Bundle Public Quality, Safety and Performance Committee 10 November 2022

0.0.0 10:00 - PRESENTATIONS

0.0.1 Welsh Blood Service - Donor Story

To be led by Julie Farrup, Donor Recruitment (WBS) and Rachael Hutchings, Welsh Bone Marrow Registry (WBS)
Link to video: https://youtu.be/ojSy_0WZgXw

1.0.0 10:15 - STANDARD BUSINESS

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

1.1.0 Apologies

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

1.2.0 Attendance

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

1.3.0 Declarations of Interest

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

1.4.0 10:20 - Review of Action Log

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

1.4.0 Public QSP action log - Nov 22.pdf

1.5.0 10:25 - Matters Arising

To be led by Vicky Morris, Quality, Safety and Performance Committee Chair
Health Inspectorate Wales Report - DBS issues and recommendations (following action 4.8.0 14th July 2022 Committee) - This is included in item 4.12.0
Receipt of briefing on oral SACT patient education (following action 2.2.8 July 2021 Committee) - 1.5.0a
Estates Assurance (following action 4.5.0 15th September Committee) - 1.5.0b

1.5.0a Pharmacy Oral SACT Education Service Update Nov 2022 (003).docx

1.5.0b Estates Assurance (003).docx

2.0.0 CONSENT ITEMS

2.1.0 10:35 - ITEMS FOR APPROVAL

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

2.1.1 Draft Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 15th September 2022

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

2.1.1 Public Quality Safety Performance Committee Minutes 15.9.22 (v4approved).docx

2.1.2 Trust Policies for Approval

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Carl James, Director of Strategic Transformation
2.1.2a - QS25 - Preceptorship Policy
2.1.2b - IPC00 - Infection Prevention & Control Framework - The Accountabilities and Responsibilities, IPC10 - Hand Hygiene Policy & Procedure, IPC21 - Policy for the Management of Respiratory Infections
2.1.2c - PP04 - Asbestos Policy, PP05 - Control of Contractors Policy, PP09 - Water Safety Policy

2.1.2a Preceptorship Policy.docx

2.1.2b QSP policy paper October 2022.docx

2.1.2c Estates Policies.pdf

2.1.3 Duties of Quality & Candour Report

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

2.1.3 Duty Candour - Duty Quality paper.docx

2.2.0 ITEMS FOR ENDORSEMENT

2.2.1 Nurse Staffing Levels (Wales) Act 2016 Report

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

2.2.1 V4 Annual Presentation of Nurse Staffing Levels to QSPOct 22.pdf

2.3.0 ITEMS FOR NOTING

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

2.3.1 Draft Summary of the unapproved Minutes from the meeting of the Private Quality, Safety & Performance Committee held on 15th September 2022

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

2.3.1 Private Quality Safety and Performance Committee Summary Minutes 15.9.2022(V3approved).docx

2.3.2 Digital Service Operational Report

To be led by David Mason-Hawes, Head of Digital Delivery

2.3.2 QSP Digital Services Operational Report.docx

2.3.3 Highlight Report from the RD&I Sub Committee

To be led by Jacinta Abraham, Executive Medical Director

2.3.3 RDI Public Highlight Report 21.07.22 Final.docx

2.3.4 Highlight Report from the Infection Prevention & Control Management Group

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

2.3.4 QSP IPCMG Highlight report October 2022 (002).docx

2.3.5 Freedom of Information Requests - deferred from September 2022 Committee

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

2.3.5 FOI QSP Report Jan to Sept 2022.pdf

2.3.6 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report

To be led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee

2.3.6 Highlight Report - PUBLIC TCS 18.10.22 - CJ - SH.docx

2.3.7 Health Inspectorate Wales

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science Health Inspectorate Wales Annual Report

2.3.7 HIW 21-22 annual report QSP.docx

2.3.7a HIW Annual Report - 2021-2022 - FINAL - EN.pdf

2.3.8 Health & Care Standards Report

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

2.3.8 Health & Care Standards - Quarter 2.docx

2.3.9 Radiation Protection and Medical Exposure Strategic Group Highlight Report

To be led by Jacinta Abraham, Executive Medical Director

2.3.9 Radiation Protection and Medical Exposure Strategic Group Highlight Report 06.10.22.docx

2.3.10 Wales Infected Blood Support Scheme (WIBBS) Annual Report 2021-22

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

2.3.10 WIBSS - Annual report - cover QSPC.docx

2.3.10a WIBSS WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS) ANNUAL REPORT 20212022 ver2.pdf

2.3.11 COVID-19 Inquiry Preparation Group

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

2.3.11 COVID 19 Prep Group Highlight Report -QSP.odt

2.3.11a Covid-19 Inquiry Preparaton Group-ToR - Aug 2022.docx

3.0.0 10:50 - Velindre Quality & Safety Committee for NHS Wales Shared Services

To be led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Services Partnership Healthcare Standards Report
To be led by Roxann Davies, Corporate Services Project Manager, NHS Wales Shared Services Partnership

3.0.0a Quality Safety Performance Committee - CIVAS@IP5 Nov 2022.docx

3.0.0b Service Report Sept 2022.pptx

3.0.0c CIVAS@IP5 Inspection Action Plan (003) .docx

NWSSP Health and Care Standards Self-Assessment.pdf

4.0.0 MAIN AGENDA

4.1.0 11:05 - IMTP - Quality Issues arising requiring Committee Assurance

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

4.1.0 IMTP 2022-23 Quarterly Actions Progress.pdf

4.2.0 Committee Effectiveness Survey Report

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of Corporate Governance

QSP Annual Effectiveness Survey Cover Report_Final(02).docx

4.2.1 Committee Terms of Reference and Operating Arrangements

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of Corporate Governance

4.2.1 QSP Terms of Reference Cover Report QSP.docx

Appendix 1 - QSP TOR Nov 2022 clean.docx

Appendix 2 - QSP TOR Nov 2022 track changes.docx

4.2.2 Quality, Safety & Performance Committee Cycle of Business

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of Corporate Governance

4.2.2 QSP Cycle of Business Cover Report_DraftNov 22 1.0.docx

QSP Committee Cycle of Business Nov22-Sep23 - REVIEW(v2).pdf

4.3.0 11:30 - Workforce & Organisational Development Performance Report / Financial Report

To be led by Sarah Morley, Executive Director of Workforce & Organisational Development and Matthew Bunce, Executive Director of Finance
Including:
Finance Report
TCS Programme Finance Report
Workforce Report

4.3.0a QSP Finance Workforce Key Risks Paper - final Nov.docx

4.3.0b Month 6 Finance Report.pdf

4.3.0c TCS Programme Finance Report.docx

4.3.0d Trust-wide WOD Performance Report - September 2022.pdf

4.4.0 11:45 - Quality & Safety Reporting

To be led by Cath O'Brien, Chief Operating Officer

4.4.0 VUNHST SEPTEMBER PERFORMANCE COVER PAPER FOR OCTOBER QSP 1.11.22 .docx

4.4.1 Welsh Blood Service Quality Safety & Performance Divisional Report

To be led by Alan Prosser, Director of Welsh Blood Service
Including:
15 step challenge action plan (Laboratories visit May 2022)
15 step challenge action plan (North Wales Collection visit (Wrexham) August 2022)

4.4.1a WBS Q+S Report November 2022 v8AP.docx

4.4.1b Sept2022 PMF Final Report.pdf

Appendix 1 - 15 step challenge WBS Laboratories.pdf

Appendix 2 - 15 step challenge WBS North Wales.pdf

4.4.2 Velindre Cancer Service Performance Report

To be led by Rachel Hennessy, Interim Director of Velindre Cancer Service
Including:
15 step challenge action plan (Radiotherapy Department visit, July 2022)
15 step challenge action plan (First Floor Ward visit, September 2022)

4.4.2 VCC Performance Report - Sep 2022 v5_.docx

Appendix 1 - 15 step challenge Radiotherapy VCC 26.7.22(OCT).pdf

Appendix 2 - 15 step challenge 19.10.22 - First Floor Ward Action Plan.pdf

4.5.0 12:00 - Putting Things Right Report - Quarter 2

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

4.5.0 Putting Things Right Report - Quarter 2 2022 v3.docx

4.6.0 12:05 - Private Patient Improvement Plan

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

4.6.0 Private Patient Report.docx

4.6.0a PPS Action Plan 230822 v 4 20.9.22.pdf

4.7.0 12:15 - Annual Estates Report

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

4.7.0 Estates Annual Report 2021-2022docx.docx

4.8.0 12:20 - Audit Wales Quality Governance Review

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, Lauren Fear, Director of Corporate Governance and Chief of Staff and Katrina Febry, Audit Lead, Audit Wales

4.8.0 QSP - AUDIT WALES - QUALITY GOVERNANCE REVIEW MANAGEMENT RESPONSE-10.11.22.docx.pdf

4.8.0a VUNHST Review of Quality Governance Arrangements.pdf

4.9.0 12:30 - Healthcare Inspectorate Wales

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

4.9.0 HIW Inspection Reports.pdf

4.10.0 12:35 - Highlight Report from the Patient Safety Alerts Group

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

4.10.0 QSP Committee Patient Safety Alerts Management Group Highlight Report October 2022 v2.docx

4.11.0 12:40 - Quality & Safety Framework and Quality Priorities Update

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

4.11.0 Quality & Safety Framework Implementation Update (1).docx

4.11.0a Quality & Safety Quality Improvement Goals.docx

4.12.0 12:45 - Highlight Report from the Safeguarding & Vulnerable Adults Group

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

4.12.0Safeguarding & Vulnerable Adults Group highlight report.docx

4.13.0 12:55 - Highlight Report from the Medicines Management Group

To be led by Jacinta Abraham, Executive Medical Director

4.13.0 MMG Update Report for QS&PC.docx

4.14.0 13:00 - Quality, Safety & Performance Committee - Policy Compliance Report

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

4.14.0 Policy Compliance Report v2.pdf

4.14.0a Appendices.pdf

4.15.0 13:05 - Highlight Report from the Trust Estates Assurance Group

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

4.15.0 Estates Highlight Report.docx

4.16.0 13:10 - Trust Risk Report

To be led by Lauren Fear, Director of Corporate Governance and Chief of Staff
Trust Assurance Framework

4.16.0 QSP Trust Risk Register Paper - 24.11.22 - Final.pdf

4.16.0a - QSP - TAF REVIEW PAPER - 10.11.2022.pdf

5.0.0 13:20 - INTEGRATED GOVERNANCE

5.1.0 November Analysis of triangulated meeting themes

To be led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members
November Analysis of Quality, Safety & Performance Committee effectiveness
To be led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members

6.0.0 HIGHLIGHT REPORT TO TRUST BOARD

Members to identify items to include in the Highlight Report to the Trust Board:
For Alert/Escalation
For Assurance
For Advising
For Information

7.0.0 ANY OTHER BUSINESS

Prior approval by the Chair required.

8.0.0 DATE AND TIME OF THE NEXT MEETING

The Quality, Safety & Performance Commitee will next meet on the 17th January 2023 from 10:00h - 13:00h via Microsoft Teams.

QUALITY, SAFETY AND PERFORMANCE - PART A					
Minute ref	**Action**	**Action Owner**	**Progress to Date**	**Target Date**	**Status (Open/Closed)**
Actions agreed at the 17th February 2022 Committee					
	A Public Health Wales representative to be invited to a future Board Development Session to facilitate a discussion in relation to the Trust's role / requirements & public health. A summary paper will be presented to the July 2022 Committee.	Lauren Fear	**Update 14/07/2022** - Professor Kelechi Nnoaham (Executive Director of Public Health CTM) has been invited to the October 2022 Board Development Session and a summary paper is to be reported to the November Committee.	10/11/2022	OPEN
Actions agreed at the 14th July 2022 Committee					
2.2.8 July 2021 Committee	Supersedes action closed at July 2022 Committee. Formal briefing in relation to how oral SACT education has been provided to all patients via the Task Force to be issued to all Committee members ahead of September Committee as the July 2022 deadline has now passed.	Cath O'Brien	**Update 30/08/2022** - A paper will be presented to SLT on 8th September 2022, followed by the November QS&P Committee (under matters arising).	10/11/2022	CLOSED
4.4.0	ND to confirm Trust position re Putting Things Right in comparison to other organisations in the next quarterly PTR report.	Nigel Downes	**Update 08/09/2022** - A comparison to other organisations will be included in a future quarterly PTR report.	17/01/2023	OPEN
4.8.0	Health Inspectorate Wales Report detailing DBS issues and recommendations to be included as a main agenda item at the September	Nigel Downes/Tina Jenkins	**Update 07/09/2022** - This will be included as an appendix within the Safeguarding Highlight Report sight of this at the Safeguarding & Vulnerable Adults	10/11/2022	CLOSED

	Committee in addition to the Trust's current position in relation to the recommendations.		Management Group at the November Committee.		
Actions agreed at the 15th September 2022 Committee					
0.0.1	RH/VCS team to explore options for improved access to ambulance transport for Radiotherapy daycase patients.	Rachel Hennessy	**Update 03/11/2022** - This will be addressed at the November Committee.	10/11/2022	OPEN
3.0.0	GT to provide appendix outlining evidence of compliance (based on local audit, national audit and regulatory) in future reporting to QS&P Committee.	Gareth Tyrrell	**Update 28/10/2022** - Confirmed that local and regulatory audits are currently reported to each QSP and will continue to be reported as well as raising of any actions arising from such audits.	10/11/2022	CLOSED
4.1.0	Executive Team to review nationally agreed Workforce Planning Principles to identify how these can be best adopted to serve the Trust's purpose.	Executive Management Team	**Update 06/10/2022** - Workforce Planning Principles approved by Executive Team at EMB Shape following Committee (26/09/2022).	10/11/2022	CLOSED
4.1.0	More specific completion dates to be included within Workforce area of triangulated report.	Sarah Morley	**Update 28/10/2022** - These are now included in reports going forward.	10/11/2022	CLOSED
4.1.0	(Staff wellbeing update) SfM to provide update at November QS&P Committee in relation to support provided by the Trust to assist staff with the cost of living crisis.	Sarah Morley	**Update 28/10/2022** - The triangulated Finance and Workforce and Organisational Development Report contains details of support offered in relation to the cost of living crisis.	10/11/2022	CLOSED
4.5.0	Progress against actions in relation to fire, electrical, water safety risk assessments (from Statutory Safety Management Group) to be reported to the QS&P Committee (and included on Cycle of Business).	Carl James	**Update 01/11/2022** - An additional paper will be included under 'matters arising' section of November Committee agenda.	10/11/2022	CLOSED

4.5.0	CJ to check accuracy of data protection breach detailed in Health & Safety Annual Report and amend if required.	Carl James	**Update 01/11/2022** - Information confirmed as accurate and closed.	10/11/2022	CLOSED
4.5.0	Executive Team to receive Health & Safety Training above core requirements once requirement have been confirmed.	Carl James	**Update 01/11/2022** - • Clarified required level of training required for Directors (IOSH). • Initial sourcing of a number of providers undertaken. • Finalising Directors' current training competence to assess training requirements. • Date to be identified around Directors' diaries.	10/11/2022	CLOSED
4.7.0	Investigate the potential for reporting against protected characteristics (PTR) at national forums.	Nicola Williams/Nigel Downes	**Update 02/11/2022** - Contact made with the Once for Wales Datix Team: the Once for Wales Datix is setup to hold 'demographic' information such as disability status, ethnicity etc. The challenge relates to obtaining this information. The national team are looking at this - the preference would be automatically pulling data from a central source but there is a question over reliability of the information held in that source and are currently liaising with DHCW.	10/11/2022	OPEN

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Evaluation of Pharmacy Oral SACT Education Service – Update paper

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Usman Malik, Principal Pharmacist Clinical Services Sarah Goman Senior Pharmacy Technician: Patient education lead
PRESENTED BY	Bethan Tranter Chief Pharmacist
EXECUTIVE SPONSOR APPROVED	CATHERINE O'BRIEN COO

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCC Senior Leadership Team VCC Medicines Management Group Chief Operating Officer	08/09/2022 14/10/2022 17/10/2022	ENDORSED FOR APPROVAL

ACRONYMS	
Pt Ed	Patient Education
MMG	Medicines Management Group
QSMG	Quality and Safety Management Group

1. SITUATION

1.1 Education on Oral SACT is provided to patients at a number of points within the patient care pathway. All patients receiving oral SACT are given the standard education which includes the following:

- written and verbal information provided at clinic by the clinical team specific to the oral SACT,
- education given when the patient is consented for treatment,
- all patients are issued with an oral SACT alert card that highlights 'red-flags' and how / when to contact the treatment helpline,
- all patients are given standard education when medications are collected from the pharmacy department

1.2 For oral SACT regimens that are considered more complex, pharmacy provide additional education

1.3 The purpose of this paper is to provide assurance on the current position in relation to Oral SACT Education within Velindre Cancer Centre and to provide the Board with an update on the work being undertaken to ensure that VCC meets patient need for SACT education

2. BACKGROUND

2.1 The number of patients initiated on oral SACT has significantly increased over the past 4 years, mainly due to new treatment options across most cancer sites. In accordance with the VCC Business Intelligence (BI) dashboard [accessed 30.8.22], the number of oral SACT dispensed over the 2018/19 financial year was 6614 cycles. Over the 2021/22 financial year, this has increased to 10,049 cycles, resulting in a 52% increase in the number of oral SACT prescriptions prescribed over a 4 year period.

2.2 In recognition that the number of patients on oral SACT will grow, and that not all oral SACTs require the same level of education, an evaluation of the service was undertaken between June – October 2021 to determine a structured approach to identify the appropriate level of education that is required for each oral SACT.

2.3 The outcome of the review was presented and approved at MMG in November 2021, which was subsequently reviewed at VCC QSMG in Dec 2021 and Trust QSP Committee in March 2022.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The following recommendations were approved:

- A Task and Finish Group was set up to develop a 'risk stratification criteria' to categorize oral SACT into different levels of complexity and levels of risk – the aim of which would be to inform which oral SACT required additional education.
- For the wider MMG to agree the categorization and the associated scoring criteria
- Undertake an assessment of all oral SACT and allocate a score

3.2 In addition to the above, a benchmarking exercise was undertaken across NHS Wales Cancer Services. It was identified that other Cancer Services across Wales provide only baseline education to patients on oral SACT in line with what VCC provide to all patients, as detailed in section 1.1. Therefore, the education being offered to patients at VCC is above or on par with the standard received in other Cancer Centre across Wales.

3.3 An exercise was undertaken to develop a stratification criteria' which identified 3 levels, namely High, Intermediate and Low. All current oral treatments were then allocated a score based on the criteria. These scores were then triangulated with the current practice in relation to patient education for these treatments. It was confirmed that patients who are initiated on 'high score' Oral SACT are already educated by pharmacy in addition to the baseline education

3.4 To further enhance the level of education given to patients on 'intermediate score oral SACT, pharmacy aim to develop education videos for this patient group. Storyboarding will be complete in early February (DHCR dependent) with digital development planned for the end of Q4. In the meanwhile these patients will continue to receive the standard education support and are able to access advice as required.

3.5 Those patients who are on 'low score oral SACT require only baseline education.

3.6 Demand and Capacity going forward is under review, recognising that we will continue to experience increases in demand for Oral SACT. The education resources will continue to be developed to offer a range of formats for patients and their carers to access. The progress on this will be reported via the normal reporting cycle through the Medicines Management Group (MMG) report.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Equality Impact Assessment will be completed as part of the work programme of developing the education videos.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related 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.

5. RECOMMENDATION

The QSP Committee is asked to **NOTE** this update on SACT education.

QUALITY SAFETY AND PERFORMANCE COMMITTEE

ESTATES ASSURANCE

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jason Hoskins, Assistant Director of Capital Planning, Estates and Environmental Development
PRESENTED BY	Jason Hoskins, Assistant Director of Capital Planning, Estates and Environmental Development
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Welsh Government's aim is to improve the health and well-being of the population through the available resources. This includes ensuring that land and property is used effectively to support strategic plans for health and social services and to support the clinical needs of the local population.

1.2 Buildings/estates and the way they are used have a strong influence on health and well-being of patients, donors, staff and wider partners who use them. NHS organisations must ensure that the variety of standards for the estate are met and maintained to ensure they provide a safe and high quality estate which supports the well-being of people who use them.

1.3 The Chief Executive Officer is accountable for the quality and safety of the services provided by the Trust. With regard to estate and facilities, the Chief Executive Officer has three distinct responsibilities":

- Strategic management of assets – regular review of their productivity, cost and fitness for purpose, and subsequent rationalisation and investment.
- Operational maintenance of assets – ensuring that the condition of the estate is assessed and reported on regularly, and assets are high-quality, appropriate and safe for day-to-day use.
- Ensuring that all statutory obligations are identified and met.

1.4 The Director of Transformation, Planning and Digital is responsible for the estate on behalf of the Chief Executive Officer, with the Assistant Director of Estates, Capital Development and Sustainability being the Trust's professional lead. It is important that the various Trust Committees and Board are provided with the required levels of assurance that the Trust is compliant with the required standards and has robust arrangements in place to manage risks and issues associated with the management of the estates. This includes monitoring, reporting and escalation of risks/issues where appropriate within the Trust Management and Committee/Board structures.

2. ASSESSMENT / CURRENT POSITION

2.1 Currently Estates compliance is managed, monitored and measured through a variety of means:

- A range of Trust key performance indicators relating to the estate.
- Internal review and management of the estate by the appropriate professional lead against the various national standards or requirements e.g. Fire Safety Officer.
- Internal professional audit undertaken by NHS Wales Shared Services Partnership – Estates.
- Internal audits.

- Professional/external consultants who provide subject matter expertise e.g. water/legionella standards.

2.2 These various sources of information and evidence are provided to the Assistant Director of Estates, Capital Development and Sustainability in the post holder's capacity as professional lead for the Trust.

The detail of the arrangement is briefly described below:-

i. Estates Key Performance Indicators

2.3 A wide range of KPIs are reported on a monthly basis and are reviewed by the Estates Management Group, who assess the information provided and ensure action is taken where required. The majority of KPI's provide information regarding the service level delivery which takes into account completed planned and reactive maintenance tasks, broken down by property. The monthly reports and KPIs are set out in a quarterly report which is presented to the Trust's Health and Safety Management Board, chaired by the Director of Transformation, Planning and Digital.

ii. Professional audit and assurance

2.4 The Trust is subject to a number of external audits carried out by NWSSP Specialist Estates Services which align to the Estates Code and Welsh Health Technical Memorandums. These audits provide a clear indication on Trust compliance levels against the standards set out for the various disciplines listed under the WHTM suite of documentation, and include;

- Decontamination (HTM 01-01)
- Medical Gas (HTM 02-01)
- Ventilation (HTM 03-01)
- Water (HTM (04-01)
- Fire (HTM 05-01)
- Low Voltage (HTM 06-02)
- High Voltage (HTM 06-03)

2.5 These are supplemented with internal audits (as part of the annual audit programme) and specialist work commissioned from external providers e.g. water/legionella reviews; asbestos reviews etc. All audits are circulated to the Duty Holder (Chief Executive Officer), Designated Person (Director of Strategic Transformation, Planning, Performance & Estates) and Responsible Person (Assistant Director of Capital Planning, Estates and Environmental Development) for information and action, where required.

2.6 All recommendations identified through the service delivery risks/issues and the range of audits are considered, with a range of action plans in place to deliver the recommendations. These plans are managed through the Estates management Group and are reported to the Trust Health and Safety Board and other key management functions.

Current position: compliance with national standards

3. Table 1 sets out the current levels of assurance across the main elements of statutory estates compliance. The table illustrates the Trust Assurance Levels as defined by the last Audit undertaken against each discipline. Audits are normally conducted on a three year cycle; this has been impacted by the Covid-19 pandemic e.g. High Voltage Maintenance has been delayed.

Table 1

Discipline	Audit Date	Assurance Attained
Decontamination (HTM 01-01)	2019	Limited Assurance
Medical Gas (HTM 02-01)	2021	Reasonable Assurance
Ventilation (HTM 03-01)	2021	Reasonable Assurance
Water (HTM (04-01)	2019	Reasonable Assurance (Audit Due November 2022)
Fire (HTM 05-01)	2021	Limited Assurance
Low Voltage (HTM 06-02)	2022	Limited Assurance
High Voltage (HTM 06-03)	2017	Reasonable Assurance (Audit out of cycle due to covid)

4. **Achieving the standards and managing risk**

4.1 The Trust strives to achieve all of the required standards and to maintain them. Subsequently, each of the audits has an improvement action plan which sets out the actions that will be undertake to secure the required level of improvement. These are managed by the Estates Team and Estates Management Group.

4.2 The audits with limited assurance are a main focus of attention. Action plans have been developed to address recommendations. Main areas of focus are:

I. **Decontamination (**HTM 01-01)

The primary area of non-compliance identified in the Audit was due to an autoclave that was in use at Velindre Cancer Centre, and the lack of skills required to support its ongoing management. Arrangements were put in place to manage the autoclave which has since been taken out of use. There is no risk to the Trust at this time.

II. **Fire** (HTM 05-01)
Surveys have highlighted concerns with fire compartmentation and condition of fire doors.
Actions being taken:

- A business case was presented to Welsh Government to address concerns, which was approved with funding secured. Works have been tendered and awarded, with contractors currently onsite and undertaking the work.

Resolved by (date)
Works are programmed for completion this financial year (2022/23)

III. **Low voltage** (HTM 06-02)
The main point of focus following the recent LV Audit was regarding the shortage of staff competent in low voltage systems work.

Actions being taken:

- Estates are currently recruiting three Electrical Technicians. Once appointed successful candidates will undertake relevant training

Resolved by (date)
April - July 2023

4.3 There are a range of mitigating arrangements in place to manage these risks whilst the actions are discharged.

5. Achieving a sustainable position across Estates Management

5.1 The Trust allocated funding in 2022/2023 to support the recruitment of additional staff/competencies to support the achievement and maintenance of the standards set out within the WHTMs. Recruitment is ongoing and by close of financial year 2022/23 the Estates team will these skills in place.

5.2 The development of data/information and insight on estates performance has also been a focus of activity to provide better management information. A new Computer Aided Facilities Management platform has been developed following a full asset review of the estate and alignment of industry standards through use of the SFG20 package which

aligns and regulates pre planned maintenance tasks to current legislation for all compliance including WHTM.

4.3 The Package will fully automate the Estates delivery process with all work allocation and management being paperless. This will improve reporting, efficiency of staff and health and safety practices.

4.4 The system will also allow any third party reports or documentation to be uploaded providing a full audit trail for maintenance of all assets.

5. RECOMMENDATION

5.1 The Quality Safety and Performance Committee are asked to:

- note the contents of the paper.
- note the current position with regard to the Trusts compliance against the main estates elements.
- note the actions being taken to achieve and sustain compliance.

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 15th September 2022
Time: 10:00 – 13:00
Location: Microsoft Teams
Chair: Vicky Morris, Independent Member

ATTENDANCE		
Prof Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Steve Ham	Chief Executive Officer	SHa
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science	NW
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Carl James	Director of Strategic Transformation, Planning and Digital	CJ
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Jacinta Abraham	Executive Medical Director	JA
Alan Prosser	Director of Welsh Blood Service	AP
Rachel Hennessy	Interim Director of Velindre Cancer Service	RH
Peter Richardson	Head of Quality Assurance and Regulatory Compliance – Welsh Blood Service	PR
Nigel Downes	Interim Deputy Director of Nursing, Quality & Patient Experience *(in part)*	ND
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

0.0.0	PRESENTATIONS	Action Lead
0.0.1	**Velindre Cancer Service – Patient Story** To be led by Ceri Stubbs, Acute Oncology Clinical Nurse Specialist The Committee had received in advance a slide set, documenting the journey of a Velindre Cancer Service patient from their initial cancer diagnosis, surgery (and resulting physical disabilities) and struggles with side effects of treatment. The story was presented by Ceri Stubbs who advised that the patient had	

	contacted the chemotherapy treatment helpline service on a number of occasions and had received effective triage and signposting to relevant multi-disciplinary services. The patient had also attended the Velindre Cancer Service Assessment Unit on a few occasions following contacting the Treatment Helpline and received prompt and effective care and treatment to avoid inpatient admissions. Ceri advised that the Assessment Unit opened in September 2018 and is the central hub of the Velindre Acute Oncology Service, working collaboratively as an integrated, multi-disciplinary team to manage often complex patients (approximately 150 patients per month, which is increasing), avoiding hospital admission in over 75% of cases. The patient wished to inform the Committee that he had 'felt safe and cared for' during his treatment and that a significant difference can be made to a patient's psychology and wellbeing by simple gestures and giving an extra few seconds or minutes' time; a level of care he had not experienced outside of Velindre. The patient is willing to film his story, which will be facilitated at a later date. CS noted the importance of data in terms of evidence and facilitation of improvements. However, this is currently collected manually on paper, preventing clinicians working to the top of their licence; therefore a digital solution is required to restore staff time spent on data collection. It is intended to support this over the next few months and CJ advised that solutions could be implemented in the interim while the end product is developed. CS also advised that access to ambulance transport to and from other hospitals for emergency day-case Radiotherapy for patients was a major issue. NW advised that WAST transportation had been identified as an issue by patients and relatives during a recent 15 step visit to Radiotherapy. It was AGREED that options would be explored with RH and the VCS team. DM advised that the issue had been raised on numerous occasions with the CEO of the Welsh Ambulance Service NHS Trust (WAST) and that notification of escalation to the Director of Operations (email to be forwarded) had been received. VM requested whether the Committee would receive sight of actions taken to support interim digital solutions. CJ advised that the current digital programme aligns to service priorities required by clinicians, responding appropriately whenever circumstances change. JA emphasised that outcomes for the patient are very much determined by the provision of Immuno-Oncology treatment and intervention at the appropriate points during the patient journey. The work undertaken by the Assessment Unit has been considered exemplar (nationally) and targets are being met. The Committee asked that Ceri provide their thanks to the patient for	**CJ** **RH** **CS**

	sharing the story and for the positive feedback in relation to the service. The Committee also commended the service provided by the Acute Oncology & Assessment Unit Teams and thanked Ceri for the compassionate sentiment in her presentation and for outlining the key areas where the service requires support in resolution of issues i.e digital informatic infrastructure and transport solutions. In terms of value based analysis, time, care and simple gestures are important elements to take forward in relation to patient experience and culture within the nVCC.	
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • Cath O' Brien, Chief Operating Officer • Colin Powell, Service Director (NWSSP) • Stephen Allen, Chief Officer (South Glamorgan Community Health Council)	
1.2.0	**Additional Attendees:** • Katrina Febry, Audit Lead, Audit Wales • Heledd Thomas, Senior Auditor, Audit Wales • Huw Jones, Healthcare Inspectorate Wales • Emma Rees, Deputy Head of Internal Audit (NWSSP) • Gareth Tyrrell, Head of Technical Services (NWSSP) *(for item 3.0.0)* • Kate Baker – Macmillan Head of Therapies *(observing only)* • Matthew Walters – Operational Senior Nurse • Louise Hanna – Consultant Oncologist *(for item 4.3.0)* • Sarah Owen – Quality & Safety Manager *(for item 4.4.0)* • Ceri Stubbs – Acute Oncology CNS *(for item 0.0.1)*	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The action log was discussed in detail. Committee members advised that they were assured that all actions identified as closed on the action log had been fully instigated and could therefore be closed. The items not yet due for completion were not discussed and will remain open. The remaining Action Log was reviewed and the following was agreed: ***3.0.0 (14.07.2022) – SHam and GT to discuss outstanding issues (governance process in relation to manufacture of new products /***	**Secretariat**

	classification of cytotoxic and immunotherapy medicines) with Colin Powell (Service Director) and summarise outcome at the September Committee – SHa advised that he had met with GT and discussed the signoff of new products in addition to the cytotoxic / non-cytotoxic product range. It was confirmed that due to its set up, the temporary medicines facility would be unable to provide cytotoxic products; however the full TrAMS (Transforming Access to Medicines) service, when delivered, will produce both cytotoxic / non-cytotoxic products for the service. This is currently being worked through with the Heads of Medicines Management Group nationally and how this will be delivered through services at the nVCC will be communicated to the Committee by Bethan Tranter, Head of SACT and Medicines Management. It was also noted that the Heads of Medicines Management are fully involved in the set up and signoff of governance processes in relation to the manufacture of new products. This will be drafted as a SOP to allow sight of the process for identifying new products. SHa also advised that the Chief Pharmacist for Wales had established a new group, which will work through a number of products to take forward to either the temporary medicines unit or TrAMS. Following this feedback the Committee agreed that ***this item could be closed.*** The Committee **NOTED** all updates as detailed above and agreed that the original target date should remain on the log when adding an updated target date in the event of the original date not being delivered.	**Secretariat** **Secretariat**
1.5.0	**Matters Arising** To be led by Vicky Morris, Quality, Safety & Performance Committee Chair • *CIVICA Electronic Feedback System Update* - The Committee **NOTED** the paper that detailed the implementation developments since the last Committee. • *Anti-Racist Wales Action Plan* – SM advised that the Anti-Racist Action Plan had been considered at Trust Board on the 28/07/2022 and further updates will be included on the Committee Cycle of Business. • *Receipt of briefing on oral SACT patient education* – This item will be presented at the November 2022 Committee. • *Historical Health Inspectorate Wales Report* – NW advised that the action plan arising from the HIW Report recommendations will be brought to the November 2022 Committee following the Safeguarding & Vulnerable Adults Management Group. The comprehensive improvement plan had been considered and further strengthening is required before presenting at Executive Management Board and the Quality, Safety & Performance Committee.	**Secretariat**
2.0.0	**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).	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 14th July 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **APPROVED** the minutes from the 14th July 2022 Public Quality, Safety & Performance Committee.	
2.1.2	**Trust-wide Policies and Procedures for Approval** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The following updated policies were discussed: • WF05 – Equality & Diversity Policy • WF44 – Working Time Regulations Policy • NHS Wales Special Leave Policy • NHS Wales Pay Progression Policy • Procedure for NHS Staff to Raise Concerns (Whistleblowing) No questions were raised in respect of these policies and procedures. The Committee were advised that all of the above listed policies / procedures for **APPROVAL** had previously been **ENDORSED** by the Executive Management Board. The Committee **APPROVED** all the above revised policies / procedures for publication on the Trust website and circulation to the policy distribution list based on the updates outlined in the cover paper.	**KB**
2.2.0	**ITEMS FOR ENDORSEMENT**	
2.2.1	**Capital Scheme for Ventilation at Velindre Cancer Centre** Led by Carl James, Director of Strategic Transformation, Planning and Digital A detailed paper regarding the proposed Cancer Centre Ventilation scheme was presented by CJ. The proposals contained within the report had been considered by the Executive Management Board who agreed that the proposed full ventilation scheme would not go ahead as initially planned. This decision had been made as it would not be possible to complete the scheme given the decanting out of critical clinical space that would be required and the increasing demand on that space due to significantly increase in demand. The decant could not take place earlier as originally planned due to ongoing COVID outbreaks and the need for the isolation cubicles. The Committee was advised that interim / temporary ventilation had been put in place during the last two summers and this will be continued until the move to the new hospital. HJ queried whether a cost benefit analysis (in relation to continuing lease or	

	purchase of equipment) would be carried out prior to a final decision and whether the equipment could be utilised elsewhere if it were purchased. CJ advised that a cost benefit analysis would be undertaken in advance of Board approval, in addition to assessing suitability for re-use or selling on. The Commitee **ENDORSED** the Capital Scheme for Ventilation at Velindre Cancer Centre for consideration at Trust Board on the proviso that a cost benefit analysis will be included within the Board paper.	**CJ**
2.3.0	**ITEMS FOR NOTING**	
2.3.1	**Draft summary of the unapproved minutes from the meeting of the Private Quality, Safety & Performance Committee held on 14th July 2022.** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **NOTED** the summary minutes of the Private Quality, Safety & Performance Committee held on 14th July 2022. No inaccuracies were raised.	
2.3.2	**Vaccination Programme Board Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science NW advised that the issue preventing the Trust from vaccinating staff has been raised with the Chief Executive of Digital Health and Care Wales and dialogue is ongoing. However, this will not change the outcome of the Trust being unable to vaccinate its staff during the Autumn / Winter 22/23 COVID-19 booster programme. The Committee **NOTED** the position in respect of the Trust being unable to provide its staff with a COVID booster vaccine as DHCW did not update the Trust's Welsh Immunisation (WIS) system, and the Trust's revised Autumn 2022 Influenza vaccination plans that were due to start in September 2023.	
2.3.3	**Information Governance Assurance Report – Quarter 2** Led by Matthew Bunce, Executive Director of Finance SH advised that (as Independent Member for Digital) quarterly meetings are held with himself and Information Governance colleagues to address issues within the report in further detail, providing further scrutiny. The Committee **NOTED** the 2022/2023 Quarter 2 Information Governance Report for assurance purposes.	
2.3.4	**Velindre University NHS Trust Annual Net Zero Report** Led by Carl James, Director of Strategic Transformation, Planning and Digital CJ advised that national discussions in relation to the accuracy of baseline information and definitions remain ongoing.	

	The Committee **NOTED**: • The submission of the Net Zero Reporting return in accordance with the requirements of the Welsh Government; • The further work required to improve the data collection and provision of information nationally, and; • Further work is required within the Trust to finalise the programme of works to support the achievement of Net Zero within NHS Wales.	
2.3.5	**Freedom of Information Requests** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Freedom of Information Requests paper is to be deferred to the November 2022 Quality, Safety & Performance Committee as this is a 6 monthly paper and did not align with the September 2022 Committee.	
2.3.6	**Trust School of Oncology Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science NW reported positive progress to date in relation to the development of the Velindre School of Oncology and advised that further multi professional externally advertised training events are planned. NW expressed gratitude for the support provided by the Finance Team and Hannah Russon. A positive meeting has been held with the Dean of the University of South Wales which will help progress the agenda further in particular in relation to accreditation and engagement will be sought from other Universities. The Committee **NOTED** the work undertaken to date and the following actions taken following approvals made at the Executive Management Board: • Nominated support Finance Officer to develop funding model and course fee reimbursement model / process appointed; • Support from within existing Trust resources to write the full business case identified; • Appointment into a band 4 Events Co-ordinator and band 2 administrative apprentice underway; Sage & Thyme licences being purchased; and, • Progression of all plans detailed within the paper and to continue with the School of Oncology proof of concept. DM noted the importance of the initiative and delivery of appropriate educational content for underpinning workforce and career aspirations and commended the work of Hannah Russon (Velindre School of Oncology) and the wider team.	
2.3.7	**Quality Safety & Performance Committee - Policy Compliance Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff LF thanked ES and wider team for leading the project collaboratively across the organisation and noted that this has resulted in increased awareness	

	among staff across the Trust in the policies for which they are responsible. The consultation process on policies and procedures is proving effective. VM noted that a number of policies are outlined for consultation during quarter 3 and there is therefore the potential for a large number to be received for approval by the Committee at one time. SfM noted that the majority of the policies are Workforce & Organisational Development and assured the Committee that development of these will be achieved on time. SfM also suggested bringing the review date forward for policies due for review going forward, to enable a more staggered approach. NW indicated that following identification of a number of out-of-date procedures during recent external inspections / peer reviews, whether procurement of a Trust-wide document management system was in progress. ES advised that work has been initiated by the Welsh Blood Service to develop a user requirement specification for a Quality Management System, and are engaging with both the Velindre Cancer Service and Corporate Teams to explore the scope and potential for a Trust wide solution. It was agreed that an update would be provided in the next report. PR noted that while it is the intention to develop a Trust-wide solution for Trust documentation and Policies, many of the systems commercially available are aimed at manufacturing organisations; therefore the challenge will be to identify a solution which encompasses the 'care' element. It may not be possible to implement a single solution, despite the best intention. The timeframe for this will be assessed following agreement of an overall approach for the Trust. SH referred to the Disciplinary Policy (review of which is currently on hold due to implementation of Respect and Resolution Policy). SH queried whether an individual progressing through the disciplinary process would be able to claim that the Policy is out of date and therefore not applicable. SfM advised that the Respect and Resolution Policy had superseded the Disciplinary Policy; therefore no aspect of the process would be overlooked. VM noted that the report indicated three Estates Policies were due to be received at the September 2022 Committee. CJ confirmed that the Policies would be received at the November 2022 Committee. Additionally, VM queried how policies could be captured (for example the absence of a DBS policy), ensuring that policies required are included in this process. SfM suggested including more comprehensive foresight and evaluation work in other areas to ensure this remains a live process. It was **AGREED** to include the Policy Compliance Report on the main agenda at future Committees to allow discussion. The Committee:	**ES** **CJ**

	• **DISCUSSED** and **REVIEWED** the findings of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety & Performance Committee; • **NOTED** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at 26/08/2022, included at Appendices 1 to 8; • Received **ASSURANCE** that progress is being managed via the Executive Management Board.	
3.0.0	**Velindre Quality & Safety Committee for NHS Wales Shared Services**	
	Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership The CIVAS@IP5 Service Performance Report was received, setting out current levels of performance against Good Manufacturing Practice Standards in addition to the Action Plan which had been developed following the MHRA (Medicines and Healthcare products Regulatory Agency) inspection on 15th February 2022 (Against the Human Medicines Regulations 2012). The following key items were highlighted: • Current 100% compliance with the internal audit schedule, which has been maintained since the service was established. • 92% of documentation review target dates are being met. • Target of <5% for environmental and batch failures met, reporting 1.8% and 3.5% respectively. • No service complaints were reported. • 96% of manufactured products are suitable for patient administration (meeting the target of 95%). • 100% compliance with controlled drugs checks (holding a Home Domestic Controlled Drugs licence). • A number of new products are currently being explored with Welsh Government and Health Board Colleagues. • All target dates for actions resulting from the MHRA inspection have been met, with the exception of the implementation of a microbiological reporting system (project delayed nationally). This will be included in the interim compliance report to the MHRA. • All other actions have been completed on target in line with expectations. VM requested that evidence in terms of compliance (based on local audit, national audit and regulatory) to be shared as part of future papers. No questions were raised. The Committee **NOTED**: • Current levels of service performance against the framework of standards set out in EU GMP and which we are legally required to comply with as an MHRA 'Specials' and Wholesale Dealer Licence holder.	**GT**

	Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings; • The findings and CIVAS@IP5 risk status assigned by the MHRA. The action plan and progress update will be provided as part of this agenda item.	
4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**Workforce and Organisational Development Performance Report / Financial Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance The combined report was received and discussed in detail, highlighting the key workforce and associated financial risks currently faced by the Trust and the required management action to appropriately mitigate the risks as far as possible and to continue the delivery of core services. The following was discussed: • A review of fixed term contracts is underway, with a view to moving as many as appropriate to substantive posts by the end of September 2022. • A recruitment and retention project has been established to attract colleagues to key hotspot areas to manage medium and long term issues in relation to workforce supply. • The Trust is addressing the requirement to change the workforce model using the 12 nationally agreed workforce planning principles. It is anticipated that this work will be completed by the end of the financial year (2022-23). • Current focus is on managing attendance and appointing to vacancies. Finance and Workforce & Organisational Development are collaboratively working to reduce cost by implementing alternatives to agency staff where possible. However, this may be impeded by high sickness levels and vacancy levels. • *Finance Risk* – Continuing high levels of sickness have resulted in the Trust incurring premium costs for use of agency staff, the recruitment of some permanent COVID response staff, overtime costs and productivity lost through provision of Time off In Lieu. HJ requested further information regarding promoting Welsh Language. SfM advised that a Welsh Language assessment of each individual role will be undertaken to identify where Welsh is essential or desirable, with translation of the relevant job specifications into Welsh. Despite the Trust's best efforts to ensure patients and donors are able to access Welsh Language, there is not a sufficient number of Welsh speakers within the Trust to routinely provide Welsh speaking staff across every clinical environment.	

	Although the importance of Welsh Language was acknowledged, it was noted that making more posts Welsh Language essential would further exacerbate current recruitment difficulties. This will be addressed in a future paper. NW advised that a significant amount of multi professional workforce redesign and transformation is required to ensure delivery of services, designed around patients and donors. It was suggested that the Executive Team review the Workforce Planning Principles, collaboratively work across departments and effectively reshape ways of working, also involving staff 'on the ground' in changing long-standing processes. Other suggestions included international recruitment and fast track training via the Trust's new School of Oncology. It was **AGREED** to review the Workforce Planning Principles via Executive Management Board to identify how they can be best adopted to serve the Trust's purpose. VM requested more specific timelines for completion of work and noted that it would be beneficial to align changes to ways of working and the risk register in one paper. The Committee **NOTED** and **CONSIDERED** the workforce risks, opportunities and associated financial impacts as outlined within the contents of the report. **Financial Report** The Financial Report was received, outlining the financial position and performance to the end of July 2022. The following was highlighted: • *Revenue* – A balanced position is forecast in line with expectations with a projected year-end position of breakeven, (assuming receipt of COVID-19 cost reimbursement, planned additional income and achievement of savings targets). • *Capital* – It is anticipated that the Trust will remain within the capital expenditure limit. • *Public Sector Payment Performance* – The administrative target of payment of 95% of non-NHS invoices within 30 days has returned to an on target position (at 95.59%). • *Risk* – Discussions underway with the Trust's Commissioners in relation to the COVID-19 funding requirement for 2022-2023, as this poses a significant finance risk should these costs not be met. It is still expected that COVID-19 response costs will be funded by Welsh Government. • Risks remain around COVID capacity investment in terms of staffing costs and income; reduced support is anticipated as time progresses. The Trust continues to work closely with Health Board colleagues to identify future demand for next year and beyond. • *Energy* – Significant growth in the cost of VCS and WBS energy is currently being managed as Welsh Government maintains control of	**SfM** **SfM**

	both financial risk and workforce pay inflation. Imminent lockdown of the financial position with Welsh Government will be required while considering mitigating actions should all exceptional cost pressures not be covered by Welsh Government. VM queried whether the cost of NICE / High Cost Drug usage is recovered from a commissioning standpoint and whether there is a potential return to the pre-COVID position. MB advised that growth is ongoing due to improved patient outcomes evidenced by their use, therefore supporting investment. It was also noted that a consistent pathway is followed in terms of use of these drugs. The Committee **NOTED**: • The contents of the July 2022 Financial Report and in particular the financial performance to date and the year-end forecast to achieve financial break even and key risk in relation to income to cover COVID backlog additional capacity costs; • The TCS Programme financial report for July 2022 attached as Appendix 1; • In line with Welsh Government expected reported guidance, the Velindre Core Trust monthly monitoring return (MMR) for July attached as Appendix 2. **Workforce Report** The following Workforce KPIs for the Trust were noted: • Personal Appraisal Development Review (PADR) – 69.29% (Trust-wide). SfM advised that there is significant focus on improvement across Corporate functions via contact with relevant Managers. • Sickness Absence – 6.36% (as at 13/09/2022). It was noted that COVID-19-related sickness is reducing. • Statutory & Mandatory Compliance – 85.27% (Trust-wide). VM requested that the Committee receive sight of actions in relation to improving PADR at the November 2022 Committee. The Committee **NOTED** the content of the report. **Staff wellbeing – Overview and future plans** The Staff Wellbeing update provided an update on the current position and activities underway to support staff wellbeing, including: • Opening of a wellbeing hub at Velindre Cancer Centre. • An established network of trained Mental Health First Aiders. • Incorporation of skills to support wellbeing of staff into training agenda for 2022/23. • Menopause cafés. • Work in confidence platform for raising concerns anonymously. • Increased focus on Financial Wellbeing and the cost of living crisis.	**SfM**

	SH requested that the Committee receives further information / updates going forward in relation to how the Trust is supporting staff with the cost of living crisis. SfM agreed to provide an update at the next Committee and suggested ongoing reinforcement of support via internal communications. It was also acknowledged that a number of factors such as the recent change in pension contributions will also affect staff. The Committee **NOTED** the content of the report.	**SfM**
4.2.0	**Quality, Safety & Performance Reporting**	
4.2.1	**Welsh Blood Service Performance Report** Led by Alan Prosser, Director of Welsh Blood Service The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of July 2022. The following areas were highlighted: • *Supply Chain Activity* – The Service remained under blue alert status from April 2022 to August 2022 (this was lifted in September 2022) and the ability of the UK as a whole to support other services remains very limited via the established mutual support agreement. It was noted that an amber alert (invoking blood supply plans and impacting patient care) had been narrowly avoided due to the positive and effective remedial actions taken. • High sickness absence and level of required staff training continue to present challenges in terms of team capacity. Volunteers are currently supporting additional collection clinics and regular planning meetings are addressing meeting demand / stock recovery. There is currently 8 days' supply across all blood groups. • The Service is seeking to open a staffing bank (not previously operated) to support balancing demand and capacity. • Donor satisfaction is at 96%. • 99% of Quality Incident Records were closed within the 30-day timeframe (exceeding the target of 90%). • *Bone Marrow Donor Recruitment* – The number of new bone marrow volunteers remains below target and an Autumn campaign to promote recruitment at Colleges, Sixth Forms and Universities is underway. • The service is showing an improved position in general and it is anticipated that this will be maintained going forward. **Summary of Serious Adverse Blood-Related Events** 3 Serious Adverse blood related Events (SAEs) were reported to the MHRA since the start of 2022/23. Proposed corrective actions have been accepted by the MHRA and an action plan is in place, to include system updates and a review of written procedures to reduce the opportunity for human error. It was noted that a number of processes have evolved 'piecemeal' into overly complex systems and implementation of additional human checks can, in fact, reduce compliance. Root causes have been resolved and PR advised that high level statistics are routinely shared between Quality	

	Managers to compare rates of reportable incidents with other blood services. The Welsh Blood Service remains the lowest of the 4 UK national blood services in terms of incidents. PR also advised that reports are shared for review and regulators regularly provide anonymised shared learning between UK services to prevent similar incidents. The Committee **NOTED** the content of the report.	
4.2.2	**Velindre Cancer Service Quality Safety & Performance Divisional Report** Led by Rachel Hennessy, Interim Director of Velindre Cancer Service The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of July 2022. The following areas were highlighted: • Evidence of improvement in relation to patients receiving radical Radiotherapy within 28 days (72% in July and 77% in August) and SACT (Systemic Anti-Cancer Therapy) within 21 days (58% in July with 77% expected in August). Key issues in relation to Radiotherapy centre around palliative care planning, a nationally recognised challenge. • Challenges relating to treatment of breast cancer patients remain, due to specialist requirements preventing the use of LINAC for treatment, in addition to the loss of Rutherford Cancer Centre capacity. Further work to reduce waiting times will be undertaken. • *Outpatients* - Data collection in relation to the 30-minute waiting time has been reinstated following a pause in December 2021 due to operational pressures and staff absence. This will be linked to the new CIVICA system and wider patient experience to support a better understanding of service delivery within Outpatients. • The two falls reported on first floor ward during July 2022 had been deemed unavoidable by the scrutiny panel. The patients were unharmed. SHa noted that while it is evident that services provided by VCS are held in high regard by patients and their families, it would be of benefit to better understand possible increases in patient complaints (in relation to delays in patient treatment) becoming litigation and potential feedback from the Medical Examiners' Service / Mortality Review. NW acknowledged that delays to treatment invariably result in a level of harm to some patients. Delays present complications for patients, as Velindre is one element of the patient pathway. Following harm review benchmarking with other national organisations and beyond, the Trust will now seek to review and develop the process, ensuring the entire patient pathway is covered; the Medical Examiners' Service will identify delays to treatment and to diagnosis and first line treatment. The outcome of harm reviews will feature in future VCS Quality & Safety Committee reports and be outcome focused.	

An audit of the SACT prioritisation process has also been undertaken, the outcome and recommendations of which will also be received by the Committee.

JA advised that a process is currently in place when clinicians wish to raise issues around harm, in the form of Datix reporting, which is immediately reviewed and responded to.

HJ queried whether staff were sighted on the effects of implementing these changes and whether they were on board. RH noted that the solutions would not have been achieved without staff involvement, their suggested solutions and subsequent delivery of these. Staff are keen to improve patient experience and outcomes and areas where support has previously been 'ad hoc' have now become part of core activity.

SH suggested that staff would welcome further communication of appreciation, in addition to engaging in dialogue and maintaining a team culture.

Radiotherapy / SACT Improvement Plan

The Velindre Cancer Service Demand & Capacity Plan was received, setting out the impact of the loss of the Rutherford Cancer Centre and current position, in addition to the recovery plan. The following was discussed:

The Executive and Senior Leadership Teams meet on a fortnightly basis to review the plan to ensure appropriate changes are made as the plan progresses.

Radiotherapy

- Evidence of an increase in referrals over and above projected numbers due to an increase in activity within Health Boards with a national increase of 8% anticipated by year end (March 2023).
- A number of issues have impacted capacity; increased sickness absence rates, difficulty appointing to specialist posts (this is a national issue) and the loss of use of the Rutherford Cancer Centre. This will be addressed via a targeted recruitment campaign in addition to the arrival of newly qualified streamlined staff from (Health Education and Improvement Wales (HEIW).
- An increase in service requirements for breast referrals will require further management due to the loss of additional capacity contracted from the Rutherford Cancer Centre and constraints on LINAC capacity.
- It is the intention to increase capacity / activity within Radiotherapy via a phased extension of LINAC working hours. This is contingent on the recruitment of newly qualified trainees (during September 2022) and identification of additional treatment planning capacity.

Systemic Anti-Cancer Therapy (SACT)

- Evidence of an increase in referrals over and above projected numbers due to an increase in activity within Health Boards with a national

	increase of 12% anticipated by year end (March 2023). • Demand for oral SACT has increased by approximately 30% from pre-pandemic levels, presenting significant challenges in managing demand. • A multi-disciplinary task and finish group has developed a plan to increase capacity within Velindre Cancer Service and Outreach units, focusing on restructuring the service and more effective utilisation of other areas and current capacity within the Cancer Centre. Additional capacity in Outreach services will be contingent on the availability of fully trained nursing staff and capacity within pharmacy to support the proposed increase in treatments. • Establishing Saturday clinics to increase capacity, to remain in place until the end of October 2022 while establishing capacity elsewhere. • An audit of SACT prioritisation is underway. Additional work will explore further development of models to facilitate additional capacity, a review of Pharmacy capacity and the possible development of an outreach service within Aneurin Bevan. SHa acknowledged receipt of a very high level of support for Saturday clinics from staff and that it is important to inform staff how long it was anticipated Saturday clinics would continue (from a wellbeing perspective). It was considered important to provide staff with an honest assessment of the current position, in addition to the positive impact their efforts have on patient experience. The Committee **NOTED** the content of the report and developments established in respect of SACT and Radiotherapy waiting times capacity and the impact of these plans on waiting times.	
4.3.0	**Medical Education Governance Framework** Led by Louise Hanna, Consultant Oncologist and Assistant Medical Director for Education The Committee received the report, which provided **ASSURANCE** around the governance in relation to Medical Education activities and the current position against the 2016 General Medical Council (GMC) standards for training. Reporting had been delayed due to the COVID-19 pandemic; as such, the report covered activity from July 2020 to August 2022. The following was highlighted: • A great deal of medication education and training has been facilitated across the Trust by a large team. Trainees are involved at all levels in terms of commissioned services. • A number of examples of excellence, including provision of the internationally renowned FRCR course (Fellowship of the Royal College of Radiologists) for trainees, with excellent examination pass rates. • A significant number of 'green flags' following the GMC survey reflects the high quality of medical education provided by the Trust.	

	• No patient safety concerns, bullying or undermining concerns were raised and there were no areas for escalation. • Clinical and Medical Oncology Consultants have reported inadequate time and training resources. These concerns will be addressed via the HEIW (Health Education and Improvement Wales) risk register, including identifying time required for training and development and implementation of a supporting action plan. • Appraisal leads are to instigate improvement and encourage 'appraisees' to utilise the constraints section of the appraisal. It was noted that a move to a single lead employer (NHS Wales Shared Services Partnership) is of benefit to trainees progressing through their programme by avoiding the requirement to change employers. Trainees will remain with the single lead employer regardless of where they are located. This process has been followed for a number of years, enabling a smooth path for trainees in terms of paperwork, mandatory training and DBS checks. DM advised that trainees often post very positive messages on social media in terms of their experience while at Velindre and suggested exploring the capture of these. The Committee **NOTED** the Medical Education Governance Report.	
4.4.0	**Medical Examiner's Service & Mortality Framework** Led by Jacinta Abraham, Executive Medical Director The Committee received the report, which provided an update on the implementation of the Medical Examiner Service Requirements within the Trust and progress made since the last update. The following was highlighted: • Following communication from Welsh Government and National Medical Examiner, it is anticipated that the statutory introduction of the system will commence in April 2023. All statutory requirements to be in place by this date are currently being met by the Trust via interim arrangements. • A Standard Operating Procedure and reviewed Terms of Reference for the new process have been developed, awaiting formal sign off. • An overarching group will be established to review all deaths (inpatient and outside of Velindre Cancer Service), identifying trends and themes, capturing actions / learning and instigating discussions with Health Boards to facilitate effective reporting. • Continued work with the Medical Examiner's Service Team over the coming period will ensure receipt of investigation outputs and triangulation of learning. Re-establishment of the Mortality Review Group and links with other areas of the Organisation will review learning and how this is documented. VM queried whether interim measures implemented to meet statutory requirements were subject to a business case and resource to achieve this	

	long term. It was confirmed that a business case had been drafted and no issues were anticipated. The Committee **NOTED** the developments to date and the next steps being taken to ensure the Trust is meeting fully its Medical Examiner / Mortality responsibilities.	
4.5.0	**Health & Safety 2021/2022 Annual Report** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee received the Health & Safety Annual Report, which provided an overview of the management of Health and Safety within the Trust for the period 1st April 2021 – 31st March 2022. The following was highlighted: • Evidence of continuous improvement over the year, creating a safer environment for patients, donors and staff. However, further improvements will be made to enable further mitigation of preventable incidents. • A number of staff were acknowledged for their involvement in implementation of improvements; (Helen Jones (Health & Safety Manager), Matthew Bellamy (Health & Safety Environmental Officer), Stuart Buswell (Operations Manager), June Price (Business Operations Manager) and Robin Weaver (Trust Fire Safety Advisor)). • Training compliance is reasonable; however 10-30% of staff still require the appropriate level of training in some areas. This is being addressed with managers and staff via multiple routes. • Further capital support is required. HJ requested assurance that fire, electrical, water safety risk assessments are up to date and it was **AGREED** that statistics / progress from the Statutory Safety Management Group would be reported to the Quality, Safety & Performance Committee and this would be incorporated into the Committee Cycle of Business going forward. CJ also advised that an additional external range of scrutiny in relation to performance against the above is currently in place (NHS Wales Shared Services Partnership, among other regulatory bodies). NW asked that staff Nosocomial infection could be included in future reporting. CJ advised that further work would be undertaken around this in relation to the COVID-19 pandemic, findings, root cause analysis and implementation of improvements. SH queried whether the personal injury claim relating to a data protection breach contained in the report had been included in error as this was not related to Health & Safety regulations. CJ agreed to check the accuracy of the case and make any amendments to the report should this be required, in addition to informing MB for Information Governance reporting purposes. VM queried when Health & Safety Training was last received by Trust Board members over and above the mandatory training. It was **AGREED** that Trust	**CJ/ Secretariat** **CJ** **CJ**

	Board members would receive Health & Safety training over and above core requirements once exact requirements had been confirmed with VM, SHa and LF. The Committee **ENDORSED** the Health & Safety Annual Report for Board **APPROVAL**.	**CJ**
4.6.0	**Welsh Language Annual Report** Led by Sarah Morley, Director of Organisational Development & Workforce The Committee received the Welsh Language Annual Report 2021/2022, which provided an overview of the Trust's compliance against Welsh Language Standards. The following was highlighted: • The Trust is currently reporting approximately 50% compliance with Welsh Language Standards. • Welsh Language training has seen an increase over the year and the recruitment process has been strengthened, identifying when and why Welsh Language is required. • SfM advised that the 'active offer' of Welsh Language featured in the recent Health Inspectorate Wales inspection report and 15-step visits will be supported by further detailed audit work across the organisation, review of bilingual signage and visibility on staff uniforms of Welsh speaking staff. The Committee **ENDORSED** the Welsh Language Annual Report for Board approval.	
4.7.0	**Putting Things Right Report – Quarter 1** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Quarter 1 Putting Things Right Report, providing a summary of concerns (complaints) and incidents received during the period 1st April 2022 to the 30th June 2022, was discussed and the following was highlighted: • During the quarter: o No National Reportable Incidents were reported. o 50 **concerns** were raised (3 relating to COVID-19), 98% of which were graded at level 1 (low). 100% of **formal concerns** were investigated and responded within the required 30-working day timeframe. Trends continue to be appointments, communication & clinical treatment. o 475 **incidents** were raised, 96% graded at low or no harm. o 3 Ionising Radiation (Medical Exposure) Regulations **incidents** were reported to Healthcare Inspectorate Wales. • Formal investigation training is underway for all key staff. VM suggested that information around CIVICA / encouraging patients to	

	provide feedback requires refining and updating in a number of areas. It was suggested that divisional reports could provide assurance that feedback zones are set up within all areas divisions as work. HJ queried the possibility of reporting against protected characteristics (age, disability, gender and the like) to provide an indication of potential cultural issues. NW advised that this had been explored but is not possible due to the inability of the Datix system to capture this level of detail. However, it was agreed that a request would be made to explore this nationally (via national forums) as part of future Duty of Candour. SH noted that although 96% of incidents raised were graded no or low harm, there was no information relating to the remaining 4% or other categories of harm. ND advised that no harm, low harm and moderate harm is applied to incident severity. It was noted that the remaining 4% were graded as moderate harm and this will be included in the summary in future reporting. NW indicated that in terms of defining of moderate harm, initial grading is included in the report; this is however often subject to downgrading following initial review and investigation, as the level of harm may have been incorrectly assigned. The Committee **DISCUSSED** and **APPROVED** the 2022/2023 Quarter 1 Putting Things Right Report.	**ND** **ND**
4.8.0	**Trust Risk Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Trust Risk Report reflecting the Trust's current risks was received, which provided oversight of the current risk profile across the Trust as identified on the Datix system. The following was highlighted: • An extensive review of Velindre Cancer Service risks has recently been undertaken and completion of all actions had been prioritised by the VCS Senior Leadership Team. RH is currently organising a specific session for Quality Safety and Assurance matters in, which risk plays a predominant part. • Migration of all new WBS risks and Board Level reporting risks to Datix has been completed. • Level 2 Risk training has been completed via Teams by over 100 staff to date (with 40 staff remaining). VM queried two risks detailed in the table: • One risk rated 20 with the aim to achieve a target of 1 by the 30/09/2022. • One risk rated 20 with the aim to achieve a target of 15 by 05/09/2022 (which had already passed). LF advised that review dates noted in the report are ongoing, regular review dates for each risk, as opposed to actual target dates for completion as this	

	field does not exist in Datix. RH advised that DHCR-related risks are contingent on the delivery of the Digital Health and Care Project (DHCR) (replacing CANISC) and is managed by the DHCR Project Board. As the project is not due to be implemented until November 2022, these risks may cease following the go live date, dependent on their nature. The Committee **NOTED**: • The risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in this paper; • The ongoing developments of the Trust's risk framework.	
5.0.0	**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)	
5.1.0	**Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members The following themes were acknowledged: • A combination of workforce issues (vacancy rate, absence and wellbeing) continue to impact on operational delivery whilst the significant undertaking by all to regain waiting times across all services was noted. • Inclusion of a number of issues highlighted during today's Committee around harm and actions taken to mitigate harm. • Discussion on potentially applying the triangulation process to a number of other Committee reports, such as progress evidenced within Health & Safety reporting and improvements in Putting Things Right. Additionally, improved performance and communication of Trust objectives across divisions would resolve emerging risks within Medical Education. **Analysis of committee effectiveness** The following was agreed: • Value of the patient story. • A number of items would be more appropriately placed in the main agenda rather than consent to note, to facilitate necessary discussion (in particular Policy Compliance). • The Cycle of Business is currently under active review and individual input would be welcomed from all Executives. • Imminent establishment of the Integrated Quality & Safety Group, which will also feed into Quality, Safety & Performance Committee.	
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items to include in the Highlight Report to the Trust Board:	

	It was agreed that VM and the Committee Secretariat would agree items for inclusion in the Board highlight report for the purposes of Escalation, Advising, Assurance and Information.	
7.0.0	**ANY OTHER BUSINESS**	
	15 Step Challenge update NW provided a general overview of the approach and advised that summary reports and improvement actions not yet provided to the Committee would be provided by the responsible Divisions at the November 2022 Committee. It is the intention to extend the programme to include other Executives and Independent Members. VM echoed the importance of the visibility of the wider Executive team and Independent Members in terms of providing feedback to Clinical teams, while also providing the opportunity for two way dialogue between 'on the ground' staff with Executives and Independent Members. This is to remain an ongoing focus for the Committee.	**RH/AP**
6.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **10th November 2022 from 10:00 – 13:00 via Microsoft Teams**	
CLOSE		
The Committee is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).		

Quality, Safety and Performance Committee

PRECEPTORSHIP POLICY

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non Applicable

PREPARED BY	Anna Harries Senior Nurse Professional Standards and Digital
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Allied Health professional Monthly meeting (virtual)	28.09.2022	APPROVED
Professional Nursing Forum	22.09.2022	APPROVED
Executive Management Board	03.10.2022	APPROVED

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with the revised Trust Preceptorship policy for **APPROVAL.**

2. BACKGROUND

The Trust Preceptorship Policy was overdue for review (due March 2018). The extensive delay was contributed to by the pandemic.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The policy review was facilitated through a small multi professional task and finish group and undertaken by the Head of Nursing, Professional Standards & Digital. The key changes made to the policy were:

- Undergraduate changed to Pre-registered throughout document.
- Client changed to Donor throughout document.
- Length of time in area removed as a way of attributing competence and competence and or skill used as a measure.
- Practice assessor used replacing nurse mentor.
- Further additions for clarity within the benefits section for each party involved (ie, organisation, preceptee and preceptor).

The policy has a short review period of one year as an All-Wales framework for preceptorship and clinical supervision is expected shortly.

Additional changes added post Executive Management Board from Corporate Governance:

- Add University to the Trust's title throughout the document.
- Section 2 bullet 2 – Standards for Health Services in Wales changed to Health & Care Standards.
- Add the Health & Care Standards 2015 in the reference section and any other standards mentioned in Section 2 that are not already referenced on the last page;
- Acronyms need to be expanded for first mention and then the abbreviation used from that point for the rest of the document;
- Remove names of individuals and include their job title only.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) Robust professional governance is a critical element of having safe high quality patient care
	Effective Care
RELATED HEALTHCARE STANDARD	If more than one Healthcare Standard applies please list below: **Safe Care**
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below) Programme specific, but not for paper reporting
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Programme specific, but not for paper reporting
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Programme specific, but not for paper reporting

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **APPROVE** the revised Preceptorship Policy**.**

QS 25
Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals

Date to be reviewed:	October 2023	**No of pages:**	13
Author job title(s):	Clinical Educator Welsh Blood Service (WBS) and Velindre Cancer Centre (VCC) Advanced Health Professional (AHP) Preceptorship Lead		
Responsible dept / director:	Executive Director of Nursing, AHP and Medical Scientists		
Approved by:	Workforce and Organisational Development		
Date approved:			
Effective Date (live):			
Version:	4		

Date EQIA completed:	
Documents and website information to be read alongside this policy:	Personal Appraisal Development Review (PADR) policy Preceptorship Framework for Newly Registered Nurses (Update awaited), Midwives and Allied Health Professionals (Department of Health (DH) 2010) All Wales Core Principles for Preceptorship Nursing and Midwifery Council (NMC) Code 2018 and website
Current review changes: This policy has been reviewed as required by date but will be re reviewed when new Framework published.	

Executive Summary:
The policy is for Newly Registered Practitioners in Nursing and Allied Health Professionals (AHPs), Managers, Preceptors and educationalists employed by Velindre University NHS Trust. The policy is intended to support the transition from Pre-registration student to autonomous practitioner**.**

First operational:	Date				
Previously reviewed:	Date	Aug 2013	March 2015		
Changes made yes/no:					

Contents

1. Introduction

The transition from pre-registration student to autonomous practitioner can be a stressful and challenging experience for many newly registered nurses, midwives and allied health professionals. Although new registrants (preceptees) are competent and knowledgeable, at the point of registration, they require support and guidance from experienced professionals to assist them to integrate into their new roles and new teams. The Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (Department of Health (DOH) 2010) articulates the benefits of preceptorship programmes stating,

"Newly registered practitioners who manage the transition successfully are able to provide effective care more quickly, feel better about their role and are more likely to remain in the profession"

(DOH, 2010:4)

Preceptorship enables a period of structured transition that provides the foundations for professional development and prepares preceptees to be safe, confident and competent practitioners.

2. Policy Statement

Velindre University NHS Trust is committed to supporting preceptorship of new registrants so that their transition from undergraduate student to registered professional is a positive experience that enables them to provide high quality safe and effective care for service users.

This policy is mapped to the following standards:

- Fundamentals of Care (Welsh Government (WG) 2003 standards 1,2,3,5
- Health & Care Standards 2015 (2, 3, 4, 6)
- Health and Care Professions Council (2016) Standards of Conduct, Performance and Ethics
- Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DH 2010)
- The Core Principles of preceptorship (WG 2014)
- NMC (2016) The Code: Professional Standards of practice and behaviour for nurses and midwives

3. Definitions/Glossary of Terms

Definitions, in the context of this policy, in relation to preceptorship are outlined below:

3.1 Preceptorship

Preceptorship focuses on supporting the development and growth of newly registered staff with a formal agreement amongst individuals to engage in a time limited relationship, typically 6 months to 1 year. This time is an orientation period whereby newly registered staff are familiarised with policies, procedures, clinical skills and consolidate competencies. Preceptorship is defined asfollows:

"A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning"
(DH, 2010: 11)

Preceptorship does not exclude the preceptee accessing other support, which may include clinical supervision, mentoring, coaching.

3.2 Preceptor

A registered practitioner with the responsibility of supporting a newly registered practitioner (preceptee) through preceptorship. There are currently no formal qualifications required to undertake the preceptor role, but the preceptor would normally be expected to have gained competence and experience within the same area of practice of the preceptee they are supporting and have undertaken formal assessed mentorship training or a preceptor preparation workshop.

3.3 Preceptee

A newly registered nurse or allied health professional who is entering employment in Velindre University NHS Trust for the first time following professional registration with the Nursing and Midwifery Council, Health Care Professionals Council or other appropriate professional bodies.

4. Scope

This policy applies to preceptees working as registered nurses or AHP's and their preceptors. It is also applicable to other individuals such as managers and supervisors who support the preceptorship process.

5. Aims and Objectives

This policy will provide clarity for preceptees, preceptors and line managers within Velindre University NHS Trust regarding preceptorship. This policy will:

- Identify robust processes for preceptorship for newly registered nurses and AHP's working in Velindre Cancer Centre or the Welsh Blood Service

- Ensure a consistent and equitable approach for the provision of preceptorship programmes

- Support preceptees to develop skills, knowledge, competence behaviours and experience that will enhance their personal development and support high quality patient/client/service user care

6. Benefits of Preceptorship

The benefits of preceptorship programmes contribute not only to preceptors and preceptees but enhance the overall patient/client/service user experience (DH 2010). The model of preceptorship is tripartite between preceptee, preceptor and manager. This model will be supported by other individuals e.g. education leads, practice educators, clinical supervisors.

The benefits of preceptorship include the following:

6.1 For the Preceptee

- Develops confidence, skills and abilities through provision of support

- Ensures professional socialisation into the working environment

- Increase job satisfaction leading to improved patient/client/service user satisfaction

- Feels valued and respected by the organisation

- Develops understanding of the commitment to working within the profession and regulatory body requirements

- Facilitates personal responsibility for maintaining up to date knowledge

- Enhances skills, and a caring and compassionate philosophy

6.2 For the Preceptor

- Professional development

- Job enrichment

- Supports lifelong learning

- May enhance future career aspirations

- Will promote respect for dignity, equality and diversity through the development of core values and behaviours

6.3 For the Organisation

- Enhanced quality of patient/donor/service user experience
- Enhanced recruitment and retention and positive organisational reputation
- Reduced sickness and absence
- Enhanced staff satisfaction
- Reduced risks of complaints
- Opportunity to recognise succession planning to meet the leadership agenda
- Identify staff that require further/additional support
- Will promote respect for dignity, equality and diversity through the development of core values and behaviours
- Improved standards of care and governance

7. Roles and Responsibilities

The preceptorship process is based on mutual relationships between individuals as outlined below.

7.1 Programme Facilitator/s

Programme facilitator/s within nursing and AHPs in their respective service areas, will:

- Plan and manage programmes and where applicable liaise with a range of individuals with various areas of expertise that may provide updates throughout the programme. Learning opportunities may range from blended learning, taught sessions/study days, reflective activities
- Ensure that any learning opportunities are current and reflect the needs of newly recruited registrants and the organisation
- Evaluate the preceptorship programme and notify key stakeholders e.g. service leads/team leaders/speakers/professional leads of key findings
- Record and maintain data bases and registers of attendance by preceptees

- Ensure that line managers and preceptors are notified of any nonattendance by preceptees

- Maintain an up-to-date list of preceptors

7.2 Preceptees

From the moment of registration practitioners are autonomous and accountable for their acts and omissions, as regulated by the NMC and HCPC**.** During preceptorship preceptees will be building their confidence and further developing competence to practice. Therefore, engagement with and completion of programmes are instrumental in supporting their development.
Consequently, it is an expectation that preceptees will:

- Commence a preceptorship programme on recruitment to Velindre Cancer Centre or the Welsh Blood Service and reviewed on an individual basis

- Take responsibility for individual learning and development and commit to learning by completing preceptorship programmes within 6 months to 1 year.

- Notify Preceptor and Line Manager / Professional Lead if any difficulties are experienced in accessing or completing any part of the programme

- Use this time to develop their portfolio towards NMC revalidation (nursing only)

- Engage in various learning activities, such as e-learning, reflection and working with others

- Engage fully in the preceptorship programme and respond appropriately to constructive feedback

- Maintain responsibility for documentation of preceptorship processes and learning resources e.g. assessment workbooks

- Liaise with the named preceptor to complete any learning resources e.g. competency record documents and present this as evidence to their reviewer during the Personal Appraisal Development Review (PADR) process

- Apply and develop the knowledge and skills already learned and develop competences that relate to the role

7.2 Preceptors

- A named preceptor will support each registrant throughout the programme. If they are not available, for example due to sickness, then another preceptor will be appointed. This will be arranged locally between registrant and line managers. Preceptors have a responsibility to support new registrants with their transition from student to registered practitioner and the role of the preceptor is clearly stated in the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DH 2010) and

the All Wales Core Principles for Preceptorship (WG 2014).

Preceptors will:

- Support the preceptee with their professional development
- Share individual knowledge and experience with the preceptee
- Maintain responsibility for documentation of preceptorship processes and learning resources e.g. assessment workbooks
- Recognise and respect cultural and individual diversity
- Discuss individual practice with the preceptee and provide regular and constructive feedback
- Have insight, compassion and empathy with the preceptee
- Facilitate the development of the preceptee through reflective learning
- Act as an exemplary role model
- Facilitate protected time to undertake preceptorship activities such as meetings between preceptor and preceptee
- Ensure sufficient supernumerary status in order to undertake a meaningful induction into the organisation
- Allow the preceptee to work alongside them whilst completing their preceptorship competencies where possible

7.3 Line Managers

Managers within their respective service areas will:

- Ensure, in conjunction with programme facilitator/s, that all preceptees are allocated a preceptor and ensure all relevant parties are informed
- Ensure that preceptors are suitably selected, ensuring they meet their required attributes
- Liaise with programme facilitator/s to ensure that preceptors and preceptees have appropriate documentation and are aware of their roles and responsibilities
- Ensure that preceptors and preceptees are given adequate protected time to achieve preceptorship requirements.
- Support preceptors and preceptees as appropriate

8 Standards for preceptorship

The standards for preceptorship will ensure that the benefits that have been identified can be most effectively delivered for all newly registered nurses and allied health professionals, regardless of their work environment or the design of preceptorship arrangements. The following standards are viewed as core principles or preceptorship (DH 2010) and will be implemented, managed and evaluated within Velindre Cancer Centre and The Welsh Blood Service.

Standards for Preceptorship
Systems are in place to identify staff requiring preceptorship
Systems are in place to monitor and track preceptees from their appointment through to completion of the preceptorship period e.g. a competency framework or protocol
Preceptors are identified from the workforce within relevant clinical area
Organisations have sufficient numbers of preceptors in place to support the number of preceptees employed
Organisations demonstrate that preceptors are appropriately prepared and supported to undertake the role and that the effectiveness of the preceptor is monitored through appraisal
Organisations ensure that their preceptorship arrangements meet and satisfy professional regulatory body
Organisations ensure that preceptees understand the concept of preceptorship and fully engage
An evaluation framework is in place
Organisations ensure that evidence produced during preceptorship is available for submission for verification by the NMC/HCPC if selected for audit

8.1. Structured Preceptorship

Structure preceptorship within Velindre cancer centre and the Welsh Blood Service will be documented in the preceptorship protocol or competency framework.

8.2 Preceptorship Protocol

Preceptorship programme will be managed and facilitated in partnership with

Educational Leads for Departments and the Trust Education and Development Departments Velindre University NHS Trust.

Programmes will be mapped to Standards for Health Services in Wales.

Preceptorship programme will include underpinning knowledge and assessment of competencies. A blended learning approach will underpin the preceptorship programme to maximise effective use of preceptors' and preceptees' time to enhance development of skills and knowledge. Teaching and learning activities can take place in classroom environments and work areas. Methods may include:

- Formal classroom sessions/study days
- 1:1 tutorials/support from peers
- Group discussions
- Reflections
- Work based learning
- Action learning sets
- Self directed learning
- Shadowing
- Portfolio development

The period of preceptorship will typically last for 6-12 months and during this time the preceptor and preceptee will meet at least bi-monthly to plan, assess and map competencies.

Throughout the preceptorship period preceptees will remain accountable for their own practice within the context and limitations of their knowledge as set out in their professional codes of practice and escalate any concerns regarding competency and abilities.

8.3. Learning records

Preceptorship learning records will be held by the preceptee and a record of completion and will be held by the relevant training department.

8.4 Evaluations

Clinical Educators/facilitators will be responsible for evaluating programmes. The content of programmes will be updated and amended, as required and based on evaluation and feedback. Evaluations will be shared with staff who contribute to teaching and learning activities e.g. speakers at study days/sessions.

8.5 Certification

Certificates of completion will be awarded to preceptees by Clinical Educators and will provide evidence at PADR.

8.6 Preceptor Preparation

A preceptor development session will be offered to all identified preceptors. The expectation is that a practice assessor or for AHPs a senior practitioner with team leading responsibilities would usually be a mentor/sign-off mentor and would draw on their generic skills in this capacity. In clinical areas where there are no trained mentors, preceptors will be required to attend preceptor preparation training. However, there are critical additional aspects about being a preceptor for new registrants which distinguish this role as different to mentorship of pre-registration student

- Giving constructive feedback
- Setting goals and assessing competency
- Facilitating problem solving
- Active listening skills
- Understanding, demonstrating and evidencing reflective- practice ability in the working environment
- Prioritising care
- Demonstrating appropriate clinical decision making and evidence-based practice
- Recognising their own limitations and those of others
- Knowing what resources are available and how to refer a newly registered practitioner appropriately if additional support is required, for example, pastoral support or occupational health services
- Being an effective and inspirational role model and demonstrating professional values, attitudes and behaviours
- Demonstrating a clear understanding of the regulatory impact of the care that they deliver and the ability to pass on this knowledge
- Providing a high standard of practice at all times

8.7 PADR

In some circumstances the preceptor may not necessarily be the preceptee's reviewer. However it is extremely important that the preceptor, reviewer and preceptee's manager maintain effective communication in order for the PADR to be a valuable experience for the preceptee. Regular communication between all parties means that the PADR process would hold 'no surprises'.

9 . Equality

All preceptorship programmes will be inclusive with the integration of a range of teaching and learning methods to cater for individual preceptee's needs e.g. disabilities, dyslexia. The Trust realises that some staff may require additional support due to specific needs, as such the Trust will aim to meet reasonable adjustments and take account of protected characteristics under the Equality Act.

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups. Staff members who are pregnant or on maternity will be signposted to the Trust policy to support them.

10. Monitoring and Effectiveness

This policy will be reviewed using the following indicators:

- Percentage of new registrants successfully completing the preceptorship process annually
- Preceptee evaluation forms
- Feedback from facilitators at taught study days
- Feedback from preceptors and line managers

The results of the monitoring will inform an annual review of preceptorship which will be undertaken by the relevant education lead for each professional group.

11. Further Information

For further information on this policy contact:
Clinical Educators
Welsh blood Service and Velindre Cancer
Centre.
Velindre University NHS Trust

12. Review

The Education leads will review the operation of the policy as necessary and at least every 3 years, However in the first instance 12 months as new Framework publication is expected.

References

DH (2010), Preceptorship Framework for newly registered nurses, midwives and allied health professionals.

Health Care Professionals Council (HCPC) (2016), Standards of conduct, performance and ethics.

NMC (2015), The code: Professional Standards of practice and behaviour for nurses and midwives.

Velindre University NHS Trust (2016) PADR policy

Welsh Government (2014), NHS Wales Core Principles for Preceptorship

Welsh Government (2015) Health and Care Standards.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFECTION PREVENTION AND CONTROL POLICIES

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Hayley Harrison Jeffreys, Head of Infection Prevention and Control
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Infection Prevention and Control Management Group	28/09/2022	ENDORSED FOR APPROVAL
Executive Management Board	26/10/2022	ENDORSED FOR APPROVAL

1. SITUATION / BACKGROUND

The paper is to provide the Quality, Safety & Performance Committee with an update on the Infection Prevention and Control policies. This includes an update on the policy review plan and three policies for ***APPROVAL*** and to ***AGREE*** to extend the review date for a further three policies for a year pending national policy reviews.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Revised Infection Prevention & Control Policies

The policies have been reviewed in line with the planned review process and latest National guidance and evidence base.

The purpose of Infection Prevention and Control policies is to outline the overarching standards process of management for the various aspects of prevention and control of infection in patients / donors and to prevent the occupational exposure of Healthcare Workers. They cover the whole Trust including both Divisions, and, where specified, for hosted organisations and to ensure compliance with national guidelines.

Three policies are presented for approval. These were existing policies that have been reviewed, references updated and re-formatting to comply with the current Trust policy requirements. Each reviewed policy has been consulted on widely. This has included the divisional Infection Prevention and Control groups, Infection Control Doctor (Consultant Microbiologist) and the Infection Prevention and Control Management Group. The following have been revised:

- **IPC21** - Infection Prevention and Control policy for the Management of Respiratory Infections
  The amendments made to the policy were:
  - *Page 5*: Addition of the latest Four Nation Infection Prevention and Control guidance for the management of COVID-19.
  - *Page 14*: References updated to latest Department of Health guidance for management of respiratory infection and influenza and Public Health Wales Infection Prevention and Control Guidance for the management of SARS-CoV-2 in health care settings.

- **IPC10** - Hand Hygiene policy
  The amendments made to the policy were:
  - Represented in correct policy template
  - *Page 10* – Addition of Information on Hand Care
  - *Page 11* – Additional information on Bare Below the Elbow moved from Appendix to main body of policy.

- **IPC00 -** Framework policy for Infection Prevention and Control.
  No real changes made. The framework includes a Terms of Reference which have been reviewed with no changes.

2.2 Extension to Policy Review Dates

There are three Infection Prevention and Control Policies being reviewed nationally and therefore the request is to extend the review date by a year to reflect the national review work that is underway:

- IPC03 Aseptic Non Touch Technique (ANTT)
- IPC05 National Infection Prevention and Control Manual
- IPC15 Control and Management of Multi Drug Resistant Bacteria

The Executive Management Board agreed the one year extension as detailed above and endorsed the three Trust policies in meeting on the 20/10/2022. It is anticipated the national reviews will be completed in the next 12 months.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **APPROVE** the following **Infection Prevention and Control Polices:**
  - **IPC21** - Infection Prevention and Control policy for the Management of Respiratory Infections
  - **IPC10** - Hand Hygiene policy
  - **IPC00 -** Framework policy for Infection Prevention and Control.

- **AGREE** to extend the following policies for a year pending national review work:
  - IPC03 Aseptic Non Touch Technique (ANTT)
  - IPC05 National Infection Prevention and Control Manual
  - IPC15 Control and Management of Multi Drug Resistant Bacteria

Appendix 1: Infection Prevention and Control policy for the Management of Respiratory Infections.
Appendix 2: Hand Hygiene policy.
Appendix 3: Framework policy for Infection Prevention and Control.

