drydydd partïon megis cleifion ac ymwelwyr â'n hadeiladau.

I'r gwrthwyneb, mae'n bosibl y bydd gan staff sydd wedi profi bwlio, aflonyddu neu wahaniaethu (megis hiliaeth) brofiadau o beidio â chael eu credu, peidio â chael eu cymryd o ddifrif, neu beidio â mynd i'r afael â'u problemau. Mae'n bosibl y byddant yn teimlo eu bod yn cael eu hannog i beidio â chodi materion, yn cael eu trin yn wael neu eu bod yn cael eu hail-erlid trwy'r broses, gan arwain at effeithiau iechyd meddwl niweidiol sylweddol ar unigolion. Dylai honiadau o'r fath gael eu cyflwyno yn ystod cam ffurfiol y broses parch a datrys, lle bo'n briodol, a phe bai tystiolaeth yn unol ag asesiad cychwynnol, byddem yn symud i brosesau disgyblu neu alluogrwydd.

Er na fyddai'n briodol i gyflogai nodi cosb a bennwyd ymlaen llaw (megis camau disgyblu) fel datrysiad posibl, rhaid rhoi disgwyliad rhesymol i staff y bydd eu pryderon yn cael eu cymryd o ddifrif, a bod ymddygiad sy'n anghyson â gwerthoedd GIG Cymru yn cael eu nodi'n weithredol ac yn cael sylw, yn enwedig mewn sefyllfaoedd lle mae tystiolaeth o batrymau ymddygiad mynych neu rai sy'n achosi tor-perthynas, gan gydbwyso cyfrinachedd â'r angen i roi'r wybodaeth ddiweddaraf i'r unigolyn.

Dylid cymhwyso egwyddorion a dulliau arwain tosturiol drwyddi draw, wedi'u hategu gan hyfforddiant ar gymhwyso'r polisi mewn modd gwrth-wahaniaethol a diwylliannol gymwys.

Yn benodol, mae angen cydnabod a mynd i'r afael â'r diwylliant o feio'r rhai sydd wedi codi profiadau o hiliaeth a dylid cydnabod a mynd i'r afael â gwadu bod sefydliadau GIG Cymru yn hiliol yn systemig.

3. DATRYSIAD ANFFURFIOL

3.1 Ein nod yw bod pob un ohonom yn cymryd cyfrifoldeb am ein perthnasoedd fel eu bod mor iach â phosibl. I helpu hyn, mae pecyn cymorth wedi'i ddatblygu sy'n cynnwys y dulliau defnyddiol hyn:

(a) Defnyddio ein disgwyliadau/addewidion a rennir
(b) Awgrymiadau Myfyrio ar sut y gallwn gael perthnasoedd iach
(c) Cael Sgwrs dros Baned
(d) Trafod ag arweinydd/rheolwr priodol
(e) Ennill cefnogaeth (a her) gan gydweithiwr *Resolution Network*
(f) Cymryd rhan mewn Sgwrs wedi'i Hwyluso'n annibynnol
(g) Cael mynediad at Gyfryngu achrededig

3.2 Disgwylir bod yr amrywiaeth o offer ac adnoddau sydd ar gael yn cael eu defnyddio i helpu i ddatrys y mater(ion) cyn gwneud cais ffurfiol am ddatrysiad. Gellir gwneud hyn gyda chefnogaeth eich rheolwr llinell, er efallai na fydd hyn yn angenrheidiol bob tro.

3.3 Gellir datrys y rhan fwyaf o anghytundebau yn gyflym ac yn anffurfiol drwy drafod â'ch cydweithwyr neu reolwr llinell. Os nad ydych yn teimlo eich bod yn gallu siarad â'ch rheolwr, er enghraifft, oherwydd bod y mater yn ei gynnwys, yna dylech gael sgwrs anffurfiol ag uwch reolwr, eich Cynrychiolydd Undeb Llafur neu aelod o Adnoddau Dynol. Os nad yw hyn yn datrys y mater, dylech ddilyn rhan ffurfiol y polisi isod.

4. CAIS FFURFIOL AM DDATRYSIAD

4.1 Mae'r cam hwn o'r polisi yn gŵyn ffurfiol.

4.2 Os na ellir datrys eich materion yn anffurfiol trwy ddefnyddio'r adnoddau a amlinellir yn y pecyn cymorth, dylech wneud eich cais am ddatrysiad yn ysgrifenedig a'i gyflwyno i'ch rheolwr llinell (neu uwch reolwr os yw'r mater yn cynnwys eich rheolwr llinell) neu aelod o Adnoddau Dynol.

4.3 Bydd Adnoddau Dynol yn penodi rhywun diduedd, o brofiad digonol i ystyried y cais. Mae'r penodiad hwn fel arfer yn digwydd cyn pen saith diwrnod ar ôl derbyn y cais. Caiff yr unigolyn hwn ei adnabod fel y Cadeirydd a bydd yn penderfynu ar ganlyniad eich cais.

4.4 Dylai eich cais ysgrifenedig am ddatrysiad gynnwys disgrifiad o natur eich mater, gan gynnwys unrhyw ffeithiau, dyddiadau, enwau unigolion dan sylw perthnasol a'r datrysiad rydych yn gobeithio ei gael. Mewn rhai sefyllfaoedd, efallai y byddwn yn gofyn i chi roi mwy o wybodaeth.

4.5 Gall cyflogai wneud cwyn neu godi mater yn Gymraeg a gall hefyd ymateb yn Gymraeg i unrhyw honiadau a wneir yn ei erbyn a dylid ei hysbysu o hyn ar ddechrau unrhyw achos. Dylai unrhyw achos dilynol gael ei gynnal yn Gymraeg neu dylid darparu gwasanaeth cyfieithu ar y pryd.

5. CYFARFODYDD DATRYS FFURFIOL

5.1 Bydd y Cadeirydd yn cwrdd â chi i drafod eich cais am ddatrysiad. Dylai hyn ddigwydd cyn pen 14 diwrnod ar ôl penodi'r cadeirydd. Diben y cyfarfod hwn yw caniatáu i chi egluro'ch mater, egluro sut rydych yn meddwl y dylid ei ddatrys, gan alluogi dod i benderfyniad yn seiliedig ar y dystiolaeth sydd ar gael a'r sylwadau rydych chi wedi'u gwneud. Dod o hyd i ddatrysiad fydd ffocws y cyfarfod hwn.

5.2 Yn dibynnu ar y manylion sydd wedi'u cynnwys yn eich cais am ddatrysiad, bydd y Cadeirydd naill ai'n edrych ar y materion gyda chi yn y cyfarfod hwn ac yn penderfynu ar ganlyniad neu bydd yn cychwyn ymchwiliad i alluogi ystyried eich cais ymhellach.

5.3 Os bydd angen ymchwiliad manwl, bydd y Cadeirydd yn penodi ymchwilydd. Cyflogai diduedd yn y sefydliad fydd hwn fel rheol. Ar y cam hwn, cytunir ar y cylch gorchwyl a'r amserlen.

5.4 Bydd lefel unrhyw ymchwiliad sy'n ofynnol yn dibynnu ar natur y materion dan sylw a bydd yn amrywio o achos i achos. Gall gynnwys cyfweliadau a chymryd datganiadau gennych chi ac unrhyw dystion, a/neu adolygu dogfennau perthnasol.

5.5 Bydd y Cadeirydd yn gwneud penderfyniad yn seiliedig ar yr wybodaeth a gasglwyd yn y cyfarfod(ydd) datrys ffurfiol a chan gyfeirio at unrhyw ymchwiliad, os yw'n briodol.

5.6 Os yw'n bosibl, bydd y Cadeirydd yn rhoi penderfyniad ar lafar i chi ar ddiwedd y cyfarfod. Beth bynnag, byddwn yn ysgrifennu atoch, cyn pen saith diwrnod ar ôl y cyfarfod datrys ffurfiol fel rheol, i'ch hysbysu o'r canlyniad ac unrhyw gamau pellach y bwriedir iddynt ddatrys y materion. Byddwn yn eich atgoffa hefyd o'ch hawl i apelio.

5.7 Gwneir cofnod cywir o'r cyfarfod a bydd ar gael ar gais.

6. APELIADAU

6.1 Os na chafodd eich mater ei ddatrys yn foddhaol, gallwch wneud apêl ysgrifenedig cyn pen 14 diwrnod ar ôl y dyddiad y mynegwyd y penderfyniad i chi yn ysgrifenedig.

6.2 Byddwn yn cynnal cyfarfod apêl, fel rheol cyn pen mis ar ôl derbyn eich apêl ysgrifenedig. Ymdrinnir â hwn yn ddiduedd gan unigolyn ar lefel uwch na'r Cadeirydd nad yw wedi bod

yn rhan o’r achos o’r blaen (er y gallant ofyn i rywun sydd wedi bod yn rhan o’r achos o’r blaen i fod yn bresennol lle bo hynny’n berthnasol i egluro rhai pwyntiau).

6.3 Bydd y person hwn yn cael ei adnabod fel Cadeirydd yr Apêl. Bydd Adnoddau Dynol yn penodi Cadeirydd yr Apêl a bydd yn cael ei benodi fel rheol cyn pen saith diwrnod ar ôl derbyn yr apêl. Unwaith eto, bydd y cyfarfod yn canolbwyntio ar ddod o hyd i ddatrysiad.

6.4 Byddwn yn cadarnhau ein penderfyniad terfynol yn ysgrifenedig cyn pen saith diwrnod ar ôl y cyfarfod apêl. Dyma ddiwedd y weithdrefn ac nid oes apêl bellach.

7. YR HAWL I GAEL RHYWUN GYDA CHI

7.1 Gallwch ddod â chydymaith i unrhyw gyfarfod ymchwilio, cyfarfod datrys neu gyfarfod apêl i’ch helpu a’ch cefnogi. Gall y cydymaith fod yn Gynrychiolydd Undeb Llafur neu’n gydweithiwr.

7.2 Yn y cyfarfodydd datrys ac apêl, gall y cydymaith annerch y cyfarfod i gyflwyno a chrynhoi’ch achos, ymateb ar eich rhan i unrhyw safbwyntiau a fynegir, gofyn cwestiynau a thrafod â chi yn ystod y cyfarfod. Ni ddylai eich cydymaith ateb cwestiynau ar eich rhan. Gallwch adael i siarad â’ch cydymaith yn breifat ar unrhyw adeg yn ystod y cyfarfod.

7.3 Bydd gan dystion yr hawl i gael rhywun gyda nhw.

8. CAIS AR Y CYD AM DDATRYSIAD

8.1 Mae’r rhan hon o’r polisi yn berthnasol pan fydd mwy nag un cyflogai yn dymuno gweithredu’r polisi ar yr un mater. Byddai hyn yn gŵyn ffurfiol ar y cyd.

8.2 Os oes angen datrysiad ar gyfer mater ar y cyd, dilynir camau'r polisi hwn yn unol ag adrannau 3 i 7 uchod. Bydd angen nodi'r holl gyflogeion sy'n cefnogi'r cais ar y cyd am ddatrysiad yn y cyflwyniad.

8.3 Bydd nifer y cyflogeion sy'n mynd i'r cyfarfod ffurfiol i gynrychioli'r grŵp ar y cyd yn cael ei gytuno ar y cychwyn (ond, fel rheol, ni ddylai’r nifer fod yn fwy na thri chyflogai ynghyd â'u cymdeithion).

8.4 Lle bo’r polisi hwn yn methu â sicrhau datrysiad i’r gŵyn a gyflwynwyd ar y cyd, gall y naill ochr gyfeirio’r mater i’r Gwasanaeth Cynghori, Cymodi a Chyflafareddu (ACAS) am gyngor neu gymodi.

9. CEISIADAU AM DDATRYSIAD A PHROSESAU DISGYBLU SY’N GORGYFFWRDD.

9.1 Pan fyddwch yn gwneud cais am ddatrysiad yn ystod proses ddisgyblu, bydd y rheolwr yn trafod â chi a'ch cynrychiolydd cyn gwneud penderfyniad ynghylch a ddylid atal y broses ddisgyblu dros dro er mwyn delio â'r cais am ddatrysiad. Lle bo cais am ddatrysiad ac achosion disgyblu’n gysylltiedig, gallai fod yn briodol ymdrin â’r ddau fater ar yr un pryd.

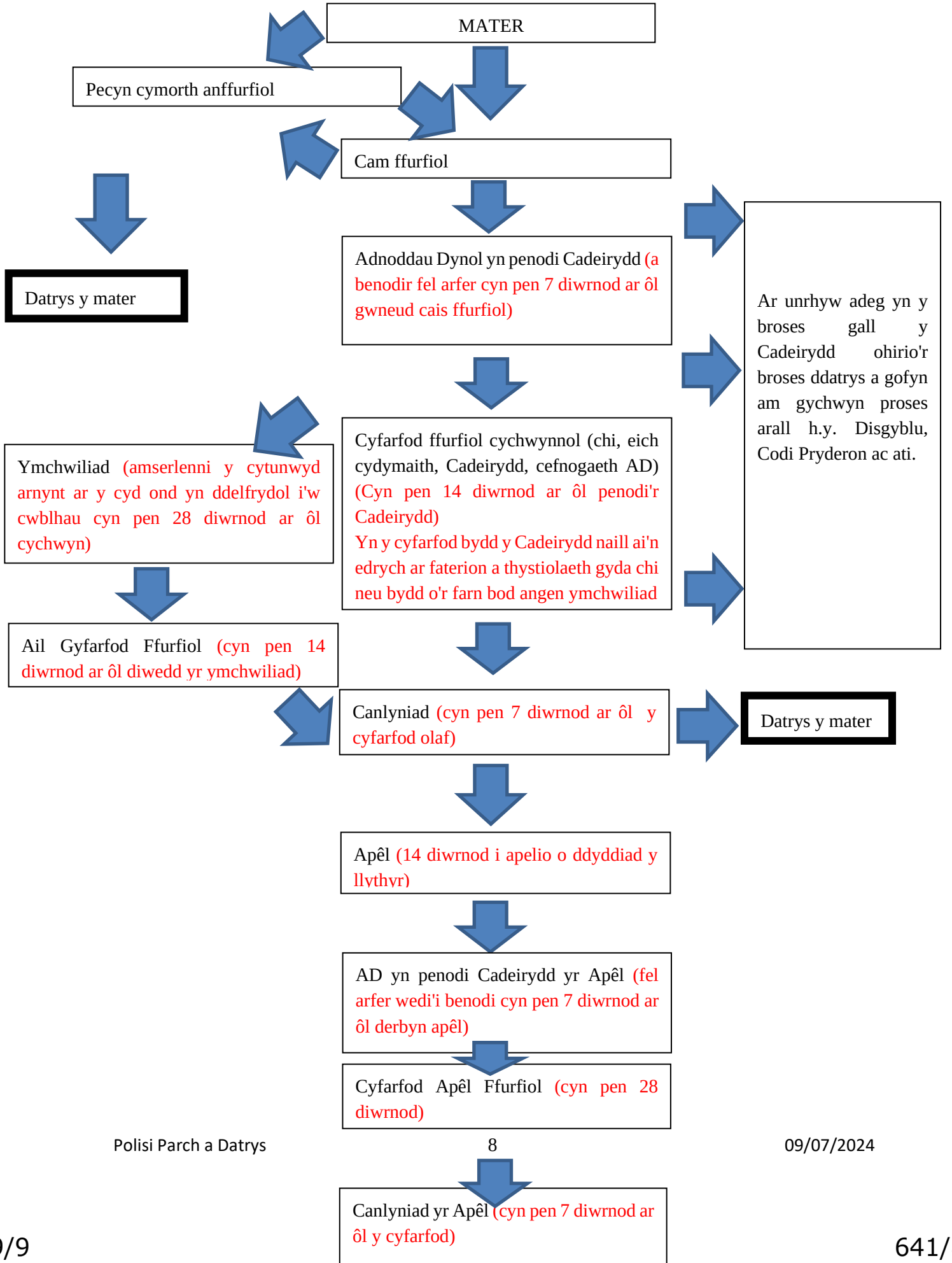
9.2 Efallai y bydd adegau pan fydd anghytundebau neu wrthdaro wedi'u datrys gan ddefnyddio'r pecyn cymorth, ond gall y sefydliad deimlo bod angen proses ddisgyblu pan fydd gwerthoedd neu safonau craidd wedi'u torri.

9.3 Mewn rhai amgylchiadau, megis mewn achosion o aflonyddu neu wahaniaethu, gall y Cadeirydd benderfynu ei bod yn fwy priodol atal y broses ddatrys a symud y mater ymlaen o dan y polisi disgyblu priodol.

10. DYSGU O DDIGWYDDIADAU

10.1 Lle y bo'n briodol, byddwn yn myfyrio ar y broses ddatrys ac yn dysgu ohoni. Nid yw'r cam hwn yn ofyniad ond mae'n cael ei annog a gallai fod yn ddefnyddiol wrth helpu i ddatblygu amgylcheddau a pherthnasoedd gwaith iachach.

10.2 Dylai'r adolygiad hwn gael ei gynnal mewn partneriaeth lle bo hynny'n briodol, gyda'r bwriad o ddatblygu a chefnogi diwylliant gwaith iach. Dylai'r trafodaethau hyn ganolbwyntio ar ganlyniadau cadarnhaol a newid (gweler y pecyn cymorth).


MATER
Pecyn cymorth anffurfiol
Cam ffurfiol
Datrys y mater
Adnoddau Dynol yn penodi Cadeirydd (a benodir fel arfer cyn pen 7 diwrnod ar ôl gwneud cais ffurfiol)
Ar unrhyw adeg yn y broses gall y Cadeirydd ohirio'r broses ddatrys a gofyn am gychwyn proses arall h.y. Disgyblu, Codi Pryderon ac ati.
Ymchwiliad (amserlenni y cytunwyd arnynt ar y cyd ond yn ddelfrydol i'w cwblhau cyn pen 28 diwrnod ar ôl cychwyn)
Cyfarfod ffurfiol cychwynnol (chi, eich cydymaith, Cadeirydd, cefnogaeth AD) (Cyn pen 14 diwrnod ar ôl penodi'r Cadeirydd)
Yn y cyfarfod bydd y Cadeirydd naill ai'n edrych ar faterion a thystiolaeth gyda chi neu bydd o'r farn bod angen ymchwiliad
Ail Gyfarfod Ffurfiol (cyn pen 14 diwrnod ar ôl diwedd yr ymchwiliad)
Canlyniad (cyn pen 7 diwrnod ar ôl y cyfarfod olaf)
Datrys y mater
Apêl (14 diwrnod i apelio o ddyddiad y llythyr)
AD yn penodi Cadeirydd yr Apêl (fel arfer wedi'i benodi cyn pen 7 diwrnod ar ôl derbyn apêl)
Cyfarfod Apêl Ffurfiol (cyn pen 28 diwrnod)
Canlyniad yr Apêl (cyn pen 7 diwrnod ar ôl y cyfarfod)

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Quality, Safety and Performance Committee

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY (Q2) ACTIONS FOR 2024 / 2025

Date of meeting	**14TH NOVEMBER 2024**

PUBLIC OR PRIVATE REPORT	**Public**

IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**

REPORT PURPOSE	**INFORMATION / NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**

Prepared by	**Peter Gorin, Head of Strategic Planning and Performance**
PRESENTED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital**
APPROVED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2024/25** 1.1 This report provides an update (position as of 30th September 2024) of progress against the actions (July to September 2024) which were included within the IMTP for 2024/25 as at Quarter 2. 1.2 These updates are provided in the form of the monitoring templates for WBS, VCS and Trust-wide (See Appendix 1, Appendix 2 and Appendix 3). 1.3 Good progress has been made again against IMTP actions as at Quarter 2.

RECOMMENDATION / ACTIONS	**The Quality Safety Performance Committee is asked to:** • **NOTE the progress made in the delivery of the agreed IMTP (2024 – 2027) actions as at Quarter 2 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide services.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCS & WBS SLT / Performance Review	**20 October 2024**
Executive Management Board - Run	**29 October 2024**
Summary and outcome of previous governance discussions: The report has been considered and endorsed at: • Velindre Cancer Service Performance Review meeting • Welsh Blood Service Performance Review meeting • Executive Management Board No amendments were requested prior to submission to the Velindre University NHS Trust Quality, Safety and Performance Committee.	

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

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 at 24/10/24.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 at 24/10/24.**
3	**Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 2 at 24/10/24.**

ACRONYMS and INITIALISM	
IMTP	Integrated Medium Term Plan

IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2024/25-2026/27 was submitted to the Welsh Government on 28st March 2024. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 2 (July to September 2024), gave a relatively short time for a detailed assessment of progress against IMTP actions during early October to meet the EMB, QSP Committee and Trust Board reporting cycle.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q2 for WBS and Trust-wide. **VCS position to be updated.**

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2024/2	Velindre Cancer Services IMTP 2024/25	Trust-wide Initiatives IMTP 2024/25
BLUE	Action successfully completed with benefits being realized	**2 Q actions**	**1 Q Actions**	**1 Q actions (1 Digital)**
GREEN	Satisfactory progress being made against action in line with agreed timescale	**16 Q actions**	**16 Q actions**	**107 Q actions (24 Digital, 27 Workforce, 6 VBHC 22 Clinical, 14 Estates & 6 Sustainability, 8 Finance)**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place		**11 Q actions**	**11 Q actions (10 Digital, 1 VBHC)**
AMBER	Delays in implementation / action paused due to external issues beyond our control	**2 Q actions**	**1 Q actions**	**1 Q actions (1 Digital)**
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2024/25 Quarterly (Q) Actions		**20 Q actions**	**29 Q actions**	**120 Full Year Actions**

3.3 WBS are making satisfactory progress, categorized as '*blue* (16) *green (2) amber (2)*', against their 20 actions as at Q1, **see Appendix 1.**

The two WBS amber actions, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relate to:

- National Wales Laboratory Information System (WLIMS) 2.0 hyperlink to (page 12)
- Plasma for Medicines service model for Wales hyperlink to (page 19)

3.4 VCS are also making satisfactory progress, categorized as 'blue (1), *green (16) or yellow (11) and amber (1)* ', against their 29 actions as at Q1 **see Appendix 2.**

The one amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' is:

- Implementation of the approved Full Business case for the development of the new Velindre Cancer Centre (nVCC) (page 29)

3.5 There are 120 Trust-wide actions or 'themes' (Digital 36 (1 blue, 24 green, 10 yellow, 1 amber); Workforce & OD 27 (all green); Estates 14 (all green); Clinical & Safety 22 & Sustainability 6 (all green); VBHC 7 (6 green, 1 yellow) and Finance 8 (all green); Good progress is again being made against these actions as at Q1, **see Appendix 3.**

The one Digital amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relates to:

- Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre hyperlink to (page 50)

4. IMPACT ASSESSMENT

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

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Quality and Safety considerations form an integral part of the Trust PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

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APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2024/25 for Quarter 2 as at 30/09/2024.

IMTP Strategic Priorities Welsh Blood Services for 2024/2509								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2033 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2026/27. 	• Personalised donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision- making). • Increased levels of efficiency/ Productivity.	Introduce updated WBS brand toolkit. Continue to support Digital with development of refreshed booking portal.	Implement refreshed booking portal.	Begin introduction of a co-design forum for donors and advocates.	Begin introduction of a donor experience hub. Begin implementation of a Customer Relationship Management (CRM) System. Continue with introduction of a co-design forum for donors and advocates.	Work ongoing on refreshed booking portal, anticipated implementation w/c 04/11/2024.	
	Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model	• Sustained growth and retention of the stem cell donor panel. • Increase in stem cells supply.	Introduce Self-Administration of G-CSF as part of the modernisation of Clinical Services.	Continue to develop model for bone marrow collections in Wales. Review of clinical model	Review and develop of clinical model for apheresis collections. Continue to develop model	Implement identified and developed strategies for maintaining growth of the registry such as collecting 3rd party cellular	The development of model for bone marrow collection in Wales continues on plan. Review of the clinical model for apheresis	

IMTP Strategic Priorities Welsh Blood Services for 2024/2509								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	and its ambition by 2026/27. WBS Futures	• Increased diversity in the donor panel. • Improved resilience in stem cell supplies. • Improved clinical outcomes nationally • / inter nationally. • Increased income levels.	Develop model for bone marrow collections in Wales. Investigate digital replacement solution for WBMDR software.	for apheresis collections. Implement JACIE Accreditation for stem cell collection services. Develop model for stem cell donor medicals. Continue to develop URS and engage with digital suppliers to replace current WBMDR Software	for stem cell donor medicals. Produce and process tender to replace current WBMDR software	products or ATMP starting materials. Follow tender process to replace current WBMDR Software.	collections continues on plan. JACIE accreditation in support of current and expanding stem cell collections is in progress with a very successful inspection report returned. Identified actions are being implemented where required. Donor self-administration of drug to support collection of stem cells now fully implemented in the WBMDR operating model. Digital solution scoping is ongoing. User Requirements Specification (URS) completed and formal tender process to commence shortly.	

IMTP Strategic Priorities Welsh Blood Services for 2024/2509								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
SP2: To provide a world class donor experience **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) WBS Futures	• Right size/shape donor panel/s. • Increased resilience for supply of products across Wales. • Improved levels of efficiency / productivity • Reduced importation and costs. • Increased brand awareness and reach. • Wider population/donor education. • Development of rich data to improved insights and	Re-submit new donor and advocate strategy for approval.	Begin to develop recommendations for systems, processes and people required to deliver the strategy.	Complete recommendations paper for systems, processes and people required to deliver the strategy		Strategy approved. Procurement of software for the Donor Contact Centre to improve donor experience is ongoing to support delivery of the strategy.	