Appendix 1:

Ref: IPC 21

INFECTION PREVENTION AND CONTROL POLICY FOR THE MANAGEMENT OF RESPIRATORY INFECTIONS

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	**Senior Infection Prevention & Control Nurse**
Approved by:	Trust Quality and Safety Committee
Approval Date:	
Date of Equality Impact Assessment:	11/12/2018 – revised August 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	Three years
Version:	4

CONTENTS

ABBREVIATIONS

ABHR	Alcohol based hand rub
AGP	Aerosol generating procedures
CPO	Carbapenemase resistant organism
ESBL	Extended-spectrum beta-lactamase
FRSM	Fluid resistant surgical mask
HCW	Healthcare Worker
ICD	Infection Control Doctor

IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team
LRTI	Lower Respiratory Tract Infection
MERS	Middle East respiratory syndrome
OPD	Out Patients Department
PHW	Public Health Wales
PPE	Personal Protective Equipment
RSV	Respiratory syncytial virus
RTI	Respiratory Tract Infections
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SARS	Severe acute respiratory syndrome
URTI	Upper Respiratory Tract Infection
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
WG	Welsh Government

1 POLICY STATEMENT

1.1 Respiratory Tract Infections (RTIs) can include infection of the sinuses, throat, airways or lungs. Upper Respiratory Tract Infection (URTI) affect the nose, sinuses and throat, Lower Respiratory Tract Infection (LRTI) affects the airways and lungs. This policy concentrates on infections affecting the lower respiratory tract.

Respiratory infections are common and can be seasonal. They principally cause the common cold in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. These can progress and cause more severe infections and even death, especially in the very young and the elderly and immuno-compromised. There is a wide variety of viral causes of respiratory infections including rhinoviruses, picornaviruses, enteroviruses, respiratory syncytial virus (RSV), influenza viruses types A, B and C, parainfluenza viruses and corona type viruses; Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) including Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2). There are also a number of common bacterial infections that can be caused by organisms such as *Streptococcus pneumonia*, *Haemophilus influenza*, *Moraxella catarrhalis* and *Staphylococcus aureus*. Atypical pneumonias may be caused by Mycoplasma, (Mycoplasma Tuberculosis is covered in IPC Policy 18 Tuberculosis Management) and legionella.

Influenza epidemics occur mainly in the winter and can result in widespread disruption to healthcare and other services. The Trust provides a flu vaccination service for all frontline staff and encourages all staff to be vaccinated. The Welsh Government (WG) sets an annual minimum target for the vaccination of staff in direct contact with patients. During an influenza outbreak or pandemic, the priority will be to identify potentially infected patients, carry out a risk assessment and use the appropriate

precautions. Velindre University NHS Trust will seek to minimise illness occurring within Healthcare Workers (HCWs), patients and their families. The priority for the Trust is to ensure that all staff who are in direct contact with service users and donors are offered and given vaccination. Any suspected cases must be isolated and reported to the Infection Prevention and Control Team (IPCT).

1.2 The purpose of this policy is to improve protection of HCWs and service users, to reduce the transmission of infection of; bacterial infections, viruses including seasonal influenza, emerging and re-emerging novel viruses. This policy is to be used in conjunction with mentioned Infection Prevention and Control (IPC) policies.

2 SCOPE OF POLICY

2.1 The purpose of this document is to ensure that staff know how to manage patients with respiratory infections in order to minimise the risk of transmission within the healthcare setting.

Implementation of this policy will minimise the avoidable spread of respiratory infections; patients with a respiratory infections are cared for appropriately.

This policy applies to all HCWs employed by Velindre University NHS Trust. It details responsibilities in respect of hosted organisations and must be used in conjunction with mentioned infection, prevention and control policies.

Copies of all Velindre University NHS Trust policies can be found on the Trust Intranet site. http://howis.wales.nhs.uk/sitesplus/972/home

Guidance on COVID-19 can be found in A-Z pathogens list (Coronavirus) in the National Infection Prevention and Control manual (NIPCM) using the following link:

https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/a-z-pathogens/

3 AIMS AND OBJECTIVES

3.1 The aims and objectives of this policy are to:

- Minimise the effect and spread of respiratory infections to all of Velindre University NHS Trust Service users and staff.
- To encourage the uptake of seasonal Influenza Vaccination Programs as recommended by the WG.
- To identify any patients in risk groups who (due to a prolonged stay in hospital) require vaccination.
- Embed the importance of infection prevention and control into everyday practice.

4 RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive has overall responsibility and accountability to the Trust Executive Management Board for the management, prevention and control of infection across the organisation. This includes the responsibility for the provision of resources and implementation of all measures needed to comply with infection control policies and procedures, associated legislation and relevant guidance.

4.2 Executive Director of Nursing, AHPs and Health Sciences

The Executive Director of Nursing, AHPs and Health Sciences has delegated corporate responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives

competent infection prevention and control advice and that adequate staff Infection Prevention and control training and monitoring is in place.

4.3 Divisional Directors and Directors of Hosted Organisations

Directors have responsibility for the day-to-day management of Infection Prevention and Control within their service area. They are directly accountable to the Chief Executive for ensuring full compliance of Infection Control Policies. They must ensure that staff are made aware of the policy that appropriate equipment is available, and training is provided to ensure that HCWs adhere to the policy within their areas of responsibility. Hosted organisations who have staff working within other Health Boards will also need to take account of the policies within the Health Boards they visit.

4.4 Consultant Microbiologist/Infection Control Doctor (ICD)

The Consultant Microbiologist / IDC has responsibility for the diagnosis, management, notification and escalation of infectious diseases to national bodies such as Public Health Wales (PHW) and Welsh Government. In consultation with the Consultant in Communicable Disease Control implement appropriate measures for diagnosis, infection prevention and control, contact tracing and transfer to regional centre as required in outbreak scenarios or when dealing with novel viruses in line with UK and national guidance.

4.5 Infection Prevention and Control Team

IPCT have responsibility for ensuring:

- The policy is implemented and monitored across the Trust.
- Ensure compliance with national initiatives or directives.
- The importance of infection prevention and control measures are embedded into everyday practice. Provide support and advice to clinical areas regarding the management of patients with or suspected to have RTIs (this may be detected via microbiological results but more commonly will be due to the patients clinical symptoms).
- All controls are in place to minimise risk of spread to other patients, service users, donors, staff and visitors.

4.6 Ward/Department Managers

Will ensure:

- Staff are aware of the policy.
- Allow all staff access to attend any necessary training / educational sessions.
- Equipment is available when needed.
- Encourage and facilitate staff to attend and receive seasonal influenza vaccination.
- Staff have opportunity to be fit tested for an FFP3 respiratory mask.
- And should maintain a record of staff who have been fit tested.
- All employees refrain from coming to work if ill.
- Promptly inform IPCT of any suspected or confirmed cases of seasonal influenza or novel viruses.
- Ensure any patient or case of seasonal influenza or novel virus is isolated immediately.
- Comply with IPC precautions advised.
- Receive Seasonal influenza vaccination.
- Limit the movement of patients outside their room to those necessary for patient management/treatment. Whilst outside the isolation room the patient should wear a fluid resistant surgical mask (FRSM). Patients with respiratory symptoms or suspected/ confirmed influenza are not mix with other patients. They should be encouraged to practice good respiratory etiquette i.e. cover their mouth & nose with a tissue when sneezing or coughing, ‘Catch it, Bin it, Kill it’ and dispose of the tissue promptly in a bin and then practice hand hygiene by washing hands with soap & water or hand sanitiser.
- Visitors or service users who have ‘flu like symptoms’ or who are coughing and / or sneezing must be advised not to come to the hospital or to donate.

5 DEFINITIONS

5.1 Respiratory infections as a communicable disease

A respiratory tract infection (RTI) is an infectious process affecting any part of the upper and/or lower airways. Symptoms of RTI can include any of the following: fever, rhinorrhoea (runny nose), sore throat and cough, limb or joint pain, headache, lethargy, chest pain and breathing difficulty. Common causes of RTIs include viruses such as: rhinoviruses, SARS-CoV, SARS-CoV-2, seasonal coronavirus, influenza and RSV; and bacteria such as pneumococci (*Streptococcus pneumoniae*) and *haemophilus influenza*. Avian influenza and MERS-CoV are less common causes of RTIs and can lead to severe illness. Where either of these are suspected advice should be sought as a matter of urgency from a Consultant Microbiologist. The majority of RTIs are self-limiting, viral infections of the upper respiratory tract. Although RTIs can happen at any time, they are most common from September through till March. The peak activity for RTIs due to influenza occurs during the autumn and winter seasons in temperate regions. In some tropical countries, influenza viruses circulate throughout the year with one or two peaks during rainy seasons. Worldwide, the epidemics of influenza result in about three to five million cases of severe illness, and about 290,000 to 600,000 people die

of respiratory diseases linked to seasonal influenza each year. Most deaths associated with influenza in industrialized countries occur among people age 65 or older.

Streptococcus pneumoniae and *haemophilus influenza* are components of the normal upper respiratory tract flora. Infections with these organisms are often secondary to a prior viral infection.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Velindre Cancer Centre (VCC)

6.1.1 In Patients admitted with Respiratory infections

- Patients admitted with confirmed or suspected RTIs should be isolated until diagnosis has been confirmed. Where single rooms are not available the IPCT may advise that suspected or confirmed cases with the same organism are cohorted in a single bay/ area.
- All adult patients with signs and symptoms of respiratory infection should receive active instruction on respiratory hygiene/ cough etiquette and importance of effective respiratory hygiene (Appendix 1).
- Throat swab will be required, sputum and nasal swabs may be required. The request form must include all relevant clinical information including possible clinical diagnosis.
- Display the relevant infection prevention and control notices.
- All respiratory equipment used on the patient should be changed or cleaned every 24 hours.
- Where viral respiratory infection is suspected in adults they should:
    - Be nursed in single room using respiratory / droplet precautions (Flow chart Appendix 3).
    - Be assessed by a member of the medical staff.
    - The door must be kept closed and a respiratory precaution sign placed on the door.
    - Staff should ensure that correct selection and use of appropriate Personal Protective Equipment (PPE) is observed, (Appendix 2).
    - Carers / visitors should be reminded about the importance of patients remaining in isolation and potential infection risks.
    - Patients should only remain in hospital if their clinical condition warrants this
    - Visitors should themselves avoid contact with other patients in the ward.
    - During an outbreak if cohorting has to be considered – Immuno-suppressed patients should not be nursed in the same area and should be admitted to single rooms.
    - When clinical signs or history (travel to affected areas) suggest infection with novel or re-emerging respiratory diseases, such as MERS- CoV), SARS- CoV, SARS-CoV-2 or Influenza like viruses the patient must be placed in a single room prior to medical assessment and discussed with IPCT, ICD or microbiologist. Specific instructions regarding the use of PPE will be given at this time. (Over 65s and immune-suppressed patients are classified at risk of severe disease).
- Pandemic Influenza advice will be continually updated on the PHW/ Public Health England website and this should be accessed by Trust personnel.

http://www.wales.nhs.uk/sites3/home.cfm?orgid=379
http://www.HPE.org.uk/

6.1.2 Transmission

Influenza and respiratory Infections can be acquired by direct and indirect contact. Transmission occurs from person to person by close contact, predominantly by large droplet/ airborne respiratory secretions and/ or contamination of hands. Infected HCWs and visitors are potential sources of hospital acquired infection. Influenza can be transmitted prior to symptoms occurring, therefore respiratory hygiene should be encouraged at all times.

The pathogens that cause RTIs are spread through one or more of four main routes:

Visitors must be advised of the risks of infection and preferably avoid visiting.

Visitors who have had close contact with people who are coughing and/ or sneezing or show signs and symptoms of a respiratory illness, must be advised not to come into the hospital or come to donate.

Droplet transmission	Droplets can be generated from the respiratory tract during coughing, sneezing or talking. If droplets from an infected person come into contact with the mucous membranes (mouth/nose, eye) or surface of the eye of a recipient, they can cause infection. Close physical contact is required for transmission. These droplets remain in the air for a short period and travel about one metre, so closeness is required for transmission.
Airborne Transmission	Aerosol generating procedures (AGP) such as coughing can produce small droplets. These small droplets can remain in the air, travel more than one metre from the source and still be infectious, either by mucous membrane contact or inhalation.
Direct contact transmission	Infectious agents are passed directly from an infected person (who has for example coughed into their hands) to a recipient who then transfers the organism into their mouth, nose or eyes.
Indirect contact transmission	This takes place when a recipient has contact with a contaminated object, such as bedding, furniture or equipment which is usually in the environment of an infected person. Again, the recipient transfers the organisms from the object to their mouth, nose or eyes.
Infectious Period	The time period over which an infected person can spread the infection to someone else. Generally in the early stages the infectious period is higher for example influenza day one after the onset of symptoms until 3-5 days later. In some groups this may be longer for example children and the immunocompromised patients with pertussis infection may remain infectious until three weeks after the paroxysmal phase of disease
Persistence in the Environment	Respiratory virus have been shown to survive in the environment for a short period of time for example influenza can be transferred from fomites to hands up to 48 hrs after initial cross contamination
High risk environment	Generally where aerosol generating procedures are occurring in communal patient areas

The time between exposure to a pathogen and developing symptoms of infection by the pathogen is the incubation period. Some of the common pathogens for RTIs and their respective incubation times are:

Respiratory Pathogen	Incubation Period	Period of infectivity
SARS-CoV-2	1-10 days	10 days from symptom onset
Rhinoviruses	1-5 days	1 day before and 5 days after onset of symptoms

Pnuemococcus and *Haemophilus influenzaei*	1-5 days	Until 48 hours effective antibiotic treatment

Influenza and parainfluenza viruses	1-4 days 2-6 days	Adults 3-5 days from onset of symptoms Young children 7-10 days (May be longer in immunosuppressed patients)
Respiratory Syncytial viruses (RSV)	3-7 days	Whilst symptomatic

6.1.3 Infection Prevention & Control precautions

Strategies should be put in place to interrupt the modes of transmission detailed above for all cases whether clinically suspected or confirmed:

- Isolate patients in a single room where possible of if there are several cases, cohort of cases of suspected influenza maybe appropriate. Please discuss with the IPCT.
- Personal protective equipment (PPE) must be worn by any HCW before entering the isolation room, consisting of gloves, plastic apron and FRSM. Hands should be decontaminated with alcohol based hand rub (ABHR) or soap and water prior to donning gloves.
- Any patient who is actively coughing should be asked to wear a FRSM (if able to tolerate) during examinations (and while visitors are present).
- Patient to be asked to wear a FRSM in communal areas / waiting rooms / during transfers to other areas of the hospital.

Below highlights the PPE required for staff and visitors before entering the room of a patient with suspected/known respiratory infection:

Staff Group	Plastic Apron	Long Sleeved Fluid Repellent Gown	Eye Protection (Visor/ Goggles)	Non sterile disposable Gloves	FRSM	FFP3 Mask
HCW	√		√ (If risk of close contact with patient – within 1 metre)	√	√	
HCW involved in AGPs*		√	√	√		√
Housekeeper/caterer/porter	√		√ (If risk of close contact with patient – within 1 metre)	√	√	
Relatives/ Visitors		√	√	√		√

- * e.g. CPAP, induction of sputum, intubation, open suctioning.

Refer to appendix 2 for correct PPE donning and doffing technique.

- If no ensuite facility is available, patient should use a dedicated commode within the isolation room i.e. not leave the room.

- Rooms should be cleaned daily.

- Visitors should be asked to stay within the isolation room with the door closed during their visit.

- Linen from affected patients should be placed in a red alginate (soluble) bag and tied. Then placed into a red 'infected linen' bag and tied with yellow hazard tape before being placed into a red cloth bag.

- All waste generated from isolation rooms must be disposed of as infectious (orange) waste.

6.1.4 Affected patients known or suspect in designated cohort wards

PPE must be worn by any HCW before entering a cohorted bay, consisting of gloves, plastic apron and FRSM. Hands should be decontaminated, prior to donning gloves, with ABHR or soap and water.

- Any patient who is actively coughing should be asked to wear a FRSM during examinations (if able to tolerate) and while visitors are present.

6.1.5 Treatment for known or suspected influenza

The full NICE guidance on the use of antiviral medicines can be accessed at: http://guidance.nice.org.uk/TA168 for treatment, and
http://guidance.nice.org.uk/TA158 for prophylaxis

See C&V guidelines for treatment options: https://viewer.microguide.global/CAVUHB/ADULT

Pregnant Staff (or others in defined risk groups)

- Vaccination is the first and most important measure in prevention seasonal influenza in individuals in risk groups.
- During a time of increased seasonal influenza activity, staff are at least equally as likely to be exposed to influenza outside of work as they are in the work setting.
- All staff, including those in risk groups must adhere to the required Standard and respiratory precautions when in contact with known or suspected influenza cases to minimise their risk of acquisition.
- The Trust may decide, despite vaccination and appropriate PPE for pragmatic reasons, to restrict those in risk groups from direct care for known or suspected influenza/ SARS-CoV-2 cases. Please contact Occupational Health for advice.

6.1.6 Discontinuing Precautions

- The majority of patients with flu will not be infectious beyond 5 days. Clinical response/ improving condition is associated with the reduction of viral load and decreased infectiousness. Precautions may be discontinued at day 5 following onset of symptoms/ treatment with antiviral drugs, providing there has been a satisfactory clinical response.
- Patients with severe immunosuppression may also shed the influenza virus for longer. Such cases should be discussed with IPCT or Virologist to determine appropriate interventions (See Appendix 4 for definitions of severe immunosuppression).
- With general bacterial infections specific precautions (other than standard precautions) may be discontinued if the patients stops coughing or the coughing is controlled and the patient able to use tissues when coughing (follow respiratory hygiene), unless the patient has a multi-resistant organism such as an Extended-spectrum beta-lactamase or Carbapenemase resistant organism where advice should be sought from the IPCT.
- All re-usable equipment used for respiratory infections must be cleaned after use according to manufacturer's instruction or the decontamination policy.

- Routine cleaning to be carried out by housekeepers using correct PPE.
- Enhanced cleaning of rooms to be carried out when patients discharged.
- Linen to be processed as infectious linen as per guidance.
- Waste to be disposed of as per Trust guidance.

6.2 Outpatients Department (OPD)/ Ambulatory services

During the influenza season it is likely that patients and donors attend outpatient and donor services, therefore it is important to ensure that the appropriate actions are undertaken to avoid outbreaks.

6.2.1 OPD Setting

In addition to using standard precautions and effective hand hygiene practices. Staff should ensure the following additional precautions are in place;

- Patients, needing assessment whilst symptomatic, should proceed straight to a cubicle/ isolation room for assessment and leave immediately afterwards to avoid symptomatic people sitting in waiting areas and exposing other patients/ service users.
- Use respiratory precautions if experiencing high levels of patients with respiratory symptoms or undertaking AGP generating – contact the IPCT.
- Consider minimising spread of respiratory viruses in waiting area by providing FRSM for patient use.
- If patients telephone VCC or WBS who are experiencing symptoms, consider deferring appointments/ treatments if appropriate.
- Use PPE when examining patients with respiratory symptoms (Appendix 2).

6.3 Welsh Blood Service (WBS)

Due to the nature of this service it is essential to ensure that HCWs, as well as donors are protected:

- Whilst donations take place during the influenza season.
- At the time of a pandemic or outbreak of a novel virus, or emerging and re-emerging types of influenza.

6.3.1 Protection of Donors at WBS

- Donors should be discouraged from attending if they have any flu like symptoms and should be asked to return home.
- If required, staff should use appropriate PPE when dealing with donors (See Appendix 2).
- Signage/ instruction to be provided on correct respiratory hygiene/ cough etiquette and supplies of tissues to ensure they cover their mouth and nose when coughing/ sneezing, to contain respiratory secretions. Provision should be made for the disposal of tissues into an appropriate clinical waste receptacle.
- Hand hygiene (refer to IPC policy 10 Hand Hygiene Policy and Procedure) must be carried out following contact with respiratory secretions or any other body fluids.
- Waste should be disposed of according to the Waste Policy (QS 20).
- HCWs should also be encouraged to use the correct respiratory hygiene/ cough etiquette when coughing or sneezing followed by hand decontamination.

All frontline staff are advised to have seasonal influenza immunisation to reduce the chances of acquiring influenza. Symptomatic staff should be advised to refrain from attending work for 5 days following onset of symptoms.

6.4 Response during a Pandemic (e.g. Novel Viruses including Coronavirus and Influenza)

Once a new (novel respiratory virus is able to infect and be transmitted between humans, a pandemic is likely to occur. Because people will have little or no immunity to the new virus, respiratory pandemics will affect a large proportion of the global population and put significant stress on health-care systems. It is evident that planning at the earliest possible stage will help in the response to the pandemic and will hopefully reduce its impact. It is a requirement that the Trust develops contingency plans to ensure that it is able to respond in the event of a pandemic. It is accepted that these plans will need to be kept under constant review having regard to developments within Wales, the United Kingdom and the world as a whole. Whilst certain elements of the planning

will be specific to pandemic influenza, there may be many similarities to other circumstances which will challenge the smooth operation of the organisation (Refer to VCC Pandemic Influenza Response Procedure). It is the aim of this procedure to ensure that the VCC is prepared, as far as is reasonably practicable, to respond to an influenza pandemic.
HCWs must be prepared to identify and manage cases of suspected pandemic influenza to ensure safe and effective treatment for patients/ donors. It is important that guidelines for clinical management are prepared, that HCWs are trained, and that medicines, supplies and medical devices are available.

- Wherever possible avoid admitting of patients with confirmed or suspected respiratory infections/ viruses. Triage by phone and if admission is required refer to hospital where correct isolation facilities are available (discuss with IPCT).
- If admission is required, place in isolation with respiratory precautions in place. All staff entering the isolation room to wear appropriate PPE (which will include a FRSM) (See appendix 2).
- Any specimens taken are to be classified and labelled as 'high risk' and the laboratory contacted prior to the specimen being sent. Ensure that the virology form contains the onset of symptoms. (Refer to IPC policy 11 Transport of Specimens).
- The door to the patients' room must be kept closed at all times.
- If AGP treatments are required an FFP3 mask and eye protection must be worn.
- Patient should only leave the room if clinical need dictates and should be asked to wear a FRSM, to prevent large droplets being expelled into the environment by the wearer.
- Hand hygiene is essential after contact with the patient or his/ her environment, and on leaving the patient's room in order to prevent transmission (Refer to IPC policy 10).
- All staff must be fit tested before using FFP3 masks.
- HCWs who are vaccinated or returning to work after illness should look after symptomatic patients where possible.
- At the appropriate time the WG will:
    - Issue guidance of prophylaxis for HCWs and at risk groups.
    - Advise on appropriate vaccination.
- All PPE must be removed and disposed of as clinical waste prior to leaving the single room or cohort area with the exception of the FRSM and eye protection,, which will be removed after leaving the room/cohort area followed by hand hygiene

6.5 Health Care Workers

6.5.1 Influenza Vaccination

Vaccination is the first and most important measure in preventing seasonal influenza. Velindre University NHS Trust encourages HCWs to take up the offer of the vaccine which is available free of charge and is recommended for all NHS HCWs with direct service user contact, from September to March each year. The immunisation needs to be repeated annually as the vaccine is adjusted in line with circulating influenza virus on an annual basis. It is the responsibility of individual employees to access this service in order to minimise the risk to service users (particularly those with frequent patient/ service user contact).

HCWs are 3 to 5 times more likely to get flu than people in other jobs. Due to repeated exposure of the virus, one in three health care staff is estimated to be infected by the flu in any season. You can pass on flu to vulnerable patients/ service users, your family, and colleagues even if you're not symptomatic.

The flu vaccine is effective in preventing influenza and could be the difference between life and death. The flu vaccine **cannot** give you flu. However, as it works by stimulating your body's immune system you may have some mild flu-like symptoms (immune response) for a day or two afterwards. This will be brief and you cannot pass these symptoms on.

This is particularly important**:**

- For all HCWs
- For pregnant women
- For those in risk groups (Appendix 4)

6.5.2 HCWs with respiratory symptoms

HCWs with respiratory symptoms suggestive of flu should be advised to stay at home e.g. coryzal symptoms (cough, runny nose, muscle aches, fever etc.).

HCWs suspected to have or diagnosed with a communicable respiratory disease must inform the Occupational Health Service (in addition to their line manager) immediately before attending work.

Anyone who is suffering from persistent, unexplained respiratory symptoms, especially following foreign travel, must report to their General Practitioner and should not attend work.

In the event of new or re-emerging respiratory diseases, such as severe acute respiratory SARS, SARS-CoV-2, MERS and Pandemic Influenza advice will be given by Infection Control and the Occupational Health Service.

6.6 Policy Conformance/ Non Compliance

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

6.7 Implementation

This policy will be implemented and maintained by the IPCT.

The policy will be available via the Trust Intranet Site and from the IPCT. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

6.8 Audit and Monitoring

HCWs must report increases in admissions of respiratory infections to the IPCT.

If an outbreak is suspected the Outbreak policy (IPC14 Outbreak Management Policy) must be followed.

7 REFERENCES and further reading

Department of Health (2022) People with symptoms of a respiratory infection including COVID-19. Guidance for people with symptoms of a respiratory infection including COVID-19, or a positive test result for COVID-19.
https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection including-covid-19

Department of Health (2022) COVID-19: managing healthcare staff with symptoms of a respiratory infection. Guidance for managing healthcare staff with symptoms of a respiratory infection including coronavirus (COVID-19), or a positive test result for COVID-19.
https://www.gov.uk/government/publications/covid-19-managing-healthcare-staff-with-symptoms-of-a-respiratory-infection

Department of Health (2022) COVID-19: infection prevention and control (IPC). Guidance on infection prevention and control for seasonal respiratory infections including SARS-CoV-2.
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

The Health and Social Care Act. (2008) 'Code of Practice for the NHS on the Prevention and Control of Health Care Associated Infections and Related Guidance'. 2015 update. Department of Health.

HSE guidance on fit testing is available at
http://www.hse.gov.uk/pubns/priced/hsg53.pdf

Loveday H.P. et al (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospital in England. Journal of Hospital Infection 86S1 S1-S70

NICE (2014) Infection Prevention and Control Nice Quality standard. https://www.nice.org.uk/guidance/qs61

Public Health England (2015) Infection Control precautions to minimise transmission of acute respiratory tract infection in healthcare settings.
http://www.guidelines.co.uk/phe/infection (2019)

Public Health Wales (2022) Infection Prevention and Control Measures for SARS-CoV-2 (COVID-19) in Health and Care Settings - WALES.
https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/infection-prevention-and-control-measures-for-sars-cov-2-covid-19-in-health-and-care-settings-wales/

Public Health Wales (2019) Managing Seasonal Influenza: Infection Prevention and Control Guidance in Healthcare Settings
https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/accordians/docs/managing-seasonal-influenza-infection-prevention-and-control-guidance-in-healthcare-settings/

WHO (2008) Your 5 moments of hand hygiene [pdf] Available at:
http://www.who.int/gpsc/tools/Five_moments/en/

8 GETTING HELP

8.1 Further information and support

IPCT: 02920196129

9 RELATED POLICIES

This policy should be read in conjunction with:

- IPC 04: Decontamination Policy
- IPC05: National Infection Prevention & Control Manual (NIPCM)
- IPC 06: Management of Occupational Exposure to Blood and High Risk Body Fluids (needle stick injury)
- IPC 10: Hand Hygiene Policy
- IPC 11: Transport of Specimens
- IPC 16: Management, Prevention and Control of Legionellosis (including Legionnaires Disease)
- IPC 18: Tuberculosis Management
- QS 20: Waste Management
  VCC Pandemic Influenza Response Procedure

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

All HCWs will undertake mandatory infection control training and must be fit tested as per Health and Safety Executive (HSE) requirement for wearing FFP3 masks.

11 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

- Control of Substances Hazardous to Health Regulation (COSHH) 2002 (Updated January 2020) as amended Approved Code of Practice and Guidance
- Department of Health (2013). Infection Control in the built environment HBN 00-009
- Department of Health (2013) Environment and Sustainability Health Technical Memorandum - Safe Management of Health Care Waste, 07-01
- Green Book- re immunisation
- Health and Safety Executive Books ISBN 0-7176-2981-3

- Health and Safety at Work Act (1974)

Appendix 1 Respiratory Hygiene/Cough Etiquette / Droplet precautions

Respiratory Hygiene/Cough etiquette

- Respiratory hygiene/cough etiquette should be encouraged:
  - Ensure mouth and nose is covered with disposable tissues when coughing/ sneezing to contain respiratory secretions.
  - Use disposable tissues for wiping or blowing noses.
  - Provision should be made to enable disposal of tissues into an appropriate waste receptacle.
  - Decontaminating hands after coughing, sneezing and using tissue or following contact with respiratory secretions.
  - Ensure supplies are available for those patients who are immobile.

Droplet Precautions

- In addition to **Standard Precautions**, use **Droplet Precautions** for patients known or suspected to be infected with micro-organisms transmitted by droplets. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or is a carrier of the disease). Droplets can be generated by the patient coughing, sneezing, and talking or during the performance of certain interventions (e.g. nebulisers) or procedures.
- Transfer between departments/wards with the patient using a standard surgical mask if tolerated.
- Isolate patient in a single room where possible (if there are several cases cohorting may be used after discussion with IPCD).
- Eye protection if risk of splash to face/eyes from uncontrolled coughing or sneezing.
- Aerosol Generating Procedures use FFP3 masks. It is important to use appropriate FFP3 mask after fit testing.

Appendix 2 - Personal Protective Equipment

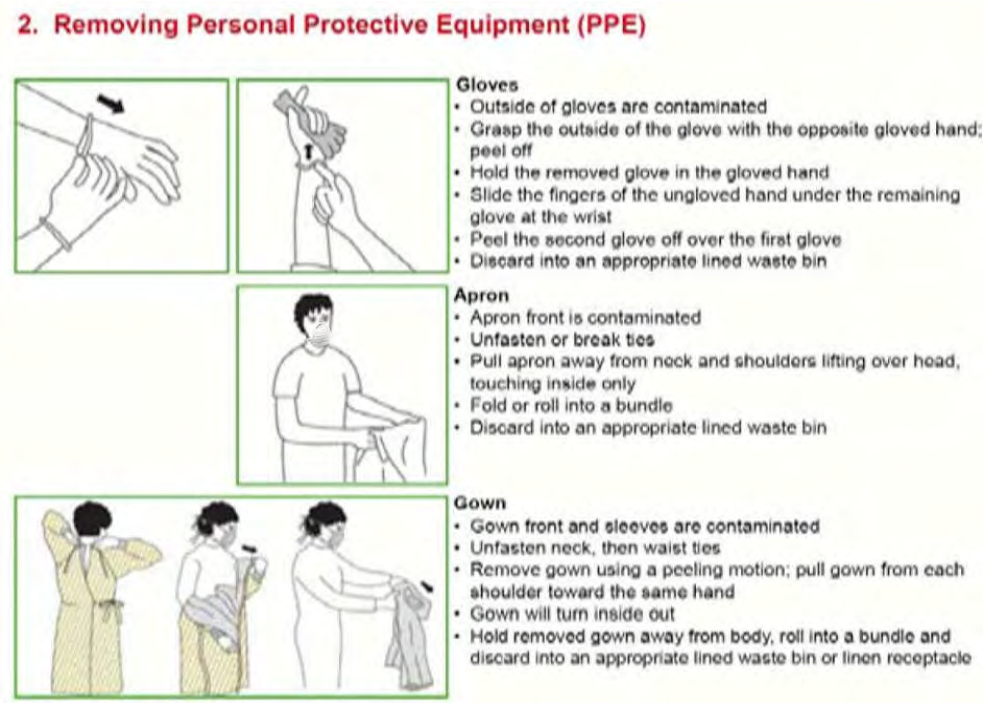
Appropriate PPE for care of patients with flu should be used; ensure the correct donning and removal is used to prevent inadvertent contamination. All contaminated clothing must be removed before leaving a patient care area. Disposable of fluid resistant surgical masks being removed last. All PPE must comply with relevant BS and EN standards.

Gloves

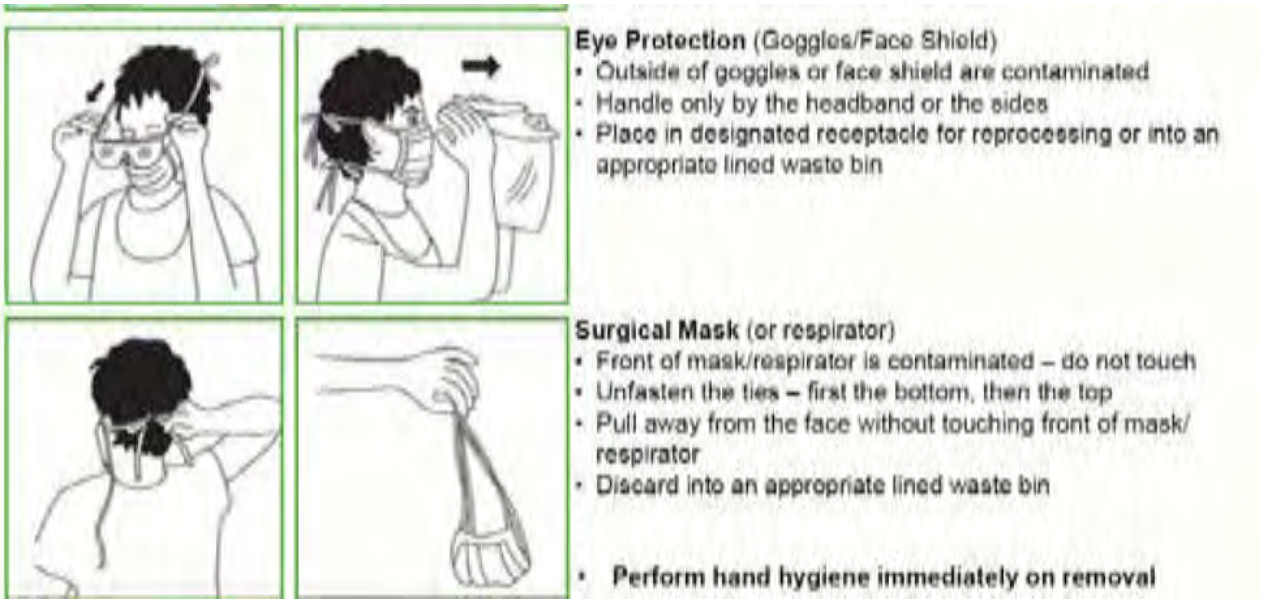
- Gloves are not required for the routine care of patients with flu; however standard infection control precautions must apply.
- Gloves must be worn when carrying out aerosol generating procedures.
- Gloves must be removed immediately after use and disposed of as clinical waste – wash hands following removal.
- If glove supplies become limited during a pandemic, priorities may need to be established. The priority for use will be for contact with blood or body fluids, invasive procedures and contact with sterile sites.

Aprons and Gowns

- Standard infection control precautions apply. Plastic aprons should be worn as single use items for one procedure or episode of patient care and then discarded and disposed of as clinical waste.
- Aprons must be worn when in close contact with patients or equipment.
- Gowns are not required for the routine care of patient with flu but should be worn:
  - for aerosol producing procedures
  - if extensive soiling of personal clothing or uniform with respiratory secretions is anticipated
  - there is a risk of extensive splashing of blood, body fluids, secretion, and excretions.
  - if gowns are worn they should be fluid repellent and single use
  - must be worn only once then placed in the appropriate waste receptacle



Eye Protection



Protection can be achieved by using a fluid resistant surgical mask with integrated visor, full face visor or safety spectacles or equivalent.

- ❖ Eye protection should be considered when there is a risk of contamination of the eyes by splashes and droplets on the basis of an individual risk assessment at the time of providing care.
- ❖ Eye protection must always be worn during aerosol generating procedures.

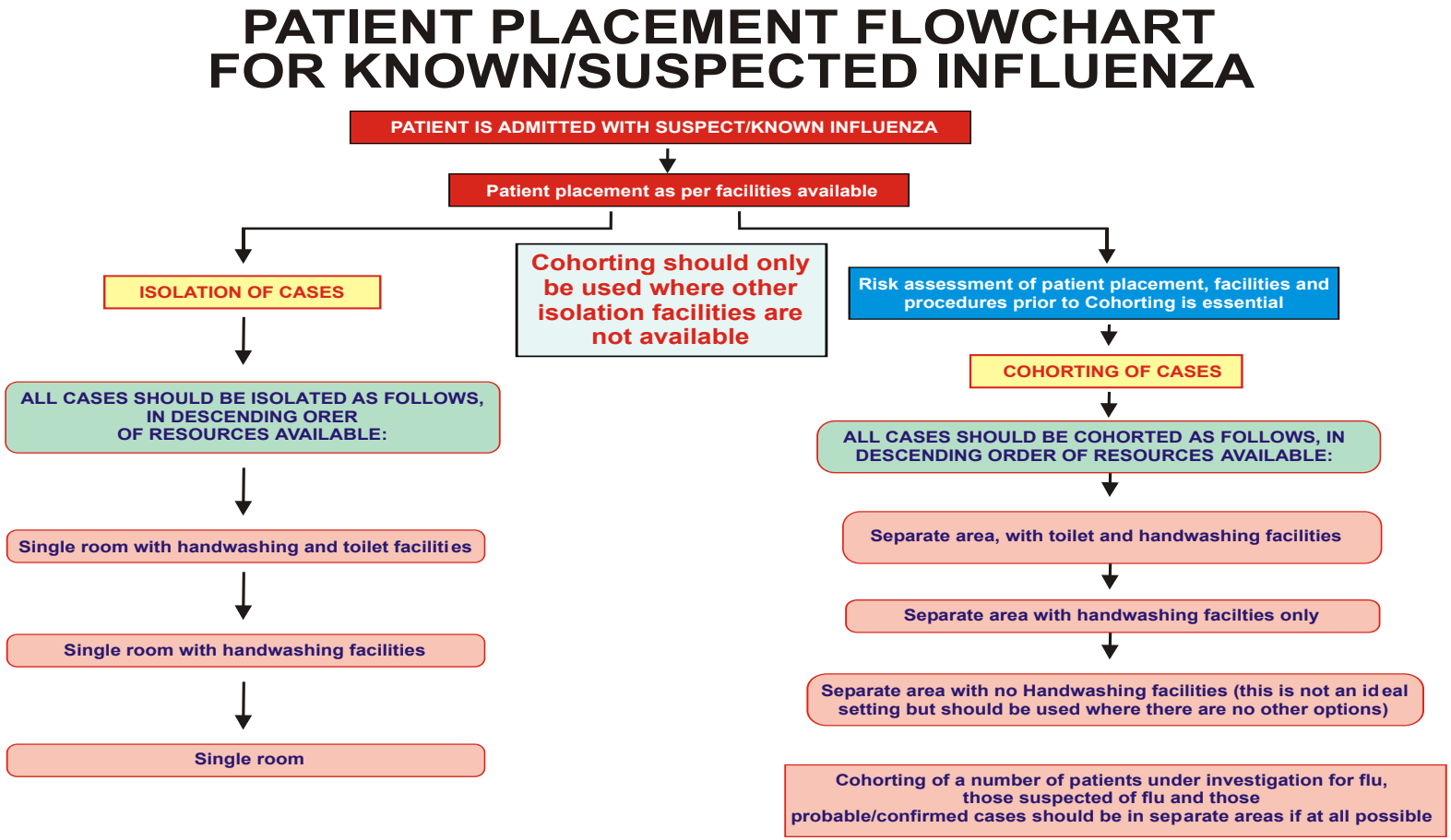
Surgical Masks

- ❖ Select the correct type of mask for the task to be undertaken:
  - o FFP3 (EN149:2001 FFP disposable respirator) – when performing procedures that will generate aerosols. (These should have been fit tested by H & S or by trained fit tester).
  - o FFP2 can be used if FFP3 masks are not available.

- Fluid resistant surgical masks - when entering an area and not performing aerosol generating procedures.

❖ **Wash hands following disposal of masks.**

Appendix 3 In Patient placement flowchart for known or suspected influenza.



Appendix 4 – Definition of Severe Immune Compromise and some issues related to vaccines

Severely immunocompromised people include those who have:

- active leukemia or lymphoma
- generalized malignancy
- aplastic anemia
- graft-versus-host disease
- congenital immunodeficiency
- recent radiation therapy
- solid-organ or bone marrow transplant patients, within 2 years of transplantation, or transplant recipients who are still taking immunosuppressive drugs
- chronic lymphocytic leukemia patients have poor humoral immunity, even early in the disease course, and rarely respond to vaccines. (Complete revaccination with standard childhood vaccines should begin 12 months after bone marrow transplantation. However, measles, mumps, and rubella (MMR) vaccine should be administered 24 months after transplant if the recipient is presumed to be immunocompetent. Influenza vaccine should be administered 6 months after transplant and annually thereafter)

People taking any of the following categories of medications are considered severely immunocompromised:

- **High-dose corticosteroid**s (>2 mg/kg of body weight or ≥20 mg per day of prednisone or equivalent in people who weigh >10 kg, when administered for ≥2 weeks, the immune response to vaccines may be impaired. Clinicians should wait ≥1 month after discontinuation of high-dose systemic corticosteroid therapy before administering a live-virus vaccine.)
- **Alkylating agents** (such as cyclophosphamide)
- **Antimetabolites** (such as azathioprine, 6-mercaptopurine)
- **Transplant-related immunosuppressive drug**s (such as cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, and mitoxantrone)
- **Cancer chemotherapeutic agents**, excluding tamoxifen but including low-dose methotrexate weekly regimens, (Limited studies show that methotrexate monotherapy had no effect on the response to influenza vaccine, but it did impair the response to pneumococcal vaccine.)
- **TNF blockers** such as etanercept, rituximab, adalimumab, and infliximab blunt the immune response to certain vaccines and certain chronic infections. When used alone or in combination regimens with methotrexate to treat rheumatoid disease, TNF blockers were associated with an impaired response to influenza vaccine and to pneumococcal vaccine as well.

Severe Immune Compromise Due to Symptomatic HIV/AIDS
(Adapted from CDC Yellow book: https://wwwnc.cdc.gov/travel/page/yellowbook-home-2020)

Appendix 5 – Respiratory precautions

Developed by the Infection control team 2018

Appendix 2:

Ref: IPC 10

Hand Hygiene Policy

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professionals & Health Science
Document Author:	Infection Prevention and Control
Approved by:	Trust Quality and Safety Committee
Approval Date:	
Date of Equality Impact Assessment:	Revised 06/06/2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	Three years – June 2025
Version:	6

CONTENTS

ABBREVIATIONS

ABHR	Alcohol based hand rub
ANTT	Aseptic Non Touch Technique
BBE	Bare below the elbow
COSHH	Control of Substance Hazardous to Health
HCAI	Healthcare associated infection
HCW	Healthcare worker
IPC	Infection prevention and control
IPCT	Infection Prevention and Control Team
SCIPs	Standard Infection Control Precautions
WBS	Welsh Blood Service
WHO	World Health Organization

1.POLICY STATEMENT

1.1 Hands are the most common way in which microorganisms, particularly bacteria, can be transmitted and subsequently cause infection, especially in those who are most susceptible. In order to prevent the spread of microorganisms to those who are at risk of developing infections, hand hygiene must be performed properly at the correct times. Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HCAI), transmitted during care delivery.

1.2 Before selecting the appropriate hand hygiene procedure, consideration should be given to the potential/actual hazards that have been or might be encountered, the subsequent potential/actual contamination of hands, and any risks that may present as a result. The nature of the work, the interaction with the patient/client/resident and the vulnerability of individuals will often determine this.

1.3 It must always be assumed that every person encountered could be carrying potentially harmful microorganisms that could be transmitted. Hand hygiene is one of the ten elements of Standard Infection Control Precautions (SICPs) and undertaking them is an essential element to ensure everyone's safety.

1.4 The term hand hygiene used in this document refers to all of the processes, including hand washing and hand decontamination achieved using other products, e.g. alcohol-based hand rub (ABHR).

1.5 It is Velindre University NHS Trust policy to promote, provide and maintain a healthy and safe environment for the employees, patients, donors and visitors. The Trust's aim is therefore to promote hand hygiene within the clinical environment, in order to reduce the number of HCAIs to an absolute minimum, thus promoting patient safety via a zero tolerance to non-compliance or poor practice.

1.6 This policy aims to provide evidence based guidance that will identify the responsibilities individuals, the correct application of the procedure and compliance requirement.

SCOPE OF POLICY

The policy applies to all staff, in all locations of Velindre University NHS Trust, including those with honorary contracts and students placement.

AIMS AND OBJECTIVES

3.1 The aim of this policy is to provide comprehensive guidance on all aspects of hand hygiene to help prevent the spread of HCAI. Objectives include:

Identifying correct provision of facilities
Use and provision of appropriate products
Required level of education and training for Trust staff, patients and visitors
Managers accountabilities and responsibilities
Necessary monitoring of compliance through audit and reporting
Use of quality improvements methods to improve and maintain hand hygiene compliance
Description of the required processes
Importance and responsibility of HCWs to decontaminate hands at the point of care in the reduction of HCAI.

RESPONSIBILITIES

It is the responsibility of every member of staff working in the health care setting to ensure adequate hand hygiene is performed where appropriate.

The Chief Executive

The Chief Executive has overall responsibility to ensure this policy is adhered to while the operational authority for appropriate and timely hand hygiene practice lies with the individual user and clinical/departmental managers. Compliance will be measured using observations and audits.

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science

The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and Control training, and monitoring is in place. This includes Hand Hygiene.

4.3 Departmental Managers/ Clinical Directors / Clinical Managers

Departmental Managers, Clinical Directors and Clinical Managers are accountable and responsible for:

Ensure that all staff receives annual instruction/education on the principles of hand hygiene and SICPs

Maintain accurate and up to date training compliance records.

Ensuring this policy is easily accessible to all staff and that all staff are aware of the policy and its content.

Monitoring compliance with this policy and taking immediate corrective action if non- compliance is identified.

Ensure participation in surveillance and audit programmes at local level and provide active support for presentation and improvement of hand hygiene compliance results.

Monitoring and enforcing Bare Below Elbow (BBE) standards in all clinical settings at all times.

Ensuring there are sufficient, trained and competent hand hygiene champions within departments who can ensure staff remain compliant with training, training is recorded on ESR and monthly compliance audits are undertaken.

Ensuring that adequate resources are in place for hand hygiene. This includes liaison with the estates and operational services teams.

Providing sufficient approved hand decontamination products including paper towels, liquid soap, alcohol sanitiser and skin moisturiser.

Making hand hygiene facilities readily available for all to use.

Undertake a risk assessment to optimise patient/ donor and staff safety, consulting expert infection prevention and control guidance if/ as required related to application of this policy.

Support staff to correct any action or intervention that may have resulted in transmission of infection.

Ensure any staff with hand health concerns, including any skin irritation related to occupational hand hygiene or those who have become ill due to occupational exposure are appropriately referred e.g. Occupational Health, health and safety manager in the first instance.

Ensure posters featuring when and how to perform hand hygiene are displayed.

Ensuring appropriate use of gloves.

Health and Safety should be informed where the cause is considered to be work related since it may require reporting under RIDDOR.

4.4 Clinical staff

Apply the principles of SICPs. All staff have a responsibility to ensure that they undertake adequate hand hygiene and encourage others who have patient contact to do so.

Ensure all other staff/agencies apply the principles of SICPs.

Explain to patients, donors and visitors any infection control requirements such as hand hygiene.

Encourage patients, donors and visitors to question lack of hand hygiene by HCWs.

Always practice the 5 moments of hand hygiene.
Always remain bare below elbow within clinical areas.
Always practice hand hygiene in line with required standards.
Understand and apply the principles in this policy.
Attend mandatory or update infection prevention and control education sessions.
Highlight to colleagues any breaches in hand hygiene practices observed.
Communicate the hand hygiene/ infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality.
Do not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, occupational health department, infection prevention and control team (IPCT) or health protection team.
Encourage patients/donors/visitors to decontaminate their own hands appropriately.
Provide patients with opportunities and supplies for hand hygiene in particular after using toilets, before and after eating or drinking.
Report to their manager inadequate facilities, equipment or products and deficits in their own knowledge or training.
Report any incidents of non-compliance with hand hygiene that may have resulted in cross contamination.
Report any illness which may be as a result of occupational exposure, to the line manager and the occupational health department (if applicable).
Not provide direct patient/ donor care while infectious as this could cause harm. If in any doubt consult with your manager, General Practitioner, occupational health department or IPCT.
Consider the elements of SICPs such as hand hygiene as an objective within staff continuing professional development ensuring continuous updating of knowledge and skills. Be aware of, and participate in, hand hygiene campaigns.
Staff must inform managers immediately if their hands become sore.

4.5 Infection Prevention and Control Team (IPCT) will:

Ensure this policy remains up to date with national/ best practice standards.
Ensure training is available for all groups of staff. Set the training and education standards for hand hygiene and ensure delivery of a robust train the trainer programme for hand hygiene.
Act as a contact for guidance and support when advice relating to hand hygiene is required.
Investigate incidents of non-compliance relating to hand hygiene.
Undertake regular validation hand hygiene audits within the Trust and feedback audit results to managers within a timely manner.
Compliance with the principle of bare below the elbow forms part of the IPC hand hygiene audit and will be included in the audit feedback.
Provide support and advice to staff on maintaining good hand skin health (Appendix 3).
Provide advice on individual risk assessments for performing hand hygiene and the site and provision of ABHR.
Provide advice on the provision, type and site of hand wash sinks and facilities.
Provide support to departmental hand hygiene champions so that they can audit staff adherence to hand hygiene and BBE.
Periodic validation of hand hygiene compliance.
Provide hand hygiene educational and audit information for patients, donors, staff and visitors.
Provide support on the wards/ departments to monitor standards and compliance, identifying areas of concern and risk, and escalating concerns so that appropriate management action can be taken to maintain the highest standards via the divisional IP&C Groups or Trust Infection Prevention Control Management Group (IPCMG) as necessary.

4.6 Patient, Donor and Visitor, involvement

Patients, donors and visitors should be seen as partners in good hand hygiene practice though they are not the responsible for HCAI reduction. Therefore:
They must be offered the opportunity to decontaminate their hands as they require but especially on arrival at clinical areas and after toileting and before and after consumption of food or drink.

Those with invasive devices insitu should be encouraged to clean their hands frequently and be advised not to touch these sites whilst the devices are in place.

All staff must ensure relatives and visitors are encouraged to decontaminate their hands when entering and leaving a ward or department. This can be achieved by using the ABHR at the entrance to wards and departments.

Visitors should be given the opportunity and be actively encouraged to decontaminate their hands, either by washing with soap and water or alcohol based hand rub:

- Before/upon and after entering into certain units or closed wards
- Before and after visiting patients in isolation
- Before and after participating in any form of patient care or contact

Hand hygiene compliance data should be displayed for patients, visitors and donors to view in the clinical areas.

4.7 Distribution

The policy will be available via the Trust intranet site and from the IPCT. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 DEFINITIONS

Hand hygiene - aims to remove transient micro-organisms carried on the hands (acquired by direct contact with the environment and/or with other people) and/or reduce resident micro-organisms (living permanently on the hands as part of normal flora).

Bare Below Elbow - is Welsh Government national standard requirement to improve the effectiveness of hand hygiene performed by HCWs. The effectiveness of hand hygiene is improved when: skin is intact, nails are natural, short and unvarnished; hands and forearms are free of jewellery (with the exception of a plain wedding band) and sleeves are above the elbow.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Best Practice

Hand hygiene is considered the most important practice in reducing the transmission of infectious agents that cause HCAIs.

Hand washing sinks must only be used for hand hygiene and must not be used for the disposal of other liquids.

6.1.1 Before performing hand hygiene

Expose forearms (BBE).

Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene.

Bracelets or bangles such as the Kara which are worn for religious reasons should be able to be pushed higher up the arm and secured in place to enable effective hand hygiene which includes the wrists;

Ensure fingernails are clean and short, and do not wear artificial nails or nail products.

Cover all cuts or abrasions with a waterproof dressing.

6.1.2 When to perform hand hygiene

Hand hygiene is considered the single most important infection control activity in all clinical or care settings.

Hands should be decontaminated at a range of times in order to prevent HCAI. The most important times during care delivery and daily routines when this should occur are described in ‘5 moments for Hand Hygiene'.

Even if gloves have been worn, hand hygiene must be performed before and after donning & doffing gloves. Hands can still become contaminated whilst wearing or on removal of gloves, and so must be cleaned appropriately.

It should also be noted that hand hygiene will have to be performed between tasks on the same patient.

The point of care is the crucial moment for hand hygiene. The point of care represents the time and place at which there is highest likelihood of transmission of microorganisms from the hands of HCW's to patients and donors.

Hands need to be decontaminated at 5 Moments of Hand Hygiene recommended by the World Health organisation. These moments include:

- Immediately before each episode of direct patient contact/care.
- Immediately before performing any aseptic procedures on patients.
- Immediately after contact with body fluids, mucous membranes and non-intact skin.
- Immediately after touching a patient and immediate surroundings, when leaving the patient's side that may result in hands becoming contaminated.
- Immediately after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.

In addition to the critical moments there are situations/occasions where hand hygiene should be performed to reduce the risk to patients/ donors and HCWs. Examples of additional situations when hands must be decontaminated are:

- Before commencing work/after leaving a work area.
- Before preparing, handling or eating food.
- Before and after handling/administering medicines.
- After handling contaminated laundry and waste, including sluice room activities.
- After visiting the toilet.
- Before and after leaving isolation rooms/bays.
- After cleaning equipment or the environment.
- Personal contamination e.g. blowing your nose, sneezing/coughing into your hand.
- After removing personal protective equipment including gloves.

Wash hands with liquid soap and water if:

Hands are visibly soiled or dirty.

Caring for patients with vomiting and/ or diarrhoea.

Where infection with a spore forming organism e.g. Clostridium difficile or with a gastroenteritis virus e.g. Norovirus is suspected/proven, hand hygiene must be carried out with liquid soap and water although it can be followed by ABHR. In all other circumstances, use ABHRs for routine hand hygiene during care. Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

For how to wash hands, see Appendix 1.

For how to hand rub, see Appendix 2.

6.1.3 Hand care

Hand care is important to protect the skin from drying and cracking. Cracked skin may harbour microorganisms and broken areas can become contaminated, particularly when exposed to blood and body fluids. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/ or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of

liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014) (Appendix 3).

Hand creams can be applied to care for the skin on hands. However, only individual tubes of hand cream for single person use or hand cream from wall mounted dispensers should be used. Communal tubs must be avoided as these may contain bacteria over time, and lead to contamination of hands. Creams used should not affect the action of hand hygiene products or the integrity of gloves.

Cover all cuts and abrasions with a waterproof dressing.

- Dry hands thoroughly after hand washing, using disposable paper towels.
- Use an emollient hand cream during work and when off duty.

Report any skin problems and/ or sensitivities to the hand decontamination products supplied to your Manager and Occupational Health in order that appropriate skin care can be undertaken and the risks of harbouring microorganisms while providing care for others can be avoided.

6.1.4 Surgical hand antisepsis

Surgical scrubbing/rubbing applies to those undertaking surgical and some invasive procedures. The most commonly used products contain Chlorhexidine gluconate or povidone-iodine. Products containing these agents act by lifting transient micro-organisms from the skin, and destroying both transient and some resident micro-organisms. These should be used when a prolonged reduction in numbers of resident flora are required for invasive procedures (surgical aseptic non touch technique (aseptic non touch technique (ANTT®)) requiring maximal sterile barrier precautions, e.g. central line insertion, surgery etc.).

Perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, e.g. before inserting central vascular access devices.
Remove all hand and wrist jewellery.
Single-use nail brushes must only be used for decontaminating nails.
ABHR can be used between surgical procedures if licensed for this use.

Follow the technique in Appendix 5 for surgical scrubbing.
Follow the technique in Appendix 6 for surgical rubbing.

6.2 Hand hygiene facilities

In order to reduce the associated risks of Legionellosis and *Pseudomonas aeruginosa* contamination a hand wash sink/basin should only be used for that purpose (Appendix 6)
ABHR will be supplied and used in accordance with the World Health Organization (WHO) and:

Will be available at the point of care and either free standing for use on trolleys or wall mounted sited at key points in all clinical environments.
Will be available at entrances to all clinical environments and in areas within the facility which have been risk assessed as safe from theft or misuse e.g. canteen entrance, key entry points of the building or department that are observed.
Wall mounted containers will be kept clean as per operational cleaning schedule with particular attention paid to the outlet nozzle to prevent build-up of product.
ABHR supplies must be stored in accordance with COSHH regulations.

6.3 Bare below the elbow (BBE)

All staff will adopt a “bare below the elbows” dress code whenever they are engaged in a direct patient/ donor care activity (Trust Dress Code & Uniform Policy, (WF 42).

All staff must be BBE whenever they are in a clinical area where they can reasonably expect to come into contact with patients or the immediate patient environment. This includes inpatient wards (particularly when undertaking ward rounds), theatres, outpatient departments, and

outreach and donor sessions**.** All staff should be prepared to approach their colleagues if they are not complying with BBE.

It has been shown that contamination of jewellery, particularly rings with stones and/or jewellery of intricate detail, can occur (Trick et al 2013, epic 3, 2014).

Jewellery and wrist watches must be removed when working in clinical care settings to prevent the spread of microorganisms by contact with contaminated jewellery.

Staff providing care and those in the clinical setting must remove jewellery at the start of the working day.

It is acceptable to wear plain bands however these must be moved/ removed when hand hygiene is being performed in order to reach the bacteria which can harbour underneath them and dried effectively.

Ensure nails are kept short (nail polish or false nails must not be worn).It has been shown that nails, including chipped nail polish, artificial nails can harbour potentially harmful microorganisms. (epic 3, 2014, CDC, 2016). Caring for nails helps prevent the harbouring of microorganisms, which could then be transferred to those who are receiving care.

Work clothes should not go past the elbow. Coats should be removed and long sleeves should be rolled up exposing the wrists and elbows.

The wrists should be included when washing the hands; forearms should be included if they have been contaminated.

Ensure cuts and abrasions are covered with a waterproof dressing.

The wearing of plaster casts or splints can affect hand washing therefore the staff member cannot decontaminate their hands effectively and should not be undertaking clinical duties. A risk assessment with the manager and occupational health is required for staff working in clinical areas.

6.4 Hand hygiene supplies

The availability of supplies for hand hygiene is essential.

Hand hygiene products (e.g. liquid soap, antiseptic hand wash solution and ABHR), should preferably be wall mounted in easy to use, and easy to clean, dispensers that contain single use, disposable cartridge sets, particularly in clinical or communal care areas. In some non-acute community care settings free standing bottles of liquid soap are acceptable.

Wall mounted moisturising cream should be available in all clinical areas.

Nozzles of solution bottles/containers should always be clean and free of any congealed product. Bottles should not be reused and the ‘topping up’ of bottles that contain solutions should not occur.

Soft, user friendly disposable paper towels for hand drying, dispensed from a wall mounted, easy to use clean holder.

Supplies of paper towels and other hand hygiene supplies should always be stored in a clean dry area prior to use.

Foot operated waste bins must be available at point of hand hygiene.

Estates and operation services staff are important partners in ensuring that hand hygiene facilities are adequate and that supplies are mounted appropriately.

Any issues with the hand hygiene supplies should be brought to the attention of operational services manager.

6.5 General Good Practice

Effective communication between all members of the health care team is imperative for patient safety.

Health and safety issues, related to staff, patients/donors and visitors should also be considered in relation to products used for hand hygiene, e.g. drips or spillages from ABHR and any risks of slips, falls or ingestion of products. Risk assessments should be carried out locally to highlight/manage relevant issues.

Control of Substances Hazardous to Health (COSHH) and product data sheets should be referred to in order to ensure safe use of/exposure to products being used for hand hygiene.

Hand hygiene is an important part of respiratory hygiene/cough etiquette. Advice which can be given on this is to:

Cover nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses.

Dispose of used tissues in the nearest waste bin.

Wash hands after coughing, sneezing, using tissues, or after contact with respiratory secretions and objects contaminated with them.

Keep hands away from the mucous membranes of the eyes and nose. Certain patient/donor (e.g. the elderly, children) may need assistance with containment of respiratory secretions; those who are immobile will need a receptacle (e.g. a plastic bag) readily at hand for the immediate disposal of used tissues and offered assistance with hand hygiene. If staff are required or requested to dispose of used tissues, gloves must be worn and hands decontaminated following removal of gloves.

Any areas of broken skin on HCWs hands areas must be covered with a waterproof dressing.

Patients unable to wash their hands should be offered assistance to do so, especially after toileting and before eating. This can be aided by the use of hand wipes available within the clinical areas.

6.6 Maintaining quality

Velindre University NHS Trust actively supports the WHO 5 Moments (Appendix 7) and other initiatives to improve and maintain standards of hand hygiene. Promotional materials produced by the Trust must be visible in all clinical areas and clearly displayed. Staff should act as role models and be able to demonstrate on-going commitment to hand hygiene.

Observational audits of compliance utilising validated audit tools e.g. WHO 'Your 5 moments for hand hygiene' (Appendix 7) are carried out by departmental staff and Welsh Blood Service (WBS) teams overseen and trained by the IPC team. The IPC team process and feedback the observational audit results at both Velindre Cancer Centre & WBS on a monthly basis. Audits of hand hygiene facilities and BBE are undertaken by the IPCT and WBS team and are reported via the Infection Prevention and Control Management Group (IPCMG). Departmental audits are undertaken and fed back through divisional IPC meeting in both WBS and VCC, as are IPCT validation audit results, and then to IPCMG. Results for VCC are also uploaded onto the Trust Performance Dashboard.

As a quality indicator, poor compliance will be highlighted and an action plan for improvement agreed with the manager of the area.

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World Health Organization. (2016b) 'SAVE LIVES: Clean Your Hands WHO's Global Annual Campaign Advocacy Toolkit'. Geneva: WHO.

8 GETTING HELP

8.1 Further information and support:

Velindre IPCT: 02920196129.

9 RELATED POLICIES

This policy should be read in conjunction with:

- Trust Dress Code & Uniform Policy, (WF 42) https://nhswales365.sharepoint.com/sites/VEL_Intranet/_layouts/15/Doc.aspx?sourcedoc=%7B99479538-AE6F-4068-BA79-7764DCFF5D91%7D&file=WF%2042%20Dress%20Code%20and%20Uniform%20Policy.docx&action=default&mobileredirect=true&DefaultItemOpen=1

- National Infection Prevention and Control Manual. Available at https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

All staff working in clinical areas need to be trained in hand hygiene.

11 MAIN RELEVANT LEGISLATION

The Health and Social Care Act. (2008) 'Code of Practice for the NHS on the Prevention and Control of Health Care Associated Infections and Related Guidance'. 2015 update. Department of Health.

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Appendix 1 – How to Wash Your Hands

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0

Wet hands with water;

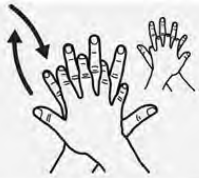
1

Apply enough soap to cover all hand surfaces;

2

Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

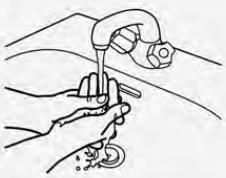
6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

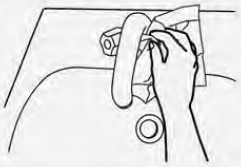


Rinse hands with water;

9

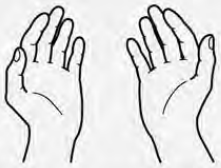
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

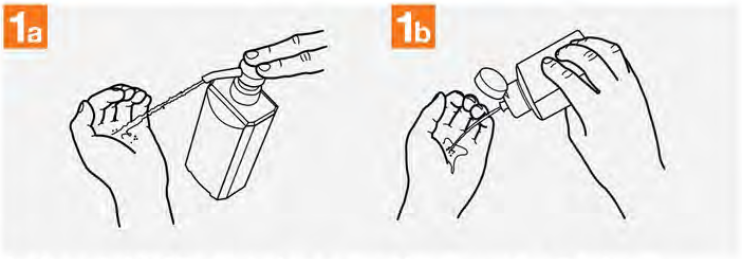
May 2009

Appendix 2 – How to use Alcohol Handrub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

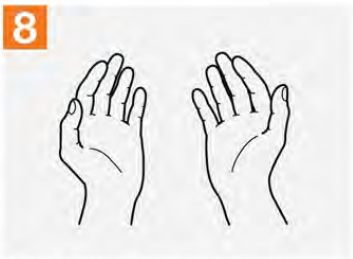
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

Appendix 3 - Hand Health and Skin Care

Care is required to protect the hands from the adverse effects of hand decontamination practice. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014).

In order to achieve effective hand hygiene, it is important to look after the skin and fingernails. Sore hands are associated with increased colonisation by potentially pathogenic micro-organisms and increase risk of transmission. Damaged or dry skin leads to loss of a smooth skin surface, and increases the risk of skin colonisation with resistant organisms such as Meticillin-resistant *Staphylococcus aureus* (MRSA). Continuing damage to the skin may result in cracking and weeping, exposing the HCW to increased infection risk, which can lead to sickness absence due to dermatitis.

Skin care, through the appropriate use of hand lotion or moisturisers added to hand hygiene preparations, is an important factor in maintaining skin integrity, encouraging adherence to hand decontamination practices and assuring the health and safety of HCWs. Only use the products available in the clinical areas, as these have been specifically designed not to interact with the soaps and ABHR.

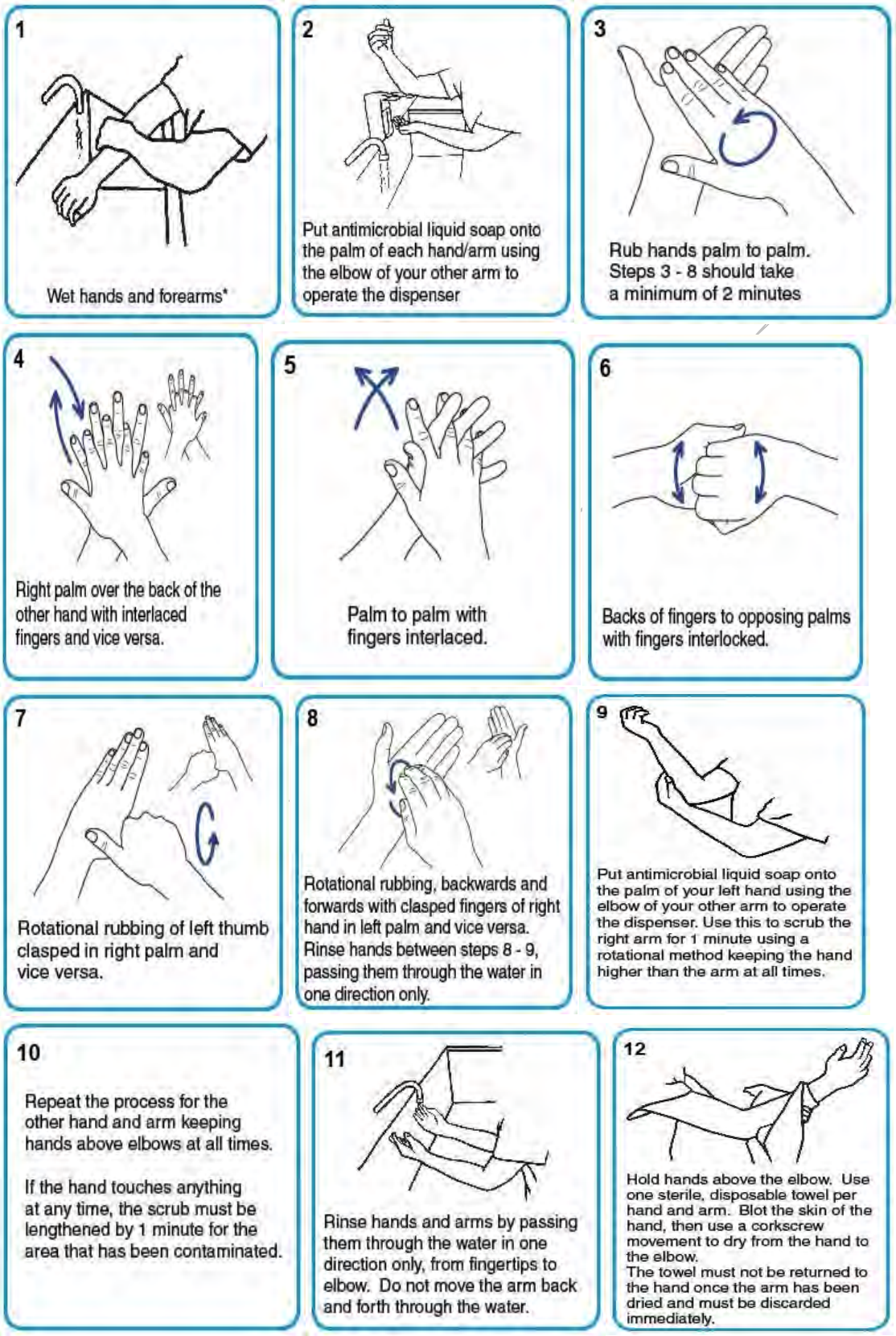
To maintain skin health:

- It is essential that only approved soap products are used, and that staff carefully follow correct hand hygiene techniques.
- Drying (pat don’t rub etc.)
- Use ABHR containing an emollient.
- Staff with acute or chronic skin lesions/conditions/reactions or possible dermatitis **must** seek advice from the Occupational Health Department at the time that they have the problem.
- Cuts and abrasions must be covered with a water-impermeable dressing, prior to clinical contact.
- All clinical areas must ensure that adequate supplies of wall-mounted moisturiser are available for staff use. This is more cost-effective than sickness-absence due to damaged skin.
- Staff should regularly use moisturiser to maintain skin integrity. The most effective use of moisturiser is before breaks and at the end of a shift, when it can be left on the hands for a greater period of time.
- Use gloves appropriately and change frequently.

Appendix 4 – Surgical Scrubbing

Step by step images for surgical hand preparation technique using antimicrobial soap

Undertake Appendix 1 prior to starting scrub.



Appendix 5 – Surgical Rubbing

The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands.

On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.

After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for hand washing. provided that the hand rubbing technique or surgical hand preparation is followed (images 1-15).

Appendix 6 – Use of the Hand Wash Basin

Hand washing sinks should not be fitted with plugs in order to avoid them filling with water, hand hygiene should be performed under running water.

Mixer taps or thermostatic mixer valves are preferred to provide the correct temperature of water for performing hand hygiene.

The tap must not directly expel/drain water straight down the plug hole. It should be sited appropriately to ensure water hits the sink basin as it flows out, otherwise aerosols from the drainage system can splash back onto the user.

Do not dispose of body fluids or any other fluids in the clinical wash-hand basin – use the sluice in the dirty utility area.

Do not use hand wash basins for storing used equipment awaiting decontamination or wash any patient equipment in hand wash basins.

Taps can be wrist, elbow or automatically operated, Velindre Cancer Centre will replace automatic taps with wrist or elbow operated during clinical area development or refurbishment in accordance with its Water Safety Action Plan.

Do not touch the spout outlet when washing hands.

Hand wash sinks must not have an overflow.

Use all hand wash stations regularly of flush in accordance with the Legionella management scheme.

Ensure correct clean and dirty separation is maintained along with use of sink free zones for high risk procedure areas, for example, where intravenous drugs are being prepared.

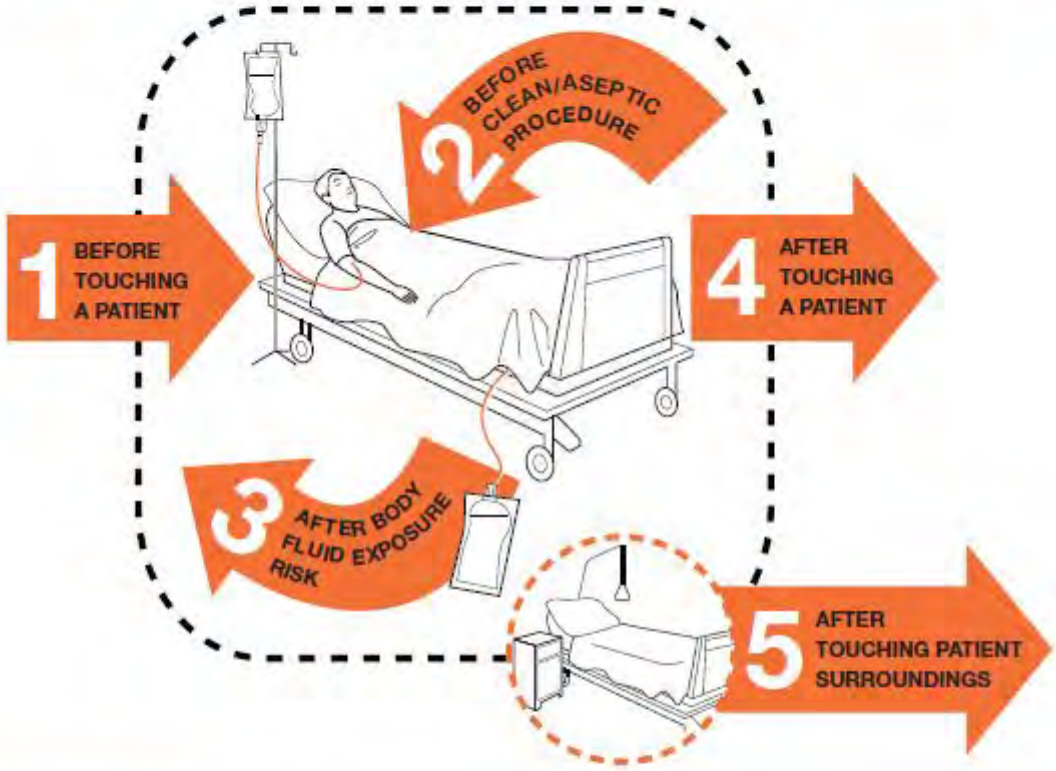
Hand wash sinks must conform to standards as uneven or damaged surfaces may harbour microorganisms.

Hands free (i.e. pedal operated) waste receptacles should be close at hand.

Designated hand hygiene sinks should be clearly labelled ‘hand hygiene only’.

Advise patients that sinks should not be used for anything other than hand hygiene: i.e. not for cleaning teeth or drinking water and should not be used for storage of patients soap etc.

Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

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Clean Your Hands

APPENDIX 3:

Ref: IPC 00

FRAMEWORK POLICY FOR INFECTION PREVENTION AND CONTROL

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	TBC
Date of Equality Impact Assessment:	10/06/2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	September 2022
Next Review Date	September 2023
Version:	6

CONTENTS

ABBREVIATIONS

AMR	Antimicrobial Resistance
ANTT	Aseptic Non-touch Technique
HCAI	Healthcare Associated Infection
HCW's	Healthcare Workers
ICD	Infection Control Doctor
IPC	Infection prevention and control
IPCMG	Infection Prevention and Control Management Group
IPCT	Infection Prevention and Control Team
RCA	Root cause analysis
KPI	Key Performance Indicator
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

2 POLICY STATEMENT

11.1 This policy outlines the overarching framework for the management and organisation of infection prevention and control (IPC).

Oncology patients are largely susceptible to infections. While all Healthcare Associated Infection (HCAI) are preventable, a consistent 'zero tolerance' approach to hospital acquired infection is required to adhere to a national strategy, best practice guidance and requirements of Healthcare standards for Wales.

HCAI refers to an infection that occurs as a result of contact with the healthcare system in its widest sense – from care provided in the home, to general practice, nursing home care, care in acute hospitals and interaction with supportive services. This broad description potentially could cover all patients who attend Velindre Cancer Centre and donors that attend a Welsh Blood Service donation clinic. A consistent approach and effective leadership within the organisation is required to prevent Trust acquired HCAI.

There are a wide range of effects of a HCAI which can range from short term discomfort to significant harm and can even lead to permanent disability or death. It can lead to an extended hospital stay, which not only can have consequences for the patient/family, but can disrupt the effective use of patient facilities. A HCAI can also be detrimental to the Trust, not only in terms of money but as a loss of reputation for the organisation.

The Infection Prevention and Control Team (IPCT) provides expert advice and support to all services of Velindre University NHS Trust, especially clinical and front facing services. It is important that the IPCT have clear lines of accountability for the effective management of the service to ensure integrated working practices across the Trust.

Please note:

COVID-19 may have an impact on Infection Prevention and Control (IPC) policy documents. Policies should be read in conjunction with the IPC organism specific policy, May 22.

IPC measures for Management of SarsCoV-2 in Healthcare Setting

3 SCOPE OF POLICY

2.1 This policy provides a framework and principles of best practice to ensure all Healthcare Workers (HCW's) are familiar with the structures in place for infection prevention and control management.

2.2 The responsibilities and programmes of work outlined aim to reduce risk and prevent HCAI and comply with National guidance and strategy.

2.3 This policy covers Welsh Blood Service, Velindre Cancer Centre and Corporate Services and applies to all staff and contactors working within these areas.

4 AIMS AND OBJECTIVES

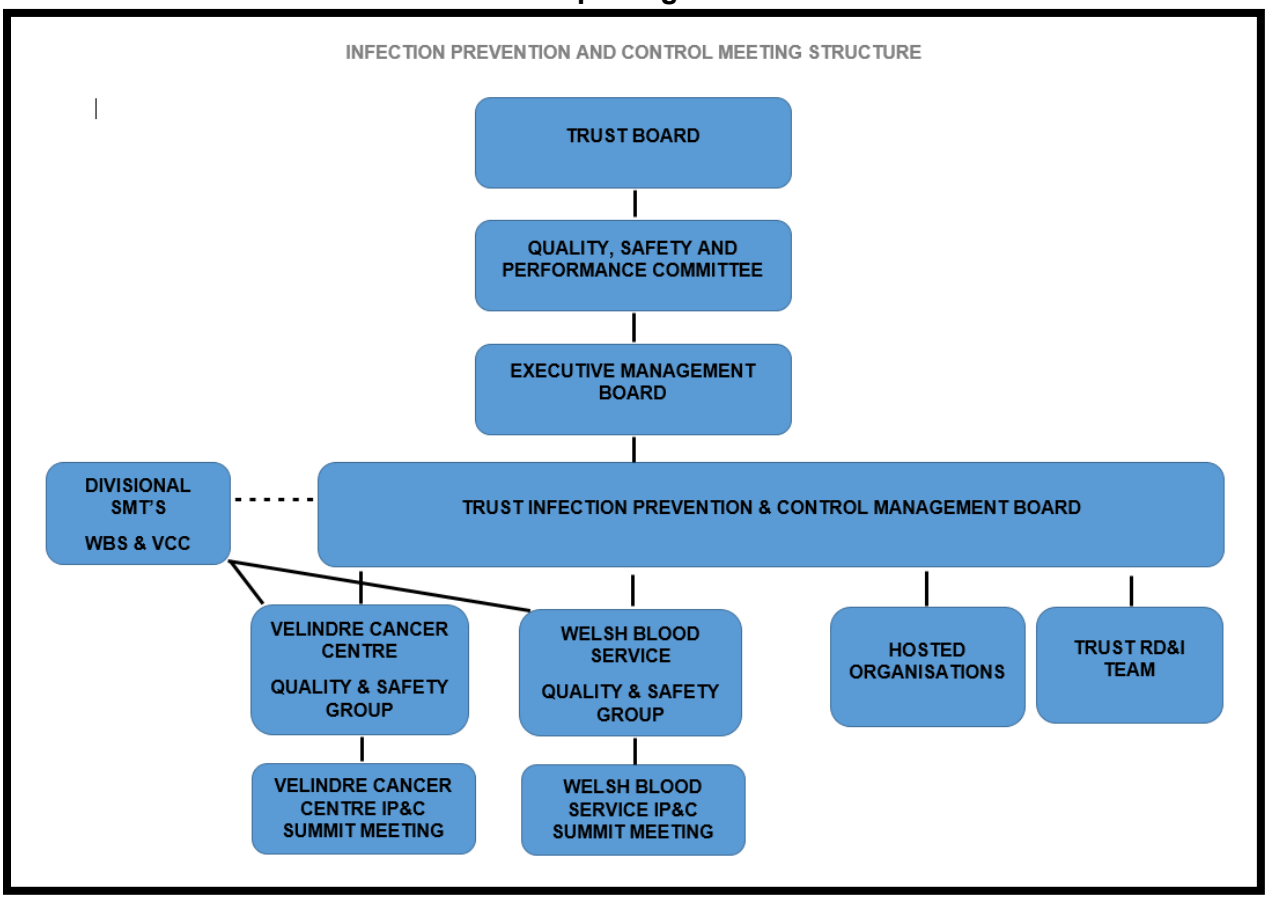
3.1 The policy objectives are to outline:

- Clear lines of accountability and responsibility in relation to Infection Prevention & Control
- Key processes and programme for infection prevention and control
- Reporting mechanisms for Infection Prevention & Control to the Trust Executive Management Board
- Key messages:
  - Infection Prevention and Control is **everybody's** responsibility
  - Departmental Leads/Managers are responsible for ensuring infection prevention and control training requirements, standards and practices are followed by all staff within their designated areas
  - Programmes for audit, training, surveillance and policy provision are managed as key strategies for infection prevention and control.

5 RESPONSIBILITIES

This framework has been developed to provide clarity throughout the Trust in relation to accountabilities and responsibilities for Infection Prevention and Control and related duties as part of the Trust governance and assurance processes. It focusses on accountabilities and responsibilities of both the Trust Infection Prevention & Control Team and those of local, Divisional and Senior Management Teams.

5.1 Infection Prevention & Control Reporting Mechanisms



MEETING	CORE IPC ACCOUNTABILITIES
Trust Board	To receive assurance and exceptions via the Quality, Safety & Performance Committee in relation to the Trust meeting its core IPC & decontamination accountabilities/responsibilities against national standards & legislative requirements. To ensure adequate resource and funding is directed to support the agenda for Trust wide IPC activities and performance.
Quality, Safety & Performance Committee	To receive clear evidence and timely advice from the Executive Management Board in order to be able to provide the Trust Board with accurate information to assist it in discharging its functions in meeting its responsibility with regard to IPC & Decontamination for quality and safety. This includes assurance against the Trust's stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales. To rapidly escalate any significant concerns and risks for patient harm or reputational risk for the organisation.
Executive Management Board	To receive highlight reports, performance reports and exceptions from divisions & the Infection Prevention & Control Management Group and agree any required Trust wide action / prioritisation. Receive any external Infection Prevention & Control / decontamination relation inspections / reviews. Monitor delivery of high level mitigation actions. Oversee any high level Infection Prevention & Control risks.
Trust Infection Prevention and Control Management Group	To have oversight of achievements, deficits and actions across all divisions for the Trust Infection Prevention & Control programme of work. Measure progress and performance so that Velindre University NHS Trust can provide evidence it is adequately executing its

	responsibilities in relation to the preventing and controlling infections & decontamination. Report and advise divisions of any new or emerging risks, policies or innovations and the associated actions required. Share learning so that all actions can be taken to prevent infection related avoidable harm to patients. Identify key risks to performance. Communicate and engage with independent member of the Board
Divisional Senior Management Team Meetings	Receive assurance that all Infection Prevention & Control / Decontamination standards are being adhered to across the Division. Receive and agreed definitive action to address any exceptions. Escalate any areas of high risk, patient / donor / staff risks or where division need support to progress.
Divisional Quality & Safety Groups	Receive the highlight / exception report – triangulate with additional Quality & Safety outcomes. Agree mitigation actions and identify areas good practice. Provide assurance / exceptions to the Senior Management Team Meeting.
Monthly Divisional Infection Prevention & Control Summit meetings	To monitor compliance with Trust and national Infection Prevention & Control policies, standards and the achievement of objectives against the Healthcare Associated Infection code of practice and national requirements for reduction expectations. To assess performance against the agreed work plan of each service/department within division in achieving its objectives and timescales. To support areas in meeting and maintaining the required standards. In particular: • Environmental standards • All relevant training & competency standards • Audit processes, outcomes & actions • Relevant Clinical practice standards (bundles) • Management of incidents or outbreak • Timely contribution to Root cause analysis (RCA) and Investigations of key Healthcare Associated Infections Provide assurance / escalation highlight report for Divisional Quality, Safety and Performance group & Trust Executive Management Board.