IMTP Strategic Priorities Welsh Blood Services for 2024/2509								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)**	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 	• Improved clinical outcomes for patients post operatively. • Reduced length of stay post-surgery. • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes. • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance. • Improved efficiency. • Cost efficiencies.	Evidence of compliance with Health Board action plans issued in July 2023.	Dataflow for treatment data established. Incorporate costing data into Dashboard development.	Health Board Benchmarking to be incorporated into treatment data to evidence compliance with NICE QS138.	Current funding stream ends 31/12/24.	Recurrent funding confirmed via Value in Health (previously Value Based Health Care). Recruitment into substantive roles in progress. Gap analysis indicates improved implementation of the NHS Wales Preoperative anaemia pathway. Ongoing improvement in screening for cause of anaemia. Escalation to Welsh Government Infected Blood Inquiry (IBI) Oversight Group relating to the need to access transfusion data. Working Group established with	

IMTP Strategic Priorities Welsh Blood Services for 2024/2509								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							Digital Health and Care Wales (DHCW).	
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2025/26. WBS Futures	• Increased • /Sustainable collection model. • Improved access for service users. • Improved collection efficiency. • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry.	Complete implementation of tours for North Wales teams.	Begin to develop options for introduction of a new fixed donation venue/s. Begin review of existing blood donation venues.	Continue to develop options for introduction of a new fixed donation venue/s. Continue to explore options for introduction of a new fixed donation venue/s. Continue review of existing blood donation venues.	Continue to develop options for introduction of a new fixed donation venue/s. Continue review of existing blood donation venues.	North Wales tours commenced in March 2025. Scoping for further venues in areas where availability is limited is underway.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Introduce clinically led collection team model by 2024/25. WBS Futures	• Improved leadership capability. • Standardization of terms and conditions across collection teams. • Improved quality. Improved safety. • Reduction in staff turnover. • Improved collection efficiency.	Continue to undertake a workforce review, to include roles and responsibilities.	Continue to undertake a workforce review, to include roles and responsibilities Develop new job descriptions.	Begin to implement workforce review in line with Organisational Change Policy (OCP).	Continue to implement workforce review in line with Organisational Change Policy (OCP).	Options Appraisal process has begun to review business needs and workforce requirements. First engagement session with staff groups has taken place, the second is planned for November 2025.	
	Develop and implement a platelet strategy by 2025/26. WBS Futures	• Improved levels of efficiency. • Improved alignment between capacity and demand. • Reduction in avoidable waste. • Reduce wastage.	Development and implementation of the validated Demand and Capacity tool. Implement new platelet pooling packs. Implement apheresis in	Continue development and Implementation of the validated Demand and Capacity tool. Continue with implementation of new platelet pooling	Development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet supply	Continue development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet	Demand and Capacity tool in final stages of development. Phase 1 trial for pooling packs completed with trial report in draft. Trial on optimum PAS/Plasma ratio complete.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			Platelet Additive Solution (PAS).	packs. Implement apheresis in PAS. Research and development of new components.	including substitutions. Research and development of new components.	supply including substitutions. Research and development of new components.	Implementation timescales to be discussed and prioritized in platelet strategy group	
	To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS Futures through the National system by 2025/26.	• Modernize patient management software with robust digital support. • Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation.	Commence deployment.	Two months delay on UAT testing proposed by DHCW. Revised timeline options shared with Health Boards. Delivery timescales and Health Board deployment order may change – pending decision on best option to take forward.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Implementation of Welsh Histocompatibility and Immunogenetics Service IT system (WHAIS IT) by 2025/26. WBS Futures	• Improved availability of information. • Increased efficiency • / Productivity. • Improved patient experience. • Reduced turnaround times. • Reduction in avoidable waste	Completion of discovery phase. Commence Implementation. Commence Data Migration.	Commence Environments set-up.	Complete implementation n. Complete Environments set-up.		Data migration environment built and migration activities have begun. Configuration of system ongoing External system interfacing development started.	
	Procure new Blood Establishment WBS Futures contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	New contract procurement commences – Competitive Dialogue. Recruitment of SMEs. Analyse Semester patch feasibility. Analyse and test Maintenance Patch.	New Contract Procurement Business Analysis – ways of working/service mapping. Implement Maintenance patch. Continue analysis of	New Contract Procurement. Business Analysis – ways of working/service mapping. Analysis of Semester patch if required.	New Contract Procurement ends. Continue analysis and testing of Semester patch. Implement Delta Release.	System specification complete. Invitation To Tender (ITT) issued. Current supplier decision to remove option of semester patch within remaining contract term. Funding confirmed by Welsh Government for	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			Virtualisation of existing infrastructure.	Semester patch. Continue virtualization of existing infrastructure.	Prepare new hardware. Plan and prepare Delta Release.		2024/25 procurement activity. Funding arrangement for implementation and business as usual costs yet to be agreed.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales. • Compliance with SaBTO recommendations.	Submit data required for review by SaBTO.	Review updated recommendation from SaBTO and agree an organizational response.	Implement any changes in practice recommended by SaBTO.	Implement any changes in practice recommended by SaBTO.	Data is being submitted to SaBTO as required. SaBTO have not changed or updated their recommendations.	
	Establish a quality assurance modernisation	• Maintain compliance with regulatory	Complete process reviews and system configuration for	System validation for new eQMS to be	Development of Medical Devices Regulations	Development of Medical Devices Regulations	eQMS system validation paused due to identified issues being	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26	standards. • Improved quality. • Improved safety. • Improved donor experience.	new eQMS. System validation for new eQMS to commence. Implement DocuSign Enterprise solution (including staff education / Support).	completed. Staff training for new eQMS to be completed. Embed DocuSign Enterprise solution across all WBS. ISO:15189 – gap analysis to be completed and submitted to UKAS.	(MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	(MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	addressed with system provider. Validation expected to recommence in November and staff trained in December following system validation DocuSign "Enterprise Edition" is being withdrawn as 'Single Sign On' cannot be implemented. Alternative platform (eSign) has been identified and expected 'go live' December 2024 ISO: 15189 gap analysis completed and transition to 2022 standard	
	Implementation of Foetal DNA typing by 2024/25.	• Reduction in avoidable administration of anti-D	Undertake digital developments to support reporting of results.	Implement all Wales service for Cell Free	Embed service.		Completed – service went live in May 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	WBS Futures	immunoglobulin to pregnant women. • Improved safety. • Improved patient experience. • Reduction in avoidable waste/costs.	Complete validation and implementation of new test.	Foetal DNA screening.				
	Implement new digital solution for National External Quality Assessment Service (NEQAS) by 2024/25. WBS Futures	• Digital solution will increase free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand customer base. • Flexibility to develop and change the service.	Begin validation of new NEQAS system.	Continue validation of new NEQAS system.	Complete validation of new NEQAS system.	Go live with new NEQAS system. Close project.	Options appraisal is ongoing. Implementation anticipated to start late 2024 /early 2025.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Capacity to expand service provision. • Improved sustainability as system doesn't rely on paper records. • Complete digital audit trails. • Removal of potential errors caused by manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	Review and Develop strategy for Nucleic Acid Testing (NAT) by 2025/26.	• Robust Service Provision • Enable income generation.	Develop User Requirement Specification. Identify preferred service model.	Continue procurement of new NAT analyzers.	Continue procurement of new NAT analyzers.	Commence validation and implementation of NAT testing platform.	Tender is due to go live by the end of October 2024. Procurement timelines agreed in	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	WBS Futures	• Service Development.	Procurement process.				collaboration with SNBTS and NIBTS	
	Introduction of West Nile Virus (WNV) Testing. WBS Futures	• Ensure minimal impact on the Blood Supply chain due to the projected increase in deferrals with the spread of WNV in Europe • Ability to maintain WBS blood supply chain • Decrease in requirement for importation of blood products to meet demand	eProgesa development work to create test codes and trigger requirement for WNV testing. Develop clinical algorithm. Validate Roche platform for WNV testing. Implement WNV testing.				Completed – service went live in May 2024.	
	Assess and implement the recommendations of the	• Learning from the findings of the inquiry and optimizing the safety of blood	Attend the launch of the report, review the recommendation	Commence implementation of the action plan and populate			WBS informing and supporting national discussions (WG Next Steps Group, Digital Solutions	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Infected Blood Inquiry (IBI).	components as recommended. • Maintained compliance.	s and draft an action plan	the predicted timescales for actions for the IMTP 2024-27.			Sub Group, UK Forum etc.) as required.	
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. WBS Futures *(Quality Priority: Introduce leucodepletion filters, Hepatitis A and Parvo B19 testing)*	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation. • Cost • Avoidance/reduction. • Avoids patient rationing.	Complete validation of leucocyte filtration (NQT) blood packs. Continue procurement of Hepatitis A and Parvo b19 testing.	Scope clinical pathway for Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG governance arrangements are clear. Develop robust shipping documentation for fractionator.	Commence validation and digital implementation of Hepatitis A and Parvo B19 testing.	The wider Plasma for Medicines programme is on hold awaiting a policy decision and funding from the Welsh Government. Interim CEO, VUNHST has written to Judith Paget, Director General, Health and Social Services. Procurement of a new NAT testing platform is ongoing, ensuring funding delays do not impact the critical path. Validation of leucocyte filtration	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							packs commenced in August 2024 and on track to complete by 31/12/24. Letter	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. WBS Futures	• Improved • Donor satisfaction. • Improved staff well- being. • Increased service resilience. • Reduction in energy consumption and utilization. • Reduction in carbon emissions. • Compliance with statutory requirements. • Improved efficiency, reduction in waste and carbon emissions.	Development of Outline Business Case.	Outline Business Case completed & internal approval process commences.	Trust Board approval and submission of Outline Business Case to Welsh Government.	Welsh Government review of Outline Business Case.	Welsh Government (WG) approached to consider combined OBC/FBC. Costs submitted to Welsh Government, awaiting confirmation from Cabinet Secretary.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
SP7 Develop great people and a great place to work **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)** 	Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	• Enhanced workforce capacity & capability to meet need. • Enhanced Leadership capacity & capability. • Improved staff satisfaction. • Improved staff well- being. • Improved service quality, safety and donor satisfaction.	Support Collection Teams workforce review. Commence review of workforce planning across WBS. Plan and deliver training / team development sessions with new Senior Leadership Team (SLT).	Support Collections Teams workforce review. Continue review of workforce planning across WBS.	Support implementation of Collections Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Support implementation of Collections Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Welsh Partnership Forum support for Recruitment and Retention Premia extension to June 2025 freeing time for workforce model introduction, consultation and implementation. Engagement sessions are underway with staff groups to consider suitable service models. Formal engagement to begin in early 2025. SLT team development sessions planned to take place in December 2024 and into 2025.	

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KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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Velindre University NHS Trust

APPENDIX 2

Velindre Cancer Service - IMTP Quarterly Progress Report 2024/25 for Quarter 2 as at 30/09/2024

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction •	Complete development of service specification and Service Level Agreement (SLA). Develop workforce plan.	• Initiate deployment of new workforce plan. Define model for delivery of outreach activity.	Define and implement necessary digital infrastructure to enable effective and efficient operation of the new Satellite Unit.	Develop and deploy plan for operational handover following successful completion of the construction phase.	• Multiple clinical pathway meetings undertaken throughout August and September to confirm patient pathways and unwell patient. • Joint finance working group established to finalise costings based on revised service specification.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							• VCC working group established to complete and agree SLA. • Completion date under review by ABHB and Construction Team.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care • • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials	Second new linear accelerator commissioned and in clinical use. Assess implications of commissioning fourth new linear accelerator to enter service on	•Implementation of InSightive radiotherapy analytics tool. • Develop capital equipment procurement contingency plan to determine options to enable the	Third new linear accelerator and associated infrastructure commissioned and made available for clinical use.		• Third linear accelerator clinically commissioned and in use treating patients at VCC. • Capacity and phasing workstream assessing	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	the current Velindre site and consider alternative options to maintain service provision. Develop contingency plans to ensure maintenance of treatment capacity in the event of catastrophic machine breakdown.	timely replacement of equipment in the event of failure, etc. before the opening of nVCC site. Develop plan to support transition of brachytherapy service to nVCC site.			capacity and planning fully underway to deliver phase 2 of the programme – 2 linear accelerators into SRU. • Working to go live of paperless system to support and realize efficiencies and benefits of the programme.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025-26**	• Increase care close to home. • Improved access. • Improved equity. • Improved patient experience.	Engage` with health boards, agree intention and principles. Establish programme board.	Define model for delivery of care on outreach contexts.		Develop workforce model.	• Scoping workshop held in August. Key outputs of meeting included:	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
		• Reduction in carbon emissions.					o Clarity on scope o Identification of key stakeholders o Early engagement with patients o Continued engagement with all local health boards • Project Initiation Document shared with health boards – awaiting feedback. • Key workstreams identified.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							Further meeting with health board's representatives scheduled for early October.	
Trust Strategic Goals 1, 2 3 and 4	**Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Work with regional stakeholders to support design and delivery of radio pharmacy delivery model. Review governance structure in the context of interim requirements and contingency planning pending delivery of TrAMs model. Secure interim support pending delivery of TrAMs. Identify resource to support	Develop and assess possible delivery models which will ensure the sustainable delivery of pharmacy services prior to the full implementation of the TrAMs model.	Identify funding stream to support the expansion of pharmacy services in anticipation of future TrAMs dependent requirements.		• Timelines for the TrAMS SE Wales Hub OBC and FBC have been revised to take account of the pace of progress in agreeing revenue funding characteristics. Current submission of • Focus is now on the preparation of the SE Wales Hub OBC,	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			clinical and scientific infrastructure for national programme.				where VCC are working on baseline and ambitious workforce models. Clinical readiness project activities are progressing on the VCC centralized clinical verification process and Meds at home direct model. • Review of internal job descriptions. In line with the National review. OCP 2 will not	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							commence until an investment decision has been made.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions. • Improved patient experience. • Reduction in carbon footprint.	Regional service coordinator recruited and in post. Project board re-established and revised governance structure defined. Undertake benchmarking exercise to facilitate assessment of similar delivery models. Undertake baseline review of current position and activity relative to the Acute	Develop proposal for OS network structure and implementation.	• Develop work plan to enable delivery of remaining project objectives aligned to Wales Cancer Network service specification. AOS network board and supporting infrastructure in place. Data sharing agreements and memoranda of understanding (MOUs) in place.	• Undertake review of data requirements. Undertake review of existing policies and standard operating procedures (SOPs). Develop shared policies and SOPs, where appropriate.	• Acute Oncology project group re-established following successful appointment of new Network manager. First meeting of group held in September 2024.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			Oncology project model. Undertake review of service implementation within VCS. Identify funding stream to support on-going delivery of the service at VCS.					
Trust Strategic Goals 1, 2 and 5	**Implementation of ePMA for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	Procure system following approval of Full Business Case (FBC) by Welsh Government. Undertake recruitment to externally funded posts required to support implementation.	Commence system implementation following approval of FBC and subsequent award of contract.	Continue implementation of system.		• Preferred bidder confirmed. • Welsh Government review of Full Business Case (FBC) complete and FBC approved (July 2024).	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							Plans for local implementation progressing.	
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision- making. • Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels. • Improved patient satisfaction.		• Implement new system and undertake testing. • Undertake data migration to the new system. Develop and deploy training package to facilitate maximize with new system.	Full implementation of electronic test requesting.		• Supporting national discussions, as required. • Go-live date now set for June 2025. • Local implementation planning progressing satisfactorily.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the Approved Full Business case for the Development of the New**	• Improved quality. • Improved patient safety. • Improved patient dignity and experience.	Develop transition plans for all services. Develop and deploy plans to maintain capacity	Develop plans to support the transition to the nVCC site and for dual-site running for all clinical and			• Working groups and structure established to enable the development of transition plans for all services.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Velindre Cancer (nVCC)	• Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being. • Reduction in carbon emissions • .Reduced staff sickness. •	during commissioning of replacement linear accelerators and other capital equipment. Undertake digital enablement work - scoping / business analysis of new systems and ways of working, e.g. patient self-check-in / patient flow, hybrid mail solution and call centre.	operational services.			• Plans to mitigate capacity loss for Radiotherapy have been developed as part of the IRS programme implementation this is fully engaged with nVCC programme board. • Digital scoping has commenced.	
Trust Strategic Goals 1, 2 and 4	**Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes**	• Improved quality of care. • Reduction in avoidable admissions. • Improved patient experience.	Identify scope of palliative radiotherapy within VCS and as part of a regional model.	• Identify opportunities for workforce redesign and develop associated workforce plan.				

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
				Identify possible funding options.				
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables**	• Improved quality. • Improved patient safety. • Reduction in cancelled treatments. • Improved patient health and well-being. • Improved clinical outcomes. • Improved patient experience.	Continue engagement with Prehab to Rehab south- east Wales collaborative and WCN national prehabilitation group. Review funding streams and commissioning models to facilitate prehabilitation service development	Develop and deploy local implementation and improvement plan.			• An internal prehabilitation project board and working group have been set up. • Phase 1 has completed scoping of prehabilitation services at VCC, understanding of prehabilitation amongst staff, bench-marking and the development of a VCC prehabilitation webpage.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							• Participation in national prehabilitation groups ongoing.	
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels. • Reduction in avoidable admissions. • Improved patient satisfaction.	Identify and secure consistent funding to support service delivery. Develop business case.				• Working group established to identify financial means to support on-going delivery of the immunotherapy toxicity service. • Engagement with commissioning health boards on the future financing of immunotherapy toxicity services commenced.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Trust Strategic Goals 1 and 2	**Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy**	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	Develop business cases to secure funding to support nursing workforce innovations and developments.	•Implementation of recommendation of Cancer Nurse Specialist (CNS) review. Undertake evaluation of the CNS Navigator role and implement recommendation Introduce Advanced Clinical Practitioner	• Develop Practice Educator role to facilitate person centered care. Define and implement Model for Clinical Supervision (CNO Mandate).	Evaluate requirement for nursing support in radiotherapy.	• Business case in development. • CNS review progressing satisfactorily.	
	Ensure the Viability of the Neuro-Oncology Service	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction.	Develop business case and secure funding to maintain service.				Development of business case progressing satisfactorily.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Reduction in avoidable admissions.						
Trust Strategic Goals 1, 2, 4 and 5	**Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping). Define Recommendati on ons, Develop and Deliver Improvement Plan**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved levels of efficiency and productivity. • Reduced costs. • Improved patient experience.	Service delivery manager recruited and in post.	Baseline assessment complete of SACT service. Service delivery plan developed. Undertake review of booking processes and identify nature and level of Business Intelligence support required to minimize clinical risk.	Alignment of SACT booking processes with wider booking processes. Complete SACT demand profiling exercise		• Work being undertaken as part of the initiation of SACT Gold. • Transition to a BAU group of which this will continue to drive and deliver improvement plans. • Business intelligence developing automation to support the clinical prioritization process and reduce harm.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Trust Strategic Goals 1 and 2	**Implement Recommendations from Peer Review of SACT Treatment Helpline**	• Improved quality. • Improved patient safety. • Improved access. • Improved clinical outcomes. • Reduced waiting times. • Improved patient experience.	Receive and prepare response to peer review and determine plan for implementation (further details to be developed following the receipt of the review).				• Improvement plan developed and being deployed.	
Trust Strategic Goals 1, 2 and 5	**Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics**	• Provision of care at home/close to home. • Reduced patient needs to travel. • Increased patient experience / satisfaction.	Development of costed business case to support service expansion. Identify appropriate funding stream to support provision in the longer term.	Deployment of service expansion plan subject to ability to secure funding.	Establish means of service monitoring following deployment of the service expansion plan.	Undertake a review of the service to inform determination of future service delivery model.	• Expansion case has been approved. • Work is underway to mobilize this with longer term funding models being developed.	
Trust Strategic Goals 2 and 4	**Implement New Molecular Radiotherapy Treatments at VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Progress the phased implementation of new Peptide Receptor Radionuclide Therapy (PRRT)	Actively engage All- Wales Molecular Radiotherapy Advisory Group (AWMOL) on development of	Develop plan to increase Molecular Radiotherapy clinical trial participation to		• VCC formally recognised by the Joint Commissioning Committee (JCC) as a	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being. • Enhanced organizational reputation for quality of service.	service from quarter 1 (dependent upon WHSSC undertaking to commission service and availability of discretionary capital to facilitate procurement of equipment). Undertake recruitment of new PRRT service. Additional workforce to support full implementation	all-Wales strategy for Molecular radiotherapy.	expand capacity and capability.		preferred provider of PRRT. • Working group established to develop and implement plan for delivery of PRRT at VCC. • Anticipated that first patient will begin treatment during quarter 4 2024-25.	
Trust Strategic Goals 2, 4 and 5	**Review the Radiation Protection Service Resource to Enable Dynamic Response to National,**	• Improved quality.		Development of resource requirement plan for design and construction and implementation at nVCC.	Undertake service development options appraisal exercise.	Identify appropriate funding stream to support sustainable. Long-term service delivery.	nVCC-related resource requirement plans in development.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources							
	Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop and deploy operational delivery plan for pharmacy which responds to previously undertaken external service reviews.	Complete development of new strategy for the pharmacy service.			Development of plans has begun in-line with outputs of previous reviews and current service demands.	
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Establish project group to direct local implementation	• Complete worksheets and labels upgrade.	Complete operational implementation of upgrade.		• Project group established and plans in development to	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	and Introduce the System for Use by Velindre Cancer Services		of upgraded system. Actively engage with all- Wales procurement of upgrade.	• Undertake testing of new upgrade. Develop and deploy staff training plan.			support upgrade. • Regional engagement in place.	
Trust Strategic Goals 1, 3 and 4	**Develop and Implement Model for Clinical Leadership and Supporting Governance Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop new divisional clinical governance structure. Establish revised Site- Specific Team (SST) governance structure. Appoint new SST lead and new deputy Clinical Director.	•Implementation of clinical decision-making framework to support wider service delivery. Embed clinical and scientific strategy.	Site-Specific Team (SST) activity and performance dashboard.		• Prospective new SST governance structure in development. Senior Leadership Team to consider and agree changes autumn 2024. • Linked in with wider organization prioritization processes for a fully aligned approach.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Trust Strategic Goals 1 and 3	**Design, Commission and Deploy Revised Patient Transport Model**	• Improved patient experience. • Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes.	Develop revised service model to include effective transport of patients undergoing emergency radiotherapy treatments.	Develop business case.	Identify funding and commission revised service.		• Bilateral operational group involving Welsh Ambulance Service Trust WAST) colleagues working to address immediate issues. • Engagement with WAST on service redesign and future provision for the Radiotherapy Satellite Unit and nVCC sites.	
Trust Strategic Goals 1, 2 and 4	**Implement Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access.	Develop and deploy plan to improve capacity and flow in the Outpatients department.	• Identify services which might be repatriated to local	• Develop options for amalgamation of booking teams across VCS.	Implement 'Hospital 2 hospital' system to support standardisatio	• Initial service improvement led work has commenced which will inform a wider	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved clinical outcomes. • Improved patient experience.	Develop implementation plan for replacement video consultation solution. Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.	health board contexts. • Introduce interim process for managing electronic referrals. Introduce revised appointment booking Standard Operating Procedures (SOPs). • Introduce revised telephone standards (to include appropriate consideration of the Welsh language) and system across VCC. • Identify opportunities	Complete full roll-out of new video consultation system.	n of patient referral processes and to promote efficiencies.	Outpatients strategic review. • Work has commenced in terms of scoping services that can be repatriated in order to otimise treatment capacity and align with patient feedback.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
				to improve access to Welsh language training for patient-facing staff. Deploy training plan for clinicians and administrative staff to support introduction of replacement video consultation solution.				
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision- making) • Improved levels of efficiency/productivity • Reduced carbon emissions					• Scoping due to commence in Q3. • Welsh Government request for separate business case to address 'digitisation'	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							costs, outside of nVCC FBC.	
Trust Strategic Goals 1, 2, 3 and 4	**Implementation of New Services / Delivery Models**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention • Improved staff well-being. • Enhanced organisational reputation for quality of service.	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments. Implement interim model for delivery of palliative radiotherapy				• Pharmacy horizon scanning group established. • New model for prioritisation developed. Engagement with Senior Leadership Team and Site-Specific Team Leads undertaken during September 2024 prior to full implementation . • Proposal for new service development	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							group developed. Proposal to be finalised and agreed by Senior Leadership Team and Site Specific Team leads prior to full implementation (November 2024).	
Trust Strategic Goals 1 and 2	**Implement DHCR Phase 2 by 2024/25**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Review learning from phase 1 to support implementation of further phases. Establish revised governance, reporting and delivery structure for VCS Agreed scope and prioritisation of VCS-specific	Clarify scope and service delivery requirements.	Develop work plan to support implementation.		• DH&CR Phase 1 closed (July 2024). • Scoping / prioritization of phase 2 requirements underway. • Phase 2 governance yet to be agreed.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			elements for phase 2.					
Trust Strategic Goal 1	**Implementation of Consolidated Document Management System Across VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Identify priority areas / services for introduction of new system. Commence deployment of implementation plan.				• Project working group established. • Implementation plan developed. • Project oversight board to be established.	
Trust Strategic Goal 1	**Respond to Low / Limited Audit Assurance Findings**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Develop and deploy remedial action plan to address recommendation of CCTV audit Develop and deploy remedial action plan to address recommendatio n of e-mail audit.				All audits described have established task and finish groups, senior leadership sponsor, a timeline for improvement. Recommendations are being developed in all cases which will be embedded in and	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			Develop and deploy remedial action plan to address recommendation of medical records storage incident..				improve business as usual practice.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation**	• Creation and sharing of knowledge across Wales/wider to improved cancer care. • Development of network of partners to tackle key issues. • Creation of knowledge economy and innovation across Wales. • Physical space to support innovation and development working across the					Established project team in place to map out plans and timescales to achieve key benefits.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
		region/Wales/wider.						