5.2 The accountability & responsibility of the Individual/team

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
Executive Director of Nursing, AHP, Health Scientists & Deputy Director of Nursing, Quality & Patient Experience	• To ensure the Trust has in place all the required governance arrangements, monitoring processes, policies, procedures, strategies, assurance systems and resources to effectively discharge its responsibility for IPC and decontamination. • Act as the Trust's named Executive lead for Decontamination in accordance with statutory requirements. • Represent the Board on HCAI at Welsh Government Meetings • Executive Lead for the Trust's multi-disciplinary Infection Prevention and Control programme • To assign a nominated deputy to act in their absence in accordance with Trust objectives • To represent the Board in national decision making via Nurse Directors/executive forum	• Operational delivery of Infection Prevention & Control / decontamination practices
Infection Prevention and Control Team	• Provide both a proactive and a reactive IPC service to the Trust operating Monday to Friday based on priorities • Develop and deliver a work programme for the team that addresses the Trust objectives and National agenda	• Owner of all identified healthcare

	• Support divisions in the development of annual IPC work plans • Provide assurance to the Board on progress against the IPC work programme • Lead IPC through a coordinated multi-professional, evidence-based approach to the prevention and control of infection including HCAIs • Operational management of the Infection Prevention and Control Team • Provide specialist advice, support guidance in relation to all IPC systems & processes including water safety, decontamination, evidence based clinical practice, environmental cleanliness, ventilation, • Support the development of the Trusts' Vaccination programme • Development of Trust wide up to date IPC / decontamination related policy, procedure, guidance – supporting the implementation of national policy, best practice, requirements into practice • Trust wide oversight of urgent response and pandemic planning • Provide expert advice and leadership in the recognition and management of increased incidents/outbreaks across all areas of Velindre University NHS Trust in accordance with national and local guidance. • Provide expert advice in relation to IPC and emergency planning including planning for pandemics and new or re-emerging pathogens. • Monitoring and Trust oversight of Trust compliance of the IPC elements of National Decontamination Standards • Specialist advice and oversight into Trust environmental and clinical cleaning & decontamination standards • To develop and deliver relevant, robust IPC related training & development programme. To monitor compliance with IPC training requirements • Establishing robust 'service delivery level to board assurance monitoring & reporting arrangements • Develop and regularly review a robust Trust wide ward to board infection control & decontamination audit infrastructure • Oversee and support the co-ordination of internal & external IPC/Decontamination related inspections and reviews e.g. Healthcare Inspectorate Wales, Environmental Health Officer, NHS Wales Shared Services • Initiate and manage a comprehensive alert organism surveillance system for key pathogens including HCAI infection reduction expectations organism. • Provide comprehensive surveillance data reports and detailed analysis of that data for scrutiny to the Board. • Support departments and teams in the co-ordination and reporting of investigations into Velindre HCAI cases in accordance with the national and local requirements e.g. Serious Untoward Incidents, Putting Things Right.	associated associate infections • Responsible for individual staff performance in relation to flu vaccinations / hand hygiene/ PPE donning & doffing / IPC Level 2 training/ Fit Testing • Keeping staff training or flu vaccination records • Sole owner of FFP3 Fit testing records • Ensuring staff attend training • Operational delivery of IPC & decontamination standards • Management of non IPC clinical staff in relation to IPC practices

	• Utilise Quality Improvements methodology in the systematic investigation of HCAI, IPC or decontamination incidents e.g. Route cause analysis • Provide expert advice and active involvement on all matters relating to infection prevention and control / decontamination for any new builds / refurbishment programme / introduction of new services. • Utilise existing incident reporting mechanisms e.g. Datix to document IPC related adverse incidents or near misses • Critically review Trust IPC Datix data to identify themes/trends/lessons learnt • Develop and lead on medical device decontamination work streams • Monitor and evaluate progress against performance measures / KPIs and report outcomes hierarchy structure for Trust Governance & assurance as stated above • Work collaboratively with the Infection Control Doctor (ICD) and Antimicrobial Pharmacist to promote antimicrobial stewardship • Organise and facilitate the Infection prevention & Control Management Group and required reporting / escalation / assurance to Trust • Oversee and monitor strategic and operational delivery of IPC / decontamination Health & Care Standards • Oversee and review/revise all Trust IPC / decontamination related risks / risk register entries • Utilise quality improvement methods and risk assessment skills to support the identification of risk and risk and reducing actions • Work collaboratively and participate in national work streams and delivery groups.	
Infection Prevention & Control Doctor (Microbiology Consultant)	• Provide timely and expert advice to support the Trust in meeting its IPC/ decontamination responsibilities • Provide strategic leadership working as part of the Trust IPC Team to ensure operational delivery of required standards and translation of national policy into local context and delivery action • Actively engages in the development and production of Trust IPC policies/ procedures/ strategies /guidance through critical review and monitoring of effectiveness. • Provide specialist advice in supporting the strategic co-ordination of IPC activities within the IPC team and the divisions • Uses leadership and specialist knowledge of antimicrobials to support the Trust and the Antimicrobial Stewardship Meeting in setting the direction for antimicrobial prescribing goals, actions and standards • Provide guidance to clinical colleagues on appropriate antimicrobial prescribing by conducting regular antimicrobial ward rounds and via telephone consultation	• Delivery of the Infection Prevention & Control Programme

	• To provide expert ICD advice on all aspects of HCAI & IPC including reactive responses to outbreak/incidents, emerging threats including pandemic Management • To work with the IPC team to critically evaluate and prioritise responses to local issues identified. • Interpret, translate and & contextualise national and local data to support decision making and prioritisation • Provide local training for all disciplines of staff including medical staff • Provide expert advice in relation to Safe Water management Systems/ Ventilation & Decontamination • Support IPC team in implementing risk reduction and quality improvement measures. • Participate and give expert advice where necessary on HCAI investigations e.g. RCA	
Associate Medical Director Role for Infection Prevention & Control & Antimicrobial Prescribing / Sepsis	• To provide medical leadership at Velindre Cancer Centre in relation to IPC / decontamination and antimicrobial stewardship • Support the IPCT / Microbiology Consultant to drive the IPC / Antimicrobial Resistance (AMR)/ Sepsis agenda forward within the Trust • Role model for IPC campaign and initiatives e.g. World Health Organization 5 moments HH, vaccination programme etc. • Provide medical leadership at relevant IPC / antimicrobial Meetings e.g. Infection Prevention & Control Management group • Review IPC policies to ensure they can be operationally implemented / support develop of new / revised IPC / decontamination / antimicrobial related Policies / procedures / strategies & guidelines • Champion IPC – increase engagement with junior doctors to ensure support for RCAs for all HCAIs • Promotion and participation in national IPC events, such as HCAI/ AMR collaborative, Aseptic Non-touch Technique (ANTT) steering group as required and act as a role model and champion of Trust work • Share HCAI and IPC best practice with established networks e.g. medical directors forum, cancer network to highlight challenges • Ensure all required Infection Prevention & Control audits feature on the Trusts annual audit plan, oversee the outcomes and actions – ensuring completion of the cycle for improvement • Senior leadership to the Trusts sepsis improvement programme • Champion & Drive IPC practices within VCC & support IPC Outbreaks meetings • Actively promote a ‘zero tolerance’ approach to HCAI	• Lead the Infection Prevention & Control Agenda • Operational delivery of IPC
Pharmacy	• Strategic direction, oversight and management of the Trusts antimicrobial improvement programme	• Be responsible for inappropriate

	• Provides expert advice to support strategic initiatives related to antimicrobial guidelines and prescribing and provide assurance to the IPCMG and Medicines Management Group on antimicrobial prescribing metrics. • Support the ICD in discharging responsibilities for antimicrobial ward rounds/stewardship • Actively contribute antimicrobial knowledge to HCAI investigations e.g. RCA • Monitor progress against antimicrobial prescribing key performance indicators (KPI's) and champion antimicrobial prescribing across the Trust. • Collect Point Prevalence Survey data monthly and promote Start Smart the Focus & disseminate data to Public Health Wales. • Participate in national work streams to share best practice and knowledge gained to shape Trust policy • Ordering, delivery and co-ordination of influenza and COVID staff vaccinations	prescribing within the Trust
Divisional Directors / SMTs	• Responsible for Divisional delivery against all national & trust agreed IPC / Decontamination and antimicrobial standards – Monthly monitoring & reporting against all IPC / decontamination outcomes and process performance measures (including Senior Leadership Team oversight of infection rates, cleaning & decontamination standards, staff IPC related training, flu vaccinations, IPC audit compliance, fit testing etc.) – ensuring robust Data collection and validation mechanisms – service level-board reporting • Ensure Division is meeting its IPC/Decontamination audit requirements and escalation of any areas on non / low compliance • Ensure all service developments / changes / redesign meets required IPC / decontamination standards • Having in place system & processes for identification & monitoring of IPC related risk and for taking appropriate action within Division for IPC risk reduction • Provide assurance to Trust Quality & Safety on Divisional progress against KPI's • Identify an Infection Prevention & Control SMT Lead & a champion from within each service area • Ensure Departmental engagement and ensure appropriate reporting on all aspects of Infection Prevention & Control • Ensure that every ward/clinical department has a designated infection control link nurse (or other registered practitioner). • Systems & processes for management of all outbreaks • Ensure all agreed IPC / decontamination actions are fully implemented • Ensure that RCA's of Healthcare associated infections are discussed at the relevant Governance meetings and the minutes of these forwarded to the DIPC's	• Lead the Infection Prevention & Control Agenda

	• Ensure that Infection control is a standing agenda item for Divisional meetings and, that as a minimum, the following are included: o Review of infection prevention and control key performance indicators (KPI's) o Outbreak reports/action plans o Infection Prevention and Control audits where any element of the audit is less than 85%	

Departmental / Ward / Team Managers	• Manage staff in line with HSE requirements – ensuring staff deliver in line with agreed IPC standards and work place is safe • Early identification of any patient / donor infection risk, seek advice and guidance as indicated & manage in line with standards / advice • Minimise risk of infection to both staff and patients / donors • Maintain robust staff IPC related records and manage any areas of non-compliance • Provide assurance, audits & monitoring in relation to key performance indicators; o Fit Testing o Hand hygiene compliance o Hand Hygiene training compliance o Staff influenza Vaccination uptake o ANTT Training compliance (E-learning & competency assessments) o Level 2 IPC Training compliance o Environmental audits o Decontamination audits • Ensure departmental representation to support staff influenza vaccination campaign, fit testing & hand hygiene training • Ensure departmental collaboration with IPCT on all RCA investigations • Ensure vaccination status of new starters is reported an held at local level	
Estates Department	Responsible for delivery of: • Leading the Trust and divisional water safety groups • Responsible person for the management of Water systems and water quality • Analysis of results and lead actions to correct water results that are out of acceptable parameters in collaboration with the IPC team • Compliance with national guidance for safe water management systems • Compliance assurance of in-house services & contractors • Induction of contactors on IPC, including: dust management and water safety • Assessing and reporting compliance against Health Technical Memorandum –in relation to Safe Water Management, Ventilation & Building/ refurbishment etc., (Regularly liaise with infection prevention & control team to ensure safe processes)	• Individually responsible for poor water management

	• Maintaining good building / estate repair though programme of repair/refurbishment and reactively through IPC environmental audit results. • Timely escalation of any issues or concerns arising on sites that would create a patient / donor or staff IPC risk • Consult IPC on planned or emergency work • Engage and consult IPCT for any new build or refurb at early stage in accordance with Infection Control in the Built environment • Ensure estates staff are compliant with IPC training and adhere to policy when working in clinical areas/dept.	
Operational Services Department	Responsible for delivery of: • Delivering the required level of cleaning to the require standards using the products relevant to the situation at the time • High standards of food safety for all aspects of in-house catering facilities • Compliance assurance & audit of in-house services and contractors. • Innovation and new technologies • Reactive services and proactive responses to managing environmental cleanliness e.g. during incident/outbreaks where there are infected cases on wards • Provides reports on standards of cleanliness and waste management. • Development and review of non-clinical polices such as Laundry, Waste Management and Cleaning. • Management of all staff in line with HSE requirements, ensuring staff received relevant training and monitoring of compliance as per training needs analysis for the role	
All staff	All employees are responsible for: • Complying with Trust Infection Prevention and Control policies, procedures & guidelines and escalating any situation that prevents this occurring. • Maintaining their legal duty to take reasonable care of their health, safety and security and that of other persons who may be affected by their actions and for reporting untoward incidents and areas of concern. • Keep up to date with all IPC training requirements according to role • Identifying infectious conditions and circumstances that may lead to transmission of / outbreaks of infection that require specific controls to protect themselves, their patients or others, informing the IPCT of any such circumstances. • Ensuring safe working practices are implemented as outlined in Infection Prevention and Control policies.	

5.3 Governance and Quality Assurance

The key forum for management and governance for the infection control service within the Trust is the Infection Prevention, Control and Management Group (IPCMG). The IPCMG receive the highlight reports from the VCC and WBS monthly IPC summit meetings. Each department should have a designated lead for IPC who is reports and is answerable to the divisional IPC lead. Please see ***appendix 1*** for the IPCMG Terms of reference

The IPCT has primary responsibility for advising on aspects of audit and surveillance pertaining to the prevention and control of infection at Trust level. The IPCT produces an Annual Report and an Annual Programme which are ratified by the Trust IPCMG and received by the Trust via the Quality and Governance Committees.

5.4 Distribution

The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

6 IMPLEMENTATION / POLICY COMPLIANCE

7.1 Infection Prevention and Control Programme

The main aim of the Infection Prevention & Control programme is to plan, manage, co-ordinate and deliver a proactive infection prevention service for the Trust while being reactive to incidents and outbreaks as they arise. The main components of an effective programme include:

- Providing infection prevention and control of infection advice to all divisions and departments of the Trust
- Incorporating divisional infection control needs within the Trust infection control programme
- Providing education and training on the prevention and control of HCAI to all levels of HCW's
- Providing bespoke education on the management of infections as they arise
- Undertaking surveillance of infections, facilitating and validating data received
- Producing, implementing, and auditing compliance with infection prevention policies

- Liaising, communicating and advising with staff on matters relating to infection prevention and control during working hours, with advice available on a 24-hour basis from Public Health Wales microbiology service
- Developing infection prevention and control policies for the Trust in accordance with Legislation, National guidance, strategy, Quality frameworks and evidence based medicine
- Advising Divisions and hosted organisations on guidelines and procedures with relation to infection control.
- Implementing Welsh Government directives with regard to surveillance and strategic direction
- Implementing and developing the Health Care Associated Infection Strategy for Wales

7.1.1 Education

Education of all Trust staff is undertaken either by using nationally agreed e-learning programmes, delivered by members of the Infection Prevention & Control Team or using materials developed or advised by the Infection Prevention & Control Team. Where possible blended learning, including classroom teaching, e-learning and opportunistic workplace methods will be utilised. The level of training is determined by a Training Needs Analysis of the role being undertaken. As a minimum ***all healthcare workers, regardless of their role undertake Infection Prevention and Control Level 1 training within 4 weeks of starting employment.***

- ***Level 1 training*** focuses on precautions and procedures undertaken by those providing direct patient / service user care or working within a clinical environment.
- ***Level 2 training*** is update training undertaken every 2 years to ensure clinical healthcare workers are kept up to date with current research, guidelines, policies and projects.
- ***Level 3 training –*** Massive Open Online Course (MOOC) which is targeted at registered practitioners and senior staff in supervisory roles who are responsible for ensuring compliance with good IP&C practices e.g., ward and Departmental clinical managers.

7.1.2 Training availability

- Both Level 1 and 2 training are available as e-learning if classroom session not available
- Junior and locum doctor induction is provided per intake
- The ICD updates consultant colleagues at Consultant meetings while the Antimicrobial Pharmacist will input into the doctor training programme.

- Additional targeted training will be provided as required for specific groups including porters, domestics, volunteers etc. and as required to respond to a new infection prevention problem or to meet a particular need.

7.1.3 Surveillance

Surveillance is a key component of the infection control programme. The aim of surveillance is to collect continuous timely data on organisms and patient information to identify infection rates and trends. It assists the early detection of outbreaks or increased incidence of infection, informs changes in clinical practice and assists the targeting of preventative methods. Types of surveillance undertaken include:

- Daily surveillance - Identification, monitoring, advising on and recording of 'alert' organisms as provided by the laboratory reports received daily.
- Routine surveillance – collection, analysis, dissemination and feedback of data on condition/infections among patients and staff, to allow the appropriate action to be taken.
- Targeted and enhanced surveillance - undertaken following risk assessment, which may identify high-risk areas of practice, to enable the monitoring of procedures and processes to identify potential problems and areas for improvement.
- Mandatory Surveillance - as identified by the Welsh Government and managed by HARP.
- National projects – voluntary participation in 'all Wales' surveillance 'projects of targeted areas/organisms.

Surveillance data may be used within a framework of performance management in an attempt to assess the effectiveness of the Infection prevention and Control standards being deployed.

7.2 Audit and monitoring

The Infection Prevention & Control Team's annual programme framework has been updated and there is now one audit programme covering both division.

Both nationally recognised and locally developed tools (to address targeted areas) are used to audit policy, standards and guidelines for the environment and clinical practices. Results are reported to the departmental and local managers and summarised in the quarterly team report and annual reports submitted to Divisional Senior Leadership

Teams, Trust Executive Management Board and Quality, Safety & Performance Committee.

7 GETTING HELP

Further information and support

IPCT: 02920 196129 or bleep 205.

8 Microbiology at UHW on 02920 744825. RELATED POLICIES

The national related Infection Prevention & Control policies can be found here:

http://howis.wales.nhs.uk/sitesplus/972/page/51445

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP

Terms of Reference & Operating Arrangements

Version:
Date Reviewed
Review Date:
Agreed by: Infection Prevention & Control Group
Approved by: Executive Management Board Date to be inserted
Approved by Quality, Safety & Performance Committee Date to be inserted

1. INTRODUCTION

1.1 These Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Standard 2.4 for Infection Prevention & Control & Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.

2. PURPOSE

The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to the preventing and controlling infections and therefore taking all actions to prevent infection related avoidable harm to patients. This includes:

2.1 Ensure systems for assessing, reducing, reporting and monitoring infection risks across the Divisions / Trust are robust.

2.2 Ensure robust governance structures for monitoring decontamination services within Divisions / the Trust, including arrangements for decontamination of reusable medical devices.

2.3 Agree Trust wide Infection Prevention and Control (IP&C), decontamination and infection / antimicrobial surveillance, audit programmes and assurance and monitor compliance in respect of these.

2.4 Oversee the development and regular review of all Trust IP&C, decontamination, antimicrobial & surveillance policies, guidelines and procedures. This will include receiving and endorsing adoption of relevant national IP&C related policies, procedures and guidelines.

2.5 Ensure there is a robust implementation plan in place corporately and across Divisions for all local & national IP&C policies, procedures and guidelines and monitor through audit the implementation across the Trust.

2.6 Receive all IP&C, Decontamination, antimicrobial related external / internal audits / reports / peer reviews and be responsible for ensuring the development of robust improvement actions and overseeing through to completion all such action plans. Reporting any exceptions through to Executive Management Board / Trust Quality, Safety &

Performance Committee.

2.7 Ensure appropriate Outbreak Management mechanisms in place and ensuring national outbreak standards are met, robust reporting in place and oversee completion of all post outbreak recommendations / actions to completion.

2.8 Endorse and monitor all IP&C, decontamination & antimicrobial related risks as logged on Trust / Divisional Risk Registers, ensuring that all such risks are being appropriately managed / escalated.

2.9 Oversee the regular review and oversight of Health and Care Standard Infection Prevention and Control (IP&C) and Decontamination. Including endorsing annual self-assessment, agreeing actions and overseeing completion of related action plan.

2.10 Develop and monitor robust Trust wide and Divisional IP&C assurance framework with KPIs that are monitored and reviewed at least annually.

2.11 Ensure there is a robust IP&C training programme in place that meets national and local standards and requirements, oversee compliance with this.

2.12 Review progress against the annual Staff Influenza Vaccination Campaign / COVID vaccine programme.

2.13 Ensure appropriate processes and procedures in place to respond to pandemics such as influenza / COVID.

2.14 Receive outcomes of all RCA investigations from all healthcare associate infections ensuring appropriate remedial actions have been taken

2.15 Oversee processes for the identification and dissemination of good practice / lessons learnt both from internal events and external to the Trust.

2.16 Oversee compliance with all PPE standards across the Trust

2.17 Agree the IP&C Annual Work Programme

2.18 Oversee compliance with Water quality standards including compliance with national guidance and the Trust's Legionella Policy

2.19 Oversee adherence to national cleanliness standards

2.20 Oversee compliance with all Decontamination standards

2.21 Oversee and ensure appropriate action taken from all IP&C HCAI Surveillance Data and monitor compliance against all nationally agreed Infection reduction / improvement goals

2.22 Oversee Divisional compliance with all IPC, Decontamination, water safety and antimicrobial standards ensuring that appropriate divisional action is being taken to mitigate risks.

2.23 Oversee the implementation of a robust antimicrobial resistance action plan

3. DELEGATED POWERS AND AUTHORITY

3.1 The Infection Prevention & Control Management group formally reports into the Trusts Executive Management Board, following which to the Trusts Quality, Safety & Performance Committee. A highlight report will be provided following each meeting that will be supplemented by any papers identified as being required at the meeting. All such reports will be approved by the meeting chair prior to submission.

4. MEMBERSHIP

4.1 The core membership of the Committee, is set out below:

Chair: Executive Director of Nursing, AHPs and Health Science

Vice Chair: Deputy Director of Nursing, Quality & Patient Experience

Co-Option: Additional members maybe co-opted onto a meeting as relevant to the agenda with prior agreement of the Chair / Vice Chair.

Secretariat: Administrator for Infection Prevention & Control Team

Membership

All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

Table 1

TITLE	ROLE & RESPONSIBILITES	REPORTING REQUIREMENTS
Executive Director of Nursing, AHPs & Health Scientists	Chair of Meeting. Leadership and strategic focus in meeting compliance. Overall Executive responsibility for infection prevention & control. Provide assurance / escalation to Trust Board members.	National information / requirements Feedback from Quality & Safety / Board Proposed strategy / direction

Deputy Director of Nursing, Quality & Patient Experience	Vice Chair of Meeting. Leadership and strategic focus in meeting compliance. Provides report to Quality & Safety Group Board.	As above
Senior Nurse for Infection Prevention and Control	Organisation, oversight and management of meeting Identify any areas of concern re non-compliance with Code of Practice/ Health & Care Standards 2.4 / work plan and inform members of risks/ hot spots. Drafting all post meeting reports Quality checking all divisional reports / documents Develop and ensure delivery against IPCMG work plan	Provision of IPCT reports, to include KPIs/ surveillance, audit and training activity, staff influenza campaign& preparedness, incidents and complaints, policy/ procedure review, risk register and produce annual report.
Infection Prevention and Control Nurses/ Respiratory Trainer	To present on specific elements of the IPCT report, including surveillance of infectious conditions and incidents, issues arising on the management of incidents and outbreaks, audit, DoH guidance, policy/procedure review and link champion training activity.	Datix Report-Incidents & Outbreaks Influenza Report Service Improvement
Consultant Microbiologist	Expert resource from Public Health Wales and to provide infection control advice to the group and inform on national and local initiatives in driving policy and management of infectious conditions.	Reports to be provided on an adhoc basis e.g. Updates on: Antimicrobial Prescribing Alerts/ outbreaks across Wales
Principal Pharmacist	Expert advice to support strategic initiatives e.g. Anti-microbial guidelines.	Antimicrobial compliance report at each meeting

(Decontamination)		
Consultant Nurse (HARP Team)	Expert advice to support strategic national initiatives.	As required
Assistant Medical Director, IPC	To provide medical leadership in respect of IPC/antimicrobial stewardship agenda.	As required.
Trust Health and Safety Manager	To act as an advisory from a Health & Safety perspective across the Trust in relation to infection prevention and control.	To provide bi-annual reports on Health & Safety Issues relating to Infection Prevention & Control.
Workforce Development Manager	Support development of IPC associated training & workforce requirements in accordance with national standards	

5. IPCMG MEETINGS

5.1 **Quorum**

The Chair / Vice Chair, Microbiologist, Anti-microbial Pharmacist, Infection Prevention & Control Nurse and a senior decision maker from each Division must be represented in order for a meeting to proceed.

5.2 **Frequency of meetings**

Meetings shall be held at least quarterly and otherwise as the IPCMG Chair deems necessary.

5.3 **Papers**

- Draft meeting notes and action log MUST be circulated to all members within 10 days of a meeting taking place.
- No verbal or tabled reports will be accepted. If an event occurs that requires reporting to the IPCMG after papers have been circulated a late paper is to be submitted after agreement with the meeting chair.
- All papers are to be provided to the meeting Secretariat at least 10 days prior to the meeting.
- The agenda and papers will be circulated at least 7 days in advance of the meeting.
- All papers should be submitted to the Senior Nurse for Infection Prevention and Control and Secretariat. The agenda will be approved by the Chair prior to issue.

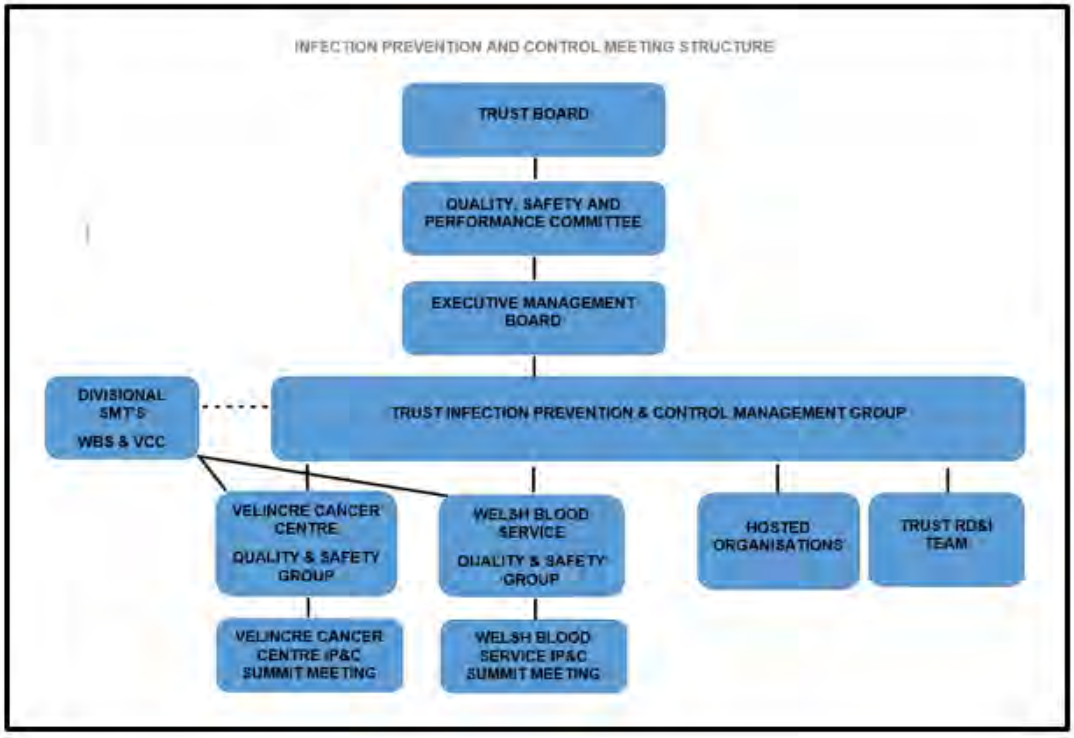
6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The IPCMG reports to the Trust's Executive Management Board and in turn to the Trusts Quality, Safety & Performance Committee by means of a highlight report after each meeting. Additional reports /papers will be provided as appendices as determined by the Group.

6.2 The IPCMG shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 There will be formal reporting mechanisms to and from Divisions into IPCMG. This will be achieved via the Divisional representative. A formal Divisional assurance paper will be provided to the IPCMG for each meeting. The reporting organogram is detailed below:



8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed in 12 months.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Estates Policies

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jason Hoskins Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	27/10/2022	Approved

ACRONYMS	
ACM	Asbestos Containing Materials
CAR	Control of Asbestos Regulations 2012

1. SITUATION/BACKGROUND

1.1 The Trust is required to ensure it has policies in place that detail arrangements to comply with specific legislation. The following policies have been reviewed and updated and require approval.

- The Asbestos Policy
- The Control Of contractors Policy
- The Water Management Policy

1.2 The Asbestos Policy outlines the how Velindre University NHS Trust adheres to the Control of Asbestos regulation 2012 (CAR 2012) setting out protocols to comply with the "duty to manage." The duty to manage asbestos is included in the Control of Asbestos Regulations 2012. The duty requires the Trust to manage the risk from asbestos by finding out if there is asbestos in the premises (or assessing if ACMs are liable to be present and making a presumption that materials contain asbestos, unless you have strong evidence that they do not), its location and condition.

1.3 The Control of Contractors Policy outlines the overarching requirements to ensure as far as reasonably practicable, the Trust maintains a safe environment for contractors to provide their services whilst not putting at risk patients, donors, staff, visitors, Trust property and equipment, and the contractor's own employees. The policy supports Contractors undertaking services on Trust premises do so in a safe and controlled manner. The document sets out at roles and responsibilities for both planned and reactive engagements.

1.4 The Water Management Policy provides guidance to ensure all new water systems are designed, specified, installed and commissioned so as to avoid, where reasonably practicable, the foreseeable exposure of people to legionella bacteria or, where avoidance is not practicable, to ensure that such risks are reduced to a tolerable level. The Trust accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to patients, visitors, staff and other persons working at or using its premises in line with the current version of the Water Safety Plan, Site-specific 'Written Schemes', and Water Safety Policy Appendices

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Asbestos Policy has been amended to reflect new date of assessment, current Trust Logo, and also benefits from addition of section listed

- Purpose
- Scope
- Roles and Responsibilities
- Training
- Implementation
- Equality
- Policy Conformance
- Legislation

The information provided provides further detail and does not detract from the wording in the original policy

2.2 The Control of Contractors Policy has been reviewed and updated to reflect new date of assessment, current Trust Logo. The document has been updated with a number of non-material alteration to improve grammar and flow. Timings have been entered to highlight duration of notice for planned works and sections outlining planned and emergency works added.

2.3 The Water Management Policy has been amended to reflect new date of assessment, and the current Trust Logo.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)

	An Equality Impact Assessment has been completed on all policies earlier in the year
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality Safety & Performance Committee are asked to **APPROVE** the attached policies.

REF: PP 04

ASBESTOS MANAGEMENT POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance & Estates
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	Planning and Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	13/04/2022
Equality Impact Assessment Outcome:	Approved
Review Date:	November 2025
Version:	1

Contents

ASBESTOS MANAGEMENT POLICY

1. POLICY STATEMENT

1.1 It is the Policy of Velindre University NHS Trust referred to as the "Trust" to do all that is reasonably practicable to protect employees, visitors, contractors and others from health hazards arising from the presence of asbestos-containing materials at all the sites within their property portfolio. This policy is specifically for Trust properties including leased areas. This Policy is a legal requirement and its requirements will be achieved by the implementation of an Asbestos Management Plan to ensure full compliance with all statutory requirements of current relevant legislation, codes of practice and guidance notes.

2. Purpose

2.1 To ensure that the Trust and its hosted bodies comply with their Statutory duties under the Health and Safety at Work Act 1974 (as amended) and Control of Asbestos Regulations 2012

3. Scope

3.1 This policy applies to all properties owned and maintained by the Trust, including properties leased, rented or occupied under lease or any other occupancy agreement.

The policy covers the maintenance of all ACM (Asbestos Contained Materials) within The Trust, to ensure a safe environment for both patients, staff and the public.

4. Aims and Objectives

4.1 The Trust is committed to:

- Identify, as far as is reasonably practicable, the locations of all asbestos-containing materials which present a potential risk of exposure to asbestos dust or debris
- Arrange for risk assessments to be conducted of the identified materials which represent a potential risk and review these assessments at least annually or as dictated by the risk assessment or when changes occur
- Establish and operate an action plan for managing and controlling risks from asbestos, including emergencies

- Ensure all contractors working on Trust properties are made aware of the presence and locations of asbestos-containing materials
- Monitor compliance with the action plan
- Review risks and the performance of the risk control measures, revising risk assessments and the action plan as appropriate
- Conduct annual audits of compliance
- Provide copies of all asbestos survey data, including registers and make these available to Consultants, Contactors and Trust staff planning or undertaking work and obtaining acknowledgment of this information being read and understood
- Maintain records and carry out regular reviews / audits
- Employ only competent, adequately asbestos awareness trained personnel and licensed asbestos contractors.
- Appoint responsible persons and provide adequate training for The Trust's Managers and employees.
- Communicate any asbestos issues / requirements with internal staff & contractors where exposure to the areas is an issue.

4.2 The management of Trust properties regards the provision and maintenance of the above as a mutual objective for management and employees at all levels within the organisation

5. Roles and Responsibilities

5.1 The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

5.2 The Duty Holder

- Oversee asbestos management provision across all properties and assets, including sufficient resources.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout all properties and assets in liaison with the Health & Safety Departments.
- Receive training on Asbestos Containing Materials (ACMs).
- Ensure all relevant parties are informed of the asbestos management system and their responsibilities.
- Ensure periodic re-inspection surveys are undertaken at least annually.
- Ensure that all work carried out on asbestos containing materials complies with current regulations and best practice.
- Review agreed roles and nominate as appropriate.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management

5.3 Nominated Asbestos Manager (NAM) / Deputy NAM

- Oversee asbestos management provision across The Trust.
- Inform all relevant parties of the asbestos management plan and their responsibilities.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout the Trust in liaison with the Health & Safety Department.
- Review agreed roles and nominate as appropriate.
- Receive training on ACMs.
- Ensure re-inspection surveys are undertaken at least annually using the approved Consultant.
- Ensure the Asbestos register is updated following any asbestos works.
- Ensure all work carried out on asbestos containing materials complies with current regulations and best practice.
- Oversee the coordination of air monitoring of the enclosure and surrounding area during asbestos works.
- Ensure an assessment of the hazards and risks from asbestos containing materials is undertaken and recommended appropriate control measures defined.
- Keep staff and managers informed about asbestos hazards and control measures that are relevant to their work, department and staff. Implement appropriate procedures to ensure appropriate management of asbestos remedial works and/or further survey etc. where day to day maintenance activities are affected by the presence of asbestos i.e. task-driven remedial works.
- Identify persons requiring specific information and instruction in asbestos work and coordinate appropriate training.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management.
- Ensure all records are maintained in accordance with the regulatory requirements and codes of practice for asbestos work.
- Act as the main point of contact for all questions and queries relating to asbestos.

5.4 Nominated Asbestos Co-ordinator (NAC)

- Oversee asbestos management provision across respective properties.
- Inform all relevant parties of the asbestos management system and their responsibilities.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout the Trust in liaison with the Health & Safety Department for respective properties.
- Receive training on ACMs.
- Ensure re-inspection surveys are undertaken at least annually

for respective properties using the approved Consultant.

- Ensure that following any asbestos works all information is returned to the NAM so that the Asbestos register can be updated.
- Ascertain that all work carried out on asbestos containing materials complies with current regulations and best practice.
- Oversee the coordination of air monitoring of the enclosure and surrounding area during asbestos works.
- Ensure an assessment of the hazards and risks from asbestos containing materials is undertaken and recommended appropriate control measures defined.
- Keep staff and managers informed about asbestos hazards and control measures that are relevant to their work, department and staff.
- Implement appropriate procedures to ensure appropriate management of asbestos remedial works and/or further survey etc. where day to day maintenance activities is affected by the presence of asbestos i.e. task-driven remedial works.
- Identify persons requiring specific information and instruction in asbestos work and coordinate appropriate training.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management.
- Ensure all records are maintained in accordance with the regulatory requirements and codes of practice for asbestos work and information is copied to the NAM.

5.5 Employees

- Report any defects to suspect materials which are damaged or disturbed. Also any suspect ACM's (in any condition) and any defects or concerns they may have related to asbestos issues or remedial works to their superior.
- Make full and proper use of any control measures provided.
- Attend asbestos awareness training when so requested;
- Keep work areas clean and immediately report any damage that occurs to suspect materials.
- Ensure that Protective equipment including RPE is used when entering potentially contaminated areas and only when agreed and supported by the Asbestos Manager or Deputy.

5.6 Licensed Contractors

- Carry out all works in full accordance with all current relevant legislation and Approved Codes of Practice.
- Provide statutory notifications to the relevant enforcing authority
- Provide detailed method statements and risk assessments
- Dispose of any waste in accordance with the Hazardous Waste Regulations 2005 and provide consignment documentation

/waste carrier's license.

- Ensure all staff are fully trained and have the appropriate medical record
- Provide adequate insurance cover
- Signed Permits to work

5.7 Non-licensed Contractors

- Provide adequate insurance cover for working with ACM's
- Provide detailed method statements and risk assessments
- Only Competent persons to undertake the works (evidence of adequate training).
- All operatives have been face fitted and issued with RPE (evidence to be made available)
- Signed Permit to Work
- Dispose of any waste in accordance with the Hazardous Waste Regulations 2005 and provide consignment documentation/waste carrier's license.

6. Training

6.1 Asbestos Awareness

This is a course or e-learning covering the properties of Asbestos, its effects on health, the types, use and likely occurrence of asbestos and ACMs in buildings and plant, the general procedures to be followed and how to avoid the risks of asbestos. This is a requirement under Regulation 10 of The Control of Asbestos Regulations (CAR 2012) and should be provided to all those with the potential to disturb asbestos during their routine activities. *This course should be completed by the Duty Holder, NAM, Deputy NAM, NAC and all other employees liable to disturb ACM in their daily working activities.*

6.2 Asbestos Management

This is a course which helps those who commission works to understand their roles and responsibilities, the procedures and their legal responsibilities. *This course should be completed by the Duty Holder, NAM, Deputy NAM and NAC.*

6.3 Asbestos Awareness Refresher

This is an annual refresher of the Awareness course (detailed above) that is required under Regulation 10 of CAR 2012. This is not a repeat of the original but a Refresher looking in detail at updates and specific areas where gaps have been identified over the previous year. *This course should be completed by the Duty Holder, NAM, Deputy NAM*

and NAC.

6.4 BOHS P405 Managing Asbestos in Buildings

This course is to provide a practical knowledge and the skills to be able to manage asbestos in buildings and to provide a basic knowledge of asbestos removal procedures. *This course should be completed by the NAM, Deputy NAM and NAC.*

7. Equality

7.1 A summary of the outcome of the EIA must be present on the front cover of the document:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or
This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

8. Implementation

8.1 The Trust expects those tasked with managing asbestos to:

- Diligently discharge their responsibilities as benefits their position.
- Have in place a clearly defined management structure for the removal, control and monitoring of asbestos.
- Have in place a programme for the assessment and review of asbestos on site
- Develop and implement appropriate protocols, procedures, action plans and control measures to mitigate asbestos risks, comply with relevant legislation and, where practicable, codes of practice and guidance.
- Develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment.

9. Policy Conformance / Non-Compliance

9.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action

taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

10. Legislation

10.1 Relevant legislation includes:

- Incident Reporting and Investigation Policy (PP01)
- Risk Assessment Policy (PP06)
- Health, Safety and Welfare Policy (PP18)
- Waste Management Policy (PP20)
- Fire Safety Policy (PP23)
- Control of Substances Hazardous to Health Policy (PP33)
- Risk Management Policy (PP35)
- Asbestos Policy (PP04)
- Control of Contractors Policy (PP05)
- Infection Prevention and Control Policy (IPC00)
- Standards for Health Services in Wales – Environment (Standard 12)
- WHTM 07-01 - Safe Management of Healthcare Waste (2013)
- Environment (Wales) Act 2016
- Planning (Wales) Act 2015
- Wellbeing of Future Generations (Wales) Act 2015
- Environmental Protection Act 1990
- The Waste (England and Wales) Regulations 2011
- The Environmental Permitting (England and Wales) (Amendment) Regulations 2018
- The Hazardous Waste (England and Wales) Regulations 2005
- The Controlled Waste (England and Wales) Regulations 2012
- Welsh Government Towards Zero Waste Strategy
- The Air Quality Standards Regulations 2010
- Modern Slavery Act 2015
- Welsh Government Ethical Employment in Supply Chains Code of Practice 2016
- A Green Future: Our 25 Year Plan to Improve the Environment (HM Government) 2018

Ref: PP05

Control of Contractors Policy

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance and Estates
Document Author:	Helen Jones – Trust Health and Safety Manager
Approved by:	Trust Health, Safety and Fire Board
Approval Date:	
Date of Equality Impact Assessment:	15 02 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	February 2025
Version:	3

Contents

Introduction

1. Policy Statement

The Velindre University NHS Trust Board recognises its health and safety responsibilities both as an employer and as a service provider. Velindre University NHS Trust (the 'Trust') is committed to creating, as far as reasonably practicable, a safe environment for contractors to provide their services whilst not putting at risk patients, donors, staff, visitors, Trust property and equipment, and the contractor's own employees.

2. Purpose

To ensure that Contractors undertaking services on Trust premises do so in a safe and controlled manner.

3. Scope

The Control of Contractors Policy covers all areas where services are provided by an external contractor. A contractor is defined as;

"*A contractor is anyone you ask to do work for you who is not an employee" as defined in HSE Managing Contractors HSG159.*

This excludes temporary or agency staff.

The policy applies to work undertaken by contractors at Velindre University NHS Trust, Divisions or Hosted Organisations". Contractors may be engaged by Estates, IT, Operational Services, Departments etc.

Responsible Manager is defined a manager who has arranged the work, engaged the contractor and is responsible for the control of contractor arrangements for the work carried out. All work carried out by contractors must have an identified Responsible Manager.

Additional procedures apply to contractors who are procured in accordance with the Construction (Design and Management) Regulations 2015 (CDM 2015) for schemes notifiable to the Health and Safety Executive. Non-notifiable construction schemes will need to address the requirements within the Construction (Design and Management) Regulations 2015 (CDM 2015) and this policy.

4. Aims and Objectives

The aims and objectives of this policy are to establish the steps to be taken by Velindre University NHS Trust to assess the competence and resources of contractors and to manage the health, safety and environmental element of their service provision to the Trust.

This policy is overarching, all Divisions and Hosted Organisations will implement procedures to support this policy. The policy sets minimum requirements for the control of contractors.

To fulfil the Board's legal duty of care to all its employees, patients, donors and others to provide a safe working environment.

5. Roles and Responsibilities

5.1 Executive Lead

The Chief Executive has overall responsibility and is accountable to the Trust Board for the management of Contractors within the organisation.

5.2 Director of Planning, Performance, Estates and Capital

The Director of Planning, Performance, Estates and Capital is responsible as part of their Board responsibility for health and safety for ensuring that management systems are in place for the implementation, communication, monitoring of this policy.

5.3 Deputy Director of Planning, Performance, Estates and Capital

The Deputy Director of Planning, Performance, Estates and Capital is responsible for the operational implementation, communication, monitoring and review of this Policy.

5.4 Directors of Divisions and Hosted Organisations

Directors of Divisions and Hosted Organisations are responsible for ensuring that the policy is implemented, communicated and monitored within their Division/Hosted Organisation and suitable procedures are in place to enable its implementation, communication and monitoring.

5.5 Heads of Department

Heads of Department are responsible for ensuring that this policy and local procedures for control of contractors are followed and that a Responsible Manager is appointed for all work undertaken by contractors. Heads of Department must also ensure liaison with key stockholders e.g. with Estates, Operational Services to ensure communication and coordination of any work undertaken.

5.6 Responsible Managers

Responsible Managers are responsible for the operational management of contractors and for following the requirements of this policy and local procedures. The Responsible Manager must plan any necessary communications about the work and any liaison with key stakeholders e.g. Estates or Operational Services.

5.7 **The Estates Department**

The Estates Department is responsible for managing Asbestos on Trust premises and for the provision of the Permits to Work specified in this policy. The Estates Department may in some instances have a role with regard to coordination of work of contractors on site and for providing additional information and support.

5.8 **All Staff**

All staff must adhere to this policy and any associated Divisional/Hosted Organisation operational procedures. Staff must report any incidences of concern in relation to contractors working on Trust premises and must not to put themselves or others at risk whilst carrying out their duties

6 Management of Contractors

The following areas must be addressed by all Divisional control of contractors procedures;

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6.1 Selection of Contractors

The Employing Division/Hosted Organisation must satisfy itself that it holds suitable and sufficient information regarding the competency and health and safety performance of any contractor it may employ.

Contractors invited to work at the Trust must be made fully aware of the standards of health and safety to which the Trust operates and expects. Only competent contractors are to be employed on Trust premises. Competency is defined as;

- with relevant related professional qualifications, and or relevant related accreditation;
- sufficient experience of the tasks to be undertaken and awareness of the risks involved;
- experience to carry out duties in relation to the work, to recognise limitations and take appropriate action to prevent harm to those carrying out the work and affected by the work;
- in possession of relevant insurance cover for the works being completed.

An assessment of competence should be carried out prior to a contractor being appointed and should be documented using (Form *)

Works must not be sub-contracted without prior written agreement from the Responsible Manager. Sub-contractors will need to comply with the same criteria as above for "*Selection of Contractors".*

6.2. **Information for Contractors**

Contractors must be briefed on the works required and the risks associated with works on Trust premises. Information should be provided such as, but not limited to;

- detailed description of what work is required
- location of the works to be completed (precise location), along with a description of the functionality of the space and adjacencies to it
- standards/legislative compliance that the works will be expected to be completed to (if applicable)
- available working hours i.e. during normal working day 9:00 until 17:00 or to reflect the working arrangements at the site.
- here work is undertaken on the fabric of the building which may disturb asbestos information about asbestos contained in the Asbestos Register together with a copy of the Trust Asbestos Management Plan. (if applicable). Any work on the fabric of the building which may disturb asbestos must be referred to the Estates department for authorisation prior to work commencing.
- presence of radiation in building (if applicable)
- any other information that will enable the contractor to understand the risks associated with undertaking works on Trust premises

6.3 **Permits to Work**

Advice must be sought from the Estates Team at least 10 days before any of the following work commences, as Permit to Works will be required.

- confined space (work undertaken by external contractors)
- electrical work on fixed installations where physical isolations are required
- excavation
- work on mains gas supplies
- hot work
- work on roofs, erection/striking of scaffolding
- Work on the fabric of the building which may disturb asbestos.

Other work on-site may require additional Permits to Work from other Departments, this must be identified and documented in the local control of contractors procedures.

6.4 **Actions prior to commencement of Service/Works**

Prior to any work commencing on site the contractor must provide a suitable and sufficient risk assessment and method statement/work instruction at least 10 days before planned work commences. The risk assessment and method statement should be checked for suitability by the responsible manager prior to work starting and a record kept using Form *.

The Responsible Manager must plan any necessary communications about the work and any liaison with key stakeholders e.g. Estates or Operational Services.

Contractors must not deviate from the agreed risk assessment and method statement without prior agreement from the Responsible Manager and the risk assessment and method statement being amended accordingly.

Contractors are responsible for ensuring that all their employees working on site are aware of the contents of the risk assessment and method statements.

All risk assessments and method statements/work instructions must be signed by, dated and agreed by, contractor's staff carrying out the works.

The method statements should address any specific Personal Emergency Evacuation Plans (PEEP's) and specific requirement needs for the contractor's workforce.

Contractors must provide evidence of relevant licensing and qualifications for their staff that will be working on site. They must also provide evidence of compliance with legal requirements for equipment used on-site for e.g. calibration records, LOLER certification.

If the service/work provision is subcontracted to a third party/supplier, the Responsible Manager should ensure that the persons actually conducting the work have either;

- Produced their own relevant risk assessment and method statement which must be submitted to the Trust at least 10 days before work commences for checking.
  Or
- Formally agreed to, signed and dated, the previously submitted risk assessment and method statements and comply with as their method for completing the works/services

6.5 **Arrival on-site and Induction**

All contractors must sign in when arriving at site and must be provided with contact details for a Trust site contact for the duration of their works.

All contractors employees must receive a Trust Health, Safety and Environment induction appropriate to the site operations. The frequency of inductions must be risk assessed in accordance with site operations, but the minimum refresher induction should be every year. If a contractor has not been to site for three months they must receive a repeat induction. Inductions must repeated more frequently if there is a significant change or addition to the information provided.

The contractor is responsible for ensuring that if additional staff start work on-site during the works, they also receive an induction. Relevant qualification and training details must be provided for any additional staff. They must also be made aware of and sign the risk assessments and method statements.

A signed and dated record of inductions is to be kept for future auditing purposes.

6.6 **Monitoring and Review of Contractors**

During the period of work, the Responsible Manager or their nominated deputy shall monitor the performance and controls exercised by the contractor. The frequency of these checks should be in proportion to the associated risks, and as a guide should be conducted at least once per day for low-risk activities, e.g. grass cutting/gardening, or basic building maintenance/decorating. Where works are of higher risk, e.g. hot works, confined spaces, working at height etc. the frequency should be increased, but as a minimum must be at least once per day. A record must be kept of all monitoring undertaken (see Form *).

Suggested activities and compliance to monitor should include but not be limited to:

- all required PPE being worn
- work being conducted in line with agreed methods
- compliance with site/location safety rules and safe working conditions
- safety devices/barriers/screens etc in place
- relevant Permits to Work in place, being adhered to and understood
- all the work party signed in and received induction
- any impact on others or the surrounding area
- housekeeping under control and acceptable
- anything changed since the last monitoring visit e.g. has the job content changed, have the hazards or environmental impacts changed

If any significant non-compliance issues are identified, the works must be stopped and made safe and the contractor brought in to discuss the future service/works delivery.

Once the works have been completed, or annually for long term routine contractor works, a review should be conducted, considering as a minimum:

- compliance with safety rules and safe working conditions

- compliance with statutory regulations for all equipment/plant used.
- compliance with agreed method statement(s) including Permit to Work systems.
- compliance with the scope of work, quality of workmanship, materials and finished work.
- overall safety and environmental performance and responses to rectify non-compliances.
- records on the above shall be recorded and forwarded to the Divisional representative responsible for contractors who will use this information as part of the contract review/ tender list process.

7 Arrangements for planned work undertaken out of usual working hours or in response to an emergency.

Arrangements for planned work that is undertaken outside normal working hours must ensure that the requirements of this policy and of Divisional/Hosted Organisations Control of Contractors procedures are followed. Arrangements must be in place for the supervision and monitoring of the work carried out.

The risk assessments for the work must reflect the work undertaken and must identify and mitigate any additional risks caused by the work being carried out outside usual working hours. Consideration should also be given to the contractors' familiarity with the site

Key Stakeholders must be identified and informed that the contractors are on site.

The Responsible Manager remains responsible for the work and must ensure that the contractors have the appropriate contact details and that suitable arrangements are in place to supervise and monitor the contractor and to manage emergency situations.

If an unplanned event results in the need for a contractor to carry out work on an emergency basis, the Estates or other (depending on local arrangements) on-call manager must be contacted in first instance. It is the responsibility of the on-call manager to determine the action to be taken and to escalate any issues/actions as appropriate. Where there is an approved list of contractors specifically for out of hours and emergency work, this should be consulted.

The Estates or other (depending on local arrangements) on-call manager may ask an Estates Technician or other (depending on local arrangements) to attend site to assess the problem and provide information for the on-call Manager. Local lone working procedures must be in place for technicians attending site out of hours. The on-call manager must decide if the technician should stay on-site to supervise the contractors. If additional support is required the on-call manager should attend site or make additional arrangements. The contractors attending site must have contact details of who they should contact if they require additional support.

Where possible unplanned work on the fabric on the building should be avoided. However, if it is unavoidable the on-call manager must ensure that for sites where asbestos is present, the Asbestos Register is interrogated and that documented information including the Asbestos Management Plan is shared with the contractor undertaking the work. Local procedures should be in place to facilitate this.

8 Equality

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

8.2 The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

8.3 The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

9 Training

9.1. Managers will be provided with information and training on this Policy.

9 Implementation

9.1 This Policy will be maintained by the Planning, Performance, Estates and Capital Department

9.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

10 Audit and Monitoring

10.1 The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

11 Policy Conformance / Non Compliance

11.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

12 Distribution

12.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

13 Review

13.1 The Assistant Director of Estates, Environment and Capital Development will review the operation of the policy as necessary and at least every 3 years.

14 Documentation

14.1 Related Documentation

1. Pre Tender information
2. Pre-appointment assessment of Contractor competence
3. Assessment of Risk Assessments and Method Statements
4. Contractors Induction
5. Pre start checks document
6. Contractors monitoring records
7. Contractor review
8. Authorisation to work document

15 Further Information

15.1 Further information and support is available from the Assistant Director of Estates, Environment and Capital Development

16 References

16.1 HSE Managing Contractors HSG159

Ref: (PP 09)

WATER SAFETY POLICY

The Management and Control of Water Quality

Executive Sponsor & Function: Director of Strategic Transformation, Planning, Performance & Estates

Document Author: Jason Hoskins, Assistant Director of Estates, Environment and Capital Development
Jonathan Fear, Estates Manager

Approved by:

Approval Date:

Date of Equality Impact Assessment: 13/04/2022

Equality Impact Assessment Outcome: Approved

Review Date: January 2025

Version: 1

1. AIM

1.1 General considerations:

Velindre University NHS Trust (the Trust) accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to patients, visitors, staff and other persons working at or using its premises in line with the current version of the Water Safety Plan, Site-specific 'Written Schemes', and Water Safety Policy Appendices.

1.2 Extent of application:

This Water Safety Policy applies to all premises whether owned or occupied by the Organisation under lease or other Service Level Agreements (SLA) including:

i. All premises owned and occupied exclusively by the Organisation.
ii. All premises owned and occupied partly by the Organisation.
iii. All premises not owned by the Organisation but occupied exclusively by the Organisation on a permanent basis.
iv. All premises not owned by the Organisation but occupied partly by the Organisation on a permanent basis.
v. All premises not owned by the Organisation but occupied partly by the Organisation on a temporary or periodic basis.

1.3 General aim:

The aim of this Policy is to introduce all structured Management practices required to allow the Organisation to deliver suitable and sufficient *Legionella* and *Pseudomonas aeruginosa,* "safe" hot water, cold water, drinking water and ventilation systems Management and Control in compliance with current Guidelines (WHTM's, HGN's, Model Engineering Specifications and Approved Codes of Practice), Legislation and Water Supply Regulations. It is expected that this Water Safety Policy will be complied with by all the Organisation's employees and by all appointed contractors, in whatsoever capacity, with or without contractual agreements.

2. MANAGERIAL APPOINTMENTS

2.1 General requirements:

As required by the Health and Safety Commissions (2013) Approved Code of Practice (L8 - Fourth Edition), the Organisation will undertake to:

i. Identify and assess sources of risk;
ii. Prepare site specific 'Written Scheme' for preventing, reducing or controlling the risk;
iii. Implement and manage and monitor precautions;
iv. Keep records of the precautions implemented for each of the premises under the Organisation's control.
v. Appoint appropriate persons, at various positions, to be managerially responsible.

Group and individual responsibilities are described in Water Safety Policy Appendix 1 – Management Responsibilities.

2.2 Executive management at 'Trust Level':

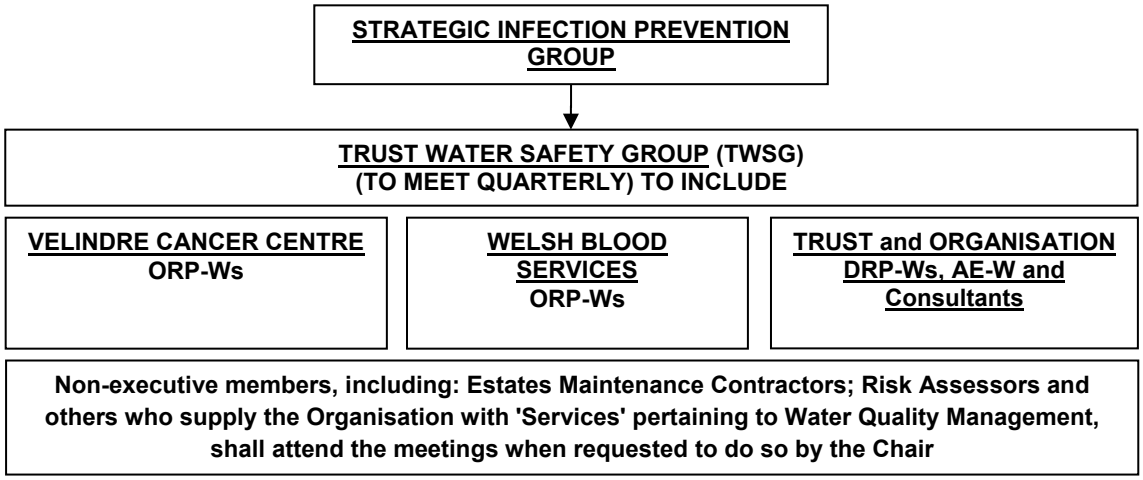
The Chief Executive shall appoint a Trust Water Safety Group (TWSG) Chair and Authorising Engineer-Water (AE-W), operating at Trust Wide Level.

The TWSG Chair shall propose Responsible Persons to the AE-W who shall assess their suitability for the position nominated, and advise the TWSG Chair upon their suitability for appointment. This shall include all TWSG members (Departmental Responsible Persons – Water and Organisation Responsible Persons - Water) Following assessment, these persons shall be appointed to accept the strategic implementation and internal auditing responsibility for the control of the 'Water Quality Management and Control' and to be legally accountable, on a joint and several liability basis, for assessing and controlling identified risks from Legionella, Pseudomonas aeruginosa and other water borne pathogens and hazards.

2.3 Management at 'Organisation Level':

Through the Trust WSG, suitable Organisation Responsible Persons - Water shall be nominated, assessed and then appointed for each Organisation within the scope of this Policy. These persons will be responsible for implementing the specific management

2.4 Water Quality Management and Control Programme Management Structure:



2.5 Measures to be taken to attain the Policy objectives include:

a) The appointment of a Trust Water Safety Group (TWSG) responsible for ensuring the suitable and sufficient implementation of Water Management and Control Programme on a Trust level.

b) The appointment of Organisation Water Safety Groups (OWSG) responsible for ensuring the suitable and sufficient implementation of Water Management and Control Programme on an Organisation level.

c) The appointment of suitably equipped, trained and financed Responsible Persons, on a Trust Wide and Organisation-specific level; capable of delivering the necessary Water Quality Management and Control Programme at the level appointed.

d) Regular monitoring of all implemented Management Systems, Training Programmes and procedures, to establish and ensure their continuing efficacy and legislation compliance.

e) The appropriate selection, design, installation and maintenance of plant.

f) Regular independent third-party Audits designed to allow for the status of the Water Quality Management and Control Programme across the Organisation to be reported.

G) Where in house (Trust) resource is not available, external resource may be appropriated to ensure the control schemes are implemented in line with the agreed requirements.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

DUTIES OF QUALITY & CANDOUR REPORT

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non- Applicable

PREPARED BY	Jayne Rabaiotti, Claims Manager & Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	Endorsed Approach

ACRONYMS	
"The Trust"	Velindre University NHS Trust
IM	Independent Member
CEO	Chief Executive Officer

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the Duties of Quality and Candour, a high-level overview of implementation plans and to provide the initial implementation plan to meet the Duty of Candour requirements as detailed in the Consultation documents.

The Duty of Quality consultation has only just commenced and a gap analysis against these requirements is underway and the required actions will be added on to the implementation plan.

This paper is provided for **NOTING** and **APPROVAL** of the implementation measures and interim implementation plan (will be updated following review of Duty of Quality consultation Statutory Guidance)**.**

2. BACKGROUND

The Health and Social Care (Quality and Engagement) (Wales) Act was passed in 2020. A national Steering Group has been developing the regulatory and statutory guidance documents for the Duties of Quality and Candour. The enactment of these duties has been delayed due to the pandemic. However, enactment will now be required for both duties from 1st April 2023.

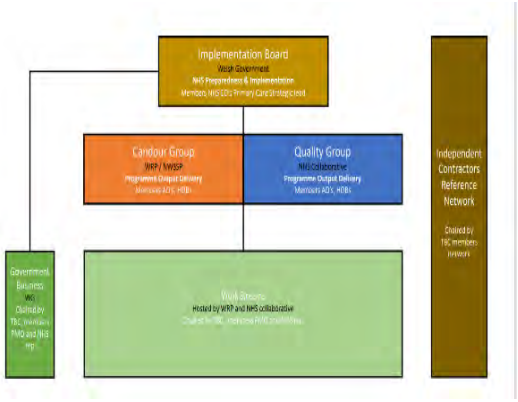
Both duties will require changes in local policies, procedures, working practices and local and national reporting requirements. In addition, there will be a requirement for organisation-wide awareness of the new duties, as well as education and training for clinical staff, leaders and Quality & Safety Teams. Given the collective responsibilities Boards will have in meeting the requirements of these Duties, Board level training will also be required.

3. SITUATION

3.1 National Meeting Structure

To date, the development of the regulatory and statutory guidance documents has been overseen by a National Steering Group (chaired by the Trust's Executive Director of Nursing, AHPs & Health Science). As these have now been drafted, national oversight arrangements have been reviewed to focus on implementation and preparedness for the April 2023 go live date. The national Steering Group will refocus as a strategic assurance board, providing assurance to the Welsh Government that the implementation programme is progressing appropriately. The Steering Group will be re-titled the Implementation Board; it will meet monthly and continue to be hosted

by the Welsh Government and chaired by the Trust's Executive Director of Nursing, AHPs & Health Science. ***It is proposed that no additional Trust membership will be required on the Implementation Board as the Executive Director Nursing, AHPs & Health Science will attend in her role as chair.***



In addition to the Implementation Board, two operational groups will be established: a Candour Group coordinated by the WRP, and a Quality Group coordinated by the NHS Collaborative to lead and oversee successful implementation across the NHS. These groups are intended to provide senior support for the operationalisation of the Duties. It is envisaged that these Groups may, in time, develop into Candour and Quality Networks to enable national coordination and learning for the Duties across Wales. In addition, workstreams will also focus on Communications & Engagement, Education & Training and Reporting & Learning and be made up of subject matter experts in these fields from across the NHS and Government.

It is proposed that Nigel Downes, Deputy Director Nursing, Quality & Patient Experience & Dr Hillary Williams, AMD Quality & Safety represent the Trust at the Quality Group and that Dr Jillian McLean, Consultant Oncologist and Jayne Rabaiotti, Claims & Redress Manager represent the Trust on the Duty of Candour Group.

3.2 Implementation Requirements / Proposals

A letter received on the 11th October 2022 detailed a number of preparedness requirements for NHS Organisations. These are detailed below with proposed plans for approval:

3.2.1 *Executive leadership* – An executive and operational lead for the implementing the Duties are required?
Proposed Executive Lead: Nicola Williams, Executive Director Nursing, AHPs & Health Science.
Proposed Operational Lead: Nigel Downes, Deputy Director Nursing, Quality & Patient Experience.

3.2.2 *Independent Member Lead: Duty Candour* - The guidance for the Duty of Candour identifies the requirement for a non-executive lead for the long term. ***Proposed:***

This would lie with the same IM Lead for Putting Things Right & Quality & Safety.

3.2.3 *Local Implementation Group Required* – ***It is proposed that a Trust wide implementation Group will be established on 8th November 2022 following publication of the Duty of Quality consultation documents. Clinical and Quality & Safety representation from both divisions is required. The Group will need to develop the Trust and Divisional implementation plans (later will need sign off and ownership at Senior Leadership Team).***

3.2.4 *Infrastructure* – A review of Trust infrastructure is required to identify how it is aligned to the new duties. This will need to include Corporate, reporting and divisional.
It is proposed that this will be determined through the Implementation Group. However, would need to be fully aligned with current Quality & Safety & Putting Things Right responsibilities and infrastructure service level to Board.

3.2.5 *Policies & Procedures* – A review of which Trust policies and procedures require a review to meet these new duties is required and identification of any additional policies, procedures or documents. These will all need to be reviewed and approved by March 2023.
It is proposed that the Implementation Group will identify these and oversee the necessary reviews / developments.

3.2.6 *Resources* – The Trust has been asked to identify what resources will be required to firstly implement the new duties in the organisation and then embed into practice?
It is identified that there will be significant Business Intelligence / patient reported outcome measures (proms) requirements – this needs to dovetail with value based healthcare (VBHC) expenditure. Additional resource requirements will be drafted through the Implementation Group.

3.2.7 *Awareness and Training* – Both Duties have graded levels of training dependent on an individual's role in processing them. A full Training Needs Analysis is required to identify which roles require full training vs those that will need basic awareness. This will differ between the two duties.
It is recognised that this will be our biggest challenge (clinical time). It is proposed that the Implementation Group compile a Training Needs Analysis and training / awareness plan.

3.3 Duty of Candour

3.3.1 Duty of Candour Requirements

The Duty of Candour regulatory documents are currently out for consultation (ends on 13th December 2022). Due to the level of wide engagement through the drafting process it is not anticipated to be substantial changes. Therefore, NHS bodies have been asked by WG to plan for implementation from the 1st April 2023, based on the consultation documents. The Duty of Candour will apply across Welsh NHS organisations when two conditions are met:

1. A service user to whom health care is being or has been provided by a NHS body has suffered an adverse outcome and
2. The provision of healthcare was or may have been a factor in the service user suffering the outcome.

A service user is treated "*as having suffered an adverse outcome if the service user experiences, or if the circumstances are such, that the service user could experience any unexpected or unintended harm that is more than minimal and includes psychological harm*".

The Duty of Candour Guidance descries the actions that must be taken by an NHS body when the Duty of Candour is triggered.

A summary of the main requirements are outlined below:

- ***Training and Support*** – The Trust is responsible for ensuring that staff are educated in relation to the Duty of Candour and the legal responsibility involved. Provision must be made to train, develop and support staff in meeting their duty. This includes individual members of staff who are also professionally registered and are separately subject to the professional duty of Candour. Training must include an understanding of when the Duty of Candour is triggered, taking into account the Level of Harm Framework and Guidance. Staff involved with duty of candour conversations will require additional support from peers, colleagues and managers.
- ***Principles of Duty of Candour*** - The Trust is required to ensure that service users and and/or their advocates are informed of the incident promptly, receive appropriate apologies and are involved in any investigation. There is also a requirement to ensure that is adequate support offered from a senior, nominated

member of staff. The statute therefore demands a specific approach to incidents that are deemed 'notifiable patient safety incidents'. The thresholds for these are consistent with the Welsh Government's Delivery Support Unit definitions of moderate and severe harm. As such, all incidents reported as moderate or severe harm require the full Duty of Candour compliance.

- ***Monitoring, Compliance and Effectiveness*** – There is a requirement to introduce systems and processes for the management of incidents, which are required to be recorded appropriately (e.g. in the relevant Once for Wales (OfW) Datix modules). Periodic audits of moderate harm incidents are required to be undertaken as part of risk governance and compliance with duty of candour reports.
- ***Policy, Processes and Templates*** - The Trust is required to have in place a Duty of Candour policy and relevant processes and templates to which it refers.
- ***Dissemination*** - A policy should be stored on the Intranet giving staff relevant access. Service directors and managers have responsibility for ensuring that staff within their division are aware of the policy and of any changes or updates made.
- ***Review*** – Policy and procedures are required for review in accordance with the Trust's organisational governance framework i.e. three years or sooner if required.

3.3.2 Duty of Candour Draft Implementation Plan:

A gap analysis against the consultation documents has been undertaken and a draft implementation plan is detailed in ***Appendix 1***.

4 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Direct impact on quality & safety
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below: Individual Care Governance Leadership and Accountability

EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	A full Trust Equality Impact Assessment (EQA) will be required in relation to how the duties will be enacted. A national EQA is currently underway
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust has a legal duty of care towards those it treats. The Duty of Candour, which comes into force in April 2023, is a legal responsibility owed by the Trust and its employees to service users and their legal advocates.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Where liability is determined as the result of an investigation that has triggered Duty of Candour, the Trust will identify/negotiate an appropriate compensation settlement based on causation and qualifying liability, which must not exceed the threshold of £25,000, in accordance with PTR Regulations. The Trust is responsible for the payment of the first £25,000 of any claim that arises in respect of negligence resulting in moderate harm, severe harm or death, including psychological damage. Any payment made over £25,000 is recouped from the Welsh Risk Pool.

5 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the position in relation to the two Duties and to **APPROVE** the implementation measures detailed in bold on pages 3 and 4 and the interim implementation plan.

Appendix 1

Quality and Safety "Duty of Candour" Gap Analysis / Implementation Plan

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	Status
Trust Requirements				
Roles and responsibilities Strategic accountability required for oversight and operation of Duty of Candour procedures & regulations Responsibility for overseeing the management of duty of candour and adverse outcomes, including those directly involved with the investigation management and/or notification of adverse outcomes and any staff dealing with concerns.	Executive Lead to be appointed	CEO	October 2022	Executive Lead: Executive Director of Nursing, AHP & Health Science identified
	Independent Member to be allocated as IM Lead	CEO/ Director Corporate Governance	November 2022	
	Divisional Implementation Leads to be identified	Divisional Directors	November 2022 2022	
	Operational responsible officer to be identified – responsible for overall day-to-day responsibility and operation of Candour Regulations, must form links between Candour and Putting Things Right.	Executive Director Nursing, AHP & Health Science	October 2022	Operational Lead: Deputy Director Nursing, Quality & Patient Experience

Accountability To adopt a constructive and non-punitive approach to patient safety incidents. To provide training and awareness on the Duty of Candour and support staff in understanding their legal responsibility and accountability. Focus on learning, with a view to improving quality in care and provision.	Measures taken to remove blame culture and barriers. Supporting staff through education, empowerment, mentoring and encouragement, to achieve cultural shift and break down in barriers.	Chief Executive/ Executive Directors/ Service Leads People and Organisational Development Directorate		1st April 2023
Supporting Staff & Service Users				
Supporting Staff To have readily available support from senior nominated staff, including access to counselling, Employee Wellbeing, Trade Union Representatives and Occupational Health.	Nominated senior staff member, with relevant attributes outlined in the Duty of Candour Guidance, to be identified within the Trust and each Division to act as a contact or advocate for support to staff when the Duty of Candour is triggered.	Deputy Director Nursing, Quality & Patient Experience Divisional Directors	November 2022	Corporate Lead identified as Claims & Redress Manager

	An inventory of wellbeing, mental health and support services to be provided and made available to Senior Candour Leads so can be provided to staff involved when the Duty of Candour is triggered	Deputy Director of Workforce & Organisational Development	March 2023	
Supporting service users and advocates Explanation leaflets, information and materials to be prepared and circulated to support service users, advocates and support groups.	A range of Duty of Candour bilingual materials to be made available across the Trust and on intranet / internet sites to include videos, easy read leaflets and materials to empower service users or advocates to seek answers regarding the care and services received.	Deputy Director Nursing, Quality & Patient Experience	March 2023	
	Duty of Candour contact details to be provided bilingually on the Trusts website.	Head of Communications	March 2023	
Training Requirements				
Duty of Candour Training All relevant staff to understand and apply Duty of Candour. Staff who are involved in performing or exercising functions in connection with the Duty of Candour procedures must undergo appropriate training.	A full Duty of Candour Training needs analysis to be undertaken identifying which staff require what level of training.	Deputy Director Nursing, Quality & Patient Experience Claims and Redress Manager	December 2022	

Training must be tailored to reflect banding, status and seniority of staff, consisting of basic training for lower graded staff, to more in-depth training for senior members of staff.	A clear training plan to be developed and delivered to relevant staff. To include: • Requirements and legal responsibilities of Duty of Candour • Understanding the legal framework and levels of harm • Understanding terminology and meaning of when duty of Candour is triggered • Investigating or managing notifiable adverse outcomes • General Data Protection Rules (GDPR) principles • Systems recording (please see above separate Datix training requirements) • Apologising and saying sorry		March 2023	
Once for Wales (OfW) Datix Reporting Concerns triggering the Duty of Candour to be captured and monitored on the OfW Datix modules to comply with compliance, assurance and reporting requirements.	Datix Duty of Candour training guide to be developed to include: • The need to understand how and when to report Duty of Candour on Datix • How to use the prompt field that trigger the duty • How to document and record conversations and progress notes. • How to audit and track incidents on the Once for Wales Datix modules.	Quality, Safety & Assurance Manager	December 2022	

	• How to open and how & when to close Datix record. • Any further individual Datix training required to ensure compliance with the Duty of Candour.			
Communication and written outcomes To address the effects of harm and the physical consequences for service users, their families, carers and advocates as soon as possible, once the Duty of Candour is triggered.	Trust Duty of Candour procedures to be developed aligned with regulatory requirements to cover all operational requirements	Deputy Director Nursing, Quality & Patient Experience Claims and Redress Manager	March 2023	
Putting Things Right Guidance 2023				
Putting Things Right Guidance 2023 - Update Awareness of the timescales and changes to the PTR guidance regarding the handling of concerns. When the duty of candour is triggered the timeframe will now run from the time the "in person" notification to the service user is made. Responses should be issued within 30 working days or within 6 months from the date notification of a concern is received, or the date on which the duty	Trust Putting Things Right policy to be revised in line with revised national putting things right guidance and Duty of Candour requirements, including the required timescales. .	Deputy Director Nursing, Quality & Patient Experience Claims and Redress Manager	March 2023	

of candour comes into effect, whichever is the later.				
Monitoring, Assurance, Effectiveness, Compliance and Review				
Monitoring Assurance, Effectiveness & Compliance	A review of service level to Board monitoring arrangements to be undertaken to incorporate required monitoring of the Duty of Candour.	Deputy Director Nursing, Quality & Patient Experience	March 2023	
	Duty of Candour reporting to be integrated into Putting Things Right reporting through to QSP Committee. Annual Putting Things Right report containing Duty of Candour data to be published on intra / internat site by 31st October each year	Deputy Director Nursing, Quality & Patient Experience	From April 2023	
Review Review of processes	A formal Duty of candour audit programme to be introduced that includes: identification of themes and trends and evidencing that learning and improvements have taken place within the required timescale		April 2023	

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NURSE STAFFING LEVELS (WALES) ACT 2016: REPORT

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non Applicable

PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead, Anna Harries, Senior Nurse Professional Standards & Digital
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP & Health Science

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	Noted

1. SITUATION

This paper is provided to update the Quality, Safety and Performance Committee in relation to the Trust's position in relation to compliance the Nurse Staffing Act (Wales) for the period 1st October 2021 – 30th September 2022 prior to submission to Trust Board.

The Quality, Safety & Performance Committee is asked to **ENDORSE** the Nurse Staffing Act report prior to submission to Trust Board.

2. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Since the 1st April 2021 and the Executive Management Board/ the Trust Board agreed that the inpatient Ward at Velindre Cancer Service does fit within the wider definition of a medical ward First floor are part of the full requirements of the Act and its full reporting requirements. Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Act Reporting

National reporting is yearly and 3 yearly, however following suit with the acuity and establishment reviews internally this update will be provided to board for noting on progress. While reporting is mandatory for first floor ward on all sections of the Act since April 2021 the wider areas within nursing workforce have also been included in part. The Staffing Act review has been completed and the report (using the national reporting template) is attached in ***Appendix 1***. This report highlights:

- Nurse staffing levels calculated using the triangulated approach
- No impact on patient care reported due to not maintaining staffing levels
- ***There have been some occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster and the vacancies that have gone out to advert should help to alleviate such issues. There have been no incidences reported where staffing levels have impacted adversely of the First Floor Ward to provide the required care or treatment to patients.***
- The implementation of SafeCare will enable us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre.
- The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor.

3.2 Establishment Reviews

Following each national benchmarked twice yearly acuity audit the Executive Director of Nursing, AHP & Health Science and Head of Nursing will undertake a formal establishment review across all nursing areas within Velindre Cancer Centre and Welsh Blood Service. The reviews are currently in progress with three areas completed and the remaining scheduled for the 3rd November 2022.

These establishment reviews extend to all nursing areas across the trust and are reported on a template for agreement at each level. Each establishment review detailed:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster

- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Service plans or Clinic Templates as applicable (not all areas)

In summary of the three areas reviewed with nursing workforce, evident knowledge of areas data and information available. No incidents or complaints effecting care linked to staffing. PADR compliance good and in some areas 100% with plans for those that are below. Training very good with reference to specific training focus and working at top of licence. Discussions also held around consideration of Band 4 Practitioners based on NHS Wales agreed standards.

3.3 Electronic Rostering

Consolidation of electronic nurse rostering (six nursing units in VCS) – Health Roster (ALLOCATE) - Health roster is now fully utilised and reporting to payroll (since Sept 2021) in all 6 nursing areas and for the nurse bank. The data reports are producing Key Performance Indicators (KPI) which are scrutinised locally for efficiency and effectiveness. These KPI's are reviewed through establishment reviews and are now generated very easily through the system, reducing workload. In addition, all rosters are reviewed easily to aid assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

3.4 Additional plans to further enhance monitoring & compliance with Nurse Staffing

Act Requirements

The following actions are being taken by Velindre University NHS Trust to further enhance its ability to robustly evidence that it is meeting the Nurse Staffing Act Requirements:

- ***Implementation of Allocate SafeCare Module*** – The SafeCare module of Allocate will facilitate automated Act reporting through Velindre University NHS Trust and to NHS Wales in line with National Nurse Staffing Act reporting requirements. Velindre University NHS Trust has just commenced kick-off for implementation and expected to complete implementation by January 2023 ready for next scheduled acuity audit.

- ***Health Care Monitoring System*** -Until the SafeCare module is complete and live all acuity data is entered into the Healthcare Monitoring System (process since 2016), It is hoped that the June 2023 Audit will be through SafeCare for all Health Boards and Trusts in Wales, however there are difficulties in gaining a visualiser out of the current SafeCare system.

- ***Tendable (Name change from Perfect ward on 1st December 2021)*** **–** The application based digital audit tool that provides real time reporting of audits which are standard-based and all tagged (linked) to the health care standards. Tendable application is now live in 15 areas including Welsh Blood service (WBS).

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes.
RELATED HEALTHCARE STANDARD	Safe Care
	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to The Quality, Safety & Performance Committee is asked to **ENDORSE** the Nurse Staffing Act report prior to submission to Trust Board.

Appendix 1	Annual Presentation of Nurse Staffing Levels to the Board
Health board	Velindre University NHS Trust
ate of annual presentation of Nurse Staffing Levels to Board	November 2022
Period covered	1st October 2021 to 30th September 2022
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical inpatient wards**	Section 25b of the Nurse Staffing Levels (Wales) Act applies to one ward (First Floor) in Velindre Cancer Centre. There has been no primary change to the ward structure during the last year. During the COVID pandemic, beds were reduced from 32 to 22 to allow for appropriate social distancing. This has remained in place since 2020, however, due to the national relaxation of Covid 19 guidance and increasing demand from May 2022 bed numbers have increased back up to the full capacity of 32 beds. The bi-annual calculation cycle took place as planned in both January and June 2022; no further calculations have taken place outside of this cycle, however, First floor ward continues to document acuity daily through the Healthcare Monitoring System. Following a review of the previous Whole Time Equivalent (WTE)) calculations, some inaccuracies have been identified. These inaccuracies have been corrected and a more robust system of calculation has been utilised. The recalculated WTE RN for first floor is 30.95 (inclusive of the ward manager and co-ordinator) and the WTE for HCSW is 14.21, both figures are inclusive of the 26.9% headroom based on 32 bed occupancy.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews take place bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Patient acuity is scored daily using the Welsh Levels of Care Toolkit. The ward manager has remained in a supernumerary capacity throughout this period, supported by a ward co-ordinator that can assist with patient care if the need arises. The ward manager and band 6 nurses measure patient acuity in a consistent manner using lay descriptors and then clinical descriptors if required. The acuity data reveals that patients are predominantly scored at an acuity level of 4 and 3 respectively. This correlates with an increase in reported acuity across health boards and trusts in Wales. There have been instances where the planned roster has not been met, however, professional judgement has been utilised and it was deemed safe due to the reduced number of beds, skill mix and patient acuity levels. Occasionally the planned roster has not

	been met due to staff sickness and unavailability of bank staff to fill the shift at short notice. Quality indicators and complaints in relation to nursing care have been scrutinised, there have been no instances of reportable quality indicators in relation to patient falls and pressure damage. There has been one medication error which resulted in low harm that was not attributable to nurse staffing levels. There has been one complaint in relation to nursing care since the Annual Assurance report in May but again this was not linked to nurse staffing levels. Health roster is in place in Velindre VCC, we are currently awaiting the implementation of SafeCare which will help inform our nursing establishment and requirements for each shift based on patient acuity. SafeCare will assist in avoiding the over or under use of staff and helps in assuring that there is an appropriate and safe skill mix. SafeCare will bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients at Velindre Cancer Centre. It will ensure consistency in recording and reporting data across organisations and support the Once for Wales Approach. Until now, health boards have only provided a narrative to describe the extent to which the nurse staffing levels have been maintained. It is anticipated that health boards/trusts will be able to collate, review and report numerical data to demonstrate the extent to which the planned roster has been maintained once SafeCare is implemented.
Finance and workforce implications	The first-floor ward establishment is historic and had not had any year-on-year increase to support increasing patient acuity and complexity until the implementation of the Nurse Staffing Act 2016. The establishment was reviewed to ensure that in order to provide care sensitively to patients, the establishment included the required 26.9% headroom to account for sickness, study leave, annual leave etc. The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor. First Floor reduced bed capacity to 22 beds during the pandemic. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to 32 beds from September 2022. First floor is currently carrying some vacancies which have gone out to advert and interviews are taking place imminently. The development of Band 4 assistant practitioners through published national framework is also under consideration in all areas across the Trust.

Conclusion & Recommendations

	• This is the first annual presentation to the board for Velindre University NHS Trust in relation to section 25b. • Previous reports have been submitted in line with the requirements of the Act (Annual Assurance Report May 22). • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • First floor is now back up to full capacity of 32 beds. • There are no concerns in relation to reportable quality indicators for falls, pressure damage. • There have been some occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster and the vacancies that have gone out to advert should help to alleviate such issues.

	• The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor. • The implementation of SafeCare will enable us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre.

Summary of Nurse Staffing Levels forwards where section 25B applies.

Health Board/Trust:	Velindre University NHS Trust	
Period being reported on :	Start date: Oct 1st 2021	End Date: Sept 30th 2022
Number of wards where section 25B has applied during the period:	**Medical:**	**Surgical:**
	1	

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge and 1 WTE supernumerary co-ordinator qualified nurse included in the establishment.**

Medical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
First Floor	E			23.68	23.68	Yes	E			30.95	14.21	Yes	Yes	No		No	NA	
	L						L											
	LD	5	3				LD	5	3									
	TW						TW											
	N	5	2				N	5	2									
	E					Yes	E					Yes	NA	NA		NA	NA	
	L						L											
	LD						LD											
	TW						TW											
	N						N											

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

Summary Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 15th September 2022
Time: 13:15-13:45
Location: Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Vicky Morris	Independent Member and Quality, Safety & Performance Committee Chair	VM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Steve Ham	Chief Executive Officer	SHa
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Jacinta Abraham	Executive Medical Director	JA
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Nigel Downes	Interim Deputy Director of Nursing, Quality & Patient Experience	ND
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies:** • Alan Prosser, Director – Welsh Blood Service • Cath O'Brien, Chief Operating Officer • Peter Richardson, Head of Quality Assurance and Regulatory Compliance – Welsh Blood Service	
1.2.0	**In Attendance:** • David Mason-Hawes, Head of Digital Delivery *(for item 3.1.0)*	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were raised.	

1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The action log was reviewed in detail. The Secretariat is to make all required amendments / updates and circulate to members following the meeting.	**Secretariat**
2.0.0	**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).	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Private Quality, Safety and Performance Committee held on the 14th July 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The draft minutes of the Private Quality, Safety & Performance Committee held on the 14th July 2022 were **APPROVED** as an accurate reflection of proceedings.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Patient Nosocomial Transmission Review Update** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee received a detailed report outlining the status of the Trust's patient Nosocomial transmission investigations and the Nosocomial (COVID-19) Executive Panel Terms of Reference. The Committee **APPROVED** the Terms of Reference and **NOTED** the progress to date in respect of undertaking patient nosocomial reviews in line with national standards.	
3.0.0	**MAIN AGENDA**	
3.1.0	**Cyber Security Strategic Plan – Annual Report** Led by David Mason-Hawes, Head of Digital Delivery The Committee received the Cyber Security Strategic Plan Annual Report, providing the current position in relation to Trust Compliance against the National Cyber Security Centre (NCSC) Framework, in addition to the Strategic Delivery Plan. The following was highlighted: • The Trust continues to operate a safe and resilient cyber security service, seeking to further improve current compliance scores and achieve all objectives by the end of this financial year.	

	The Committee **APPROVED** the content of the Cyber Security Annual Report.	
3.2.0	**Trust Claims Report – Quarter 1** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee received the Quarter 1 Trust Claims Report. This provided an analysis of the claims being managed by the Trust as of 30th June 2022, an update on redress cases and associated learning, an overview of inquest activity together with strategic updates from the Welsh Risk Pool and NHS Wales Shared Services Partnership Legal and Risk Services. The Committee **DISCUSSED** and noted the Quarter 1 Claims, Redress and Inquest Report and no issues were raised.	
3.3.0	**Offsite Records Storage Incident *(Datix Ref: 4411)*** Led by Matthew Bunce, Executive Director of Finance The Committee received an update on the current position with regards to the offsite records storage incident (February 2022). A number of key areas were highlighted which included a summary of legal action taken against the named party, any communication plans required, specialist restoration and contract contract extension requirements and current Trust policy position preventing the destruction of records against backdrop of Infected Blood Inquiry and COVID-19 Inquiry. The Committee **NOTED** the Offsite Storage Incident and record of considerations and decisions made by the Executive Management Board on 1st September 2022.	
4.0.0	**Analysis of meeting outputs** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
	In terms of the Offsite Records Storage Incident, it was agreed to include an update on salient points, Executive decisions and the response received from the Information Commissioners' Office for reporting to Board.	**Secretariat**
5.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items for inclusion in the Highlight Report to the Trust Board: • **For Escalation** • **For Advising** • **For Assurance** • **For Information**	

	It was agreed that all agenda items would be reported to Trust Board under **ADVISE** or **ASSURE**.	
6.0.0	**ANY OTHER BUSINESS**	
	No other business was raised.	
7.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on **10th November 2022 from 13:15 – 13:45 via Microsoft Teams.**	
CLOSE		

Quality, Safety & Performance Committee

DIGITAL SERVICES OPERATIONAL REPORT

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	David Mason-Hawes, Head of Digital Delivery
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	Noted
VCC SLT Part 2	19/10/2022	Discussed

ACRONYMS	
ABUHB	Aneurin Bevan University Health Board
BAU	Business As Usual
CANISC	Cancer Information System Cymru
DHCR	Digital Health & Care Record
DHCW	Digital Health & Care Wales
PSBA	New Velindre Cancer Centre
nVCC	Public Sector Broadband Aggregation (NHS Wales network)
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service
WHAIS	Welsh Histocompatibility & Immunogenetics Services
WTAIL	Welsh Transplant & Immunogenetics Laboratory

1. SITUATION/BACKGROUND

1.1 This paper has been produced to inform and update the Quality, Safety & Performance Committee of key projects/programmes of work underway for Digital Services, this includes but is not limited to:

1.1.1 Digital Delivery & Programme Update.

1.1.2 Any significant IT business continuity incidents during the period June 2022 to September 2022 inclusive.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Digital Delivery & Programme Update

The table below outlines the key digital deliverables within the Trust IMTP 2022/23 Objectives:

Action	Timeframe
Velindre Cancer Centre IMTP	
Integrated Radiotherapy Solution – digital enablement	Digital enablement for LA6 refurb underway. Scrutiny approval for Digital Services IRS resources received, recruitment started.

Action	Timeframe
nVCC – digital enablement	Tender awarded to Acorn. Work ongoing to fully cost digital aspects of Full Business Case. Resource requirements are being worked through.
Maximise use of 'virtual consultations' (AttendAnywhere)	Awaiting confirmation of funding position. Meeting with SRO late-October 2022. Aim to re-commence project Q3 2022/23 (post-DHCR).
Digital Health & Care Record (Canisc Replacement)	Go-live planned for 14th November 2022.
Radiotherapy Satellite Centre – FBC development / digital infrastructure	Digital infrastructure designs complete – FBC approved by Trust Board. Awaiting WG feedback.
Patient Treatment Helpline – review system capability / possible redevelopment	Aim to commence re-platform of current system late-Q3 2022/23 – subject to confirmation of approach with Service Leads.
eMedicinesManagement (ePMA)	Business case to be developed by Dec 2022. Digital Pharmacist now in post.
Welsh Blood Service IMTP	
Deliver Welsh Histocompatibility and Immunogenetics Service (WHAIS) IT system for Welsh Transplantation and Immunogenetics Laboratory (WTAIL)	PIN issue February 2022. Supplier engagement sessions – March 2022. URS in development, aim to issue for procurement in Q3 2022. Business Case approved by Strategic Development Committee in mid-Oct 2022, for review/approval at Trust Board in November 2022.

Action	Timeframe
Laboratory Information Network Cymru (LINC)	Procurement completed, supporting design/build phase (tranche 2), as required. Wider all Wales discussions re: future governance / programme management arrangements for LINC taking place which may need updated plan.
Implementation of Foetal DNA typing	National project group established, implementation plan to be agreed.
Laboratory Modernisation Programme – digital support	Scoping to support development of Business Case ongoing.
Digital Services – Annual Plan	
Re-procurement of the Blood Establishment Computer System (ePROGESA)	New 2-year contract due to be agreed in October 2022, commencing 1st November 2022. ToR for BECS Procurement Project Group agreed via WBS SMT. First meeting to be planned for late-Oct / early-Nov. PIN to be issued before end of December 2022.
Implement ePROGESA Delta Release	ePROGESA delta release process re-started, as part of wider review of MAK / ePROGESA roadmap. Backlog review in progress, first delta release scheduled for delivery early 2023.
Implement eDRM (Donor Relationship Management)	Deferred (see 2.1.4)
Implement Transition State Labelling	Deferred until 2024/25. Deadline (UK timelines) for completion is end of 2024.
Chemocare Version 6 Upgrade	**COMPLETED** – October 2022

Action	Timeframe
Initiate Single Sign-on Pilot for Clinicians within Velindre Cancer Centre	On-hold, status to be reviewed post-DHCR.
Upgrade of VCC PSBA network infrastructure	**COMPLETED** – June 2022
Office 365 – increase adoption	New Microsoft agreement in place. Staff O365 licences re-distributed according to new licence plan for VUNHST. Office 365 project to be re-established post-DHCR.
DRIS – new IT system for Radiation Protection Service	Target go-live date deferred until Q4 2022/23, to resolve a number of outstanding user requirements.
Telephony Strategic Plan	New SIP circuits deployed into WBS. Aim to deploy new SIP circuits into VCC Q3 2022/23 – awaiting release of capital monies. Service engagement on new, Trust-wide telephony arrangements underway.
Review of printer estate / management	New approach for printer management agreed with Finance and Konica – budgets to be centralised and invoicing process simplified. Proposal for new 'managed service' for VUNHST printing services to be presented to EMB late-2022/23.

The following sections provides further detail for key number of key strategic and operational programmes of work:

2.1.1 Digital Health & Care Record (DHCR)

Digital Services resources continue to be prioritised towards the delivery of the DHCR (Canisc Replacement). Significant progress is now being made through User Acceptance Testing (UAT) and staff training. The go-live for this business-critical programme of work is 14th November 2022.

The prioritisation of this work programme has resulted in limited capacity within the Digital Services team to support some other programmes of work across the Trust.

2.1.2 nVCC

The digital / 'smart' aspirations of the nVCC programme are a key aspect of the design and delivery of the new cancer centre. The digital work stream of the nVCC programme has helped ensure the ongoing competitive dialogue and review of bids has progressed to plan.

Following confirmation of the preferred bidder – Acorn – the Digital Services team are now actively engaged with their project team to further refine the scope of the digital and IT infrastructure and associated services to be deployed into nVCC for the Full Business Case.

2.1.3 Integrated Radiotherapy Services (IRS)

Work is on schedule to ensure the digital infrastructure is deployed in support of the upgrade to the LA6 radiotherapy suite. The key enabling works are due to be completed in late-October.

A revised IT infrastructure design for the wider IRS programme has been provisionally agreed. The new approach seeks to deploy the required IT infrastructure via a secure, off-site data centre. The Digital Services team are working with the IRS Programme Team and the supplier to ensure the appropriate assurances are received in respect of the design and proposed 'business as usual' operations for the full IRS solution.

Recruitment to the Digital Services roles required to support the IRS programme is underway – it is anticipated that roles will be filled in early Q4 2022/23.

2.1.4 WBS Blood Establishment Computer System (BECS)

As reported in the July report, the roadmap for the WBS Blood Establishment Computer System (BECS) platform has been reviewed, in light of the planned 2-year extension to the current agreement. This is to be established to allow sufficient time for the Service to establish a new BECS contract via a formal, open procurement. The new 2-year agreement is due to be agreed in October, to

commence from 1st November 2022 until 31st October 2024. In order to minimise financial risk and ensure directorate resources are effectively utilised, work on the Electronic Donor Records Management (eDRM) module of ePROGESA is to be deferred, with organisational resources being refocussed on the delivery of a series of 3-4 'delta release' updates to ePROGESA over the next two years.

2.1.5 WTAIL LIMS

The Business Case for a new **Welsh Histocompatibility & Immunogenetics Service (WHAIS) IT system** is in development. The case was approved in the October meeting of the Strategic Development Committee, with a view to achieving final approval at the November meeting of the Trust Board. The case sets out a proposed approach to procure a commercial digital system, to replace the current 'end of life' in-house system current in use across the H&I laboratory within WTAIL.

Issues associated with a lack of equivalence across the Production and non-Production environments for the **Prometheus** application provided by Digital Health & Care Wales (DHCW) delayed go-live. DHCW have now completed the required remediation activity to ensure all environments are aligned. Revalidation of the system is due to start on Monday 24th October, with a target go-live of Sunday 6th November 2022.

2.1.6 System Developments

A number of key system enhancements have taken place over recent months, summarised below:

- In early October 2022, the **Chemocare** systems used across Velindre Cancer Centre was upgraded to version 6. The focus of the latest upgrade was to improve overall performance of the system, but other new functionality included improved response times, general system bug fixes and the correction of specific issues relating to dose banding and infusion rates.

- The **VCC PSBA network upgrade** was completed late-June 2022. The upgrade significantly improves network performance and overall resilience, providing faster connections and general performance of IT services that work across the VCC network, including the use of those services from home.

- Further updates were deployed into the **WBS 'ePROGESA' Blood Establishment Computer System (BECS)** in August. In the same month, a 'delta release' upgrade was deployed to the **WBS Appointments System**, enabling new functionality around appointment reminders and cancellations, the exporting of data for use in other systems, and reminders to help drive up the recruitment of Bone Marrow Volunteer donors.

- In September 2022, the Digital Services team supported the Business Intelligence team to deploy a **data collection tool** for the new **IO Toxicity service** in VCC.

2.1.7 **Capital Spend – 2022/2023**

Digital Services have committed their initial £50k discretionary capital allocation for 2022/23. A prioritised list of requirements has been developed, should further capital monies become available later in the year.

2.1.8 **ABHB Satellite Radiotherapy Site**

No change from previous report.

The Digital Services team have continued to support the design and costing of the ABUHB satellite centre, with the aim of submitting a business case to Welsh Government for funding. However, due to the national position in respect of the availability of capital monies into NHS Wales, this programme of work has been paused, to recommence in 2023/24.

2.1.9 **DIGIHWB @ Bobath**

In September 2022, the team started using a dedicated space within the former 'Bobath' building. The 'Digihwb' will be used as a dedicated place for deployment of new IT equipment to staff. In the future, it will also be used to support drop-in sessions to support staff in using their IT equipment, as well as lunch & learn sessions for specific topics – e.g. Office365.

2.2 Significant IT Business Continuity Incidents (June to September 2022 inclusive)

There was one significant IT business continuity incident in the period June to September 2022:

2.2.1 **10 June 2022 – Failure of Virtual Server Infrastructure**

Failure of virtual server infrastructure that support various VCC services, including Medical Physics, data warehouse, Chemocare, DMS and a number of IT infrastructure services. This failure was a similar incident to that experienced on 19th May 2022.

The incident lasted for approx. 3 hours – no patient harm was caused.

Since the incident, the Digital Services team have reconfigured the VMWare infrastructure, this is currently being tested by the Medical Physics team. Following completion of all testing, the new design will be made live and should remove the risk of any reoccurrence.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Capacity within the Digital Services team to support timescales for various Trust-wide projects may delay the realisation of the benefits of those programmes.
RELATED HEALTHCARE STANDARD	Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Work is ongoing to further develop the Digital Services resource plan, to enable sufficient capacity and skills within the team to move forward at greater pace with the delivery of the Trust's digital ambitions. This includes plans to secure further investment into Digital Services and related areas to enable sufficient capacity to take forward a number of priority programmes of work.

4. RECOMMENDATION

The Quality, Safety & Performance Committee are requested to **NOTE** the contents of this report.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	10/11/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director
REPORT PURPOSE	FOR NOTING

ACRONYMS	
CReSt	Cancer Research Strategy for Wales
H&CRW	Health and Care Research Wales
RD&I	Research, Development and Innovation
QSP	Quality, Safety and Performance Committee

1. PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the **Public** Meeting of the Research, Development and Innovation Sub-Committee on the 21/07/2022. Key highlights from the meeting are reported in Section 2.

The Quality, Safety and Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	**Robyn Davies, Head of Innovation** Congratulations and farewell wishes were given to Robyn Davies, Head of Innovation who was leaving the organisation on the 29th July 2022. A Legacy Report on all Innovation Activity has been provided prior to Robyn's departure. As an update, following the committee, the Head of Innovation Post was advertised shortly after, but no appointments were made at interview. Currently arrangements are in progress for a suitable secondment post for Head of Innovation for the Trust. **RD&I Sub-Committee Endorsed the Annual Report 2021/22** Key achievements highlighted in the Research, Development & Innovation (RD&I) Sub-Committee annual report for 2021/22 include: • The formation of a new sub-committee, with refreshed agenda and streamlined Trust RD&I Integrated Performance report • Despite the pandemic, our continuation to excel in research study recruitment • Several new key appointments • The establishment of the WBS component laboratory • Trust approval of the 10-year Velindre Cancer Research Ambitions
ASSURE	**TRUST Research, Development, and Innovation Performance Report 2021/2022** The first iteration of the RD&I Integrated Performance Report for Quarter 1 of Financial Year 2022/23 was received by the Sub Committee. The report reflects on the RD&I strategic priorities published in the Velindre University NHS Trust's Integrated Medium-Term Plan (IMTP) that has been updated for 2022 - 2025. The report includes the progress of work and key achievements for Q1 of FY2022/23 demonstrating activity against these strategic priority areas, the cross-cutting themes that support these areas and Trust RD&I corporate work. The Sub-Committee congratulated the RD&I Team on a tremendous effort in collating this Report.

INFORM	**FAKTION** Prof Rob Jones, Co-Chief Investigator of the Trust sponsored FAKTION trial presented the latest trial data to the Sub Committee. This data had also been presented by Prof Jones at the American Society of Clinical Oncology Conference held on 4th June 2022 and published simultaneously in Lancet Oncology. The data shows that Capivasertib gives a significant 19-month extension in overall survival in aromatase inhibitor-resistant ER-positive, HER-2 negative advanced breast cancer patients. The Sub Committee were pleased to receive the positive outcomes of this important study. **EXECUTIVE SUMMARY HIGHLIGHTS** The Executive Medical Director briefing reported high-level activities relating to Research, Development and Innovation that took place during quarter 1 of the financial year 2022/23. The following key highlights were reported : ➢ Welsh Blood Service ➢ Cancer Research Strategy for Wales (CReSt) ➢ Joint Executive Team Meeting ➢ University Designation Status ➢ University Designation Showcase Event ➢ Cardiff Cancer Research Hub ➢ One Site Wales ➢ MediWales Connects ➢ Moondance Cancer Awards ➢ Integrated Medium-Term Plan ➢ RD&I Internal Audit ➢ Radiotherapy Research **Cancer Research Strategy for Wales (CReSt)** The first-ever coordinated Cancer Research Strategy for Wales (CReSt), which will bring together the whole research community in the fight against cancer, was published on 6th July 2022. The strategy has been developed by Health and Care Research Wales (HCRW), the Wales Cancer Network (WCN), and the Wales Cancer Research Centre (WCRC), as well as representatives from VUNHST alongside health board partners, patients, members of the public and cancer researchers. Importantly, it also builds on key strategic advice received from a panel of external experts.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the **Public** Meeting of the Research, Development & Innovation Sub-Committee held on the 21/07/2022.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Hayley Harrison Jeffreys, Head of Infection Prevention and Control
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
INFECTION PREVENTION & CONTROL MANAGEMENT GROUP	28/09/2022	Content Agreed
EXECUTIVE MANAGEMENT BOARD	26/09/2022	NOTED

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Infection Prevention and Control Management Group during the meeting held on 28th September 2022.

2. BACKGROUND

The Trust's Infection Prevention & Control Management Group is chaired by the Executive Director of Nursing, Allied Health Professionals and Healthcare Science, and is attended by key personnel from both Divisions. The Group considers all national guidelines relating to Infection Prevention and Control (IPC), and all internal compliance and performance data regarding infection prevention and control standards. The Group reports to the Executive Management Board and the Quality, Safety and Performance Committee.

Prior to the COVID-19 Pandemic, the Group met on a quarterly basis, and during the Pandemic, the frequency increased to monthly meetings. The meetings are now being held on a bi-monthly basis. At the meeting it was agreed that meetings would revert back to quarterly given the levels of assurances received and enhanced divisional oversight arrangements. The Divisional Infection Prevention and Control Summit meetings provide additional oversight and assurance.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following are the Highlights from the Infection Prevention & Control Management Group meeting held on the 28th September 2022:

ESCALATE/ALERT	**Nil to be escalated.**
ADVISE	**Compliance with PPE measures:** ***Velindre Cancer Centre Training & Competency*:** It was noted that overall PPE and Fit Testing training and competency rates were anticipated to significantly decrease during October and November 2022. The group were assured that Managers have been asked to ensure that plans are in place to ensure that staff are updated and that they don't lapse. The training and compliance data will be

	scrutinized at the VCC Infection Control Meeting and reported back at the next Management Group meeting. ***Incidents and Risks:*** The group were advised of challenges gathering DATIX and risk information for learning and reporting, as currently the IPC Team do not have sight of all DATIX forms submitted relating to IPC and decontamination matters. Work at a Trust level has commenced to develop a notify box. Nationally, the All Wales DATIX group are commencing system development work from December 2022. In the interim, the Trust IPC Team are working with Trust Quality & Safety Team to identify key words, to ensure that IPC are linked in to relevant incidents and risks. Progress will be reported to the VCC and WBS IPC meetings.
ASSURE	***Healthcare Acquired Infections* (July - August 2022):** The detailed Trust surveillance report was received by the Group. The following key surveillance outcomes were noted: o There has been no Healthcare Acquired Gram negative, MSSA, MRSA, Klebsiella or Pseudomonas bacteremia. o No cases of C. *difficile* during July - August 2022. o Over 8 years since MRSA bacteraemia – last case December 2013. o One E. *coli* bacteraemia cases was reported in July - August 2022 from the outpatient population and was community acquired. ***Water Safety Report:*** The group were provided with a brief background of water sampling regimens for both pseudomonas and legionella and approximately 60 samples are taken per month. No positive legionella / pseudomonas samples on VCC site at present however 4 outlets are subject to a 6 week, post work testing regimen, before the can be assured as clear. A Water Safety Power Point Training content has been produced during a recent site visit by Hydrop. This has been endorsed by the WSG at the March meeting and it will be uploaded to the staff ESR in due course. Schematics of the cold and hot water systems on VCC site are now complete which will provide assistance with problem solving where outlets are fed from.

	A new Authorising Engineer for VUNSHT has been identified who is to be appointed by Director of Strategic Transformation, Planning and Digital. Until then Hydrops continue to provide contingency support. All actions with regard to the WS documents have been closed and the Trust WS Policy and Appendices are now available via the Velindre Intranet Page. ***Frequency of Meetings*:** The frequency of IPCMG meetings increased due to meet requirements of the pandemic and have been held between monthly and bi- monthly. Although the pandemic is not over and there is a tricky winter, it was agreed that given the levels of assurance now being receive and enhanced ownership, accountability & responsibility through monthly divisional IPC meetings return to quarterly meetings could now take place. It was agreed that, if required this frequency would be increased by the Group Chair.
INFORM	**IPC policies:** Three IPC related policies were approved by the group for submission for final approval to Executive Management Board and Quality, Safety & Performance Committee: • IPC00 – Infection Prevention and Control Framework – The Accountabilities and Responsibilities • IPC10 – Hand Hygiene Policy and Procedure • IPC 21 – Policy for the Management of Respiratory Infections Two further policies are currently under review and will be brought to the next Group for approval: • IPC13 CJD Policy • IPC 11 Transport of Specimens There are a further three IPC policies being reviewed nationally: • IPC03 Aseptic Non-Touch Technique • IPC05 National IPC Manual • IPC15 Control and Management of Multi Drug Resistant Bacteria The group agreed that the current policies would remain extant until updated. The group was informed that going forward IPC06 Management of Exposure and IPC09 Sharps Safety are going to sit under Health and Safety with input from IPCT. The revised policies will be ratified

	through Trust IPCMG and the Trust Health, Safety and Fire Management Board. ***IPC Audit tool:*** The group requested work to review what IPC electronic audit tool should be used by the Trust going forward. MEG (backed by the Infection Prevention Society) has been used to date. Suitability to use the Tendable audit tool to be explored so that staff all use one system and that triangulation can take place. Meetings with digital booked for early October and progress will feed back progress at next IPCMG. **NWSSP audit**: A report by HSIB – Healthcare Safety Investigation Branch Reports, was highlighted to the group, the report alerted several issues with sterile services provision, not directly linked to Wales. However the All Wales SSD Managers group discussed the common concerns which included, consistency of training, leadership, presentation of instruments and contingencies. Annual audits by NWSSP this year will focus on infrastructure, equipment and environments within sterile services. It was acknowledged that VCC doesn't have a sterile services department John Prendergast – Specialist Decontamination Engineer will visit theatre at VCC to review storage, transportation and traceability of sterile products.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Choose an item.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Infection Prevention & Control Management Group Highlight Report.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FREEDOM OF INFORMATION REQUESTS

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Julie Mann – Communication and Compliance Officer
PRESENTED BY	Lauren Fear – Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear – Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	(26/10/2022)	NOTED

ACRONYMS	
	• FOI – Freedom of Information • IG – Information Governance • QSP – Quality, Safety and Performance Committee • EMB – Executive Management Board • ICO – Information Commissioners Office

1. SITUATION/BACKGROUND

The purpose of this report is to provide assurance to the Quality, Safety and Performance Committee (QSP) in relation to the Trust's compliance with the requirements of the Freedom of Information Act 2000 and Environmental Information Regulations 2004 (known as the Act).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Key Points for the Committee:

1. Compliance with the timeliness of requests in 2022 has improved during 2022, the current figure at the end of Sept is 72% although this is still below the target figure of 80% set EMB. A period of leave and sickness during the April and May months having an impact on the overall figure to date.

2. The analysis of requests in 2022 continues to show the three most significant volumes on IT/digital requests (22 requests); drug treatment data from healthcare organisations (48 requests); and workforce requests (15 requests).

2.2 The Trust has a corporate responsibility under the Act to provide a general right of access to the Public to information held in the Trust's Information Management systems.

Specific requests for information not listed in the Trust's Publication Scheme or on the Trust website will be processed by the Trust's Communication and Compliance Officer specific responsibility for formulating responses rests with the Executive Team within each Division.

The Trust and/or respective Divisions must acknowledge a request within 2 working days and respond to any request within 20 working days. Where clarification of a request is needed, further reasonable details can be requested in order to identify and assist in locating the information.

The Trust reports its FOI data into a weekly report that is sent to Welsh Government in respect of the requests received by all Health Boards and Trusts in Wales.

2022 – Jan-Sept figures

The details below are compiled from data from Jan to Sept 2022, the Trust received a total of 143 requests, 139 FOI requests and 4 EIR requests. The figure increasing by 23 over

that received for the same period in 2021, our compliance has also increased from 58% in 2021 to 72% in 2022, as noted above a period of leave and sickness had an effect on the Trusts ability to respond to requests within the FOI timescales. As a result, for the period Jan – Sept 2022 the Trust failed to respond to **40 out of 143** completed requests within the 20 working day deadline.

ICO Decision Notices

The Trust has received three case references from the ICO advising that they had received complaints from requestors advising that they had not received a trust response to a request within a timely manner, the ICO instructed that the Trust had 10 working days to provide a full Trust response to all three of the requests. The Trust failed to comply with one notice within the 10 day timeframe. This resulted in the serving of a Decision Notice on 12 January 2022 which provided the Trust with 35 calendar days to provide a substantive response, the Trust responded to the decision notice and supplied a final response to the original requestor on 17th January 2022.

The Trust has complied with the ICO instructions on the remaining two notices within the 10-day timeframe.

Complaints and Reviews

If the requestor is not content with the reply or the processed by which the trust replied, they are advised in the response, and on website, that they can request a review by the Trist Information Governance Officer. If the requestor continues to be not content, they can refer to the Information Commissioner's Office.

During 2022, three requests were referred to an internal review stage all reviews were completed within the timeframe.

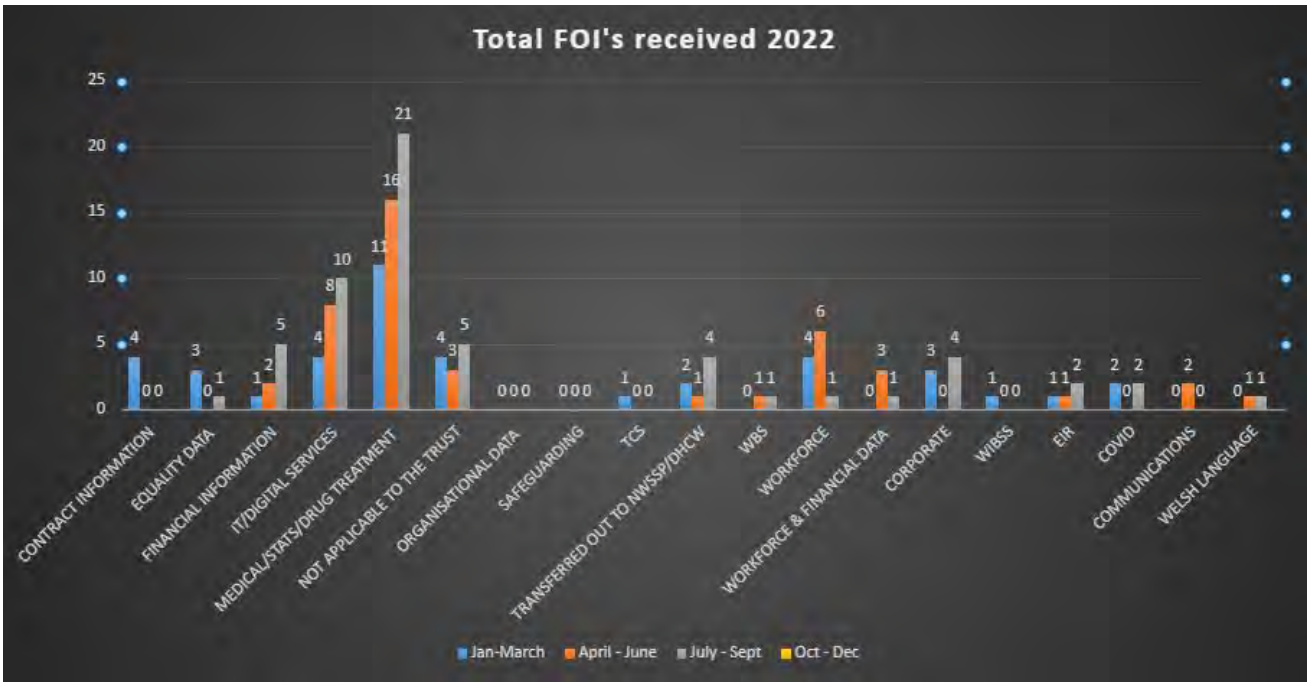
During 2021 the Trust received two requests for internal reviews of the original Trust response.

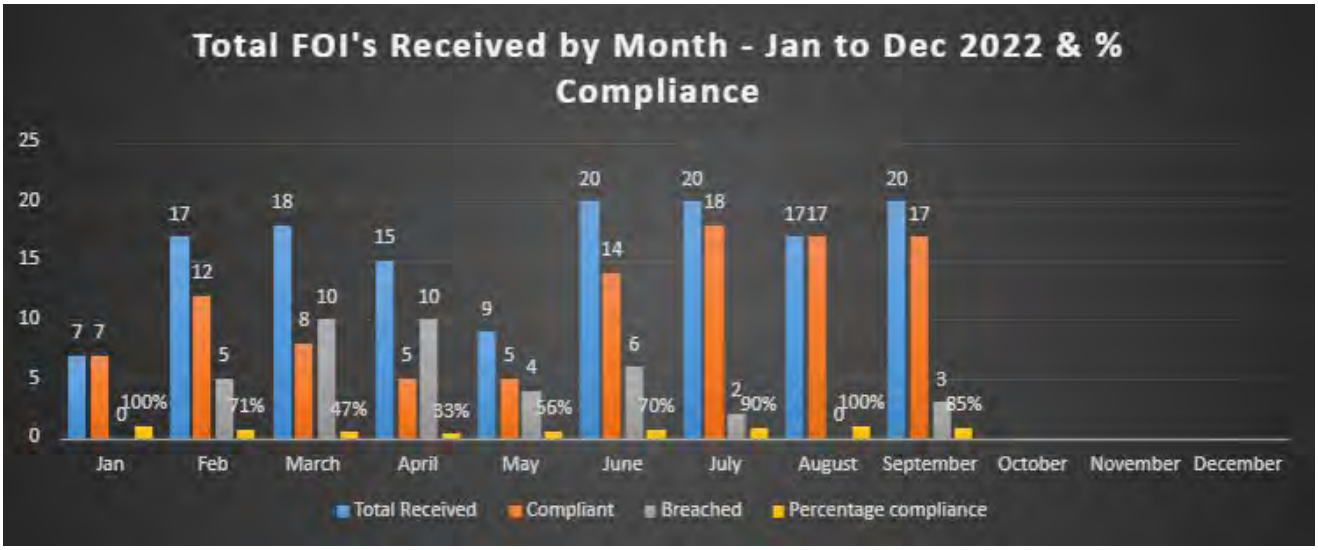
Website Publication

All 2022 FOI responses to date are published on the Trust Disclosure log.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

2022 FOI figures





Further Analysis of 2022 Requests

Drug Treatment FOI requests

We received 48 drug treatment FOI' from a variety of healthcare companies.

Workforce Information

We have received 15 WorkForce requests within the year, five of which were seeking information in relation to agency use and total spend within each agency.

IT & Digital Information

Of the 22 requests received, 8 were contract requests seeking renewal dates and costs of existing contracts.

We have also received 9 requests from the same organisation seeking different information in relation to how and if the Trust is wasting tax payers' money. To note, discussions are now underway to assess the application of further exemptions in this respect going forward, catered for in the Act.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Any financial impact will be captured in the detailed report relating to the Trust FOI's.

4. RECOMMENDATION

The Quality, Safety and Performance Committee are asked to **NOTE** the contents of this report.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
WG	Welsh Government
LHB	Local Health Board

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 18th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert/Escalation to the Quality, Safety & Performance Committee.
ADVISE	There were no items identified to Advise the Quality, Safety & Performance Committee.
ASSURE	The Sub-Committee **received** the TCS Programme Finance Report and the following key points were noted: • It is anticipated that of the £15m remaining in the capital budget, the full amount would be utilised in 2022/2023. • The statement that "Formal delegation of both budgets is pending" was queried. It was explained that this is due to the fact that the budgets are currently set aside in the reserves centrally and need to be transacted out into the TCS budget, which will be done prior to the next report. • Concern was raised regarding the virements between the Trust's discretionary and major capital programmes; with clarification sought on the risks to the Trust discretionary capital programme and overall capital delivery. It was explained that the main virement from the discretionary capital programme was to support the Integrated Radiotherapy Solution project costs, and that this would likely be returned to the Trust on approval of the Full Business Case. This has allowed the planning of the capital programme (major and discretionary for the remainder of 2022/2023). • The risks associated with the statement that "…any further slippage after this point will be managed by the Trust's capital programme or returned to Welsh Government with no reprovision" were queried. It was explained that this refers to WG requiring confirmation of the capital expenditure for 2022/2023 to enable effective national planning of the overall capital resources i.e. any capital underspends at LHB/Trust level across Wales that can be utilised nationally against priorities.

	• The potential underspend on the capital programme was queried, given that it had been earlier advised that the full amount would be utilised. It was explained that one of the restrictions is that as there is no "carry forward" facility – should there be any slippage the Trust would be expected to manage that by bringing forward schemes, then reproviding the capital back to the enabling works project in the new financial year. • Following a query on the allocation of the £15m capital for the enabling works and nVCC project, it was agreed that the report be updated to include the cashflow forecast for the next six months along with a simplified, easier to scrutinise format of the complex data contained within the report. The Sub-Committee **noted** the TCS Programme Finance Report. **Programme Director's Report** The Sub-Committee received the Programme Director's Report and noted the following key points: • IRS Contract Award – although this had not been achieved by the expected date it was understood that almost all conditions (delivery of an implementation plan, approval letters from four Local Health Boards) had been met. The Trust is awaiting approval from the Minister. • Risk Register - the persistent risks (272, 2408) were highlighted, and the Sub-Committee noted that these are expected to be reduced following discussions at the forthcoming Extraordinary Scrutiny Sub-Committee meeting. Clarification was sought on what effect waiting for the stocktake paper was having on the progress of these works. The Sub-Committee was assured that there would be no elevation to the risk as a result of the delay in receiving the paper. The Sub-Committee **noted** the Programme Director's Report.
INFORM	**Communications & Engagement** The Sub-Committee received an update and discussed the Community Engagement Events. The Chair extended his thanks to the team involved in what can often become a challenging environment. The Sub-Committee **noted** the Communications and Engagement update.

	RD&I Update The Sub-Committee received and noted the RD&I update which was a late distribution. The quality of the report was highlighted and it was agreed that it would be brought back to a future meeting of the Sub-Committee for a fuller discussion once members have had an opportunity to study the paper.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HEALTHCARE INSPECTORATE WALES ANNUAL REPORT 2021-2022

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A as Public Paper

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	NOTED

ACRONYMS	
HIW	Healthcare Inspectorate Wales
NWSSP	NHS Wales Shared Services Partnership
HEIW	Health Education Improvement Wales
PHW	Public Health Wales

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with the Healthcare Inspectorate Wales 2021-2022 Annual Report. The paper is provided for **NOTING**.

2. BACKGROUND

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of the NHS and regulator of independent healthcare in Wales. Its purpose is to check that people in Wales receive good quality healthcare. HIW through their work aim to:

- Provide assurance - Provide an independent view on the quality of care.
- Promote improvement - Encourage improvement through reporting and sharing of good practice.
- Influence policy and standards - Use what we find to influence policy, standards and practice.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Annual Report

The annual report provided. The elements specifically related to Velindre University NHS Trust are detailed on page 61. The report details:

''We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. COVID-19 remained the biggest risk to service delivery with staff absences, capacity reductions and increasing patient numbers impacting on the Trust's ability to reduce waiting times for treatment and services such as radiotherapy.

Attempts to undertake HIW assurance work at the Trust were hindered by an increase in infections in early 2022. This work will now take place in 2022-2023 and will provide us with a sense of how services are recovering from the pandemic.

We noted the efforts of the Welsh Blood Service to build and sustain blood stocks throughout the pandemic. We noted evidence of the organisation continuing to plan for future service requirements and monitored progress with the Transforming Cancer Service Programme.

We have seen transparent and constructive challenge taking place by independent members on all aspects of the Trust at committee meetings.

Engagement between HIW and the Executive team for the Trust remains positive and constructive, with a welcome for the scrutiny we are able to provide.''

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Choose an item.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Healthcare Inspectorate Wales 2021-2022 Annual Report and its key findings in relation to Velindre University NHS Trust.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales
Annual Report 2021-2022

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of the NHS and regulator of independent healthcare in Wales.

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Goal

To encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide assurance

Provide an independent view on the quality of care.

Promote improvement

Encourage improvement through reporting and sharing of good practice.

Influence policy and standards

Use what we find to influence policy, standards and practice.

Page 4

Foreword

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life

Page 7-12

Priority 1

To maximise the impact of our work to support improvement in healthcare

Page 15-62

Priority 2

To take action when standards are not met

NHS Health Boards and NHS Trusts

Page 64-65

Priority 3

To be more visible

Collaboration and joint working with other organisations is an integral part of the way in which we work

Page 66

Priority 4

To develop our people and our organisation to do the best job possible

Although the last year has been one of significant change, we have continued to invest in the development of HIW

Foreword

Alun Jones
Chief Executive

“I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.”

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life.

Healthcare services continued to be under intense pressure from the impact of the COVID-19 pandemic and our role has been crucial in supporting the delivery of safe healthcare for the people of Wales. Our core purpose of checking the quality and safety of healthcare services did not change, and we continued to adapt our processes and approach to work in response to the ongoing unprecedented situation.

The report sets out our key findings from the regulation, inspection and review of healthcare services in Wales. It outlines how we carried out our functions and the number of inspections and quality checks we undertook across Wales.

Change and flexibility have been key features of life since March 2020 and as an organisation we have learned much about how and where our work can add value to the healthcare improvement agenda. Through this report we will offer an insight into our work over the 12-month period, outlining how we adapted and used our resources most effectively to deliver our work and support improvement. This involved continuing with quality checks which we introduced earlier in the pandemic and enabled us to gain assurance remotely. We worked collaboratively with others to harness insight and understanding, building on lessons learnt. We also used new styles of reporting which enabled us to share our findings quickly to enable healthcare services to take improvement action more quickly.

In a year which has seen healthcare services work hard on recovery from the early days of the pandemic, to restore services which had been paused, whilst continuing to deal with emerging variants, outbreaks and further peaks of COVID-19, we have seen significant turbulence. I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.

Senior managers leading services have demonstrated tenacity and ability to continue innovating and supporting their organisations. Staff working on the front line have continued to demonstrate their compassion and resilience, as once again, patients have told us of their positive experiences of staff despite highly challenging circumstances.

It is clear that there remain many challenges ahead, for services, for the staff who work within them and for the people of Wales whilst the gargantuan task of service recovery continues. For healthcare organisations, it will be staff who will be the key to the success of this recovery. Supporting staff wellbeing, continuing to invest in training and support services for them and continuing to innovate within existing service delivery will be key to the effective recovery of staff and services from the fatigue brought on by the pandemic.

The year in question reflects a time when we worked on the commitments we made in our one year Strategy and Operational plan. We made good progress in meeting the achievements we set out to deliver. I am proud to have continued leading the organisation through this time, working daily alongside a team of professional and committed staff who work hard to support the organisation as we deliver our vision of improving healthcare for the people of Wales.

In March 2022, we published our new and ambitious strategy, and we are fully committed over the next three years, to implementing and delivering our new priorities which further our aim to drive improvement in healthcare.
We will continue to use our role to encourage improvement in healthcare, building on the best of what we have done to date to deliver the greatest impact.

If you have any questions, comments, ideas or feedback on our work, please do get in touch with us – we would love to hear from you.

Alun Jones
Chief Executive, Healthcare Inspectorate Wales

Overview

Our 2021-2022 Strategic Priorities:

1. To maximise the impact of our work to support improvement in healthcare
2. To take action when standards are not met
3. To be more visible
4. To develop our people and our organisation to do the best job possible

For HIW, as for many healthcare services and organisations, it was a year of continued and significant change, where we had to adapt to ensure that we continued to check that people in Wales were receiving good quality healthcare. We introduced new ways of working to ensure we discharged our statutory functions, whilst being as flexible and adaptable as possible to ensure we did not add undue burden to a system already under significant pressure following the COVID-19 pandemic.

We continued with a full range of assurance and inspection activities, building on our enhanced ways of working, allowing us take action where standards were not met but to also support a broader recovery of healthcare services. During the year, we kept our activity under regular review to ensure that we targeted our resources most effectively. We operated responsively, with our work underpinned by our strategic priorities. This report describes our progress against these priorities as we aim to drive improvement and promote quality in healthcare services across Wales.

To maximise the impact of our work to support improvement in healthcare

HIW has an ongoing programme of national and local reviews which helps us to evaluate how healthcare services in Wales are delivered.

Local reviews are pieces of work which explore an aspect of one organisation or region, whilst **national reviews** explore healthcare services across Wales.

National and Local Reviews

COVID-19 National Review - How healthcare services across Wales met the needs of people and maintained their safety during the pandemic

The purpose of our COVID-19 review was to understand how healthcare services across Wales met the needs of people and maintained their safety during the pandemic. We also considered how services managed their environments of care, infection prevention and control measures, and how the physical and mental well-being of staff was supported.

A key theme to have emerged from our review was the need for healthcare services to further strengthen their infection prevention and control arrangements to mitigate the risk of cross infection or further outbreaks of COVID-19. In addition, the arrangements for supporting and maintaining the physical and mental well-being of staff required attention and focus as healthcare services continued through the recovery phase of the pandemic. However, in general, our review found the quality of care being provided across Wales was good and was delivered by hugely committed and dedicated groups of staff.

National Review of Mental Health Crisis Prevention in the Community

The focus of our review was to understand the adequacy of the measures in place across Wales, to help mental health crisis being prevented in the community, through timely and appropriate care. We considered the experiences of people who accessed care and treatment to support their mental health and prevent crisis. In addition, whether the services provided were safe and effective, and how healthcare teams worked collaboratively throughout the community to help prevent mental health crisis. Furthermore, we explored how third sector organisations support this.

Our review found challenges across Wales inhibiting the ability of people to access timely support for their mental health, which could increase the risk to their safety (or to others) and may result in hospital admission.

Key findings included inefficiencies in process, particularly for direct referrals where patients were caught in a cycle of continually accessing GP services to re-commence the referral process. This resulted in individuals experiencing lengthy waiting times and a lack of support for their mental health. HIW's review urged health boards to consider how they can address this gap in provision, strengthening the engagement between GPs and other primary and community care services and secondary mental health services. The review did find healthcare staff were committed and dedicated to providing support and care to people with mental health needs.

HIW noted several positive initiatives across Wales, including the implementation of a single point of access. Where this was in place, it ensured that specialist mental health professionals were available to provide clinical triage, onward referral, and effective signposting to individuals in crisis. HIW made a recommendation that health boards must ensure that single point of access services are implemented across Wales and are accessible to all those experiencing mental health crisis.

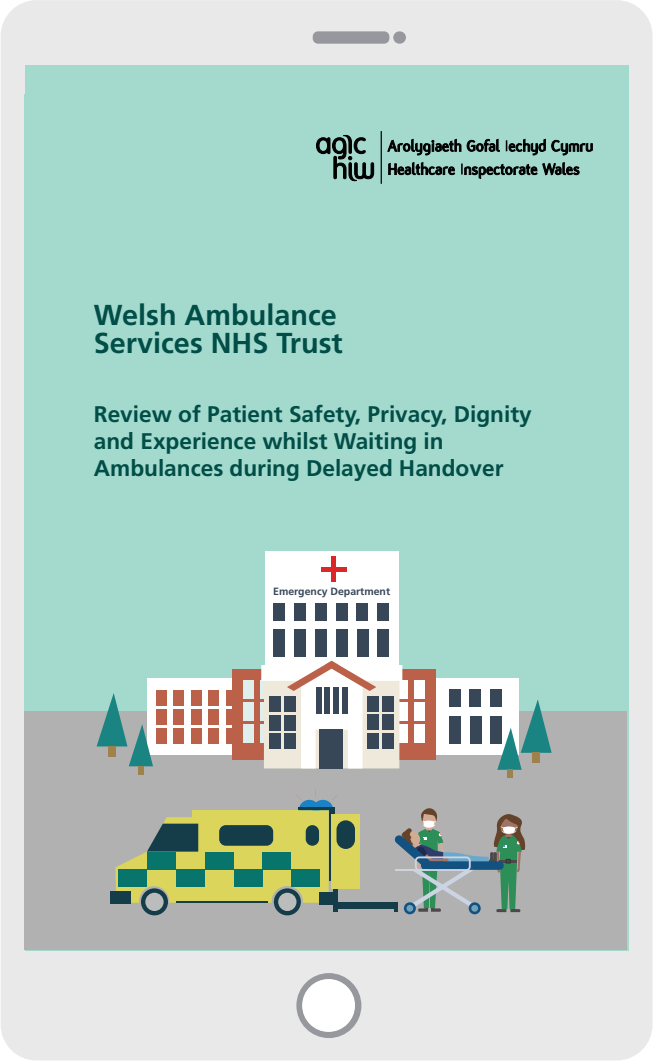
Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances During Delayed Handover

Our review found that the issue of prolonged handover delays is a regular occurrence with ambulance wait times outside Emergency Departments (EDs) across Wales. The delays and variations in process between and within health boards was having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, and dignified care to patients.

Whilst there are expectations and guidance for NHS Wales to follow, and a clear will to meet these guidelines, there are substantial challenges to achieve timely patient handover across Wales which inhibit efforts to consistently achieve these. The challenges are indicative of the wider patient flow issues across all hospitals. Our review team found some inconsistencies and a lack of clarity between the Welsh Ambulance Services NHS Trust (WAST) and ED staff about responsibility for patient care, until transfer of care to health board teams. These types of inconsistencies were increasing risk and having a detrimental impact on patient care and safety.

Patients were generally positive about their experiences and provided good feedback about ambulance crews and ED staff, however, this should not detract from the issues associated with delayed handover.

A significant amount of work is already underway across NHS Wales to tackle these issues. Progress has been made in some areas, and improvement work is ongoing between WAST, health boards and Welsh Government to meet these challenges.

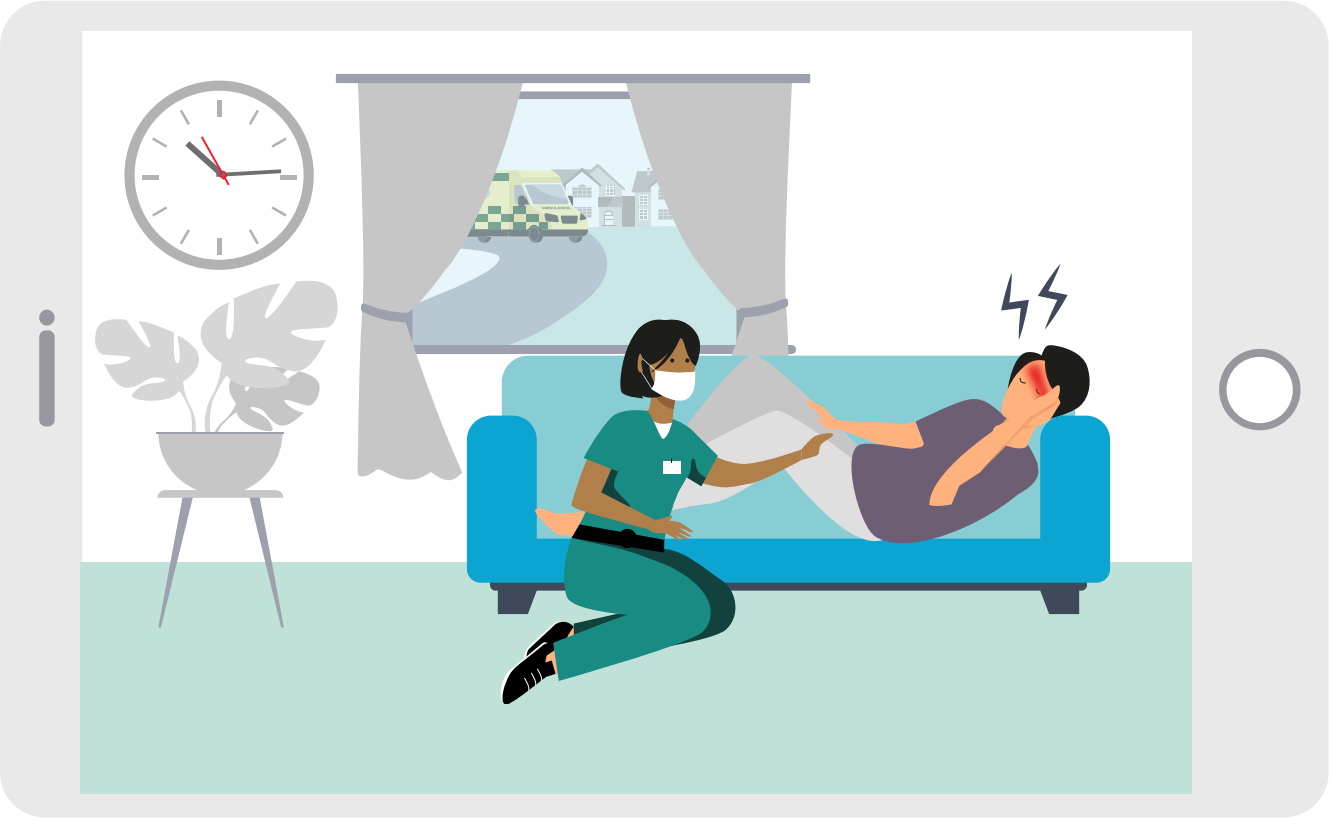


Current Ongoing Reviews

National Review of Patient Flow (Stroke Pathway)

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. As a result, we decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

The planning of the review commenced in autumn 2021, and the field work began in March 2022. Throughout our review we will consider how NHS Wales addresses peoples' access to acute care at the right time and if care is received in the right place, by people with the right skills, through to timely discharge from hospital services. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. We aim to publish the review report during winter 2022–2023.



Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We made the decision to undertake this review following our assessment of a range of information sources which indicated significant concerns around mental health services within Cwm Taf Morgannwg University Health Board (CTMUHB). We commenced the review in January 2022 which will progress into late summer and the report will be published later in 2022. The focus of the review is to explore the quality and safety of discharge arrangements of adult patients from inpatient mental health units, back into the community.

Local Review of the Quality Governance Arrangements in Place within Swansea Bay University Health Board (SBUHB) for the delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea

We decided to undertake a review of the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea.

The review assessed the actions taken by the health board to address the issues highlighted following previous inspections by Her Majesty's Inspectorate of Prisons, which we contributed to, and how effective the health board's quality governance arrangements are regarding prison healthcare. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea.

We identified a need to strengthen these arrangements and raise the profile of prison healthcare within the health board to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively. The review report details our findings and recommendations for improvement within several areas of the health board and Prison Partnership Board.

HIW recommended that prison healthcare, including the quality of the service, needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.
HIW asked the health board and Prison Partnership Board to carefully consider the findings from this review and act upon the recommendations set out within the report.

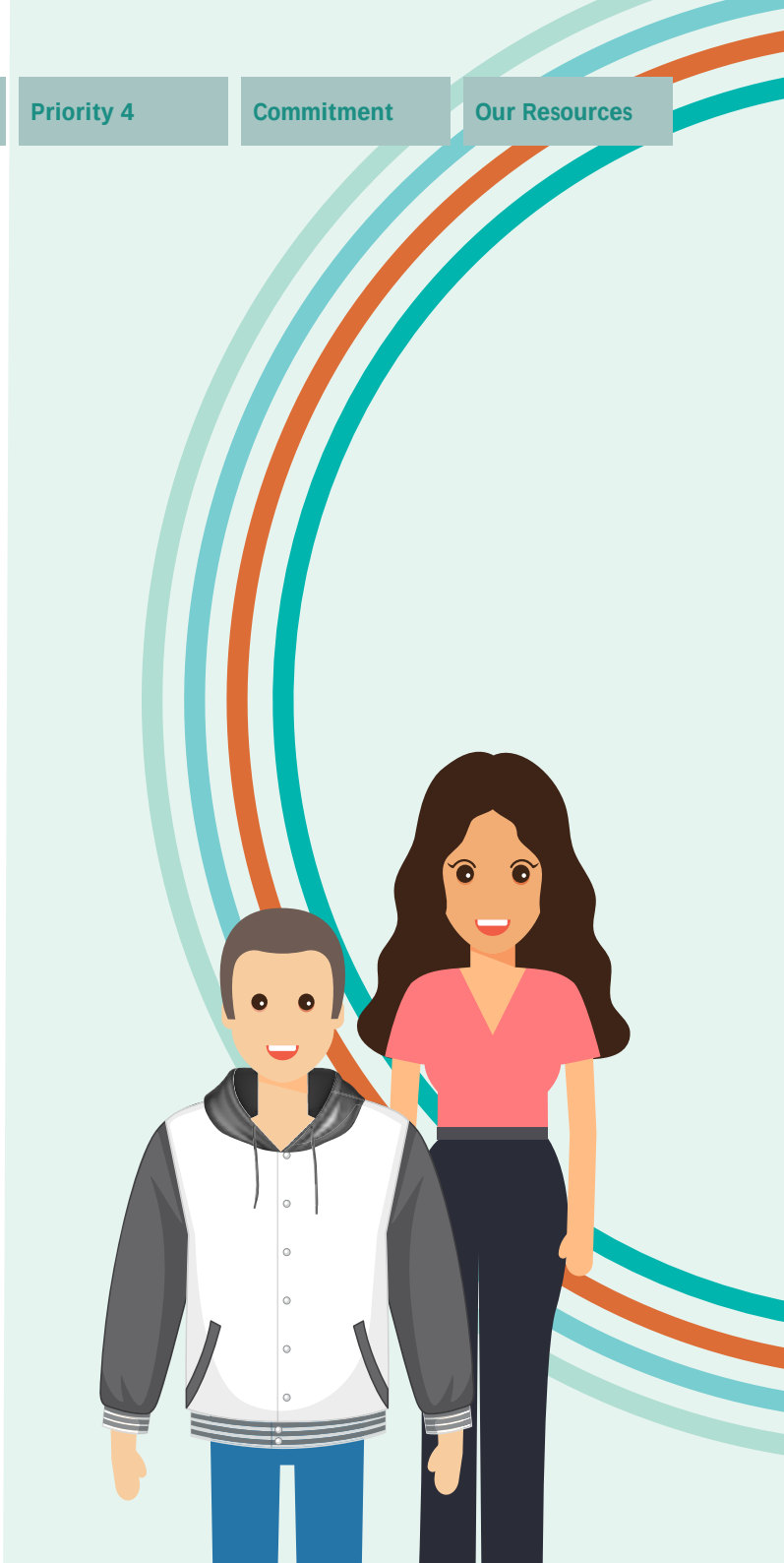
HIW continue to work with the health board to ensure improvements are made in a timely manner and will monitor the progress made. The report was circulated to other health boards to share lessons learnt, and to consider the findings against their own quality governance arrangements.

Joint Inspection of Child Protection Arrangements (JICPA)

During 2021, we worked jointly with four other inspectorates on a second pilot review of child protection arrangements. The review was undertaken in the Neath Port Talbot local authority which is situated within Swansea Bay University Health Board. It was led by Care Inspectorate Wales (CIW), and included HIW, Estyn, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation.

The focus of the review was to explore the arrangements in place for the multi-agency response to children at risk of criminal and sexual exploitation. On completion of the review, we identified several key strengths across the multi-agency partnership in relation to processes, structures and relationships which helped to facilitate effective partnership working where a child was at risk of exploitation. We also identified areas for improvement throughout the review, which included the need to strengthen contextual safeguarding, and the need to reduce the waiting times for Children and Adolescent Mental Health Services (CAMHS) assessment following referral.

In the last quarter of 2021-2022, HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue the JICPA work, to enable us to review processes within a further four local authorities across Wales. As part of the plan, we would complete work in six further local authorities and evaluate all JICPA reviews undertaken to produce a national report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023.



To take action when standards are not met

We are responsible for inspecting, reviewing, and investigating NHS services and independent healthcare services throughout Wales. We inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. When through our work we find this is not the case, we will take action so that health boards and their services know where they need to make improvements.

Service of Concern process introduced for NHS Bodies in Wales

One of the key priorities set out within our strategic plan was to take action when standards are not met. In line with this priority and wishing to increase transparency about how we discharge our role in providing assurance to the public regarding the quality and safety of healthcare services, we introduced a Service of Concern process for the NHS in November 2021.

This process is used when we identify significant service failures, or when there is an accumulation of concerns about a service or setting. The intention of the process is to support improvement and learning, both for the service in question, and across NHS services more broadly. Our escalation and enforcement process for independent healthcare currently utilises such a process.

The process may lead us to make a Service Requiring Significant Improvement designation. This enables us to plan and deliver future activities necessary to gain assurance about the quality and safety of care by a service. We then work with the health board and services to ensure improvements and effective actions are made in a timely manner. We will then consider and review whether the service can be de-escalated and removed from the process.

This process enables a range of stakeholders including health boards to take the rapid action necessary to ensure safe and effective care can be provided to people. The Service of Concern process has strengthened the action we take to drive improvement when services fall significantly short of the required standard. Examples of our use of this process are outlined later within this report.

Use of HIW's legal powers

In February 2022 following a criminal investigation relating to an unregistered service, HIW issued a caution for a breach of section 11 of the Care Standards Act 2000.

As the regulator of independent healthcare services in Wales, HIW is committed to taking action when standards are not met. In order to ensure that patients receive safe effective care the use of legal powers on this occasion highlights how HIW will take action when a healthcare provider does not comply with the regulatory requirements.

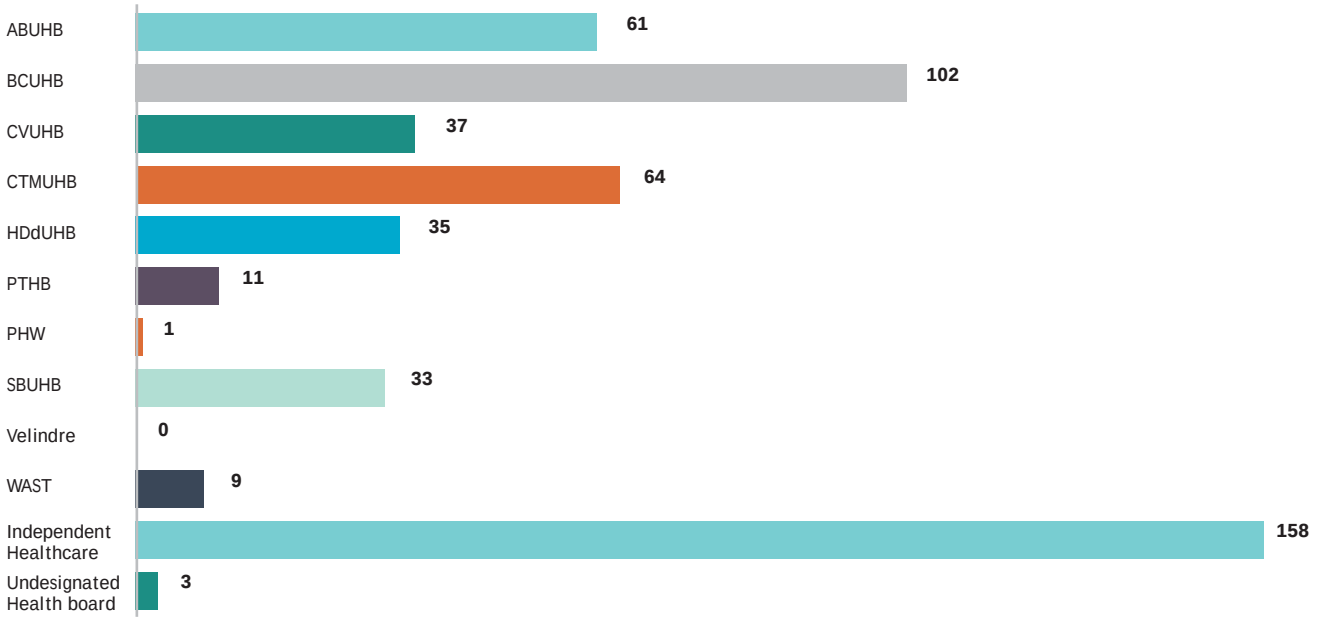
Concerns

The concerns we receive continue to be an invaluable source of intelligence to the organisation and their importance cannot be underestimated. Some of the onsite inspection work we undertook during 2021-2022 was as a direct result of concerns that had been raised with us. In addition to the evidence we have gathered directly from our inspection and Quality Check activity, we have also sought assurance from healthcare organisations in relation to concerns received.

In total, we received 514 concerns from April 2021 to March 2022. This represents an increase of eighty compared to the previous year. Of note, however, is that HIW is seeing a sustained increase in numbers of concerns being raised since the start of the COVID-19 pandemic.

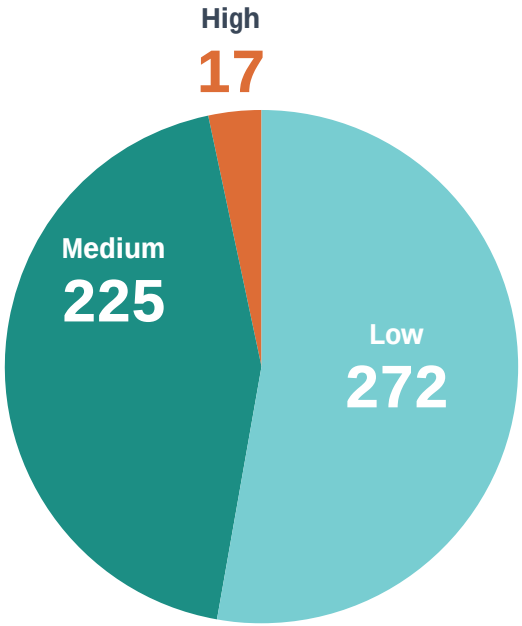
We have seen a **40% increase** in the number of concerns being raised since the 2019-2020 year.

Location of concerns



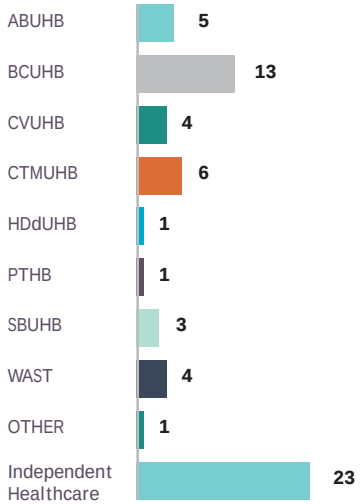
Concerns, Whistleblowing and Safeguarding

Risk levels of concerns received



- High-risk concerns require immediate action and response within 2 working days, either by HIW or other agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by way of signposting towards Putting Things Right or the respective local complaints process for independent health providers and responses should be actioned within 7 working days.

Whistleblowing Concerns



Whistleblowing Concerns

25 received for **2019-2020**

100 received for **2020-2021**

61 received for **2021-2022**

In total, we received 17 high risk concerns in 2021-2022. All high-risk concerns were evaluated, actioned and escalated and assurances requested from health boards / trusts or independent healthcare settings. Where appropriate we also contacted the local safeguarding team and shared any safeguarding concerns that we may have identified. At times we have also had to share information with the emergency services such as the police due to the nature of concerns raised or due to concerns over a person's well-being.

Concerns were received from a range of individuals including, patients, their families, friends, staff, and allied health professionals. It is important to note that of 61 concerns received from whistle-blowers, 37 were in relation to NHS health boards / trusts and 24 were in relation to independent healthcare settings. Common themes identified from concerns received were mainly in relation to two key areas. The first group of concerns were in relation to clinical assessments and treatment. The second group of concerns related to infrastructure, staffing, and facilities.

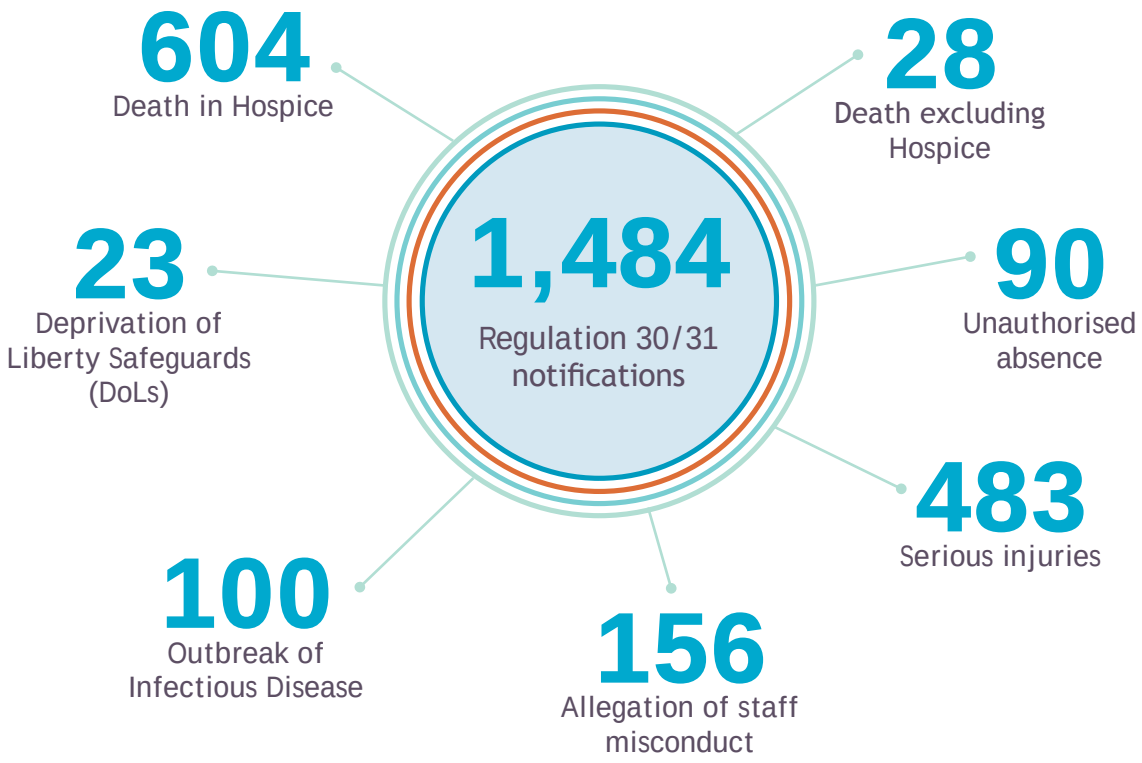
In total we received 404 safeguarding referrals from local authorities.

Local authorities and the police are the statutory lead for all safeguarding referrals and the final decision on action is made by them. HIW is invited to initial strategy meetings where we can have an input into any potential actions that are taken. We also review all referrals that are submitted, and the information is shared internally with relationship managers for intelligence. Relationship managers are the first point of contact for HIW staff and health boards/ trusts. They also take the lead in determining the inspection and assurance activity within each health board. If there is a need for further action, we write out to the health boards / trusts or independent healthcare setting and request assurance or a regulatory notification where applicable.

Regulatory Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications is as follows:



This is a **36% increase** in the number of notifications we received, compared to 2020-2021. The number of serious injuries reported within independent healthcare services has increased significantly by **72%** over the last year.

During 2021-2022 we received 156 Regulation 25 notifications (The Private Dentistry (Wales) Regulations 2017).

They are as follows:

All notifications are reviewed by a case manager when they are submitted and then reviewed weekly by the Investigation team. For every notification submitted we request follow up information to provide reassurance that the incident has been handled appropriately and that the setting has attempted to mitigate the risk of similar incidents happening again. When similar themes are noted, we refer the information to the enforcement team and the escalation and enforcement pathway starts.

Death in Custody Reviews

It is the responsibility of the Prisons and Probation Ombudsman (PPO) to undertake an investigation of every death that occurs in a prison or approved premises in Wales. HIW supports these investigations by undertaking a clinical review of all deaths within a Welsh prison or approved premises. This collaboration has been formally outlined within a Memorandum of Understanding between the PPO and HIW. A link to the agreement can be found on our website.

The purpose of our clinical reviews is to critically examine and evaluate the quality of healthcare services provided to prisoners during their time within a prison or approved premises.

From 1 April 2021 to 31 March 2022, we were commissioned by the PPO to undertake 15 clinical reviews. This is one less compared to 2020-2021. These clinical reviews were conducted at four out of the six prisons located in Wales. No clinical reviews were undertaken in relation to HMP Prescoed or HMP Usk.

The table below identifies the number of reviews and their locations:

Location	Total
HMP Parc	7
HMP Berwyn	2
HMP Cardiff	5
HMP Swansea	1

Overall, our death in custody reviews highlighted that the care provided to prisoners in Wales was equitable with the expected level of care a person in the community would receive. Access to GPs, nursing staff and allied health professionals was deemed sufficient in the vast majority of our reviews.

In all of our clinical reviews we identified the need for improvement and highlighted good practice. There were two key areas highlighted for improvement, these were the need to ensure comprehensive and detailed documentation was completed for all patients and improvement in relation to the timely undertaking of investigations such as blood tests and x-rays.

Good record keeping is a fundamental part of delivering safe and effective patient care. An accurate documented record that details all aspects of the patient's care and treatment is fundamental as it contributes to the dissemination of information amongst different care practitioners involved in the patient's treatment or care. A specific area of documentation that was identified as needing improvement was the recording of physical observations as part of patient assessments. These observations provide a significant insight into a patient's state of health and can alert practitioners to the clinical deterioration of an individual.

It was acknowledged that on some occasions, delays were experienced by prisoners in obtaining blood tests and x-rays. Numerous factors were identified which can impact on the timeliness of these investigations being undertaken, such as transport and the availability of specific staff. In addition, vulnerabilities were identified in alerting healthcare staff when a prisoner had not attended an appointment. The importance of recognising these missed appointments need to be clearly embedded in policies and procedures and escalated accordingly to ensure individuals receive the required investigations.

Our clinical reviews highlighted that healthcare professionals working in prisons were motivated, dedicated and committed. Evidence showed that staff endeavoured to provide high levels of holistic care and treatment to their patients. HIW's findings following a review into the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea did provide a differing perspective. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the prison population. We identified a need to raise the profile of prison healthcare within the health board to ensure that the quality healthcare is designed, delivered, and monitored effectively. HIW recommended that prison healthcare needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.

NHS Assurance and Inspection Findings

We continued to deliver a blended approach to assurance and inspection via onsite inspections and remote Quality Checks. There was ongoing work to develop and enhance current methodologies, which are the tools used to undertake inspection and assurance work. All methodologies continued to include a specific focus on COVID-19.

Hospitals

COVID-19 continued to impact the way in which we inspected and sought assurance of NHS hospitals throughout 2021-2022. During Winter 2021, rates of COVID-19 transmission continued to increase, including the emergence of the Omicron variant. It was important that we took a cautious approach to reduce burden on the services most affected. We therefore cancelled all routine NHS onsite inspection work throughout December and January. We still undertook onsite inspection work where we considered there to be a high risk to patient safety as a result of specific issues that we were aware of and was not possible to gain assurance remotely. All other work during this period we conducted remotely. In February 2022, we resumed all our routine NHS onsite inspections following the move to alert level 0 across Wales and the general decreasing trend in rates of COVID-19. We provided 24 hours' notice for inspections to elective, scheduled care areas where the flow of patients is planned, and COVID-19 precautions are structured around patients who are being admitted for planned surgery, or where there are patients with compromised immunity due to the treatment they are receiving and in maternity services. This allowed our inspection teams to communicate with NHS staff and for arrangements to be put in place so that the inspection could be undertaken safely. We continued to conduct unannounced inspections (no notice provided) of clinical areas within unscheduled care areas.

During this period, we undertook:

Of the eight onsite inspections we completed, two of those were categorised as a 'green' pathway[1].

Our onsite inspections and Quality Checks covered a variety of different types of hospital wards including emergency departments, maternity, oncology, cardiac, paediatric units, step down facilities and one minor injury unit.

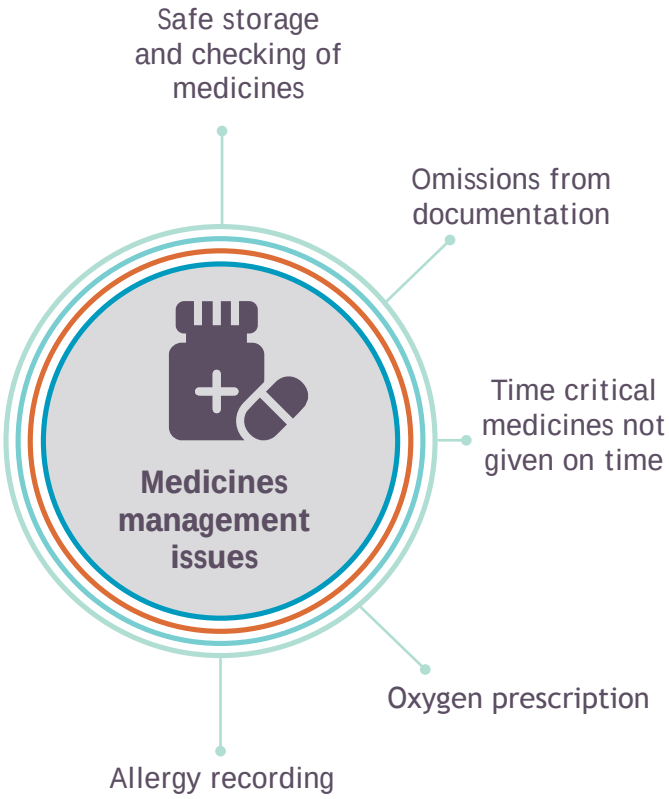
It was clear, from work carried out throughout the year, that there was significant and sustained pressure on the emergency care system, and that this directly impacted patient care. Through our inspection and assurance work we identified a clear difference between scheduled and unscheduled care. We identified many more areas requiring improvement within unscheduled care compared to scheduled care. In particular, scheduled care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care had fewer areas for improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

[1]The Green Pathway is the term given to COVID-free areas of a hospital. Within the pathway there are specific pathways such as surgical pathways. Measures taken can include patients being assessed as having no current risk of COVID and patients booked for surgery may be asked to self-isolate in their homes.

Medicines management continues to be a concern for HIW, as we identified issues across all of our hospital inspections in relation to:



Through our work we experience many clinical areas. We encounter patients who receive their care within and from services, and when visiting is possible, we also meet relatives, carers and others involved in their lives away from healthcare. We also encounter the staff working within services day to day; therapy staff whose work takes them to departments to support with specific issues, housekeeping staff whose input supports the smooth running of departments, and managers and senior leaders who provide the governance and leadership that is needed daily to ensure services achieve and maintain standards, and where necessary, improve. We have observed services at times of significant pressure, and the staff within them working relentlessly to deliver care. We have seen services at times when pressure is not significant, but staff still working hard to deliver care. We acknowledge the challenge and stress that sustained high pressure can cause. The case studies below demonstrate the way in which we continued to focus on patient safety in 2021-2022, challenging services and health boards to look for different ways of doing things when outcomes for patients could be improved.

Case Study – Inspection of the Emergency Department, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board

In the following case study, we have focussed on the findings and outcome of an inspection we carried out of the Emergency Department (ED) in Prince Charles Hospital. This example of our work illustrates a department working under significant pressures leading to issues with patient safety. What happened next was an example of a health board working responsively and constructively to tackle the issues our work highlighted. By responding in this way, early progress was made in improving patient safety and outcomes for patients.

During our inspection in September 2021, we found that the ED, as the front door to a wider healthcare system, was experiencing a period of heightened pressure due to high demand on services. Patient flow throughout the hospital was clearly an issue.

We acknowledged that this was a very challenging and stressful environment for staff, who continued to work above and beyond in exceptional and challenging conditions.

The inspection revealed extensive issues in relation to patient safety, meaning that we could not be assured that patients in attendance at the ED were receiving safe care. These concerns related to inadequate infection prevention and control arrangements, ineffective arrangements for the segregation of COVID-19 patients, inappropriate or incorrect usage of Personal Protective Equipment, and numerous environmental factors impacting on the ability of staff to provide safe and dignified care. The department and GP assessment unit were significantly overcrowded to a level where this affected patients' dignity and safety. The paediatric area was not sufficiently staffed, and the environment was not conducive to safe and dignified care. Patients were not always monitored at a frequency which would identify deterioration and changes in their condition. Our discussions with staff also revealed concerns about their well-being, due to the environment that they were working within.

We used our Immediate Assurance process, where we formally write to a health board immediately after the inspection, to outline the urgent remedial actions that were needed to ensure patient safety. Our full inspection report identified the longer-term improvements that were required.

Key staff at the health board were positive in their response to our feedback, and in our subsequent engagement, with a clear commitment to addressing the issues highlighted. The health board's responses included a comprehensive set of actions, with much progress already made at the time our report was published.

Due to the significance of the issues found in the inspection, we undertook a follow-up inspection in January 2022.

At the time of the follow-up inspection, we found that the ED continued to experience a period of heightened pressure due to high demand on services. Once again, we acknowledged that this remained a very challenging and stressful environment for some staff, who continued to work above and beyond in exceptional and challenging conditions. Whilst some areas still needed attention, there were no urgent patient safety issues.

There was a clear commitment to addressing the issues highlighted in the initial inspection and we found that the health board had made significant progress in addressing most of the improvements raised in a sustainable way, rather than quick fixes to issues which cannot be maintained. The rapid and positive outcome achieved within this example is of note, with this being achieved through a constructive and supportive style adopted by senior leaders in supporting staff in the department. Staff felt there was a shared responsibility for improvement. Our work provided an insight into challenges at the department, and this will support the health board in continuing to improve delivery of care provided by the ED. The outcome of our work and the effort from the health board was improved patient safety in the department.

Case Study – Enhanced Quality Check Ysbyty Glan Clwyd, Betsi Cadwaladr University Heath Board

In May 2022, we identified the Emergency Department (ED) at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as a Service Requiring Significant Improvement.

This designation was based on an accumulation of evidence where HIW identified specific risks following a No Surprises Notification in January 2022, concerning potential unsafe discharge from the ED. A patient was unfortunately found deceased after discharge. Following insufficient assurances from the health board in response to HIW's initial correspondence, HIW undertook an in-depth review of the case notes of the patient involved. This review highlighted a number of concerns and significant patient safety concerns. This was fed back to the health board and assurance and actions were provided to HIW that safe care and treatment was being provided at this time.

HIW subsequently completed an enhanced Quality Check of the department in March 2022. Quality Checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas: infection prevention and control, governance (specifically around staffing) and the environment of care.

Due to the issues noted in January 2022, we expanded our usual methodology to seek assurance on how the health board ensures patients are cared for, and discharged, safely.

Our work identified numerous patient safety issues. We issued an Immediate Assurance letter, where we write to the health board immediately after the Quality Check, outlining urgent remedial actions to ensure patient safety.

Whilst the health board responded positively with a detailed action plan, the severity of the issues identified led HIW to remain concerned about wider patient safety at the department. Consequently, we undertook a full onsite inspection in May 2022 to inspect the full environment of care, and ensure the actions set out in the health board's response to the March Quality Check were completed and sustained.

Our onsite inspection identified further significant patient safety issues. We also identified areas where the health board's actions in response to the March Quality Check had been ineffective. We escalated our concerns to senior staff at the health board during the inspection, as well as at our standard feedback meeting at the end of the inspection. We received verbal assurances from the health board on actions that would ensure patient safety, and we issued a further Immediate Assurance letter on 9 May 2022.

Having considered the findings and evidence gathered since January 2022, HIW determined that the health board had not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care, with particular concern regarding the poor standard of nursing documentation. Our May 2022 onsite inspection highlighted that the health board had not demonstrated improvement to an acceptable standard in response to the Immediate Assurance issues identified during the March 2022 Quality Check. Furthermore, the May 2022 inspection identified several additional areas of concern relating to patient safety. As a result, we were concerned there was a risk to the safety of patients seeking care at the Emergency Department in Ysbyty Glan Clwyd.

The designation of Ysbyty Glan Clwyd Emergency Department as a Service Requiring Significant Improvement enabled HIW to plan and deliver any future activities necessary to gain assurance about the quality and safety of care in the service. This process considers the timing of any follow up activity, to enable HIW to decide whether the service can be de-escalated and removed from this process.

General Practice

We continued to use Quality Checks to seek assurance on the quality of care being provided by GP practices during 2021-2022. Our Quality Checks continued with a specific focus on COVID-19. During this period, we undertook 25 Quality Checks of GP practices across health boards in Wales.

It was positive to note from our assurance work that there was good evidence of GP practices using their membership of a cluster[2] to support the provision of patient care and sharing of ideas and good practice between GP practices. We noted that most GP practices had made significant changes to their practice environments to ensure that they were safe for patients and could be easily cleaned in response to the challenges of the COVID-19 pandemic.

However, it was disappointing to discover that at some GP practices there was a lack of cleaning policies and full cleaning schedules. We also noted a lack of completed risk assessments at some practices for home visits, practice staff and the environment. Policies and risk assessments are management tools which help to ensure that all staff are aware of what is expected of them, they can be used to help outline and ensure safe practice and they can help to maintain consistency in standards and support improvements in quality. Where these tools are absent or are not kept up to date it indicates a weakness in management practices, and this is of concern. GP practices and primary care leaders within health boards should ensure there are processes and systems in place to support effective management of these services.

We identified a theme through our activity and intelligence relating to the accessibility and availability of face-to-face appointments. This showed that although practices were doing their best to recover services affected by the pandemic, issues of access still persisted. People told us that they could not always get appointments when they needed them and found it difficult in some areas to access practices by phone. We also found that an element of digital exclusion has continued, with some people unable to access services in an equal way due to a focus on online and telephone consultations. We found that practices had continued to respond well to the challenges of the pandemic. This included releasing staff to provide vital support to vaccination programs and clinics. A number of areas had developed innovative approaches to manage consultations and meet the demands of their communities. As a result, we have redesigned our methodology for GP inspections and introduced new peer reviewers to this process. This will ensure that HIW keeps pace with the developments in this sector.

[2] A cluster is a group of GP surgeries working together to pool resources and share best practice in a bid to help patients remain fit and healthy, and to improve the way patients are cared for if they become unwell.

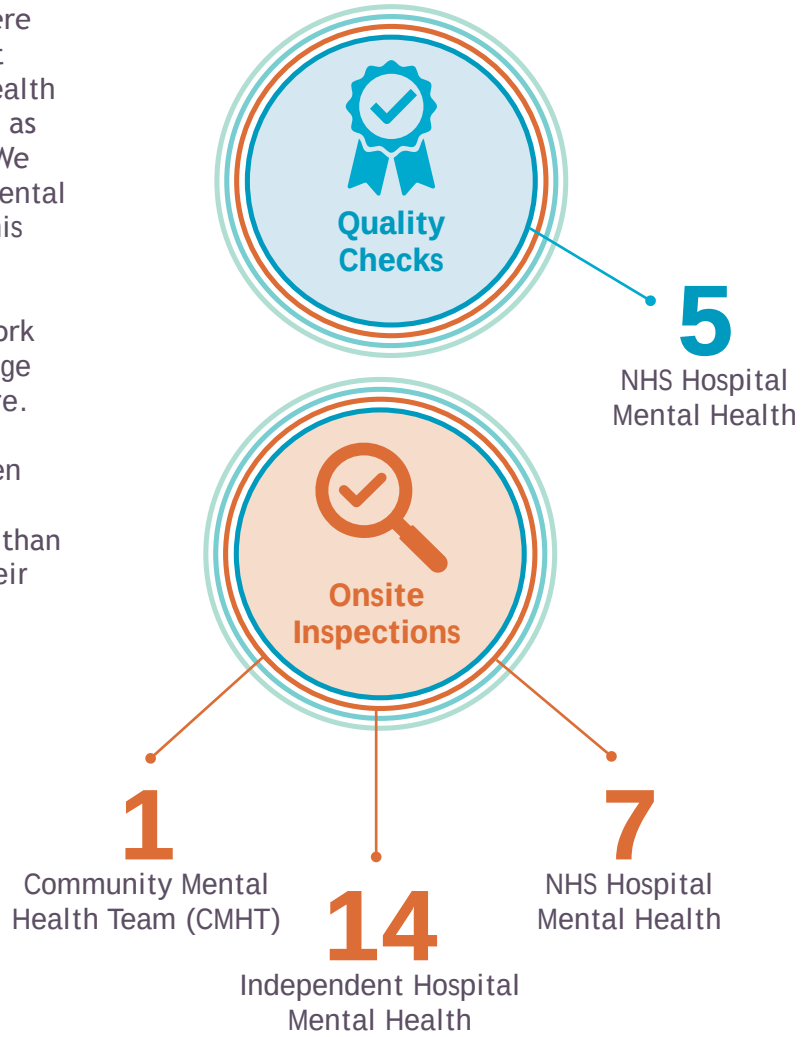
Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

The provision of mental health care during the pandemic has been challenging and complex for both the NHS and independent healthcare service providers. We continued to use a mix of remote Quality Checks and onsite inspections for our work to mental health care settings. This hybrid approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was high and to conduct our work onsite when either the COVID-19 risk was lower, or where the risk to patient safety was of significant concern. Our Review Service for Mental Health (RSMH) continued during this time, as well as our concerns and notifications processes. We also continued to respond to patients in mental health settings who contacted us during this period.

Over the past 12 months, our assurance work evidenced several key themes across a range of settings in relation to mental health care. Mental health is challenging and complex and inspections highlighted staff were often required to intervene to manage patient behaviours and ensure their safety, rather than provide care and treatment bespoke to their needs.

During 2021-2022 we undertook:



Inspections also highlighted instances of:

- **Mandatory training for staff not being completed or up to date**
- **Poor medication management including incomplete administration charts and medication being stored incorrectly**
- **Risks being identified and subsequently not addressed in a timely manner or not addressed at all**
- **An over reliance on agency staff and repeat periods of inadequate resourcing**
- **Care and treatment plans not being monitored and regularly updated**
- **A lack of governance oversight including collaborative working and sharing information for future improvement.**

In most cases we found that staff working in services providing mental health care and treatment, treated patients with kindness and respect. We also saw that most services continued to work well to adapt to the changing needs presented by the pandemic. Patients were receiving compassionate care in most cases which promoted their independence and autonomy. We also saw that in some cases the recovery from the pandemic was going well, with improvements on previous inspections noted.

During 2021-2022 we inspected two out of the three children and adolescent mental health units in Wales, Tŷ Llidiard in Bridgend, and Hillview Hospital in Ebbw Vale.

Learning Disability

HIW undertook eight Quality Checks and five inspections of facilities providing learning disability services. In most cases, we found that patients accessing care in these facilities were receiving person centred and compassionate care and treatment. Tailored care plans were in place and allowed staff and patients to work towards common goals for the benefit of patients. We saw that staff interacted with patients in a kind and compassionate manner and worked hard to meet patient needs. However, we did find that staffing numbers were not always at a level which met patient needs. We also saw that the COVID-19 pandemic had negatively affected the promotion of independence in some of these settings. We saw in one case that there were significant issues relating to the environment, governance and safety of the unit. As a result, an Immediate Assurance letter was issued, and significant improvements were implemented by the Hywel Dda University Health Board.