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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APPENDIX 3

Trust-wide Initiatives - IMTP Progress Report 2024/25 for Quarter 2 as at 30/09/2024

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Digital Initiatives **Trust Strategic Goals 1, 2, 5** **Digital Strategy: Ensuring our Foundations**	Trust-Wide Telephony including Call Centre Solution	• Improve telephony resilience • New call Centre capability to support improved services for VCS / WBS	Scope	Procure	• Build UAT	• Validate Go-Live	Work due to commence in Q3 / Q4 – delayed awaiting appointment of Business Analysis and Project Management resources. PIN / informal supplier engagement to be scoped for Q3 2024/25.	
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organisation**	"Agile" Delivery Squads introduced to Digital target operating model	• Improved delivery of value-adding Digital services • Improved time to value for Digital services • Digital staff attraction and retention	Discovery	• Pilot – Microsoft 365 • Pilot – Digital Inclusion	• Pilot – Microsoft 365 • Pilot – Digital Inclusion		Work yet to commence due to competing priorities / capacity.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Alignment with industry best-practice						
Trust Strategic Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	Digitally enable Value-Based Healthcare through digital services for the Value Intelligence Centre	• Enable the benefits for the Trust Value Based Healthcare programme	• Data driven sense making • Data Maturity Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity Technical development of SST Dashboards	• Data driven sense making • Data Maturity • Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity • Technical developme nt of SST Dashboard s		
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare	• Digital system in place for capturing PROMS from patients • Improved efficiency over current PROMS collection methods		Business Case	• Procure	• Build of PROMS • Go-live	Supplier confirmed, aim to deliver initial PROMS measures across 3 SST areas (Neurology, Lung and Prostate) in Q4 2024/25.	
Trust Strategic Goals 1, 2	Robotic Process Automation (RPA)	• Reduced burden of administrative tasks	• Establishme nt of PoCs / pilots for non-clinical	Commence set up of RPA service.	• Establish RPA service (non-clinical	• Transfer to BAU	Permanent funding confirmed to establish service	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Digital Strategy: Digital Organization		• Efficiency and effectiveness of processes			workflows only). • Clinical coding pilot		and move forward with PoCs. Procurement of commercial RPA platform due to be completed in Q3/Q4 2024/25.. Microsoft PowerAutomate already being used to support various use cases.	
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Inclusion**	Digital Inclusion Plan	Digitally connect our donors, patients, and carers and staff to our services 24/7 Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and	• Digital Inclusion Charter Accreditation Digital Inclusion Plan Q1 Delivery	Digital Inclusion Plan Q1 Delivery	• Digital Inclusion Plan Q3 Delivery	• Digital Inclusion Plan Q4 Delivery	Digital Inclusion plan approved via Trust Board in Q1 2024/25. Process to achieve accreditation underway.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		support they require. Deliver the technology which supports the provision of more services at home and as locally as possible. Provide our staff with the technology to work from a wide range of locations across Wales. • Reduce digital exclusion of people across Wales.						
Trust Strategic Goals 1, 2, 5 **Digital Strategy: Safe and Secure Systems**	New Trust-Wide Network	• Improved network resilience & capacity • New network services available (e.g. location tracking) to support new	Complete design	Commission central network components	• Radiotherapy Satellite Unit on new network		Design completed. Technical 'lab' created in WBS to support upskilling of Digital Services team. First deployment in RSC underway. New HPE Aruba network will be	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		services for users • Decreased costs for network equipment					rolled out across other service areas after RSC.	
Trust Strategic Goals 1, 2, 5 **Digital Strategy: Ensuring our Foundations**	IT Service Management (ITSM) Tool - Halo	• Improved efficiency of ITIL processes • Improved visibility of IT Assets for Cyber and Information Governance • Compliance with best practice approaches for ITSM	• Build of core ITIL processes UAT	• Validate	• Transition • Go-Live		Completed – HaloITSM service deployed October 2024.	
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach –	• Improved resilience • Reduced number of Cyber security incidents • Staff are more confident dealing with Cyber threats					Bi-monthly phishing campaigns now established. Annual update to Cyber Security Strategic Plan agreed via QSP Committee in June 2024.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Cyber Security Strategic Development Plan (CSSDP)							
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Server refresh/virtualization and refresh backup/storage	• Reduction in legacy technology in use • Improved infrastructure resilience • Simpler infrastructure changes to support new services	Scope Server refresh/virtualization	• Procurement Server refresh/virtualization Scope Backup/Storage	• Build / UAT / go-live Server refresh/virtualization • Procurement Backup/Storage	• Build / UAT / go-live Backup/Storage	Work ongoing.	
Trust Strategic Goals 1, 2, 4 **Digital Strategy: Digital Organization**	Introduce new Digital Training Platform	• Improved efficiency of training to colleagues • Enablement of the Trust Digital Inclusion Plan	Go-live for digital training platform	Transfer to Business as Usual			LMS 365 deployed – work ongoing to scale / adopt.	
Trust Strategic Goals 1, 2	Windows 10 to Windows 11 migration and common	• Improved Cyber Security • Simplified management of devices	• Win 11 Build Single Sign-On	Win 11 Transition plan	• Win 11 Go-live		Migration of users to Win11 underway – due to complete in Q4 2024/25.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Digital Strategy: Safe and Secure Systems	user/device experience							
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organization**	Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre	• Improved digital capabilities to manage fundraising donors/WBS donors • Digitally enabled service plans	• Funding raising scope WBS Donor scope	• Funding raising Procurement • Fundraising Build	• Funding raising Go-Live		Procurement of CRM service for Velindre Fundraising underway, for deployment in Q3/Q4 2024/25. Deployment to inform CRM options for other areas of the Trust (e.g. patient engagement).	
Trust Strategic Goals 1, 2 **Digital Strategy: Insight Driven**	Performance Management Framework (Quality Measures) dash board	• Improved efficiency in performance reporting • Automated processing of metrics • Improved data driven decision making	Phase 1 Measures available in PMF dashboard	Phase 2 Measure dashboard definition	• Phase 2 Build • Phase 2 go-live			
Trust Strategic	Transition to VXRails data	• Improved performance of	• LDR go-live	Transition from existing Data			VCC migration completed,	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	warehouse platform as the Local Data Repository (LDR)	Data and Insight jobs • Improved infrastructure resilience	Transition from existing Data Warehouse (VCC + WBS)	Warehouse (VCC + WBS)			planning underway to migrate WBS service.	
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	National Data Resource roadmap	• Whole system cancer pathway • Support service improvement re-design • Enable VBHC	• Local Data Repository to National Data Repository connectivity	• Velindre NDR Google Cloud Slice commission ed NDR Roadmap Agreed	• NDR Pilots • Integration of local and national datasets	• NDR Pilots • Integration of local and national datasets		
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	Trust wide Data and Insight plan	• Creation of a Trust wide service for Data and Insight • Improved business intelligence for decision making • Improved data quality	• Agree Plan for Data and Insight Service • WBS Priority Data and Insight Workplan VCS Priority Data and Insight Workplan	• Transition to Data and Insight Service • WBS Data and Insight Workplan in Place • WBS Data and Insight Workplan in Place	• Transition to Data and Insight Service • WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •	• WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •		
Trust Strategic	New Velindre Cancer Centre	• SMART hospital as set out in the	Recruitment of nVCC Digital team	• Scrutiny of ACORN	• Patient check	• Scrutiny of ACORN	Digital workstream of nVCC established –	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
Goals 1, 2, 3, 4, 5 **Digital Strategy: Ensuring our Foundations**	(nVCC) digital enablement	nVCC strategic case • Modern, secure digital infrastructure • Improved patient experience of digital • Improved colleague digital experience • Flexible Digital infrastructure to support service redesign		Digital systems • Design and Procurement of Trust Digital Systems	implementation into VCS • Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems	Digital systems • Design and Procurement of Trust Digital Systems	currently scoping ways of working, priorities etc. Initial engagement with VCC SLT undertaken, to explore approach / resources required for service design activity. Initial priorities to focus on patient flow / self check-in and patient comms	
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision-making. • Improved patient outcomes.		• Implement new system and undertake testing. • Undertake data migration to the new system. • Develop and deploy training package to	• Full implementation of electronic test requesting.		Supporting national discussions, as required. Work has commenced to enable local infrastructure deployment to support implementation. Revised go-live	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels. • Improved patient satisfaction.		facilitate maximize with new system.			timescales for VCC, following delay to national pre-implementation activities.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of the Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels	• Quadris Datacenters commissioned Upgraded Varian solution available to support service design	Integration of IRS into National Architecture	• Integration of IRS into National Architecture		Work ongoing to finalise integration requirements for phase 1 of IRS solution. Significant amount of scoping and development required. Delayed delivery of interfacing requirements, working with DHCW to resolve.	

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		• Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions						
Trust Strategic Goals 1, 2 and 5	**Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	• Procure system following approval of Full Business Case (FBC) by Welsh Government. • Undertake recruitment to externally funded posts required to support implementation.	• Commence system implementation following approval of FBC and subsequent award of contract.	• • Continue implementation of system.	• Continue implementation of system.	Preferred bidder confirmed. Implementation placed on hold pending confirmation of ongoing revenue funding for post-implementation system management. Implementation now anticipated to commence 2025/26 (TBC).	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of clinical service at**	• Increased patient access.	Scope and procure PSBA		• Define and implement necessary digital	• Digital Infrastructure build at RSU	Work progressing to plan.	

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	Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)	• Increase in uptake of radiotherapy. • Reduced patient travel times. • Improved clinical outcomes. • Improved equity of care regionally. • Increased patient satisfaction.	network connectivity		infrastructure to enable effective and efficient operation of the new Satellite Unit. • PSBA network connectivity in place			
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Establish project group to direct local implementation of upgraded system. • Actively engage with all-Wales procurement of upgrade.	• Complete worksheets and labels upgrade. • Undertake testing of new upgrade. • Develop and deploy staff training plan.	• Procurement for SACT ePrescribing completed		Approval obtained to establish new contract for current service until November 2027, to allow for additional time to undertake procurement to establish new, long-term (5+5) agreement for ChemoCare platform. Timeline for delivery of	

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							'worksheets & labels' upgrade yet to be confirmed	
Trust Strategic Goals 1, 2 and 4	**Upgrade Video Consultation platform to support Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes. • Improved patient experience. •	• Develop implementation plan for replacement video consultation solution. • Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.		• • Complete full roll-out of new video consultation system.		Contract for current AttendAnywhere platform extended. Scoping work to determine 'next steps' for VCC yet to commence.	
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision-making)			• Scoping	• Establish project group. • Identify service improvements / opportunities for change. • • Identify additional	Scoping due to commence in Q3. Options appraisal to be completed in Q3 2024/25, to determine approach.	

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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved levels of efficiency/productivity • Reduced carbon emissions				resource requirements	WG request for separate business case to cover 'digitisation' costs, outside of nVCC FBC.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions. • Improved patient experience. • Reduction in carbon footprint.	• support project board re-establishment • support baseline review, benchmarking, and VCS implementation		• Develop digital work plan to enable delivery of remaining project objectives. • • Data sharing agreements and memoranda of understanding (MOUs) in place.	• Undertake review of data requirements.		
Trust Strategic Goals 1 and 2	**Electronic Patient Record – Phase 2**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Scope Digital Health Care Record Phase 2 Requirements and investment case		• Support Cansic decommissioning	• Implement 'Hospital 2 hospital' system to support standardization of	Closure of DH&CR Phase 1 delayed, sign-off of 'lessons learned' report. Initial scoping / prioritization of	

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			• Cancer Informatics Programme – palliative care			patient referral processes and to promote efficiencie s.	phase 2 requirements completed – approach and delivery yet to be agreed with DHCW. Phase 2 governance yet to be agreed.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**VCS Service Changes – Other digital activities in support of the VCS plan**	• Improved patient safety. • Improved clinical outcomes.	• Agree PSA Tracker Phase 2	• Transfer RITA chatbot service into business as usual		• VCS Call Centre on new telephony platform		
	WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibilit y and Immunogenetics Service	• Improved availability of information. • Increased efficiency /productivity through improved patient experience. • Reduced turnaround times.	Completion of Discovery Phase. Commence Implementation. Commence Data Migration.	Commence Environments set-up.	Complete implementation. • Complete Environment s set-up.		Data migration environment built and migration activities have begun. Configuration of system ongoing External system interfacing	

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	(WHAIS) by 2025/26.	• Reduction in avoidable waste.					development started.	
Trust Strategic Goals 1 and 5	**WBMDR Digital**: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27.	• Increased stem cell donor panel. • Increase in stem cells supply. • Improved resilience in stem cell supplies. • Improved clinical outcomes in Wales / globally. • Increased income levels.	Investigate digital replacement solution for WBMDR software.	Continue to develop URS and engage with digital suppliers to replace current WBMDR software,	• Produce and process tender to replace current WBMDR software.	• Follow tender process to replace current WBMDR software.	Work ongoing to scope suitable solution. A first draft of the URS has been completed. The URS completion will allow us to move to a formal tender process.	
	BECS: Procure new Blood Establishment Computer System (BECS) contract and implement digital system.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	New contract procurement commences – Competitive Dialogue. Recruitment of SMEs. Analyze Semester patch feasibility.	New Contract Procurement. Business Analysis – ways of working/service mapping. Implement Maintenance patch.	New Contract Procurement. Business Analysis – ways of working/service mapping. Analysis of Semester patch if required.	New Contract Procurement ends. Continue analysis and testing of Semester patch. • Implement Delta Release.	System specification complete. Invitation To Tender (ITT) issued – evaluation due to commence in November 2024. Funding confirmed by Welsh Government for 2024/25	

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			Analyze and test Maintenance patch. Virtualization of existing infrastructure.	Continue analysis of Semester patch. Continue virtualizations of existing infrastructure.	Prepare new hardware. • Plan and prepare Delta Release.		procurement activity. Funding arrangement for implementation and business as usual costs yet to be agreed	
	NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS).	• Digital solution will free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand service provision. • Improved sustainability as system doesn't rely On paper records. • Complete digital audit trails. • Removal of potential errors caused by		Begin Validation of new NEQAS system.	• Continue Validation of new NEQAS system.	• Complete Validation of new NEQAS system.	Options appraisal is ongoing. Implementation anticipated to start late 2024 /early 2025.	

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		manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system.	• Modernize patient management software with robust digital support. • Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation. 1st deployment activity.		Two months delay on UAT testing proposed by DHCW. Revised timeline options shared with Health Boards. Delivery timescales and Health Board deployment order may change – pending decision on best option to take forward.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Plasma for Medicines**: Digitally enable the Plasma for Medicines programme	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation.	Support procurement of Hepatitis A and Parvo b19 testing.	Support the Scope of the clinical pathway for Hepatitis A and Parvo B19 testing.		Commence validation and digital implementation of Hepatitis		

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		• Cost avoidance/reduction. • Avoids patient rationing.				A and Parvo B19 testing. •		
Strategic Goals 1, 2	**Prometheus**: Migrate digital solution from DHCW once service support ceases as part of WLIMS 2.0 programme	• Continuity of the Prometheus messaging platform after LIMS 2.0	Scope service requirements	Procure new service arrangements	Build new hosting platform • Test new hosting platform	Validate new hosting arrangements • Transition and go-live	Supplier engagement commenced. Options appraisal of deployment approaches underway. Target Q3 2024/25 migration of service.	
	Foetal D: Digital enablement of Foetal DNA typing.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women. • Improved safety. • Improved patient experience. • Reduction in avoidable waste/costs.	Undertake digital developments to support reporting of results. Complete validation and implementation of new test.	Support the implementation of all Wales service for Cell Free Foetal DNA screening.	• Embed service.		Completed – service live.	

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Strategic Goals 1, 2	**Live Connectivity:** Introduce live connectivity for the blood collection teams	• Improved connectivity to systems	Pilot live connectivity system	Scale live connectivity system to all teams	•	•	Pilot in progress with Collections 'West' team. Procurement of cases to facilitate wider deployment across all Collection Teams due to be completed in Q3.	
Strategic Goals 1, 2	**Donor Interaction and Appointments**: Digitally enable improved donor interaction by 2026/27.	• Personalized donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision-making). • Increased levels of efficiency/ productivity.	Developmen t of refreshed booking portal.	Implement refreshed booking portal.		Begin introduction of a donor experience hub. Begin implementatio n of a Customer Relationship Management (CRM) System.		

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Workforce and Organizational Development **Strategic Goal 1** Outstanding for quality, safety and experience	**Theme 1: Wellbeing and Engagement** **Theme 2: Supply and Shape** **Theme 3: Skilled and Developed People** **Theme 4: Leadership and Succession Planning** **Theme 5: Digital Ready People** **Theme 6: Attracting and Retaining the Best Talent**	• Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement. • Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge • Develop a new Trust Strategic Equality Plan that supports the implementation of our Anti-	**Annual Actions continuous throughout 2024/25** **Planned and Sustained Workforce** ***Right people, right place, right time*** • Velindre University NHS Trust Workforce Action Plan approved by EMB. • Attraction and Resourcing Plan and Campaign approved • People and OD Policy Group underway. • Values and Behaviour Framework and embed into People Policy and Processes. • Development of Velindre University NHS Trust Industrial Action framework. • Careers page redesign ongoing. • Self-assessment to move from level 2 to level 3 disability employer completed. • NHS Staff Survey results 23-24 received and reported to Committees and Trust Board. • 3 Year implementation plan for the People Strategy shared with EMB and Divisional Leads. • Ongoing infrastructure of workforce planning training embedded via the Trust management and leadership Inspire Programme • Workforce planning and establishment control built into the Recruitment planning process through the new Recruitment Processes. **Skilled and Developed Workforce** ***Achieving Excellence through our staff*** • New People Development Policy completed and approved. • New PADR Policy completed and approved.				Actions completed in Q2 – on progress to achieve expected benefits	

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		Racist Action Plan and other aligned anti-discriminatory practices • Implementing an agile approach to working • Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce • Improving the ways we celebrate success ensuring our staff feel highly valued for the amazing work they do • Growing the Trust Inspire Leadership and Management Programme	• Initial launch of Fundamentals of Management Training. • Began development of Trust Training Plan with service leads. • Completion of all recommendations from the Education Strategy Audit. **Healthy and Engaged Workforce** • Dedicated wellbeing spaces launched. • Launch NHS Wales Health and Wellbeing Framework locally. • Engagement with HEIW on launching Staff Survey 2024-25 • Annual action plan to implement the Strategic Equality Plan developed and reported through Healthy and engaged steering group. • New Values and Behaviour Framework launched and evaluation beginning. **People Function Cultural Development – People and Relationships Model** 1. Develop an engagement plan for the function to support the engagement and alignment with service development. 2. Implementation of the holistic People and Relationships model 3. Engagement and Commitment from EMB Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback.					

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Clinical Quality and Safety **Strategic Goal 1** Outstanding for quality, safety and experience		•	**Annual Actions continuous throughout 2024/25** **Clinical Quality and safety Priorities:** 1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience. 2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice. 3. To Integrate Clinical Audit within VCS Quality and Safety function 4. Development of robust Site- Specific Quality Metrics 5. To improve incident and risk management. 6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System 7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service. 8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma- derived medicines. 9. Review and improvement of donor selection and screening processes					

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			10. Introduction of all Wales foetal D Screening for RhD negative pregnant women. 11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results. 12. Achieve JACIE accreditation for the WBMDR 13. Commencing rollout of live connectivity of the BECS at community-based donation clinics 14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact 15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.					
	The Quality Impact Assessment (QIA) focuses on Three Main Areas:	•	**Annual Actions continuous throughout 2024/25** • Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care. • Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. • Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care					

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	Strategic Equality Plan and Equality Impact Assessments (EQIA)	•	**Annual Actions continuous throughout 2024/25** • Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps • Objective 2: Engage with the community • Objective 3: Communicate with people in ways that meet their needs • Objective 4: Ensure service delivery reflects individual need					
Value Based Healthcare (VBHC)	**Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre** **Pre-op anaemia programme** This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10	Reduced post-operative LOS, Reduced demand for blood transfusions for surgery. Eliminating unwarranted variation through implementing a consistent approach to anaemia management across Wales, • Improved patient outcomes	Progress with WBS access to transfusion data Consultation on All Wales Preoperative Anaemia Pathway	All Wales Preoperative Anaemia Pathway guidance issued Promotion of programme aims through conferences, training and senior leadership fora.	Ongoing monitoring of Pre-op anaemia pathway adherence, continued provision of training. Initial preparation for widening scope of programme to allow earlier intervention for patients	Major Surgery dashboard revised to include costing information. Financial benefit of Programme to be costed	Recurrent funding secured to ensure sustainability of existing interventions and increase in spread of the programme to other pathways, including earlier intervention for surgical pathways, paediatrics and obstetrics. The engagement with the programme has increased with closer input from a key Health Board. Alignment with the Infected Blood Inquiry recommendations	

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	procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).						will add weight to data integration challenges that the team have faced.	
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre Training, Engagement and Communicatio n: Creating, sharing and delivering developmental content to staff.	• Increased engagement and confidence with the aims and principles of VBHC			Communication strategy created. Case study catalogue underway	Implementatio n of Communicatio n Plan including engagement sessions with Patients and Staff on the digital PROMS system	Creation of an internal web resource, ongoing development sessions with staff on the principles of VBHC and tools such as the SST dashboard. Funding provided for staff to attend Executive Level training by Swansea University.	

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	This includes generating case studies of value in action projects.							
	Value Intelligence Centre Technical Development: Ensuring that linked data sets (e.g. activity, outcomes, and use of resources) are accessible to services to inform decision making. This takes the form of information tools such as dashboards which will be iterated to meet service needs	• Accessible data for decision making for clinical services. • Provides the ability to compare treatments.	Development of SST dashboard in conjunction with VCS division	SST Dashboard Launched with demonstration sessions to support staff to engage with this tool.	Ongoing refinement of SST Dashboard and use of tool to understand variation within treatment algorithms.	Embedding usage	Ongoing refinement of the SST dashboard including addressing some coding issues. Sub group to agree future developments and monitor usage in place.	

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	Value Intelligence Centre Data Maturity: This theme focuses on ensuring that the accuracy and completeness of data within patient IT systems is sufficient to enable meaningful analytics. Working with service areas to identify and resolve the most common and critical issues.	• Improved accuracy of key patient pathway data, this improves patient safety, accuracy of income and analysis of activity	Data Quality issues relating to open pathways identified	Clinical requirement for comprehensive metastatic breast patient cohort identified and initial assessment of options undertaken	Data Quality Management Framework agreed	Focused Data Quality Management group in place for SACT	Resolution identified for a significant proportion of the open pathways within WPAS, enabling accurate reporting. Significant progress made in exploring options for reliably recording Breast patients as metastatic via a route that enables cohorting. This will be shared with the service for an agreed way forwards.	
	Digital PROMs Platform: To enable the systematic digital collection of patient reported outcome	Increased time spent on what matters to patients Enhances research and quality initiatives,		Business Case approved by Trust Board	Implementation of digital solution into 3 clinical areas	Ongoing implementation of system within VCS	Business case approved. Implementation Sub Group in place. Phase 1 confirmed and preparatory work underway.	

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	measures (PROMs) to capture and understand the quality of life and symptom burden that our patients experience.	driving innovation Supports a reduction in unwarranted variation • Improved patient engagement and treatment adherence					Awaiting contract sign off	
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Patient Outcomes:** We need to agree the questions to be asked. This ensures consistency across pathways and the ability to analyse aggregated data	• Consistent questions in place across Wales that meet the needs of patients and clinicians for each tumour site.	Approach for reaching consensus on a National PROM set agreed. Process initiated for Breast Cancer	Workshop held for Breast PROMS with initial set proposed as an outcome. Review of nationally agreed PROMS for “fit”.	Agreement reached for national set for Breast. Process initiated for CUP and Gynae	Support the creation of the national Breast Set (including timelines), Agree national set for CUP	National set for Breast Cancer due to be finalised on the 4/11/24. Changes proposed to the Prostate Set to ensure alignment with ICHOM. A set for CUP has been agreed within VUNHST. To be taken to the WCN for national agreement.	

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	to assess the benefits or the negative side-effects that treatments can have. These parameters are already agreed nationally for some cancer sites, e.g. Lung Cancer. The Value Intelligence Centre is working with our Clinical Teams, the Welsh Cancer Network, and the Welsh Value in Health Centre to agree validated PROMs tools (sets of questions to capture Patient Reported Outcome Measures) for							

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	different types of cancer							
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Food Mission:** Velindre's Food Mission sets a long-term ambition to provide our people with access to affordable, healthy food with an objective to source 70% of Velindre's food from Welsh, environmentally friendly or globally responsible providers by 2035.	• It is expected that this will improve the wellbeing of patients, donors, staff, and their families. Further, it will support the delivery of Velindre's wider Value Based Healthcare, Workforce and Sustainability Strategies, the Trust's Wellbeing Objectives, and its ambition to reach Net Zero by 2030. •	Food Mission approved by Trust Board	Preparation for Value Lab and the implementation of a staff veg box scheme. Collaboration with Menter Mon initiated	Value Lab held to create action plan Launch of Veg Box scheme	Implementation of Food Mission action plan, monitoring impact of changes.	Food Mission Value Lab postponed to the 28th November. Collaboration with Menter Mon ongoing.	

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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
The Estates Plan	**Theme 1: A safe and high quality estate which provides a great experience** **Theme 2: Healthy buildings and healthier people** **Theme 3: Minimizing our impact to the environment** **Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	**Annual Actions continuous throughout 2024/25** **Estates Actions** 1. Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs 2. Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces				1) Regular stakeholder operational meetings are being held to discuss and address operational needs. We are currently in the process of developing the scope of work to enhance the clinical facility requirements. 2) Our Arts in Health coordinator is delirvering projects to engage patients in creative activities, including a writing program for palliative care patients, bedside activities for those on the ward, and a creative support group at St Fagans. The events have been very well received and	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			3. Investing additional resources in the maintenance of the existing estate to maintain a Category B 4. Implementing our estates, digital, workforce and sustainability strategies 5. Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles				patients and staff are improving their well-being through artistic expression. 3) Condition survey review completed for the Trust Estate. Risk Assessment SBAR presented to SLT VCC October. WBS SLT November. Ongoing progress being made. 4) We are currently planning implementation meetings for the site improvement plans (SIP) to enhance and align with our sustainability strategies. 5) Following the travel survey was completed in Q1 to	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			6. Identifying innovative ways to adopt renewable energy sources to service our requirement 7. Identifying facilities we can share the use of with other public bodies and wider partners				identify trends and staff transportation modes. The results have been assessed and following which, comments and ideas generated from the work are being considered. 6) Further operational improvements are being implemented as part of the site optimization for Heating sources across VCC and WBS. This Quarter the team has focused on Radiotherapy with an audit taking place in November 2024. 7) Ongoing community events like the Sustainable Autumn Jamboree emphasise	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			8. Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets 9. Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services				sustainability and nature, offering staff, the community, patients, and their family's opportunities to engage in eco-friendly activities on site. 9) A comprehensive Arts in Health program is underway and funding. The program is offering creative writing courses, music on the wards, and staff choirs throughout the Trust. We are partnering with the Arts Council for Wales to further support these efforts, and the BBC Orchestra has already performed on the wards, with continued	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			10. Delivering a number of transformative capital programmes which have sustainability at their centre of design: 11. Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 12. Refurbishment / development of new outreach facilities by 2024/2025				collaboration at St Fagan's. 10) Ongoing progress being made with nVCC & TGI running through RDD and RIBA2 stages with good progress being made with sustainability being the main focus. 11) TGI Programme benefits meetings taken place, further progress to be made on the combined OBC - FBC to be made in Q3. 12) No progress has been made in this area. Q3 to reestablish update program.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			13. Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 14. Opening of the new Velindre Cancer Centre by 2027				13) Good progress made on SRU, delay has been noted as 8.4 weeks due to Asbestos discovered in undercroft of SRU. 14)Date to be changed to 2027	
The Sustainability Plan	**Theme 1: Creating Wider Value** **Theme 2: Sustainable Care Models** **Theme 3: Carbon Net Zero**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our	**Sustainability Actions** 15. Implementing our sustainability strategy 16. Applying the principles of the circular economy into our business	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Developing clinical service models which support sustainability • Implementing our sustainability strategy	Good progress being made against all actions	

	Theme 4: Sustainable Infrastructure **Theme 5: Transition to a Renewable Future** **Theme 6: Sustainable Use of Resources** **Theme 7: Connecting with Nature** **Theme 8: Greening our Travel and Transport** **Theme 9: Adapting to Climate Change** **Theme 10: Our people as**	patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	processes through design, procurement, re-use and lifecycle. 17. Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day').	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community	• Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			18. Continuous work on major capital projects including the TGI, RSU & nVCC. 19. Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport 20. Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities	to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Using our procureme nt activities and NHS Wales Shared Services capability to drive a sustainabl e approach and achieve wider ethical and		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy	as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy o	to maximise the reach of the Trust within the Government s Foundationa l economy o	social value in areas including local employme nt and prosperity; carbon reduction; anti-slavery and unethical practices. • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employme		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
						nt and apprentice ships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programm es); becoming an anchor institution in place making; and procureme nt to maximise the reach of the Trust within the Governme		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
						nts Foundational economy		
The Financial Plan	**Strategic Goal 5** A sustainable organization that plays it part in creating a better future for people across the globe	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. **These actions are all annual and ongoing through the year to year end**	**Annual Actions continuous throughout 2024/25** **Value & Sustainability** • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In line with the Trust's decision to rescind income protection from marginal currency rates and volumes in 2023/24 and work undertaken with NWSSP Medicines Unit to enable supply of two immunotherapy drugs from their Medicines Unit at lower cost than from the incumbent provider, we will continue to explore ways to relieve financial pressures on the system in 2024/25 and beyond. • The Trust will continue to integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived				Good progress being made against these annual actions	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
			medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.					

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	14th November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 23rd July 2024.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

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2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	There were no items to advise the Quality, Safety and Performance Committee.
ASSURE	**Programme Directors Report (including all project updates in scope)** The Delivery Confidence Assessment (DCA) for the overall programme is amber. <u>Project 5: Outreach</u> The Project Initiation Document (PID) for the Programme of work has been completed and shared with Health Board colleagues for approval. There are key elements of the project that are to be taken forward as part of the current work plan which are outlined within the report. <u>Cardiff Cancer Research Hub</u> Over the last six weeks the TCS Programme Team have been supporting the Cardiff Cancer Research Hub project which has been running for two years. Recently, it has been decided that Velindre will be the lead organisation for the centralised Project Management Office, a Heads of Terms have been signed and a high-level twelve-month plan has been developed. It has been proposed that the TCS Programme would be a suitable place to govern this collaborative project, and as such a new project request will be submitted for consideration once the wider programme scope is agreed. <u>Transforming Access to Medicines (TrAMS)</u> The project is actively progressing forward. Phase 1 of the project is SACT delivery which is required for Velindre Cancer Centre patients. This is on track to be completed in time for the nVCC. It was confirmed Radiopharmacy is separate piece of work. Within the private TCS Programme Scrutiny Sub-Committee there is a more detailed plan but due to commercially sensitive detail this cannot be included within the public Programme Directors Report. Further discussions to be held in the private section.

	The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Directors Report. **Radiotherapy Satellite Centre Project: Plan and Progress Update** An overview of the current position was provided to the TCS Programme Scrutiny Sub-Committee. Carl James took over as SRO following Cath OBrien leaving the Trust. Carl James thanked Rachel Hennessy and the team to getting to this point. The risks of the Radiotherapy Satellite Centre are considered at Project Board and are scored appropriately. Project Board will be reviewing the risks, confirming if they are risks or issues. Following the Project Board these will be included within the Programme Directors Report. A clinical working group is being established from August 2024. The TCS Programme Scrutiny Sub-Committee **NOTED** the Radiotherapy Satellite Centre Project: Plan and Progress Update.
INFORM	**TCS Programme Finance Report** The overall forecast outturn for the Programme is an overspend of £6.866m for the financial year 2024-25 against a budget of £0.663m. No capital funding has been allocated yet for the nVCC Project for financial year 2024-25, resulting in the overspend. An interim funding request for the nVCC Project has been submitted to Welsh Government for c£2.632m and the Enabling Works project funding request will be as part of the Enabling Works Full Business Case Addendum. The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the aforementioned funding request. To date there is no funding provided by Welsh Government for the Whitchurch Hospital Site, however at present the risk to the Programme is low. The associated costs will be reimbursed by Welsh Government. I was highlighted that a business justification case might be required to be submitted to Welsh Government.

	The TCS Programme Scrutiny Sub-Committee **NOTED** the TCS Programme Finance Paper. **Communication and Engagement Report** The Communication and Engagement Report was presented to the TCS Programme Scrutiny Sub-Committee. The following points were brought to the Committees attention: - There is a good working relationship between the Trust and Acorn. The content of the report reflects this - Positive public communications - Positive community engagement events - Useful construction timeline illustration The TCS Programme Scrutiny Sub-Committee **NOTED** the Communication and Engagement Report. **nVCC Project Board Terms of Reference** The Project Board Terms of Reference were delivered to the TCS Programme Scrutiny Sub-Committee. The Terms of Reference were endorsed at Extraordinary Project Board on 16th July 2024. It was confirmed the SRO will chair the nVCC Project Board once appointed. Currently the nVCC Project Board is chaired by Matt Bunce, Executive Director of Finance. It was requested to include a caveat that if it was decided it was not appropriate for the meeting to be chaired by the SRO, but that it should be chaired by another senior officer, the Terms of Reference would be amended as required. From September onwards the nVCC Project Board will include external parties including NWSSP, Welsh Government and Acorn. The TCS Programme Scrutiny Sub-Committee **ENDORSED** the nVCC Terms of Reference in principle.
APPENDICES	None.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	14/11/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	INFORMATION / NOTING

ACRONYMS	
HCRW	Health and Care Research Wales
RDI	Research, Development and Innovation
QSPC	Quality, Safety and Performance Committee
VCS	Velindre Cancer Services
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service
WG	Welsh Government

DRAFT

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 17/09/2024. Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	There were no items identified for **ADVISE** to the Quality, Safety & Performance Committee.
ASSURE	**TRUST RD&I Integrated Performance Report (Quarter 1, Financial Year 2024/25)** The Quarterly Report provided an update on activities of the Trust's Research, Development and Innovation service for Quarter 1, Financial Year 2024/25. Key highlights included: • Successful collaboration with BioNTech, leading to significant investment and new trials in Wales. • Performance indicators for Q1 show stable activity with 245 studies at different stages, 63 active studies, and recruitment slightly up from the previous year. • Future reports will adopt a dashboard format for clearer presentation of performance indicators. Capacity and Resource Issues: • Radiotherapy: Ongoing collaboration with the radiotherapy service to manage capacity and ensure contractual obligations are met. • Pharmacy: New appointments and additional resources to address capacity issues and manage a small backlog of trials. • Biopsies: Continued collaboration with Cardiff and Vale to manage radiological biopsy requirements for trials. Financial Performance: • Income: Slightly below target due to timing but not expected to impact the overall financial position. • Savings: On track to deliver the targeted savings of £230,000 for the financial year. • Invoice Payments: Compliance with the 30-day payment target is improving but remains below the required 95%. Strategic Initiatives: • Cardiff Cancer Research Hub: Progress on formalizing the partnership agreement and developing a website for a unified front door for industry partners.

	• Innovation Projects: Launch of the Simply Do platform pilot for patient communication and securing funding for small grant schemes to support innovation. Welsh Blood Service: • Engagement Panel: Enhancing the patient and public involvement panel to support research and grant applications. • Strategy Update: Ongoing development and approval process for the Welsh Blood Service RDI strategy The Radiotherapy Risks are now included as an appendix of the RD&I Integrated Performance Report FY2024/25 Q1. This has been previously discussed at the RD&I Operational Management Group Meeting (06 August 2024) and will continue through the RD&I Governance Framework onwards to RD&I Sub-Committee.
INFORM	**RD&I Presentation** The RD&I Sub-Committee received a presentation by Claire Lang, CCRH Senior Research Nurse Manager, Amanda Jackson, Team Lead Clinical Trials Unit alongside Mr Russell Goodway who gave a patient's perspective of the opportunities that the Vaccine Programme brings to Wales. Claire Lang presented an overview of the BioNTech collaboration and its potential benefits for patients in Wales through innovative cancer vaccine trials and other therapeutic approaches. Mr Goodway, patient representative, also shared his perspective on the opportunities the Vaccine Programme brings to Wales, as well as providing context on patient communication issues and booking processes. The committee agreed that incorporating patient experiences and feedback leads to more patient-centred research and innovation. This collaboration is seen as a positive step towards enhancing the research climate and patient care in Wales. **Executive Medical Director Briefing** The briefing provided an overview of high-level activities relating to Research, Development and Innovation during Quarter 1, Financial Year 2024/25 along with noteworthy items from the RD&I environment since the last meeting of the RD&I Sub-Committee. Key highlights included: • Welsh Patients benefit from increased access to pioneering clinical trials for cancer treatments. • Voluntary scheme for branded medicines pricing, access, and growth (VPAG). • Director of the UK Office for Life Sciences visits Wales. • LLAIS visit to Velindre Cancer Centre Clinical Research Treatment Unit. • Partners in Care Network research study support. • Empowering Patients & Public: Shaping Future Research with Welsh Blood Service.

	Welsh Blood Service Research, Development & Innovation Strategy Project The Research, Development & Innovation Sub-Committee endorsed the WBS RD&I Strategy Project for onward submission to the Strategic Development Committee and Trust Board, noting its alignment with broader strategic goals and the importance of sharing the strategy with other health boards across Wales. **Research, Development & Innovation Annual Effectiveness Survey 2023-2024** The Research, Development & Innovation Sub-Committee approved the Annual Effectiveness Survey 2023-2024. **Research, Development & Innovation Annual Committee Report 2023-2024** The Research, Development & Innovation Sub-Committee endorsed the Annual Report for onward submission to the Quality, Safety & Performance Committee & Trust Board for approval. **Retirement of Professor Jane Hopkinson, Velindre Cancer Service Professor of Nursing and Interdisciplinary Cancer Care** The Committee formally acknowledged the impending retirement of Professor Jane Hopkinson, who has served as the Velindre Cancer Service Professor of Nursing and Interdisciplinary Cancer Care. Her dedication and hard work in promoting the Healthcare agenda within the Trust have been invaluable. On behalf of the Committee, we extend our heartfelt thanks to Jane for her contributions and wish her all the best in her retirement.

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 17/09/2024.

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Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Research, Development & Innovation Sub-Committee Annual Report 2023-2024

DATE OF MEETING	14/11/2024
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 Townsend, Head of Research & Development
PRESENTED BY	Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The Research, Development & Innovation Sub-Committee Annual Report summarises the key areas of business activity undertaken during the period 1st April 2023 – 31st March 2024.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the Research, Development & Innovation Sub-Committee Annual Report prior to submission to Trust Board.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB SHAPE	09/09/2024
RD&I SUB-COMMITTEE	17/09/2024
QS&P COMMITTEE	14/11/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ENDORSED FOR APPROVAL	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** N/A

APPENDICES	
Appendix 1	Research, Development & Innovation Sub-Committee Annual Report 2023-2024

1. SITUATION / BACKGROUND

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

The report details the key areas of business undertaken by the Research, Development & Innovation Sub-Committee between 1st April 2023 - 31st March 2024.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Research, Development & Innovation Sub-Committee Annual Report ***(Appendix 1)*** summarises the key areas of business activity undertaken by the Sub-Committee from 1st April 2023 – 31st March 2024, and highlights some of the key issues the Sub-Committee will progress and further consider over the next 12 months.

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	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The RD&I Committee provides evidence-based, timely advice to the Board to assist in discharging its functions and meeting it responsibilities with regards to research, development and innovation activity. Assurance is also provided in relation to compliance with the Trust's regulatory responsibilities related to research, development and innovation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	*There are no socio-economic impacts linked directly to the activity outlined in this report*

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	*There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.*
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	*There is no direct equality impact in respect of the activity outlined in this report.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	*There are no specific legal implications related to the activity outlined in this report.*

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Research, Development & Innovation Sub-Committee Annual Report 2023-24

Committee Chair's Reflection

I am pleased to present the 2023-24 Annual Report of the Velindre University NHS Trust Research, Development & Innovation (RD&I) Sub-Committee, which outlines the coverage and results of the Committee's work for the year ending 31st March 2024.

This is my first Annual Report, having taken up the role of Chair in early 2022. In that time, I have been ably supported by RD&I Committee colleagues, most notably Dr Jacinta Abraham, Sarah Townsend, Jennet Holmes and Sandra Cusack; to whom I give thanks, alongside other committee members who have played active roles in shaping RD&I priorities and actions.

These are exciting times for the Velindre RD&I community. The full business case approval in March 2024 of the new Velindre Cancer Centre (nVCC) provides the platform for enhanced clinical cancer research and innovation opportunities within expanded state-of-the-art facilities. The opportunities afforded by the nVCC, including major facility investments in areas such as advanced radiotherapy, will help to attract and retain healthcare specialists delivering enhanced patient care at scale. Alongside the nVCC, the Trust is actively engaged in partnership with Cardiff & Vale UHB and Cardiff University in the development of the Cardiff Cancer Research Hub, bringing next generation advanced therapies and early phase trials to Cardiff. Other important oncology-based programmes supported through the work of the committee include the Velindre Oncology Academy; the All-Wales Advancing Radiotherapy Cymru (ARC) programme; and the healthcare professional 'first into research' scheme. Developments within the expanding research base of the Welsh Blood Service, such as the pioneering component development and transplantation services research laboratories, regularly feature in RD&I committee discussions.

These exciting developments place safe patient and donor care at the heart of everything we do, within a research led culture supported by continuing improvements in digital technology. Patients and donors receive the best level of service and care when actively involved in studies within research and innovation led centres – this ethos remains core to our RD&I mission.

Professor Andrew Westwell
Chair of the Velindre University NHS Trust Research, Development & Innovation Sub-Committee
May 2024

1. Introduction and Background

This report summarises the key areas of business activity undertaken by the Research, Development & Innovation Sub-Committee during the period 1st April 2023-31st March 2024.

The Research, Development & Innovation Sub-Committee annual business cycle ended on 31st March 2024 and this report reflects the Committee's key role in the development and monitoring of the Trust's Research, Development and Innovation agenda.

2. Roles and Responsibilities

The purpose of the Research, Development & Innovation Sub-Committee is to:

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust feeding into its overarching Strategic Development Committee
- Provide assurance on the performance of Research and Development activity feeding into its overarching Quality, Safety & Performance Committee
- Promote and encourage a RD&I ethos and culture, integral to the Trust's vision, mission and values
- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time
- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board

3. Membership of the Research, Development & Innovation Sub-Committee

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

Chair: Prof. Andy Westwell, Independent Member

Members: Professor Donna Mead OBE, CStJ, Chair of the Board
Vicky Morris, Independent Member

4. Quoracy and Frequency

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

5. Meetings and Attendance Planning

The Research, Development & Innovation Sub-Committee met four times during the period 1st April 2023 to 31st March 2024. This is in line with the Committee's Terms of Reference.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. During the year, attendance by Committee Members and Officers across the year is detailed in the table below:

Committee Members	20/07/23	19/09/23	07/12/23	06/02/24	Attendance %
Prof. Andrew Westwell (Chair)	✓	✓	✓	✓	100%
Vicky Morris	✓	✓	×	✓	75%
Prof. Donna Mead	×	×	✓	×	25%

Trust Officers	20/07/23	19/09/23	07/12/23	06/02/24	Attendance %
Dr Jacinta Abraham (Exec Lead)	✓	✓	✓	×	75%
Libby Batt	✓	✓	×	×	50%
Matthew Bunce	×	✓	✓	✓	75%
Christopher Cotterill Jones	✓	✓	✓	✓	100%
Dr Eve Evans	×	×	×	×	0%
Chloe George	×	×	×	✓	25%
Steve Ham	✓	×	✓	×	50%
Rachel Hennessy	×	×	×	×	0%
Jennet Holmes	×	×	✓	✓	50%
Prof. Jane Hopkinson	×	✓	✓	✓	75%
Sian James	✓	✓	✓	✓	100%
Dr Robert Jones	✓	✓	✓	✓	100%
Dr Edwin Massey	✓	✓	✓	✓	100%
Amie Garwood-Pask	×	×	✓	✓	50%
Alan Prosser	✓	×	×	✓	50%
Peter Richardson	✓	×	×	×	25%
Emma Stephens	✓	✓	✓	×	75%
Sarah Townsend	✓	×	✓	✓	75%
Nicola Williams	✓	×	✓	✓	75%

6. Agenda Process / Action Log

In-line with the agreed Research, Development & Innovation Sub-Committee Cycle of Business, the Chair in conjunction with the Executive Medical Director, Head of Research & Development and the Head of Corporate Governance, will set the agenda for Committee meetings. In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

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

7. Planning and Review

The Research, Development & Innovation Sub-Committee Terms of Reference and Operating Arrangements are reviewed on an annual basis as follows:

- Review and approve its Terms of Reference
- Approve the Cycle of Business/Work Programme

The Trust's strategic approach to Research, Development and Innovation (RD&I) is informed by patient need, strategic funding priorities and staff RD&I expertise at a national and local level and is underpinned by established RD&I processes: robust research governance, performance monitoring and quality assurance mechanisms; increasing service improvements and knowledge and expertise amongst staff.

The Research, Development & Innovation Sub-Committee Cycle of Business is configured to obtain assurance, on behalf of the Board, in relation to Trust activities within the Committee's scope.

During the last year, the Research, Development & Innovation Sub-Committee supported the collaborative work plans of the divisions of the Trust – the RD&I Division, Welsh Blood Service (WBS) and Velindre Cancer Service (VCS) and where appropriate the Trust's collaboration with key stakeholder organisations within the NHS and Higher Education Institutions.

8. Research, Development & Innovation Sub-Committee Activity

For 2023-24, the RD&I Sub-Committee has fulfilled its core work programme with the following key priorities continuing to provide focus for the Sub-Committee:

- The continued development of one Trust-wide Research, Development & Innovation (RD&I) Strategy and implementation plan

- Provision of a robust governance framework and infrastructure to support the Trust's RD&I agenda
- Assuring the RD&I arrangements support the delivery of the RD&I agenda
- Reviewing the resources available for support within the Trust
- Ensuring the Trust is fully engaged in national programmes and policies
- Ensuring RD&I related risk is considered and managed appropriately
- The review of RD&I related business cases

The monitoring of performance against key RD&I deliverables on behalf of the Trust Board including:

- The RD&I priorities for the annual Operational Plans
- Health and Care Research Wales (HCRW) key performance indicators
- Healthcare Standards Standard 3.3 Quality Improvement, Research and Innovation
- Progress against the Integrated Medium-Term Plan (IMTP) / Annual Planning Framework

During 2023, the Committee obtained assurance in relation to a wide range of additional RD&I activities over and above those highlighted, these are summarised below.

8.1 Presentations

Each Committee meeting commences with a focused Presentation, these include as follows:

- Progress & Plans in Transplantation Research (Felicity May, Clinical Specialist Histocompatibility & Immunogenetics & Deborah Pritchard, Welsh Transplantation and Immunogenetics Lab Manager, Welsh Blood Service)
- Cardiff Cancer Research Hub (CCRH) - ATMP Trials Progress (Claire Lang, CCRH Senior Research Nurse Manager)
- RD&I Communications & Engagement - Making a Difference (Helen Robertson, RD&I Communications & Engagement Officer)
- A Partnership Approach to Establishing Sero-surveillance in Wales (Sian James, Head of Research, Development and Innovation Services, Welsh Blood Service & Sophie Harker, Senior Epidemiological Scientist, Public Health Wales)

8.2 Research, Development & Innovation Performance Annual Report 2022-23

An overview of the Trust Research, Development & Innovation Performance Annual Report 2023-24 was presented. The report reflects on the four RD&I Strategic Priorities, updated from 2022-23 with key achievements as published in the Trust's IMTP including the Financial Summary and Outputs.

Summary of Performance Indicators

Overall, there has been marked improvement in the Trust run number of studies that have been RAG rated "GREEN" for the Health and Care Research Wales (HCRW) key indicators:

- OPEN studies – Percentage of studies recruiting to time and to target at NHS organisations in Wales with open studies being up 21% for non-commercial studies and up 11% for commercial studies.

- CLOSED studies – Percentage of studies recruiting to target at NHS organisations in Wales with closed studies being up 37% for non-commercial studies; up 21% for commercial studies since last year.

The RD&I Sub-Committee acknowledged and congratulated the Team on a comprehensive Annual Report which included a substantial list of publications e.g. 29 pages of publications, in leading international journals including posters and presentations.

8.3 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.

As the Sponsor of the FAKTION trial and owner of the intellectual property, the Trust protected and leveraged the IP through licensing, generating financial benefits that that will be used to enhance its research capacity for the benefit of its patient cohort.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 H&CRW / VUNHST Annual Review Meeting

Formal feedback from Health and Care Research Wales was received by the Trust on the 2nd January 2024, describing the meeting as constructive, outlining the discussions, their feedback and proposed next steps. A SMART action plan will now be developed to address the points raised as appropriate with timelines to be determined following further discussion within the RD&I Senior Core Team. The Trust will respond to HCRW feedback in due course.

9. Velindre Futures Cancer R&D Ambitions

A successful bid to Velindre Charitable Funds brought in new posts to implement the Cancer R&D Ambitions. This included giving research interested trainees the opportunity to gain higher degrees, funding key research posts in Palliative and Supportive Care for the first time and increasing research capacity by funding dedicated sessional time for research.

2023-2024 also saw key milestones achieved for the Cardiff Cancer Research Hub (CCRH). The first CCRH patient was treated in December and a Strategic Outline Case, outlining the physical infrastructure required for a full, expanded CCRH, was submitted to the Welsh Government in July. A Strategic Investment Case was also finalised that outlined a strategy for ensuring the CCRH's long-term financial sustainability.

10. Head of Innovation

A full-time Head of Innovation was appointed by the Trust in June 2023 and joined the Trust RD&I Senior Leadership Team, further strengthening the Trust's Innovation Service and leading the development of a Trust-wide innovation strategy aligned with the Trust 2032 strategy. The Innovation Strategic Plan is enclosed, and the innovation activity themes are featured below:-

10.1 Innovation Activity Themes

10.2 Innovation Activity Overview

- Innovation Management System implementation - Commenced implementation of ISO 56001 (with a view to seek external verification in 2024/25 period). A copy of the innovation policy is enclosed.
- Funding sustainability – identified opportunities with other Trusts, Regions / Third sector/government. Secured SBRI drone project funding, Welsh Government Health and Social Care Funding, Welsh Government, Economy, innovation funding, and Bevan Exemplar and intensive learning week innovation training
- Developed Trust innovation induction training
- Feasibility/review assessment of accreditation of innovation training course in collaboration with Oncology Academy
- Developed innovation portal for capture and prioritisation of innovation ideas (using the SimplyDo platform) and planned first challenge.
- Undertook branding survey to inform recommendations for updates to Trust brand guidance
- Undertook an evaluation of RITA chatbot to inform future options paper
- Confirmed governance arrangements for staff management (as appropriate) recruit to vacant posts for ARC programme,
- Undertook review of Industry collaboration activity to inform blueprint for future collaboration. Supported applications for two MediWales Innovation Award submissions
- Supported Moondance Innovation Awards
- Published 3 x innovation articles in MediWales Life Science magazine
- Represented on ARC board
- Developed Strategic Plan for Innovation for 2024/25 period
- Developed innovation workstream themes
- Led Coordination of workshop for the Collaborative Centre for Research Learning and Innovation to inform vision statement development
- Supported the business case narrative development for CCfRLI submission for Welsh Government submission
- Commenced evaluation of the RITA chatbot
- Developed innovation reporting dashboard

11. Nursing and Interdisciplinary Led Research

In September 2023, a 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.