The Second Opinion Appointed Doctor (SOAD) Service

HIW operates the SOAD service for Wales, and we appoint registered medical practitioners to approve some forms of treatment. The role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the number of electroconvulsive therapies (ECTs) given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

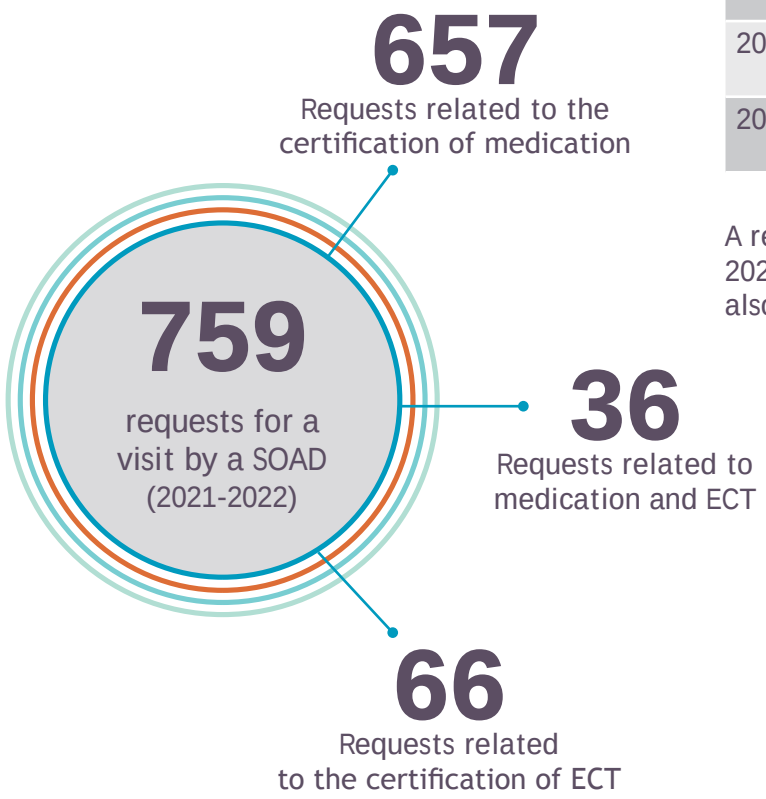
- **liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients**
- **serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)**
- **detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)**
- **patients under eighteen years of age, whether detained or informal, for whom Electroconvulsive Therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and**
- **detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).**

Due to the ongoing COVID-19 pandemic and health and safety concerns regarding on site visits for the SOADs, in 2020-2021 we operated a temporary COVID-19 safe methodology for the SOAD service, wherein onsite hospital visits were temporarily suspended and replaced with teleconference or telephone call appointments. As we move to a post-pandemic operating model, the SOAD service now operates a hybrid methodology where onsite visits, where safe and practicable, are carried out, however, remote certification is still also utilised enabling the efficiencies gained from the remote methodology to continue, whilst ensuring patients safety and rights are prioritised.

We continue to work with Mental Health Act administrators in health boards and independent providers to ensure that patients get timely access to a SOAD and that the process is as smooth as possible to ensure that the rights of patients are protected. We attended the Mental Health Act Administrators annual forum and engaged with stakeholders directly to support understanding of our hybrid methodology.

In Wales during 2021-2022, there were 759 requests for a visit by a SOAD. This figure is a slight drop from the previous year, although it remains broadly consistent with figures from previous years.

These were:



The following table provides a breakdown of requests per year:

Requests for visits by a SOAD in 2021-2022

Year	Medication	ECT	Both	Total
2019-2020	**855**	**50**	**27**	**932**
2020-2021	**869**	**60**	**27**	**956**
2021-2022	**657**	**66**	**36**	**759**

A regular programme of training is provided to all SOADs to encourage best practice. In the year 2021-2022 training which focussed on depression treatment and medications was provided. SOADs also attended a session in winter 2022 focussing on Legal Updates to the Mental Health Act 1983.

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the sixth consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis.

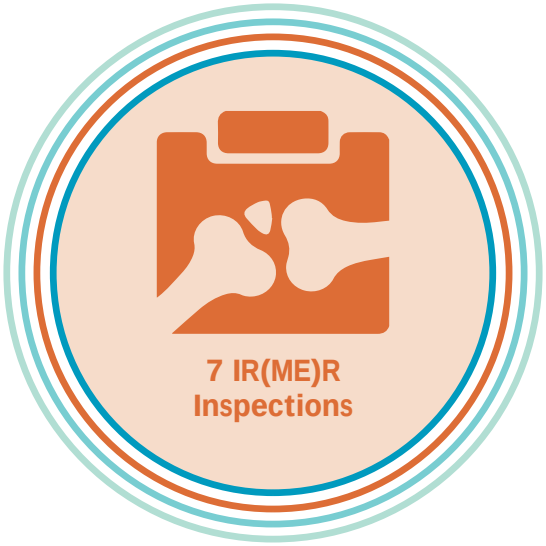
There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO[3] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

[3] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation. Our inspection approach checks that services are compliant with these (IR(ME)R) regulations and looks at whether care and treatment is being provided in line with the Welsh Government's Health and Care Standards.



During 2021-2022 HIW completed seven IR(ME)R inspections, covering the three modalities of medical exposures. Six of these inspections covered the NHS and one covered independent hospitals.

HIW was assisted in these inspections by a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys. The QR code to access the survey was displayed on posters in the services we inspected, and we promoted the surveys through our social media channels. Paper copies of the patient survey are also provided in advance of the inspection to the setting to accommodate patients who are unable to access the online survey. HIW received 273 completed patient questionnaires and 214 staff questionnaires covering these seven inspections.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R and we were assured that examinations at all sites inspected were undertaken safely.

Medical Physics Experts (MPEs) are qualified staff who are able to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine, and radiotherapy. We noted that the relationships between the various IR(ME)R locations inspected and the MPEs was good, whether this was provided as part of a service level agreement with another health board or by staff employed directly by the health board.

Some common themes have emerged across our IR(ME)R inspections this year. They are summarised as follows:

Employer's Procedures – on several occasions we identified that these did not provide enough detail and did not reflect the actual agreed practices staff described to us. We also saw examples where procedures were not up to date and had not been reviewed. Therefore, whilst staff could describe safe practises to us, we could not be assured that the written procedures would provide new, locum or agency staff with the required level of information to guide them in performing their relevant roles. Examples of common areas where detail was lacking in Employer's Procedures included:

- **The information supplied in the self-assessment form contained additional information which should be included in the employer's procedures to explain the process in more detail.**
- **Pregnancy employer's procedures and relevant documents did not always reflect the terminology used in IR(ME)R 2017. Also, pregnancy enquiry EPs were a common area where agreed practise described by staff was not reflected accurately in the employer's procedures itself.**

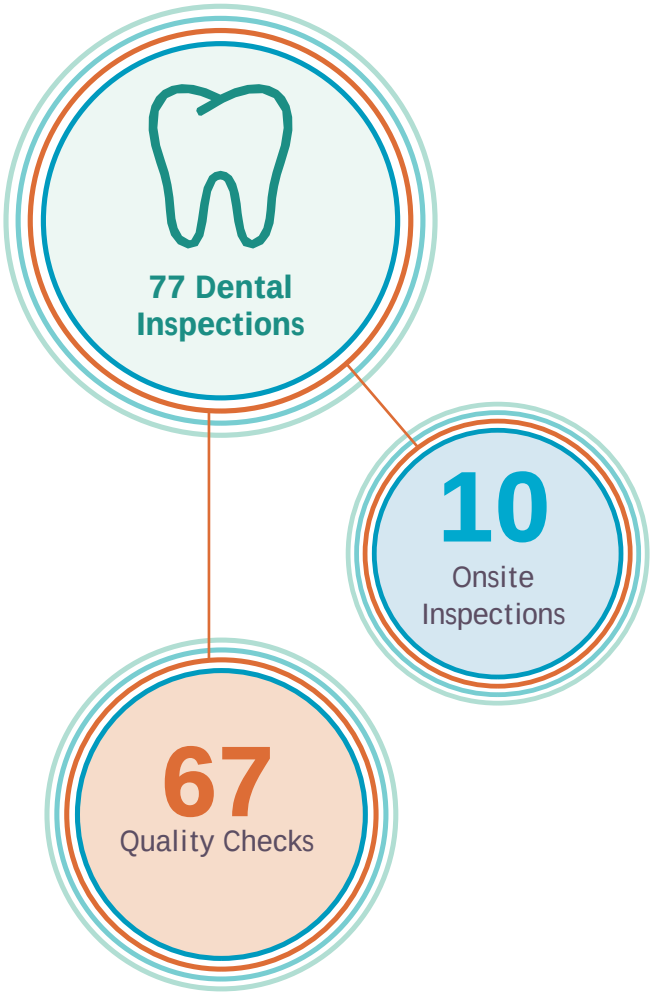
Entitlement - is the process of defining the roles and tasks that individuals, referred to as duty holders, are allowed to undertake. We identified that duty holders had not always been formally notified of their entitlement and scope of practice under IR(ME)R.

Clinical audit - is a key component of improving patient care through identifying areas for improvement and to promote effective use of resources and enhance clinical services. Audits should also highlight any discrepancies between actual practice and standards. Some instances were noted where the difference between IR(ME)R audit and clinical audits was not fully understood and as a result clinical audits had not been completed.

Staff Capacity - in most cases staff told us that they felt supported by senior management and the wider organisation. However, they did tell us that they struggled in terms of capacity to undertake all relevant tasks required as part of their duty holder roles. This may have been evident in the number of recommendations made in relation to mandatory training levels being low and appraisals not being completed in a timely manner.

We identified recommendations for improvement relating to collecting feedback from patients and informing staff of the results of this feedback. In most cases this was due to the COVID-19 pandemic which had reduced the collection of feedback. It is hoped that the process of collecting feedback would return to pre-pandemic levels in 2022-2023.

Dental Practices



Earlier in the pandemic, dental practices worked under a Red Alert which was issued by the Chief Dental Officer for Wales and which prevented them from undertaking any Aerosol Generating Procedures (AGPs). Enhanced cleaning and the requirement for time in between patients, led to a much more limited dental care provision than pre-pandemic. In summer of 2020 dental practices were able to increase the treatment they could provide and during 2021–2022 we saw them steadily increase service provision, working to recover back towards pre-pandemic levels.

During the year we undertook 77 pieces of assurance work across dental practices across Wales. Due to COVID-19 risk levels, we conducted most of this work remotely, and undertook ten onsite inspections where the level of risk to patient safety could not be explored remotely.

In three Quality Checks we had concerns which meant we needed to ask the practices to take immediate action to reduce risks to patient safety; we did this either via our Immediate Assurance process or issuing a Non-Compliance Notice, dependant on whether the practice provided NHS dental treatment, private dental treatment or a mixture of both. In one instance, a health and safety assessment had been correctly carried out by the practice, but the findings had not subsequently been acted on, leaving outstanding areas of health and safety concern. In the other two instances we found that there were inadequate seals to either flooring or to the flooring and worksurfaces in clinical decontamination rooms. Appropriately sealed floors and worksurfaces are necessary to reduce the risk of contamination and to support good standards of infection prevention and control.

Overall, we found evidence that dental practices had effective COVID-19 procedures in place to reduce the risk of virus transmission. This included social distancing, fallow time (settle time in between patients which is necessary for reducing levels of circulating air particles), and quick methods of communication with staff teams to ensure they received timely updates on COVID-19 procedures.

We also found evidence that many dental practices had considered the Welsh language needs of the patient population and were able to provide bilingual information to patients and a bilingual service where possible.

We were also pleased to note the efforts made by some practices to support and accommodate patients with additional needs to receive their treatment. One practice, 'MyDentist' in Wrexham told us that they held dedicated sessions, twice per year, for patients diagnosed with autism to receive treatment in a calming environment. Extra time was set aside for each appointment, lights are dimmed, and the radio volume lowered. We were also told that there were sensory toys, light blocking glasses and ear defenders available for patients to use.

Bryant Dental Practice also told us that during the pandemic, the practice utilised the 'Attend Anywhere' service and remote triage to reach patients who were too nervous to attend the practice due to COVID-19. We were also told that protected appointment slots are made available for vulnerable or at-risk patients at the start or end of each day.

We did find some common areas for improvement through our work. The majority of dental practices needed to improve their documentation recording staff training and ensure that all staff completed mandatory training sessions. We recognise that training has been challenging to source at times during the pandemic, but practices must continue to prioritise this as up to date training supports with quality and patient safety.

We found some areas of management and governance which needed strengthening:

- **A number of practices did not have a system which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date. Risk assessments are an important management tool which helps to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.**

- **Some dental practices did not have an up-to-date Infection Prevention and Control policy to work from. Whilst we acknowledge there have been some frequent updates to infection control advice over the course of the pandemic, correct IPC procedures (which should be governed through a policy) are crucial for maintaining patient safety.**

- **We also found numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency.**

Practices should ensure they take account of the above findings, considering whether they can apply any of this learning to their service to improve the quality and safety of care and treatment that is provided.

Independent Healthcare

Acute Hospitals

Due to the impact of NHS waiting times, independent healthcare is being utilised by patients now more than ever. After exclusively making use of remote Quality Checks throughout 2020-2021, it was important for our inspectors to return to onsite visits of independent hospitals to ensure patients received safe and effective care.

During 2021-2022 we completed four onsite inspections of Independent Hospitals.

Overall, our inspections found that safe and effective care is being provided to patients. Most patients who participated in the inspection expressed satisfaction with the care and treatment received.

Patients told us that staff were kind and caring and we observed good interactions between staff and patients, with staff supporting patients in a calm, dignified and respectful manner.

We found that the staff teams were committed to providing patients with safe and effective care and patients' care needs had been assessed by staff and monitored to promote patient well-being and safety.

The hospitals we inspected were clean and tidy and arrangements were in place to reduce cross infection. This is of high importance as during the time of our inspections, COVID-19 was still prevalent. However, even our most positive of inspections identified issues in medicines management procedures, for example, daily controlled drugs checklists not fully completed. We also noted issues with medications security, storage, and temperature checks.

We found good management and leadership in the hospitals with staff commenting positively on the support that they received from the management team. There was a clear multi-disciplinary approach to provisions of care across all three inspections.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured. Due to the vulnerability of the patients, it is imperative that hospices have policies and procedures in place to protected patients from COVID-19.

During the year we completed:

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Adults

We noted the interaction between staff and patients was good and it was evidence that family members were engaged and involved in their relative's care. There were good examples of multi-disciplinary working to improve provisions of care.

Staff emphasised the importance of maintaining visiting as far as possible for the well-being of patients and their relatives, particularly for patients in their last days of life. Staff described how this was achieved in a timely and effective manner in line with public health guidance at that time. This included initially restricting visiting numbers and COVID-19 testing for relatives before visiting.

We did find some common areas for improvement through our work:

- Environmental risk assessments and action plans were not always complete.
- Low levels of completed mandatory training.

Young People and Children

During our inspection we observed staff being kind and respectful to children. We saw staff making efforts to protect children's privacy and dignity when providing assistance with personal care needs. We viewed staff communicating with children in a calm, friendly and cheerful manner. Staff were observed communicating with children in an encouraging and inclusive manner.

The multi-disciplinary team provided patients with individualised care according to their assessed needs. There were robust processes in place for referring changes in patients' needs to other professionals such as tissue viability nurses, speech and language therapists and dieticians.

Children who completed the online survey told us that they were involved in the planning and provision of their own care. Parents/guardians told us that they were being consulted and encouraged to ask questions and make decisions around care provision.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

The 2021-2022 year saw many registered lasers and IPL providers re-open their services to patients following a period of closure due to the COVID-19 pandemic.

Once these services reopened, we returned to seeking assurance that laser and IPL services were safe for patients through our Quality Checks.

During this period, we conducted 15 Quality Checks and one onsite inspection of laser and IPL registered providers across Wales.

The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

Registered laser and IPL services provided us with good evidence of COVID-19 procedures, such as social distancing arrangements for patients and staff in waiting areas. Many services also had comprehensive COVID-19 risk assessments in place. It was reassuring to find that many of the services had taken time during their period of closure to understand the COVID-19 regulations and put safe practices in place to reduce the transmission of COVID-19. We found that nearly all providers ensured that a face-to-face consultation was carried out on prospective patients prior to the start of any treatment. They also ensured consent was obtained from patients ahead of treatment taking place.

During our Quality Checks we discovered that not all providers had an up-to-date safeguarding policy. Safeguarding policies and procedures which are accurate and up to date are an important means of supporting safe practices. We also noted that not all providers had a valid set of local rules that refer to the current IPL device in place. Local rules are set by the Laser Protections Adviser (LPA) which outline the safe and correct use of the laser machine. Providers must have a contract in place with an LPA to be able to provide laser treatments safely and legally.

Many providers were required to update their Infection and Prevention Control Policy.
By ensuring the policy is up to date, providers can be assured that staff and patients are protected infectious diseases and infections.

Nearly half of the providers did not have a policy in place which outlined how the service would approach the need to communicate and provide information in Welsh should the patient request it. Standard 18 of the National Minimum Standards of Independent Health Care Services in Wales[4] states that services should comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and address all language and communication needs.

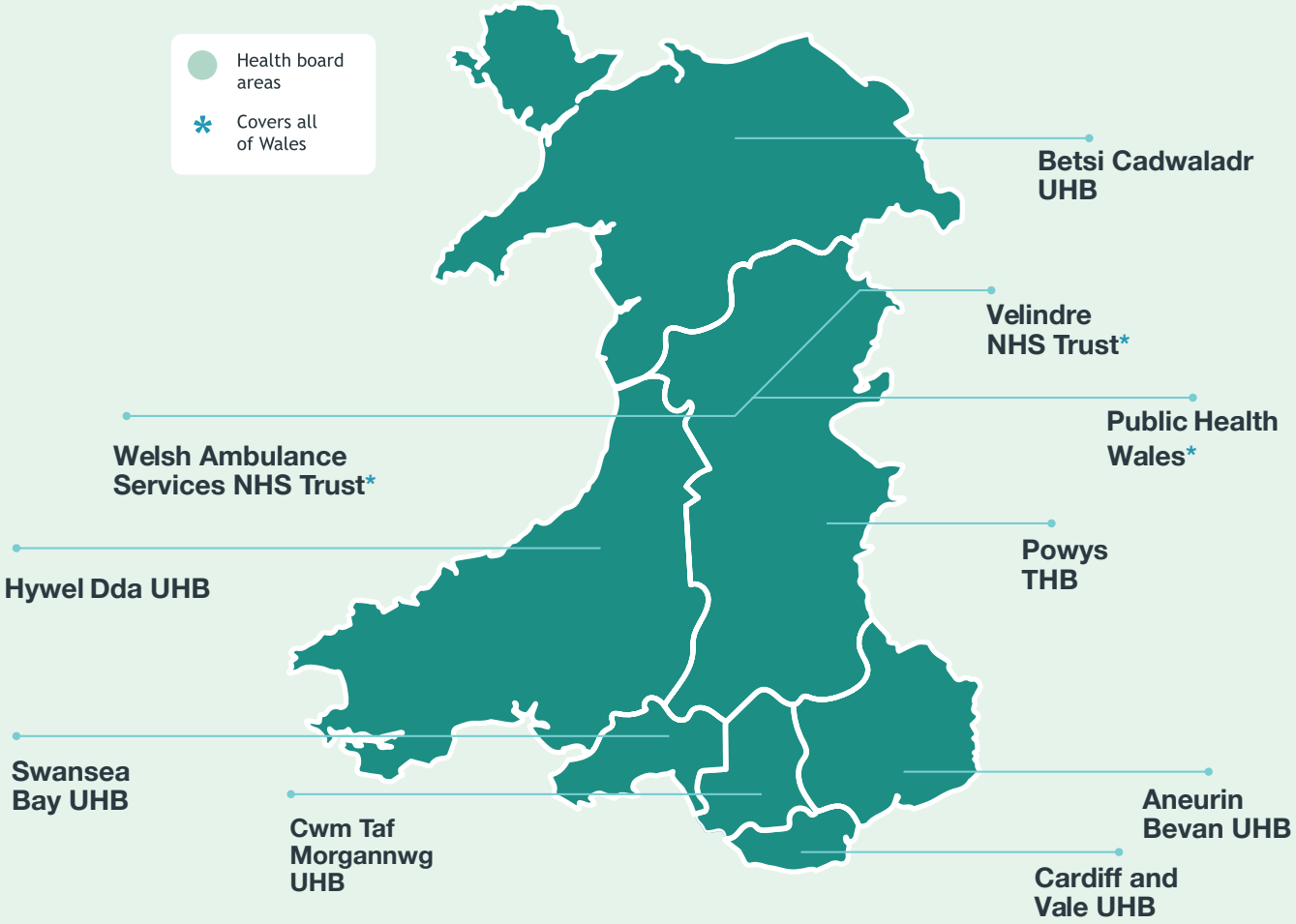
[4] https://gov.wales/sites/default/files/publications/2019-07/the-national-minimum-standards-for-independent-health-care-services-in-wales-2011-no-16.pdf

NHS Health Boards and NHS Trusts

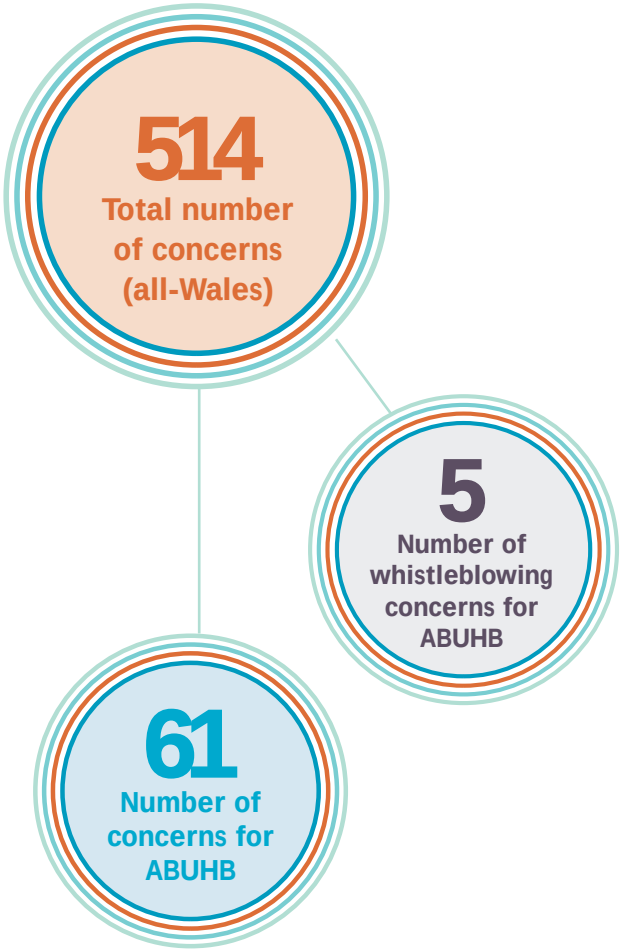
The period covered by this report, 1 April 2021 - 31 March 2022, continued to present healthcare services, and health boards with unique pressures and challenges.

This year they have faced not just the challenge of dealing with COVID-19 itself, but the added challenge of recovering services, tackling long waiting lists and demand for services as a result of many being paused in the initial pandemic response.

Across Wales we noted some common areas of concern through our work; in general, these were pressures associated with recovery of services, waiting times for treatment and significant issues with patient flow in hospitals, and notable pressure and demand on children's services, mental health services and primary care.



Aneurin Bevan University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	5
Hospital	2
Learning Disability	1
Community Hospital	1

Onsite	3
Hospital	2
IRMER	1
Mental Health Hospital	1

Within Aneurin Bevan University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Aneurin Bevan University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and in specific service areas where there have been particular challenges.

Changes made to governance structures during the pandemic have been carried forward due to the beneficial impact the health board found these had. We noted that engagement with senior leaders continued to be positive and considered that communication between the health board and HIW had shown improvement.

The health board has been proactive in sharing the learning from our assurance and inspection work across its services and has also proactively worked to deliver and embed actions for improvement that we have recommended through our work. The health board has kept us up to date on its progress on a regular basis.

A challenge for the health board throughout this time has been the newly opened Grange hospital. We undertook an onsite inspection to the emergency department and found several issues, some of which required immediate attention to improve patient safety. Staff who responded to our questionnaire told us about feeling pressured and struggling to cope with high levels of demand. High levels of demand for emergency department treatment have been seen across Wales, but this coupled with a new department, new building and new team pose an additional challenge and we urged the health board to continue with the positive input to support the department as it matures as a service.

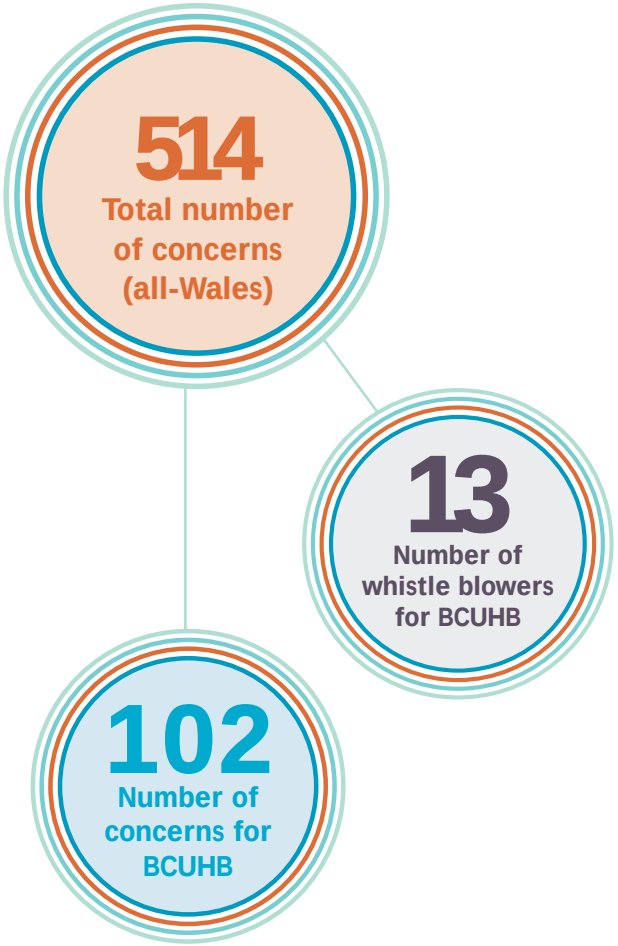
In many of our Quality Checks, our findings were positive, in particular around access to PPE, with minimal improvements required in any area. However, we were disappointed to note that compliance rates with mandatory training continued to need improvement.

During this period, we noted the health board working hard to maintain service delivery in the face of some substantial staffing challenges. At times, emergency actions have needed to be taken, such as temporarily pausing some services until staffing levels were safe again. Recruitment drives and promoting positive working cultures across services will need to be areas of focus for the health board as it continues to tackle this challenge.

The concerns we received the most for Aneurin Bevan UHB related to:

- **Clinical Assessment**
- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**

Betsi Cadwaladr University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	7
GP	3
Hospital	2
Learning Disability	2

Onsite	4
Mental Health Hospital	2
IRMER	1
Learning Disability	1

Within Betsi Cadwaladr University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.
During the period in question, the health board had recently come under the leadership of a new Chief Executive, Jo Whitehead, who was appointed in January 2021. We noted positive evidence of change at this most senior level through open dialogue and a commitment to working together with us and other partners to help bring about change and improvement in services throughout the health board.

We noted that the culture in many areas across the health board still required work to ensure that staff feel empowered to challenge issues and raise concerns. It is critical that the health board continue to work on this area, empowering staff and developing a culture where staff feel confident to raise concerns and constructively challenge.

As a result of ongoing concern about standards of care in mental health inpatient services at the health board we conducted two onsite inspections to the Hergest unit. We were concerned to find issues relating to staffing levels and significant staff fatigue, and infection prevention and control during our inspection work to Hergest.

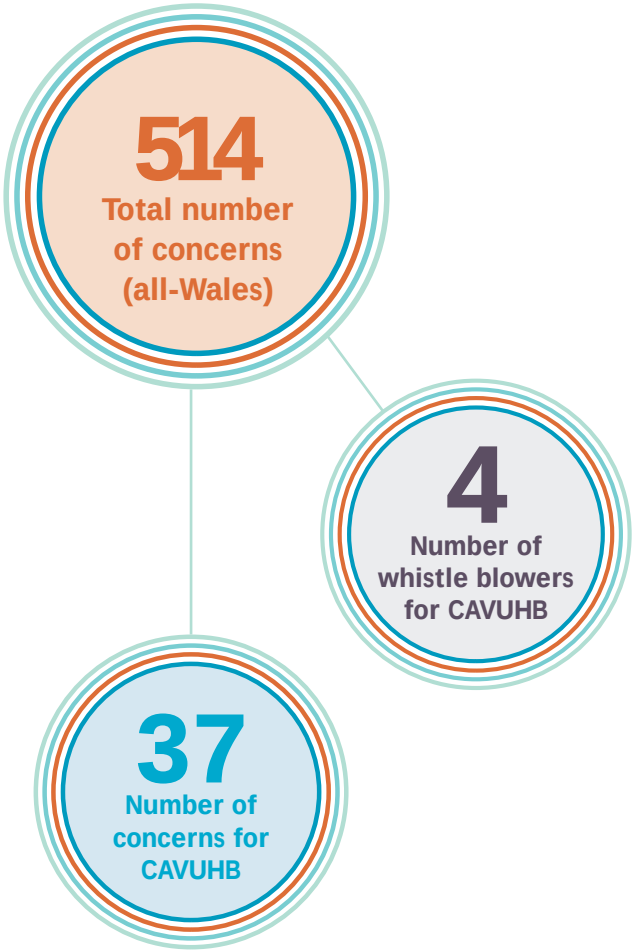
The health board responded constructively to the challenges we raised as a result of this work, but continued input from the health board will be necessary to bring about and sustain the level of improvement needed in this service. We will continue to monitor the progress made against the specific recommendations we made following our inspection to Hergest and will consider how the learning is shared to other services across the health board.

Poor record keeping was also an area of concern emerging through our ongoing work and monitoring of the health board. As a result of this emerging trend, we specifically focussed on record keeping in work within the health board during this year. We undertook an offsite Quality Check of the emergency department at Ysbyty Glan Clwyd in March 2022, with a significant focus on the evidence drawn from patient record keeping. We found a high level of risk to patient safety through this work and requested the health board take immediate action to reduce the risk. The outcome and findings of this work have contributed to the overall view of this specific service as an emergency department in Wales. We will continue to monitor the progress the health board makes in this specific department and how the learning is shared and used to shape improvement across their services.

The concerns we received the most for Betsi Cadwaladr UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Whistleblowing**
- **Clinical Assessment**

Cardiff and Vale University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	6
GP	5
Hospital	1

Onsite	3
Hospital	1
IRMER	1

Within Cardiff and Vale University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care provided by the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Through our assurance work, we did not identify any significant concerns during the year. However, we noted a significant increase in demand for services, as the health board began recovery form the pandemic. This was also evident within the University Hospital for Wales Emergency Unit, which saw a rapid rise in demand at a time where additional measures were required to help maintain adequate infection prevention and control. The health board is undertaking a significant amount of work to improve the infrastructure, environment, and processes to manage this. We also noted significant pressure within the health board's Mental Health services including Child and Adolescent Mental Health Services (CAMHS).

This includes the timely compliance with referral, assessments, and treatment times. However, the health board has made progress with some improvements already in these areas.

Bed availability within inpatient CAMHS units nationally, is at a premium. Challenges remain in the health board, with its ability access CAHMS inpatient services in other localities.

As a result, where children and adolescents require inpatient treatment, and beds are not available in a specialist unit, some patients require admission to general paediatric areas, with the support of registered mental health nurses, and at times, older adolescents have been admitted to the adult inpatient services located in Hafan Y Coed. The challenge for the health board will be to sustain and continue improvements in this area, particularly when the demand for CAMHS services remains high. We will continue to monitor our findings for the past year throughout the 2022–2023 inspection year. This will include undertaking planned and reactive inspection and assurance work as necessary, maintaining our relationship manager communication with the health board and partner organisations and through our engagement with service users and staff. This will enable us to check that healthcare services are provided in a way which maximises the health and well-being of people who use services within the health board's hospitals and its community services.

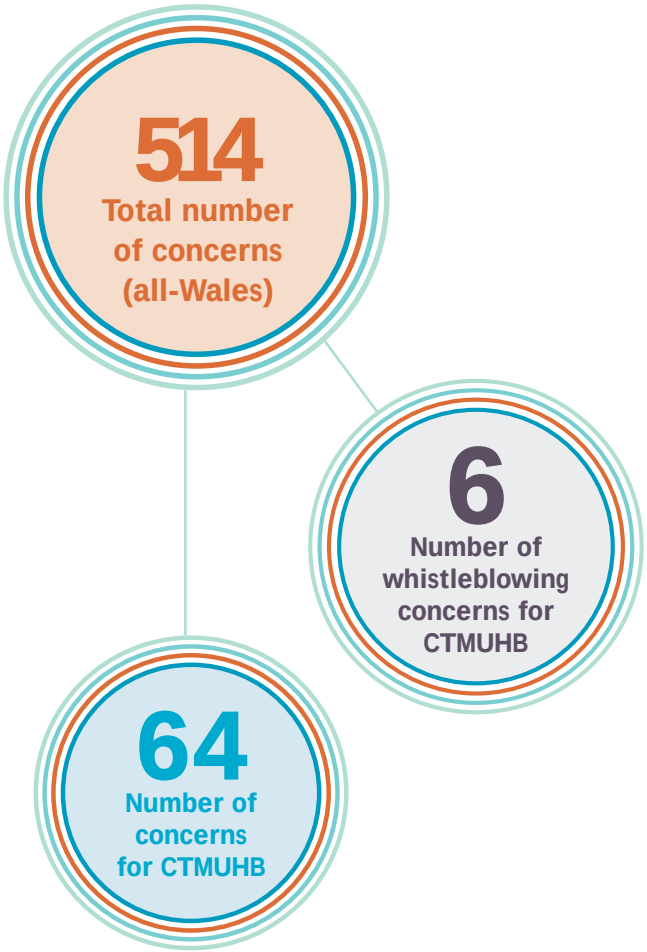
Throughout the year, we identified that the health board teams have continued to work tirelessly during several significant challenges which remain as a result of the pandemic. These challenges include an increase in staff absences and vacancies, stretched services and the resulting impact these challenges can have on staff well-being and patient safety. The health board has been proactive in supporting its staff, with a plan in place to support their health and well-being.

Our engagement with the executive team has continued to be positive and constructive, both to HIW and the health board. There has been number of changes within the executive team which included the appointment of a new Chief Executive, and the recruitment process in place to obtain additional key executives, which included the Executive Director of Nursing, Medical Director, and Chief Operating Officer. We endeavour to maintain our positive relationships with the executive team and other senior leaders.

The concerns we received the most for Cardiff and Vale UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Mental Health Act**
- **Clinical Assessment**

Cwm Taf Morgannwg University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	3
Mental Health Hospital	3
Learning Disability	2
Hospital	1

Onsite	5
Hospital	3
IRMER	1
Mental Health Hospital	1

Within Cwm Taf Morgannwg University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Overall, we found that the health board was continuing to make progress against the joint Audit Wales and HIW review of governance conducted in 2019. Both organisations jointly followed this up during 2020, reporting in May 2021. We found that there was a greater strategic focus on quality, safety and risk than had been previously found. However, we noted that it was too early to fully assess the effectiveness of the improvements and consequently we will be undertaking a further follow-up review during 2022-2023.

As a result of growing concern about the Emergency Department in Prince Charles Hospital, we carried out an unannounced inspection of the unit. We had significant concerns about patient safety and the potential high levels of risk to patients because of our findings. We were pleased that the health board responded very positively to our findings, noting their openness and willingness to work on tackling and addressing the issues we had highlighted through our work. We returned to the department unannounced four months later to consider their progress and could see several improvement initiatives in place which were already beginning to make a difference. We noted, however, that there were still areas which needed more work and urged the health board to maintain the momentum behind the improvement.

A challenge for Cwm Taf Morgannwg University Health Board will be around sustaining these improvements. Some of the issues we identified indicated that the culture at the department needed to be addressed. Where there are cultural issues, the challenge of maintaining the impetus and embedding changes may be greater. In a health board that has previously faced challenges with quality governance, it was positive to note the beginnings of change and the progress made by the health board to improve and sustain those improvements. The work done on improving the culture, values and behaviours across the organisation is a positive step for the whole health board but one that will need continued focus to make sustainable change.

The concerns we received the most for Cwm Taf Morgannwg UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Hywel Dda University Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	2
Mental Health Hospital	2
Learning Disability	2
Hospital	2

Onsite	3
Hospital	2
IRMER	1

Within Hywel Dda University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Hywel Dda University Health Board working hard through difficult times to recover services following the early restrictions of the pandemic. Through our engagement with senior leaders in the health board and observing at quality and safety meetings, it has been evident that quality is clearly embedded in their approach to leading the health board, and we have seen a strong focus on a learning culture.

Difficulty in recruiting qualified staff continues to be a challenge for the health board, although there had been an increase in numbers of applicants for roles as healthcare support workers. The health board has continued

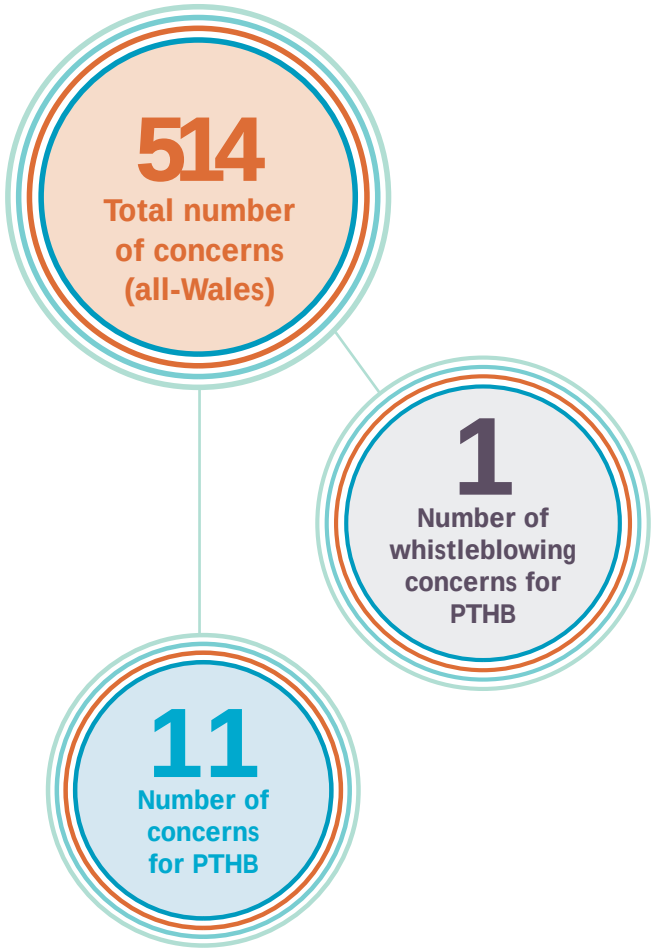
to tackle recruitment challenges through initiatives such as the use of an apprenticeship scheme, which enables people to work and gain healthcare qualifications. Resilience across their services has been fragile at times due to the staffing issues and compounded by the rurality and geographical spread of the health board and their hospitals. We note that senior leaders continue to plan and work proactively in an attempt to develop sustainable services for the future.

We carried out an offsite Quality Check of one of the health board's inpatient learning disability services and had significant concerns about the safety of the environment and the day-to-day management of risks in a service which was caring for vulnerable patients. The health board responded very quickly and constructively to the issues we identified and sped up their intention to discharge the patients to alternative placements. This action meant the service was empty and the health board did not admit any further patients for the remainder of the year while they worked to tackle the numerous service delivery issues that were present. We will continue to closely monitor the progress and re-opening of this service through our work and will consider further intervention and escalation if necessary. Through our partnership working with the Community Health Council (CHC), we were made aware of reports of poor patient experience within maternity services provided by the health board. The CHC ran a survey asking for experiences of maternity services within the health board. The results were mixed and saw several negative responses from patients. We engaged with the health board and have monitored their initial response to the issues; the challenge for them will be to fully embed the changes and maintain the momentum behind the improvements. We will continue to engage with the CHC to understand whether the patient experience within these services is improving and will consider future assurance work to check on the improvements in service delivery that have been made because of these interventions.

The concerns we received the most for Hywel Dda UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Self-harming behaviour**

Powys Teaching Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	2
GP	2

Onsite	3
Hospital	1
CMHT	1

Within Powys Teaching Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period there have been several changes to senior leadership and management within the health board. This includes staff leaving, retiring, and undertaking secondments elsewhere within the organisation. Due to the level of recruitment, this is an area which may take time to stabilise, but it has been positive to note that the executive team is focusing on supporting and embedding leadership changes as a priority in support of their workforce and the continued delivery of frontline patient care.

There has been continued positive engagement with the leadership team, including regular and ongoing meetings with the Director of Nursing and Medical Director throughout the year.

Powys Teaching Health Board commissions a significant proportion of its services from providers in both England and Wales. There are arrangements in place to monitor the performance of the providers used to deliver services to Powys patients via a Commissioning Assurance Framework. However, some of the performance data was paused earlier in the COVID-19 pandemic, therefore this monitoring arrangement has not been fully functional throughout the year. As some services are provided by other health boards and trusts, the restarting of services has been variable, leading to a potential inconsistency and impact on Powys residents.

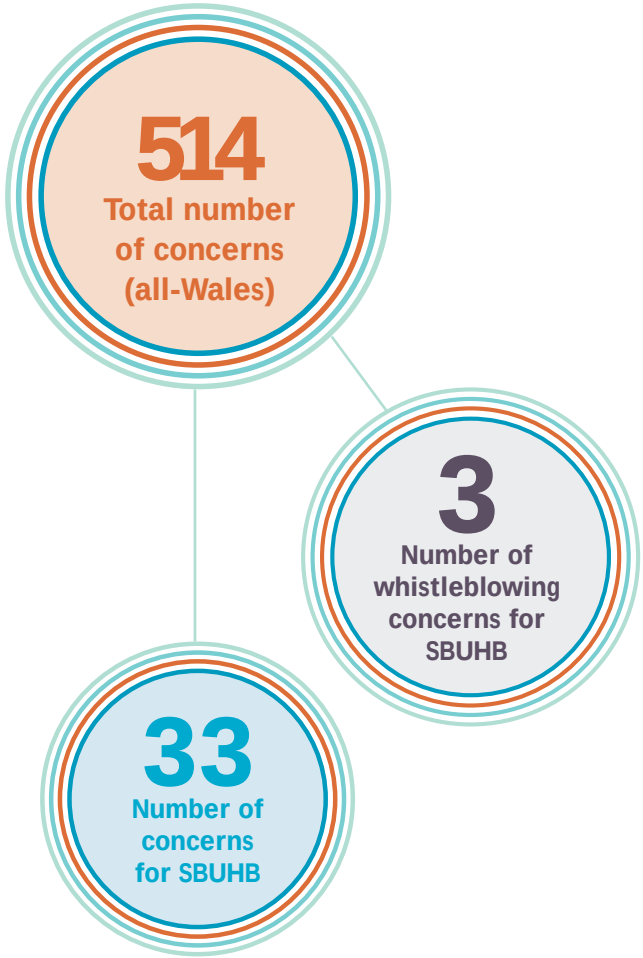
The health board has been monitoring this closely, reporting issues openly at quality, safety, and performance forums. We will continue to engage with the health board on this to ensure we remain up to date on this complex situation, and we will consider future work to better understand commissioning arrangements.

We undertook an onsite inspection to the mental health ward at Bronllys Hospital and identified that there had been limited improvements to some of the recommendations we had made at an inspection we carried out there in 2019. The lack of progress seemed to be particularly around the buildings and maintenance issues that we had identified. We urged the health board to improve their oversight of this area and make progress on these actions. Since then, it has been pleasing to observe updates provided by the health board to their quality and safety committee regarding the overall progress made against HIW recommendations and their subsequent completion.

The concerns we received the most for Powys THB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Swansea Bay University Health Board



Below is a breakdown of assurance work that took place within the health board

Quality Checks	8
GP	5
Hospital	2
Learning Disability	1

Onsite	4
Learning Disability	1
Mental Health Hospital	1
IRMER	1
HMP	1

Within Swansea Bay University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Swansea Bay University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and also in specific service areas where there have been particular challenges.

There have been changes in the executive team over a number of years, however, the health board has made new executive appointments, including a new CEO and Executive Nurse Director. We also note the positive impact of stability in the executive team will require time to achieve and will continue to monitor progress through our work.

As a result of negative findings from a previous HIW inspection to Morriston Hospital Emergency Department in January 2020, we undertook an offsite Quality Check to check on progress and to consider how the department was responding to the ongoing challenges of the pandemic. We found that there had been improvements made but a significant demand for emergency care and lack of capacity elsewhere in the hospital due to the high number of inpatients was continuing to be a challenge. We were concerned to find that the training data being maintained by the department was not up to date so we could not be assured that there was an appropriate number of trained staff covering the area. The health board responded positively to this challenge and was able to assure us of sufficient numbers of trained staff by providing additional evidence. Whilst this is one specific example, we noted that demand and capacity challenges were present in other areas, these can present immediate challenges and divert the focus away from longer term improvement work.We were pleased to see that the health board was continuing to look for solutions to demand and capacity issues, such as dedicating the Neath Port Talbot site for planned and elective surgical procedures, supporting a better flow of patients at acute sites and to ensure continued attempts to reduce lengthy waiting lists. We recognise this is an ongoing challenge for the health board which will need to support and maintain the resilience of its workforce to meet continued high demand.

We also carried out a review of the governance arrangements in place by the health board in the provision of healthcare services to the prison population in HMP Swansea. This review was as a result of previous concerns raised by Her Majesty's Inspectorate of Prisons (HMIP) regarding the prison. The evidence we gathered pointed to gaps in oversight by the health board and processes that were not robust enough to ensure an effective service was being provided. The health board responded constructively and positively to our findings on this and will need to continue working on the recommended actions in order to create and sustain improvement.

The concerns we received the most for Swansea Bay UHB related to:

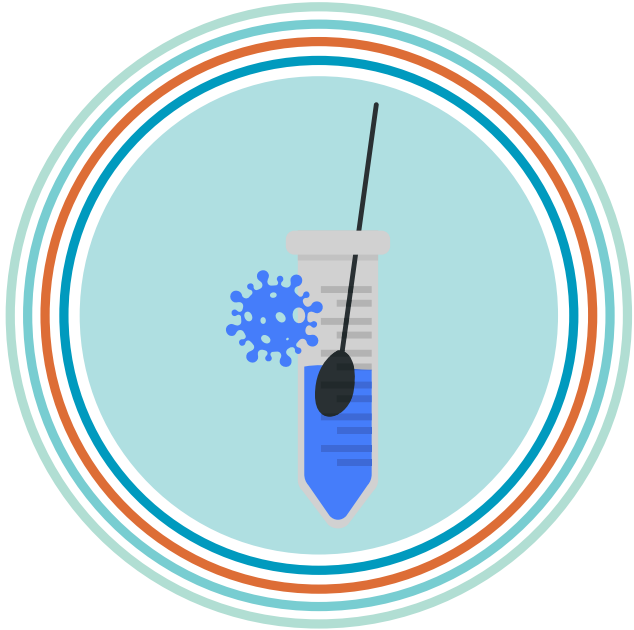
- **Infrastructure (Staff facilities and the environment)**
- **Safeguarding**
- **Clinical Assessment**

Public Health Wales

Within Public Health Wales, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of consideration of the themes and trends arising from concerns, attendance at quality and safety meetings, engagement with the senior executive team, monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

During this period, we observed Public Health Wales providing an important contribution to the ongoing surveillance of COVID-19 rates and communication of this to the public. Health Improvement programmes demonstrated innovation to delivering services remotely. Valued work was undertaken to support schools and businesses look after the emotional and mental well-being of pupils and staff as the nation came out of the pandemic. The delivery of vital public health screening services provided by the trust continued to be impacted by the COVID-19 pandemic. We saw evidence of services working to overcome these challenges in line with agreed recovery plans. Dedicated resource has been invested to tackle demand for each service and find solutions to the loss of community facilities which were used to host clinics pre-pandemic.

We recognised improvements with the recovery of services such as bowel and cervical screening and activities operating at pre-pandemic capacities for services such as breast screening and abdominal aortic aneurysm screening. We have noted the trust has an open and constructive culture amongst their staff and senior leaders which is positive as they continue working post-COVID-19. Through our work and engagement with the trust we will continue to monitor these areas which have been a particular challenge and will consider undertaking assurance work to further investigate issues as appropriate.

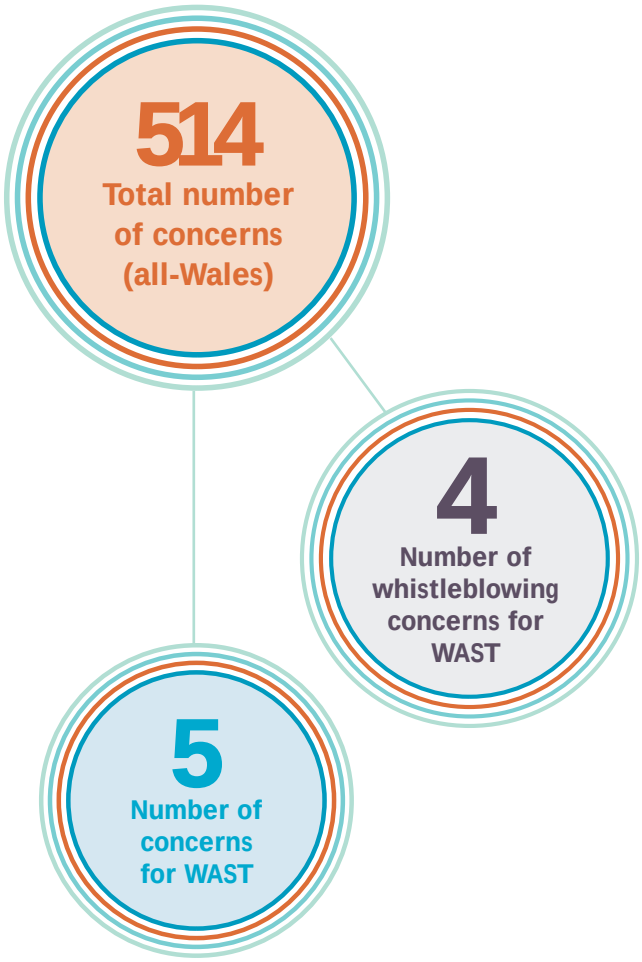


Velindre University NHS Trust

Our work to seek assurance on the safety and quality of care within Velindre University NHS Trust during the 2021–2022 period comprised of an offsite Quality Check of the inpatient service and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)].The view of the trust developed over this time is a culmination of all the above sources of evidence.

We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. COVID-19 remained the biggest risk to service delivery with staff absences, capacity reductions and increasing patient numbers impacting on the trusts ability to reduce waiting times for treatment and services such as radiotherapy. Attempts to undertake HIW assurance work at the trust were hindered by an increase in infections in early 2022. This work will now take place in 2022-2023 and will provide us with a sense of how services are recovering from the pandemic.

We noted the efforts of the Welsh Blood Service to build and sustain blood stocks throughout the pandemic. We noted evidence of the organisation continuing to plan for future service requirements and monitored progress with the Transforming Cancer Service Programme. We have seen transparent and constructive challenge taking place by independent members on all aspects of the trust at committee meetings.
Engagement between HIW and the executive team for the trust remains positive and constructive, with a welcome for the scrutiny we are able to provide.



Welsh Ambulance Services NHS Trust

During the 2021-2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of the final part of our local review exploring the impact of patients being delayed on the back of ambulances, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

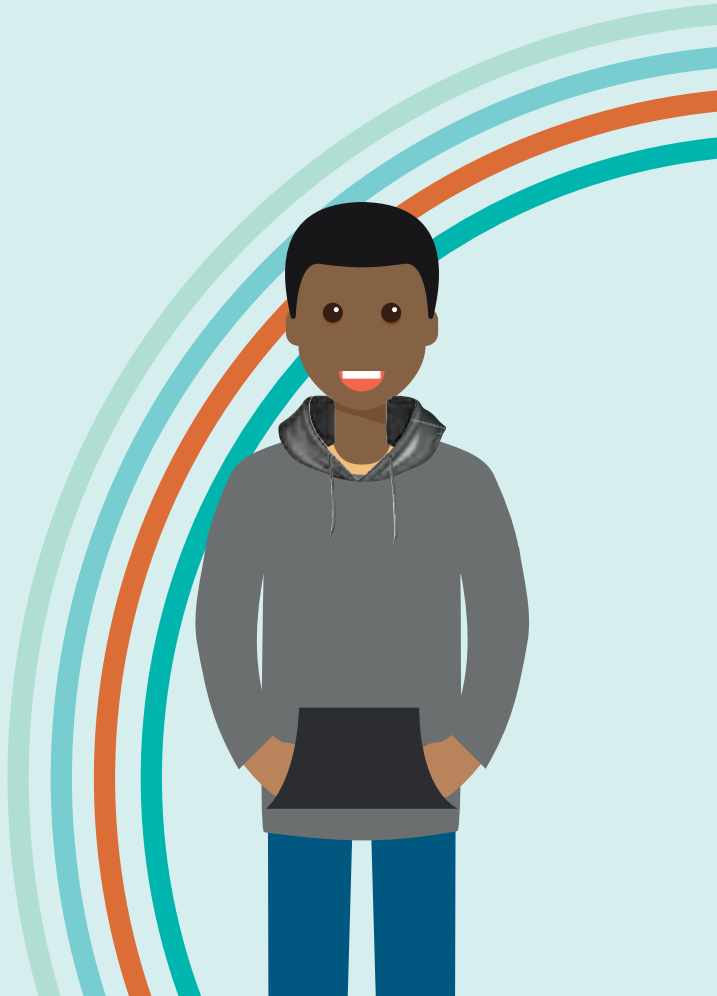
During this period, we noted the trust working through highly challenging times to provide their services and expertise across all parts of Wales.

Throughout the year the trust has been very open and honest with HIW, responding promptly to requests for information and data. We observed good levels of scrutiny and challenge at quality and safety meetings and have been assured that senior leaders seem to clearly recognise the issues they are facing and are committed to improvement. However, we also noted ongoing issues in service delivery despite this commitment to improvement.

Staffing has been a particular and significant challenge for the trust as it continues to see COVID-19 related absences impacting their workforce. Military personnel were brought in to support on community response vehicles and whilst this may have provided a temporary solution, once this resource is no longer available, the trust will need to continue to find solutions to their workforce challenge. We realise that this will not be simple to resolve and we will continue to monitor the trust's approach to service design and workforce planning through our work.

Our local review of patient experience whilst waiting in the back of ambulances found a number of examples where delays in handover had impacted extremely negatively on patients, but also on the ambulance staff providing their care. Staff told us that they were frustrated to find themselves waiting for long periods of time, sometimes entire shifts, waiting outside a hospital to transfer a patient and felt demoralised at not being able to provide care to patients in need of their help within the community. Whilst patients reported being cared for well by the ambulance staff who looked after them, they did not report positively about the length of time spent in the ambulance environment.

We made several recommendations through our review which we recognised were a substantial challenge to the trust and wider NHS system, however, to improve patient safety and tackle the impact on staff well-being, these recommendations must be acted on. The challenge for the trust will be the need to collaborate with health boards across Wales, all of whom have their own unique features and challenges. Supporting the well-being of ambulance staff who provide direct patient care and have direct contact with patients as call handlers will need to be of the utmost priority to the trust as it continues working on the recommendations and through this challenging time.



To be more visible

Collaboration and Engagement

Collaboration and joint working with other organisations are an integral part of the way in which we work. This year we continued to build on the strong relationships we have in place with our partners, once again acknowledging the additional insight this provided and the positive impact on our work that this gave us.

Collaboration

We continued to work with partners to explore how we can share data and intelligence. This included hosting two Healthcare Summits, in May and November 2021.

The summits were attended by the key regulatory and improvement bodies for healthcare in Wales. We agreed a collective view on the key national issues and risks across Wales, for example access to Child and Adolescent Mental Health Services (CAMHS). We shared these concerns, on behalf of all partners, with the NHS Wales Chief Executive. The purpose of this was to help us better understand what improvement action is underway at a national level. This forum continued to be a rich and valuable source of information and route for information sharing. We also started working with partners to develop a new mechanism, for members of the Healthcare Summit to share emerging serious patient safety risks and concerns across the sector. The work to develop this new mechanism will continue into 2022-2023.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW).

In March 2022 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care. We worked alongside CIW again, plus Her Majesty's Inspectorates of Probation (HMIP) and of Constabulary and Fire Services (HMICFRS), as well as Estyn, the education and training inspectorate for Wales to review the child protection arrangements in place in the Neath Port Talbot area.

We also work closely with Audit Wales, and in May 2021 we published a report providing detail on the progress made by Cwm Taf Morgannwg University Health Board in addressing the recommendations from our 2019 joint review into their governance arrangements. HIW's clinical team has been actively working in collaboration with training providers and professional organisations to support training delivered by the General Medical Council and to pre-registration nursing students. This supports greater awareness and understanding of the role of HIW in Wales. The clinical team has also been sharing good practice we have identified through our inspection work by signposting health board teams to the services they can approach to learn from.

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is of the highest priority to us. By doing this, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey, and when we are able to speak to patients in person during onsite visits, we gather views directly. This year, for example, we used a short engaging video on social media to help explain our National Review of Patient Flow and to encourage people to tell us about their personal experience, or the experience of their loved ones if they have been treated for a stroke. In January 2022, we launched a refreshed area on our website, keeping all our surveys in one place and making it easier for people to find out what active work we have ongoing, and provide their comments. Work on our 2022-2025 strategy was a key focus during the year and as part of this we undertook two large scale online surveys open to stakeholders and the public. We used these surveys to help shape our future direction through the increased understanding the responses gave us about the impact of our work on people and services.

In February 2022, we increased our social media presence and launched on LinkedIn. We recognised this as an important additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. Across our digital platforms we have seen an increase in engagement with a higher number of impressions and a wider reach of our content.

We also developed a new methodology for onsite inspections of Mental Health Units. One important change in this area is the implementation of a process to use questionnaires for patients, staff, friends, and family members. This will increase our engagement with people who use mental health services and those who work within them.

In response to previous feedback from the public that our reports can be hard to understand, we concluded a project to implement a new reporting style for onsite inspections. This new approach was implemented in April 2022 and involves publishing a public summary and a full detailed report for the setting. We also reviewed how we report to remove unnecessary duplication and make the reports easier to read. The outcome of this will be reports that are easier to understand and engage with.

To develop our people and our organisation to do the best job possible

Internal Update

Although the last year has been one of significant change, we have continued to invest in the development of HIW and its people in order to ensure we monitor and check that people in Wales are receiving good quality healthcare. We introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve.

We listened to and supported the well-being of our people to enable them and our organisation to do the best possible job and keep our communities safe and well. Our Corporate Service department developed a bespoke Learning and Development programme for our staff, tailoring unique opportunities to enable our workforce to build on vital skills. Following the launch and implementation of our internal Well-being Strategy our staff survey scores have shown clear signs of improvement across our key themes including inclusion, leadership and change.

We have also recruited to several new roles including Mental Health Act and peer reviewers to strengthen our access to clinical expertise alongside developing a professional pathway f or all our HIW inspectors. Over the past 12 months we have recruited a number of peer reviewers with experience in specialised nursing roles including stroke and child and adolescent mental health.

We implemented a new Customer Relationship Management system in March 2022. The new system replaced many of our existing spreadsheets and documentation. The system has been successfully rolled out and allows our staff to use data and information more effectively and efficiently to strengthen our ability to generate intelligence and insight. We have continued to work with partners to explore how we can share data and intelligence. This includes early collaborative work to develop a new process for healthcare organisations and partners in Wales to share serious patient safety risks and concerns across the sector.
We have held regular staff forums to discuss lessons learnt, areas of improvement and empower our workforce to have their say. The forum and anonymous staff suggestion box are monitored and fed back to senior leadership, where ideas, concerns and proposals are reviewed and actioned.

Commitment Matrix

The following table is a list of the objectives HIW set itself for 2021-2022, together with details of how we met the objective.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 1		
Process applications to register, or changes to registration, in a timely manner. Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	The following registration work was completed during 2021-2022 **Independent Healthcare Services** • 44 New Registrations • 28 Changes of Registered Managers • 12 Changes of Responsible Individuals • 22 Variations of HIW Registration Conditions **Private Dental Practices** • 14 New Registrations • 37 Changes of Registered Managers • 12 Changes of Responsible Individuals • 1 Variation of HIW Registration Conditions

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 2		
Conduct a programme of visits to suspected unregistered providers as required. Deliver a programme of assurance and inspection work on independent settings in line with our frequency rules. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of visits undertaken. Number of Quality Checks undertaken. Number of reports published four weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where urgent action is required, following assurance working the independent sector, the service will be issued with a Non-Compliance Notice within two days.	We carried out three visits to unregistered providers. We carried out 91 Quality Checks of independent services. We carried out 34 onsite inspections of independent services. We published 91 Quality Checks during 2021-2022. 75 of these were published within four weeks. We published 34 onsite inspections reports during 2021-2022. 28 of these were published within three months following the inspection. We issued 16 Non-Compliance Notices.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner.	Number of concerns received. Number of Regulation 30/31 notifications received. Analysis of source and action taken.	During 2021-2022 we received 144 concerns from the public or staff. We also received 16 concerns in relation to unregistered providers or settings that do not require registration with HIW. All concerns are reviewed and evaluated on a weekly basis and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications are as follows: • Death in Hospice – 604 • Death excluding Hospice -28 • Unauthorised absence – 90 • Serious injuries – 483 • Allegation of staff misconduct – 156 • Outbreak of Infectious Disease – 100 • Deprivation of Liberty Safeguards (DoLs) – 23

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
		In total we received 156 Regulation 25 (The Private Dentistry (Wales) Regulations 2017) notifications during 2021-2022. They are as follows: • Serious injuries – 8 • Outbreak of an Infectious Disease – 147 • Allegation of staff misconduct – 1 • Death of a patient – 0 All notifications were evaluated, and additional assurances were sought where necessary.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 4		
Deliver a programme of assurance and inspection work in the NHS across all settings informed by analysis of risk and how our resources are best deployed. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of Quality Checks undertaken. Number of reports published five weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where immediate assurance is required following an NHS assurance process, letters will be issued to the Chief Executive of the organisation within two days.	We carried out the following Quality Checks and inspections: **Quality Checks** 25 GP 10 NHS Hospital 5 NHS Mental Health Hospitals 8 Learning Disability 1 Step Down Community Hospital **Onsite Inspections** 8 NHS Hospitals 7 NHS Mental Health Hospitals 5 Learning Disability 6 IR(ME)R We published 49 Quality Checks during 2021-2022. 26 of these were published within four weeks. We published 23 onsite inspection reports during 2021-2022. 17 of these were published within three months following the inspection. We issued 12 out of 14 Immediate Assurance letters within two days of inspection/Quality Check.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 5		
Continue our programme of reviews including: • Mental health crisis prevention in the community. • Medicines management review. • Focused local reviews; one of these will be a local review of WAST. That will consider thesafety, dignity, well-being and overall experience of patients whilst waiting in ambulances at hospital emergency departments. • COVID-19: Themes and learning from our work. Undertake follow-up work on previously published local or national reviews, including: • Phase one of our National Review of Maternity Services. • Review of Patient Discharge from hospital to GP Practices. • Review of Integrated Care: Focus on Falls. • Substance Misuse Services in Wales. • WAST – Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centers. • PHW – Assessment of how the breast screening process is managed in a timely manner for women who have an abnormal screening mammogram.	Analysis, production and publication of the review. Publication of terms of reference for these reviews. Commence programme of follow up work.	During the year we published: • COVID-19 National Review • National Review of Mental Health Crisis Prevention in the Community • Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover We also completed our local review of Governance Arrangements at Swansea Bay University Health Board for the Provision of Healthcare services to Her Majesty's Prison Swansea. We started work on our National Review of Patient Flow (Stroke Pathway) and Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 6		
Conduct a high-level review of each NHS body through: • Further development of the Relationship Management function. • Producing an annual statement for each health board and NHS trust.	Publication of health board and NHS trust annual statements.	As part of our 2021-2022 annual report, we have undertaken a high level review of each NHS health board and trust. We have produced a statement for each health board and trust, and these can be found in the *'To take action when standards are not met'* section of this report.

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 7		
Undertake a programme of assurance and inspection work on NHS, independent mental health and learning disability settings. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety. Undertake a minimum of one piece of Learning Disability assurance work in each Health Board area in this inspection year.	Number of assurance and inspection activities undertaken.	During 2021-2022, we undertook the following assurance and inspection work across NHS, independent mental health and learning disability settings: **Quality Checks** • 5 NHS Mental Health Hospitals • 8 Learning Disability **Inspections** • 14 Independent Mental Health Hospitals • 7 NHS Mental Health Hospitals • 5 Learning Disability

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 8		
Provide a Second Opinion Appointed Doctor service for approximately 1000 SOAD requests.	Publication of Key Performance Indicators.	The SOAD services undertook 759 case reviews. These were: • 657 – Medication • 66 – ECT • 36 – Medication and ECT

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 9		
Publish reports from all our assurance activity in accordance with our performance standards.	Publication of reports according to our Publication Schedule. Publication of HIW performance against targets. Publication of Annual Report for 2020-2021.	We published 140 Quality Checks during 2021-2022. 101 of these were published within four weeks. We published 57 inspection reports during 2021-2022. 45 of these were published within three months following the inspection.

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 10		
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare. In particular in relation to: • Hospital Assurance activity • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: Learning bulletins distributed. Case studies of good practice distributed. Improved website content.	We held regular workshops with Community Health Councils and quarterly summits key stakeholders for the NHS and independent healthcare sector. We issued 19 newsletters throughout the year ranging from updates and guidance to dental practices, winter update to stakeholders, and monthly newsletters. We have supported improvements to our website in 2021-2022 including: • created a new surveys section on our website. • created a new social media feature on our website. • Made regular improvements to the functionality of the website to provide a better user experience including engaging features, streamlined navigation tools and the use of branded imagery.

What we said	Measured by	Outcome
Working with others		
Deliverable 11		
Continue our joint inspection work with UK agencies. Details to be agreed on a quarterly basis.	Number of inspections undertaken.	We carried out 15 death in custody investigations. We undertook two prison inspections with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
Continue working with other agencies on inspections and influencing best practice. Our five planned reviews with other Inspection Wales and Her Majesty's Inspectorate services are: • Review of Health Board and Trust Quality Governance arrangements (Governance reviews with Audit Wales).	Participation in joint work. Consolidation of the key findings and emerging themes from our joint work, and consider how these can inform our future work programmes.	CIW had involvement in design of work through our stakeholder group for our Mental Health Crisis review. We continued to work with Audit Wales to review Health Board and Trust Quality Governance arrangements. We undertook a JICPA second pilot review with all relevant agencies of child protection arrangements.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
• CIW providing support to our Mental Health Crisis Prevention review. • Joint Inspectorate of Child Protection Arrangements (JICPA) review (with CIW, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, Her Majesty's Inspectorate of Probation (HMI Probation) and Estyn). • Supporting HMI Probation with their joint thematic inspection of community-based drug treatment and recovery work with probation service users (for intelligence to support our Mental Health Crisis Prevention review). • Supporting HMI Prisons with their inspections of prison services in Wales. • Work with the Welsh Government, Care Inspectorate Wales and other stakeholders to review the effectiveness of Regional Partnership Board joint working.		HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue our JICPA work, to enable us to review processes within a further four local authorities across Wales. Within the plan, we would conclude the work undertaken in six local authorities and will evaluate all JICPA reviews undertaken to produce a national picture within a report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023. HIW continued to work closely with CIW and Welsh Government to undertake work with and assess the effectiveness of the regional partnership boards. Our newly appointed Director of Strategy and Engagement will be leading this work through work with the partnership boards and providing regular updates to our review steering board.

Our priorities for 2022-2025

Healthcare exists for people and communities, and the work we carry out looks at whether it meets the needs of a community and whether it is of a good quality. Where we find inequalities in healthcare provision, where a service is not designed for the needs of the community it serves, we will challenge this.

Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Our responsibilities in relation to mental health span both the NHS and the independent sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

As we head into the next three years we will be working to our new strategy.

Our goal is:

To be a trusted voice which influences and drives improvement in healthcare.

These priorities will help us to consider whether healthcare meets the needs of a community and whether it is of a good quality. Equality and diversity will be core to the work we do and our strategy supports us to consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

Our Resources

For 2021-2022 we had a budget of approximately £4.3m. Although the pandemic impacted our ability to deliver a full programme of onsite activity, we continued to make use of our new method for gaining assurance offsite, known as a Quality Check, where appropriate. We strengthened this approach during 2021-2022 following an evaluation of its effectiveness and suitability for its use beyond the pandemic. However, we continued to respond to emerging in-year intelligence which gave us immediate cause for concern or where the risk to patient safety was such that onsite activity was the most appropriate method for gaining assurance.

We have posts equivalent to approximately 83 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have over 30 Patient Experience Reviewers and Experts by Experience.

The table shows the number of full or part time posts in each team within HIW during 2021-2022.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence, and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our 2021-2022 Operational Plan.

	£000's
HIW Total Budget	**£4,376,000**

Expenditure	£000's
Staff costs	**3,882,624**
Travel and Subsistence	**13,150**
Learning & Development	**18,883**
Non staff costs	**45,944**
Translation	**59,939**
Reviewer costs	**414,358**
ICT Change Program costs	**333,816**
ICT Non CRM costs	**15,102**
Depreciation of assets	**13,866**
Total expenditure (a) £	**4,797,682**

Income	£000's
Independent healthcare	**311,790**
Private dental registrations	**241,900**
Total income (b) £	**553,690**
Total Net Expenditure (a-b) £	**4,243,992**

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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QUALITY SAFETY AND PERFORMANCE COMMITTEE

HEALTH AND CARE STANDARDS SELF-ASSESSMENTS

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non- Applicable
PREPARED BY	Jade Coleman, Quality, Safety and Assurance Manager
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Healthcare Professionals and Health Science

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	Trust Position Noted

ACRONYMS	
HCS	Health and Care Standards
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION

The purpose of this report is to provide the Quality, Safety and Performance Committee with the Quarter 2 position in relation to the Trust's compliance with the Health and Care Standards for Wales (2015). In particular, it provides:

- An overarching Trust compliance self-assessment with the Health and Care Standards
- A progress update against the 2022/23 Trust Improvement plan.
- The overarching Trust compliance scoring table for the Health and Care Standards.

The Quality, Safety & Performance Committee is asked to **NOTE** the position at the end of Quarter 2 in respect of the Health & Care Standards.

2. BACKGROUND

The 'Health and Care Standards' programme for NHS Wales provides a framework for ensuring compliance and ongoing improvements in the provision of high quality, safe and effective care.

The Trust will continue to drive quality improvement through 2022/23 by formally reviewing the Health and Care Standards every quarter ensuring each Standard remains firmly embedded in the core business of the Divisional and Corporate Teams. The Executive Management Board and Quality, Safety and Performance Committee will receive regular update reports.

Throughout 2022/23 the Trust will start to prepare for the introduction of the *Quality and Engagement Act* and will consider how best to review the Health and Care Standards in a way that aligns with the duty of quality. The Trust will respond to the current challenges around their value, use and content, within the time and resources we have available to implement the duty.

A national review of the Health and Care Standards has commenced in order to ensure they reflect the requirements of the Wales Quality and Engagement Act (2020) and the national Quality & Safety Framework (2021) requirements. It is proposed in the Duty of Quality National Consultation that the Health & Care Standards will be replaced with new National Quality Standards from April 2023.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Compliance across the Trust with the enhanced quarterly Health and Care Standards self-assessment process

The Trust will continue to engage in the quarterly self-assessment process throughout

2022/23, actively improving compliance with the Health and Care Standards and ensuring they are embedded into their 'business as usual'. The Divisional Senior Management Team will continue to review and approve the compliance data, and the progress against the Improvement Plans.

3.2 Overview of the compliance status at Quarter 2 2022/23

Despite the challenges of operational service delivery, the teams have reported continued good results in the compliance with the Health and Care Standards. The compliance has been reviewed and approved via the following internal process:

1. Health and Care Standard Operational Lead
2. Divisional Senior Management Teams
3. Executive Health and Care Standard Lead

The aggregated Trust wide self-assessment scores for each Health and Care Standard is attached in ***Appendix 1.***

The overarching aggregated Trust compliance score with the entire Health Care Standards remains a level 4 i.e. ***'we have well developed plans and processes, and can demonstrate sustainable improvement throughout the organisation/business'.***

The Divisional assessments are available if required from the paper author.

3.3 Progress with the Health and Care Standards Improvement Plan

The Health Care Standards Improvement Plan details the actions that are required per Standard in order to improve compliance, and to ultimately improve the quality of care provided within the organisation.

A number of actions were completed during 2021/22 despite the ongoing operational challenges and positive progress was made with the improvements that had been identified and the current Improvement plan has been included within this report **Appendix 2**.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The areas considered to have an impact on quality and safety are identified in the Health and Care Standards
RELATED HEALTHCARE STANDARD	All related to the Health and Care Standards.
EQUALITY IMPACT ASSESSMENT	All areas considered to have an impact on equality are identified in the Standards.
LEGAL IMPLICATIONS / IMPACT	There would be potential legal implications of non-delivery of these core standards.

FINANCIAL IMPLICATIONS / IMPACT	There would be financial implications aligned to both delivery and non-delivery of the Health and Care Standards. The non-delivery will be in relation to possible litigation due to non-compliance. Delivery of financial requirements will be worked through as part of local implementation/delivery plans.

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **NOTE** for quarter 2 position the:

- current status and progress in respect of the Health and Care Standards;
- status in respect of the Health & Care Standard Improvement Plan;
- the overarching Trust compliance scoring table for the Health and Care Standards; and,
- the planned national move to Quality Standards from April 2023.

Appendix 1

OVERARCHING TRUST COMPLIANCE WITH THE HEALTH & CARE STANDARDS FOR 2022/23

	HCS Standard	VCC self-assessment rating	WBS self-assessment rating	Overarching Trust assessment rating post Executive Review	Comment 2022/23
Governance, Leadership and Accountability	Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person centred care.	**4**	**4**	**4**	**Working towards 5**
STANDARD 1 Staying Healthy	**Standard 1.1 Health Promotion, Protection and Improvement** People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.	**4**	**4**	**4**	**Working towards 5**
STANDARD 2 Safe Care	**Standard 2.1 Managing Risk and Promoting Health and Safety** People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.2 Preventing Pressure and Tissue Damage People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.	**4**	**NA**	**5**	**Overarching score increased to 5 following Exec review**
	Standard 2.3 Falls Prevention People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.	**4**	**NA**	**5**	**Overarching score increased to 5 following Exec review**
	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.	**4**	**4**	**4**	**Working towards 5**

	Standard 2.5 Nutrition and Hydration People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.	**4**	**NA**	**4**	**Working towards 5**
	Standard 2.6 Medicines Management People receive medication for the correct reason, the right medication at the right dose and at the right time.	**5**	**NA**	**4**	**Working towards 5**
	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.8 Blood Management People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.	**5**	**4**	**4**	**Working towards 5**
	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.	**4**	**5**	**4**	**Working towards 5**
STANDARD 3 Effective Care	**Standard 3.1 Safe and Clinically Effective Care** Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.	**4**	**5**	**4**	**Working towards 5**
	Standard 3.2 Communicating Effectively In communicating with people health services proactively meet individual language and communication needs.	**4**	**4**	**3**	**Working towards 4**
	Standard 3.3 Quality Improvement, Research and Innovation Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.	**5**	**5**	**4**	**Overarching score decreased to 4 following Exec review**
	Standard 3.4 Information Governance and Communications Technology Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.	**4**	**5**	**5**	**Change to overall score following CDO review** **Needs review** **Working towards 5**

	Standard 3.5 Record Keeping Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.	**4**	**5**	**4**	**Working towards 5**
STANDARD 4 Dignified Care	**Standard 4.1 Dignified Care** People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, and cultural, language and spiritual needs.	**4**	**4**	**5**	**Work towards maintaining 5**
	Standard 4.2 Patient Information People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.	**4**	**5**	**3**	**Change to overall score following Exec review** **Working towards 4**
STANDARD 5 Timely Care	**Standard 5.1 Timely Access** All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.	**4**	**NA**	**4**	**Working towards 4**
STANDARD 6 Individual Care	**Standard 6.1 Planning Care to Promote Independence** Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.	**3**	**NA**	**3**	**Changed to 3 at VCC following consultation with Exec Lead**
	Standard 6.2 Peoples Rights Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.	**4**	**5**	**3**	**Changed to 3 following Exec review** **Working towards 4**
	Standard 6.3 Listening and Learning from Feedback People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback	**3**	**4**	**4**	**Working towards 4**
STANDARD 7 Staff and Resources	**Standard 7.1 Workforce** Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.	**4**	**5**	**4**	**Working towards 4**

SENIOR LEADERSHIP TEAM

HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2022/23 DIVISIONAL HIGHLIGHT REPORT QUARTER 2

DATE OF MEETING	13.10.2022

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	SLT is a private meeting

PREPARED BY	TRACEY LANGFORD QUALITY & SAFETY OFFICER VIV COOPER HEAD OF NURSING, QUALITY, PATIENT EXTERIENCE AND INTEGRATED CARE
PRESENTED BY	VIV COOPER HEAD OF NURSING, QUALITY, PATIENT EXTERIENCE AND INTEGRATED CARE
EXECUTIVE SPONSOR APPROVED	NICOLA WILLIAMS, EXECUTIVE DIRECTOR OF NURSING, ALLIED HEALTH PROFESSIONALS & HEALTH SCIENTISTS

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**

ACRONYMS	
	SLT- Senior Leadership Team VCC – Velindre Cancer Centre WBS – Welsh Blood Service

1. SITUATION

The Health and Care Standards Wales 2015 set out the requirements for the delivery of health care in Wales at every level and in every setting. The standards have been designed to fit the seven themes of the NHS Outcomes and Delivery Framework and establish a basis for improving the quality and safety of healthcare services, by providing a framework to identify strengths and areas for improvement.

2. BACKGROUND

The seven themes collectively describe how a service provides high quality, safe and reliable care, centred on the person. Person centred care is positioned in the centre of illustration and the dependence on good governance, leadership and accountability is illustrated by placing them around the seven themes.

The service divisions undertake the self-assessment process and provide assurance reports that detail ongoing evidence of compliance across the Division.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Improvement actions identified from the self-assessment are included within the divisional and Trust HCS improvement plan and monitored by the divisional SLT and at quarterly Divisional Reviews. A comprehensive update report mid-year and year end will be received at Executive Management Board and the Trust Quality, Safety and Performance Committee.

3.1 FINDINGS

Scores and a summary of compliance against each standard can be found below

Overall compliance with the standards for health services

Self-Assessment Rating – Theme 1 - Staying Healthy					
Assessment Level	1 We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from

3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Full						Amanda Jenkins
Standard 1.1 Health Promotion							
TRUST RESPONSE REQUIRED *Additional Information:-* Achievements							

3.1.2 Standard 2 - Safe Care

Safe care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 2.1 Managing Risk and H&S (VC&LM)	Partial	4	4				Lisa Miller/Viv Cooper
Std 2.2 Preventing Pressure Damage	Partial	4	4				Viv Cooper
Std 2.3 Falls Prevention	Partial	4	4				Viv Cooper
Std 2.4 Infection Prevention and Control	Partial	4	4				Viv Cooper
Std 2.5 Nutrition and Hydration	Partial	4	4				Viv Cooper
Std 2.6 Medicines Management	Full	5	5				Bethan Tranter
Std 2.7 Safeguarding	Partial	4	4				Viv Cooper
Std 2.8 Blood Management	Full	5	5				Viv Cooper
Std 2.9 Medical Devices, Equipment and Systems	Partial	4	4				Kathy Ikin
Priorities • Implementing BOPA recommendations to screen all patients for Hepatitis B service antigen and antibodies prior to immunosuppressive SACT. • Revise the process for maintenance of the prescriber registry at VCC. • Increase awareness of yellow card reporting							

3.1.3 Standard 3 – Effective Care

Effective care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 3.1 Safe and clinically Effective Care	Full	4	4				Viv Cooper
Std 3.2 Communicating Effectively	Partial	4	4				Viv Cooper
Std 3.3 Quality Improvement, Research and Innovation	Full	5	5				Christopher Cotterill-Jones
Std 3.4 IG and Technology	Full	4	4				David Mason-Hawes/ Ian Bevan
Std 3.5 Record Keeping	Full	4	4				Lisa Miller

Additional Information: -

Priorities

- The Trust will drive forward the implementation of its Cancer Research & Development Ambitions.
- Complete the implementation of the immediate term plan (first 18 months) for the Cardiff Cancer Research Hub that utilises existing CV UHB facilities. (Q4).
- Establishment of Clinical Academic posts in cancer research to strengthen our links with Academic Partners and enable translational research. (Q3).
- Implementation of the Digital Health Record and the Welsh Patient Administration System.
- Strategy for the management of the paper medical record

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead

Std 4.1 Dignified Care	Partial	4	4				Viv Cooper
Std 4.2 Patient Information	Partial	4	4				Viv Cooper
Additional Information: - **Priorities** • Not all patients have access to a CNS and/or a Macmillan navigator to assist in completion of electronic holistic needs assessments							

3.1.5 Standard 5 – Timely Care

Timely care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Standard 5.1 Timely Access	Full	3	3				Lisa Miller
Additional Information: - **Priorities** • Develop plans for increased ambulatory care provision.							

3.1.6 Standard 6 – Individual Care

Individual care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 6.1 Promote Independence	Partial	3	3				Eve Gallop-Evans
Std 6.2 Peoples Rights	Full	4	4				Lisa Miller
Std 6.3 Learning from Feedback	Full	3	3				Viv Cooper
Additional Information: - **Priorities**							

• Planning coproduced timetables on ward with patients to timetable their therapy sessions and treatment appointments to give increased sense of ownership over their day. .

3.1.7 Standard 7 – Our Staff

Our staff	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Full						Amanda Jenkins
Standard 7.1 Workforce							
TRUST RESPONSE REQUIRED							

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Choose an item.
	The related healthcare standard will vary.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The SLT are asked to note that:

- Standard 1 – Staying Healthy – This should be completed by corporate colleagues.
- Standard 7.1 – Workforce - This should be completed by corporate colleagues
- No significant changes.

Due to some staff changes the designated leads will need to change for the second quarter reporting, the changes will be agreed with the Director of Nursing, Quality, Patient Experience and Integrated Care and communicated to the standard leads in time for the quarter 3 update.

And to;

- **APPROVE** the findings of the Quarter 2 2022/2023 Divisional Health & Care Standards self-assessment.

Velindre University NHS Trust Quality Safety and performance Committee

HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2021/22 DIVISIONAL HIGHLIGHT REPORT

DATE OF MEETING	

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	PETER RICHARDSON, HEAD OF QUALITY ASSURANCE AND REGULATORY COMPLIANCE, WBS
PRESENTED BY	Alan Prosser, Interim Director, WBS
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, INTERIM CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Regulatory Assurance and Governance Group	31/10/2022	

ACRONYMS	
	SMT- Senior Management Team VCC – Velindre Cancer Centre WBS – Welsh Blood Service NWIS –NHS wales informatics Service

6. SITUATION

The Health and Care Standards Wales 2015 set out the requirements for the delivery of health care in Wales at every level and in every setting. The standards have been designed to fit the seven themes of the NHS Outcomes and Delivery Framework and establish a basis for improving the quality and safety of healthcare services, by providing a framework to identify strengths and areas for improvement.

7. BACKGROUND

The seven themes collectively describe how a service provides high quality, safe and reliable care, centred on the person. Person centred care is positioned in the centre of illustration and the dependence on good governance, leadership and accountability is illustrated by placing them around the seven themes.

The service divisions undertake the self-assessment process attached (Appendix 1) and provide assurance reports that detail ongoing evidence of compliance across the Division.

8. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

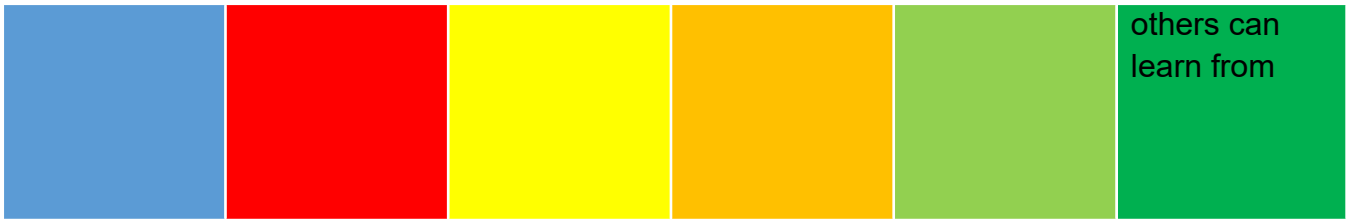
Improvement actions identified from the self-assessment are included within the divisional and Trust HCS improvement plan, and monitored by the divisional SMT and at quarterly Divisional Reviews. A comprehensive update report mid-year and year end will be received at Executive Management Board and the Trust Quality & Safety Committee.

3.1 FINDINGS

Scores and a summary of compliance against each standard can be found below

Overall compliance with the standards for health services

Self-Assessment Rating – Theme 1 - Staying Healthy					
Assessment Level	1 We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which



3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 1.1 Health Promotion						
Many of the standards are not relevant to WBS, but the division is able to demonstrate compliance with standards 8, 10 and 11						

3.1.2 Standard 2 - Safe Care

Safe care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 2.1 Managing Risk and H&S	Partial	Partial	Partial			
Std 2.2 Preventing Pressure Damage	N/A	N/A	N/A			
Std 2.3 Falls Prevention	N/A	N/A	N/A			
Std 2.4 Infection Prevention and Control	Full	Partial	Partial			
Std 2.5 Nutrition and Hydration	N/A	N/A	N/A			
Std 2.6 Medicines Management	N/A	N/A	N/A			
Std 2.7 Safeguarding	Full	Partial	Partial			
Std 2.8 Blood Management	Partial	Partial	Partial			
Std 2.9 Medical Devices, Equipment and Systems	Full	Full	Full			

WBS has completed the implementation of the revised corporate Risk Management project and cutover to the new system. A new requirement to test all blood donors for occult Hepatitis B infections has also been implemented by the end of Q1 2022/23 as planned.

2 areas of non-compliance with JPAC guidelines and one area of non-compliance with British Society of Haematology guidance remain. These represent a low risk to patients using current risk assessment tools.

Standard 2.8:

- The project to introduce Haemoglobin S testing for red cells issued for neonatal use is proving challenging delivery is now likely to slip towards the end of 2022/23.
- The project to address non-compliance to advise monitoring of antenatal patients with anti-D is ongoing, delivery is now likely to slip towards the end of 2022/23.

Standard 2.9

- WBS has received the MHRA consultation report on medicines and medical devices legislation, and is awaiting publication of the final draft of the legislation.

3.1.3 Standard 3 – Effective Care

Effective care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 3.1 Safe and clinically Effective Care	Full	Full	Full			
Std 3.2 Communicating Effectively	Partial	Partial	Partial			
Std 3.3 Quality Improvement, Research and Innovation	Full	Full	Full			
Std 3.4 Information Governance and Technology	Partial	TBC	TBC			
Std 3.5 Record Keeping	Full	Full	Full			

Care, treatment and decision making reflects best practice based on evidence to ensure that donors receive the right care and recipient safety is maintained. Robust governance processes are in place to ensure that research activities follow the highest ethical and scientific standards, including controls on the sharing of tissue samples and confidential data.
Recent communication improvements include the introduction of aids for people who are hard of hearing. Access to welsh-speaking members of collections teams remains a key challenge

Updated guidance on the use of pseudonymised data relating to donated samples, and new guidance on the need for Data Protection Impact Assessments in these instances has been issued by the Head of Information Governance during Q1. During Q2 other instances where pseudonymised data is provided to third parties have been identified and a wider review of the need to use pseudonimised data has been agreed by SMT.

Robust information governance and technology systems and processes, to support delivery of donor and patient services; however, work ongoing to establish a resilient business intelligence platform to support organisational information and reporting needs.

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 4.1 Dignified Care	Full	Partial	Partial			
Std 4.2 Patient Information	Full	Full	Full			

Following the successful implementation of the The FAIR individualised Donor assessment approach WBS continues to play a leading role in the UK project to widen access to donation for previously excluded groups.

3.1.5 Standard 5 – Timely Care

Timely care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 5.1 Timely Access	N/A	N/A	N/A	N/A	N/A	

Whilst the individual standards do not directly apply to WBS as the division deals predominantly with healthy donors, robust clinical governance arrangements are in place to monitor the quality and timeliness of donor care, and the support WBS provides for recipients of our products and services.

3.1.6 Standard 6 – Individual Care

Individual care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 6.1 Promote Independence	N/A	N/A	N/A	N/A	N/A	
Std 6.2 Peoples Rights	Full	Full	Full			
Std 6.3 Learning from Feedback	Full	Partial	Partial			

Standard 6.1 does not apply to WBS and Standard 6.2 only applies in part (sub criteria 1-3 only)

3.1.7 Standard 7 – Our Staff

Our staff	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 7.1 Workforce						

- WBS staff continue to be enrolled on courses run across the trust to support Welsh language skills, mental health and wellbeing and leadership skills. The Clinical Services team is currently working with HEIW and OD to create a bespoke HCSW framework for Collection Teams.
- Collaboration between WBS and colleagues in the hospital clinical transfusion setting has allowed us to improve services for patients by developing All Wales policies and guidance ensuring safer transfusion practice and appropriate use of blood. These initiatives have been particularly important during Q1 2022-23 and have helped Wales recover from low blood stocks over the summer and ahead of the rest the UK.

9. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Choose an item.
	All Healthcare Standards have been assessed.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Positive impact through compliance with Standards 3.2 and 6.2
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

10. RECOMMENDATION

The EMB is asked to:

- **ENDORSE** the findings of the divisional Health & Care Standards self-assessment.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE RADIATION PROTECTION AND MEDICAL EXPOSURES STRATEGIC COMMITTEE

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Arnold Rust, Head of Radiation Protection Matthew Talboys, Head of Nuclear Medicine
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
HSE	Health and Safety Executive

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues and items considered by the Radiation Protection and Medical Exposures Strategic Committee (RPMSC) on the 06/10/2022.

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 Executive Management Board.
ADVISE	The Inaugural Meeting of the Radiation Protection and Medical Exposures Strategic Group held on 21st September 2022. The function of the previous Radiation Protection Committee incorporating Medical Exposures has been split into two groups: this strategic group and an operational group. The motivation in splitting this group is to ensure that overarching strategic topics can be discussed away from radiation protection operational details, thus enabling greater focus and attendance at both meetings by an appropriate constituency. The report of the HIW inspection of Nuclear Medicine undertaken on the 14th and 15th June 2022 has been published. The report in general notes a high level of positive feedback including the following comments. *"Staff at this hospital are fabulous, caring and friendly, and very reassuring to nervous patients."* *"All staff made my treatment and care feel amazing. Nothing was too hard for them. Thank you."* *"All staff I have encountered during … visits have been courteous, supportive and reassuring. I could not ask for any better treatment - I'm very grateful."* No Areas of immediate concern were noted in the report. All those involved were thanked for their efforts number of recommendations were made and are currently being progressed. Issues around provision of nuclear medicine MPE support were noted with the service operating significantly below national recommended staffing levels. The future of radioactive sources in the former Research laboratories was discussed. The recommendation of the committee was to proceed with a process for removal and disposal. This will now require an outlining of the process involved, costings and governance route for ratification of the recommendation. Revised Ionising Radiation Protection policy was endorsed, subsequent to final review to determine whether any items from Clinical Evaluation policy need to be included. Then to go forward for Trust ratification.

ASSURE	Covered in report from Radiation Protection and Medical Exposure Operational Group.
INFORM	There were no items identified to **INFORM** the Executive Management Board.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 06/10/2022

QUALITY, SAFETY & PERFORMANCE COMMITTEE

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS) ANNUAL REPORT 2021-22

DATE OF MEETING	10.11.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mary Swiffen-Walker, Service Manager, WIBSS
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	26.10.2022	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

WIBSS supports 217 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of the beneficiaries.

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government through Velindre University NHS Trust. The membership of the Group is:

- Director of Corporate Governance, Velindre University NHS Trust (Chair)
- Director of Operations, Velindre Cancer Centre
- Director of Planning, Performance and Informatics, NWSSP
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Senior Welfare Rights Manager
- Consultant Psychologist

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The report provides: an update on the finance and support services during 2021-22 as part of the WIBSS; detail on the proactive work carried out by WIBSS during 2021-22; and a to look ahead to WIBSS priorities relating to 2022-23.

One of the matters arising in the report relates to the Compensation Framework. In May 2021, it was announced that Sir Robert Francis QC had been appointed to consider a compensation framework for those people infected and affected by infected blood. Sir Robert Francis submitted his report to UK Government in March 2022 for consideration. He also appeared in front of the Infected Blood Inquiry to discuss the report in July. On 29 July 2022, it was announced that interim payments of £100,000 would be made to all who were currently registered with one of the UK Infected Blood Support Schemes by October 2022. These payments were all processed by the WIBSS team w/c 23rd October 2022.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Infected Blood Inquiry - Safety
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Across WIBSS scope
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Infected Blood Inquiry
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Trust processing of compensation framework payments

4. RECOMMENDATION

Quality, Safety and Performance Committee is asked to **NOTE** the Annual Report.

Cynllun Cynorthwyo Gwaed wedi'i haentio Cymru

Wales Infected Blood Support Scheme

ANNUAL REPORT 2021/2022

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICE PARTNERSHIP (NWSSP)
AND
VELINDRE CANCER CENTRE (VCC)

ANNUAL REPORT 2021/2022

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Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

WIBSS supports 217 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of our beneficiaries.

Purpose of Report

The purpose of this report is:

- **to provide an update on the finance and support services during 2021-22 as part of the Wales Infected Blood Support Scheme;**

- **to detail the proactive work carried out by WIBSS during 2021-22;**

  and

- **to look ahead to WIBSS priorities relating to 2022-23.**

Matters arising during 2021-2022

COVID-19 – The Pandemic

In March 2020 the UK entered its first lockdown, because of the global COVID-19 pandemic. Everybody who could work at home, was told to work at home, this included the staff at WIBSS. We successfully made this transition and operated on a "business as usual" basis throughout 2021-22.

We continued to make all regular payments and to offer help and support to all our beneficiaries, many of whom were shielding because of their condition. We provided updates and advice on our website and were available throughout, to help with any queries, provide benefit checks etc. Whilst we did need to stop home visits, to comply with Government guidance, we adapted to offer the well-being and counselling services remotely, over the telephone, on Microsoft Teams or via skype calls.

Public Inquiry – The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970.

In 2021-2022 we responded to four Rule 9 requests from the Infected Blood Inquiry. The requests were seeking clarification of information contained in the witness statement previously provided by Alison Ramsey, Director of Planning, Performance, and Informatics at NWSSP, prior to her appearance before the inquiry in May 2021.

https://www.infectedbloodinquiry.org.uk/evidence/transcript-london-thursday-20-may-2021-vaughan-gething-and-alison-ramsey, and following her appearance.

In providing evidence to the Inquiry, the WIBSS team committed to take stock, and review all our procedures, documentation, communication channels e.g., our website and newsletters etc. This review identified a few areas where we needed to update our advice and guidance to reflect changes since the service was first established. This included updating a few our application forms and improving the guidance to completing some of those forms. The website and documentation have now been refreshed to provide an accurate reflection of how the service is provided.

Matters arising during 2021-2022

Parity across the four UK nations

When the four devolved infected blood schemes were established in 2017, three of the four operated largely on similar terms and payment rates. Scotland adopted a slightly different model. WIBSS introduced a welfare rights service, which the other schemes did not have, but the payment rates were initially comparable to those in England and Northern Ireland.

With effect from 1 April 2019, the UK Government directed EIBSS to significantly increase the payment rates for their beneficiaries, leading to disparity between the schemes. This subsequently then triggered a series of meetings between government officials across all four nations with the aim to reach an agreement on parity across the four schemes.

The WIBSS finance team worked closely with UK government colleagues to model the estimated costings, including back dated elements and an estimate for future years.

On 25th March 2021 the then Welsh Minister for Health and Social Care announced agreement on parity had been reached and payments would be made by the end of the calendar year (December 2021).

https://gov.wales/written-statement-infected-blood-update-financial-parity
Under the parity model, provided by Welsh Government in March 2021, the overall additional funding required, totalled £13.1m in 2021/22. This also included some backdated elements relating to 2019/20 and 2020/21.

Following the announcement, WIBSS staff worked closely with Welsh Government to clarify the likely detail of the agreement, and then calculate the individual payments to be made to each beneficiary on the WIBSS.

This was complex work, requiring attention to detail to ensure that accurate payments could be made promptly to the WIBSS beneficiaries.

Welsh Government issued the final directions on 13 August 2021 and the payments were made on 20 August 2021. During the latter half of 2021-22, two further parity adjustments were made:

- Co-infected HIV and Hep C Stage 1 widows were
- paid the additional £30,000 lump sum payment.
- Widows received the winter fuel payments.

Matters issues arising during 2021-2022

Compensation Framework

In May 2021, it was announced that Sir Robert Francis QC had been appointed to consider a compensation framework for those people infected and affected by the infected blood scandal.

The Terms of Reference of the Framework were:

- Give independent advice to the Government regarding the design of a workable and fair framework for compensation for individuals infected and affected across the UK to achieve parity between those eligible for compensation regardless of where in the UK the relevant treatment occurred or place of residence. While the Study is to take into account differences in current practice and/or law in the devolved nations, it is not asked to consider whether delivery of that framework should be managed centrally or individually by the devolved administrations.

- To Submit to the Government its report and recommendations as quickly as possible and no later than the end of February 2022 [amended to 14 March 2022], to provide the Government with advice on potential options for compensation framework design.

In January 2022, the WIBSS Manager, together with the policy manager from Welsh Government, met with Sir Robert and his staff to discuss the operation of WIBSS and what the beneficiaries wanted from the framework.

The WIBSS Manager explained the operation of the scheme and highlighted the fact that WIBSS operates a “wraparound” holistic service, providing, not only financial support, but also welfare rights support and a bespoke psychology and wellbeing service, staffed by people who have a good knowledge of the subject area, who can empathise and understand the issues our beneficiaries are facing on a daily basis.

Whilst we felt that the financial support was important, many of our beneficiaries have commented how they value the face-to-face support, the personal interactions with them and the fact that the service is easily accessible. They would not want to lose that, in any revised service that was proposed.

Sir Robert Francis submitted his report to UK Government in March 2022 for consideration. He also appeared in front of the Infected Blood Inquiry to discuss the report in July.

On 29 July 2022, it was announced that interim payments of £100,000 would be made to all who were currently registered with one of the 2 UK Infected Blood Support Schemes by October 2022. The schemes all wrote to their beneficiaries notifying them of this fact.

As a result of the announcement, WIBSS received an increased number of enquiries about how to register with the scheme.

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG) through Velindre University NHS Trust.

The WIBSS Governance Group (VCC and NWSSP) is authorised to:

- Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance Teams remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR). It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It is empowered with the responsibility for:

- Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries budgets and provisions

- Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK

- Implementation of Welsh Government policy

- Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

Governance Group

The membership of the WIBSS Governance Group is as follows:-

- Director of Corporate Governance, Velindre University NHS Trust (Chair)
- Director of Operations, VCC
- Director of Planning, Performance and Informatics, NWSSP
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Senior Welfare Rights Manager
- Consultant Psychologist

In 2021-22 the Governance Group met on 21st July and 14th December and 29th March 2022, postponed to 5th April 2022.

Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- New Applicants to the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme. These were set out in our 2020-2021 Annual Report and are on the WIBSS website Home - WIBSS (wales.nhs.uk).

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

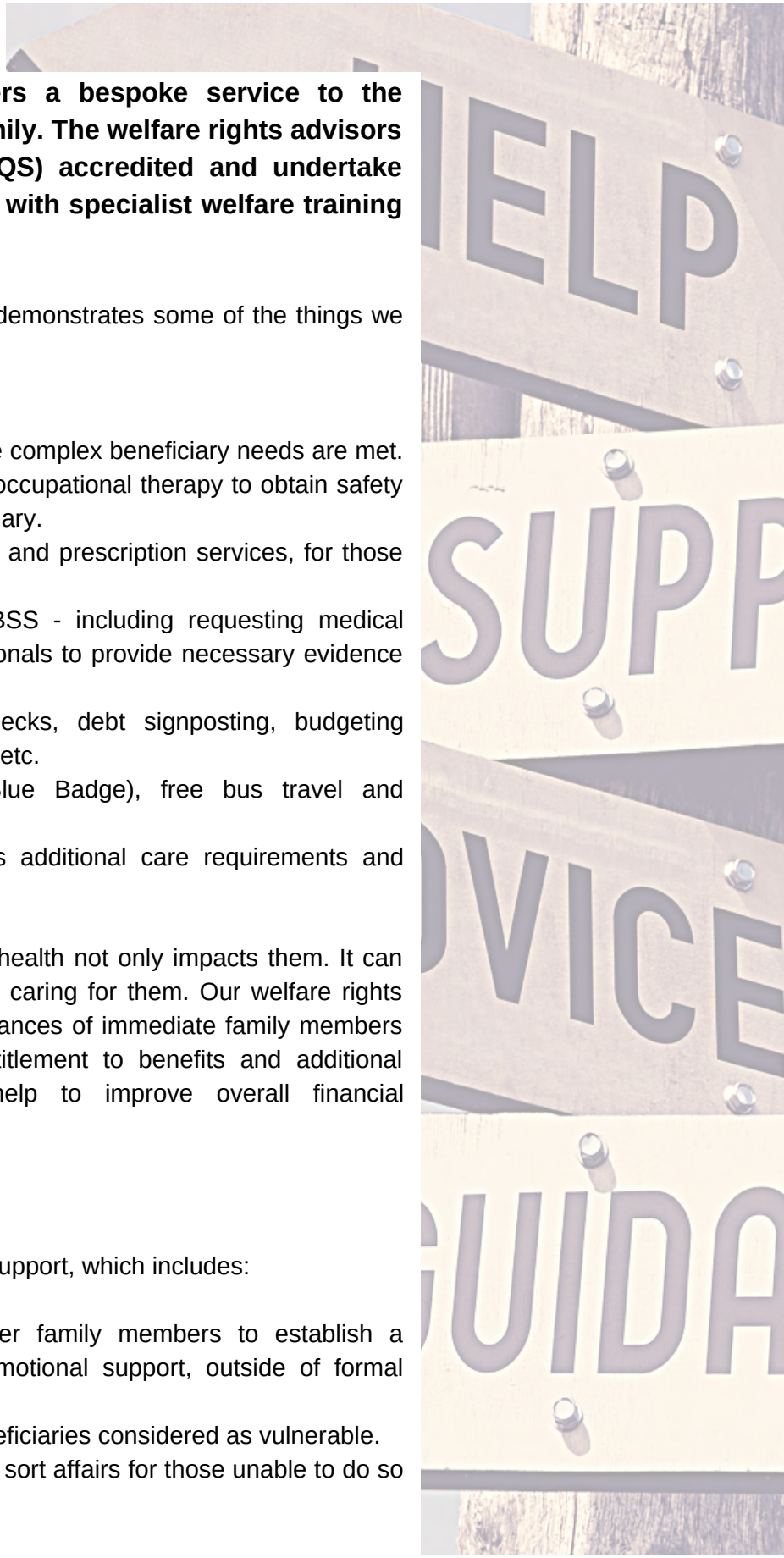
During 2021-22, two appeals were submitted, and an appeals panel was convened in March 2022. One appellant decided to postpone her appeal, prior to the Appeal Panel considering it. The Panel considered the remaining appeal.

The panel considered all the documentation received by WIBSS and detailing the decision-making process of WIBSS. The appellant also appeared in front of the panel to present their case. The panel then considered all the evidence, and upheld the original decision made by WIBSS to reject the application and the appellant was notified of the panel's decision.

The appeals panel process does not cover appeals regarding the Discretionary Small Grants process. At the inception of WIBSS we did not think a formal appeals process was proportionate given the value of these grants. To date we have not declined any small grant applications, however, as this was queried during WIBSS appearance at the Inquiry, we considered the issue and have introduced a less formal system of reconsideration for any applications for small grants that may be declined in the future.

The approach allows an applicant, unhappy with the outcome of their grant application, to resubmit it to WIBSS for reconsideration. The WIBSS Manager will arrange for the decision to be considered by somebody independent of the original decision-making process. As part of our overall review of our documentation and guidance, we have amended the small grants section to reflect these changes.

Welfare Rights Service



The Welfare Rights Service offers a bespoke service to the individual beneficiary and their family. The welfare rights advisors are Advice Quality Standards (AQS) accredited and undertake continuing professional education with specialist welfare training providers.

Although not exhaustive, the list below demonstrates some of the things we may be able to assist with:

- liaising with social services to ensure complex beneficiary needs are met. i.e. support from a social worker or occupational therapy to obtain safety adaptions to the home of the beneficiary.
- signposting to free NHS dental care and prescription services, for those eligible.
- assisting with applying to join WIBSS - including requesting medical records or chasing medical professionals to provide necessary evidence to support an application.
- undertake benefit and welfare checks, debt signposting, budgeting advice, navigating financial products etc.
- applying for a parking badge (Blue Badge), free bus travel and concessions.
- accessing health services, such as additional care requirements and health care transportation.

WIBSS also recognises a beneficiary's health not only impacts them. It can also have a significant impact on those caring for them. Our welfare rights advisors can also consider the circumstances of immediate family members and carers. They can check their entitlement to benefits and additional support requirements, which may help to improve overall financial circumstances.

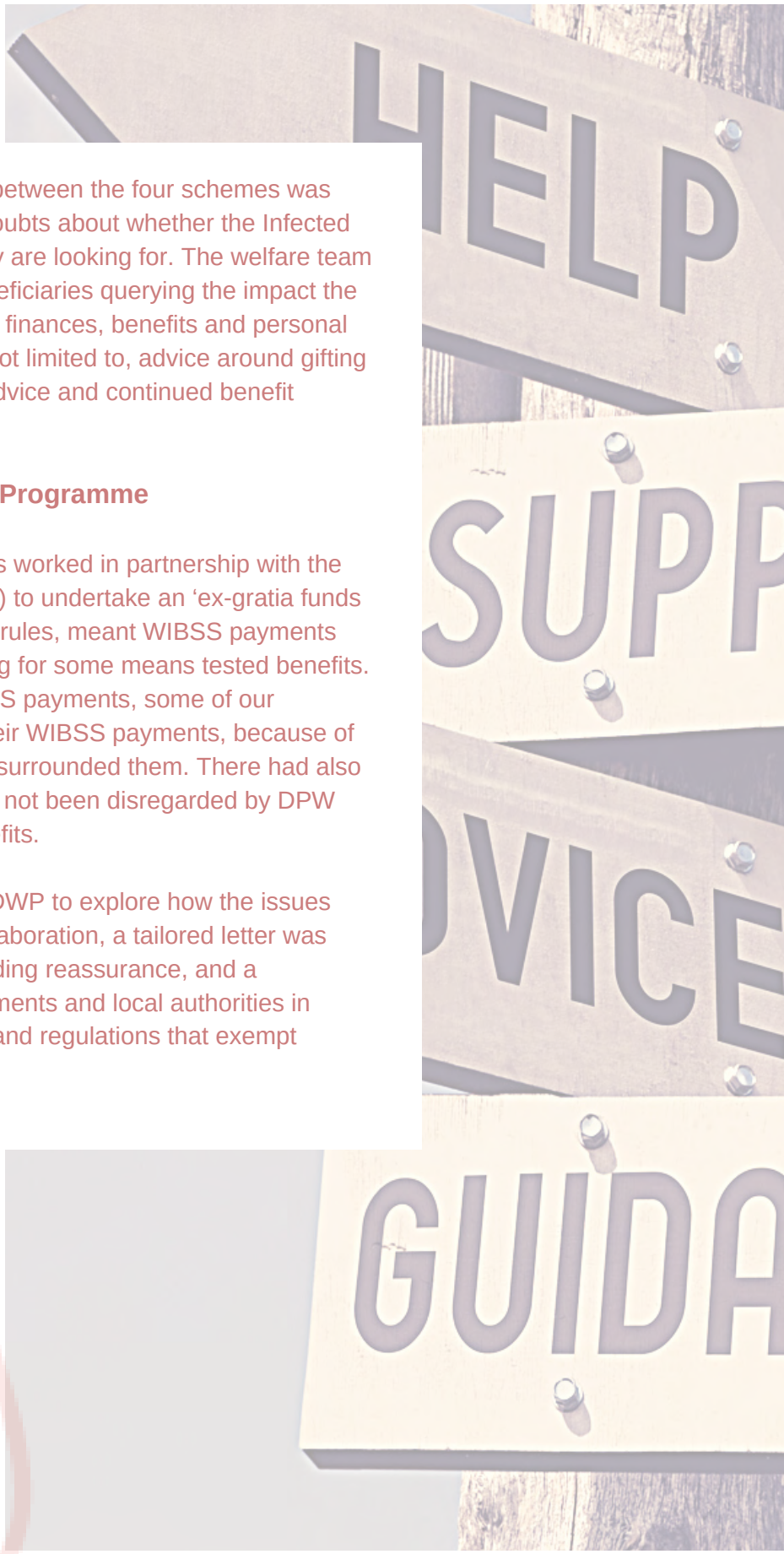
Key worker support

Another service provided is key worker support, which includes:

- liaising with beneficiaries and wider family members to establish a trusting relationship and provide emotional support, outside of formal psychology and well-being referrals.
- regular outbound check-ins with beneficiaries considered as vulnerable.
- completion of paperwork and help to sort affairs for those unable to do so themselves.

The welfare rights service is often the first point of contact for updates and reassurance on issues impacting WIBSS.

Welfare Rights Service



The lack of parity in the payment values between the four schemes was provoking feelings of anger, along with doubts about whether the Infected Blood Inquiry would find the answers they are looking for. The welfare team provided reassurance and advice for beneficiaries querying the impact the back payments would have on their other finances, benefits and personal circumstances. These included, but are not limited to, advice around gifting money to family and friends, budgeting advice and continued benefit entitlement.

DWP 'Ex-gratia Funds Declaration' Programme

In March 2022, the welfare rights advisors worked in partnership with the Department of Work and Pensions (DWP) to undertake an 'ex-gratia funds declaration' programme. A change in the rules, meant WIBSS payments now needed to be declared when applying for some means tested benefits. However, due to the sensitivities of WIBSS payments, some of our beneficiaries were reluctant to declare their WIBSS payments, because of the perceived stigma that has previously surrounded them. There had also been cases where WIBSS payments had not been disregarded by DPW staff, when assessing entitlement to benefits.

The WIBSS welfare team contacted the DWP to explore how the issues could be alleviated. As a result of the collaboration, a tailored letter was issued to beneficiaries by the DWP providing reassurance, and a memorandum was sent to benefit departments and local authorities in Wales, reiterating to staff the disregards and regulations that exempt WIBSS payments.

Welfare Rights Service

Case Study

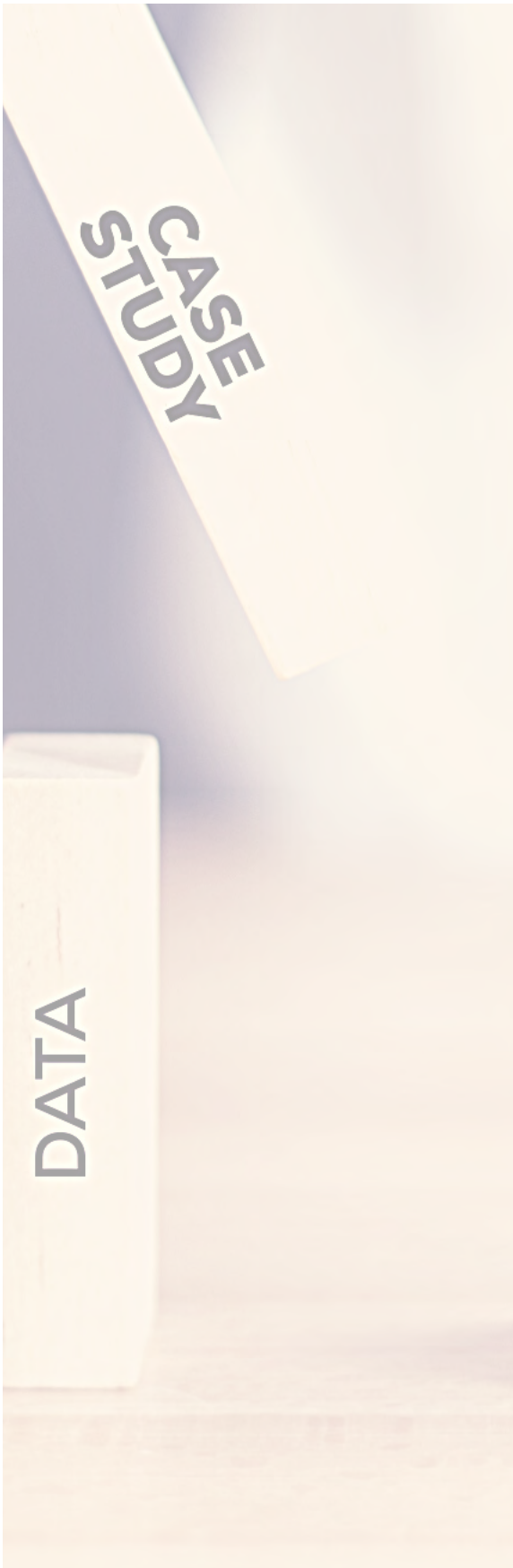
To provide an equitable service to our beneficiaries, our welfare rights advisors travel throughout the UK to provide assistance.

Case study A involved a 455-mile round trip, as the beneficiary had requested a home visit. Although, we continued to provide our services remotely during the pandemic, as soon as COVID restrictions were lifted, we arranged to visit this beneficiary. They had been reluctant to receive support remotely, due to their nervousness and limited knowledge of technology.

The benefit check undertaken resulted in the following eligibility:

- a full claim for Universal Credit, including housing costs to help towards rent,
- a review of PIP entitlements due to deterioration of health,
- a claim for free NHS prescriptions in England
- a full reduction of Council Tax payable that year.

Prior to the visit, the beneficiary's household had been living solely on WIBSS funds. With the cost of living rising, the additional benefits identified by the welfare rights advisor, has provided our beneficiary with financial peace of mind. This, in turn, has eased their physical and mental health pressures.

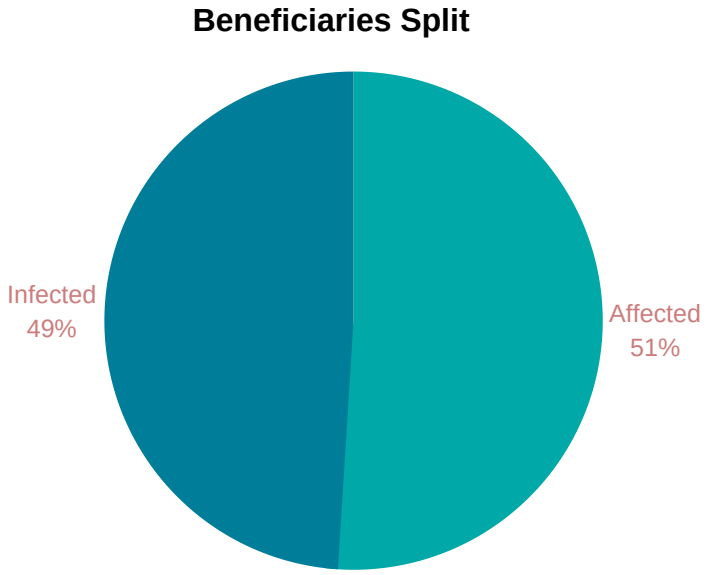


Psychology and Emotional Well-being Service

Operation and Delivery

The Wellbeing and Psychology Service continues to provide specialist one to one psychological support to those infected and affected.

The split between those infected and affected who have accessed the service is shown in the chart below 49% (infected):51% (affected).



To date, over 80 people have accessed the service. The current caseload is 34.

For most of 2021/2022, therapy was delivered virtually or via telephone, due to COVID restrictions. As soon as the COVID restrictions were eased, face-to-face appointments were reintroduced. Where possible, upon request, the team also provide home visits for those with mobility issues and/or chronic co-morbidities commonly related to Hep C, HIV/AIDS or the treatment received, such as Interferon.

Therapy is heavily focussed on developing the therapeutic relationship with the client. It strives to deliver consistency and to promote trust and reliability, in a support service that is allied with the NHS system that provided the infected blood and blood products that have had such a devastating effect on their lives.

Feedback from those accessing the service would suggest that this approach is successful.

Psychology and Emotional Well-being Service

The team have been able to offer effective therapeutic interventions around a raft of themes including trauma (panic attacks and flashbacks), hypervigilance, loss and bereavement, stigma (secrecy), fear and isolation, misplaced guilt and responsibility, living with related life-limiting health issues, anger, mistrust, distress caused by a lack of understanding expressed by NHS staff as to the causes of chronic health conditions (e.g. the assumption that someone with Hep C is an alcoholic and the implication that they are lying about the causal factor of a cirrhosis diagnosis), carrier status, imposed infertility (the fear of passing on HIV or Hep C), relationship difficulties, anxiety and depression.

The ongoing proceedings of the Infected Blood Inquiry, the contentious evidence presented by some of those who have participated, and the creation and dissemination of the Compensation Framework have complicated the trauma responses of many. It has caused secondary and continued psychological trauma, resulting in many being stuck within a loop of psychological distress and reliving painful and traumatic events of the past.

Subsequently, therapy is having to address the immediate psychological and emotional responses to minimise further psychological harm, in the first instance, whilst addressing historic trauma is a secondary task in some cases.

The team feel that meaningful resolution-focussed therapy, to address historic trauma, might be more effective once the Inquiry is concluded and Compensation Framework has been agreed. In addition, preparatory therapy is underway around people's expectation of the Inquiry's findings and outcome (realistic vs unrealistic, what would justice look like? etc) to minimise further psychological harm in the future.

Developments

The team hosted an online focus group event earlier this year. It was held via Zoom, due to Covid restrictions. All WIBSS members were invited, and a small but lively group attended.

Attendees were asked for their ideas to help develop the Psychology and Wellbeing Service now that the specialist one to one support had been firmly established. WIBSS believe it is important the service users have a say in shaping the service to meet their needs.

There was a consensus around creating peer support opportunities and bringing together people as a community through shared experience. As a result, it was agreed the following ideas should be presented to the wider WIBSS community for their input and opinion:

1) Regular Zoom and/or face to face regional meetings to allow people to come together and discuss common themes and topics around wellbeing and share individual experiences.

2) A group regional and/or All-Wales social event to bring together all those infected and affected with the aim of creating a common community. The event could potentially encompass workshops with psychoeducational opportunities, links to promote peer support and guest speakers.

Psychology and Emotional Well-being Service

3) The creation of a ‘buddy’ system where people can register their interest in being paired with others within their community (small groups or one-to-one) to reduce isolation and create links with others through shared experience and friendship.

All WIBSS members have been asked for their expressions of interest in relation to these ideas, which the team intend to implement later this year, based on feedback.

In addition, the team have established the Infected Blood Psychology Network with colleagues from the Irish and Scottish psychology services. The group meet bi-monthly to share ideas, information, best practice, common themes and potential opportunities for research and cross-border work.

The network has also been consulted by colleagues from NHS England to help shape the English Infected Blood Support Scheme (EIBSS) psychology service, with emphasis on the importance of delivering a specialist service.

The Network are also examining and discussing published research around the cognitive impact of Hep C with the aim of creating a common assessment framework across the network to assess those members who present with cognitive impairment. The framework could also be applied to those with HIV.

Testimonials

Feedback was requested from those who has accessed the service, and they have given consent for their testimony to be shared.

Testimonial 1

A friend suggested that I contact WIBSS, as he was aware that attending the public inquiry in Cardiff had affected my health. I had tried counselling, via my workplace, but found that it was time restrictive i.e., six sessions, and was not that helpful. Eventually I couldn't cope with my emotions, so I contacted WIBSS, and am so glad I did. I now have help and support from my counsellor, who not only has great insight of the Infected Blood issue, but also appreciates that our suffering has been endured for a considerably long time, and so it will take time to be able to overcome the difficulties.

This counselling is tailored to suit my needs and I don't feel pressured to make a fast recovery. I have made progressive steps and also taken retrograde steps, but I know that no matter what I have the full support and encouragement of my counsellor which gives me strength to keep going. Every session leaves me feeling more able to cope with my issues. COVID 19 has impacted on my mental health, however, once again the counselling has been tailored to suit my current needs. I would advise anyone who is thinking about seeking counselling to approach WIBSS. This counselling is so different. It is helpful, supportive and adapts to the individual.

Psychology and Emotional Well-being Service

Testimonial 2

I'm a normal person, I live a normal life, but I sometimes find myself crying myself to sleep and I hide it. I'm in the car, and the tears just come from nowhere. Why do I feel so so sad and alone when I have so many people around me, friends and family?

It hasn't always been easy, not just the bad blood and everything that brings with it, but many other things that a person shouldn't cope with endure or experience, but I'm a strong person and I can cope, I'm the one everyone needs to help them, and then one day I can't anymore, and I need someone.

It's not easy to get help, it's not easy to ask.

WIBSS is there. I just filled out a form a couple of years ago, to say how I felt, and they came to help me. Just having someone to talk to about something or nothing is a safety net, I don't know why but it is. I look forward to the calls, it helps me. It could help you too.

Testimonial 3

The treatment I received for Hepatitis C had a devastating effect on my life. I found that talking to the WIBSS Wellbeing Service was reassuring and helped me understand some of the emotional and psychological issues that I have been dealing with. In particular, talking about some problems I have had with my relationships, with my family and friends, has enabled me to put things into context and enabled me to improve things. Talking to someone outside my circle has been very helpful.

In addition, some mindfulness exercises that she introduced me to have helped me with my sleeping difficulties.

Testimonial 4

The service has been helping our son, who has been struggling with issues relating to his dad's health, giving him ways to help cope with this and other anxiety and problems he is facing. He is finding the sessions really helpful.

Psychology and Emotional Well-being Service

Testimonial 5

I first decided to utilise The Wellbeing Service at WIBSS about a year ago. I have benefited enormously and have welcomed the support and reassurance that I have experienced during the last twelve months.

It has been a difficult year for all of us, especially so if you have been feeling isolated in your own home. Added to this, has been The Infected Blood Inquiry hearings, which may have transported many of us back to very traumatic and heart-breaking times, recreating difficult memories.

The Wellbeing service has provided me with a crutch to lean on and a safety net, giving me the support that I have needed for a very long time. I wish that this service had been available thirty years ago when I lost my Husband to AIDS.

I would encourage anyone to use this service which is confidential. Use it and don't suffer alone help is available to you.

Further testimonials are available on the WIBSS website.

Beneficiaries activity 2021-2022

There are 217 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31 March 2022).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	40
Hepatitis C Enhanced Stage 1+	77
Hepatitis C Stage 2	41*
HIV	2
HIV & Hep C Stage 1 (Co-infected)	3
HIV & Enhanced Stage 1+ (Co-infected)	11
HIV & Hep C Stage 2	2
Bereaved spouse/partner	41*

*2 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/partners.
**2 beneficiaries and 1 bereaved spouse passed away during Q4 2021/22. However, they are still included in the above numbers they continue to receive payments until the end of the quarter in which they pass away i.e., the 31st March 2022.

Payments Rates 2021-2022

The levels of payments available to beneficiaries in 2021/2022 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	£18,912
Hepatitis C Enhanced Stage 1+	£28,680
Hepatitis C Stage 2	£28,680
HIV	£28,680
HIV & Hep C Stage 1 (Co-infected)	£38,928
HIV & Enhanced Stage 1+ (Co-infected)	£45,072
HIV & Hep C Stage 2 (Co-infected)	£45,072

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. Under Parity, a new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment.

A new applicant who has already developed to Hepatitis C Stage 2 would receive a £70,000.

A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500.

A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased infected beneficiary to assist with funeral costs.

WIBSS also make regular payments to bereaved spouses/partners/dependant relatives, of an infected beneficiary who has passed away. These payments are equal to 100% of the rate the deceased beneficiary was on at time of death for one year and 75% of the rate thereafter.

WIBSS Structure

The main WIBSS team consists of eight members of staff, led by the WIBSS Manager.

Alison Ramsey
Director of Planning,
Performance and Informatics
NWSSP

Lisa Miller
Head of Operational Service and
Delivery
Velindre Cancer Centre

Mary Swiffen-Walker
WIBSS Manager

Psychology and Well-being

Caroline Coffey
Clinical Psychologist

Julie Armytage
Counsellor

Finance

Stefan Dakovic
Finance Officer

Welfare

Hayley Price
Welfare Rights Manager,
Deputy WIBSS Manager

Rebecca O'Callaghan
Welfare Rights Advisor

Sarah Ferrier
Welfare Rights Advisor

Admin Support

Ryan Clappe
Support Officer

Finance Report

The table below summarises the claims expenditure for 2021-22, which includes full year payments paid at parity rates, and includes £9m of backdated payments, relating to 2019/20 and 2020/21 that were paid in 2021/22 as a result of the parity agreement. Announced in March 2021 and actioned in August 2021. These costs include ad-hoc, widows and small grants payments.

WIBSS Claims Expenditure	2021-22	2020-21 Comparative
No. of Beneficiaries	217*	176
Regular Payments	£7,294,727	£3,382,927
Backdated Parity Payments	£0	£8,996,254
Total Payments to Beneficiaries	£7,294,727	£12,379,181

**Please note the 2021-22 No of Beneficiaries difference of 41 relates to the on-going payments to bereaved spouses/partners as result of Parity.*

Please note the figures above have been subject to in year movements i.e. new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the NHS Wales Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Running costs for 2021/22

A summary of the running costs for 2021-22 is set out below with a 2020-21 comparative:

WIBSS Running Costs	2021-22	2020-21 Comparative
Pay	£215,298*	£218,749
Expenditure	£11,328	£10,372
Total	£226,626	£229,121

**Note the 2021-22 running cost spend is not a full comparative to 2020-21, the reduction in pay is due to the impact of maternity leave within the team during the year.*

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Description of key performance indicator	20/21 Target	Status
Responding to correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information requests within required deadlines	In line with Trust policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with applications within required timescales	100% 2 appeals were lodged, but one was withdrawn by the appellant prior to the panel taking place, as they were unable to obtain the evidence they required. The other appeal was heard within the required timescale. However, we acknowledge that this appeal was postponed and needed to be re-arranged due to COVID-19 related pressures faced by clinicians on the panel.	100%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date	100%
Advising WG on CPIH Uplifts and the cost implications for the next financial year	In February each year	100%

Performance Report

Description of key welfare rights indicators	Status
Total Welfare Rights cases opened in previous 12 months	62
No of Key Worker Advice Only	34
No of welfare rights casework	28
Income Generated for beneficiaries (1 Apr 2021 - 31March 2022)	£45,928.62
Outstanding outcomes March 2022	1 PIP review 1 PIP claim 1 Pension Credit claim 1 ESA claim

New Applications for Financial Support

WIBSS received 9 applications in 2021-22.

Application Type	Applications received	Outcome
Hepatitis C Stage 1	5	1 Accepted, 4 Declined
HIV	1	Accepted
Widows' application	3	Accepted
Total	9	5 Accepted, 4 Declined

Where an application is declined, it will be because it does not meet the criteria set in Wales Infected Blood Support Scheme Directions, or insufficient evidence has been provided to support the application.

Support and Assistance Grants Scheme

In 2021-22 we received 12 applications for a support Grant. This is an increase a 50% increase from 2020-21. We believe this increase is as a result of promoting the support and assistance grants in a WIBSS Newsletter issued to all beneficiaries.

Forward Look 2022 -2023

The workplan for 2022-2023 will include the following –

- Progress the work started by the Psychology and wellbeing team around focus groups etc.
- Launch an outbound campaign, aimed at assisting beneficiaries during the cost-of-living crisis i.e., identify schemes to provide new boilers, reduce heating costs etc.
- Respond promptly to any future and additional directions of Ministers in their response to the Inquiry recommendations.
- Process interim compensation payments, as directed to do so by Welsh Government
- Respond to the Rule 9 request received in July 2022 and any subsequent Rule 9 requests received.
- On the 29 July the Chair of the Inquiry also published an interim report, with a recommendation to make interim payments, but at the time of writing this report, no decision has been taken by UK or Welsh Ministers. Respond to any action required as a result of response.

QUALITY SAFETY AND PERFORMANCE COMMITTEE

COVID 19 INQUIRY (PREP GROUP)

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Modupe Akinrinade, Executive Support Administrator
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THE MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26.10.2022	Noted

PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key discussions held and issues considered by the COVID 19 Inquiry Preparation Group during their meeting held on 21st October 2022.

BACKGROUND

The Trust's COVID 19 Inquiry Preparation Group is chaired by the Director of Corporate Governance and Chief of Staff and is attended by key personnel from Corporate and both Divisions. The Group has been established to support the preparation of the Trust to respond to the Inquiry once it is established. The Group reports to the Executive Management Board.

The Group has now been formally established and meets monthly, the frequency of which will be reviewed as matters progress with the Inquiry.

The following are the highlights from the COVID 19 Preparation Group meeting held on 21st October 2022.

ALERT/ESCALATE	No items to escalate
ADVISE	**Terms of Reference** The Group has updated the Terms of Reference in line with the developments in the Inquiry – Attached. **Core Participant Status** There will be a decision before end of calendar year on the Trust's position on whether to apply for Core Participant Status of Module 3 of the Inquiry. It has been agreed with the Chair and Acting CEO that this will be a Trust Board decision. **Leavers** It has been established that in some cases, staff leaving the organization may take information with them to their new organisation within NHS Wales. The DHCW is developing some measures to ensure the protection of the integrity of all data, to ensure that all NHS organisations will have access to their own data should there be any request for it
ASSURE	**Legal and Risk** Solicitors from Legal and Risk are represented in the group providing guidance and legal support. Counsel has also been instructed
INFORM	**Archivist** An Archivist has been appointed and is working with the Head of Information Governance and this Group to progress the workplan of the Records Management and the Timeline workstream. **Staff Communication** The activities of the Group will be updated in the Trust Newsletter. The Group agreed key messages.
APPENDICES	Appendix 1: Archivist Job Description Approved by Scrutiny Committee Appendix 2: UK COVID-19 Inquiry – Terms of Reference and Recommendations

RECOMMENDATIONS

The Quality Safety and Performance Committee is asked to **NOTE** the key deliberations and highlights from the meeting of the COVID 19 Prep Inquiry Group meeting.

Covid-19 Inquiry Preparation Group

Terms of Reference

1. Framework

The Covid-19 Public Inquiry will operate under the Inquires Act 2005. Key aspects of the Inquires Act include:

- The aim is to help restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence.
- Can compel evidence to be provided, both documents and witnesses.
- No power to determine civil or criminal liability.
- Inquiries' findings do not have legal effect.
- However responsibility may be inferred from a determination of a fact

2. Principles

The Group will coordinate the Trust Board engagement in, and possible refreshed commitment, in this context (previously signing up to in relation to Infected Blood Inquiry in 2018) the Charter for Families Bereaved through Public Tragedy.

The Group will have an approach based on empathy for all those involved and will strive to ensure positive actions as a result of this preparation work at all times, whether in learning from any lessons or supporting ensuring the continuation of improved ways of working for our staff, patients, donors and all other stakeholders.

3. Objectives

The Group's objectives are aligned to two core initial workstreams: 1. Record Retention and 2. Timeline. The objectives are aligned to All Wales guidance documents provided by NWSSP Legal and Risk team.

1. Record Retention Workstream

- To ensure a strategic oversight of the archiving, cataloguing and records management process across the Trust as a whole, in order to:
  - Prepare the necessary evidence for a future Public Inquiry in relation to the Covid-19 pandemic
  - Preserve relevant information
  - Ensure there is a robust, secure document management system with adequate storage
  - Archive documents, evidence, complaints, decisions and testimonies in an orderly format that is easy to search, locate and export, including recordings, digital and paper evidence

- Provide a systematic audit trail of the pandemic response

- To consider and recommend the necessary archiving during the recovery phase of the pandemic; immediate, medium and long term recovery

- To review and agree appropriate retention periods for documents, in line with Trust Policy

2. Timeline Workstream

- To prepare organograms of organisational changes and Trust Policies in place at the time, as well as relevant interaction with third parties

- To identify partner bodies and organisations which impacted on the Trust's pandemic response and to liaise with these to ensure joint documents are archived and catalogued

- To identify groups set up with partner bodies and organisations, membership of those groups and, to prepare charts setting out the organisations the groups reported to and which reported into them

- To coordinate decision making and effective use of resources in terms of Public Inquiry readiness

3. Other Objectives

- To identify senior members of staff who can provide evidence in respect of decisions made, if gaps are identified in the documentary evidence

- To provide guidance to staff on the ongoing process for managing information in relation to the pandemic

- To seek legal and other independent guidance, as necessary, during the preparatory stages

- To consider expenditure requirements

- To engage with other NHS bodies on an All Wales basis to share practices and learning

- To consider the identifying, obtaining and provision of additional support, if required, such as for staff members who may be required to provide witness evidence

4. Scope

From an initial review of the possible areas that may be covered as part of the Inquiry's terms of reference, those relevant to the Trust are:

- Pandemic preparation
- Clinical decision making – including immediate and longer term impacts – at patient/donor and system level
- PPE provision – staff, patients, donors
- Interaction with other public section bodies
- Discharge to other healthcare settings
- Disproportionate impact on Black and ethnic minority communities
- Nosocomial infections
- Testing processes
- Care provided to patients with Covid-19 in hospital
- Stepping down and up of other healthcare services
- Vaccination roll out
- Support given to staff
- Staff management – including Covid-19 status of staff/ families/ contacts
- How Government Directives and guidance was implemented
- Key specific accountabilities – e.g. convalescent plasma trial

5. Membership

- Lauren Fear, Director Corporate Governance & Chief of Staff – Chair
- Lisa Miller, Head of Operational Services and Delivery VCC
- Sarah Richards, General Services Manager WBS
- Nigel Downes, Deputy Director of Nursing, Quality and Patient Experience
- Annie Evans, Clinical Transformation Lead
- Helen Jones, Health & Safety Manager
- Susan Thomas, Deputy Director Workforce and Organisational Development
- David Mason-Hawes, Head of Digital Services
- David Osborne, Head of Business Partnering

- Laurie Thomas - Trust business continuity lead
- Ian Bevan – Head of Information Governance
- Covid-19 Inquiry Archivist
- Caldicott Guardian and Divisional Leads, as required (standing meeting invite)
- NWSSP Legal and Risk Legal Support Leads, as required (standing meeting invite)
- Modupe Akinrinade - Executive Support Administrator

6. Decision Making

The Group does not have a formal delegation of decision making authority and any formal decision making will be managed through the Business Continity, Divisional and Executive level governance arrangements as appropriate.

7. Reporting Arrangements

- The Group will report a highlight report into:
    - Executive Management Board
    - Trust Business Continuity Group.
- In addition, there will be reporting into Divisional SLT/SMT.
- Divisional level coordination will be via Divisional Leads.

8. Meeting Arrangements

The Group will meet monthly initially and frequency will be adapted accordinaing the the stage of the inquiry process.

9. Appendicies

APPENDIX 1 - CHARTER FOR FAMILIES BEREAVED THROUGH PUBLIC TRAGEDY *(Below)*

APPENDIX 2 – COVID-19 INQUIRY TERMS OF REFERENCE *(Attached)*

APPENDIX 1

CHARTER FOR FAMILIES BEREAVED THROUGH PUBLIC TRAGEDY

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.

2. Place the public interest above our own reputation.

3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.

4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.

5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.

6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

(CIVAS@IP5)

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	GARETH TYRRELL – HEAD OF TECHNICAL SERVICES - CIVAS@IP5
PRESENTED BY	GARETH TYRRELL
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
		Choose an item.

ACRONYMS	
CIVAS	Centralised Intravenous Additives Service
IP5	Imperial Park Building No.5, Celtic Way, Newport, NP10 8BE
TMU	Temporary Medicines Unit

GMP	Good manufacturing Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
GDP	Good Distribution Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
MHRA	Medicines and Healthcare products Regulatory Agency
MS	MHRA Manufacturers' "Specials" license
WDA	MHRA Wholesale Distribution Authorisation

GLOSSARY	
Drug	A substance used to prevent, diagnose, treat or relieve symptoms of disease
Immunotherapy	A type of cancer treatment that activates or suppresses the immune system to treat disease
Cytotoxic	A substance toxic to cells, preventing replication or growth and used to treat cancer as well as some other diseases

1. SITUATION/BACKGROUND

1.1 CIVAS@IP5 is an MHRA Licenced "Specials" Manufacturer, Wholesale Dealer and Home Office Licenced holder funded by Welsh Government and Hosted by NHS Wales Shared Services Partnership.

1.2 The service is hosted by NHS Wales Shared Services Partnership with legal responsibility for adherence to Medicines Law residing solely with the names Head of Production and Head of Quality Assurance

1.3 The purpose of this service is to provide Licenced “Specials” to Health Boards and Trusts across Wales where there is a clinical need, and local aseptic service capacity does not support local manufacture.

1.4 Subsequently, CIVAS@IP5 has also expanded services to incorporate other Licenced “Specials” products, COVID-19 Vaccine Packdown and Wholesale Dealer activities

1.5 The CIVAS@IP5 application for General Pharmaceutical Council (GPhC) Premises registration was accepted in March 2021. CIVAS@IP5 has also obtained Home office Domestic Controlled Drugs license, MHRA Manufacturers’ “specials” license (MS) and Wholesale Distribution Authorisation (WDA).

1.6 Due to facilities and design restrictions, as well as regulatory guidance, the service is unable to handle cytotoxic therapies and as such future products will focus on CIVAS medicines.

1.7 The CIVAS@IP5 service has prepared over 30000 doses of ready to administer intravenous infusions, which have been supplied to each of the health boards to support critical care during the COVID-19 Pandemic CIVAS@IP5 has packed down under the MHRA Specials Licenced just over 200000 vaccine doses to support booster roll out and facilitated a drug saving of >£900000 through wholesaling activities.

1.8 On February 15th-16th 2022 CIVAS@IP5 was subject to a GMP Inspection against the Human Medicines Regulations 2020 (SI 2012/1916). This inspection was undertaken to identify adherence to the principles and guidelines of Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP).

1.9 The inspection outcome has assigned the CIVAS@IP5 unit with the **lowest risk rating** and the **longest inspection interval** available. The facility will now be inspected again in February 2024

1.10 As well as the regulatory, compliance and assurance framework for the activity itself, it was also important to consider the wider quality governance framework in which this part of the NWSSP model operates in. To support consideration of this, appendix one was compiled which outlines, from various internal and external sources, key elements which make up an Organisational quality governance framework. The right-hand column then articulates how TMU and NWSSP fulfill these elements. The document has been previously discussed and approved in advance of the Committee with Medical Director NWSSP, Executive Medical Director Velindre University NHS Trust and Executive Director of Nursing, AHPs and Health Science.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Attached to this document is the CIVAS@IP5 Service Board Report for 22/23. This report identifies the following

- Performance metrics for operational output up to September 2022
- Regulatory performance against EU GMP
- Service development progress

2.2 Operational output has stabilized over June/July due to temporal stability of service. It is anticipated that all current vacant posts be recruited into by year end 2022. Performance metrics to highlight:

- 100% Internal Audit compliance
- 93% Documentation Review dates met
- Environmental failure rates for critical area and operators of 0% respectively (target of <5%)
- 2 service complaints for August
- 90% Production yield (target >95%)
- 100% compliance with CD checks

An increase in equipment and facilities deviations for September is in relation to the new fridge and freezer facilities and remedial work required.

2.3 Compliance with Healthcare Standards

See Appendix 2

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	The CIVAS@IP5 was specifically commissioned to ensure equality of access to medicines by supplementing existing aseptic manufacturing capacity.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	CIVAS@IP5 is operating in compliance with relevant legislation, specifically the Medicines Act (1968), The Human medicines regulations (2012) and the misuse of Drugs act (1971). Legal responsibility of this compliance lies with the Head of Production and Head of Quality named on the MS Licence
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Welsh Government has confirmed continuing funding of revenues for the project to 31/3/23.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **note** current levels of service performance against the framework of standards set out in EU GMP and which we are legally required to comply with as an MHRA “Specials” and Wholesale Dealer license

holder. Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings.

The Quality, Safety and Performance Committee is asked to **note** the findings and CIVAS@IP5 risk status assigned by the MHRA. The action plan and progress update will be provided as part of this agenda item.

Appendix 1 - CIVAS@IP5 Governance Arrangements – notes

1.1	Quality as drive for organisational strategy	Quality and safety priorities clearly defined, documented and periodically reviewed	CIVAS@IP5 operates in compliance with Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP) these internationally recognised standards designed to ensure safe manufacturing, storage and distribution of medicines are clearly defined: https://ec.europa.eu/health/documents/eudralex/vol-4_en https://ec.europa.eu/health/human-use/good_manufacturing_distribution_practices_en The facility and its operation are clearly defined in the CIVAS@IP5 site master file and in standard operating procedures. The CIVAS@IP5 was inspected by the MHRA against GMP and GDP on 15-16th December 2020, and for pack down of covid vaccines on the 6TH Sept 2021. All newly licensed manufacturing units are inspected within 12 months of the first inspection. A further inspection in Feb 2022 resulted in a low risk rating applied to the facility. The CIVAS@IP5 will be inspected against GMP and GDP on behalf of WG and the Welsh Chief Pharmacists Group by the All Wales QA Pharmacist during 2021.
1.2		These priorities are reflected in organisation's IMTP	The CIVAS@IP5 development is fully supported by the Shared Service Partnership Committee and Welsh Government. The Minister has provided funding for CIVAS@IP5 project in response to COVID requirements

			and continuity of supply. It is also integral to supporting the COVID vaccination Program. Funding is currently assured until March 2023
1.3		Quality and safety strategic risks are reflected in Board Assurance Framework	The CIVAS@IP5 Board Agenda includes an agenda item on project risk. Any significant quality and safety risks will be also highlighted and discussed at the Shared Service Partnership Committee and the NWSSP Senior Leadership Team as part of the normal operational management and reporting within NWSSP. A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards, the agenda will include a section on associated risks.
1.4		Quality and safety risks central in the risk management strategy and processes of the organisation	Quality and Safety is integral to GMP and GDP quality improvement and quality by design are inherent within the approach to processes within CIVAS@IP5. As above in terms of reporting risks within NWSSP and to the NWSSP part of the Velindre University NHS Trust Quality, Safety & Performance Committee if approved.
2.1	Leadership of quality and safety	Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads	The CIVAS@IP5 lines of accountability are clearly defined. There are clearly defined professional roles. The CIVAS@IP5 Head of Technical Services now reports to the NWSSP Service Director for TrAMS

			managerially and to the Chief Pharmaceutical Advisor to WG professionally. The CIVAS@IP5 Head of Technical Services also reports to the Service Board, which in turn reports to the Shared Services Partnership Committee. The CIVAS@IP5 Head of Technical Services is the Superintendent Pharmacist for the CIVAS@IP5 General Pharmaceutical Council Premises Registration, and the Site lead, and Person Responsible for Security on the Home Office Domestic Controlled Drugs license. A suitably qualified and experienced individual is employed in the Accountable Pharmacist role. A new accountable pharmacist has been appointed to take over from the incumbent's retirement. The QA and Production Leads report to the CIVAS@IP5 Head of Technical Services. The QA and Production lead are named on the MHRA Manufacturers' "specials" (MS) license as being responsible for Quality and Production respectively. The QA lead is the named Responsible Person on the MHRA Wholesale Distribution Authorisation (WDA). All staff working in the CIVAS@IP5 will be formally engaged to job roles within NWSSP, to ensure accountability for the work undertaken. These engagements will be a mixture of:

			• Honorary Secondments of staff already employed by Health Board or Trust Pharmacy units • Bank Staff engagements • Permanent or where appropriate temporary employment contract All staff have a quality element to their role and an understanding of quality assurance of the operation of the service.
2.2		There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and safety	The CIVAS@IP5 board provides scrutiny of safety, quality and performance and of the service. The board also provides strategic and operational support. The board has met monthly since the service was envisaged in April 2020. The capacity of the board to carry out the oversight and support roles is evidence by the successful MHRA license applications and service delivery, respectively, within the projected project timescales. All health boards through the support of Chief Pharmacists have helped support the creation of the TMU and they are fully supportive and committed to the Unit. NWSSP is about collaboration and support service provision.
3.1	Organisational scrutiny of quality and patient safety	The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Safety	It is proposed that the following are submitted to the Quality and safety Committee • Annual Quality Statement • Inspection reports (as and when received)

		Governance Framework and key corporate risks for quality and safety	• MHRA Update/Action plan
3.2		Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them	A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards. Regular updates will be provided as part of the normal course of business to the Shared Service Partnership Committee, which includes representatives from every NHS organisation as the responsible body for shared services.
4.0	Clinical Audit	There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning	The CIVAS@IP5 service is a professional technical service whereby all clinical decisions are made by health board clinicians and not the CIVAS@IP5 staff. The unit is an accredited production unit which has a self-inspection programme for GMP and GDP. The unit is independently inspected by the All Wales QA Pharmacist. Best practice is shared through the Welsh Chief Pharmacists Group's pharmacy technical services sub-group (CPTS) and lessons learned from the development of the TMU have been captured. A number of senior health board technical pharmacy staff have been involved in putting in place the quality and operating procedures.

5.1	Organisation promotes a quality and safety focused culture	Organisational values and behaviours support a quality and safety focused culture	The organisational structure of CIVAS@IP5 is designed to ensure adequate supervision of all processes. All grades of staff are empowered and supported in identifying process deviations. The service will operate in line with the values and culture of NWSSP
5.2		Organisation actively participating in quality improvement initiatives	The service has a robust Corrective Action/Preventative Action (CAPA) system built into the Pharmaceutical Quality System (PQS). This ensures lessons are learnt and appropriate actions taken, within an appropriate timescale. The CAPA system also ensure continuous quality improvement.
5.3		Organisation takes steps to listen to staff and involve them in monitoring service change/improvement	All grades of staff are empowered and supported in identifying process deviations, during manufacturing process or at daily pre and post manufacturing session meetings. Feedback is provided on issues raised.
5.4		Strong culture of learning lessons from staff feedback or concerns	The CAPA system is an essential component of the Pharmaceutical Quality system. Staff training encompasses the PQS and the role of team members in its operation. The management recognize the importance of responding appropriately to staff concerns and providing feedback.
5.5		Quality and safety an integral part of workforce management processes	Quality and safety are pre-requisites for compliance with GMP and GDP

6.1	Organisational structures and processes support delivery of high-quality, safe and effective services	Clear lines of accountability for quality and patient safety across the organisational structure ie 'floor to Board'	Included as point 9 of PQS in Internal Assurance section
6.2		Effective corporate and operational controls to support delivery of high-quality and safe services	Operational controls in PQS in Internal Assurance section Current corporate and operational controls have been extended to cover the operation in line with existing processes. Once fully established the Q&S Committee for Shared Services will also provide an additional level of assurance for NWSSP Committee members
6.3		The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning	The DATIX is used to report clinical incidents and health and safety incidents. It is recognised that the DATIX system does not have the level of detail in classification of incidents for a CAPA system which meets the expectation of the MHRA. The Q-Pulse system is therefore used in addition to DATIX for management of CAPA and other components of the PQS. Complaints will be managed through Q-Pulse, the NWSSP Complaints Management Protocol and if these relate to product quality and or patient safety the MHRA's Defective Medicines Report Centre (DMRC). There is a Recall Procedure, the effectiveness of which is tested annually.
6.4		Enough resource and expertise to support and improve quality governance arrangements	The CIVAS@IP5 Head of Technical Services is an appropriately qualified and experienced Pharmacist. The CIVAS@IP5 Head of Technical Services is supported by QA lead, Production Lead and Production

			Managers with the necessary qualifications, skills and experience. The senior team is supported by a workforce designed, recruited and trained specifically for the operation of the service. The team has a clear understanding of their required contribution to the PQS. Capacity planning carried out as part of workforce design has ensured that the PQS is appropriately resourced.
6.5		Organisation has comprehensive and timely information for monitoring and reporting on quality and safety	Q-pulse is used to manage the PQS. This system is used to record, monitor and report on information relevant to the PQS: CAPA, facilities and equipment, customer, suppliers, external audit and self-inspection, The working environment is monitored by the team. End of batch tryptone soya broth fills are carried out at the end of each manufacturing batch. Public Health Wales provides Microbiological services, including incubation, species level identification and reporting for the environmental monitoring and end of batch testing. Finished product is quarantined pending confirmation of satisfactory environmental and end batch testing data.
6.6		Quality and patient safety receives effective coverage at both corporate and operational management meetings	The Board receives and reviews a monthly operational report, which includes both quality, safety and operational performance.

Appendix 2 – Adherence to Health and Care Standards

Standard	Criteria	Evidence of Achievement
Governance, Leadership and Accountability	Setting direction, igniting passion, pace and drive, and developing people.	
	Focus on outcomes and choices based on evidence and insight. Approach through collaboration building on common purpose.	Medicines preparations and manufacturing processes based on evidence-based literature and collaboration with clinical colleagues across Wales to ensure medicines are provided in professionally recommended presentations.
	Services innovate and improve delivery, plan resource, and prioritise. Develop clear roles and responsibilities, manage performance and value for money.	CIVAS@IP5 service manages resource via the internally completed UK Aseptic Services Capacity Plan, a regulatory requirement to ensure resources do not exceed 80% utilization. Innovation for improved delivery and resource utilization include Once-for-Wales purchasing, manufacture and distribution of wholesale and manufactured medicines. The roles and responsibilities for these activities are detailed on MHRA licenses for Wholesale Dealing, Specials manufacture and handling of controlled drugs via the Home Office License. Innovative new products and manufacturing techniques developed and introduced internally via Change Control and Validation processes with

		engagement of end user to identify safety, efficiency, and value for money outcomes.
	Foster a culture of learning and self-awareness, and personal and professional integrity.	Service hosts and contributes to All Wales study days, where learning and development from within the service is shared with partners across the UK.
Safe Care – managing risk and promoting health and safety	Best practice to manage and mitigate risk and safety notices and alerts acted on	Internal processes in place for identifying relevant safety notices and drug alerts, with approved pathway for customer and clinician notification. Fully validated recall procedure, tested annually, ensures the robust and expedient identification of affected medicines and their immediate removal from health service circulation for quarantine and destruction.
	Compliance with legislation, regulatory and professional guidance.	Internal Pharmaceutical Quality System (PQS) in place to ensure compliance with Human Medicines Regulations 2012 and EU Good Manufacturing Practice. Monthly internal audit completed and periodic inspection by MHRA/Home Office to ensure legal compliance.
	Qualified in respect to regulatory bodies and fit to practice within professional competencies	All staff required to complete CPD to maintain professional registration. 2 Yearly refresher training provided for QC Medical Gas Testing to maintain competency.

Safe Care – Medical devices, equipment, and diagnostic systems	Processes to ensure equipment in maintained, calibrated, and cleaned ensuring appropriateness for intended use and environment.	Asset register and validation master plan, housed on the ePQS within NWSSP provides a schedule of maintenance, calibration & revalidation for all facilities, equipment & processes within CIVAS@IP5. Intervals based on regulatory guidance, manufacturer recommendation and service requirements.
	Timely reporting of faults and issues.	Asset module on ePQS provides mechanism for documenting, reporting, and trending faults with all assets. Service Level and Technical agreements as well as service contracts in place with all suppliers/manufacturers.
Effective Care – Safe and clinically effective care	People are protected from avoidable harm	All medicines quarantined until confirmation of quality and sterility received. Immediate batch rejection and destruction if release criteria not met. Automated preparation of production documentation and medicines preparation remove human error from internal manufacturing processes.
	Practice evolves to reflect new evidence and promote clinically effective care.	Quarterly review of manufacturing performance with corrective actions plans implemented where evidence requires. Program of clinical review in relation to products prepared to identify any changes in clinical landscape that require a modification to quantities prepared,

		preparations required or packaging presentations which are currently designed along a “design for quality” approach.
	Systems and processes comply with safety directives	All systems and processes are fully validated and comply with EU GMP and MHRA guidelines. Manufacturing within CIVAS@IP5 is a needle-free.
	Non-compliance is reported and investigated.	All non-compliance is reported via the internal PQS. This is also submitted as an interim compliance report to the MHRA every 6 months.
	Practice keeps up to date with best practice, national and professional guidance, new technologies and innovation.	6 monthly review of site master file and quality policies take place, and built into this is a review of all regulatory and guidance documents for Good Manufacturing and Distribution Practice.
Effective Care – Safe and clinically effective care	Local capacity is developed to support and enable teams to identify improvement opportunities.	Capacity managed via the UK Aseptic Services capacity plan and operational activities are kept to below 80% in order to allow regulatory and continuous improvement activities to take place. This is a key regulatory requirement and compliance is mandatory.
	Progress is measured and shared.	Service improvement is measured and shared monthly via the CIVAS@IP5 Service Board. KPI’s tie in with operational objectives based on EU GMP requirements.

	Research has a direct impact on improving efficiency and effectiveness of services.	The R&D program within CIVAS@IP5 focusses on two key improvement metrics. Product quality and improved efficiency. All service developments are centred around work in these areas and are managed via the change control process. Outputs are presented locally via governance boards and nationally as published or presented work
	Visible leadership and collaboration with industry partners.	The service development work is shared nationally and locally via service board and national forums. CIVAS@IP5 have actively engaged commeric al partners win relation to technology improveements and development and also the pharmaceutical industry such as having the UKs first direct national purchasing contracts. This has improved financial expenditure on these medicines and improved medicines resilience during shortage issues nationally.
Effective Care – Information governance		All aspects of the CIVAS@IP5 service adhere to the ALCOA+ and regulatory principles for information governance and data integrity.
Effective Care – Record Keeping	Good record keeping is essential to ensure that people receive effective and safe care. Services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.	All documentation is completed and recorded in line with legislation and EU GMP guidance. Adherence is monitored via internal audit

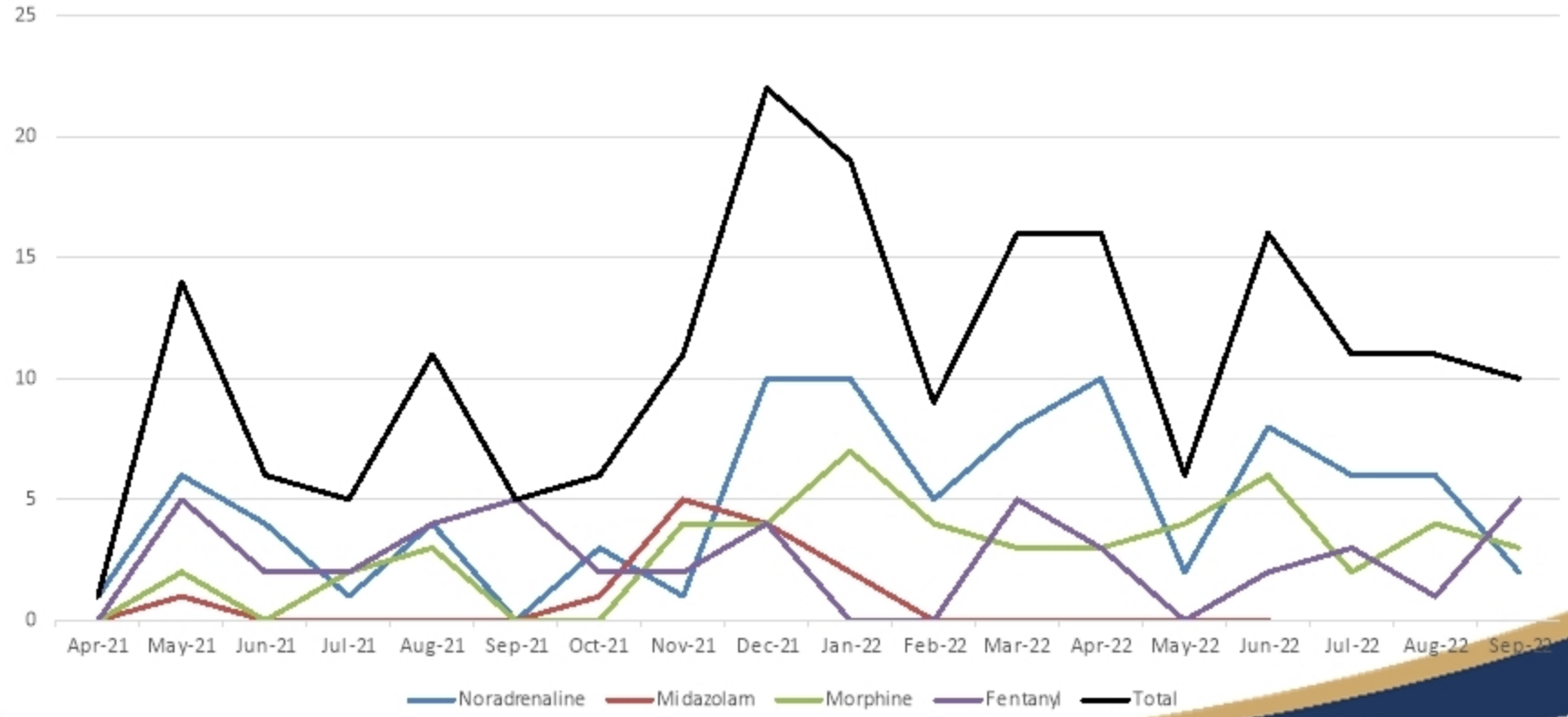
Workforce	Effective workforce plans integrated with service and financial plans	Workforce requirements are reviewed 6 monthly to develop a workforce that meets the service requirements and falls within the agreed operating budget.
	Have appropriate skill mix of staff	Capacity plan ensures the right mix off staff are available to perform tasks daily.
	Promote continuous improvement through better ways of working	Periodic workforce meetings to review working practices against performance metrics and regulatory changes take place.
	Staff are appropriately recruited and trained	All staff undergo nationally recognized technical services training programs as well as internal validation of processes, methods and equipment usage. These are reviewed and updated every 6 months.
	Staff able to raise concerns over service delivery, treatment, or management	Staff are provided the opportunity during team meetings, individual discussion or via annual PADR process to raise concerns Staff have access to all relevant NWSSP and All Wales policies in relation to raising concerns.
	Dealt with equitably and fairly when performance causes concern	Concerns with staff performance are dealt with via the relevant All Wales policies around performance management and dignity at work.
	Maintain workforce support around training, appraisals, CPD and have access for collaborative working	All staff receive support and time out to undertake adequate appraisals, training and CPD as required. Each staff member is given communication around

		opportunities for further development via internal and external training.