The next call for applications was January 2024 and offered an opportunity for staff members to conduct research relevant to their clinical practice, two days per week over a two-year period.

12. Trust RD&I Small Grant Scheme

In order to support an increase in activity in the Nursing and Interdisciplinary led research portfolio the Trust has established an annual Small Grant Scheme. The award for 2023 was £50k, (5 studies of £10k or pro-rata for smaller projects) and will be coordinated and managed by the Trust R&D Office. The scheme seeks to support the development of nurse, allied health professional and health/clinical science researchers in a multidisciplinary and supportive environment to undertake research aligned to strategic priorities.

13. Component Development Research Laboratory

Felicity May was awarded 'Doctor of Clinical Science' after fulfilling the five-year rigorous demands of the NHS's Higher Specialist Scientist Training (HSST) programme. Felicity undertook an NHS Research study during the programme, looking at improving desensitisation treatments for renal patients.

14. Governance and Assurance Development

14.1 Policies, Procedures and Plans

The Committee received and approved:

- Policy for Use of Small Animals in Research

14.2 Endorsements / Approvals

The Sub-Committee **ENDORSED** a number of items to support and enable the Trust's ongoing commitment towards quality and excellence in Research, Development and Innovation:

- RD&I Committee Financial Performance Report
- Trust RD&I Integrated Performance Report

14.3 Strategy, Policy Implementation and Performance

The Sub-Committee has sought assurance through regular review and scrutiny of the regularly received RD&I Performance Reports to provide the Sub-Committee with the necessary assurance around performance of the RD&I Division. These provide the Sub-Committee with an update on the key performance outcomes and metrics for the research activity of the Welsh Blood Service and Velindre Cancer Service as well as the following reports :

- Research, Development & Innovation Annual Operational Plan
- Research, Development & Innovation Integrated Performance Report
- Research, Development & Innovation Financial Performance Report
- Trust Innovation Updates
- Welsh Blood Service RD&I Updates

- nVCC Research, Development & Innovation Group Updates
- Advancing Radiotherapy Fund Highlight Report

15. Discussion held in Part B / Private Committee

There is facility for the Committee to consider reports that contain commercially sensitive or potentially identifiable / sensitive information in Part B / Private Committee.

The Sub-Committee also received presentations on a number of Business Cases relating to the supporting and improving research activities in the Trust.

The Committee considered reports in Private in relation to:

- Business Case Expenditure Proposals
- Business Case Annual Evaluation Reports

16. Reporting the Committee's Work / Highlight Report

The Chair of the RD&I Sub-Committee reports key issues discussed at each of its meetings by way of a Highlight Report to the Quality, Safety & Performance Committee and Strategic Development Committee as appropriate.

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

17. RD&I Sub-Committee Annual Effectiveness Survey

The Committee continued to review its effectiveness through the year, to ensure effective use of time and to ensure it fulfilled its role to provide assurance to the Board.

During the year, the Research, Development & Innovation Sub-Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach. The Committee has engaged with a formal Committee Effectiveness Review Process which took place in April 2024 and determines the effectiveness of the Committee in meeting its operations in accordance with its Terms of Reference and the Trust Standing Orders.

18. Key Areas of Focus for the Coming Year

During 2024-2025, the Committee is committed to ensuring that research & development continues to be managed in accordance with legislative and regulatory requirements, and best practice guidance. Members of the Research, Development & Innovation Sub-Committee have extended thanks to all those involved in supporting the work of the Committee, and for the constructive and positive way in which attendees have contributed to the work of the Committee.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Research, Development & Innovation Sub-Committee Annual Effectiveness Survey 2023-2024

DATE OF MEETING	14/11/2024
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 Townsend, Head of Research & Development
PRESENTED BY	Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	This report provides the Quality, Safety & Performance Committee with the results of the Research, Development & Innovation Sub-Committee Annual Effectiveness Survey for the reporting period 1st April 2023 – 31st March 2024.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the Research, Development & Innovation Sub-Committee Effectiveness Survey Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB SHAPE	09/09/2024
RD&I SUB-COMMITTEE	17/09/2024
QS&P COMMITTEE	14/11/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
Endorsed for Approval

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** N/A

APPENDICES	
Appendix 1	Research, Development & Innovation Sub-Committee Annual Effectiveness Survey 2023-2024

1. SITUATION

All Board level meetings are required to assess their effectiveness throughout the year and to carry out an Annual Effectiveness Survey to inform how best to undertake the Sub-Committees roles and responsibilities.

This report provides the Quality, Safety & Performance Committee with the results of the Research, Development & Innovation Sub-Committee Annual Effectiveness Survey for the reporting period 1st April 2023 – 31st March 2024.

2. BACKGROUND

The Research, Development & Innovation Sub-Committee Annual Effectiveness Survey consisted of twenty questions administered via an online survey platform (Microsoft Forms). All questions were posed in a structured format and survey respondents were invited to provide their answer together with any supporting comments as required. The questionnaire was designed to require respondents to answer each question before enabling progression onto the next question. Respondents were given the opportunity to complete the survey within one due to tight timings, following which the survey link became inactive. No personal data was collected in the completion of the survey questionnaire.

20 people were asked to complete the survey including the Trust Chair, Independent Members, Executive Directors and Non-Executive Directors of the Research, Development & Innovation Sub-Committee. 12 responses were received, giving an overall completion rate of 60%. The full survey results are outlined within the report ***(appendix 1).***

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Choose a domain/domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	*There are no socio-economic impacts linked directly to the activity outlined in this report*
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	*There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.*
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report*

EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*There is no direct equality impact in respect of the activity outlined in this report.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	*There are no specific legal implications related to the activity outlined in this report.*

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE ANNUAL EFFECTIVENESS SURVEY 2023-2024

1. INTRODUCTION

The Research, Development & Innovation (RD&I) Sub-Committee Annual Effectiveness Survey provides a tool for RD&I Sub-Committee to assess its effectiveness against more than just the basic requirements: it provides the opportunity for the Sub-Committee to check and assess its effectiveness and operations to give greater confidence and assurance on how it can best meet the requirements of its role.

This report provides the RD&I Sub-Committee with the results of the Annual Effectiveness Survey for the reporting period 1st April 2023 – 31st March 2024.

2. METHODOLOGY

The Annual RD&I Sub-Committee Effectiveness Survey consisted of twenty questions administered via an online survey platform (Microsoft Forms). All questions were posed in a structured format and survey respondents were invited to provide their answer together with any supporting comments as required. The questionnaire was designed to require respondents to answer each question before enabling progression onto the next question. Respondents were given the opportunity to complete the survey within one due to tight timings, following which the survey link became inactive. No personal data was collected in the completion of the survey questionnaire.

3. FINDINGS

20 people were asked to complete the survey including the Trust Chair, Independent Members, Executive Directors and Non-Executive Directors of the RD&I Sub-Committee. 12 responses were received, giving an overall completion rate of **60%**.

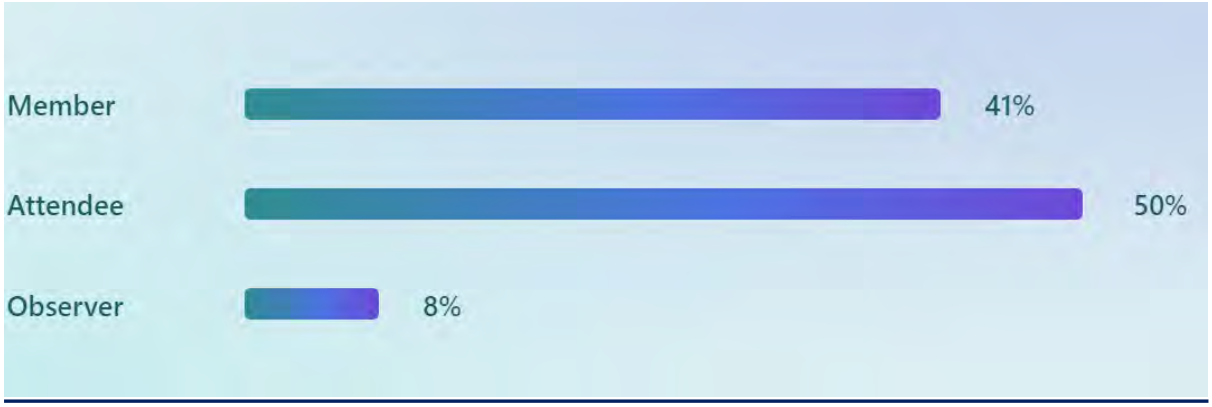
Note: This survey allows multiple answers for each question.

The full survey results are outlined below:

SURVEY RESULTS

SURVEY QUESTION 1:

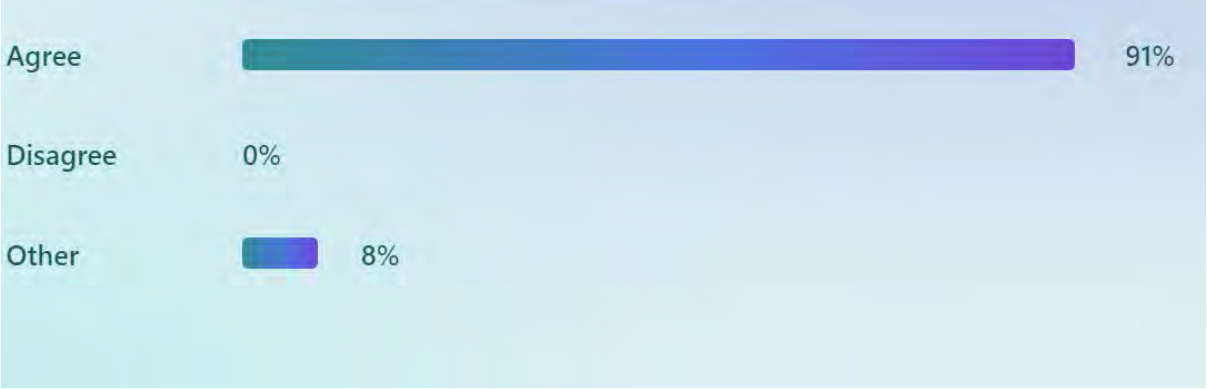
Please indicate if you are a 'Member' of the Research, Development & Innovation Sub-Committee i.e. Independent Member or a regular 'Attendee' of the Committee.



Of all 20 individuals invited to complete the survey, 12 responses were received. 5 were member of the RD&I Sub-Committee and 6 attendees and 1 observer.

SURVEY QUESTION 2:

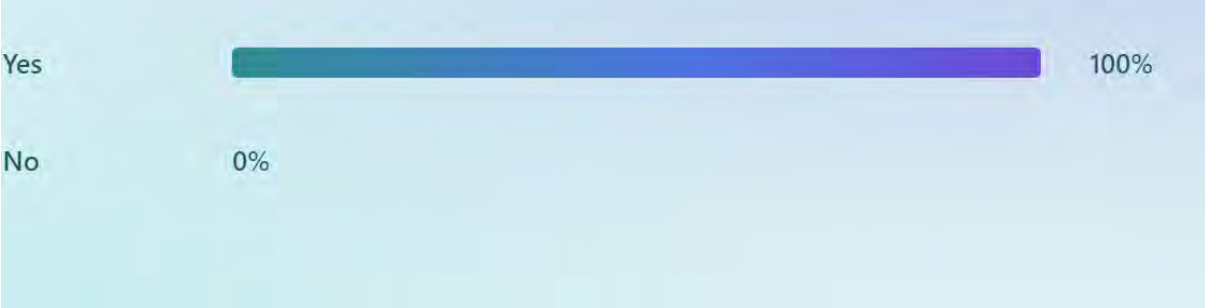
There are clear Terms of Reference, with clarity as to the role of the Research, Development & Innovation Sub-Committee and the relationship between the Committee and the Trust Board?



11 out of 12 responses received agreeing there are clear Terms of Reference with clarity as to the role of the RD&I Sub-Committee and the relationship between the Committee and the Trust Board.

SURVEY QUESTION 3:

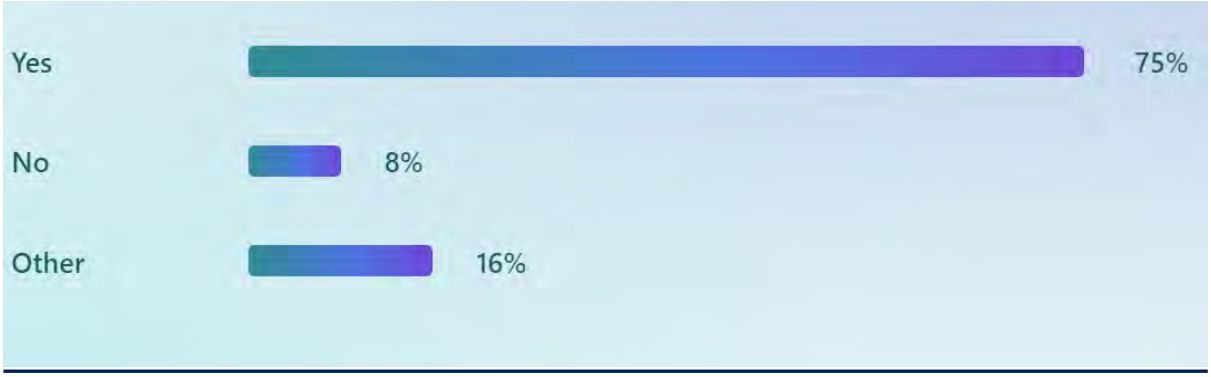
Has the Research, Development & Innovation Sub-Committee been provided with sufficient authority and resources to fulfil its role effectively?



12 responses agreed the RD&I Sub-Committee had been provided sufficient authority and resources to fulfil its role effectively.

SURVEY QUESTION 4:

Has the Research, Development & Innovation Sub-Committee established a Cycle of Business to be dealt with during the year?

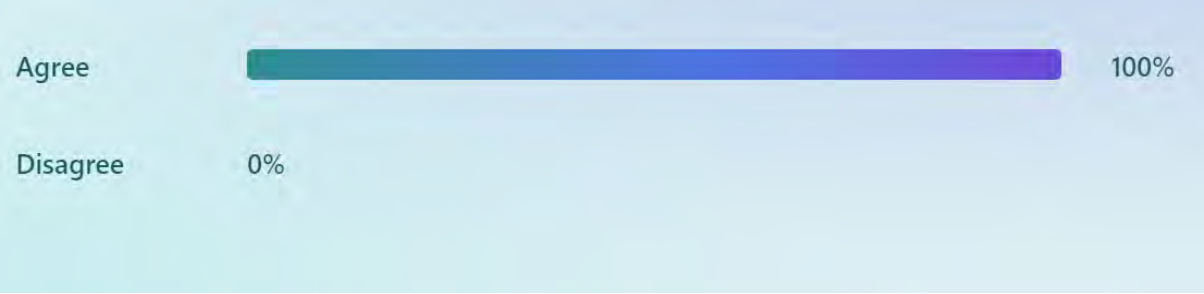


9 responses agreed the RD&I Sub-Committee has an established cycle of business which has been dealt with during the year. 1 response disagreed. The following comments were noted:

OTHER - COMMENTS	
1	Innovation not so firmly embedded with a cycle of business

SURVEY QUESTION 5:

The number and length of meetings is sufficient to allow the Research, Development & Innovation Sub-Committee to fully discharge its duties?



12 responses agreed the number and length of meetings were sufficient to allow the RD&I Sub-Committee to fully discharge its duties.

SURVEY QUESTION 6:

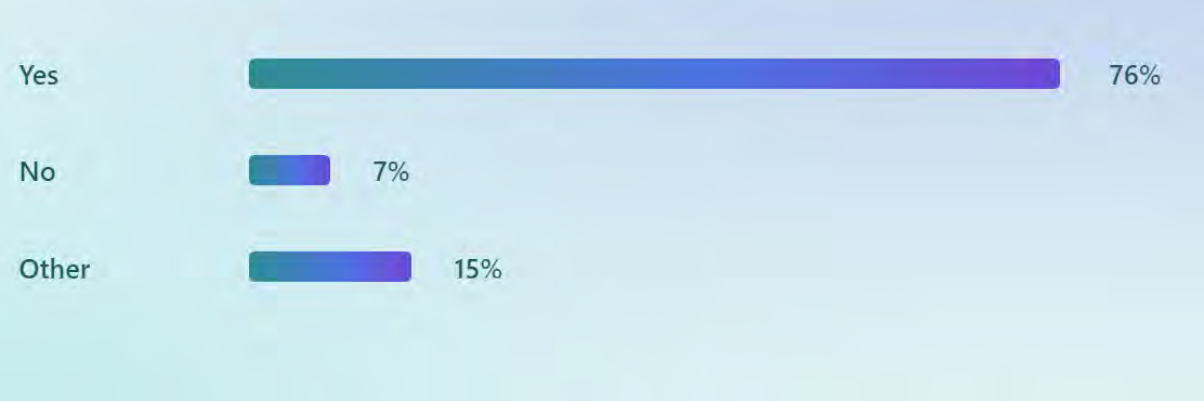
Is sufficient time allowed for questions, discussion and debate at the Research, Development & Innovation Sub-Committee meetings?

11 out of 12 responses were of the opinion the RD&I Sub-Committee meetings scheduled allowed sufficient time for important questions / decisions being made. 1 response disagreed. The following comments were received:

OTHER - COMMENTS	
1	Yes, protracted drawn out discussions that are not in the strategic space.

SURVEY QUESTION 7:

The Research, Development & Innovation Sub-Committee papers are received sufficiently far in advance of meetings?

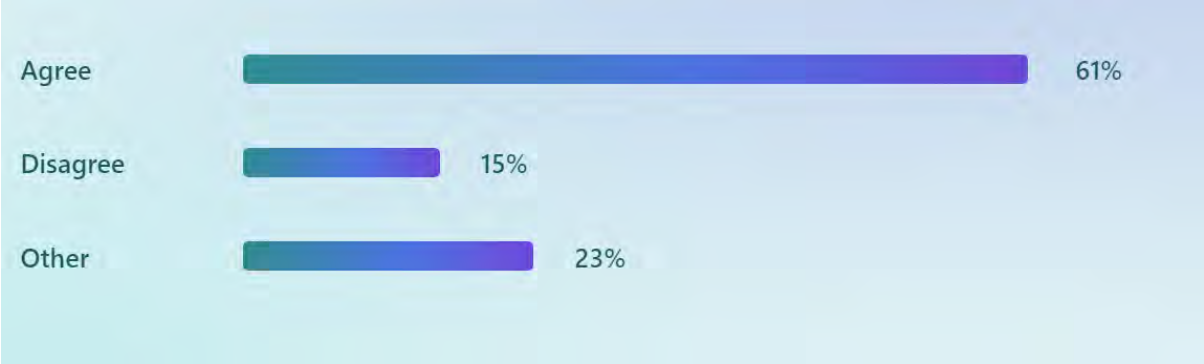


10 responses received agreeing the papers are sufficiently received in advance of the meetings. 1 response disagreed. The following comments were recorded:

OTHER - COMMENTS	
1	Due to the RD&I related governance structure for papers it would be challenging to alter the current timelines.
2	It would be difficult to change paper deadlines and still be able to submit the papers to other meeting prior to the committee and ensure that the papers are still relevant to the committee's business.

SURVEY QUESTION 8:

The papers received by the Research, Development & Innovation Sub-Committee are concise and relevant?

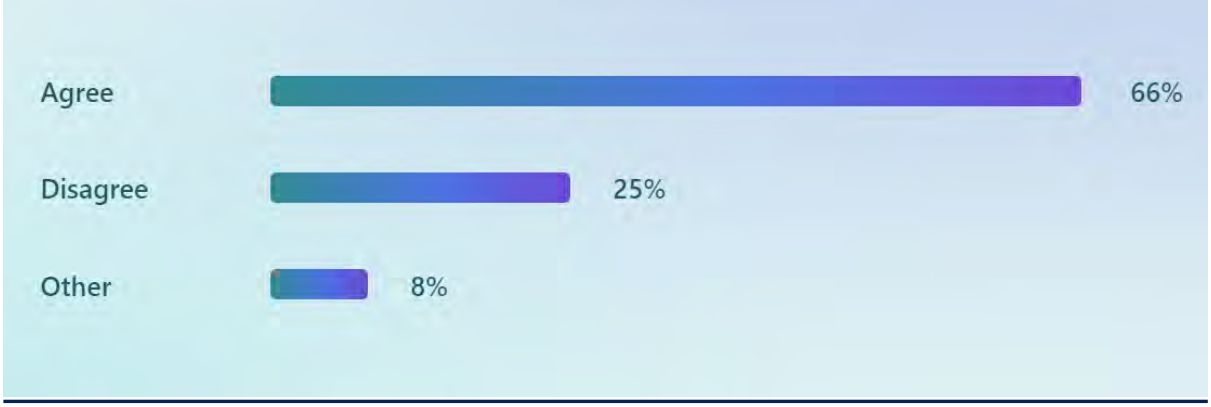


9 responses received agreeing the papers are concise and relevant. 2 responses disagreed. The following comments were made:

OTHER - COMMENTS	
1	Papers submitted by grant holders and potential grant holders aren't always filled with attention to important detail causing delays.
2	The papers are very lengthy.

SURVEY QUESTION 9:

I feel the Research, Development & Innovation Sub-Committee receives sufficient detail, at the right level to allow me to focus on asking the right questions?

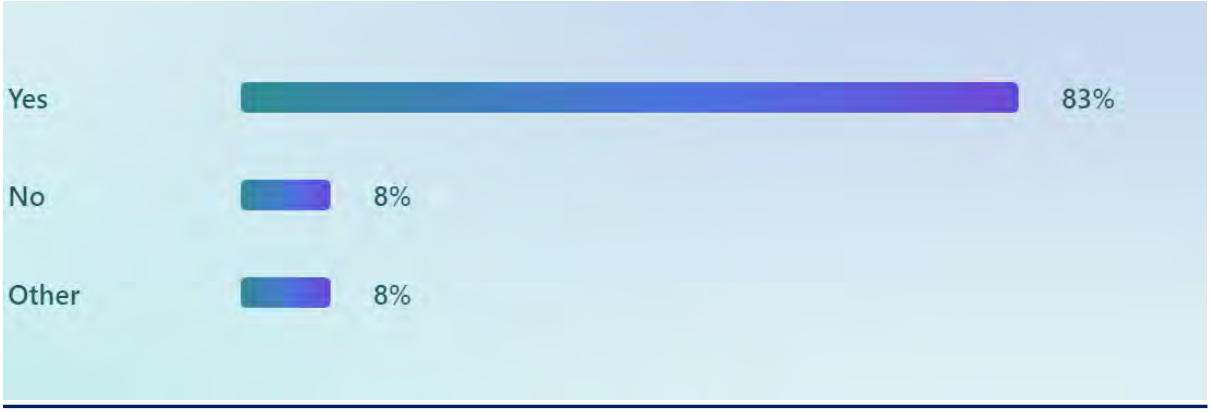


8 responses received agreeing the papers have sufficient detail, at the right level to allow to focus on asking the right questions. 3 responses disagreed. The following comments were made:

OTHER - COMMENTS	
1	Too much detail - should be strategic.

SURVEY QUESTION 10:

Are Research, Development & Innovation Sub-Committee meetings scheduled prior to important decisions being made?

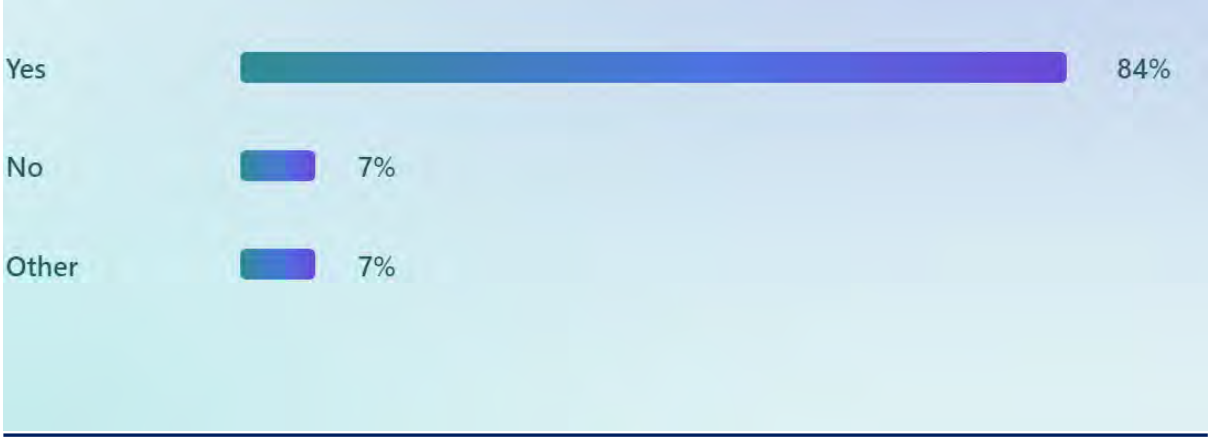


10 responses received agreeing there is sufficient time allowed for questions, discussion and debate for the RD&I Sub-Committee. 1 response disagreed. The following comments were received:

OTHER - COMMENTS	
1	It's not clear what specific decisions are needed to be made.