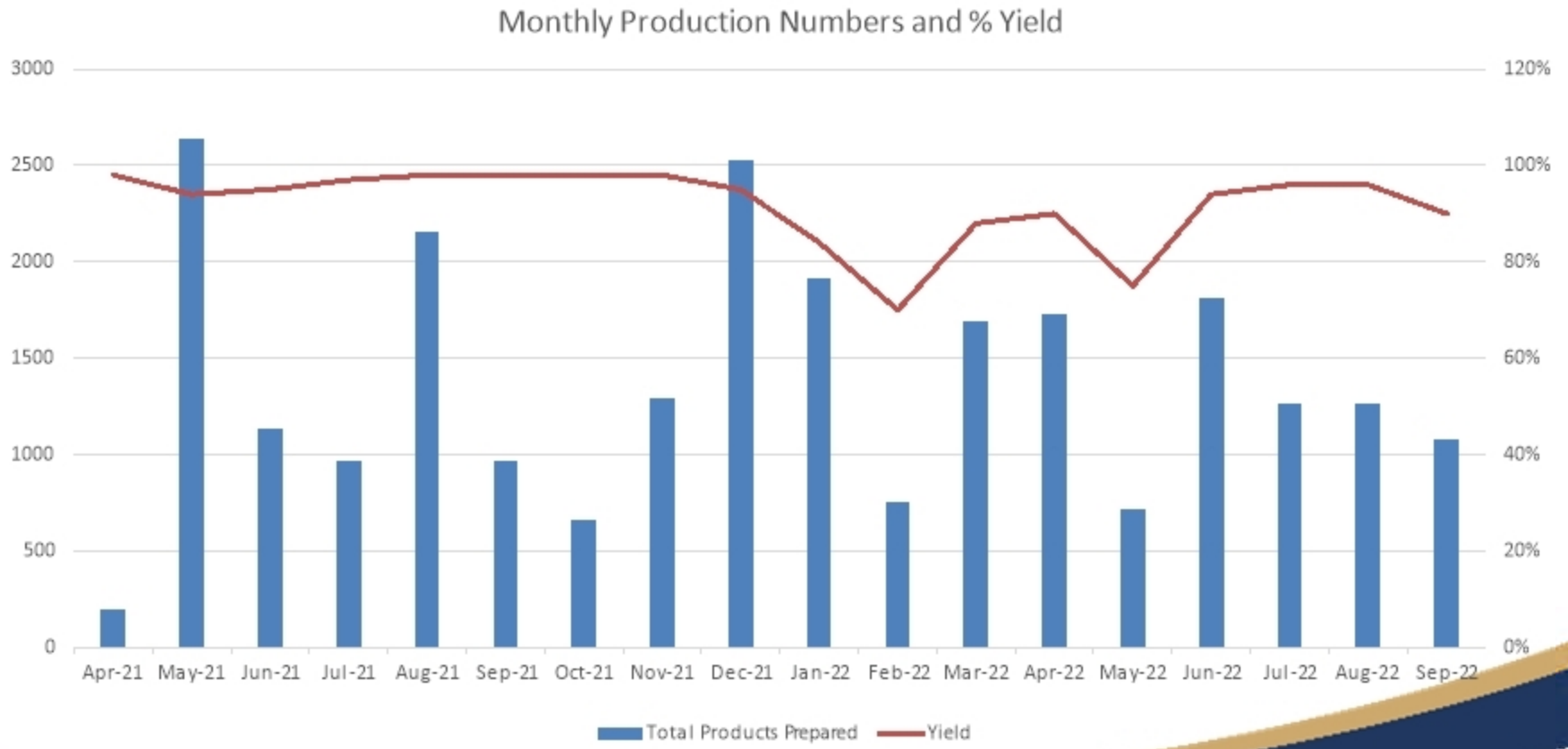
CIVAS@IP5 Service Board

Service and Quality Report

Batch Production



Total Production and % Yield



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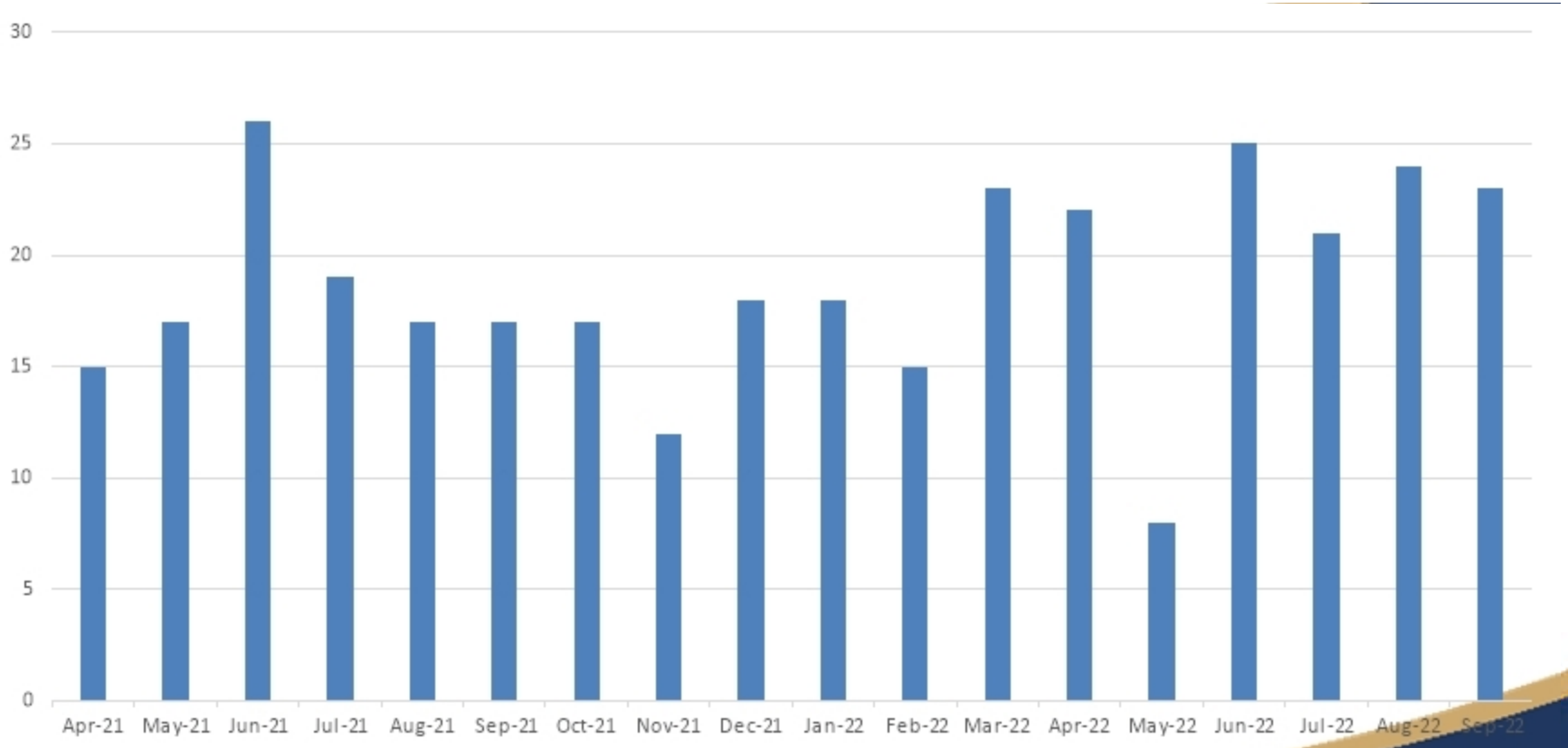
Partneriaeth Cydwasanaethau
Shared Services Partnership

UHB Production Orders Received



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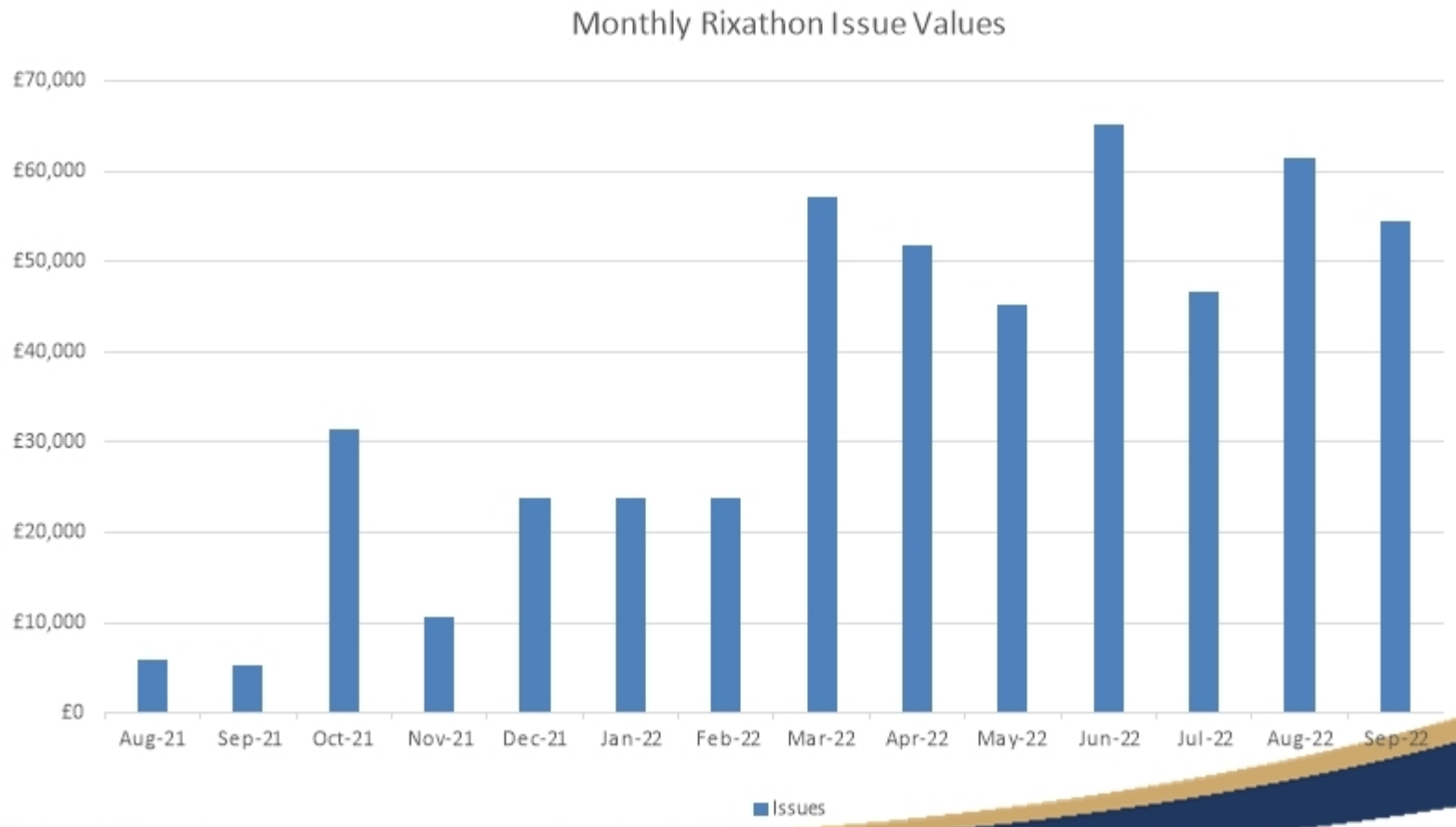
Partneriaeth Cydwasanaethau
Shared Services Partnership

Rixathon WDA Service



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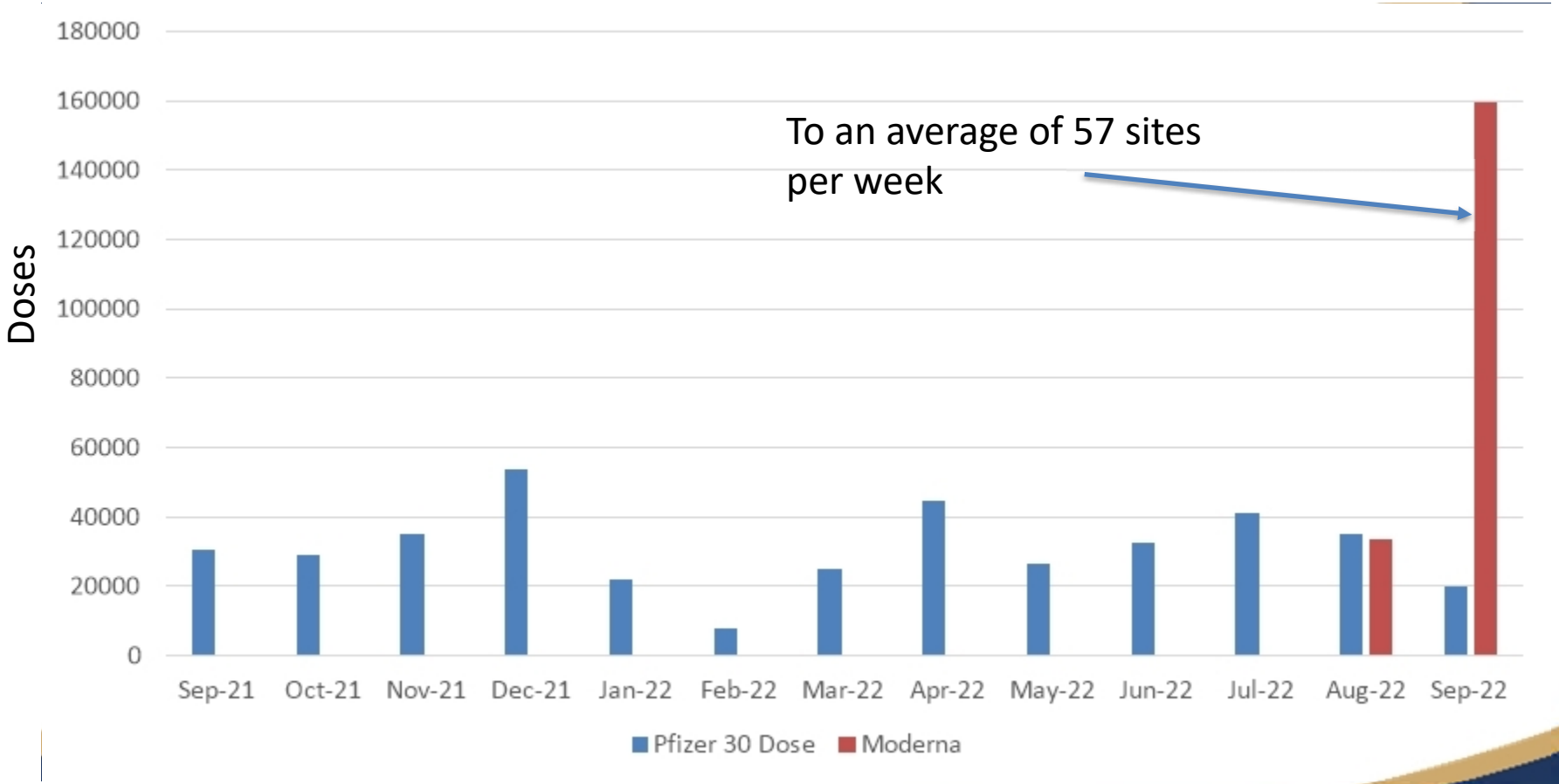
Partneriaeth Cydwasanaethau
Shared Services Partnership

COVID-19 Vaccine Service



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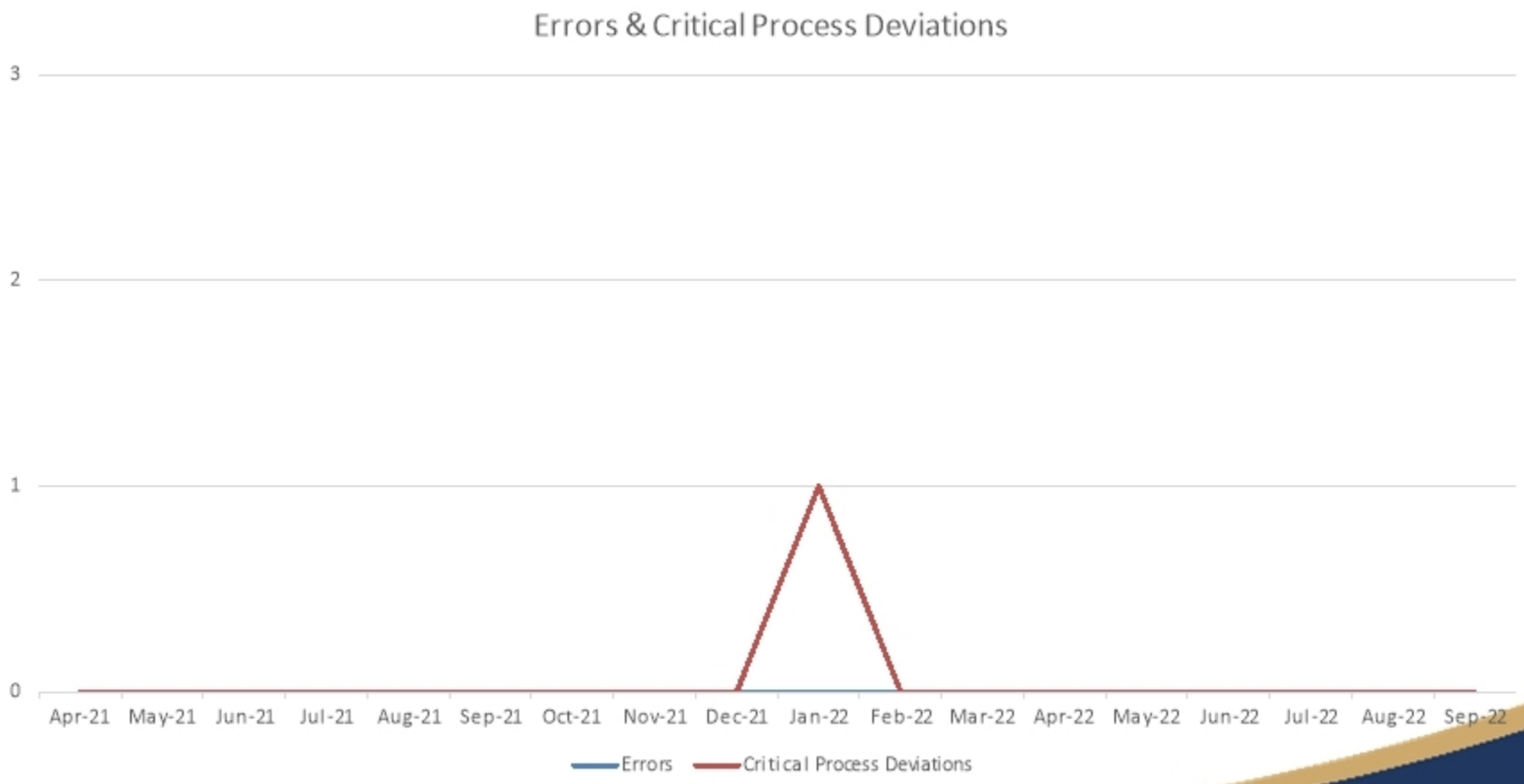
Partneriaeth Cydwasanaethau
Shared Services Partnership

Errors & Critical Deviations



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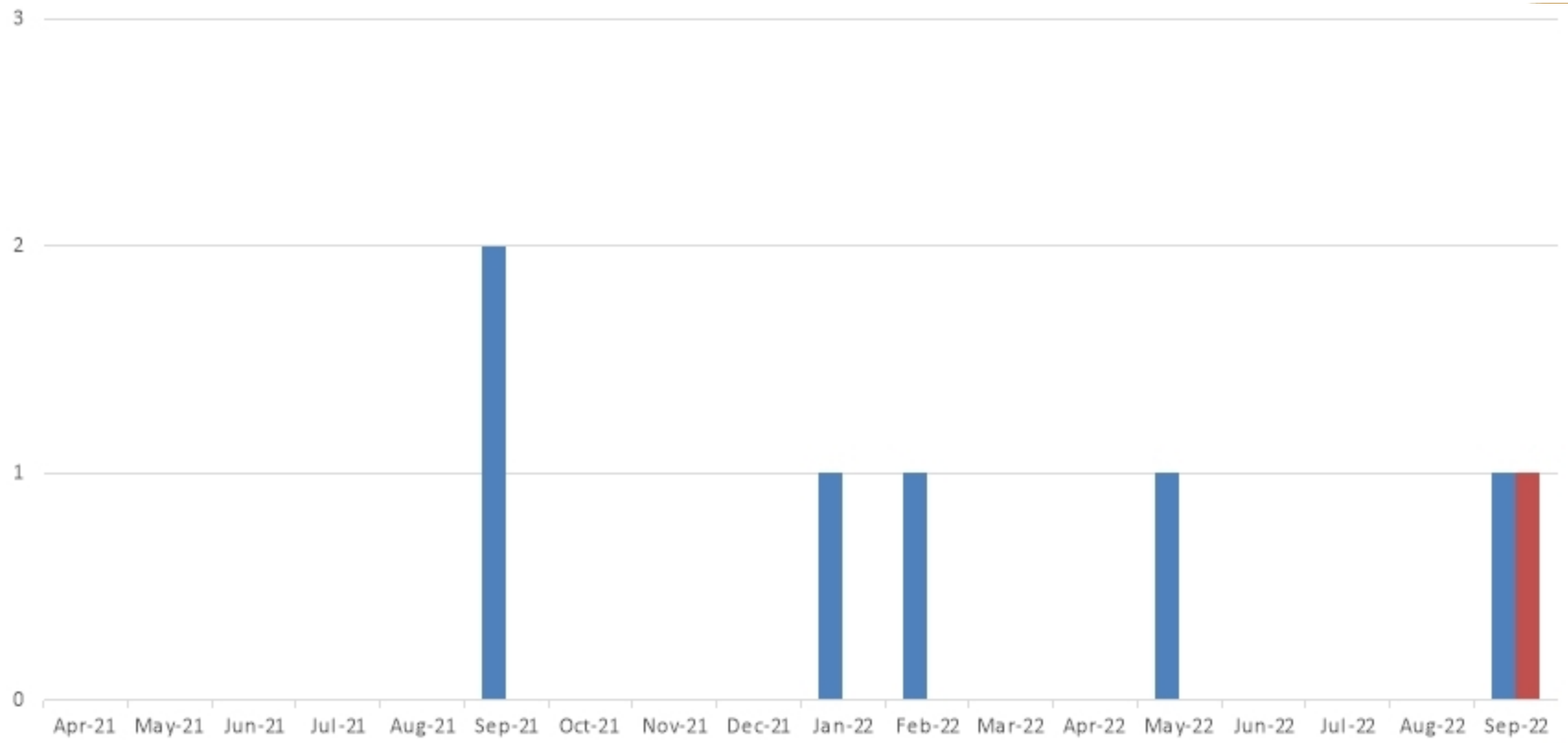
Partneriaeth Cydwasanaethau
Shared Services Partnership

Facilities & Equipment Deviations



Other Quality Metrics – Sept 22

Internal Audit Compliance – 100%

Documentation review rate – 93% (92% Target)

Critical Zone Environmental Failure rate – 0% (<5% Target)

Operator Environmental Failure Rate – 0% (<5% Target)

Service Complaints – 0

Environmental Adverse Trends - Progress

- 4 instances of operator sessional failures
- Growing fungus burden within support rooms
- Mitigating actions
  - Additional high level cleans - completed
  - Additional monitoring of supportive areas - completed
  - Escalation in agents for clean room clothing transfer – completed
- Further risk assessments being undertaken due to use of non-sterile face masks and also goggles usage
- September performance reduced to zero incidence of environmental failures

Vaccination WDA Incidents

1: Incorrect quantities delivered to two sites with a 900 dose shortfall.

2: Incorrect dispatch notes in wrong box with incorrect batch number

- Root cause analysis identified
  - Operators not following segregation procedures
  - Operator unfamiliar with dispatch notes process
- Corrective actions
  - Clearer work areas to improve segregation
  - Further training on booking our of items
  - Feedback to PHW Delivery unit on poor documentation and late minute changes to schedules that contributed to this event
- Actions implemented and work continues with no further service errors

Service Development Progress Report

- Potassium Chloride 50mmol in 50mL product manufactured and awaiting release to SBUHB
- Patient safety pilot with CAV – Emergency Intubation Drugs. Awaiting go live date from CAV
- SLA signed with Powys UHB for Medical Gas Quality Control Testing
- Advanced discussions with Roche regarding Atezolizumab purchase and compounding to begin November 2022.
- Capital awarded and tender underway for incubators

CIVAS@IP5 Medicines Unit. MS52641

Imperial Park

Newport

NP10 8BE

Philip Rose

10 South Colonnade

Canary Wharf

London

E14 4PU

Dear Mr Rose,

Thank you for your letter in relation to our recent inspection against the Human Medicines Regulations 2012, and the detailed deficiencies identified in relation to compliance with the principles of Good Manufacturing and Distribution Practice.

As requested in your letter please find attached a detailed action plan in relation to the deficiencies identified with proposed corrective actions and target dates for completion.

I look forward to your response to this proposed action plan.

Kind Regards

Gareth Tyrrell

Head of Technical Services – CIVAS@IP5

CIVAS@IP5 Action Plan

Deficiency Number	Deficiency Identified	Corrective Action	Target Date	Comments
2.1	**Document practices and processes to ensure the integrity of data and traceability of all significant manufacturing activities were deficient in that:**			
2.1.1	The component reconciliation section of the batch record for batch 2601220027 (Noradrenaline) had not been completed despite the section being signed as complete.	Post-inspection the production process has been reviewed and risk assessed to identify areas of weakness in relation to ingredient reconciliation and completion of associated batch documentation. The recommendations from the review will be raised as change controls and implemented to strengthen the post-production process. Corrective and preventative actions will be targeted towards separating the post-production ingredient reconciliation and visual inspection process, as well as separate signatures required for completion of each step. There will be a resulting requirement to identify an area for post-production ingredient reconciliation prior to visual inspection of final products and a change to the worksheet layout to reflect these changes. These measures will be risk assessed prior to implementation and	**April 2022** **April 2022**	**Owners AD/ET** **COMPLETED – AWAITING VALIDATION OF SMARTFILLER TO DETERIN SITE WITH ADEQUATE CAPACITY FOR RECONCILIATION** **Owner GT/LL/MJ** **COMPLETED**

		supportive justification for these actions documented. All changes will require a re-training of all individuals who are required to complete GMP critical documentation, as well as an updated teaching session on Data Integrity and ALCOA+ principles. The production operatives involved in the deficient GMP actions have been identified and a period of re-training will be undertaken. A program of monthly internal self-inspection of all critical GMP -related logs and documentation monthly to identify incidences of incomplete documentation. These will be categorised and trended to identify further corrective process actions. These actions will be supported by the National Quality Assurance Lead	**March 2022** **March 2022**	**Owner LL** **COMPLETED** **Owner AD/ET** **COMPLETED**
2.1.2	The label reconciliation section of the batch record for batch 0511210007 (Midazolam) had not been completed despite the batch being released.	A review of the label reconciliation process and associated steps within all process and batch documentation will be undertaken to identify improvements to the documentation and management of label reconciliation actions. Any recommendations identified within this review will be managed via the change control process and will include retraining and competency assessment of all	**April 2022**	**Owner GT/LL** **COMPLETED**

		individuals required to complete label reconciliation actions. Within the updated training sessions relating to Data Integrity and ALCOA+ principles there will be clarification on the requirement to retain, control and deactivate all rejected documentation.		
2.1.3	The electronic stock movement section of batch 0511210007 had not been confirmed within the paperwork despite the batch being released and shipped.	SOP QC-1 Product Assessment and Release & DOC6 Batch Release of Comirnaty Vaccine will be updated to state that the final electronic transfer of products must be done by the Releasing Officer or Nominated deputy only. This relates to the transfer quarantine to live stock on the Pharmacy Stock Management system "EDS" Production Module. QA staff to be provided training on the EDS Production Module to ensure these tasks are carried out contemporaneously and accurately.	**March 2022**	**Owner AD/LL** **Q-Pulse Ref: REG78** **COMPLETED**
2.1.4	There was no confirmatory check of "picked" production components within the production facility, prior to use.	The accuracy of the ingredients used within the Laminar Air Flow cabinet is checked by the Production Supervisor at the point of production and is confirmed as correct by a signature only.	**Worksheet Amendments - April 2022**	**Owner GT/LL** **WORKSHEETS COMPLETED BUT NOW UNDER FURTHER REVIEW DUE TO IMPLEMENTATION OF THE SMARTFILLER**

		The batch documentation will be updated to include steps that document the batch number and expiry of each ingredient and critical component prior to use. This will be signed for immediately prior to use by the Production Supervisor. SOP ASS-WPI3, which is the work-place instruction for syringe filling and in-process checking will be updated to reflect change in practice. Production operators and Supervisors to be re-trained in the additional requirements and competency assessed. Supervisors will be provided with additional training and competency assessment for checking and documenting of in-process batch details. In the longer term the service plans to introduce barcode scanning of critical ingredients and consumables to provide a digital log of all critical batch information. The manufacturer of the compounding equipment will be approached to provide additional training and design of the in-process batch documentation that can be achieved by the Medimix/Vigo pumps.	**Barcode scanning of critical ingredients – Aug 2022**	
2.1.5	The receipt log for the vaccines required a “min/max” temperature entry but only the current displayed temperature of the courier’s vehicle was recorded.	The receipt log for vaccines (FORM3) has been amended to include separate boxes for the maximum and minimum temperatures to be recorded as well as stating the acceptable temperature range.	**March 2022**	**Owner AD** **Completed**

		This will be assessed as part of the monthly self-inspection of GMP-critical documentation as detailed in 2.1.1 above. ALCOA+ and data integrity principles added to the training competencies of all current and future staff to emphasise the importance of accurate documentation practices. This training will also include a review of the understanding of the type and importance of information requested within the batch documentation to ensure complete understanding of the documentation process.		
2.1.6	The item layout diagram used to aid component assembly (picking) was not a controlled document within the Pharmaceutical Quality System (PQS).	This identified document has been uploaded to Q-Pulse as a version-controlled training aid document and approved for use. A further review of all documentation used within service has been undertaken to identify further uncontrolled documents in use. All documents identified have either been removed or added onto Q-Pulse as a controlled version.	**March 2022**	**Owner AD** **PROD-WPI4 created and approved** **Completed**
2.2	**Controls to prevent contamination were deficient in that:**			
2.2.1	Process Validation media fills were not performed every six months at full scale.	Validation master plan (VMP) to be reviewed to ensure appropriate validation intervals as per MHRA Q&A 2015. Validation schedule interval on Q-Pulse to be reduced from the recommended 6	**March 2022**	**Owner – AD update VMP** **Completed**

		months to a 4 month interval to provide adequate buffer for rescheduling of validations. Validation of process to be undertaken within February 2022 to reflect full scale manufacturing process.		**Owner MJ – arrange PV** **Completed**
2.2.2	Goggles were not worn within the Grade B area posing a risk of shedding.	The production team will approach current clean room and consumable suppliers to identify opportunities to procure sterile goggles. Once an appropriate supply mechanism has been identified this will be introduced immediately into the gowning practices within the Grade B area of the facility. A change control will be raised to manage the change process in relation to gowning and will include updated documentation, re-validation of gowning processes and updated training of staff with competency assessments carried out individually.	**April 2022**	**Owner ET** **COMPLETED**
2.2.3	Production surfaces were not smooth, impervious, and unbroken such as the speak-through hatches and gaps between the coving and walls within production footprint.	A monthly visual inspection of the fabric of the facility will be carried out by the production team, against an approved checklist. Identified deficiencies to be recorded on Q-Pulse and provided to clean room contractor Enbloc for resolution during 6 monthly site visits.	**May 2022**	**Owner AD/LL** **COMPLETED**

		Unit deficiencies identified during this inspection to be documented as a facilities deviation and raised as corrective actions with Clean Room contractor Enbloc for resolution during service visit scheduled for May 2022. Melaphone grille to be replaced during visit. Monthly facilities status review will be outlined within an approved SOP and initiated to provide ongoing inspection of fabric of the facility, as well as identification of issues.	 **May 2022** **April 2022**	**Owner AD** **Completed** **Owner LL** **COMPLETED** **WITHIN MONTHLY AUDIT PROGRAM BY QA - COMPLETTED**
2.2.4	Justification was unavailable for particle monitoring not being performed during the critical activities.	Current non-compliance relating to sessional particle monitoring for the closed system processes undertaken within the service will be risk assessed and justification for non-compliance provided.	**May 2022**	**Owner AD** **Completed – QC25**
2.2.5	Environmental Monitoring (EM) trends lacked sufficient detail or magnitude to allow appropriate actions to be taken as they were reported as percent excursions only.	Ongoing trending will be converted to absolute numbers from % failures for all grade areas to ensure changes to data trends are identified and actioned at the earliest opportunity. The long-term actions include the installation and use of the Microbiological Reporting System (MRS) which allows the automated reporting of environmental deviations and adverse trend patterns. This	**March 2022** **August 2022**	**Owner GT** **Completed** **Owner ET** **Installation to recommence after national agreement of version number to be used.Programme behind**

		will allow early identification of issues that require risk assessment and Corrective and Preventative actions.		**schedule. This is to be detailed in MHRA interim compliance report**
3.1	The decision and associated justification to release batches following Grade A recoveries was weak and inadequately documented. For example, the full assessment of risk and mitigations was not documented but often relied on the end of session broth results rather than assessing the associated risk to the product. (This is categorised as an "other" based on the finding primarily being poor justification recorded rather than any adverse risk identified to the products).	A review of all critical Grade A/B Environmental Monitoring excursions be introduced monthly within the existing Monthly Quality Meeting agenda. The aim of the review will be to critically assess the excursion-related data recorded risk assessment of the event, the decision-making process and corrective/preventative actions undertaken with justification for each event. This review will be multidisciplinary in nature with input from the All-Wales QA Pharmacist and Service Director. Outcomes and actions from this review will be included in the meeting minutes as well as actions/learning regarding reporting and investigations.	**August 2022**	**Owner AD** **COMPLETED**
3.2	**The management of recall of potentially defective product was deficient in that:**			
3.2.1	The site had failed to notify the competent authority (Defective Medicines Reporting Centre) of the recall of batch 1001220008 (Morphine).	SOP PQS14 – Recall Process will be updated to provide clarification that once collected by courier (external or internal) then the product is required to be reported to the DMRC where a recall or quality issue is identified.	**March 2022**	**Owner AD** **Q-Pulse Ref: REG 69** **Completed**

		Senior staff to receive training regarding updated RECALL SOP, with a rotation of staff required to undertake Recall validation to remain competent in identification of the actions required for differing levels of Recall.		
3.2.2	The site had not recorded the reconciliation of the batch following recall within the recall report to ensure that no defective product remained available for use.	SOP PQS14 – Recall Process will be reviewed to identify where the current recall process does not facilitate effective reconciliation and documentation of all products associated with the recall, including where a second check of the reconciliation is required. The SOP will be updated to outline the reconciliation process for products received back into stock, those used by the end user and total issued to customers as well as how this data should be presented within the recall documentation. The Head of Technical Services, Production and Quality leads and associated deputies will receive training regarding the updated RECALL SOP. These staff will be required to participate in the annual Recall validation to remain competent in identification of the actions required for differing levels of Recall.	**March 2022**	**Owner AD** **Q-Pulse Ref: REG79** **Completed**
3.3	The technical agreement with Health Courier services did not state how quickly the site	As part of annual SLA review with Health Courier Service, the QA team will discuss	**May 2022**	**Owner GT/AD** **COMPLETED**

	should be notified of a temperature excursion of product during shipment to ensure that appropriate actions could be taken.	and identify the capacity for HCS to report in real time the event of a temperature excursions. This review with HCS will inform an updated Service Level Agreement between CIVAS@IP5 and Health Courier Service Wales to formalise time frames for notification of temperature excursions. The agreed time frame will be risk assessed for suitability. This update and requirements for notification will be tested in a dummy recall event to ensure lines of communication and ability to identify temperature excursions do not place product or patient at risk.		
4.1	The site should review the available stability data for the product portfolio to ensure that the expiry date of 89 days is reflective of available data and meets the associated requirements.	There will be an internal review of all procedures and documentation in relation to assigning of product shelf life. This will also include a review of all currently assigned shelf lives for live products supplied and detail the recommendations with MHRA Q&A 2015 relating to the assigning of product shelf lives. Further sterility and syringe integrity testing will also be reviewed.	**April 2022**	**Owner AD/ET** **Q-Pulse Ref: CC31** **In progress – completed by CIVAS@IP5. Awaiting confirmation from QCNW that able to start accepting sampled**

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NWSSP HEALTH AND CARE STANDARDS SELF-ASSESSMENT 2021-22

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Roxann Davies, Corporate Services Project Manager, NWSSP
PRESENTED BY	Roxann Davies, Corporate Services Project Manager, NWSSP
EXECUTIVE SPONSOR APPROVED	Ruth Alcolado, Medical Director, NWSSP

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Senior Leadership Group, NWSSP	13/10/2022	ENDORSED FOR APPROVAL

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership
SLG	Senior Leadership Group

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with an update as to the Health and Care Standards Self-Assessment within NWSSP for 2021-22.

2. BACKGROUND

The Standards for Health Service in Wales provide a framework for consistent standards of practice and delivery across NHS Wales and for continuous improvement. In accordance with the programme of Internal Audits, the process is tested and is an integral part of the organisation's assurance framework process. The Framework comprises seven main themes and sub criteria against which NHS bodies need to demonstrate compliance:

- Governance, Leadership & Accountability
- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

Process for Completion

The process for undertaking the annual self-assessment is that NWSSP Corporate Services undertake an evaluation against the Standards, which is presented to the SLG for discussion and consultation at Directorate level, where appropriate. Any feedback provided from Directorates is then reviewed and incorporated into the Self-Assessment and then this is reviewed by the NWSSP Medical Director.

Following completion of the Self-Assessment, an Action Plan to manage and monitor areas whereby we may develop and strengthen our compliance against the Standards has been developed, in consultation with Services, linked to the wider well-being agenda and is presented at a future SLG meeting, for discussion and approval.

In addition, once approved by the SLG, the Self-Assessment and Action Plan is presented to the Partnership Committee, Audit Committee and the Velindre University NHS Trust Quality and Safety Committee, for endorsement and assurance.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Assessment of Ratings

Each theme is assessed and given an overall rating of between 1 and 5. As a largely non-clinical service provider, not all of the sub-criteria are applicable to NWSSP. A summary of the self-assessment ratings is outlined overleaf:

Theme	Rating
Governance, Leadership & Accountability	4
Staying Healthy	4
Safe Care	4
Effective Care	4
Dignified Care	Not applicable
Timely Care	Not applicable
Individual Care	4
Staff and Resources	4

Appendices 1 to **8** contain the detailed criteria and assurances provided against each theme of the Standards.

The overall rating against the mandatory Governance, Leadership and Accountability module and the seven themes reflects NWSSP's overall compliance against the Health and Care Standards and has been rated as a **4,** as outlined below. This rating is based on the work undertaken to address staff well-being across the organisation, in line with A Healthier Wales and as a result of the recovery and response work undertaken in relation to the pandemic. An assessment level rating of **4** sets out that ***"we have well-developed plans and processes can demonstrate sustainable improvement throughout the organisation".***

In line with the actions identified for the Action Plan, that will be monitored by the NWSSP SLG, we hope to be in a position to award a self-assessment rating of **5** during 2022-23, which sets out that "***we can demonstrate sustained good practice and innovation that is shared throughout the organisation, and which others can learn from"***.

Developments

In light of the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the associated duty that this brings upon the organisation, this is likely to alter the way in which we report and approach this Self-Assessment, going forward. It is hoped that the Duty will lend itself better to NWSSP and the Services that we provide to NHS Wales.

The approach supports the five ways of working (Sustainable Development Principle) in the Well-being of Future Generations (Wales) act 2015, to achieve a Healthier Wales. The Duty will see active consideration of whether decisions will improve service quality and secure improvement in outcomes and applies to all health services functions (not just clinical), requiring health services to demonstrate that quality is at the heart of all we do. There will be a system-wide approach to achieving quality of care in a way that secures continuous improvement and in addressing this, we will consider the domains of quality and how these apply to NWSSP:

- ***Safe***: Avoiding harm to patients from the care that is intended to help them;
- ***Effective***: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively);
- ***Patient-centred***: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- ***Timely***: Reducing waits and sometimes harmful delays for both those who receive and those who give care;
- ***Efficient***: Avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- ***Equitable***: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

In recognising the role that NWSSP plays in terms of the Services that we deliver within NHS Wales and our contributions through these Services (both directly and indirectly) towards the well-being of the wider population of Wales, we have chosen to include links to case studies within this year's Self-Assessment, to help to tell the story of the organisation's impact.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	• Health and Care Standards Self-Assessment for NWSSP
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the **NWSSP Health and Care Standards Self-Assessment for 2021-22**.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Health and Care Standards

Self-Assessment

2022-23

NWSSP Health and Care Standards

The Standards for Health Service in Wales provide a framework for consistent standards of practice and delivery across the NHS in Wales, and for continuous improvement. In accordance with the Partnership's programme of Internal Audits, the process is tested and is an integral part of the organisation's assurance.

There are seven main themes and under each theme there are a number of standards with some overlap across themes and standards. The themes with their individual standards are represented in the "Person Centred Care" Diagram.

NWSSP has evaluated which of the standards outlined within the Health and Care standards framework are applicable to its service areas. The evaluation process included a mapping exercise of Services, which contributed towards the self-assessment evidence and scoring and Directors were given the opportunity to review the Health and Care Standards, prior to approval at Formal Senior Leadership Group (SLG).

Self Assessment Rating - Governance, Leadership and Accountability					
Assessment Level	**1** We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	**2** We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	**3** We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	**4** We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	**5** We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from

Governance, Leadership and Accountability

1.Governance, Leadership and Accountability (Mandatory Standard)			
Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care			
	Sub Criteria	**Evidence**	**Responsible Person**
1	Health services demonstrate effective leadership by setting direction, igniting passion, pace and drive, and developing people.	**Vision and Mission** • Vision and mission statement is Adding Value Through Partnership, Innovation & Excellence. **Core Values** • Four Core Values which are Listening and Learning, Working Together, Innovation and Excellence. o Listening & Learning to constantly improve the quality, effectiveness and efficiency of all we do; o Innovating to encourage continuous improvement; o Taking Responsibility for decisions and making things happen; and o Working Together with colleagues, customers and suppliers. **Strategic Objectives** • Five strategic objectives, upon which all business decisions are based, which are Value for Money, Service Development, Excellence, Our People and Customers and Partners. o Value for Money ➢ Highly efficient and effective organisation. ➢ Deliver real term savings and service quality benefits in partnership with our customers. ➢ Measure value in terms of quality, socio-economic benefit and not solely on cost. o Service Development ➢ Extend the range of high-quality services provided to NHS Wales and Welsh public sector. ➢ Adapt and change our processes and systems to support the foundational economy in Wales. o Excellence ➢ A customer centric organisation that delivers process excellence.	SLG SSPC Audit Committee

		➢ Focus on continuous service improvement, automation and the use of digital technology. ➢ Leads the way on adopting new ways of working to tackle climate change and decarbonisation targets. o Our People ➢ Appropriately skilled, productive, engaged and healthy workforce. ➢ Embed diversity and inclusiveness into our NWSSP culture and actions. ➢ Encourage the use Welsh in our roles and workplaces, supporting staff to improve their skill level. o Customers and Partners ➢ Open and transparent customer-focussed culture that supports the delivery of high-quality services. **Eight Overarching Goals** • We will promote a consistency of service across Wales by engagement with our partners whilst respecting local needs and regional requirements. • We will extend the scope of our services, embracing sustainability, within NHS Wales and into the wider public sector to drive value for money, consistency of approach and innovation that will benefit the people of Wales. • We will continue to add value by innovating, standardising and transforming our service delivery models to achieve the well-being goals and the benefits of value based and prudent healthcare. • We will be an employer of choice for today and future generations by attracting, training and retaining a highly skilled and resilient workforce who are developed to meet their maximum potential and can work in Welsh and English. • We will maintain a balanced financial plan whilst we deliver continued efficiencies, direct and indirect savings and reinvestment of the Welsh pound back into the economy. • We will provide excellent customer service ensuring that our services maximise efficiency, effectiveness and value for money, through system leadership and a 'Once for Wales' approach. • We will work in partnership to deliver resilient services that will help NHS Wales recover from the challenges of COVID-19, lead to a healthier Wales and supports sustainable Primary Care. • We will support NHS Wales meet their challenges by being a catalyst for learning lessons and sharing good practice. Identifying further opportunities to deliver high quality services.	

		Strategic Drivers and Long-Term Visions Strategic drivers and long-term visions of achieving Ministerial priorities, Well-being of Future Generations (Wales) Act 2015, A Healthier Wales and the response to the challenges of Covid-19 pandemic and NHS recovery. **Integrated Medium Term Plan (IMTP)** NWSSP demonstrate effective leadership and sets out a clear vision and direction of travel for the future in its three year Integrated Medium Term Plan (IMTP) 2022-25. The IMTP includes information relating to the strategies for quality improvement, people and organisational development, finance, building capacity and capacity to deliver outcomes and governance, as well as Service Delivery Plans across the organisation. **Annual Plan** Following the Covid-19 pandemic, NWSSP launched an Annual Plan to support the delivery of services through the response and recovery period. **Shares Services Partnership Committee (SSPC)** The governance of the NWSSP is overseen by the NHS Wales Shared Services Partnership Committee (SSPC) which was established under the Velindre University NHS Trust (Establishment) (Amendment) Order 2012. The purpose of the Committee is to: • Set the policy and strategy for NWSSP; • To monitor the delivery of NWSSP through the Managing Director; • To seek to improve the approach to delivering Shared Services which are effective, efficient and provide value for money for NHS Wales & Welsh Government; • To ensure the efficient and effective leadership, direction and control of NWSSP; and • To ensure a strong focus on delivering savings that can be reinvested in direct patient care. **Senior Leadership Group (SLG)** The Managing Director is responsible for the delivery of Shared Services and assumes overall accountability in relation to the management of NWSSP. The Managing Director is supported by a Senior Leadership Group (SLG) who are responsible for determining NWSSP's policy, setting the strategic direction and ensuring that there are effective systems of internal control and that high standards of governance and behaviour are maintained.	

2	Strategy is set with a focus on outcomes, and choices based on evidence and people insight. The approach is through collaboration building on common purpose.	**Partnership Working & Integrated Medium Term Plan (IMTP)** NWSSP's strategy is set with a focus on service delivery outcomes and performance through ongoing dialogue and consultation with partners and stakeholders. Since the first Plan was introduced in 2014, NWSSP has built upon the strong foundation of the Annual Pans that had been developed from the inception of NWSSP, thus demonstrating that the process for developing the plan has evolved and matured. We annually review, refresh and refine our goals to ensure they remain fit for purpose and capture our aim, vision and mission effectively, setting the right tone for the organisation. Our Overarching Goals outline our long-term strategic direction, focusing on actions that improve the experiences of our service users, the quality of our services and supporting NHS Wales organisations to deliver their priorities. **Quarterly Review Meetings** All Directors have quarterly review meetings with the Health Boards/Trusts to monitor efficiencies being made, service delivery and quality of service. In addition, there are in-house quarterly reviews undertaken for each Service's projects, plans, targets and Key Performance Indicators (KPIs) to be scrutinised by the Managing Director and SLG. **Customer Insight** Our customer's views are important to us and we work hard to improve and strengthen the service we provide to customers. Our Directorates have well established systems in place for collating useful information from their customers, including: • The Managing Director and Committee Chair attend Board meetings with the Executive teams at each Health Board/Trust to gain a clearer understanding of their operational requirements; • Quarterly review meetings with Health Boards/Trusts; • Monthly professional peer group meetings, including the Directors of Finance Group, the Directors of People and Organisational Development and the Directors of Governance/Board Secretaries Group; • Customer satisfaction surveys and feedback opportunities; and • Post-project surveys. **Working in Partnership – Trade Unions** NWSSP works in partnership with Trade Union organisations through its "Local Partnership Forum (LPF)" and associated sub-groups. NWSSP and the SLG work closely with the LPF on a wide range of corporate and strategic issues. This includes engagement on all aspects of organisational change, re-organisation, re-structuring and re-location.	SLG

		The Staff Partnership and other local partnership groups contribute to key planning processes at divisional and corporate level. The Local Partnership Forum (LPF) meets bi-monthly and is used to engage with trade union representatives on all employment matters which affect NWSSP staff which builds on the principles of the prudent healthcare agenda and has also been agreed by the SSPC. The Terms of Reference for the LPF are frequently reviewed and revised to reflect the maturing nature of the organisation. **Business Intelligence/Benchmarking** NWSSP is proactive in reviewing performance and utilising business intelligence to review its own service outputs. NWSSP is a member of the UK Benchmarking Group. We have a Business & Performance Manager who specialises in Key Performance Indicators (KPIs) and performance reporting and statistics, who sits within the Planning, Performance and Informatics directorate. **Recruitment and Retention** Where recruitment and retention challenges exist, Service specific strategies continue to be implemented as an ongoing priority including: o People and Organisational Development Plan o 'Social sourcing' for professional staff o Strengthening relationships with local Universities, Schools, etc. o Attending careers fair, etc. o Work based degree opportunities o Utilisation of collaborative bank o Work experience opportunities o Apprenticeship scheme o Network 75 scheme In addition, we have committed to develop our recruitment and retention strategy, to source, attract, train and retain a diverse workforce of the future, considering different entry routes to our organisation, reaching out to Universities and Colleges, Schools, and to community groups and those 'hard to reach areas' (Resourcing and Diversity and Inclusion strategies).	
3	Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models, and manage performance and value for money.	**Integrated Medium Term Plan (IMTP)** Each directorate has its own "Service Delivery Plan" which outlines the delivery model for their area of work. The detailed service delivery plans are devised in consultation with customers and other key stakeholders which ensures that service provision and performance is in alignment with customer expectations.	SLG

		Peer Reviews NHS Peer Reviews allowed organisations to have conversations about the main themes in their plans in order to identify how to collaborate and support each other. This was beneficial in shaping the content of the plan allowing focus on adding value to our partner's needs and priorities. **Certifications and Accreditations** NWSSP maintains a number of certifications and accreditations within Services, including: • Lexcel • Customer Service Excellence • ISO9001 Quality Management • ISO27001 Information Security • ISO14001 Environmental Management • ISO 45001 Occupational Health & Safety • STS Food Safety (SCLT regional Warehouses) **Service Level Agreement's (SLA's)** When NWSSP was created a number of operational agreements were inherited, which after a period of consultation with specialist groups across NHS Wales resulted in a detailed overarching Service Level Agreement (SLA) outlining the mutual agreement for the provision of services between NWSSP and the Health Boards/Trusts, and several accompanying schedules outlining the specific agreements in place for the provision of Audit and Assurance Services, Employment Services, Specialist Estates Services, Legal and Risk Services, Primary Care Services, Procurement Services and Health Courier Services. More recently, developments as regards the Single Lead Employer model, has been extended from GP trainees to medical professionals and specialists such as dentists, etc. A suite of Service Level Agreements were developed to ensure each stakeholder had an understanding of their roles and responsibilities under the new employment arrangements. SLAs are routinely reviewed through the SSPC and updated, where appropriate. There are a number of overarching SLAs and more specific Memorandums of Understanding in relation to more recently acquired areas, such as Welsh Risk Pool (WRP), Welsh Infected Blood Support Services (WIBSS) and Welsh Language Translation Services (WLTS) for example.	

		Finance and People and Organisational Development (POD) performance reports/KPIs The SLG and SSPC receive detailed reports on finance and performance and scrutinise expenditure and performance information to maintain and improve service delivery. In addition to this, localised reports are provided to individual directorates reflecting key POD information and these reports inform the monthly Formal SLG meetings.	
4	Health services foster a culture of learning and self-awareness, and personal and professional integrity.	**Core Skills Training Framework** All NWSSP staff are required to complete the online statutory and mandatory training modules of the Core Skills Training Framework. The framework comprises of 11 mandatory modules. Individual modules must be refreshed between every 1-3 years: • Health & Safety • Fire Safety • Resuscitation • Information Governance • Infection Control • Safeguarding Children • Safeguarding Adults • Manual Handling • Equality • Violence & Aggression • Cyber Security There are also optional online modules available via ESR, that range from topics such as environmental management, to counter fraud. In addition, a number of face-to-face and remote training courses are provided to staff including corporate induction training, fire safety, people management skills for managers, stress awareness, information governance and Welsh language awareness. There are a number of All Wales policies which have been approved by the Wales Partnership Forum which aim to encourage a consistent approach to the management of staff across NHS Wales, covering areas such as Managing Sickness Absence, Managing Capacity, Recruitment & Selection, Performance Appraisal Development Review (PADR) and Managing Conflict. **NWSSP Core Values**	SMT

		NWSSP's core values are the guiding principles that dictate behaviour and action, in accordance with the Standards of Behaviour Framework Policy and the 7 Nolan Principles of Public Life. To support the implementation of the Pay Progression Policy NWSSP has developed a set of core organisational objectives that all staff must demonstrate they have fulfilled in addition to their work objectives. These core organisational objectives have been aligned to the NWSSP Core Values. **PADRs** Performance Appraisal Development Review (PADR) processes are a key building block of staff engagement practices and NWSSP has set a target of 100% compliance. KPIs across each Service are reviewed at monthly Formal SLG meetings and monitored locally at team meetings. **Governance & Probity** **Velindre University NHS Trust Audit Committee for NWSSP** NWSSP has an established Velindre University NHS Trust Audit Committee for Shared Services, which meets four times a year, as part of the wider governance arrangements for hosting NWSSP as a non-statutory body. The purpose of the Audit Committee is to advise and assure the Shared Services Partnership Committee (SSPC) and the Accountable Officer on whether effective arrangements are in place, regarding the design and operation of NWSSP's system of governance and assurance. This supports the SSPC in its decision making and in discharging its accountabilities for securing the achievements of NWSSP's objectives in accordance with the standards of good governance determined for the NHS Wales. **Accountability and Assurance Framework** The following arrangements are in place, as part of our Governance and Accountability Framework, to ensure that our work is supported by clear standards of ethical behaviour: • Standing Orders • Standing Financial Instructions • Hosting Agreement • Memorandum of Co-operation • Service Level Agreements (SLAs) with supporting schedules • Terms of Reference for all Committees • Register of Interests for SLG, Independent Members, Chair of NWSSP and all staff (recorded via ESR)	

		• Gifts and Hospitality Procedure • Standards of Behaviour Framework • Managing Personal Relationships at Work Protocol NWSSP has a high proportion of professionally registered staff who abide by their own professional code of conduct. The NWSSP utilises the policies of Velindre University NHS Trust, where appropriate, which are available to all staff on the website and detail the expectation of working practices and behaviours. Counter Fraud arrangements have been developed with the All Wales Counter Fraud Service and NWSSP has a dedicated Local Counter Fraud Specialist who undertakes a minimum of 75 days per annum. An assessment of arrangements has been undertaken and a subsequent report presented to the Audit Committee. Appropriate policies are in place and there has been good progress in raising awareness. The Director of Finance & Corporate Services leads on Governance within the NWSSP and is supported by Director of Corporate Governance within Cwm Taf Morgannwg University Health Board, the Head of Finance and Business Improvement and the Corporate Services Manager, within NWSSP, in advising the SSPC. The overarching Corporate Risk Register is supported by each Directorate having its own Risk Register to record risks pertinent to their areas of work. Any risk categorised as being red triggers an automatic referral to the SLG for them to assess whether it needs to be recorded on the Corporate Risk Register. Directorates also maintain Assurance Maps relating to their Service. NWSSP has a Risk Management Protocol and Strategy which is reviewed annually. **Finance Academy** The NHS Wales Finance Academy brings together finance representatives from all of the Welsh Health Boards and Trusts with a shared vision to develop a centre of expertise for finance to support the NHS Wales finance community. **Vacancy Control Process** The NWSSP vacancy control process has been enhanced to ensure a robust audit trail is in place for approval to recruit to new and replacement posts. The process provides that: • All recruitment activity supports the organisational aims of providing an effective and efficient Shared Service, adding value through partnership, innovation and excellence;	

		Voluntary Early Release Scheme The Voluntary Early Release Scheme has been designed to assist staff in taking a personal decision regarding their future employment and enable staff who may wish to leave their employment with NHS Wales to do so with an appropriate compensatory payment. In considering individual applications for early release, NWSSP acts in accordance with the governance principles to ensure that funding for posts is released on a recurrent basis within the required payback period. **Professional Qualifications** Professional standards underpin NWSSP's services and staff. There are appropriately qualified staff in place throughout all services. Staff are also supported and encouraged to study towards professional qualifications and this is encouraged through the PADR process.	

Supporting Guidance Questions – What you need to do:

a) Upholds organisational values and standards of behaviour;

	Question	Evidence	Responsible Person within each Directorate
1	Have you identified and set objectives for your organisation / service?	NWSSP demonstrates effective leadership and sets out a clear vision and direction of travel for the future in its three year Integrated Medium Term Plan (IMTP) 2022-25. The plan builds on the maturing nature of the organisation and recognises the future challenges and actions we will need to take to ensure effective delivery of services to meet the needs of our users and stakeholders. Adding Value through Partnership, Innovation and Excellence, NWSSP delivers a wide range of high quality, professional, technical, and administrative services to NHS Wales working with wider public services, including the Welsh Government. We are an integral part of the NHS Wales family; supporting the staff and patients of Health Boards, Trusts and special Health Authorities in Wales and we also provide a range of services to the GP practices, dentists, opticians, and community pharmacies.	SLG

		Since the first plan was introduced in 2014, NWSSP have built upon the strong foundation of the annual plans that had been developed from the inception of NWSSP, thus demonstrating that the process for developing the plan has evolved and matured. The IMTP includes information relating to NWSSP's strategies for quality improvement, people and organisational development, finance, building capacity and capacity to deliver outcomes and governance. NWSSP has developed a set of core organisational objectives as part of the implementation of the Pay Progression Policy, which align themselves to the NWSSP core values. These core organisational objectives form part of all staff's PADR discussions, and they must be able to demonstrate that they have met these core organisational objectives to receive a satisfactory rating for their Pay Progression discussion.	
2	Have you identified risks and barriers to achieving these objectives?	NWSSP has developed an executive and operating management structure which reflects the different areas of accountability where risk resides. The responsibility for overseeing risk management in these areas rests with the Audit Committee. Horizon scanning is conducted annually with the SLG and key individuals from each Service, which aims to consider the internal and external risks for NWSSP, as part of the IMTP planning process. The overarching Corporate Risk Register is supported by each Directorate having its own directorate Risk Register to record risks pertinent to their areas of work. Any risk categorised as being red triggers an automatic referral to the SLG for them to assess whether it needs to be recorded on the NWSSP Corporate Risk Register. The Corporate Risk Register is a standing item on the agenda for the SSPC, Audit Committee and Formal SLG meetings.	SLG
3	What corporate policies exist within your organisation / service to guide your staff and others on how you do business?	NWSSP is governed by the Velindre NHS Trust Shared Services Regulations 2012(2012/1261(w.156)). The required standards for effective governance are outlined within the Shared Services Partnership Committees (SSPC) Standing Orders, core values and Standards of Behaviours Framework, and associated policies. NHS	

		Wales organisation representatives are members of the Shared Services Partnership Committee and take collective responsibility for the delivery of the services through a Hosting Agreement between the Partners. Collectively, the SSPC supports NWSSP in making an effective contribution to the achievement of the strategic vision for health services in Wales. Where, the Velindre policies do not align with NWSSP operations, NWSSP has autonomy to introduce "protocols" to ensure effective governance for standards operating procedures, for example, the NWSSP Complaints Management Protocol. Velindre, as the hosting organisation, is defined as the employing organisation for all NWSSP staff. The employment relationship is governed by the All Wales policies and Velindre workforce policies and procedures. In addition, NWSSP is committed to maintaining a consistent partnership approach to the evaluation of posts to ensure pay bands comply with the principles of equal pay for work of equal value, which underpins the NHS Job Evaluation Scheme.	
4	How do you know your staff are aware of the values and standards of behaviour expected of them?	Staff are made aware of the values and standards of behaviour expected of them through: • Corporate induction toolkit – all new staff are required to complete corporate induction, which includes information on workforce and corporate policies, Welsh language, information governance, health and safety and expected behaviours and organisational core values. The induction process is also supported through local workplace inductions which deal with the environment, health and safety. • Standards of Behaviour Framework (underpinned by the 7 Nolan Principles of Public Life) and its supporting policies are designed to protect individuals in respect of declaring interests, gifts, hospitality and sponsorship. It allows them to continue to receive the benefits of these activities within the confines of the Framework Policy and good governance arrangements, thus avoiding any potential challenge or conflict. The Register of Gifts and Hospitalities is presented as a standing item within the Governance Matters Report taken to Audit Committee. • Register of interests – all staff are required to declare any personal interests that may impact on their work through	

		completing a declaration of interest through ESR. We have recently revised the process and tightened controls to request all staff across the organisation complete a declaration, which is considered a lifetime declaration, by exception reporting and by exception of the SLG, Independent Members and Chair, who are required to complete an annual refresh of their declaration. • Staff are required to comply with the policies and procedures which govern the employment relationship, such as the Managing Personal Relationships at Work Protocol. The Disciplinary Policy ensures that all employees are made aware of the standards expected of them and the consequence of failing to adhere to them and clearly understand their rights and obligations. NWSSP has developed a set of core organisational objectives as part of the implementation of the Pay Progression Policy, which align themselves to the NWSSP core values. These core organisational objectives form part of all staff's PADR discussions, and they must be able to demonstrate that they have met these core organisational objectives to receive a satisfactory rating for their Pay Progression discussion.	
5	How do your corporate policies uphold the values of your organisation / service?	Employment Policies - All staff working within NWSSP are required to comply with the provisions of the All Wales policies and procedures and Velindre University NHS Trust policies that govern the employment relationships. The policies set out the consequences of failing to adhere to them. The NHS Wales Pay Progression policy has been implemented within NWSSP and applies to all members of staff on NHS Terms and Conditions of Service and must be used in conjunction with the PADR/Appraisal principles. The policy sets out the procedure to be followed to deal with annual incremental reviews. To support the implementation of the NHS Wales Pay Progression Policy, NWSSP has developed measurable criteria to form a suite of core values, which apply to all NWSSP staff. Staff are set work related objectives during their PADR discussions with their line manager. The organisation's PADR compliance is recorded and reported to the SLG each month.	SLG

		The NWSSP core organisational objectives for the Pay Progression Policy have been aligned to the NWSSP core values, and form part of all staff PADR discussions. Cultural awareness – NWSSP undertakes regular staff surveys which provide an insight into the views of staff to inform what needs to be implemented to strengthen effective working relationships and develop the culture of NWSSP.	
b) Complies with all relevant regulatory, accreditation, licensing requirements, standards, directions and instructions;			
	Question	**Evidence**	**Responsible Person within each Directorate**
1	Do you know about all accreditation and licensing schemes that apply to your organisation and how do you comply with them?	**Certifications and Accreditations** NWSSP maintains a number of certifications and accreditations within Services, including: • Lexcel accreditation with Legal and Risk Services • Customer Service Excellence • ISO9001 Quality Management • ISO27001 Information Security • ISO14001 Environmental Management • ISO 45001 Occupational Health & Safety • STS Food Safety (SCLT regional Warehouses) • Undertaking the Health and Safety Executives (HSE) "Managing for Health & Safety" HSG65 assessment framework • Surgical Materials Testing Laboratory (SMTL) offers a wide range of medical device testing services, for which they hold UKAS accreditation to ISO17025.	SLG
2	How will you act on outcomes from completing the HIW's Governance and Accountability Module self-assessment?	As a non-statutory, hosted organisation, NWSSP are not required to be inspected by the Health Inspectorate Wales (HIW).	-
3	How do you ensure that you comply with Welsh Government and other requirements / directives that apply to your organisation?	The Senior Leadership Group (SLG) are responsible for overseeing legal and regulatory compliance for NWSSP and the forward plan of business outlines the statutory and mandatory reporting requirements which feeds into the SSPC and Audit Committee, of which the SLG, SSPC and Audit Committee receive regular assurance reports on matters, including: • Annual review of the Standing Orders	SLG

		• Policy/protocol reviews, e.g. Complaints Management Protocol, Whistleblowing Policy • HSG65 annual assessment on compliance in relation to health and safety • Finance and performance reports which includes sickness absence targets • Freedom of Information responses • Caldicott Principles Into Practice (CPIP) self-assessment • Health & Care Standards self-assessment • Welsh Language • Pay progression, PADR and Core Skills Training Framework compliance The Integrated Medium Term Plan (IMTP) 2022-25, which sets out the priorities and actions that will be delivered on a rolling three year basis. The IMTP is approved by the Shared Services Partnership Committee (SSPC) which includes representatives from each Health Board and Trust. In addition, each directorate have their own local service delivery plans which are developed in association with peer groups.	
4	How do you comply with professional standards?	The Shared Services Partnership Committee's (SSPC) standing orders, values and standards of behaviours framework, and associated policies outline the standards of behaviour expected of all employees. The NWSSP has a high proportion of professionally registered staff who abide by their own professional codes of conduct. In addition finance and audit practitioners abide by ethical standards including the Public Sector Internal Audit Standards and the ACCA auditing and accounting standards. NWSSP applies and embeds professional standards and quality requirements to ensure that a professional service is provides to its stakeholders. **Professional Qualifications** Professional standards underpin NWSSP's services and staff e.g. Consultative Committee of Accountancy Bodies (CCAB) standards, Professional Investment Management Services (PIMS) and Chartered	SLG

		Institute of Personnel and Development (CIPD). There are appropriately qualified staff are in place through all services including; • Chartered Institute of Purchasing and Supply (CIPS) • Association of Accounting Technicians (AAT) • The Law Society & Solicitors Regulation Authority • Chartered Institute of Personnel and Development (CIPD) • Chartered Institute of Internal Auditors • Chartered Institute of Management Accountants • Institute of Healthcare Management (IHM) • Institute of Healthcare Engineering and Estate Management • (IHEEM) • Royal Institute of Chartered Surveyors (RICS) • Chartered Institute of Building (CIOB) • Chartered Institution of Building Services Engineers (CIBSE) • Institute of Engineering and Technology (IET) • Royal Institute of British Architects (RIBA) • Chartered Management Institute (CMI) • Institute of Fire Engineers (IFE) • Chartered Institute of Financial Accountants (CIPFA) • Association of Certified Chartered Accountants (ACCA) • The Institute of Chartered Accountants (ICAEW) • Royal College of GP Practitioners (RCGP) • Nursing and Midwifery Council (NMC) The Single Lead Employer (SLE) model has a variety of specialist trainees which have a range of professional standards and CPD to uphold. The requirements are managed locally within the SLE team and communicated to trainees, as appropriate. There is a tripartite SLA for the SLE model. Procurement Services are required to abide by NHS procurement standards and the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in Supply Chains, which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.	

		Legal and Risk Services abide the Law Society's Lexcel standard and Primary Care Services take cognisance of the General Pharmaceutical Council's standards, when consulting and engaging with pharmaceutical professionals. The SSPC adheres to the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments processes within the Commissioner's remit. Unlike the previous Codes of Practice which were drawn up and published by the Commissioner for Public Appointments, the Governance Code was drawn up and published by HM Government. (Note, appointments made between April 2012 to 31st December 2016 will be subject to the archived documents for April 2012).	

c) Secures the efficient, effective and economic use of resources;

	Question	**Evidence**	**Responsible Person within each Directorate**
1	Have you established effective reporting structures for all services?	The reporting system hierarchy has the Shared Services Committee (SSPC) at the top which comprises of senior representatives from the organisations across NHS Wales. The SSPC has an independent Chair and the Managing Director is the Accountable Officer for NWSSP. The SSPC is supported by the Velindre Audit Committee for NWSSP. The Senior Leadership Group (SLG) report to the Managing Director and comprise of ten Directors each with specialist responsibility for: o Director of Finance and Corporate Services o Director of People, Organisation Development and Employment Services o Director of Audit and Assurance Services o Director of Specialist Estates Services o Managing Solicitor/Director of Legal and Risk Services o Director of Primary Care Services o Director of Procurement Services o Director of Planning, Performance and Informatics o Medical Director o Director of All-Wales Pharmacy Technical Services	SLG

		The SLG have an informal and formal meeting each month. Each Director convenes monthly Directorate meetings with their senior managers to discuss business issues and to keep them informed and engaged on any business decisions made by the SLG/SSPC. The SLG are linked into a number of stakeholder peer groups which also are a valuable source of information with regard to NWSSP's services. These groups directly influence the work of the Partnership. Each Director has quarterly meetings with their peers at Health Board/Trust level to monitor performance and customer satisfaction. This includes discussing the Service Level Agreement (SLA) schedules that are in place which outline the mutually agreed terms of the service delivery areas. NWSSP has formal arrangements in place whereby the Chair and NWSSP's Managing Director attend Board level meetings across the seven health boards and three trusts to inform them of NWSSP's performance and to engage and consult with them on strategic objectives and activities. In addition, a minimum of two performance reports are presented to each Board meeting per annum as directed by the Chairs Group for NHS Wales. Directors and their deputies/key nominated individuals attend service specific peer groups across NHS Wales to contribute and engage with Welsh and National agendas, including: o Directors of Finance Forum o Boards Secretaries Network o Directors of Digital Meeting o Directors of People and Organisational Development Group o Directors of Planning Group	
2	Do you have effective leadership, direction and decision making within your organisation / service?	The Managing Director for NWSSP is responsible for the delivery of the Shared Services functions and assumes overall accountability in relation to the management of NWSSP and report to the SSPC. The Managing Director is supported by the SLG who are responsible for determining NWSSP policy, setting the strategic direction and ensuring that there are effective systems of internal control and that high standards of governance and behaviour are maintained. The SLG are responsible for approving all business decisions, protocols and projects and their work is supported by a number of	SLG

		working groups which ensure that decision making is in the interest of NWSSP as a whole, including: • Information Governance Steering Group • Health and Safety Group • Communications Strategy Group • IT Group • Local Partnership Forum The SLG reviews it leadership through a range of methods, including undertaking PADR's with Directors and participating in annual assessments the Customer Service Excellence Standard and other accreditations and certifications, such as ISO14001, which refers specifically to Leadership at Clause 5 of the Standard. **Leadership Development** We will continue to focus on the development of leaders at all levels of the organisation. A number of leadership competence aligned to the leadership competence framework contained within the NHS Leadership Model. The PADR process mechanisms will be used to ensure that staff are assessed against these standards in the context of what is required for their leadership position. We continue to promote the People Development through the Learning & Development team, and our focus on improving and upskilling our staff so we can best the best in our roles and deliver the best service possible for NHS Wales. This includes ILM professional qualifications across all levels of the organisation and have a range of training specifically targeted at Managers, such as the People Management Skills programme, Manager's support toolkit, coaching and mentoring skills, etc. In line with individual identified personal development needs, we also actively encourage managers to access development programmes provided by Academi Wales and source external specific training courses, as required. We support work based learning opportunities and take advantage of free training and qualifications that are funded and promote these to staff to further their personal and professional development. The SSPC and the Audit Committee undertake annual; "Committee effectiveness" surveys to evaluate the performance and effectiveness of:	

		• the SSPC members and the Chairman of SSPC; • the quality of the reports presented to committee; and • the effectiveness of the committee secretariat.	
3	What levels of delegation have been agreed? Do they provide a robust framework for accountability?	The SSPC's Standing Orders (SOs), underpinned by the Standing Financial Instructions (SFIs) and agreed by the Velindre University NHS Trust Board, set out the governance framework to which NWSSP must operate which includes a Scheme of Delegation which details the levels of delegation the Committee gives to individuals & Committees/Groups and provides an appropriate balance between finance, safety and governance. The SOs are reviewed annually, NWSSP has put in place a robust Governance and Accountability Framework and its Standing Orders set out the codes of conduct and probity expected of all staff. These are supported by a number of policies and procedures such as the Standards of Behaviour Framework Policy and Raising Concerns (Whistleblowing) Policy. These policies are accessible to staff via the intranet. The following arrangements are in place, as part of our Governance and Accountability Framework, to ensure that our work is supported by clear standards of ethical behaviour, in line with the 7 Nolan Principles of Public Life: • Standing Orders • Standing Financial Instructions • Hosting Agreement • Memorandum of Co-operation • Service Level Agreements with supporting schedules • Terms of Reference for all Committees • Register of Interests • Gifts and Hospitality Procedure • A Scheme of Delegation included within the Disciplinary Policy and Procedure. It outlines the level of manager with the delegated powers to issue warnings, invoke suspension and dismiss. The NWSSP uses the host organisation's Standards of Behaviour Framework Policy. The Framework Policy and its supporting policies are designed to protect individuals in respect of interests, gifts, hospitality and sponsorship. It allows them to continue to receive the	Managing Director

		benefits of these activities within the confines of the Framework Policy and good governance arrangements, thus avoiding any potential challenge or conflict. The Register of Gifts and Hospitalities is presented as a standing agenda item within Governance Matters report, taken to Audit Committee.	
4	Do you have sound systems of financial control?	The Standing Orders set out the codes of conduct and probity expected and includes detailed Standing Financial Instructions (SFI's) to ensure effective control of NWSSP's financial activities. NWSSP has enhanced the vacancy control approval procedure to ensure that there is a robust audit trail for the recruitment to replacement and new posts. This procedure ensures all recruitment supports the IMTP for services, operates within its financial envelope and provides appropriate consideration to redeployment. During the process approval is provided by the appropriate Finance Business Partner and the Director of Finance and Corporate Services. The Director of Finance and Corporate Services is responsible for managing and monitoring NWSSP's financial expenditure and provides an update on finance and performance at each meeting of the SSPC, Audit Committee and SLG. NWSSP's system of internal control is audited annually by internal audit and assurance is provided through the publication of the Annual Governance Statement. The Finance Team maintain robust financial systems and procedures in line with the Integrated Medium Term Plan. Any applications for the Voluntary Early Release Scheme are subject to consideration and ratification by Velindre Trust's Remuneration & Terms of Service Committee, in accordance with the standards, as determined by the NHS in Wales.	Director of Finance & Corporate Services
5	Do you have clear arrangements for monitoring governance activities?	NWSSP has developed and enhanced governance arrangements which were originally put in place in April 2011 and subsequently updated following the Welsh Government consultation, which led to the current governance arrangements which came into force on 1 June 2012. NWSSP has developed its overall strategy and vision and put in place effective governance arrangements working in conjunction with its host organisation. NWSSP continues to perform well in this area	Director of Finance & Corporate Services

		which is supported by reports from Internal Audit and external auditors, Audit Wales. The overall governance arrangements received a ”substantial assurance” rating in the most recent internal audit review. The Annual Governance Statement explains the processes and procedures in place to enable the NWSSP to carry out its functions effectively and is approved by the Audit Committee and endorsed by the SSPC. The Velindre University NHS Trust Audit Committee for Shared Services which meets four times a year, as part of the wider governance arrangements for hosting shared services. The purpose of the Audit Committee is to advise and assure the Shared Services Partnership Committee (SSPC) and the Accountable Officer on whether effective arrangements are in place, regarding the design and operation of NWSSP’s system of governance and assurance. This supports the SSPC in its decision making and in discharging its accountabilities for securing the achievements of NWSSP’s objectives in accordance with the standards of good governance determined for the NHS Wales. The composition of the Audit Committee includes an independent Chair and two other independent members (all of which are members of Velindre University NHS Trust’s substantive Audit Committee), representatives from Internal Audit, Audit Wales, Counter Fraud, Director of Corporate Governance/Board Secretary, Director of Finance and CEO of Velindre University NHS Trust, Chair of SSPC, Managing Director and the Director of Finance and Corporate Services of NWSSP. The standing items on the agenda for Audit Committee include Counter Fraud Position Statement, Internal Audit Reports, External Audit Position Statement, Governance Matters (including single tender actions, gifts and hospitality, and tenders awarded), Corporate Risk Register, Audit Tracking Register and Forward Plan of Business. The Audit Committee provides the SSPC with an annual report on the Committee’s activities and conducts a review of the Terms of Reference to ensure they remain fit for purpose.	
6	Are all new services / business cases underpinned by the Standards for Health Services in Wales?	All new Services require business cases to be undertaken which are considered and scrutinised by the SLG at the Formal SLG meetings that take place on a monthly basis. They follow appropriate guidelines for Better Business Cases and Project Managers should ensure that	SLG

		EQIIAs have been completed on each project prior to submission for consideration and approval, To strengthen the decision making process, the report proforma for the SSPC was reviewed in its entirety in September 2014 and in 2017 and a new revised format was produced and approved by the SSPC. The new report proforma: • better aligns with the overarching strategic direction of NWSSP; • provides clarity of purpose; • includes appropriate evidence and where relevant, information and benchmarking to support decision making; • outlines the impact the required decision and where appropriate not making a decision will have, including the Health and Care standards; and • outlines the related implementation plan, associated timescales and review / monitoring arrangements. When developing the new report proforma, reference was made to the following source documents: • An Overview of Governance Arrangements, Betsi Cadwaladr University Health Board. Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office (June 2013); • Financial Reporting Council (FRC), Guidance on Board Effectiveness (2011); • The National Leadership Academy, The Healthy NHS Board, Principles for Good Governance (2013). • Good Practice in Existence at Cwm Taf LHB	

d) Safeguards and protects all assets, including its people;

	Question	Evidence	Responsible Person within each Directorate
1	Do you have a risk framework and a system of assurance?	As a non-statutory hosted organisation, NWSSP follows the Velindre University NHS Trust (Velindre) Risk Management Strategy and Risk Assurance Framework, which complies with legislation and supports best practice. NWSSP has also developed its own Risk Management Protocol. The Policy and supporting Protocol are reviewed on annual	Director of Finance & Corporate Services

		basis and approved by the SLG and Audit Committee and endorsed by the SSPC and Velindre Trust Board. The SSPC has set out the Governance Framework and a Scheme of Delegation for the organisation which provides a suitable balance between finance, safety and governance. The governance framework includes the Corporate Risk Register and forward plans of business for SLG, SSPC, Audit Committee and Head of Internal Audit Opinion. NWSSP has also developed a Risk Appetite Statement to support its Risk Strategy and the Risk Assurance Framework. Key risks and enablers are set out in our Integrated Medium Term Plan (IMTP). We have an overarching Corporate Risk Register, which is presented at each Formal SLG meeting for review and amendment, as necessary, it is also presented at SSPC and Audit Committee as a standing agenda item. SLG periodically dedicate a session to a 'deep dive' of the Corporate Risk Register. We have Service-specific, directorate level Risk Register which are maintained locally and scrutinised at Quarterly Reviews. During the pandemic, there was a need to maintain a COVID-19 Risk Register and this was reviewed at the Planning and Response Group, which was established to deal with pandemic related risks. The Adapt and Future Change Group highlighted lessons learned from the pandemic response and recovery. In addition, a Health and Safety Risk Register and an Environmental Aspects and Impacts Register are maintained within the organisation, which are monitored and reviewed at each Health and Safety and Green Team meeting. Information Governance holds its own Risk Register, which is monitored through the Information Governance Steering Group (IGSG), on a quarterly basis. Any incident or "near miss" incident is discussed at the meetings and demonstrates a lessons learnt culture within the organisation. Assurance Mapping exercise have been undertaken across the Services, by the Head of Finance and Business Improvement and these are periodically reviewed and updated.	

		Each project has its own Risk and Lessons Learned Logs, which are maintained by the Project Lead/Manager. Services are encouraged to consider lessons learned and take proactive steps to implement customer and partner feedback received. Complaints Management Protocol is reviewed annually and has supporting guidance for Vexatious Complainants. Staff across the Services have attended various risk assessment training courses to identify health and safety hazards in their workplace. Building Managers / Site Leads have undertaken IOSH Working and Managing Safely courses. Core Skills Training Framework (CSTF) modules include fire safety, manual handling, safeguarding children and adults, information governance and cyber awareness. Implementation of Datix Once for Wales Concerns Management System for reporting, managing and investigating incidents (e.g. Health and Safety/Information Governance). Work is ongoing as to an All Wales Risk Management approach, led by the Head of Finance and Business Improvement, through the Board Secretaries Network. Business Continuity Plans (BCP) and action cards have been developed for each Service. Equality Integrated Impact Assessments (EQIIAs) undertaken which provides an opportunity to mitigate risk ate the outset and prevent issues occurring, captures legislation such as Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. • Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant.	

<table>
<tr><td></td><td></td><td>• Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation</td><td></td></tr>
<tr><td>2</td><td>How do you gain assurance about your organisation / service?</td><td>In addition to the above evidence provided (including IMTP, Annual Review, Policies, EQIIAs, etc):

The Risk Assurance and Governance Framework provides assurance as to the organisation's controls in place to manage effective governance, including documentation such as the Annual Governance Statement and Head of Internal Audit Opinion. Assurance Mapping exercise have been undertaken across the Services, by the Head of Finance and Business Improvement and these are periodically reviewed and updated and provides a level of visual assurance over and above the Risk Registers held.

Risk Registers are very visual and scored using a risk scoring matrix, which is standard across all Risk Registers compiled within NWSSP and provides a level of visual assurance.

<table>
<tr><td colspan="7">Key to Impact and Likelihood Scores</td></tr>
<tr><td colspan="2"></td><td colspan="5">Impact</td></tr>
<tr><td colspan="2"></td><td>Insignificant</td><td>Minor</td><td>Moderate</td><td>Major</td><td>Catastrophic</td></tr>
<tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td colspan="2">Likelihood</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5</td><td>Almost Certain</td><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr>
<tr><td>4</td><td>Likely</td><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr>
<tr><td>3</td><td>Possible</td><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr>
<tr><td>2</td><td>Unlikely</td><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr>
<tr><td>1</td><td>Rare</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td></td><td>Critical</td><td colspan="5">Urgent action by senior management to reduce risk</td></tr>
<tr><td></td><td>Significant</td><td colspan="5">Management action within 6 months</td></tr>
<tr><td></td><td>Moderate</td><td colspan="5">Monitoring of risks with reduction within 12 months</td></tr>
<tr><td></td><td>Low</td><td colspan="5">No action required.</td></tr>
</table>

NWSSP has an independent Audit Committee which provides scrutiny of its financial and governance arrangements. The Audit Committee acts in compliance with the NHS Wales Audit Committee Handbook and reports through to the Shared Services Partnership Committee.

The Audit Committee set a programme of business and has agreed an internal audit plan which demonstrates assurance for the Committee. These ongoing arrangements represent a continuance of the review</td><td>Director of Finance & Corporate Services</td></tr>
</table>

		and independent scrutiny of the governance and controls operated by Shared Services. The objective of the Internal Audit of Corporate Governance was to evaluate and determine the adequacy of the systems and controls in place for ensuring compliance with statutory and regulatory requirements, in order to provide reasonable assurance to the NWSSP Audit Committee that risks material to the achievement of system objectives were managed appropriately. The level of assurance given as to the effectiveness of the system of internal control for Corporate Governance when it was last tested by Internal Audit was Substantial Assurance.	
3	Where do you get the assurance from?	As above, we have many sources of assurance which have been referred to and explicitly set out in the Standards above, NWSSP has an independent Audit Committee which provides scrutiny of its financial and governance arrangements. The Audit Committee acts in compliance with the NHS Wales Audit Committee Handbook and reports through to the Shared Services Partnership Committee. The objective of the Internal Audit of Corporate Governance was to evaluate and determine the adequacy of the systems and controls in place for ensuring compliance with statutory and regulatory requirements, in order to provide reasonable assurance to the NWSSP Audit Committee that risks material to the achievement of system objectives were managed appropriately. The level of assurance given as to the effectiveness of the system of internal control for Corporate Governance when it was last tested by Internal Audit was Substantial Assurance. The Audit Committee's annual report and the Annual Governance statement provide assurance that NWSSP has effective governance procedures in place.	Director of Finance & Corporate Services
4	How do you use internal and clinical audit mechanisms to provide assurance?	The Audit Committee agree and approve an annual programme of internal audit assessments and external audit assessments through the Audit Wales for NWSSP. Audit reports are presented to the Audit Committee to provide assurance. All audit recommendations are captured on an Audit Tracking Register which provides a dashboard view of recommendations for both internal and external audit. This is	Director of Finance & Corporate Services

		a standing item on the monthly Formal SLG meetings and Audit Committee. The Head of Internal Audit Opinion should also be considered when considering the mechanisms used within NWSSP to provide assurance, both internally and externally. Audit and Assurance Services undertake audits of new services, periodic reviews, specific requests for advisory reports and audits undertaken on a risk basis. Internally, Health and Safety and Environmental and Quality Teams undertake local audits of their management system and assurance can be taken from the results. Certificates of competency of auditors within the workforce are maintained for training records in accordance with the standards, with refreshers being undertaken periodically, or as required.	
5	How do you identify, assess and manage your risks?	NWSSP has developed an executive and operating management structure which reflects the different areas of accountability where risk resides. The responsibility for overseeing risk management ultimately rests with the Audit Committee. The overarching Corporate Risk Register is supported by each Directorate having its own Risk Register to record risks pertinent to their areas of work. Any risk categorised as being red triggers an automatic referral to the SLG for them to assess whether it needs to be recorded on the NWSSP Corporate Risk Register. Assurance mapping is used within Services to visually gauge where assurances could be strengthened to mitigate risks, The Corporate Risk Register is a standing item on the agenda for the SSPC, Audit Committee and Formal SLG. Horizon scanning and deep dive sessions with the SLG and key individuals provides opportunity to identify, assess and manage potential risks as part of the IMTP planning process. Programme Management Office (PMO) provides a robust project methodology is applied to identify and manage risk to ensure that projects are delivered successfully.	Director of Finance & Corporate Services

		Within Environmental management, significant aspects and impacts (risk) of the activities conducted on site are assessed periodically and reviewed at each Green Team meeting, this forms the basis of the Risk Register for ISO14001.	
6	How do you identify and mitigate against risk in respect of this standard?	As a non-statutory hosted organisation, NWSSP follows the Velindre University NHS Trust (Velindre) Risk Management Strategy and Risk Assurance Framework, which complies with legislation and supports best practice. NWSSP has also developed its own Risk Management Protocol. The Policy and supporting Protocol are reviewed on annual basis and approved by the SLG and Audit Committee and endorsed by the SSPC and Velindre Trust Board. The SSPC has set out the Governance Framework and a Scheme of Delegation for the organisation which provides a suitable balance between finance, safety and governance. The governance framework includes the Corporate Risk Register and forward plans of business for SLG, SSPC, Audit Committee and Head of Internal Audit Opinion. NWSSP has also developed a Risk Appetite Statement to support its Risk Strategy and the Risk Assurance Framework. Key risks and enablers are set out in our Integrated Medium Term Plan (IMTP). We have an overarching Corporate Risk Register, which is presented at each Formal SLG meeting for review and amendment, as necessary, it is also presented at SSPC and Audit Committee as a standing agenda item. SLG periodically dedicate a session to a 'deep dive' of the Corporate Risk Register. We have Service-specific, directorate level Risk Register which are maintained locally and scrutinised at Quarterly Reviews.	Director of Finance & Corporate Services
e) Ensures good governance when working in partnership with others.			
	Question	**Evidence**	**Responsible Person within each Directorate**
1	Do you know about all partner organisations / networks?	NWSSP actively engages with its partners and stakeholders through the SSPC, attending quarterly meetings with Health Boards/Trusts, Joint Executive Team (JET) meetings with Welsh Government,	SLG

		meeting with counter fraud specialists, meeting with suppliers, customers and partners, etc and through being involved in professional peer groups. For example, there are peer groups in existence across NHS Wales for Directors of Finance, Directors of People & Organisational Development and Directors of Governance/Board Secretaries. NWSSP has formal arrangements in place whereby the Chair and NWSSP's Managing Director attend Board level meetings across the NHS organisations to inform them of NWSSP's performance and to engage and consult with them on strategic objectives and activities. In addition, a minimum of two performance reports are presented to each Board meeting per annum as directed by the Chairs group for NHS Wales. NWSSP works in partnership with Trade Union organisations through its "Local Partnership Forum (LPF)" and associated sub groups. NWSSP and the SLG work closely with the LPF on a wide range of corporate and strategic issues. This includes engagement on all aspects of organisational change, re-organisation, re-structuring and re-location. Trade Unions are represented on a variety of subgroups and we are proud to work in partnership with them. NWSSP's commitment to engaging with its stakeholders is demonstrated through attaining and maintaining certifications, Standards and accreditations that Services have achieved, e.g. Customer Service Excellence, Lexcel, etc.	
2	What accountability arrangements exist for partnerships and networks?	In 2010, the Health Minister set up a programme to develop a Shared Service structure for NHS Wales which fundamentally supported the improvement of patient care by reducing bureaucracy, removing internal artificial boundaries and channelling more money into front line services through greater efficiency. One of the key objectives of the programme was to enable Health Boards and Trusts focus on delivering the Strategic Vision for health services in Wales and more recently delivering "Together for Health". The programme led to the establishment of the NHS Wales Shared Services Partnership (NWSSP) on 1 April 2011, in a virtual format before becoming a separate organisation as hosted by Velindre University NHS Trust on 1 June 2012. The accountability arrangements for NWSSP are through the Shared Services Partnership Committee	SLG

		(SSPC) which comprises of representation from the NHS Wales organisations. NWSSP primarily provide a range of professional, administrative and technical services to the Health Service in Wales and prior to 2011 a number of these Shared Services were originally hosted by individual Health Boards and NHS Trusts. NWSSP was created with the intention that all NHS Wales organisations could work together collaboratively and make use of their expertise. The governance surrounding these new arrangements were laid out within a specific overarching Service Level Agreement (SLA), with supporting schedules that provide clarity on the key services to be delivered by the NWSSP and the respective responsibilities of the parties to the agreement to ensure highly efficient and cost effective service delivery. The overarching SLA is supported by service schedules functions. The Procurement Services department have specific policies in place which outline the accountability arrangement's when entering into contracts, including Sustainable Procurement Policy, NWSSP Procurement Policy and NWSSP Supplier Policy and address the recommendations of Wales Procurement Policy Statement (April 2015) and Well-being and Future Generations (Wales) Act 2015.	
3	Are you compliant with local compact arrangements between the NHS and Third Sector?	NWSSP does not have any written compact agreements which define and manage the relationship between the third sector and one or more public sector bodies when managing partnership agreements. However, NWSSP do have third sector contractual relationships which are officially recognised through official procurement tenders.	Director of Procurement Services and Health Courier Services
4	What corporate policies exist within your organisation / service to guide your staff and others on how you do business?	NWSSP is governed by the Velindre NHS Trust Shared Services Regulations 2012(2012/1261(w.156)). The required standards for effective governance are outlined within the Shared Services Partnership Committees (SSPC) standing orders, values and standards of behaviours framework, and associated policies on quality and safety and workforce issues. Where the Velindre policies do not align with NWSSP operations, we have autonomy to introduce "protocols" to ensure effective governance for standards operating procedures (e.g. Complaints Management Protocol).	SLG

		A number of Standards Operating Procedures (SOPS) are in place across Primary Care Services (PCS) and the Health Courier Service (HCS).	

Self Assessment Rating - Governance, Leadership and Accountability					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating				✓	
Comments	In light of the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the associated duty that this brings upon the organisation, this is likely to alter the way in which we report and approach this Self-Assessment, going forward. It is hoped that the Duty will lend itself better to NWSSP and the Services that we provide to NHS Wales. The approach supports the five ways of working (Sustainable Development Principle) in the Well-being of Future Generations (Wales) act 2015, to achieve a Healthier Wales. The Duty will see active consideration of whether decisions will improve service quality and secure improvement in outcomes and applies to all health services functions (not just clinical), requiring health services to demonstrate that quality is at the heart of all they do. There will be a system-wide approach to achieving quality of care in a way that secures continuous improvement and in addressing this, we will consider the domains of quality: • **Safe**: Avoiding harm to patients from the care that is intended to help them; • **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively); • **Patient-centred**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions; • **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care; • **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy; and • **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.				