SURVEY QUESTION 11:

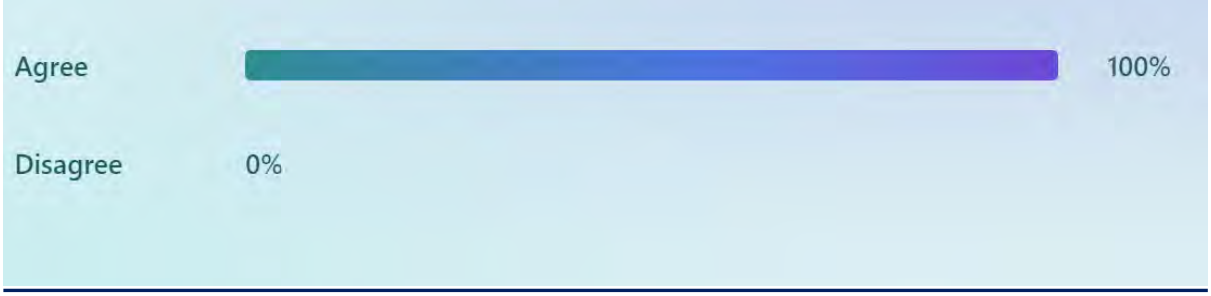
Is the behaviour of all Members / Attendees at the Research, Development & Innovation Sub-Committee meetings courteous and professional?



11 responses received agree the behaviour of all member / attendees at the RD&I Sub Committee meetings is courteous and professional. 1 response disagreed.

SURVEY QUESTION 12:

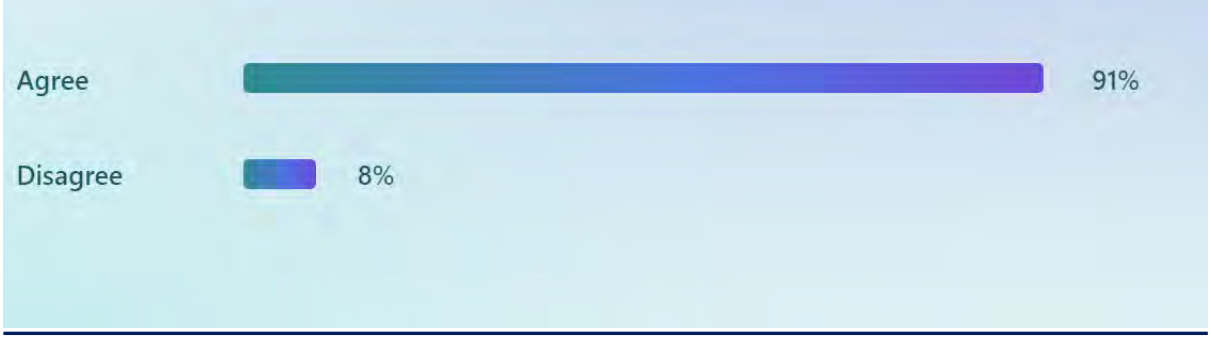
The Research, Development & Innovation Sub-Committee Chair has a positive impact on the performance of the Committee?



All responses received agreed with the Committee Chair having a positive impact on the performance of the Committee.

SURVEY QUESTION 13:

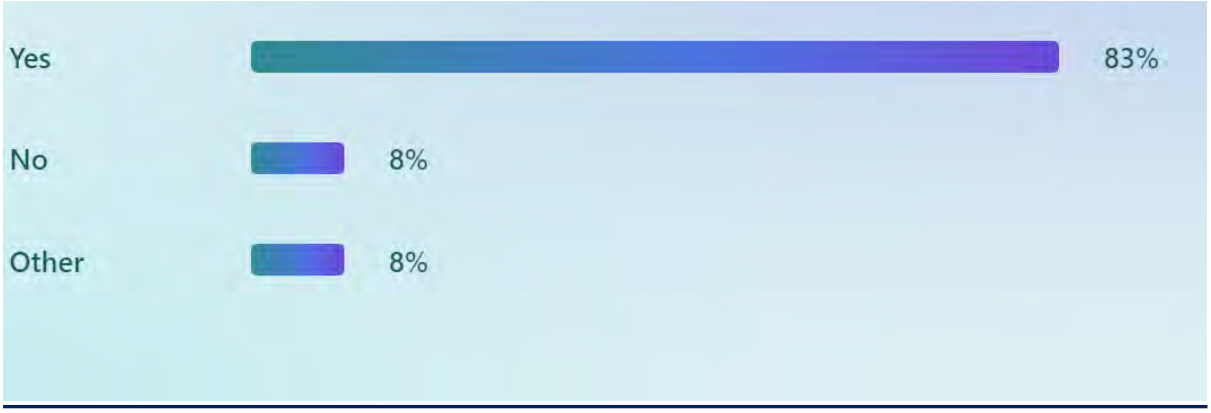
The Research, Development & Innovation Sub-Committee meetings are chaired effectively with clarity of purpose and outcome?



11 responses agreed with the RD&I Sub-Committee meetings being chaired effectively with clarity of purpose and outcome. 1 response disagreed.

SURVEY QUESTION 14:

Is each agenda item at the Research, Development & Innovation Sub-Committee closed off with clarity on the decision / outcome of discussion?

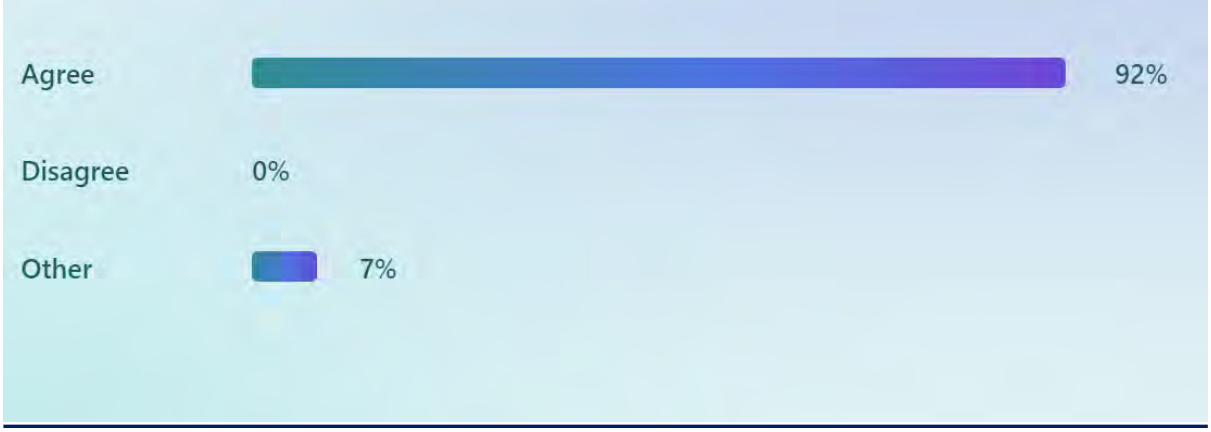


10 responses agreed each agenda items closed off with clarity on the decision / outcome of discussion. 1 response disagreed. The following comment was provided:

OTHER - COMMENTS	
1	The level of significant detail of the discussions makes this difficult.

SURVEY QUESTION 15:

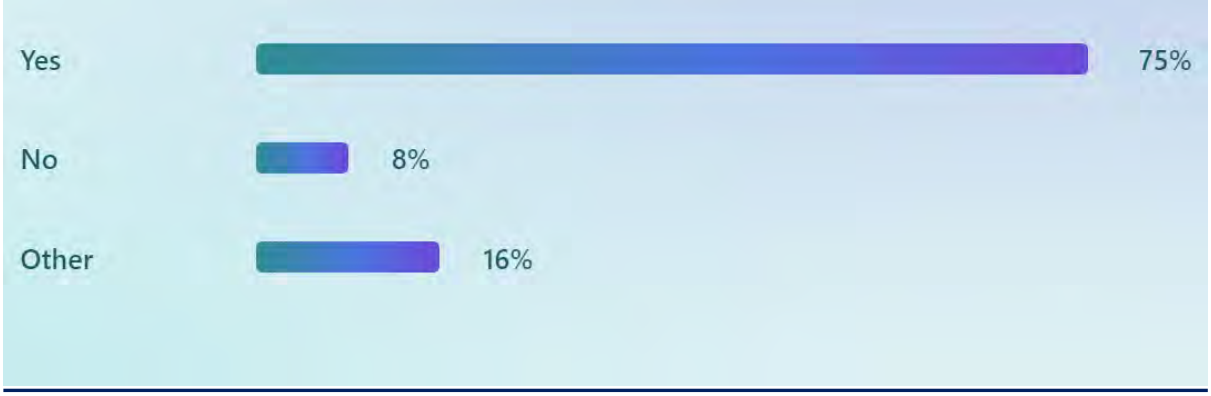
The Research, Development & Innovation Sub-Committee Chair allows debate to flow freely and does not assert their own views too strongly?



All 12 responses agreed the RD&I Sub-Committee Chair allows debate to flow freely and not assert their own views too strongly.

SURVEY QUESTION 16:

Is the atmosphere at the Research, Development & Innovation Sub-Committee meeting conducive to open and productive debate?

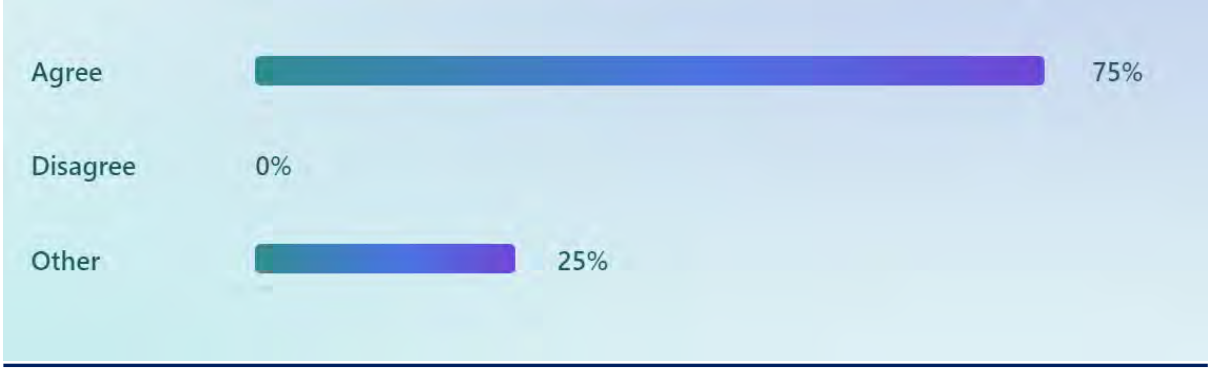


11 responses received agreed the atmosphere at the RD&I Sub-Committee meetings is conducive to open and productive debates. 1 response disagreed. The following comments were recorded:

OTHER - COMMENTS	
1	Face to face meetings are the most conducive.
2	As with many other things, in person meetings allow great understanding to be productive.

SURVEY QUESTION 17:

The Research, Development & Innovation Sub-Committee has effective escalation arrangements in place to alert relevant individuals, Committees, Board of any urgent / critical matters that may affect the operation and / or reputation of the Trust?

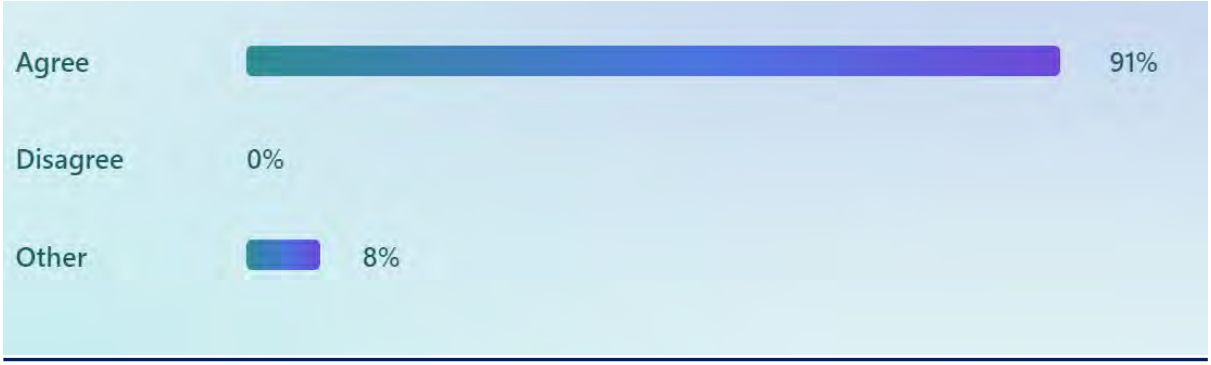


9 responses received agreeing the RD&I Sub-Committee have effective escalation arrangements in place to alert relevant individuals, Committees, Board of any urgent/critical matters that may affect the operation and/or reputation of the Trust. No responses received disagreed. The following comments were recorded:

OTHER - COMMENTS	
1	These could be better clarified in relation to changes being made to other committees.
2	Is there a definition of the scope of escalation arrangements? I'm aware of the process of escalation but what exactly gets escalated and what doesn't is not clear.

SURVEY QUESTION 18:

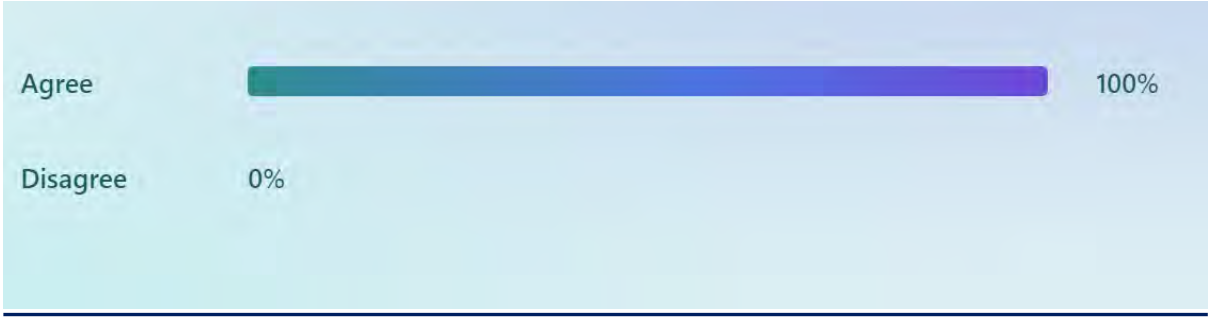
Do you consider that where Private (Part B) Research, Development & Innovation Sub-Committee meetings are held, that these have been used appropriately for items that should not be discussed in the public domain?



11 responses received agreeing the RD&I Sub-Committee private (part b) meetings were held in an appropriate way to discuss items that are not suitable for public domain i.e. commercially sensitive or identifiable.

SURVEY QUESTION 19:

The Governance and Executive Support Function provide Committee Secretariat for the Committee. I am satisfied with the support provided?



12 responses agreed they are satisfied with the Governance and Executive Support Function provided to the RD&I Sub-Committee.

SURVEY QUESTION 20:

Any Other Comments?

12 responses received with the following comments recorded:

OTHER - COMMENTS	
1	Cycle of business, work plan, agenda's, presentations and discussions all need to be strategic - far too much detail covered.
2	There are lots of updates/detail shared at this meeting and whilst this is a reflection of the amount of work going on, it sometimes feels that there is too much information, so it becomes more about updating rather than decision making. It would be interesting to know what specific information is filtered up/out via the various governance structure or if much of the information is repeated in all stages.
3	Hasn't been necessary to schedule RD&I meetings prior to particular urgent RD&I related items. Meetings are scheduled regularly through calendar year.
4	Committee should have equivalent status as statutory committee's e.g. audit.
5	Performance reports improving.
6	At times, the Admincontrol system can be challenging to use for the committee meetings.
7	The content of the Committee papers has been driven by feedback from the Committee and continues to support decision making and provides assurance allowing the Committee to execute their responsibilities.

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Estates Highlight Report

DATE OF MEETING	14th November 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	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Management Group Meeting	**17/10/2024**
Executive Management Board – RUN	**29/10/2024**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS No changes recommended to the report from Executive Management Board..	

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

APPENDICES	

1. SITUATION

The Estates Assurance Report provides a comprehensive update on the progress made against the 2024/25 estates objectives. This report also highlights key risks and includes a summary of the training and compliance objectives achieved within the Trust during Quarter 2 of 2024/25.

2. BACKGROUND

The Trust Estates Assurance Report is a key component of the Trust's commitment to maintaining and enhancing the physical environment and infrastructure essential for delivering safe, high-quality healthcare services. The Estates Department plays a critical role in ensuring that all facilities are safe, compliant with regulatory standards and fit for purpose. This report provides an overview of the department's performance in achieving its objectives for the 2024/25 financial year. It includes updates on progress, key risks, and the status of training and compliance objectives, all of which are crucial for sustaining operational excellence across the Trust's estate.

3. ASSESSMENT

Compliance remains stable at the Welsh Blood Service Headquarters (WBS HQ), meeting or exceeding the 95% benchmark. However, compliance at Velindre Cancer Centre (VCC) is slightly below this target, primarily due to challenges with the Synbiotix CAFM provider. Efforts are underway to address these issues by enhancing training programs, improving monitoring systems, and updating protocols. A recent building condition survey for both VCC and WBS HQ has also identified a substantial backlog of maintenance work; full details and recommended next steps are outlined in the report.

4. SUMMARY OF MATTERS FOR CONSIDERATION

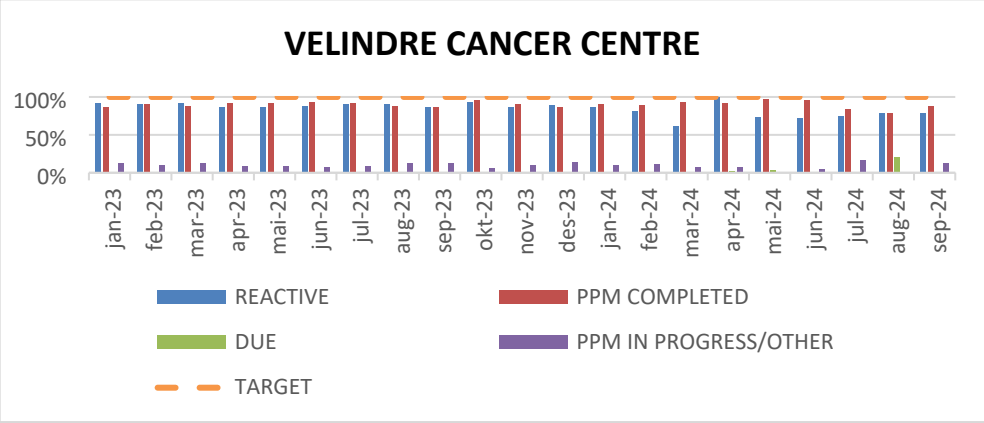
No immediate matters for consideration / action.

The report is presented to the Committee to provide assurance in respect of the delivery of the Trusts Estate operational delivery program.

ALERT / ESCALATE	Nil to alert escalate.
ADVISE	**Operational Estates Issues.** **Synbiotix CAFm system.** The Trust recently transitioned its CAFM system to a new software provider, Synbiotix, to manage its maintenance programs. However, ongoing challenges with the supplier have arisen, including unresolved development requests with no clear timelines for resolution. Currently, only the assets for Velindre Cancer Centre have been migrated to the new system, requiring manual cross-referencing of PPM tasks to ensure compliance. This has been escalated both within Symbiotix and with Trust Officers. Interim assistant director estates have drafted a CAFm management SOP to support the management of operational estates PPM and reactive work tasks. **VCC Water Management** Issues identified in Modular Building Velindre Cancer Centre with hot water cylinder, suggested to change the size of the unit to reduce capacity to prevent stratification issues. **VCC SACT Lloyds Pharmacy Unit** VUNHST AP (Authorised Person) water safety currently seeking assurance on water safety measures on mobile unit, currently awaiting servicing information. Suggestion sent to compliance manager Lloyds Pharmacy to filter outlets in addition to maintenance activities. **WBS Plasma Freezer** A new plasma freezer was delivered on 27/09/2024. It has since been discovered that the freezer is not connected to the Contronics system, meaning there is no live logging or alarms in case of a power outage or freezer failure. This is due to the absence of a network system in the garage. MM raised the question of why the unit was not equipped with Wi-Fi-enabled Contronics. The QA Manager, as the owner of the Contronics system, is currently obtaining quotes for installing a Wi-Fi link. The issue was flagged due to the high value of stock stored in the freezer. **Liquid Nitrogen Welsh Blood Service** SBAR has been drafted with two options to replace the liquid nitrogen vessel at WBS. Currently awaiting feedback from department leads on the potential Cryo Freezer option to add into paper. **Building Condition Survey VUNHST** A review has taken place of all the recommendations for VCC and WBS noting a total backlog of 11.22 million across the Trust. SBAR was presented to SLT VCC with risk mitigation actions. The paper will now be presented to

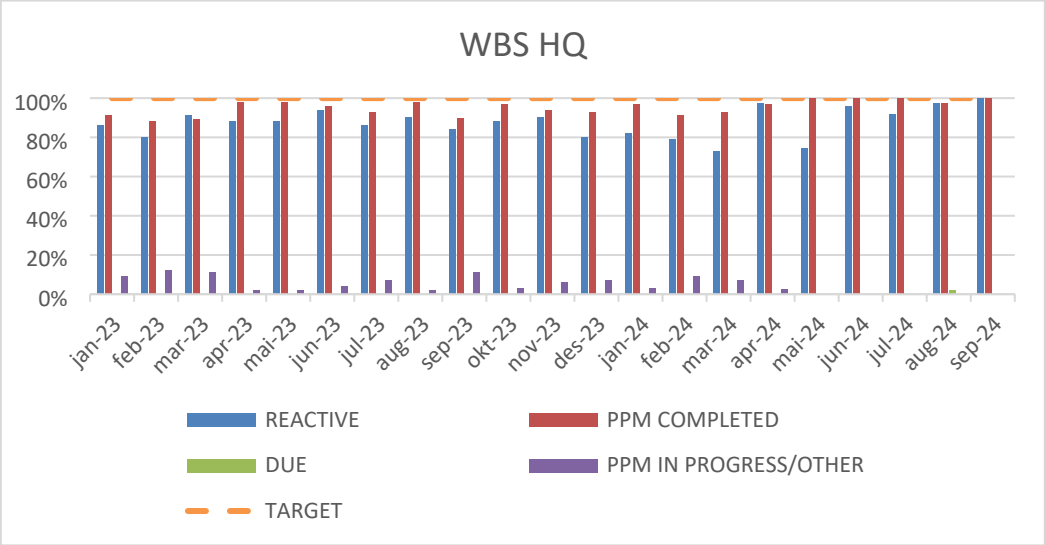
	EMB updating governance discussions for further funding requirements. WBS SBAR to be presented to WBS SLT in November for further assurance – governance discussions next steps. EMB – QSP Building condition paper sent separately to request funding for risk assessed backlog Building Management.
ASSURE	**Capital Works** **Welsh Blood Service Electrical Infrastructure Works** The electrical infrastructure works for the Welsh Blood Service in Talbot Green have returned from tender, with a total cost of £350,000, funded by the Welsh Government. A tender review is currently underway, with the aim of raising the purchase order by the end of October 2024. The estates team is collaborating with operational colleagues to develop a comprehensive end-to-end plan, aligning it with an FMEA risk assessment to ensure all potential risks are fully considered and addressed.it is our ambition to complete these works prior to the new pending WBS requirements. **Estates Discretionary Capital £75k** **The estates discretionary allocation has been fully allocated this financial year to address the items listed below.** 1) Isotopes Hot water return issues, boiler installed to rectify issues in unit – works completed. 2) Emergency chiller works MRI Xray, resulted in chiller rental for 12 weeks while awaiting parts from supplier – works completed 3) Scaffolding erected to Zone 8 to address issues with Roof Leaks- works completed. 4) Window replacement in Zone 9 following condition survey recommendation and signs of water ingress and damp in offices- works completed. 5) Velindre Decarbonisation LED upgrades to various corridors to replace old fluorescent type fittings – works completed. 6) Patient Manual Handling equipment purchase to support the PMH training facility in VUNHST – Awaiting delivery of kit. 7) LA4,5 waiting area roof repairs to address leaks – Awaiting date.

Trust Compliance by Building



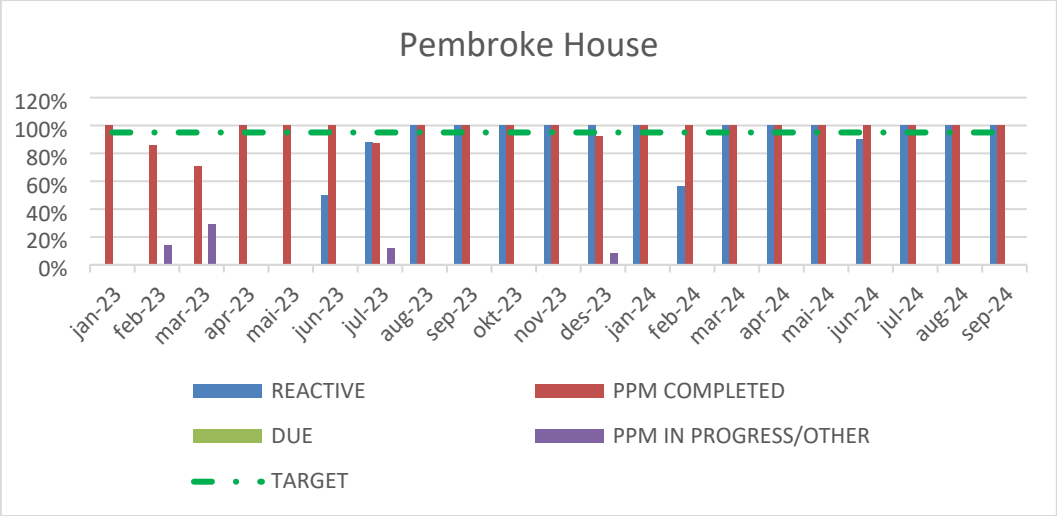
PPM-88%
Reactive-78%
Velindre Cancer Centre has currently migrated to Synbiotix SFG20 WHTM aligned which has created a high number of PPM tasks and we are currently experiencing operational issues as listed in CAFm section (Advise).

Welsh Blood Service HQ



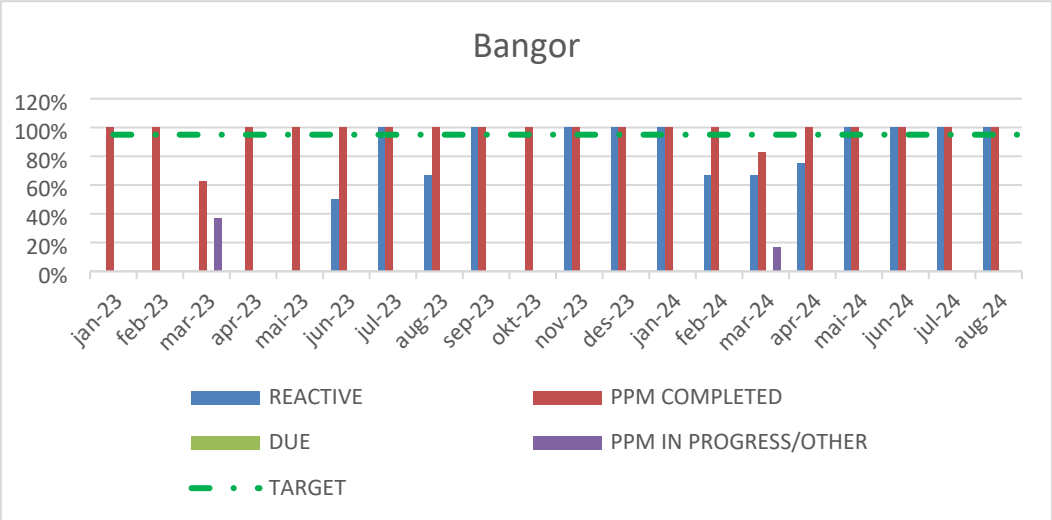
PPM-100%
Reactive-100%

Welsh Blood Service Pembroke House



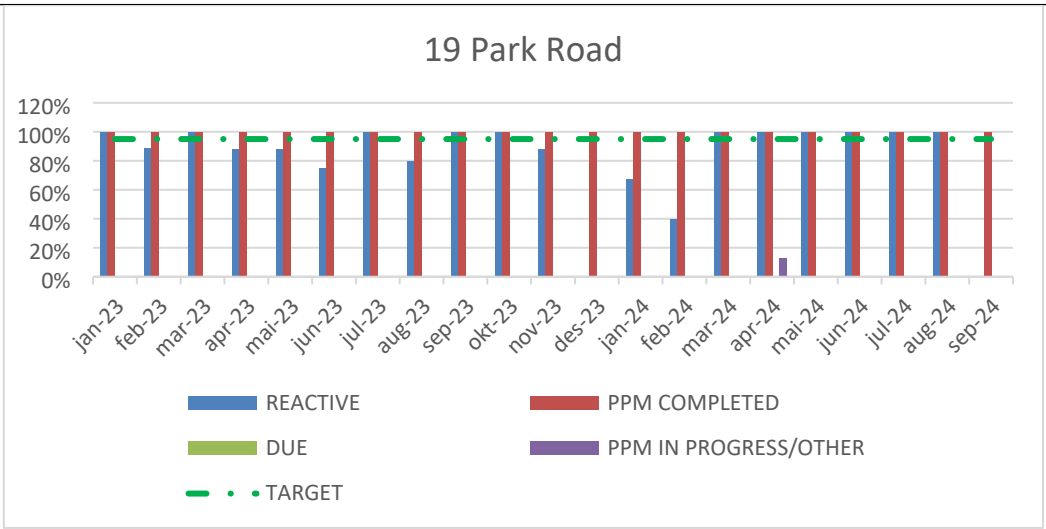
PPM-100%
Reactive-100%

Welsh Blood Service Bangor



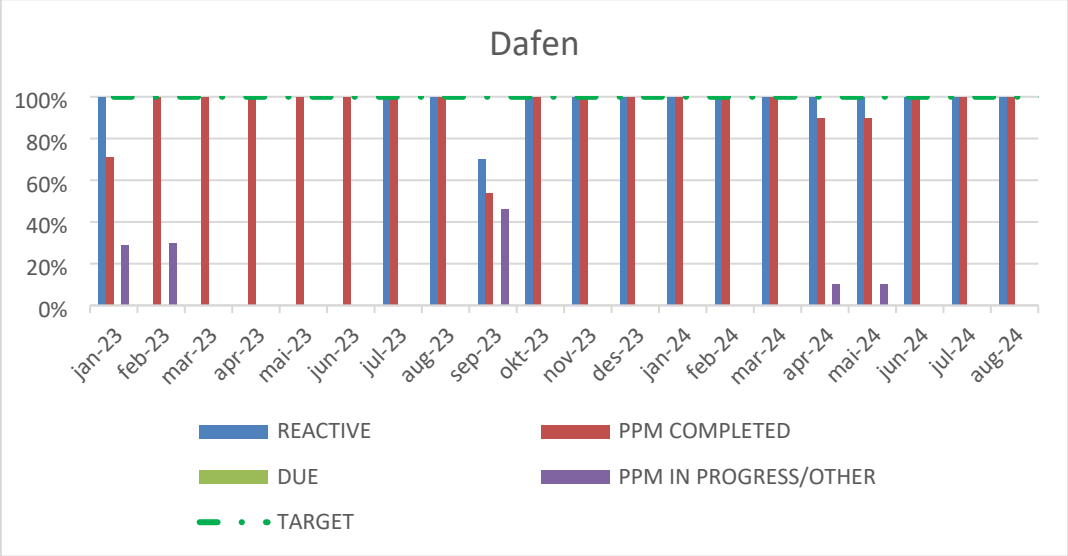
PPM-100%
Reactive-100%

19 Park Road VCC



PPM-100%
Reactive-100%

Welsh Blood Service Dafen



PPM-100%
Reactive-100%

<u>Water Compliance Trust</u>

VCC Water Sampling
Legionella - 29 samples collected – 0 positives.
Pseudomonas PYO – 38 samples collected – 1 positive
Zone 15 room 6 LA 5 staff toilets, out remove cleaned, chlorinated, tested positive after those works. Pipe work then sample and results negative, so the contamination lays within the outlet, resampled 09/10/2024 waiting results.
WBS Water Sampling

Legionella – 17 samples collected – 2 positive.
Positives x2 Donor clinic.

Pipe work modified and outlets replaced to allow filters to be fitted, estates are now flushing daily, sampling scheduled for October.
Positives x1 first floor ward donor clinic.
Outlet filter fitted and estates sampling daily, sampling scheduled in October with all assurance sampling ppm.

WBS Water Sampling Bangor, Wrexham
O positives

Water safety Group VUNHST
Water Safety Groups have met consistently every quarter with good progress and attendance.

Ventilation Compliance Trust

Critical Ventilation Inspections
All Critical Verifications for 2024 are complete on time and any remedial works have been actioned, details in appendices 14/10/2024.
Assets have recently been validated and updated at VCC; a critical plant risk assessment information table is being compiled 14/10/2024.

Ventilation Group VUNHST
Ventilation Group Meets consistently with good attendance.

Electrical Compliance Trust

Low Voltage Compliance
Black start Testing
Following last month's (July) black start test and ACB servicing, the Electrical Estates Officer has revised the site's power outage procedure. The updated procedure will be presented at the upcoming Electrical Safety Group meeting for review and approval.

Electrical SOP's
The Electrical Estates Officer has prepared a Standard Operating Procedure (SOP) for PAT testing of patients' equipment. This SOP will also be presented at the upcoming Electrical Safety Group meeting for review and approval.

Generator Maintenance
Both generators at VCC have been refuelled for 2024/2025, and the legs on the SR 1 generator bulk storage tank were reinforced before refuelling.

	Quotes are being gathered for two new fuel polisher systems for the generator bulk storage tanks at VCC, following a recent recommendation by a servicing Contractor. Work has been carried out on the VCC generator fuel tanks due to signs of corrosion on the existing tank structure, PO raised for the cleaning, treating and painting of the fuel tank. Tank support steel work has been completed. **LV Electrical Inspection and Testing** Plans are being made with contractors for the remaining five-year fixed wire testing at VCC in Zones 5, 7, 8, 10, 14, and 15. These works are taking place out of hours to meet departmental requirements, all LV permits are completed and countersigned by Trust appointed AP's. **Electrical Safety Group** Electrical Safety Group continue to meet consistently with good attendance. Excellent progress has been made completing the actions identified by NWSSP. **Electrical Compliance HV** Black start Testing has been completed without any impact to site; overall exercise was a success with lessons learnt in preparation for next year's plan. An end-to-end document was produced by the Electrical Estates Officer that was presented to SLT VCC. Further progress is being made to complete the operational procedure manual for HV VCC. Estates staff undertaking appointments with NWSSP for limited duties via assessment. HV Contractors **<u>Medical Gas Compliance VCC & Liquid Nitrogen WBS</u>** The Trust has recently successfully appointed 2 AP's for medical gasses assessed by NWSSP Authorising Engineer. **Works** VCC, BOC 15/10/25 Oxygen VIE telemetry upgraded on a low-risk permit. **Medical Gas committee** Medical gas meetings have taken place consistently with good attendance. **Liquid Nitrogen Vessel WBS** Ongoing works to establish future provision of Liquid Nitrogen service at WBS. Continue to manage current vessel in WBS and associated contracts and servicing.

	<u>Fire Safety Compliance</u> The Trust has successfully appointed a Fire Safety Technician who has settled really well into the organisation and is covering all fire safety PPMs and reactive tasks. Fire safety cause and effect exercise is being undertaken in VCC with Fire Safety manager supporting Fire safety technician. Ongoing work with estates team to close Desar fire recommendations. PO's raised to undertake works to paint the Gas main through VCC. Monthly meetings implemented for Fire Safety Manager to meet with Estates team to track and implement actions. **Asbestos** Asbestos awareness training scheduled for VUNHST Estates staff prior to the end of period 2024. Asbestos annual reinspection to be undertaken in VCC January 2025. Asbestos Refurbishment and Development Survey undertaken in WBS prior to WBS electrical resilience works completed. Awaiting report, no issues raised. Assurance document to be completed for WBS Asbestos for TGI works. **Scalding Risk Assessment VCC** All high-risk items have been completed. Meeting to be scheduled to finally agree sign off the outstanding Medium and Low Risks.

INFORM

ISO Audit VUNHST
ISO Audit took place in October 2024 estates supported process, no immediate concerns to raise.

Training Staff
Donning, Doffing and Face mask fitting.

Competency	APRIL	MAY	JUNE	JULY	AUG	SEPT
Donning and Doffing Core	90%	100%	100%	100%	100%	100%
Donning and Doffing Assessment	90%	100%	100%	100%	100%	100%
Hand Hygiene	90%	100%	100%	100%	100%	100%
Fit Mask testing	90%	100%	100%	100%	100%	100%
IPC level 1	94.4%	94.4%	94.4%	89%	89%	77%

NWSSP Audits
Estates has started to centralise the audit actions and will be reporting seven levels of assurance for each area and update on Audit actions as part of this report for the following areas listed below. This will give assurance on the areas of compliance assurance assessed by NWSSP.

- Electrical LV
- Electrical HV
- Medical Gas
- Ventilation
- Water Safety
- Decontamination

Health and Safety
Datix
There were 3 Estates Health and Safety incidents raised on Datix.

1) WBS report of staff and Contractors not using HI Visibility Jackets in Transport Yard.
2) Estates staff member had an accident where he bent down and cut his head on a metal object
3) Office temperature reported as cold in IPAC office.

All Datix incidents are being managed by Senior Estates Officer

5. IMPACT ASSESSMENT

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

If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required - Highlight report for assurance only

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☒ • 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. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
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 – Highlight report for assurance only
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Fire Safety – Highlight Report [September 2024]

DATE OF MEETING	14th November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	ASSURANCE
PREPARED BY	Robin Weaver, Fire Safety Manager
PRESENTED BY	Robin Weaver, Fire Safety Manager
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The report provides a snapshot of the current position of fire safety up to the end of September 2024.

RECOMMENDATION / ACTIONS	The Committee is requested to **NOTE** this report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VUNHST Estates Management Group Meeting	17/10/2024
VUNHST Executive Management Board – RUN	29/10/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS 1. The report was DISCUSSED and NOTED by the Estates Management Group. 2. The report was DISCUSSED and NOTED by the EMB-RUN meeting. Key point was to move the overall training compliance from “Alert / Escalate” to “Advise”, given the good progress made.	

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	NOT APPLICABLE

ACRONYMS	
ESR	Electronic Staff Record
WOD	Workforce & Organisational Development
C&VUHB	Cardiff & Vale University Health Board
ToR	Terms of Reference
FARS	NWSSP Fire Audit & Risk Assessment module
IRR17	The Ionising Radiation Regulations 2017
HSE	The Health & Safety Executive

1. SITUATION

This report provides information to the VUNHST Quality, Safety and Performance Committee on fire safety issues up to the end of *SEPTEMBER 2024*.

The Committee is asked to **NOTE** the contents of the report and the actions which are being taken.

2. SUMMARY OF MATTERS FOR CONSIDERATION

ALERT / ESCALATE	**Strategic** *NIL* to ALERT/ESCALATE for this reporting period. **VCC** *NIL* to ALERT/ESCALATE for this reporting period. **WBS** *NIL* to ALERT/ESCALATE for this reporting period. **Corporate** *NIL* to ALERT/ESCALATE for this reporting period.

ADVISE

Strategic

Fire Safety training

Although work has been undertaken to "cleanse" ESR and fire safety competencies, it is understood that individual training records still have multiple entries for the same competency.

The head of Health & Safety and Trust fire safety manager have discussed the monthly ESR training reports with the ESR team but the suggestion to remove data around long-terms sickness, maternity leave and seconded staff would not have significant impact on the overall number of staff.

Therefore, it is important that heads of department and other managers continue to support their staff to complete their statutory and mandatory training. It is also of value that a more flexible approach to the delivery of training is adopted i.e. time and location of training to allow training to be delivered to suit the needs of staff.

Level 1 fire training across the Trust has improved slightly since August 2024 [up 0.7% from 80.1% (August 2024) to 80.8% (September 2024)] but remains below the 85% benchmark:

MONTH	Mar-23	Jun-23	Sep-23	Dec-23	Mar-24	Jun-24	Sep-24
Actual (%)	88.9	89.4	87.0	80.3	80.8	80.3	80.8
Target	85	85	85	85	85	85	85

Level 2 fire training across the Trust has dropped slightly since August 2024 [down 0.1% from 69.3% (August 2024) to 69.2% (September 2024) and remains below the 85% benchmark:

MONTH	Mar-23	Jun-23	Sep-23	Dec-23	Mar-24	Jun-24	Sep-24
Actual (%)	55.9	58.7	40.3	56.4	59.9	66.8	69.2
Target	85	85	85	85	85	85	85

Drills & Exercises

Although there has been little evidenced progress with drills and exercises, where sites experience incidents requiring emergency evacuation, these events can also be classed as evacuation drills/exercises as staff have had opportunity to "practice" evacuation; procedures have been validated and lessons learnt identified and communicated.

However, this is not considered good practice and should not be relied upon to provide assurance in the medium to long term.
Refer to ASSURE for further commentary.

Miscellaneous Issues

The Trust is taking formal ownership of the former Whitchurch hospital site from C&VUHB; an existing fire risk assessment undertaken by C&VUHB has been received but it is overdue for review. This has been reviewed, alongside the other technical documents and assurance provided to the Trust Board to support the transfer process.

VCC

Policy, Protocols & Procedures

- Work continuing to ensure that there is sufficient evacuation warden coverage across the VCC site with oversight by VCC SLT.
- VCC to undertake departmental gap analysis to identify "regular visitors" to the site.
  Once identified, an abridged version of the Control of Contractor induction to be provided to identified "regular visitors" and records kept.
  Agreed completion date – **end of December 2024**.

Assessments, Audits & Inspections

- VUNHST Estates currently requesting quotations for the provision of access hatches to allow access to fire dampers.

	Agreed completion date – **end of December 2024**. **WBS** *Policy, Protocols & Procedures* Following installation of facilities for lock-down, WBS need to update their Evacuation and Shelter procedure. *Assessments, Audits & Inspections* VUNHST Estates currently requesting quotations for the provision of access hatches to allow access to fire dampers. Agreed completion date – **end of December 2024**. *Miscellaneous Issues* ONGOING ACTION: no further update on progress with the fire dampers in Pembroke House and the need to liaise with the landlord's incumbent fire alarm contractor to rewire the fire damper relay to ensure that dampers remain open until the fire alarm is reset.
ASSURE	**Strategic** *Drills & Exercises* Following request from the Trust Health, Safety and Fire Management Board, the divisions have developed schedules for drills and exercises which will be used to monitor compliance and provide assurance to the divisional Cynefin groups and relevant Trust Boards and Committees. *Refer to appendices regarding development of a schedule for drills & exercises.* **VCC** *Assessments, Audits & Inspections* Fire risk assessments up to date and when due for review, assessments will be recorded using the new FARS module. Actions from annual audit agreed with VCC and action plans in place to resolve and presented to Trust Health, Safety and Fire Management Board: • **Fire Training and Evacuation Drills -** *Do persons visiting this site on a regular basis receive appropriate training in fire safety?* • **Maintenance -** *Are all Mechanical Ventilation Systems and Fire Dampers maintained in accordance with BS 9999:2017 Annex W and Clause 32 and/or with the manufacturers recommendations?*

	WBS *Policy, Protocols & Procedures* ONGOING ACTION: WBS have scheduled delivery of training to staff acting as Evacuation Warden; due to commence September 2024 into October 2024 with mop-up sessions to be scheduled if required. Agreed completion date – **end of November 2024**. *Assessments, Audits & Inspections* Fire risk assessments up to date. Actions from annual audit agreed with WBS and action plans in place to resolve and presented to Trust Health, Safety and Fire Management Board: • **Fire Training and Evacuation Drills -** *Is specific fire safety training provided to staff at this site who have predefined roles in a fire emergency?* • **Maintenance -** *Are all Mechanical Ventilation Systems and Fire Dampers maintained in accordance with BS 9999:2017 Annex W and Clause 32 and/or with the manufacturers recommendations?* **Corporate** *Drills & Exercises* Evacuation drill held for HQ in September and report with lessons learnt shared with Corporate Services lead. *Assessments, Audits & Inspections* Fire risk assessment up to date.
INFORM	**Strategic** *Policy, Protocols & Procedures* Work to develop protocols and strategies to support implementation of the policy [PP01]. *Refer to appendices regarding development of a prioritised schedule for development of protocols.* *Assessments, Audits & Inspections* ONGOING: existing FRAs will need to be migrated over to the new module; project plan to be developed to ensure that FRAs are reviewed in timely fashion based on risk. *Miscellaneous Issues* Continued involvement with other areas of compliance [IRR17, EPRR and ISO14001]: • Authorised Person (Fire) continues to be member of Trust IRR17 working group and T&F group supporting with preparation for HSE registration of sources.

	• Activity includes contribution to risk assessments and development of appropriate emergency evacuation strategies and exercises to validate procedures. **VCC** *Fire Safety training* Training sessions for non-clinical evacuation wardens have been scheduled and advertised; training scheduled to run between late October and mid-November 2024 with option for locally arranged sessions if requested. **WBS** *NIL* to INFORM this reporting period. **Corporate** *NIL* to INFORM this reporting period.

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 ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required – not a strategic decision
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: NO	
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
	Covered by EQIA as developed as part of the Fire Safety Policy
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

Refer to commentary in the ALERT/ESCALATE and ADVISE sections of the report.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Compliance for a number of statutory and mandatory training subjects including fire safety are regularly below the 85% benchmark set by Welsh Government*
WHAT IS THE CURRENT RISK SCORE	Scoring to be re-assessed through November governance cycle
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	1. ESR competencies reviewed to ensure that the correct training is being offered to staff. 2. Cleanse of ESR to ensure that the number of staff requiring training is as accurate as possible. 3. Managers and Heads of Department to own local training needs and support staff to attend training.

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	

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Sustainability Q2 Highlight Report

DATE OF MEETING	14/11/2024

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	**Rhiannon Freshney,** Trust Sustainability Manager **Owen Barnett,** Trust Environment Officer
PRESENTED BY	**Lauren Fear,** Interim Director of Strategic Transformation, Planning & Digital
APPROVED BY	**Lauren Fear,** Interim Director of Strategic Transformation, Planning & Digital

EXECUTIVE SUMMARY	The attached report outlines Update of Q2 the latest position regarding the Trust's Sustainability plans, initiatives and targets. Reporting period July – September 2024. The report covers the following areas: • Trust Well-Being Objectives • Audits • Decarbonisation, Waste, Water & Energy • Biodiversity • Sustainable Travel & Transport

	• Communications, Engagement & Events • Education & Development • Arts in Health • Priorities for the next period

RECOMMENDATION / ACTIONS	No actions required – this report is presented to the Committee for NOTING in respect of the current & ongoing delivery of the Trust's Sustainability Strategy.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Management Group	**17/10/2024**
Executive Management Board	**29/10/2024**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussed and noted by the Estates management Group and Executive Management Board. There were no changes to the report recommended by Executive Management Board.	

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

APPENDICES	
Appendix 1	Sustainability Highlight Report

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1. SITUATION

The Sustainability Highlight Report sets out progress against the sustainability objectives set out in the Trust Integration Medium Term Plan and Trust Sustainability Strategy.

2. MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There are no matters to alert or escalate

ADVISE	**ISO14001 2015 External Audit – Recertification**
	• The Trust has undergone for the first time in five years the ISO14001:2015 recertification audit in the next month.
	• This is required every three years**,** where the entire EMS is audited to ensure ongoing compliance with the ISO 14001 standard and continuous improvement in environmental performance.
	• The first five days audited VCC, Talbot Green and Trust Headquarters. The next two days are 8th and 22nd November respectively.
	• To date, the audit has garnered positive feedback from the auditor.
	
	Energy Management Audit
	• Audit underway to assess the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust
	• It takes account of other supporting regulatory and procedural requirements, as appropriate.
	• The audit will include a review of both central monitoring and site-based implementation of controls (including sample testing).
	• the focus of the current audit will be directed to the following areas:
	  o **Governance** – To ensure that key roles have been assigned and responsibilities of key staff are understood. An appropriate forum has been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.
	  o **Contracts** – Recognising the national contracts in place, to obtain assurance that the Trust obligations under the national contract arrangements are fully understood and applied.
	  o **Data Capture** – Appropriate systems are in place to capture data on energy consumption in a timely manner.
	  o **Data Validation** - Adequate checks are undertaken to verify the quality/ reliability of the data - any anomalies are fully investigated.

- **Monitoring and reporting** – The audit will also look at resulting internal/ external monitoring and reporting arrangements to ensure that anomalies are understood, benchmarking is undertaken where appropriate, and any resulting management action is appropriately tracked.
- **Energy Awareness** – Appropriate training has been established for general and key energy staff focused on increasing awareness of obligations and requirements. Assess any other initiatives established to increase awareness e.g. intranet pages, staff circulars, team briefings etc.
- **Payments** – energy related billing is verified, authorised, and processed in accordance with contractual payment terms.
- **Risk Management** – Examine the systems and controls in place to manage energy-related risks, and to escalate as appropriate. This involves evaluating risk mitigation strategies, ensuring compliance with regulations, and addressing any risk exposure.

Electricity Consumption

- Across the organisation, electricity consumption continues to decrease, this is due to the installation of a new, more energy efficient LINAC, continual LED lighting upgrades and staff campaigns to reduce consumption.

Gas Consumption

- Gas consumption has increased across all sites
- A review of outside air temperatures shows that, compared to the previous year, where there were 15 days of shorter cold spells below 15°C, this year had 25 days of extended periods below 15°C. This triggered the Building Management System (BMS) to activate heating more frequently.
- The installation of new LINAC machines require a stable 21°C for 24 hours, so whilst the electricity consumption from the new machines has been beneficial, the temperature requirements to stabilise the machine has contributed to the increase in gas.

Location of Artworks

- Following a meeting with Soft Facilities Management, the following places have been identified for artworks;
  - Mural outside Assessment Unit
  - Wall in Outpatients
  - Corridor between OPT & RT
  - Radiotherapy wall

Team Sigma

- Working to integrate sigma into the meter read reconciliation - will share log-in details for sigma to team so that validated invoices can be accessed by all team.
- Benchmarking data from 2018/2019 will be inputted into the system in order to assess improvements or highlight areas which are increasing consumption

SIP Plan in draft

- Significant work was undertaken to develop the Sustainability Implementation Programme
- As the SIPs are now complete, how to implement, monitor and manage them have been completed to align
- Discussions with leads across the Trust is underway to ascertain the most appropriate representatives.
- A paper has been submitted to EMB for first review, then will be presented to SLTs/EMB for approval.

St Fagan's Walks

- Monthly support groups for all patients at St Fagan's, which started 26 September
- Following the successful 6-week pilot over the summer we are returning offering a monthly support group that invites patients on a mindful walk followed by a creative activity.

BBC Orchestra of Wales

- Monthly performances in the SACT department
- Incredibly positive feedback from patients and staff

The Art Cart

- Artist will attend VCC and undertake sensory projects, for example, decorating lavender bags.
- Projects will be adapted depending on the patient need and accessibility.
- If patients have a specific passion or interest the artist will bring allow the relevant materials
- Weekly workshops at the bedside on the First-Floor ward started September 24th.
- Week 2 of a pilot delivering art sessions at the bedside on the first floor ward. Patients although a little reluctant are enjoying the interaction and the opportunity to do something different.

ASSURE

Environmental Awareness Compliance

- The Trust is at an all-time high for Environmental Awareness compliance, at 92.5%

Assignment Count	Required	Achieved	Compliance %
1760	1760	1628	92.50%

Org L4	Assignment Count	Required	Achieved	Compliance %
120 Corporate Division	234	234	220	94.02%
120 Research, Development and Innovation Division	60	60	57	95.00%
120 Transforming Cancer Services Division	21	21	19	90.48%
120 Velindre Cancer Centre	983	983	881	89.62%
120 Welsh Blood Service	462	462	451	97.62%

- To increase this further, a targeted action plan has been developed and any and all staff who are non-compliant have been emailed to remind them to undertake the training on ESR or the sustainability team will attend team meetings to undertake training.

Operational Energy Audits

- In alignment with the Trusts Sustainability Strategy, this site energy audit supports the Carbon Zero and Sustainable Infrastructure themes by assessing energy consumption, identifying efficiency opportunities, and recommending actions that will contribute to the Trust's goal of reducing carbon emissions and achieving net-zero targets.
- The audits will focus on optimising energy performance across the Trust's sites, ensuring operational sustainability and supporting the wider objective of transitioning to renewable energy sources.
- The first two audits have been booked in with Estates technicians and Sustainability team. A template has been produced (Appendix 1).

Internal Audits

- In alignment with the Management Review schedule, the following audits have been undertaken;
  - Trust EMS
  - Legal Register
  - Trust Headquarters
  - WBS Talbot Green

- Any non-conformities or OFIs are being tracked and managed through the Corrective Action Tracker, if any actions are not being progressed in line with the agreed timeline they will be escalated to this meeting.

Environmental Manual

- The Trust Environmental Manual has been updated and tailored further to the Trust activities
- In April 2024, an important amendment was made to ISO 14001:2015 as part of the ISO's broader effort to address climate change in organizational management systems. This amendment requires the Trust to integrate climate change considerations directly into their Environmental Management Systems (EMS), this has now been incorporated into the Environmental Manual
- Key Changes to ISO 14001:2015:
    - **Clause 4.1:** Organizations must now assess whether climate change is relevant to their operations. This means evaluating potential risks and opportunities related to climate change within their organizational context.
    - **Clause 4.2:** New guidance highlights the importance of understanding the needs of interested parties (stakeholders), including any climate-related expectations they may have. This could include patients, staff, or regulators within the healthcare system.
- The Trust now has now added responsibility to:
    - Regularly monitor and assess climate-related risks that could affect its services and infrastructure (e.g., extreme weather events impacting hospital services).
    - Incorporate sustainability strategies into its core governance processes and engage stakeholders on climate action.
    - Align its operational goals with broader legislative frameworks in Wales, such as the Well-being of Future Generations (Wales) Act 2015, which mandates public bodies to act sustainably and consider long-term environmental impacts.
- The two major capital projects, nVCC & TGI are considering the affects of climate change
- Work is underway with the Risk & Assurance Manager to develop the EMS Risk Register to comprehensively consider climate change risks
- The Trust has aligned the Sustainability Strategy, SIPs to Environment (Wales) Act and WBFGA.
- In order to adequately assess and monitor associated environmental risks, work is underway with the Risk & Assurance Manager to capture any and all risks on DATIX.

	• The initial assessments have been undertaken and a paper is in draft and with the Risk Manager and ISO14001:2015 Management Group for review. They will be presented to the next EMG.
	
	Well-being Objectives
	• The refreshed Well-being Objectives have been approved.
	• The Trust is required to set its own well-being objectives, which align with the seven national well-being goals outlined in the Act.
	• The Trust must regularly review and assess the effectiveness of its objectives and the steps it is taking to achieve them.
	• The Trust is legally obligated to produce annual reports that detail the progress it has made towards its well-being objectives. These reports must demonstrate:
	  o The steps taken to achieve the objectives.
	  o The extent to which those steps have improved well-being.
	  o The application of the five ways of working (long-term thinking, prevention, integration, collaboration, and involvement).
	• The review undertaken included internal and external engagements. The multi-faceted communications ensured there was a breadth of opinions received.
	• To continually improve and assess the relevance and compliance with the Trust objectives, setting up annual reviews to ensure continued relevance and indices/targets to help measure. Draft indices are under development and being mapped to existing PMF.
	• A mixture of qualitative and quantitative methods will be utilised in order to address the complex nature of the objectives. Work with the Future Generations office is underway to discuss this approach. To date, the Office has been supportive of the work.
	
	Well-being Objectives Audit
	• Currently being undertaken by Audit Wales
	• Once a full report has been provided, findings and management IP responses will be provided to the EMG
	
	ISO14001:2015 Management Group Terms of Reference
	• Annual review of ToR has been undertaken
	• Presented to the EMG for approval.

INFORM	**IP & C & Sustainability** • Working group set up with IP & C and Sustainability team to identify areas of working together to provide more sustainable options across the Trust. • To date, the following changes have been identified; • **Trial of Enhanced Pods**

	o Trial ongoing at the moment- looking at replacing toxic chemicals o Currently trial First Floor ward o Looking to trial at WBS o Likely to trial for 2 weeks o Has been trialled in ABUHB o If not successful, looking at an alternative • **Hexiprep** o Looks similar to a medi swap but half price & reduction of clinical waste o Hoping to get a small number of packs to trial o Currently discussing using in NHS BT o Approved in ANTT o Estimate savings £30k annually o Hayley to share rep as they have calculators on savings • **Gloves** o Arka are making ethically made gloves within Portugal o The dispensers (which release one at a time) made by recycled o Gloves are individually tested – meaning all gloves are usable, and won't be thrown away o Aligns with the *'Gloves Off'* campaign and the company provide training o At WBS, looking at the glove wastage (due to out of date stock) highlighting when it is required to be purchased o At VCC, looking at what / when to use the gloves • **FFP3** o Pre pandemic had 1 size (67p each) o During pandemic have 5 sizes o Looking to streamline, having only one mask with two fits o Out of date stock potentially being donated over to the Ukraine – will follow up on Dave/Paul • **Blue Roll** o Currently using roll after cleaning the beds o Potential for removing this process o o Is being discussed at the next PNF

	• **Alcohol Free Hand Sanitiser**
	  o More sustainable product
	  o Efficacy is the same as the alcohol sanitiser
	  o Kinder to hands / addresses sensitivity issues
	
	Travel Survey
	• The Trust Travel Survey has closed.
	• The survey received 356 responses, this is due to the extensive engagement, both digitally and in person
	• The initial findings showcase good representation from all divisions.
	• Furthermore, there is representation from colleagues from all departments - significantly from clerical, but also positively an increase in responses nursing, clinicians & AHPs, likely due to the increase in person engagement events.
	• The initial findings highlight car is the most common way to travel but staff do travel in a range of ways with (especially considering the second most common way to travel)
	• There has been an increase in the amount of ultra-low emissions EV car ownership.
	• A comprehensive analysis of the survey (with comparison to previous year) will be presented through the governance cycle in November.
	
	Employee Excellence Awards
	• To incorporate sustainability into the event, the awards were made from wood & recycled materials.
	• Sacyr are paying for awards created from wood that has been recycled from the nVCC site.
	• Collaboration with Fab Lab, an open access workshop, will create these awards for our staff.
	• This provides positive linkage with nVCC and good news story, and embeds the circular economy, supporting local jobs and creates links with a new organisation, Fab Lab.
	
	Biodiversity
	• The Trust has a legal obligation to **enhance biodiversity** under several key pieces of legislation. These laws promote the protection, enhancement, and sustainable management of biodiversity and ecosystems.
	• This includes, but is not limited to, the Environment (Wales) Act and WBFGA.

- In the past month, staff events at Talbot Green were held, were staff were invited to make bird houses and decorate batboxes, decorate plant pots and take home wildflower seeds
- wildflower seed planting is being undertaken across sites in readiness for bloom in the Spring.
- Hedgehog houses have been placing at Talbot Green, and spaces in VCC have been identified.
- Volunteers are onsite on 23rd October to sew wildflower seeds across VCC in readiness for bloom in Spring.

Creative Voices

- A creative writing workshop has been arranged for palliative patients.
- The 6-week workshop started on the 9th of September with positive feedback for the first session.
- The sessions are held in the conservatory on site at VCC and are managed by the Arts in Health Coordinator and supported by the Psychology tea.
- Providing patients with an opportunity to express themselves and learn writing skills.
- Halfway through the creative writing pilot for palliative patients. Patients are finding it a useful experience and as a result of the group session, have been steered away from 1-2-1 clinical psychology appointments.

Choir VCC & WBS monthly sessions.

- Both divisions now have a choir, open to all staff, the choir is facilitated by Tenovus.
- The choir will be performing at the Trust AGM 26th September.

Breathe Creative

- Working with Breathe Creative we delivered Arts Engagement training for 40 volunteers – how to use art to start conversations with patients.
- We have been invited back to the Patient Board to deliver a further session.

Cynatope Workshop

- A cyanotype workshop for 20 international nurses which emphasised the importance of being creative at work.
- To celebrate National Poetry Day, we held a poetry reading in the canteen. Members of staff, patients and the wider the community came together to share their love of poetry.

	Waste Management Posters • Developed by NWSSP SES, Waste Management posters have been circulated to be presented on an All Wales basis (Appendix 4).

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
	High performing Estates services are key to maintain the safe, effective and efficient delivery of all Trust clinical and operational services.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A Resilient Wales A Globally Responsible Wales
	The Trust Well-being goals being impacted by the matters outlined in Annual Report
	A Globally Responsible Wales
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This paper provides and update last years progress in terms of the delivery of the Trust Estates programme and associated objectives - themes. There are no aspects of the update that change or introduce changes that impact upon equality.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Anti-racist Wales Action Plan – six-monthly update

DATE OF MEETING	14 November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

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

RECOMMENDATION / ACTIONS	To NOTE the update.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29.10.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
NOTED.	

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

APPENDICES	
1	Anti-racist Action Plan Progress - October 2024.

1. SITUATION

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

- It is built on the desire to strive for a nation in which there is zero tolerance of racism in all its guises
- It has been developed through co-creation with stakeholders from the breadth of racial and ethnic groups in Wales
- It is designed as a stepping stone between the legal requirements under the Equality Act 2010 and the practical implementation of racial equality in day-to-day life

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

2. BACKGROUND

2.1 An update on the Anti-racist Action Plan and WRES report was presented to EMB and QSP in September. QSP asked for a more specific action plan to be developed and submitted to their meeting in November 2024. This action plan is attached at Appendix 1.

3. ASSESSMENT

3.1 The attached report shows that 12 of the 34 actions are now closed.

3.2 The Trust has put in place the building blocks for becoming an Anti-racist organisation through:

- Embedding anti-racism into the Strategic Equality Plan 2024-2028
- Embedding anti-racism in the Integrated Medium Term Plan
- Enforcing a comprehensive approach to undertaking Equality Impact Assessments for all policies and decisions through the Trust's governance systems
- Mainstreaming anti-racism into management development programmes
- Supporting the launch of the Workplace Race Equality Standard (WRES) and acting on its findings.

3.3 Priorities for Quarter 3 2024-25 are:

- Establishing the Staff Race Forum
- Running a pilot of Diverse Cymru's Cultural Competence training
- Rolling out the Anti-racist training programme on ESR
- Designing the next steps for Board development on cultural competence and anti-racism
- Delivering the changes highlighted by the Trust's 2024 WRES report.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 There are a two outstanding issues where the Trust is awaiting national developments: the Cultural Ambassador Role profile and the Board training materials.

4.2 In addition, the Trust will need to work with organisations across NHS Wales to develop a talent pipeline and succession plan for Black, Asian and Minority Ethnic staff. Whilst positive principles can be embedded into our approaches to

recruitment, development and progression, the size of the Trust means that any effective pipeline would need to work across a wider part of the health system.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	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 More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	None
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Ref	National Actions	Original Deadline set in 2022
1	Trust Chair's objectives to be set in support of this anti-racism work, to be discussed by relevant stakeholder groups and agreed by Ministers or Welsh Government Senior officials.	sep-23
2	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	mar-23
	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	December 2022 and ongoing
3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	Summer 2023
3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	des-23
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	December 2022 and ongoing
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	des-23
5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	des-23
5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	jun-23
6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	sep-23
6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	sep-23
7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	sep-23
7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	sep-23

8	Review People policies to ensure they fully support all employees	des-23
9	Implement an anti-racist communication plan and create forums for Black, Asian and Minority Ethnic staff to communicate their experiences and ideas.	sep-23
9	Providing Ethnic Minority Networks appropriate levels of resource and access to the Board.	sep-23
10	Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)	sep-23
10	Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process.	des-23
11	Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	
11	Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	des-23
11	Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	des-23

11	Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	des-23

Trust SMART Objectives

Share the Chair's objectives with all Board members to highlight Anti-racism commitments

Consult with staff, patients and donors to test what their experience is and what needs to change

Develop, implement and monitor these plans through the Healthy and Engaged Steering Group.

Deliver Board Development awareness session on importance of cultural competence

Deliver Board development programme during 2023 commissioned by Public Bodies Unit, WG

Board members will role model anti-racist practices by challenging discrimination, listening to lived experiences and considering racial perspectives when making decisions.
Anti-racist objectives to be cascaded through every level of the organisation and made relevant to each job role.
Implement programme when available.

Offer coaching to support leaders implement and enhance practice in supporting their Black, Asian and racially minoritised colleagues

Build on existing role of Executive Equality Ambassador
Develop Cultural Ambassador role once role profile is available
Establish a pipeline for Black, Asian and Minority Ethnic staff as part of Trust talent management approach
Review promotion and development process to ensure there is no bias or bias is mitigated

Examine all Trust recruitment processes through an anti-racist lens

Re-Establish Black and Ethnic Minority staff group. Terms of Reference to set out how they have access to the Board and that they are a resource for consultation and communication.
Standardise the consideration of staff, patient and donor stories setting out the lived experience of people from different racial backgrounds.
Ensure monitoring is in place and includes Leavers, Promotions, Training Opportunities, Grievances, Complaints, recruitment applications v shortlisted v successful and staff engagement surveys
Capture and include discrimination and bullying data within Workforce Reports.

Capture and include discrimination and bullying data within Workforce Reports.

Develop clear robust processes and provide sufficient channels for staff to record and report racial discrimination and for the Trust to take action

Issue regular communications regarding zero tolerance of inappropriate behaviour

Work with Trades Unions to find ways for lower paid workers from ethnic minorities to raise concerns such as Speak Up initiatives, surveys and networks.
Monitor uptake and remove barriers to access.

Progress 17.10.24	Open or Closed
Specific objective regarding Anti-racism contained within Chair's and Independent Member for ED&I's Objectives for 2023-24. Situation for 2024-25 to be confirmed.	Open
Staff Race Forum recruited to throughout 2024. Patient forum and Donor forum are in place to consult with people and develop anti racism plans.	Open
	Open
Introductory presentation from Diverse Cymru presentation 27.10.22.	Open
Awaiting on materials from Welsh Government	Open
A specific development programme for Board Members is to be developed in conjunction with the Independent Member for ED&I.	Open
	Open
Package added to ESR in September 2024. To be rolled out acrsoo Trust by 31.3.25	Open
	Open
	Open
Not yet available	Open
	Open
The WRES 2024 report reflects opinions about access to development in line with ethnic origin. Fuller analysis to take place at year end 2024-25.	Open

WRES data was reviewed by the People and OD team on 3.10.24 to determine any changes to processes required. The recommendations of the All Wales Audit of Workforce Policies through an anti-racist lens was also shared. Changes being implemented.	Open
Advertising and recruitment to the Forum undertaken in 2024. Will seek support from Executive Amabassodor for Race to prompt acivity.	Open
To be developed by staff forum.	Open
To be reported for year end 2024-25	Open
The systems for Speaking Up Safely have been established with links available and information on the intranet providing clear processes for recording and reporting discrimination. The NHS Staff Survey data and the WRES indicators on Bullying and Harassment will be examined during Q3 2024-25 to lead recommendations of how to bring this to life for all staff by removing barriers to access	Open
The systems for Speaking Up Safely have been established with links available and information on the intranet providing clear processes for recording and reporting discrimination. The NHS Staff Survey data and the WRES indicators on Bullying and Harassment will be examined during Q3 2024-25 to lead recommendations of how to bring this to life for all staff by removing barriers to access	Open
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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NHS Staff Survey Update

DATE OF MEETING	14 November 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	As requested at QSP on 12 September 2024, this paper presents a revised Action Plan for 2024-25.

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

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29.10.24

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
This paper updates the action plan that was submitted to EMB and QSP in September 2024 providing a more detailed action plan at Appendix 1. The update was NOTED by EMB on 29 October 2024.

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

APPENDICES	
Appendix 1	Table of actions supporting the NHS Staff Survey themes

1. SITUATION

1.1 Initial results from the NHS Staff Survey 2023 were first shared with EMB on 18 March 2024. Subsequent reports have presented more detailed findings and included an outline of actions in hand.

1.2 As requested at QSP on 12 September 2024, this paper presents a revised Action Plan for 2024-25.

2. BACKGROUND

2.1 The NHS Staff Survey was introduced in 2023 as a medium for gaining feedback from staff about their experience of working in their organisation. Whilst it is a large survey and is replicated in all NHS Wales organisations, it is not the only source of feedback the Trust has relating to staff experience. The Trust has sought to align actions indicated as required by staff survey results with existing programmes of work so that change is owned by relevant stakeholders across the Trust.

3. ASSESSMENT

3.1 The table at Appendix 1 shows the progress with the workstreams relevant to the NHS Staff Survey themes.

3.2 Actions already completed are:

- Develop Retention Plan for Nursing following the HEIW Retention Framework.
- Approve Incident Management Framework and Learning Framework
- Adopt Values and Behaviour Framework
- Run the Employee Excellence Awards 2024

3.3 Priorities for Quarter 3 are:

- Build a report for measuring psychological safety
- Create development sessions for staff to explore the Values and Behavioural Framework
- Systemise access to team development
- Progress the project for digitising the PADR form and the People Development Policy form.

3.4 The communications which is supporting the roll out of the 2024 Survey includes a summary of actions under a You Said/We Did article on the intranet, as below.

Job Satisfaction *- **58%** of staff agreed they were satisfied in their current role and intend to remain in it for the foreseeable future. To build on that figure, we have used staff feedback in the generation of our Nursing Retention Plan. This will see the introduction of 'stay interviews', which provide an effective way to understand why you stay working for the Trust and the reasons for your continued loyalty. These will be implemented further over the next couple of months. The Nursing Retention Plan will be extended to a Trust wide Retention Plan in the coming year.*

Growth and Development *- **72%** of staff have had an appraisal in the last 12 months and **59%** say they feel supported to develop their potential. We have just updated our PADR Policy and our People Development Policy to give you easier access to development opportunities and satisfying project within your work. You will see new forms and training being rolled out over the next six months.*

Bullying and getting a Psychologically Safe Workplace *- The survey said, in the last year, **18%** of staff had experienced bullying by a colleague and **15%** had been bullied by a manager. The last time colleagues experienced bullying and harassment, only **20**% reported it. **9%** of staff did not feel secure raising a concern about unsafe clinical practice. As well as setting in place the Freedom to Speak Up system, we are prioritising wellbeing and building a positive culture based on the values of Caring, Respect and Accountability.*

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The NHS Staff Survey captures a snapshot of views against certain aspects of working life at a point in time. This feedback can help inform our understanding of employees' daily experience in the Trust from the perspective of ten Themes. It is necessary to take a step back to look at a range of interventions across the board that are in hand to improve employee experience, including actions specifically provoked by Staff Survey feedback but also those emanating from other sources of feedback or guidance.

4.2 Furthermore, success with the actions in the attached Appendix depends on a Trust-wide approach to improving culture and inclusion, which is a wider question than addressing NHS Staff Survey feedback.

4.3 The NHS Staff Survey 2024 is open between 1 October 2024 and 28 November 2024. This has been supported by video items from the Interim Chief Executive and the Executive Director of OD and Workforce as well as a short You Said/We Did item on the intranet and a heavy emphasis on managers encouraging staff in their teams to participate.

4.4 The results from the 2024 survey will be available in March 2025. The presentation of the figures and scope for analysis will be improved compared with 2023. The

Trust will be in a position to track year-on-year changes in key questions and start to work at a more granular level with departments.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☐
	The Staff Survey contains sections for Patient Safety, for Diversity, Equality and Inclusion and Nurturing Healthy Working Environments which reports on Harassment and Bullying. Using these results will directly support building a Safe and Equitable workplace.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	No proposals for changes that impact on people are included.

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • 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. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	No proposals for changes that impact on people are included.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Theme	Action 2024-25
Morale	Develop Retention Plan for Nursing following the HEIW Retention Framework.
Patient Safety	Approve Incident Management Framework and Learning Framework
Compassionate and Inclusive	Adopt Values and Behaviour Framework
Recognising Contribution	Run the Employee Excellence Awards 2024

Measure	Cross reference	Lead
An agreed retention plan in place.	Retention Action Plan	Retention Lead
Frameworks approved and in place	Integrated Quality and Safety workplan	Head of Quality and Safety
Values and Behaviour Framework approved and in place	OD Programme	Head of OD
Event takes place, increased nominations from 2023	Wellbeing Action Plan	Head of OD

Deadline for completion	Open or Closed	Progress at 22.10.24
30.9.24	Closed	Draft Nurse Retention Action Plan accepted by EMB 25.9.24 as first phase in Trustwide Staff Retention Plan
30.9.24	Closed	Frameworks have been approved and are in place.
30.9.24	Closed	Values approved January 2024. Working Together staff briefing took place 22.7.24. All People policies were updated by the end of September 2024.
31.10.24	Closed	Nominations closed with over 200 received (up from 2023). Event took place on 8 October 2024.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Duty of Quality Update Report November 2024

DATE OF MEETING	14/11/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	DR RUTH ALCOLADO (NWSSP)
PRESENTED BY	Dr Ruth Alcolado
APPROVED BY	Choose an item

EXECUTIVE SUMMARY	The Duty of Quality which applies to both clinical and non-clinical services came into force in April 2023. This paper outlines the steps made in NWSSP in ensuring improving quality is at the heart of the wide variety of services provided by NWSSP on behalf of NHS Wales.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee are asked to **NOTE** the progress made against the Duty of Quality.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
MD reviewed and approved	(16.10.24)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE - N/A

APPENDICES – N/A

1. SITUATION

The Duty of Quality came into force in April 2023.

The Duty is measured against 12 Health and Care standards which should be taken into account when making decisions regarding delivery of clinical and non-clinical services.

The traditional 6 domains of clinical quality were supplemented with 6 enablers to produce the 12 Health and Care standards.

12 Quality Standards:

1) Safe
2) Timely
3) Effective
4) Efficient
5) Person Centred
6) Equitable
7) Leadership
8) Workforce
9) Culture
10) Information
11) Learning/Improvement
12) Whole System

2. BACKGROUND

Quality as outlined in the Duty, comprises12 domains, these domains should be reflected in 4 processes that make up a quality management system, namely quality planning, quality control, quality improvement and quality assurance.

Reporting was mandated in the form of a public facing annual report and 'always-on' reporting, again aimed primarily at the public in Wales.

The mechanism for reporting for NWSSP has been agreed at Partnership committee, and previously presented at this meeting.

There are 3 strands to Duty of Quality reporting in NWSSP:

1) Annual report to be provided as agreed as a separate annex to the VUNHST Annual Duty of quality report. This was delivered in May 2024 for the period April 2023-March 2024.The next report will be delivered in May 2025.
2) Always on reporting on NWSSP quality, a monthly update will be provided on the NWSSP intranet site.
3) Information will be provided to NHS bodies in Wales in support of their duty of quality where NWSSP provides services for and to them on behalf of NHS Wales.

3. ASSESSMENT

3.1 Update on progress:

3.1.1 A duty of quality site has been introduced to the NWSSP SharePoint site. Videos continue to be produced by each division in turn and are uploaded to the intranet. The service submissions can be found at https://nhswales365.sharepoint.com/sites/SSP_Intranet/SitePages/Dui.aspx

These videos will provide details of the current quality management systems in place in various divisions. The videos give examples of quality improvement work as well as outlining the quality planning, quality control and quality assurance mechanisms in place, and align to the Duty of Quality enablers and domains.

3.1.2 Details of external and internal awards are shared within each division, on SharePoint and in the annual report.

3.1.3 The NWSSP implementation group continues to meet and share best practice.

3.1.4 The 2024/27 IMTP underwent an impact assessment to ensure that our plans outlined in the document took account of, and would have a positive impact on, the 12 health and care quality standards. This was done for the first time and

was well received. The 2025/28 IMTP including the Quality Impact Assessment is in development, in line with WG planning timelines.

3.1.5 NWSSP has undergone Customer Service Excellence (CSE) Assessment for the second time as a whole organisation, following on from last year's successful submissions. NWSSP is the first organisation within NHS Wales to retain this prestigious accreditation. The CSE accreditation team assesses the organisation and measures customer focused areas that research has identified as a priority to customers with a particular focus on Customer Insight, Culture of the Organisation, Information and Access, Delivery and Timeliness and Quality of Service. The assessment process took 5 days and used remote assessments, documentary self-assessment and corporate management team and assessor meetings.

As part of the assessment NWSSP maintained 12 Compliance Pluses - which means that the organisation exceeded the required standards. This was particularly noted, as organisations usually receive between 2-3 Compliance Pluses when assessed. Shared Services also achieved 45 Compliances where in each instance the standard required is met, with no Partial Compliances / areas of Improvement which is a fantastic achievement. Aspirationally there is room to increase the number of Compliance Pluses.

The certification is valid for three years.

3.2 Annual Report

The annual Duty of Quality report is in preparation detailing the progress made against the duties placed upon us to demonstrate the continuous improvement of the quality of services we provide to our partners, customers and the people of Wales. Welsh translation is ongoing and will enable us to make the report public facing.

The NWSSP report will again form a separate annex or chapter, within the VUNHST report and the reporting structure remains unchanged from last year.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Quality, Safety & Performance Committee are asked to **NOTE** the progress made against the Duty of Quality.

5. IMPACT ASSESSMENT

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

If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). This report is focused on the domains of quality and the associated enablers.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No