	Case Studies help to tell the stories of how NWSSP's impact is felt in the wider population and well-being of Wales and how our Services contribute towards outcomes in the wider context of NHS Wales: • https://nwssp.nhs.wales/corporate-documents/corporate-case-study-documents/imtp-case-studies-2020-2023/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/five-year-plan-to-transform-hospital-pharmacy-services-in-wales/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/electrification-of-health-courier-services-fleet/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/mass-vaccination-centre-roll-out/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/staff-health-and-well-being-partnership/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/once-for-wales-e-systems-contract-award/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/supporting-nhs-wales-in-responding-to-the-pandemic/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/legal-and-risk-services-property-team/ • https://nwssp.nhs.wales/corporate-documents/annual-plan-2022-2023/all-wales-covid-19-workforce-risk-assessment-tool/ • https://nwssp.nhs.wales/corporate-documents/corporate-case-study-documents/imtp-case-studies-2019-2022/

Theme 1 - Staying Healthy

1.1 **Health Promotion, Protection and Improvement**

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

	Sub Criteria	Evidence	Responsible Person
1	People know and understand what care, support and opportunities are available, locally, regionally and nationally, including community support and support for people from protected groups.	• Staff are made aware of what care, support and opportunities are available through a variety of communication channels, including: o Staff Intranet o Health and Well-being Staff Centre o Newsletters – Health and Well-being – Health and Safety, People and Organisational Development, etc. o Managing Director Communications o Health and Well-being Champions/Mental Health First Aiders o Team meetings and One to Ones o Social Media o Health and Well-being Strategy o Policies, protocols and guidance ▪ Special Leave Policy, Sickness Policy, Work Life Balance Scheme, Flexible Working Policy / Agile Working, Purchase of Annual Leave Policy, Domestic Abuse Policy, Stress and Mental Health Well-being Policy, Health, Safety and Welfare Policy, Welsh Language Policy, etc. ▪ All relevant People and Organisational Development policies are available in both Welsh and English. Information provided as to Health and Wellbeing is available to staff in both Welsh and English. • Health and Well-being Staff Partnership meetings are chaired by the Director of Finance and Corporate Services. • NWSSP is also able to demonstrate support, dignity and respect of children via its initiatives such as childcare vouchers scheme and school holiday childcare subsidies.	Director of People & Organisational Development and Employment Services Director of Finance & Corporate Services

		• Corporate Induction and e-induction toolkit includes information on Health and Well-being and ensure staff are made aware of the support available to them during their employment. This is also captured within the staff handbook. • NWSSP staff can also access the Employee Assistance Programme which provides staff with advice and support on a range of matters from financial support to counselling. This can be accessed 24/7 either online or via a free-phone telephone number. This can also be shared with friends and family to access. Resources are available online for a range of well-being matters. • Dedicated space for staff to access support and resources – topical, up to date information • Schemes to support staff in purchasing items such as Cycle 2 Work Scheme, Salary Sacrifice Lease Car Scheme, Home Electronics Scheme. • NHS Staff benefit from Blue Light Card and NHS discounts (e.g. Health Services Discounts). • ESR learning modules offer a variety of courses online that staff can choose to undertake in addition to the CSTF modules mandated (e.g. Romani and Traveller Healthcare, etc.). o Equality, Diversity and Inclusion offering, including Staff Support Groups, Inclusion Network, LGBT+ Staff and Ally Network "Proud/Balch", Disability Network, BAME Staff and Ally Network and Menopause Café, Carer's Network, etc. During the pandemic, we promoted Velindre's Shielding Staff Support Network. • Promotion of local and national initiatives and campaigns (e.g. Pride Cymru, Breastfeeding Week, Disability Awareness Week, etc.) • Support from local organisations and charities, such as Sustrans Cymru, etc. • Staff Recognition Awards. • Published documents such as Integrated Medium Term Plan (IMTP) and Annual Review, and associated Case Study library. • The NWSSP staff newsletter also features regular articles on staff involvement in charitable events. • Equality Integrated Impact Assessments (EQIIAs) and Panel of Subject Matter Experts and Trade Union Representation. • Health and Well-being Conference	
2	People are supported to engage, participate and feel valued in society.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Staff Health and Well-being Centre on the intranet is a dedicated area for support resources, signposting of services, benefits for staff and provides specific guidance on health and well-being including smoking cessation, alcohol and substance misuse, mental health and well-being promotion and nutrition. We are also proactive in promoting well-being campaigns to staff through the internal newsletter, intranet	Director of People & Organisational Development and Employment Services

		articles and posters, including alcohol awareness, healthy eating, screening services and health checks. • NWSSP staff newsletter also features regular articles on staff involvement in charitable events. • Staff Recognition Awards – held remotely and recorded for maximum inclusion and has a number of well-being theme categories for awards and nominations. • Annual Review and IMTP case studies relating to health and well-being. • Health and Well-being Conference • **Work to attain the Corporate Health Standard remains ongoing.**	Director of Finance & Corporate Services
3	People are supported to be healthy, safe, and happy, and to lead an active life.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP has a dedicated area on the intranet for providing information and guidance on health and wellbeing topics, including the services available and the benefits for staff. These include smoking cessation, alcohol and substance misuse, mental health, physical activity and nutrition, financial well-being, emotional well-being, physical well-being and mental well-being etc. • We promote well-being campaigns to staff through internal newsletters, articles and posters, email and roadshows at different sites. Staff are encouraged through these means to participate in various wellbeing enhancing activities and to share stories of good practice and positive outcomes, with the hope of encouraging others. • Health and Well-being Champions / Mental Health First Aiders • The Health and Safety Manager and Site Leads ensure that all working environments are safe and that the appropriate risk assessments, equipment and personal protection equipment are present and available to minimise any risk to staff. • Flexible working / agile working approach adopted and staff surveys have been undertaken to support continued implementation. • Courses on a variety of health and well-being matters are available, including mindfulness, stress awareness, mental health, etc. • Staff Support Networks (as listed above). • Local initiatives on sites such as Matrix House Lakeside Walking Group, Sound Choir, etc.	Director of People & Organisational Development and Employment Services Director of Finance & Corporate Services
4	Children have a good, healthy, safe and nurturing start in life.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP's services do not directly affect children, but we recognise the indirect impact that we have on the wider population of Wales, through the Services we deliver to NHS Wales organisations. However, NWSSP adhere to Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.	Director of People & Organisational Development and Employment Services Director of Finance & Corporate Services

		• The Director of People and Organisational Development and Employment Services is our Ethical Employment Champion for NWSSP. We have an Ethical Employment Statement, which is reviewed annually, • All staff are required to complete the "Safeguarding" children online training module contained within the statutory and mandatory core skills training framework (CSTF) for NHS Wales. • NWSSP adhere to the Velindre NHS Trust Policy for the Photography, Video and Audio Recordings of Service Users and ensure that consent is sought for any photography/videography featuring children under 16. In addition, NWSSP Communications team has a protocol for obtaining consent for photography and videography. • If records or information are requested around children's medical information held by the NWSSP, then the Common Law Duty of Confidence is a pre-requisite for all confidential information. Information requests are actioned under the Subject Access (DSAR) provisions of the UK General Data Protection Regulation(UK GDPR, the UK Data Protection Act (2018) and all applicable confidentiality and Information Governance protocols to ensure safe use and processing of such data. NWSSP also holds a quarterly Information Governance Steering Group (IGSG) with representatives from each area of the organisation and meetings are chaired by the Director of Finance and Corporate Services who is also the Senior Information Risk Owner (SIRO).	
5	Carers of individuals who are unable to manage their own health and wellbeing are supported.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP promotes the Velindre University NHS Trust Carers Policy which signposts staff who are carers to appropriate support and guidance. • These individuals are also able to access the support provided through the Occupational Health Service and the Employee Assistance Programme, which provide access to wellbeing advice and counselling services. • Staff Support Networks include Carer's Network, which is available through our hosts, Velindre University NHS Trust.	Director of People & Organisational Development and Employment Services Director of Finance & Corporate Services
6	People are supported to make decisions about their health behaviour and wellbeing which impact on their health and the health and wellbeing of their children.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Through various well-being campaigns, staff are encouraged to think about the impact of lifestyle on their children (e.g. smoking, nutrition and alcohol consumption). • The encouragement of physical activity also encourages family participation, (e.g. walking, cycling, etc), which is supported by schemes such as the Cycle 2 Work Scheme. • Employee Assistance Programme (EAP) offers resources online and advise in relation to issues with well-being and in particular there are a number of resources available relating to children and family life that staff (and their friends and family) can access at any time. • Local and nationwide NHS discounts available, as above (including certain supermarkets, gyms, Blue Light Card, Health Services Discounts, etc).	Director of People & Organisational Development and Employment Services Director of Finance & Corporate Services

		• Promotion of the new NHS Eatwell plate and its inclusivity to culture, including recognising intolerances and specialist diets based on belief, such as Veganism. • Travel Plan and Active Travel to support healthy choices and improve physical activity. • We recognise the link to the Future Generation Commissioner's strategic objective to tackle adverse childhood experiences.	
7	Breast feeding is promoted and supported.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • In accordance with the legislative framework outlined within the Workplace (Health, Safety & Welfare) Regulations 1992, the Management of Health and Safety at Work Regulations 1999, the Equality Act 2010 and the Maternity, Adoption and Parental Leave Policy, NWSSP undertakes risk assessments for new and expectant staff and provide suitable rest facilities for breastfeeding purposes. NWSSP also adhere to the Health and Safety Executive's (HSE) Guidance for New and Expectant Mothers[1]. • As a non-clinical service NWSSP is not required to attain UNICEF UK Baby Friendly accreditation. • We recognise that breastfeeding staff will often require a quiet, clean and private space to facilitate pumping or expressing of milk and provide such facilities on site. • In addition, we understand that breastfeeding staff will require the support of managers and teams in seeking time away from their duties to pump or express breastmilk at regular intervals throughout their working day and recognise that this is important and essential for both the breastfeeder and their child's well-being, health, comfort and equality. It is essential that staff be able to take time away to facilitate this when they feel the need to do so, to prevent problems arising, such as mastitis, etc. • We also provide safe and appropriate washing facilities on site and fridges for storing breastmilk, as appropriate.	SLG
8	Smoking cessation and smoke free environments are promoted and supported.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is aware of the actions contained within the Welsh Government's Tobacco Control Strategy for Wales, which provides a clear direction of work to reduce smoking prevalence in Wales, with an overall long-term vision of a smoke-free society for Wales by 2030, in which the harm from tobacco is eradicated. • The Public Health (Wales) Act 2017 introduced further legislation in Wales to support efforts to reduce smoking and to prevent the uptake of smoking. • Staff and visitors are not permitted to smoke cigarettes or e-cigarettes within the building or grounds of NWSSP's estate and this is now an All Wales Policy for all the NHS Wales estate and grounds. • NWSSP is committed to reducing smoking prevalence and is proactive in promoting smoking cessation services via the intranet, internal staff newsletters and the dedicated page on smoking cessation within the Health and Well-being Centre. Public Health	All

[1] HSE Guidance New and Expectant Mothers http://www.hse.gov.uk/pubns/indg373.pdf

		Wales' "Help Me Quit" campaign for smoking cessation in Wales is promoted and we publish regular information on smoking cessation in our internal communications. • Face to face sessions on smoking cessation have been offered to staff within NWSSP. • Where NWSSP has leased sites or shared occupancy of an estate or buildings, we endeavour to influence smoking cessation and negate smoking on site (e.g. Mamhilad, Matrix House and Companies House). However, we recognise that for the well-being of staff who are smokers, they must be afforded with an appropriate shelter for smoking, such as Companies House, where it is not within our gift to further impose on site rules around this. • NWSSP support a Healthier Wales and recognise that the Sustainable Development Principle and associated 5 ways of working (prevention, long-term, collaboration, involvement and integration) links in to tackle smoking cessation.	
9	People are supported to avoid harm to their health and wellbeing by making healthy choices and accepting opportunities to prevent ill health.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Within NWSSP we aim to maintain a safe and healthy working environment, to have a workforce making healthier choices and managing their own health and well-being and a well-being support network and resources available to all staff members. • NWSSP support a Healthier Wales and recognise that the Sustainable Development Principle and associated 5 ways of working (prevention, long-term, collaboration, involvement and integration) links with making healthy choices now, to avoid and prevent ill health in the future. • Managing Director communications focussing on key issues (e.g. financial well-being crisis more recently), Cycle 2 Work Scheme, Travel Plan / Active Travel, Mental Health First Aiders, Employee Assistance Programme, etc. • Well-established Health and Safety governance framework supporting staff in the avoidance of harm and to improve their own personal well-being. Health and Safety network, overseen by a dedicated Health and Safety Manager, ensuring safe conditions within the workplace across all sites and providing advice on issues such as manual handling equipment and display screen equipment. • NWSSP are proactive in supporting staff to maintain and improve health, well-being and independence through promoting healthy choices and opportunities to prevent ill health (e.g. through various policies, induction, internal staff newsletters, intranet, email, posters and Health and Well-being Conference, etc). • Promotion of Health Shield screening checks through corporate induction toolkit. • Staff offering of seasonal influenza vaccinations and during the pandemic, prioritisation of key front-line staff for the COVID-19 vaccination. • Occupational health referral service, mental health awareness and counselling services available through the Employee Assistance Programme (EAP). • NWSSP refer to a number of effective policies and procedures, utilising those from both our host, Velindre University NHS Trust and those adapted specifically for NWSSP.	All

		• Facilitate reasonable adjustments to reduce long term sickness absence by supporting staff to attend work in a healthy capacity. • Free eye tests offered for NHS Wales staff, with funding offered towards spectacles specifically for work purposes.	
10	There is active promotion of healthy and safe workplaces and communities.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Corporate induction toolkit, local training (specific to role / site and identified through PADRs) and Core Skills Training Framework for manual handling, fire safety, etc. • Building Management Group (BMG) established during pandemic response and recovery. Adapt and Future Change Group and also Planning and Response Group were established during the pandemic to oversee operational and strategic issues as regards healthy and safe workplaces at this time. • Formal SLG meetings and SSPC, Audit Committee, Local Partnership Forum agenda items include Health and Well-being Staff Partnership meeting updates and also Health and Safety quarterly and annual reports, etc. • Local Landlord and Tenant / Building User Group meetings. ISO14001 Green Team meetings also discuss green space and staff well-being issues arising from environmental aspects and impacts. • The Health and Safety Manager for NWSSP ensures that all working environments are safe and that the appropriate risk assessments, equipment and personal protection equipment are present and available to minimise any risk to staff. Information is disseminated to staff through the Corporate Induction, Local Induction, risk assessments, handbooks (if necessary) and e-Learning modules. • The Health & Safety Group continuously review and evaluate that NWSSP environments and communities are health and safe through internal audits through HSG, analysing incidents and implementing remedial action, as required, and adhering to robust health and safety processes and appropriate local working instructions. • Further promotes and protects the physical and mental health and well-being of staff through promotion of well-being guidance and campaigns and the proactive marketing of well-being initiatives through our range of internal communication channels, as outlined above. • Policies, procedures, protocols, working instructions, guidance, flash cards, etc. • Health and Safety dedicated intranet pages for staff and Health and Well-being Centre. • With regards to the community, the nutritionist within Procurement Services influences healthier options when tendering for catering and food supplies for NHS Wales. Further, vending machines, the supply of which is procured through Procurement Services, are filled with a proportion of healthier options. NHS Eatwell plate is promoted and its inclusivity to culture, including recognising intolerances and specialist diets based on belief and healthy choices, such as Veganism.	Director of Finance & Corporate Services
11	There is active promotion of the health and well being of staff.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.):	Director of People & Organisational

		• NWSSP promotes and aims to protect the emotional, physical and mental health and well-being of staff through promotion of well-being guidance and campaigns and the proactive marketing of well-being initiatives through our range of internal communication channels including various newsletters, emails, Managing Director communications, intranet, Health and Well-being Centre, Health and Well-being Champions, social media, Corporate Induction, etc. • Noticeboards are also used to display well-being information and to promote upcoming initiatives and campaigns. • Staff are made aware of available initiatives that may support their health and well-being such as Health Shield which has been promoted via the intranet, posters, corporate induction and through site visits.	Development and Employment Services Director of Finance & Corporate Services
12	Systems, resources and plans are in place to identify and act upon significant public health issues so as to prevent and control communicable diseases and provide immunisation programmes; with effective programmes to screen and detect disease.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is proactive in identifying and acting upon Public Health issues and access public health advice from newsfeeds and alerts from Health Boards, Public Health Wales (PHW), newsletters, Managing Director communications, social media, website, intranet and through attending seminars and training. • NWSSP identities and mitigates risk in relation to this standard through its local and national health and safety meetings and through proactive reporting of incidents on to the Datix, the Once for Wales Concerns Management System for incident reporting. • Staff receive training on health promotion, protection and improvement through the mandatory online core skills training framework (CSTF) via ESR. • All staff within NWSSP were encouraged to receive an influenza vaccination in line with the NHS “Flu Fighter” campaign and drop-in flu clinics were in place across several of our sites, in addition to working collaboratively with Health Boards to encourage staff to attend one of their local clinics. • During the pandemic, key front-line staff were prioritised to receive their COVID-19 vaccinations. A COVID-19 hub was established on the staff intranet and website to enable staff to access the most up to date guidance and local working instructions as regards to the latest control measures and restrictions on site and across Wales. • Redeployment and enabling working from home including for staff who were shielding during the • Building Management Group (BMG) established during pandemic response and recovery. Adapt and Future Change Group and also Planning and Response Group were established during the pandemic to oversee operational and strategic issues as regards healthy and safe workplaces at this time. • Campaigns and initiatives locally and nationally are promoted as regards health and well-being, preventable diseases, screening and immunisation programmes. • Communications, publications and infographics.	Director of Finance & Corporate Services Director of People & Organisational Development and Employment Services

13	Needs assessment and public health advice informs service planning, policies and practices.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation • Narrative, contextual approach taken to EQIIAs. • Project Managers, Stakeholder Groups and Peer Reviews • Risk Assessments undertaken, as appropriate. • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • As a non-statutory hosted organisation, we also benefit from being included in Velindre University NHS Trust's Networks and Equality offerings and we comply with their Equality and Diversity Policy and associated All Wales Policies and guidance, available for staff to view on the intranet page, including Dignity and Work Policy, Raising Concerns (Whistleblowing) Policy and Standards of Behaviour Framework Policy, etc. • Working in partnership with Trade Union colleagues. • Trade Union representation for Shared Services Partnership Committee (SSPC) meetings, Staff Health and Well-being Partnership and Equality, Diversity and Inclusion Groups.	SLG
14	Health services have systems and processes in place that play their part in reducing inequalities and protect and improve the health and wellbeing of their local population.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP has effective systems and processes in place to attempt to reduce inequalities and protect and improve the health and well-being of their local population. In accordance with the provisions of the Well-being of Future Generations Act (Wales) 2015, we produced a Well-being Statement**,** which informed the inaugural setting of our Well-being Goals, which then were reviewed, revised and adopted as our organisation's key Overarching Goals. We have identified where our strongest links have been made, however, collectively, our set of Well-being Objectives, contributes to all seven Well-being Goals. Each of the Overarching Goals contributes towards at least one specific Well-being Goal and often touches upon multiple Goals, given that we have purposefully aligned and integrated our approach as the golden thread, running through our organisation. • Our Sustainable Development Statement. Annual Review, Integrated Medium Term Plan are all key publications where we set out our role in delivering services that reduce	SLG

		inequalities and protect and improve the health and well-being of the population of Wales. • Our Annual Report features case studies showcasing real life projects and stories and we report against the Sustainable Development Principles, 5 ways of working and our achievements against our Overarching Goals. • As above, Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015 for projects, processes, policy changes, etc. • NWSSP adhere to Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains, which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage. The Director of People and Organisational Development is our Ethical Employment Champion and signs an Ethical Employment Statement reinforcing our commitment annually. • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • NWSSP are members of the Employers Network for Equality and Inclusion (ENEI). • Equality, Diversity and Inclusion offering, including Staff Support Groups, Inclusion Network, LGBT+ Staff and Ally Network "Proud/Balch", Disability Network, BAME Staff and Ally Network and Menopause Café, Carer's Network, etc. During the pandemic, we promoted Velindre's Shielding Staff Support Network. • Procurement Services' Community Benefits approach to contracting activity, with Sustainability Risk Assessments being undertaken, audits and contract obligations, value based and prudent healthcare principles and links to Ministerial priorities, including a more equal, resilient and healthier Wales. • Staff recruitment and retention schemes including Network 75, work experience and placement offerings, apprenticeship schemes, attendance at University and careers fayres, All Wales Recruitment Services toolkits and equal opportunities processes through TRAC and NHS Jobs. • Healthier Wales, Well-being of Future Generations, Active Travel, Sustainable Development, Ethical Procurement, Modern Slavery Act considerations, Health and Well-being, to include drivers and enablers of our customers, partners, key stakeholders and interested parties.	
15	Relationships and allocations of responsibilities between the various organisations with public health	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is proactive in working with customers and partners, stakeholders and key interested parties in order to reduce health inequalities and population health. Whilst	SLG

	responsibilities are clear and acted upon.	NWSSP, as a non-statutory hosted organisation, is not named within the Well-being of Future Generations Act (Wales) 2015, and is therefore not required to attend Public Services Boards, as a pan-Wales support service, we are committed to supporting NHS bodies to deliver their plans and priorities towards these agendas. • As above, we have an integrated approach to reporting which provides assurance to align with Ministerial and strategic priorities and delivering on WBFG is seen as the golden thread running through our organisation's strategy map. Our IMTP and Annual Review set out how NWSSP is supporting achievement of the Well-being Goals that Wales should be prosperous, resilient, healthier, more equal, globally responsible and a country of cohesive communities, have a vibrant culture and a thriving Welsh language. • Managing Director holds quarterly review meetings with Health Boards / Trusts and other NHS Wales organisations and Services hold regular review meetings with their customers and partners. • Service Level Agreements (SLAs) are insitu and regularly reviewed. • Shared Services Partnership Committee (SSPC) meetings, Audit Committee, Formal SLG meetings, Local Partnership Forums (LPF), etc.	

Self Assessment Rating – Theme 1 - Staying Healthy					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating				✓	

Theme 2 – Safe Care

Standard 2.1 Managing Risk and Promoting Health and Safety People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.			
	Sub Criteria	**Evidence**	**Responsible Person**
1	Best practice is applied in assessing, managing and mitigating risk which draws on people's experiences of the service.	• As a non-statutory hosted organisation, NWSSP follows the Velindre University NHS Trust (Velindre) Risk Management Strategy and Risk Assurance Framework, which complies with legislation and supports best practice. NWSSP has also developed its own Risk Management Protocol. The Policy and supporting Protocol are reviewed on annual basis and approved by the SLG and Audit Committee and endorsed by the SSPC and Velindre Trust Board. • NWSSP has also developed a Risk Appetite Statement to support its Risk Strategy and the Risk Assurance Framework. • We have an overarching Corporate Risk Register, which is presented at each Formal SLG meeting for review and amendment, as necessary, it is also presented at SSPC and Audit Committee as a standing agenda item. SLG periodically dedicate a session to a 'deep dive' of the Corporate Risk Register. We have Service-specific, directorate level Risk Register which are maintained locally and scrutinised at Quarterly Reviews. • During the pandemic there was a need to maintain a COVID-19 Risk Register and this was reviewed at the Planning and Response Group, which was established to deal with pandemic related risks. The Adapt and Future Change Group highlighted lessons learned from the pandemic response and recovery. • Key risks and enablers are set out in our Integrated Medium Term Plan (IMTP). • In addition, a Health and Safety Risk Register and an Environmental Aspects and Impacts Register are maintained within the organisation, which are monitored and reviewed at each Health and Safety and Green Team meeting. Information Governance holds its own Risk Register, which is monitored by the Information Governance Manager and presented to the Information Governance Steering Group (IGSG), on a quarterly basis and divided into 3 categories – Action (action required), Monitor (review and keep a check on risk activity) or Archive (risk no longer a concern). Any incident or "near miss" incident reported using RLDatix is discussed at the meetings and demonstrates a lessons learnt culture within the organisation.	SLG

		• Assurance Mapping exercise have been undertaken across the Services, by the Head of Finance and Business Improvement and these are periodically reviewed and updated. • Each project has its own Risk and Lessons Learned Logs, which are maintained by the Project Lead/Manager. • Services are encouraged to consider lessons learned and take proactive steps to implement customer and partner feedback received. • Complaints Management Protocol is reviewed annually and has supporting guidance for Vexatious Complainants. • Staff across the Services have attended various risk assessment training courses to identify health and safety hazards in their workplace. Building Managers / Site Leads have undertaken IOSH Working and Managing Safely courses. • Core Skills Training Framework (CSTF) modules include fire safety, manual handling, safeguarding children and adults, information governance and cyber awareness. • Implementation of Datix Once for Wales Concerns Management System for reporting, managing and investigating incidents (e.g. Health and Safety/Information Governance). • Work is ongoing as to an All Wales Risk Management approach, led by the Head of Finance and Business Improvement, through the Board Secretaries Network. • Business Continuity Plans (BCP) and action cards have been developed for each Service. • Equality Integrated Impact Assessments (EQIIAs) undertaken which provides an opportunity to mitigate risk ate the outset and prevent issues occurring, captures legislation such as Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation	
2	Risk management and health and safety are embedded within all healthcare settings and are monitored to ensure continuous improvement.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • There are structures in place throughout the organisation, which underpin the management of Health and Safety. • NWSSP has active Health and Safety Groups which in turn feed into the Velindre University Trust Health and Safety Management Group. There are a range of quarterly regional and local meetings held, etc.	Director of Finance and Corporate Services

		• Quarterly Health and Safety newsletter and regular communications issued with intranet page. • There are mechanisms in place to undertake audits of the health and safety management system and objectives set for a two year period, based on data and statistics captured from across the organisation. The Health and Safety Procedure is provided and accessible to all staff and sets clear guidelines for the management of health and safety within NWSSP. Any incident or "near miss" incident is discussed at the meeting and demonstrates a lessons learnt culture within the organisation. NWSSP adheres to the Health and Safety Executive's (HSE) HSG65 self assessment tool for assessing compliance across its sites and performance is monitored and verified on an annual basis. • Environmental standard ISO14001 is maintained and this is based on a cycle of continuous improvement using the well-known project management method the Plan, Do, Check, Act. We identify significant Aspects and Impacts (risks) for each site across NWSSP and undertake internal audits against the standard, raising opportunities for continuous improvement and monitoring these through the NCR, Obs and Opps Log, which is a standing agenda item at each Green Team meeting. The Environmental Management System (EMS) also provides for scenario testing for emergencies, to ensure preparedness. Environmental objectives and targets are set annually, based on the previous year's carbon footprint and most significant aspects and impacts identified. Our certification the ISO14001:2015 Standard is reviewed annually at surveillance visits and recertification takes place on a rolling 3 year period. • Risk management and health and safety are embedded into NWSSP's operational delivery of services. • We have an overarching Corporate Risk Register, which is presented at each Formal SLG meeting for review and amendment, as necessary, it is also presented at SSPC and Audit Committee as a standing agenda item. SLG periodically dedicate a session to a 'deep dive' of the Corporate Risk Register. We have Service-specific, directorate level Risk Register which are maintained locally and scrutinised at Quarterly Reviews. • NWSSP continuously works to manage and minimise risks of harm to people, services and NWSSP itself, to an acceptable level and ensures that: o There is compliance with statutory legislation; o All sources and consequences or risks are identified; o Risks are assessed, evaluated and managed; o Damage and injuries are reduced, and people's health and well-being is optimised; and o Lessons are learnt from incidents, in order to share best practise and prevent reoccurrence.	

3	Access to up to date and relevant information is readily available to identify, prioritise and manage real risks that may cause serious harm.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP use the Datix incident reporting system is a Once for Wales Concerns Management System implemented and designed to capture information relating to any incident/accident or "near miss" incident. The system records the required information and once reported an investigation is undertaken. Following investigation, remedial/preventative action is taken and lessons learnt are captured and shared with managers in an effort to raise awareness of potential risks and to prevent a reoccurrence of the incident. • If a serious incident occurs within NWSSP, the Health and Safety Manager will investigate and also report on observations or non conformities, ensuring information is escalated and disseminated across the organisation. • The SLG and the Audit Committee are provided with quarterly reports on health and safety and incident reporting and the SSPC is presented with an Annual Report on Health and Safety activity. The Annual Review also highlights Health and Safety key statistics and performance. • Health and Safety and Environmental Management hold Registers of Legislation and Compliance and ensure that all legislation is adhered to across NWSSP. The organisation also benefits from the legal update service from CEDREC and British Assessment Bureau and topical training events and refreshers as to relevant legislation. • Regular site audits/visits are undertaken on the sites within NWSSP and reports are written to capture observations or non conformities, which are monitored to completion, prioritised and given a timescale for action. Implementation is monitored. • As regards Audit and Assurance Services, Internal Audit report recommendations are captured in an Audit Tracking Register and monitored at each Formal SLG meeting on a monthly basis and at each Audit Committee. External Audit report recommendations are also captured in the same way and added to the Master Tracker. External Auditing body is Audit Wales, but recommendations made by other external bodies auditing NWSSP for Standards, accreditations, etc, are also monitored in this way,	Director of Finance and Corporate Services
4	Safety notices, alerts and any such communication are acted upon.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is proactive in issuing safety notices, consignment/handling alerts and newsletters to all staff in a timely manner (e.g. Winter safety newsletter and communications). • The Health and Safety Group meet on a quarterly basis and monitor if actions arising from notices and alerts, etc have been adhered to and provide assurance to the SLG through quarterly update reports outlining progress and compliance. • Procurement Services issue Workers Health & Safety Centre (WHCS) WHNS notices to staff to prevent hazards.	Director of Finance and Corporate Services Director Primary Care Services Director of Procurement Services and

		• Primary Care Services issue alerts and notices to primary care contractors which include GP practices, Community Pharmacy, Dental Practices and Community Ophthalmic Contactors. • Surgical Materials Testing Laboratory (SMTL) undertake a range of safety and quality testing and also have produced a number of white papers (e.g. analgesia). Like many laboratories, they publish the results of research and investigations in scientific, medical and nursing journals. They also run World Wide Wounds, an electronic woundcare journal and their sister site, Medidex, contains technical and test reports from testing we have performed for the NHS and for commercial companies, whilst www.dressings.org contains a wide variety of woundcare datacards. • Welsh Health Circulars (WHC) issued and circulated for action within appropriate Services (e.g. Procurement Services, Finance and Corporate Services, Health Courier Services, Primary Care Services, Specialist Estates Services). • COVID-19 pandemic response and recovery programme within NWSSP is an excellent example of the organisation's execution of acting upon safety notices, alerts and communications relating to safety. • Health Courier Services alerts on PDAs, flash cards, reflections on lessons learned, etc. • Pharmacy Technical Services, Temporary Medicines Unit (TMU) and the Transforming Access to Medicines (TrAMS) project act upon any safety notices, alerts and communications relating to their Service. TMU was established operationally in response to the pandemic and associated outbreak.	Health Courier Services Director of Pharmacy Technical Services
5	Measures are in place to prevent serious harm or death where the required controls are well known.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The SLG and the Audit Committee are assured that there are effective controls in place to prevent serious harm or death where the required controls are well known, by receiving quarterly update reports on health and safety at their meetings. The reports include information on risk assessments that have been undertaken where hazards were identified, feedback from "toolbox talks" with operational staff in Procurement Services and health and safety related training undertaken across NWSSP. • There are also measures in place to prevent serious harm through Service Standards Supplier Contracts which are managed via KPI's and Audits. • Due to the largely non-clinical services provided by NWSSP, the risk of "Serious Incident" and "Never Event" (defined as 'largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) investigations being undertaken is low. However, as part of its Risk Management Strategy the Corporate Risk Register and particularly the Health and Safety Risk Register, captures potential large scale risks	Director of Finance and Corporate Services
6	Issues relating to the environment such as security, safe and sustainable design, clear signage, planning,	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.):	Director of Specialist Estates Services

	privacy, fire safety, age related general health and safety, and disability accessibility are considered.	• All of NWSSP's premises are accessible to service users and staff and Specialist Estates Services (SES) provides advice on accessibility requirements, in line with the most recent Standards. • The SES team undertake local Equality Impact Assessments when planning changes to an environment or when managing a new development. • NWSSP sites are accessible by public transport and all sites have adequate parking facilities, (e.g. Staff at Companies House participate in a "team of two" scheme for car sharing and staff at Charnwood Court, use the car park opposite the main site when the main car park is full). • The signposting for all sites meets accessibility requirements and all sites are safely accessible for people with a disability or sensory loss. • Any recommendations arising from fire risk assessments are addressed and responded to promptly (e.g. the gas suppression system for Companies House). A fire suppression system has been installed in Brecon House, Mamhilad Park Estates, for Primary Care Services (PCS), where they store medical records. • When considering service re-design requirements, SES consider how environments can be made more accessible for people with a visual impairment, including: o Use of colour contrast in interior design (e.g. doorways, stairways) and in furniture and other equipment; o Ensuring signage and way-finding is clear, bold and has large print lettering; o Ensuring adequate lighting; o Audio enabling lifts; and o Clearing obstacles to make the environment safer. • NWSSP ensures compliance with the "All Wales Standards for Accessible Communication and Information for People with Sensory Loss" through the All Wales Equality Leadership Group (ELG) and by ensuring that key staff receive training and awareness on communication support tools, including: o British Sign Language interpreters; o source assistive equipment such as Sonido Listeners, where appropriate; o large print corporate documents; and o text phone service. • There is a quarterly checklist which is completed by Site Leads which considers accessibility, a security checklist, and a monthly fire checklist. • Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015.	Director of Finance and Corporate Services

		o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation.	
7	There is compliance with legislation and guidance to provide safe environments that are: • accessible; • well maintained; • fit for purpose; • safe and secure; • protect privacy; • sustainable.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP occupy a range a different buildings across Wales. The vast majority being offices, archive facilities and warehouses/stores, rather than typical 'healthcare' buildings and settings. The buildings are assessed for fitness for purpose by utilising the HSG65 Self Assessment Audit Toolkit and the Estates Statutory Compliance process. Action plans are developed and work undertaken to address any risks identified, in the spirit of a cycle of continuous improvement. • NWSSP have an Estates Statutory Compliance Spreadsheet which looks at all the statutory requirements of a building. We have also adopted a Guidance Booklet for Site Leads to further understand when certificates (Energy Performance Certificates, etc), are required. • Maintenance is addressed on each site by the Site Managers and regular workplace checklists are completed to ensure compliance. Fire risk assessments are undertaken on an annual basis. There is also a security checklist, which is completed on site. Certain sites have CCTV installed, where appropriate. • The Business Continuity Process and associated Steering Group mandates a Security Questionnaire for all key sites to complete, which is reviewed annually. • There is an estates compliance monitoring system in place whereby certain statutory compliance issues are monitored (e.g. emergency lighting, PAT testing, fire alarm systems, etc). • The Health and Safety Managers undertakes regular site audits/visits to ensure that good housekeeping is adhered to. NWSSP follows the HSG65 process to manage health and safety and these issues are raised in this process. • Defects/hazard reporting is undertaken by informing the Site Leads of issues and these are usually dealt with in a timely manner. All Velindre leased sites have winter maintenance standard operating procedures in place. All premises are adequately heated, ventilated and lit. • Premises have cleaning contractors to undertake the cleaning each evening (with the exception of Alder House, where we employ an in-house Domestic Team). If there are any issues, then these are reported to the Supervisor, to ensure remedy and compliance. Appropriate measures are in place regarding COSHH training and security controls (.e.g. locked cupboard / access restricted) and environmentally friendly cleaning products are procured, where possible. No treatment is provided to patients at any sites, but each building does have First Aid Kit and facilities.	Director of Finance and Corporate Services

		• Building condition surveys and any design modifications are identified through the same process as described above. Environment Performance Monitoring is an integral element of the certified Environmental Management System (EMS), ISO14001:2015 Standard. This Standard is applied to all NWSSP's major sites and will be extended to include Laundry Services, post modernisation project completion. The Standard and EMS cover sustainability within NWSSP, using a cycle of continuous improvement. • SES are aware of the minimum standards for practice premises set out in The National Health Services (General Medical Services – Premises Costs) (Wales) Directions 2015 and provide advice and support to Health Boards concerning queries from independent contractors in Primary Care. • As above, NWSSP ensures compliance with the "All Wales Standards for Accessible Communication and Information for People with Sensory Loss" including BSL interpreters, sourcing of assistance equipment, large print corporate documents available upon request, text phone service, etc. • Personal Emergency Evacuation Plans (PEEPs) are in place, where applicable, at sites. If staff have a disability regarding mobility, there are evacuation chairs or buddy system, etc in situ. Refresher training is undertaken annually (e.g. Evac Chair). Fire alarms are testing on a regular basis and this is recorded for auditing purposes. Where we have disabled toilet facilities, there are emergency pull cords available and assistance will be provided, as and when required. • Key fob systems are in situ on the offices where staff have access / restrictions to certain areas, in certain buildings. Receptionists are front of house on sites and a process of meet and greet is well-established. Many sites now have introduced a doorbell with a camera to view visitors, for security purposes. All sites are alarmed and managed by security companies, should a break-in occur. • Violence and Aggression – staff are trained on the Module A part and, if certain staff require to undertake module B, this is also available on ESR. All violence and aggression incidents are recorded onto the Datix system and addressed by People and Organisational Development, as required or via management with the Emergency Services. All violence and aggression incidents are also reported onto the quarterly information under health and safety and Velindre University NHS Trust report statistics to Welsh Government. • Should any private and confidential information need to be discussed, then meeting rooms are available for all staff and service users to utilise as well as other confidential methods of discussion where office based working is no longer the "norm". Identifiable information is locked in cupboards, in adherence to Information Governance Protocols and clear desk/records management guidance and regular review. A key fob system is also in situ, so that no persons can explore areas that are not within their remit. • All computers have passwords and automatic screensavers applied at a timed interval and staff are encouraged to lock their screens.	

8	There is compliance with the requirements of the Civil Contingencies Act 2004 and supporting guidance. This will include undertaking risk assessments, having current and tested emergency plans and business continuity arrangements developed through collaboration with partner agencies. This will ensure delivery of a robust response and ensure continuity of essential health services in the event of a major incident or emergency situation.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As a hosted organisation under Velindre University NHS Trust we are required to take cognisance of their GC 12 Business Continuity Management Policy and ensure that NWSSP has effective strategies in place for: o People – the loss of personnel due to sickness or pandemic; o Premises – denial of access to normal places of work; o Information Management and Technology (IM & IT) and communications/ICT equipment issues; and o Suppliers internal and external to the organisation. • NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify assess and implement applicable legislation and regulation requirements related to the continuity of operations, services as well as the interests of interested parties. At present there are local directorate procedures in place for ensuring business continuity arrangements are in place for key services. Action cards are utilised for Services to aid swift and timely actions/remedies. • In preparation for the Winter period, individual directorates have their own plans in place for staff and operational resilience specific to their areas (e.g. Health Courier Service has robust BCP in place to ensure effective front line delivery of services and an on-call rota to ensure effective communication outside of normal working hours). • There are also, robust “building continuity plans” in place for the main sites which are maintained and monitored by the Site Leads. In the event of building closures, following approval by the Director of Finance and Corporate Services, the home page of the website will be used to inform staff that access to the building is prohibited. This will be in addition to local communication through directorate managers, social media and the Building Manager’s WhatsApp Group, which has been established in the event of a emergency communication being required. • Disaster testing and emergency scenario testing are periodically tested and undertaken, with key individuals (e.g. cyber attack). • The Velindre University NHS Trust Adverse Weather Policy provides advice and guidance on the procedure to follow if staff cannot attend work, will be late attending work ,or are delayed in returning from annual leave, due to adverse weather conditions. However, it is recognised that some directorates within NWSSP have their own local arrangements for managing such occurrences, and therefore managers are advised to be sensitive to this when agreeing local arrangements for staff absence. • In the absence of a “Major Media Incident Plan” for NWSSP, an emergency contact list has been compiled to ensure that the contact details for Directorate leads are easily available. In the event that SLG need to collectively discuss urgent business then they will use the dedicated WhatsApp Group outside of hours to communicate to all and convene urgent meetings via Microsoft Teams, or face to face, as required and appropriate.	Director of Finance and Corporate Services Director of Procurement Services and Health Courier Services

		• Due to the nature of their work the Health Courier Service (HCS), has a robust business continuity plan in place which is tested regularly. The Head of HCS is also attends multi-agency emergency planning meetings as the HCS service is classed as a category 1 responder under the provisions of the Civil Contingencies Act. • Fire risk assessments are undertaken at each site and each site has an emergency evacuation procedure. These are tested biannually. • In addition, the Caldicott Principles Into Practice (CPIP) annual self-assessment also assesses if organisations have up to date and tested business continuity plans in place for all of their critical infrastructure components and core information systems.	

Standard 2.2 Preventing Pressure and Tissue Damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

	Sub Criteria	Evidence	Responsible Person within each Directorate
1	People are assessed for risk of pressure and tissue damage and if considered at risk, they receive further assessment and a plan of care is developed and implemented.	Not Applicable	-
2	People are made aware of the risks of pressure and tissue damage and shown ways of preventing them. They and those caring for them are encouraged and advised on appropriate care procedures, including nutritional advice.	Not Applicable	-
3	Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and specialist preventative equipment such as special mattresses and cushions are also available if necessary. All equipment is clean and properly maintained.	Not Applicable	-
4	Correct moving techniques are encouraged, including regular turning	Not Applicable	-

	and appropriate self-care, helping people to avoid pressure and tissue damage, increasing their well-being, independence and dignity.		
5	Risk assessments are in place to identify if a person is at risk, their skin is checked at least once daily, and preferably when their personal hygiene is attended to.	Not Applicable	-
Standard 2.3 Falls Prevention People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	Falls prevention strategies are implemented based on national standards and evidence based guidelines.	Not Applicable	-
2	People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and those caring for them.	Not Applicable	-
3	Staff receive appropriate information, training and supervision to ensure that people and their carers are safe.	Not Applicable	-
4	People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety.	Not Applicable	-
5	People are able to summon help easily at all times, using a telephone, bell or other convenient means. If unable to do so their needs will be checked regularly.	Not Applicable	-
Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.			

	Sub Criteria	Evidence	Responsible Person within each Directorate
1	There are appropriate organisational structures and management systems for infection prevention, control and decontamination in place.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As a non-statutory hosted organisation under Velindre NHS Trust, NWSSP are required to adhere to the Velindre Health and Safety policies which include management systems for infection prevention, control and decontamination. NWSSP attend the Velindre Health and Safety Group and infection control and prevention is standing item on the agenda. • All Velindre leased sites have a legionalla risk assessment undertaken and all actions are undertaken and are overseen by the H& Health and Safety Manager and SES representative. Certain staff members also undertake the bi-annial legionella awareness training. • The majority of NWSSP's are non-clinical, however, Health Courier Services does have a specific standard operating procedure which covers infection control measures for its services. • All fire related incidents including false alarms are reported on the Datix system and investigated. • During the pandemic, SES and the Building Managers Group (BMG) sought advice and guidance from the Infection Control Lead within Public Health Wales, to ensure an appropriate All Wales response as regards cleaning vehicles, offices, etc. • BMG, Adapt and Future Change Group and Planning and Response Group were established during the pandemic to ensure appropriate controls were in place for all sites, with key representatives from across the organisation focussing on response and recovery.	Director of Finance and Corporate Services Director of Procurement Services and Health Courier Services
2	Physical environments are maintained and cleaned to a standard that facilitates infection prevention and control and minimises the risk of infection.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP has designated environmental leads at each site who are responsible for ensuring that environmental standards are met in line with ISO14001:2015 and the Environmental Management System. • Each cleaning contract has a specification for exactly what cleaning is required in each part of the premises (e.g. periodic cleaning of the fridge at Charnwood Court). A schedule of cleaning frequencies can be made available. This also applies at Alder House, where we employ an in-house Domestic Team. • Certain staff have undertaken the COSHH level 2 course and within the stores/warehouse environments, spill kits are readily available, maintained and checked regularly. • Sites have a legionalla risk assessment undertaken and actions undertaken and are overseen by the Health and Safety Manager and SES representative. Certain staff members also undertake the biannual legionella awareness training.	-

		• Due to the largely non-clinical nature of NWSSP's work, there is no requirement to for decontamination of instruments and other equipment, outside of the rigorous testing that takes place within Surgical Materials Testing Laboratory (SMTL). SMTL site does contain an autoclave for decontamination testing. • There is adequate provision of suitable hand hygiene facilities at all of our sites, including hand driers, paper towels and alcohol hand gel. Posters are displayed encouraging staff to wash their hands to maintain good hygiene. • NWSSP Laundry Services supply linen and laundry to NHS Wales and when the Service recently came across to NWSSP, we engaged the support of a specialist laundry consultant to increase the knowledge base of Laundry Services, through collaboration with specialist providers. Installation of a new water softening plant providing improved water quality extending plant life and delivering energy savings. Introduction of microbiological testing to ensure the supply of clean safe linen at that point of use. Activity metrics introduced to facilitate local benchmarking and development of All Wales contracts. Commissioning of a new towel folder delivering increased plant throughput and introduction of BS14065 lite providing training for staff in the delivery of clean disinfected linen. The development of a consolidate plant and equipment risk register profiling areas of risk exposure during the transformational programme. The modernisation programme for Laundry Services remains ongoing and will be added to the scope of ISO14001:2015 Standard following completion.	
3	Suitable and accurate information on infections is available.	Not Applicable	-
4	Suitable, timely and accurate information on infections is provided to any person concerned with providing further support or nursing/medical care when a person is moved from one organisation to another or within the same organisation.	Not Applicable	-
5	Staff employed to provide care in all settings are fully engaged in the process of infection prevention and control.	Not Applicable	-
6	Adequate isolation facilities are provided to support effective infection prevention and control.	Not Applicable	-

7	Policies on infection prevention and control are in place and made readily accessible to all staff.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As a non-statutory hosted organisation, NWSSP are required to adhere to Velindre's Health and Safety policies which include management systems for infection prevention, control and decontamination. NWSSP attend the Velindre Health and Safety Group and infection control and prevention is standing item on the agenda. Information is cascaded to NWSSP own Health and Safety Group and management systems are in place (e.g. Legionella Protocol). • All information is available on the staff intranet and Health and Safety has a dedicated accessible hub with signposting. • All Velindre leased sites have a legionalla risk assessment undertaken and all actions are undertaken and are overseen by the Health and Safety Manager and SES representative. Certain staff members also undertake the biannual legionella awareness training. • As above, regarding Laundry Services, who supply linen and laundry to NHS Wales and when the Service recently came across to NWSSP, engaged the support of a specialist laundry consultant to increase the knowledge base of Laundry Services, through collaboration with specialist providers. Installation of a new water softening plant providing improved water quality extending plant life and delivering energy savings. Introduction of microbiological testing to ensure the supply of clean safe linen at that point of use. Activity metrics introduced to facilitate local benchmarking and development of All Wales contracts. Commissioning of a new towel folder delivering increased plant throughput and introduction of BS14065 lite providing training for staff in the delivery of clean disinfected linen. The development of a consolidate plant and equipment risk register profiling areas of risk exposure during the transformational programme. The modernisation programme for Laundry Services remains ongoing and will be added to the scope of ISO14001:2015 Standard following completion.	Director of Finance and Corporate Services
8	So far as is reasonably practicable staff are free of and are protected from exposure to infections that can be acquired or transmitted at work.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As a hosted organisation, NWSSP staff have access to assistance and support via Occupational Health & Well-being Referral Service, Confidential counselling provision and Employee Assistance Programme. • Velindre has Occupational Health Policies on the prevention and management of communicable infections in staff in place and also keep a record of any flu vaccinations given to staff, including NWSSP. We also encourage staff to take up the winter flu vaccinations and hold clinics at many of our sites to facilitate this. • All NWSSP staff are provided with Protective Equipment (PPE) if relevant for their role. • All Velindre leased sites have a legionalla risk assessment undertaken and all actions are undertaken and are overseen by the H&S Manager and SES representative. Certain staff members also undertake biannual legionella awareness training. • There is also an Asbestos Policy and all Velindre leased sites have an asbestos survey undertaken annually where applicable and any contractor works are monitored and	Director of Finance and Corporate Services Director of Procurement Services and Health Courier Services

		controlled by using the Control of Contractor Policy and associated Handbook, Method Statements, etc. • The pandemic response and recovery is an excellent example of NWSSP's commitment to delivering on this Standard. Other sources of evidence include staff surveys during and post pandemic, BMG minutes and factsheets, Health and Safety guidance and Managing Director's Communications, etc. Agile working approach during and post pandemic, control measures introduced, risk assessments, BCP and lessons learned. During the pandemic we actively encouraged staff to take up the COVID-19 vaccination and prioritised staff working on the front line to receive their vaccines. We worked with staff who were shielding and redeployment, working from home and agile working. Control measures were put in place regarding social distancing and these were reviewed 3 weekly during the height of the pandemic, in line with Welsh Government's reviews of restrictions.	
9	Staff are suitably trained and educated in infection prevention and control associated with the provision of healthcare.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The principles and practice of infection prevention and control are included as part of the statutory and mandatory core skills training framework (CSTF) induction and training programmes for all new staff, with a specific modules on health and safety and infection control. This training is an ongoing programme of learning and all staff are required to re-complete the online modules every 1-3 years, dependent upon module. Compliance rates are monitored at Formal SLG meetings. Due to the largely non-clinical nature of NWSSP's services the online training on infection prevention and control is considered appropriate with no need for follow up face to face training. However, in higher risk areas, such as Laundry Services, additional training is procured and mandated, as appropriate. • All Velindre leased sites have a legionalla risk assessment undertaken and all actions are undertaken and are overseen by the H&S Manager and SES representative. Certain staff members also undertake the biannual legionella awareness training, COSHH level 2 awareness and asbestos lead training. Site Leads and key individuals have also undertaken the IOSH Working and Managing Safely qualifications.	Director of Finance and Corporate Services
10	Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.	• Surgical Materials Testing Laboratory (SMTL) undertake a range of safety and quality testing and also have produced a number of white papers (e.g. analgesia). Like many laboratories, they publish the results of research and investigations in scientific, medical and nursing journals. They also run World Wide Wounds, an electronic woundcare journal and their sister site, Medidex, contains technical and test reports from testing we have performed for the NHS and for commercial companies, whilst www.dressings.org contains a wide variety of woundcare datacards. • NWSSP hosts the Evidence Based Procurement Board (EBPB), which considers medical device procurement.	Director of Surgical Materials Testing Laboratory

11	Patients and visitors are supported to achieve and maintain high standards of hygiene.	There are no patients or members of the public currently permitted on site for NWSSP. However, visitors and staff are supported to achieve and maintain high standards of hygiene and as such, appropriate hand washing facilities, hand gel, antibacterial soap, hand driers and paper towels are provided in washrooms. Since the pandemic, hand gel and antiviral wipers are provided around the buildings and upon arrival, at reception desks. Hand washing posters, prompts and materials are displayed throughout the building and in washrooms, on reception, etc.	-
12	Proper arrangements exist for the segregation, handling, transporting and disposal of waste including human tissue and subsequent disposal appropriately and sensitively.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Health Courier Services (HCS) have Standard Operating Procedures (SOPs) in place to support the safe handling, segregation, transport and disposal of waste in healthcare settings. They have robust and well-established frameworks in place, which adhere to all relevant legislative and regulatory requirements and adopt best practice. • HCS have flash cards and guidance available to all relevant staff through their handheld PDAs and staff undergo specialist training relevant to their role, to ensure maximum competence and compliance. • As regards waste disposal, HCS are neither the consignor, not the consignee of waste and the waste is owned by the relevant Health Board / Trust or NHS Wales organisation and as such, is returned to them for appropriate and responsible disposal, in line with local arrangements for clinical waste.	Director of Procurement Services and Health Courier Services
Standard 2.5 Nutrition and Hydration People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People's nutritional needs and physical ability to eat and drink are assessed, recorded and addressed. They are reviewed at appropriate intervals and are referred to dietetic services as required for specialist advice and support.	Not Applicable	-
2	People are offered a choice of food and drink which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and is accessible 24 hours a day.	Not Applicable	-

3	People are encouraged to eat nutritious, varied, balanced meals, hygienically prepared and served at regular times.	Not Applicable	-
4	Food and drink are served in an acceptable setting, with minimal interruption and are at the right temperature and attractively presented. People have a positive eating experience.	Not Applicable	-
5	Carers and family members who wish to support people at meal times are encouraged and enabled to do so.	Not Applicable	-
6	If a meal is missed, alternative food is offered and/or snacks and drinks can be accessed at any time.	Not Applicable	-
7	Fresh drinking water is available at all times, and water and appropriate fluids are encouraged throughout the day for people to meet their hydration requirements, except when restrictions are required as part of treatment.	Not Applicable	-
8	People are provided with therapeutic diets in accordance with their medical needs.	Not Applicable	-
9	If eating and/or drinking cause people difficulties, they receive prompt assistance to eat or drink encouragement and appropriate aids or support.	Not Applicable	-
10	People with swallowing difficulties are assessed by a speech and language therapist and where necessary training in assisting people to swallow food or drink safely is given.	Not Applicable	-

11	People are supported who require artificial nutritional support via enteral or parenteral routes.	Not Applicable	-
12	Where food and drink are provided: a choice of food and drink are offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and is accessible 24 hours a day.	Not Applicable	-

Standard 2.6 Medicines Management
People receive medication for the correct reason, the right medication at the right dose and at the right time

	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	There is compliance with legislation, regulatory and professional guidance and with local guidance for all aspects of medicines management	Not Applicable	-
2	Health professionals are qualified, registered with their respective regulatory bodies and fit for practice to prescribe, dispense and administer medicines within their professional competence and appropriate to the needs of the patient.	Not Applicable	-
3	There is timely, accessible and appropriate medicines advice and information for patients, carers and staff. Patients are provided with sufficient information to meet their needs regarding the purpose and correct use of their medication and alternate treatment options. All patients have an opportunity to discuss and agree their treatment plan.		-

4	Adverse drug reactions and medicine related adverse incidents are reported and investigated where appropriate.	Not Applicable	-
Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	There is compliance with legislation and guidance to include: • All Wales Child Protection and Vulnerable Adults Procedures • Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The statutory and mandatory core skills training framework (CSTF) induction and training programmes for all new staff, include specific modules on safeguarding children and adults which complies with the All Wales Child Protection and Vulnerable Adults Procedures. This training is an ongoing programme of learning and all staff are required to re-complete the online modules every 2 year, with compliance rates for each Service reported to Formal SLG on a monthly basis, • NWSSP does not have the same services as Health Boards; therefore there are some gaps and areas of the Standards which will not be applicable, including Children's Services. • Due to the largely non-clinical service provided by NWSSP, we do not receive complaints from patients directly. However, we do have a Complaints Management Protocol which provides for an effective and efficient complaints management process. • As a non-statutory hosted organisation under Velindre, we comply with the Rights of Children and Young Persons Measure (Wales 2011) which has a duty on Welsh Ministers to consider the United Nations Convention on the Rights of the Child (UNCRC) in all decisions.	Director of People & Organisational Development and Employment Services Director of Finance and Corporate Services
2	Assurance of safeguarding services and processes is evident across all levels of the organisation	Not Applicable	-
3	Effective multi-professional and multi-agency working and co-operation are in place complying with the Social Services and Well-being (Wales) Act.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Vision and mission statement is Adding Value Through Partnership, Innovation & Excellence. Four Core Values which are Listening and Learning, Working Together, Innovation and Excellence: o Listening & Learning to constantly improve the quality, effectiveness and efficiency of all we do; o Innovating to encourage continuous improvement; o Taking Responsibility for decisions and making things happen; and o Working Together with colleagues, customers and suppliers. • In addition, our Strategy Map outlines our 8 Overarching Goals and 5 Strategic Objectives, which are integrated with our strategic drivers and long-term visions of	SLG

		achieving Ministerial priorities, Well-being of Future Generations (Wales) Act 2015, A Healthier Wales, etc. • Our integrated reporting approach provides assurance through the Annual Review, where we report against the Sustainable Development Principle and highlight achievements against the 5 ways of working (long term, prevention, collaboration, integration and involvement). • We work in collaboration with Health Boards and support them in complying with the provisions of the Social Services and Well-being (Wales) Act and respond appropriately to all requests from partners and agencies. This continuous dialogue is supported though Directors having quarterly review meetings with Health Boards and Trusts, peer review meetings (e.g. Directors of Finance), tender framework exercises, surveys, etc. • Proactive in identifying needs for multi-agency working. This is often initiated through utilising business intelligence data to identify areas for efficiencies. • We monitor that partnerships are working well through regular dialogue, collating customer and partner feedback (e.g. surveys, etc) and through annually reviewing Service Level Agreements (SLA), quarterly review meetings and through the SSPC. • Many Services have achieved the Customer Service Excellence accreditation or similar certifications and standards, such as ISO14001:2015, which provides that we have assessed and acted upon consideration of key Interested Parties and their needs and expectations.	
4	Staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP's Complaints Management Protocol and associated literature is reviewed by the SLG on an annual basis and once approved is disseminated broadly through various communication channels intranet, newsletters, email and through discussion at SLG directorate meetings. Externally, a complaints leaflet is available to set out the process for making a complaint, which is available on our website. The report on Gift of Complaints has been considered when reviewing the Protocol and we encourage Services to reflect upon lessons learned to prevent reoccurrence. Complaints is a standing agenda item on the monthly Formal SLG meeting. • NWSSP's Information Governance Steering Group (IGSG) share issues/concerns and share good practice and learning, as do the Counter Fraud Steering Group (CFSG). Concerns and incidents are reported via RLDatix, the Once for Wales Concerns Management System. Findings are reported to Formal SLG meetings via the Health and Safety quarterly reports.	Director of Finance and Corporate Services
5	People are informed how to make their concerns known	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As above, the Complaints Management Protocol and accompanying leaflet clearly sets out the complaints procedure, including issuing an acknowledgement within 2 working days and an aim to provide a full response within 30 working days, where possible. All staff are made aware of how they can raise concerns during the	Director of Finance and Corporate Services

		induction toolkit for new starters, which includes links to workforce and corporate policies, such as Complaints, Raising Concerns (Whistleblowing), information governance, communications and counter fraud. The counter fraud helpline is promoted and the Raising Concerns (Whistleblowing) Policy are signposted. This information is promoted through the staff intranet and posters on display at each site, via noticeboard, they are also circulated through various internal channels periodically, such as email communications, newsletters, etc. • Due to the non-clinical nature of NWSSP's services we do not deal with safeguarding cases.	
6	Priority is given to providing services that enable children and vulnerable adults to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language. (They are recognised as a priority group in More than just Words).	Not Applicable	-
7	Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.	Not Applicable	-
8	Risk is managed in ways which empower people to feel in control of their life.	Not Applicable	-
9	Arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes	Not Applicable	-
Standard 2.8 Blood Management People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	Health services have robust governance systems in place to maintain a safe sufficient supply of blood, blood components and blood	Not Applicable	-

	products to support timely appropriate and effective use for all.		
2	There is compliance with legislation and national guidance on the supply and appropriate use of blood, blood components and products.	Not Applicable	-
3	Effective schemes and systems are in place to actively manage stock, minimise wastage, and plan effectively for shortages	Not Applicable	-
4	A continuous innovative programme of education, training and competence assessment covers all staff involved in the transfusion process in line with national strategy.	Not Applicable	-
5	Processes are in place that enhance the safety of blood transfusion and support the recognition and reporting of, and shared learning from all incidents, adverse blood events and reactions.	• The Wales Infected Blood Support Scheme (WIBSS) is a service hosted by NWSSP, on behalf of Welsh Government. Established in October 2017, WIBSS' aim is to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue in the 1980s and 1990s.. Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), WIBSS also aims to provide the following services: o A dedicated support service operated by experienced Welfare Rights Advisors; o A dedicated Psychology and Wellbeing Service operated by experienced psychologists and counsellors; o A reliable, responsive, and accurate Payments Process; o A dedicated website that will be maintained with useful information, signposting; o Building upon the current excellent working relationships with Velindre Cancer Centre, and with the Department of Work and Pensions, to ensure the beneficiaries circumstances are understood and that they receive a sensitive and dignified service; o Supporting people navigate the healthcare system by acting as their key worker; o A seamless service with a single point of contact; o A development of outcome based reporting measures; o Achievement of Quality Accreditation for Support Service; and o An independent Appeals Process.	Director of Planning, Performance and Informatics Director of Finance and Corporate Services

		• There are also close links to many external stakeholders and organisations, ensuring strong partnership networks for referrals, signposting and fair representation across the sector. The team has received much positive feedback from service users.	
6	There is a collaborative approach to optimal blood management	Not Applicable	-
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	There is compliance with health, safety and environmental legislation, regulation and Guidance	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP ensures it conforms with health, safety and environmental legislation, standards and guidance through undertaking the Health and Safety Executive (HSE) HSG65 annual self-assessment to monitor legislative and regulatory compliance on health and safety. In addition, the organisation has maintained ISO14001 certification since 2014, which provides assurance on compliance for environmental matters. • The Health and Safety Manager liaises with local experts/advisers in NWSSP's SES Team, Velindre's Health and Safety Group and other external bodies, as required to keep abreast of developments. The NWSSP Health and Safety Group meets quarterly and each site has a Health and Safety Group Lead with local health and safety meetings. • Health and Safety and Environmental Management hold Registers of Legislation and Compliance and ensure that all legislation is adhered to across NWSSP. The organisation also benefits from the legal update service from CEDREC and British Assessment Bureau and topical training events and refreshers as to relevant legislation. Environmental Team benefit from CEDREC specialist consultant advice on this matter, through an annual subscription. • Regular site audits/visits are undertaken on the sites within NWSSP and reports are written to capture observations or non conformities, which are monitored to completion, prioritised and given a timescale for action. Implementation is monitored.	Director of Finance and Corporate Services
2	Processes ensure that equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Where applicable, NWSSP had processes in place to ensure that equipment and devices are cleaned and maintained in accordance with the manufacturer's guidance and relevant EN standards (e.g. defibrillator devices have a standard operating procedure (SOP) for their use and an annual maintenance schedule). • Procurement Services ensure that there are robust arrangements in place for safe, ethical and effective procurement, through its policies and procedures and work with the Health Boards/Trust's to ensure that ensure that potential suppliers are in compliance with relevant legislation, regulation, guidance and standards (e.g. Ethical Employment in Supply Chain guidance issued by Welsh Government).	Director of Finance and Corporate Services Director of Procurement Services and Health Courier Services

		• There is a Use of Work Equipment Policy which is adhered to. A defect sheet is used for staff to identify issues prior to using certain equipment. Maintenance contracts have been set up, where applicable, for plant, machinery and equipment held on sites and maintenance schedules are available for these. This is also covered as part of the ISO14001 Standard and the organisation's Environmental Management System (EMS). Equipment is logged on an Asset Register at sites, where applicable.	
3	An ongoing programme of training and competence assessment covers staff and users	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • All NWSSP staff are required to complete the online statutory and mandatory training modules of the Core Skills Training Framework (CSTF) as set out above, compliance is monitored monthly at Formal SLG meetings. • In addition, a number of training courses are provided to staff, including well-being matters, fire safety, people management skills for managers, stress awareness, information governance and Welsh language awareness. The Learning & Development Team manage the CSTF and work with the Directors of People and Organisational Development across NHS Wales, to develop the online training requirements for NHS Wales staff. • The Health and Safety Group also consider what additional training is required to ensure that NWSSP is complaint with Velindre and local policy and legislative and regulatory requirements, in addition to this being considered by Managers at PADRs (e.g. it was agreed to introduce face to face safety training in addition to the module and annual training on using the defibrillator, Evac Chair training, Fire). • Learning and Development Team have a range of offerings to support staff in their professional and continual development.	Director of Finance and Corporate Services
4	Timely reporting and management arrangements exist to address any device, equipment or system faults in use or in stock, including any alert or warning notices issued by appropriate agencies such as MHRA	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP used the Datix reporting software system the timely reporting, management and communication of faults, breakdowns and incidents. In addition, managers are proactive in addressing issues swiftly and keeping the Health and Safety Manager informed of progress. The system is a Once for Wales Concerns Management System which was recently redeveloped and implemented across NHS Wales. • All staff are made aware of the importance of reporting incident on to the DATIX system and we monitor what has been recorded and what actions were taken to address the issue. Each site has a Datix lead with responsibility for Datix management. All incidents reported are discussed at the Health and Safety Group and alerts are issued to staff, as required. Key Managers receive an email alert for relevant categories under their responsibility, when an incident is logged onto Datix. • NWSSP do not use medical devices, however, the HCS are required to monitor the temperature of goods when transporting them on behalf of NHS bodies (e.g. flu vaccine stock, etc). • Pharmacy Technical Services (TMU and TRAMS) are regulated by the MHRA, as are HCS.	Director of Finance and Corporate Services Director of Procurement Services and Health Courier Services Director of Surgical Materials Testing Laboratory Director of Pharmacy Technical Services

		• Surgical Materials Testing Laboratory (SMTL) undertake a range of safety and quality testing and also have produced a number of white papers (e.g. analgesia). Like many laboratories, they publish the results of research and investigations in scientific, medical and nursing journals. They also run World Wide Wounds, an electronic woundcare journal and their sister site, Medidex, contains technical and test reports from testing we have performed for the NHS and for commercial companies, whilst www.dressings.org contains a wide variety of woundcare datacards. • As above, alerts are received and acted upon by the relevant Service(s) immediately and information is shared and disseminated in a timely fashion for action, or information.	
5	Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment	• Surgical Materials Testing Laboratory (SMTL) undertake a range of safety and quality testing and also have produced a number of white papers (e.g. analgesia). Like many laboratories, they publish the results of research and investigations in scientific, medical and nursing journals. They also run World Wide Wounds, an electronic woundcare journal and their sister site, Medidex, contains technical and test reports from testing we have performed for the NHS and for commercial companies, whilst www.dressings.org contains a wide variety of woundcare datacards. SMTL staff maintain training records which can be reviewed upon request. Staff do utilise autoclave, for example, to decontaminate instruments and equipment and they also do testing of medical devices, as appropriate. • NWSSP Audit Committee endorse the Terms of Reference for the Evidence Based Procurement Board (EBPB) who consider procurement of medical devices.	Director of Surgical Materials Testing Laboratory

Self Assessment Rating – Theme 2 - Safe Care

Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating				✓	

Theme 3 – Effective Care

Standard 3.1 Safe and Clinically Effective Care Care, treatment and decision making should reflect best practice on evidence to ensure that people care and support to meet their individual needs.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People are safe and protected from avoidable harm through appropriate care, treatment, information, support and early detection of risks.	Not Applicable	-
2	People are supported to protect their own and their families' health	• There is a variety of resources and support mechanisms available in order to support NWSSP staff and their families in protecting their health. • Staff are made aware of what care, support and opportunities are available through a variety of communication channels, including: o Staff Intranet o Health and Well-being Staff Centre o Newsletters – Health and Well-being – Health and Safety, People and Organisational Development, etc. o Managing Director Communications o Health and Well-being Champions/Mental Health First Aiders o Team meetings and One to Ones o Social Media o Health and Well-being Strategy o Policies, protocols and guidance ▪ Special Leave Policy, Sickness Policy, Work Life Balance Scheme, Flexible Working Policy / Agile Working, Purchase of Annual Leave Policy, Domestic Abuse Policy, Stress and Mental Health Well-being Policy, Health, Safety and Welfare Policy, etc. • Health and Well-being Staff Partnership meetings are chaired by the Director of Finance and Corporate Services. • NWSSP is also able to demonstrate support, dignity and respect of children via its initiatives such as childcare vouchers scheme and school holiday childcare subsidies. • Corporate Induction and e-induction toolkit includes information on Health and Well-being and ensure staff are made aware of the support available to them during their employment. This is also captured within the staff handbook. • NWSSP staff can also access the Employee Assistance Programme which provides staff with advice and support on a range of matters from financial support to	All

		counselling. This can be accessed 24/7 either online or via a free-phone telephone number. This can also be shared with friends and family to access. Resources are available online for a range of well-being matters. • Dedicated space for staff to access support and resources – topical, up to date information • Schemes to support staff in purchasing items such as Cycle 2 Work Scheme, Salary Sacrifice Lease Car Scheme, Home Electronics Scheme. • NHS Staff benefit from Blue Light Card and NHS discounts (e.g. Health Services Discounts). • ESR learning modules offer a variety of courses online that staff can choose to undertake in addition to the CSTF modules mandated (e.g. Romani and Traveller Healthcare, etc.). o Equality, Diversity and Inclusion offering, including Staff Support Groups, Inclusion Network, LGBT+ Staff and Ally Network "Proud/Balch", Disability Network, BAME Staff and Ally Network and Menopause Café, Carer's Network, etc. During the pandemic, we promoted Velindre's Shielding Staff Support Network. • Promotion of local and national initiatives and campaigns (e.g. Pride Cymru, Breastfeeding Week, Disability Awareness Week, etc.) • Support from local organisations and charities, such as Sustrans Cymru, etc. • Staff Recognition Awards. • Published documents such as Integrated Medium Term Plan (IMTP) and Annual Review, and associated Case Study library. • The NWSSP staff newsletter also features regular articles on staff involvement in charitable events. • Equality Integrated Impact Assessments (EQIIAs) and Panel of Subject Matter Experts and Trade Union Representation. • Health and Well-being Conference and Health and Well-being Centre (hub of resources and signposting).	
3	Welsh speakers are able to use the Welsh language to express themselves and information is communicated effectively	• As a non-statutory hosted organisation under Velindre University NHS Trust (Velindre), NWSSP are required to comply with the Velindre Welsh Language Scheme which includes adhering to the 'More than Just Words' Strategic Framework and the Welsh Language (Wales) Measure. All public facing information is provided in a bilingual format, including Clauses within Procurement contracts for bilingual services/goods, bilingual forms, corporate literature, surveys, communications, publications and Committee papers. • NWSSP hosts the Welsh Language Translation Service (WLTS) within the People and Organisational Development directorate, which offers translation services across NHS Wales organisations that support the requirements of the Health Board/Trust and	All

		reduce the cost of translation services, providing a value for money option, whilst freeing up time for clinical matters. Statistics can be viewed in our Annual Review. • Staff who are confident in using Welsh in the workplace, or learners who are confident in speaking Welsh wear a 'Iaith Gwaith' or 'Dysgu Cymraeg' badge or lanyard, to show that they can speak Welsh. • Receptionists all have a suitably appropriate level of meet and greet Welsh, if not fluent. NWSSP has a list of Welsh speaking staff so that they can be matched with Welsh speaking service users, as required, should an individual wish to converse in the medium of Welsh. • Recruitment Services ensure that adverts are issued bilingually and that Welsh essential or desirable roles are categorised appropriately to promote equal opportunities. • All of our sites have a bilingual environment and are welcoming for Welsh speakers, including signage, reading materials and, where possible, television facilities and videography. We have a bilingual website and staff intranet site. • Our Welsh Language Services Manager attends the Velindre Welsh Language Steering Group and the NHS Wales Welsh Language Officers Group and ensures compliance with Welsh Language Standards and the Welsh Language Act and Measures within NWSSP. • Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation o There is a separate comprehensive Welsh Language Impact Assessment that is required to be completed for a variety of projects. • Welsh language taster sessions are held regularly to encourage staff to gain confidence in conversing bilingually in the workplace and wider.	
4	Practice evolves to reflect new evidence and provides an efficient and effective response to promote safe and clinically effective care.	• Although due to the largely non-clinical nature of NWSSP services, this Standard may not be directly applicable, Surgical Materials Testing Laboratory (SMTL), Primary Care Services (PCS), Pharmacy Technical Services (PTS), Procurement Services and Health Courier Services (HCS) are Services within NWSSP which contribute towards providing safe and clinically effective care through delivery of business as usual operations. For example, SMTL undertake a range of testing from biological to medical	SLG

		devices and dressings and have published a number of white papers on best practice and Procurement Services have the influence over purchasing for NHS Wales.	
5	Systems and processes comply with safety and clinical directives in a timely way, including alerts.	Not Applicable	-
6	Systems ensure that non-compliance or variance from best practice is properly recorded and audited and any risks identified are managed appropriately	• As a non-statutory hosted organisation, NWSSP follows the Velindre University NHS Trust (Velindre) Risk Management Strategy and Risk Assurance Framework, which complies with legislation and supports best practice. NWSSP has also developed its own Risk Management Protocol. The Policy and supporting Protocol are reviewed on annual basis and approved by the SLG and Audit Committee and endorsed by the SSPC and Velindre Trust Board. • NWSSP has also developed a Risk Appetite Statement to support its Risk Strategy and the Risk Assurance Framework. • We have an overarching Corporate Risk Register, which is presented at each Formal SLG meeting for review and amendment, as necessary, it is also presented at SSPC and Audit Committee as a standing agenda item. SLG periodically dedicate a session to a 'deep dive' of the Corporate Risk Register. We have Service-specific, directorate level Risk Register which are maintained locally and scrutinised at Quarterly Reviews. • During the pandemic there was a need to maintain a COVID-19 Risk Register and this was reviewed at the Planning and Response Group, which was established to deal with pandemic related risks. The Adapt and Future Change Group highlighted lessons learned from the pandemic response and recovery. • Key risks and enablers are set out in our Integrated Medium Term Plan (IMTP). • In addition, a Health and Safety Risk Register and an Environmental Aspects and Impacts Register are maintained within the organisation, which are monitored and reviewed at each Health and Safety and Green Team meeting. Information Governance holds its own Risk Register, which is monitored by the Information Governance Manager and presented to the Information Governance Steering Group (IGSG), on a quarterly basis and divided into 3 categories – Action (action required), Monitor (review and keep a check on risk activity) or Archive (risk no longer a concern). Any incident or "near miss" incident reported using RLDatix is discussed at the meetings and demonstrates a lessons learnt culture within the organisation. Assurance Mapping exercise have been undertaken across the Services, by the Head of Finance and Business Improvement and these are periodically reviewed and updated. • Each project has its own Risk and Lessons Learned Logs, which are maintained by the Project Lead/Manager. • Services are encouraged to consider lessons learned and take proactive steps to implement customer and partner feedback received. • Complaints Management Protocol is reviewed annually and has supporting guidance for Vexatious Complainants.	SLG

		• Staff across the Services have attended various risk assessment training courses to identify health and safety hazards in their workplace. Building Managers / Site Leads have undertaken IOSH Working and Managing Safely courses. • Core Skills Training Framework (CSTF) modules include fire safety, manual handling, safeguarding children and adults, information governance and cyber awareness. • Implementation of RLDatix Once for Wales Concerns Management System for reporting, managing and investigating incidents (e.g. Health and Safety/Information Governance). • Work is ongoing as to an All Wales Risk Management approach, led by the Head of Finance and Business Improvement, through the Board Secretaries Network. • Business Continuity Plans (BCP) and action cards have been developed for each Service. • Equality Integrated Impact Assessments (EQIIAs) undertaken which provides an opportunity to mitigate risk ate the outset and prevent issues occurring, captures legislation such as Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation	
7	People receive a high quality, safe and effective service whilst in the care of the NHS which is based on agreed best practice guidelines including those defined by condition specific Delivery Plans, National Institute for Health and Clinical Excellence (NICE), NHS Wales Patient Safety Solutions, and professional bodies	Not Applicable	-
8	Practice keeps up to date with best practice, national and professional guidance, new technologies and innovative ways of working	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP's Vision and mission statement is Adding Value Through Partnership, Innovation & Excellence. Our Core Values are Listening and Learning, Working Together, Innovation and Excellence. Our Strategy Map set outs our Strategic Objectives, Overarching Goals and our Long Term Drivers and Enablers. o Listening & Learning to constantly improve the quality, effectiveness and efficiency of all we do;	-

		o Innovating to encourage continuous improvement; o Taking Responsibility for decisions and making things happen; and o Working Together with colleagues, customers and suppliers. • For example, SMTL white papers and associated guidance from testing outcomes, etc, HCS reflecting on lessons learned and best practice and the developments in robotic process automation through Central Team (CTES).	
Standard 3.2 Communicating Effectively In communicating with people health services proactively meet individual language and communication needs.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	Welsh speakers are offered language services that meet their needs as a natural part of their care.	• NWSSP does not have patient facing Services, as it is largely non-clinical and therefore we influence the delivery of this Standard for other NHS Wales organisations through the Welsh Language Translation Service (WLTS) within the People and Organisational Development directorate, which offers translation services across NHS Wales organisations that support the requirements of the Health Board/Trust and reduce the cost of translation services, providing a value for money option, whilst freeing up time for clinical matters. Statistics can be viewed in our Annual Review.	Director of People & Organisational Development and Employment Services
2	Open and honest communication is emphasised in the spirit of co-production.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • In accordance with the 7 Nolan principles of public life, NWSSP fosters a culture of open and honest communication with its staff, customers and partners and members of the public, as set out in the Standards of Behaviour Framework Policy. • NWSSP has a range of open and honest communication channels that keeps staff, partners and service users abreast of our activities. This includes one to ones, team meetings, PADRS, intranet, website, variety of internal and external newsletters, hearsay, contact points, Managing Director communications, social media, global emails, google analytics, staff survey, media, external publications, freedom of information requests, concerns and complaints, Communications Engagement Strategy, peer reviews, quarterly review meetings, minutes of meetings and Committee papers, SSPC reports and Audit Committee reports. • Feedback from staff and service users is encouraged in any form of communication and issues, concerns or suggestions for improvement are addressed as part of our commitment to customer led developments and co-production and lessons learned reflections. • All customer facing written communications are produced in a bilingual format and are produced in alternative formats that are accessible to the reader, where possible (e.g. large print, audio and Braille versions of frequently used leaflets and documents), with translation to other languages facilitated upon request. • NWSSP's commitment to open and honest communication is recognised through having attained the Customer Service Excellence standard for several of its Services.	All

3	Special care is taken in communicating with those whose mental capacity may be temporarily or permanently impaired	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The statutory and mandatory core skills training framework (CSTF) induction and training programmes for all new staff, with a specific modules on safeguarding children and safeguarding adults, which complies with the All Wales Child Protection and Vulnerable Adults Procedures and "Treat Me Fairly" e-learning module which focuses on equality and diversity. This training is an ongoing programme of learning and all staff are required to re-complete the online modules every 2 years. Compliance rates are monitored at Formal SLG meetings. • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • NWSSP complies with the Equality and Diversity Policies of our host, Velindre, and All Wales policies, including Dignity at Work, Raising Concerns (Whistle blowing) Policy and Standards of Behaviour Framework Policy. • Personal data relating to equality and diversity is captured via the Electronic Staff Record (ESR) and staff are responsible for updating their own personal records using ESR Self-Service, including Ethnic Origin, Nationality, Disability, Country of Birth, Religious Belief, Sexual Orientation and Welsh language competencies. Our equality information helps us identify and understand potential key equality issues across our functions, including employment and service delivery areas. • The "NHS Jobs" all Wales recruitment service, run by NWSSP adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure that there are no discriminatory elements. • A recruitment and selection toolkit is available for managers which provide advice and guidance on the equality requirements of the recruitment and selection process. • Externally, NWSSP may receive from time to time concerns or complaints incorrectly directed to the organisation, which are of a clinical nature. These cases are dealt with in a sensitive way and we recognise the emotive nature of such matters. The Complaints Management Protocol provides for vexatious complainant guidance which can be introduced when two or more criteria are met, which details the handling processes that can be utilised in that circumstance.	All
4	Language and communication needs are addressed for people with specific care needs including: learning disabilities, dementia, stroke, sensory loss, neurological developmental problems and brain injury	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The statutory and mandatory core skills training framework (CSTF) induction and training programmes for all new staff, with a specific modules on safeguarding children and safeguarding adults, which complies with the All Wales Child Protection and Vulnerable Adults Procedures and "Treat Me Fairly" e-learning module which focuses on equality and diversity. This training is an ongoing programme of learning and all staff are required to re-complete the online modules every 2 years. Compliance rates are monitored at Formal SLG meetings. Additional modules on Sensory Loss are available via ESR through the learning portal.	All

		• NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • In the event of a service user with sensory loss requiring information in an alternative format, the Communication team would manage the request, seeking advice and guidance from the Equality Lead. • The organisation also promotes the All Wales It Makes Sense campaign for Sensory Loss Awareness Month. • We ensure that the communication needs of people with sensory loss are met through ensuring that our website is complaint with the standards of the World Wide Web Consortium (W3C), we prepare easy read versions of corporate reports, where appropriate, ensuring that information is provided in an alternative format, upon request (e.g. braille, large print, audio or subtitles), using info graphics to depict information, where possible, in corporate literature (e.g. Annual Review), Equality Integrated Impact Assessments (EQIIAs) are undertaken for proposed projects, service changes, processes, and policies, etc and that there are induction loop systems installed at reception areas. • NWSSP adheres to the All Wales Standards for Accessible Communication and Information for People with a Sensory Loss, which is aimed at helping frontline NHS staff communicate with service users who have hearing and/or sight loss. The Communications team take cognisance of the principles of the guidance when designing and distributing corporate information.	
5	Effective, accessible, appropriate and timely communication is tailored to the needs of each individual person and reasonable adjustments are made as defined in the Equality Act 2010.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • NWSSP adheres to the All Wales Standards for Accessible Communication and Information for People with a Sensory Loss, which is aimed at helping frontline NHS staff communicate with service users who have hearing and/or sight loss. The Communications team take cognisance of the principles of the guidance when designing and distributing corporate information. • Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation	All

		• Recruitment Services has received awareness training on the needs of complying with the 'two ticks' positive about disability symbol as awarded by Jobcentre Plus to employers who have made a proactive move to avoiding discrimination against disabled people in the recruitment process. • The NHS Jobs All Wales Recruitment Service, run by NWSSP, adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure that there are no discriminatory elements. • A recruitment and selection toolkit is available for managers which provides advice and guidance on the equality requirements of the recruitment and selection process, promoting equal opportunities. • All reasonable adjustments are considered and discussed with the individual and the appropriate Manager, in consultation with Recruitment Services for a new starter and People and Organisational Development for existing staff, to accommodate requests, where possible. • We have also facilitated reasonable adjustments (.e.g. specialist equipment, etc) in relation to attracting a more diverse workforce through accommodating reasonable adjustments. We offer a range of Staff Support Networks including, BAME and Allies, LGBT+ and Allies, Disability Network, Menopause Cafes, etc.	
6	Methods of on and off line communication in various languages and accessible formats are used	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • NWSSP adheres to the All Wales Standards for Accessible Communication and Information for People with a Sensory Loss, which is aimed at helping frontline NHS staff communicate with service users who have hearing and/or sight loss. The Communications team take cognisance of the principles of the guidance when designing and distributing corporate information. • We ensure that the communication needs of people with sensory loss are met through ensuring that our website is complaint with the standards of the World Wide Web Consortium (W3C), we prepare easy read versions of corporate reports, where appropriate, ensuring that information is provided in an alternative format, upon request (e.g. braille, large print, audio or subtitles), using info graphics to depict information, where possible, in corporate literature (e.g. Annual Review), Equality Integrated Impact Assessments (EQIIAs) are undertaken for proposed projects, service changes, processes, and policies, etc and that there are induction loop systems installed at reception areas. • In the event of a service user with sensory loss requiring information in an alternative format, the Communication team would manage the request, seeking advice and guidance from the Equality Lead.	All

		• The organisation also promotes the All Wales It Makes Sense campaign for Sensory Loss Awareness Month.	
7	Communication is age appropriate and considers people's ability to engage in health related conversations	Not Applicable	-
8	Support is given for carers and advocates who in turn are supporting the needs of people with communication needs	Not Applicable	-
9	There is compliance with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing. The purpose, effectiveness, methods, security and appropriateness of communication is considered internally and externally with patients, service users, carers and staff, and about patient, service users and carers using a range of media and formats.	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP are required to adhere to the Velindre Welsh Language Scheme and whilst, NWSSP were not named as one of the organisations within the provisions of the Welsh Language Measure (Wales) 2011, there is an expectation that compliance with the legislation is demonstrated. NWSSP is required to contribute compliance information for the Velindre Annual Welsh Language Monitoring Report, and monitor compliance with the Standards through a range of measures, including: o Monitoring Welsh Language skillset of the workforce through the ESR system; o Training and awareness session given to staff; o Number of staff learning Welsh; o Number of request for Welsh translations; o Audit of bilingual signage, corporate literature; o Number of complaints received regarding Welsh language service provision; and o Mystery customer exercise on bilingual telephone greeting. • NWSSP's commitment to ensuring that all of its diverse services are compliant and that both the Welsh and English languages are treated on the basis of equality. • People and Organisation Development monitor the effectiveness of systems to facilitate timely two-way communication with the workforce (e.g. through staff surveys and meetings with the NHS Wales Directors of People and Organisation Development). • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • NWSSP adheres to the All Wales Standards for Accessible Communication and Information for People with a Sensory Loss, which is aimed at helping frontline NHS staff communicate with service users who have hearing and/or sight loss. The Communications team take cognisance of the principles of the guidance when designing and distributing corporate information.	All

		• We ensure that the communication needs of people with sensory loss are met through ensuring that our website is complaint with the standards of the World Wide Web Consortium (W3C), we prepare easy read versions of corporate reports, where appropriate, ensuring that information is provided in an alternative format, upon request (e.g. braille, large print, audio or subtitles), using info graphics to depict information, where possible, in corporate literature (e.g. Annual Review), Equality Integrated Impact Assessments (EQIIAs) are undertaken for proposed projects, service changes, processes, and policies, etc and that there are induction loop systems installed at reception areas. • In the event of a service user with sensory loss requiring information in an alternative format, the Communication team would manage the request, seeking advice and guidance from the Equality Lead. • NWSSP website encourages users to make enquiries through shared.services@nhs.wales.uk and through nwssp.complaints@wales.nhs.uk. Both accounts are monitored by Communications and Corporate Governance, respectively and an acknowledgement is issued within 48 hours. Enquiries can be made through our main telephone line, by letter, facsimile or through our social media accounts on LinkedIn, YouTube or Twitter, etc. • NWSSP has a range of open and honest communication channels that keep staff, partners and service users abreast of our activities and support effective communication. This includes one to ones, team meetings, PADRS, intranet, website, variety of internal and external newsletters, hearsay, contact points, Managing Director communications, social media, global emails, google analytics, staff survey, media, external publications (IMTP, Annual Review), freedom of information requests, concerns and complaints, Communications Engagement Strategy, peer reviews, quarterly review meetings, minutes of meetings and Committee papers, SSPC reports and Audit Committee reports. • Members of the public can provide feedback to NWSSP and we can, in turn, respond to queries, via a range of communication methods, including email, letter, telephone call, in person, through corporate reports, magazines, web articles or through social media. • NWSSP have their own templates and policies for information sharing that closely mirror All NHS Wales Policies on information sharing. Any information sharing is monitored by the NWSSP information governance manager using internal procedures and compliance. • NWSSP ensures that all of its public facing information is provided in a bilingual format, in both English and Welsh. Any requests received for information in an alternative language are managed by the Communications Team in conjunction with the Equality Lead. All reasonable requests are considered and facilitated.	

Standard 3.3 Quality Improvement, Research and Innovation Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.			
	Sub Criteria	Evidence	Responsible Person within each Directorate
1	Local capacity and capability is developed to support and enable teams to identify and address local improvement priorities, including participation in audit and recognised quality improvement methodologies, activities and programmes	Not Applicable	-
2	Progress is measured, recorded and learning is shared	Not Applicable	-
3	There is consistent application of the principles and requirements of the Framework for Health and Social Care Research and Development	Not Applicable	-
4	Research and innovation has a direct impact on improving the efficiency and effectiveness of services, delivering better health and well being outcomes for people, and improving the experience of care	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is proactive in reviewing performance and utilising business intelligence to review its own service outputs. NWSSP is a member of the UK Benchmarking Group. • Examples of best practice include Health Courier Service (HCS) being a member of the NHS Transport & Logistics Best Practice Group which meets quarterly. The Group shares best practice, policy and documents and also undertake benchmarking exercises. • Surgical Materials Testing Laboratory (SMTL) have their own Research and Development Team, as do Central Team (CTES). • Strategic drivers and long-term visions of achieving Ministerial priorities, Well-being of Future Generations (Wales) Act 2015, A Healthier Wales and the response to the challenges of Covid-19 pandemic and NHS recovery. Our approaches are aligned to Well-being of Future Generations (Wales) Act 2015, considering the 7 well-being goals (in particular, a more Resilient Wales, a Healthier Wales and a more Equal Wales), the sustainable development principle (5 ways of working; long-term, prevention, collaboration, involvement and integration). • Equality, diversity and human rights are incorporated into the governance considerations on the front cover for SSPC reports, which seeks to reduce health inequalities and promote fair and equal treatment. • We recognise the impact that the Services we deliver have on the wider population of Wales, in an indirect manner, through working with NHS Wales organisation and the	All

		research and development into innovation facilitated by many services to improve our efficiency and effectiveness of services delivered.	
5	There is a structured approach to promoting and supporting research and Innovation and it is applied in every day practice	Not Applicable	-
6	There is clear visible leadership and a strong collaborative approach with university and industry partners	• Single Lead Employer (SLE) is an employment arrangement that was put in place to effectively manage and support all Medical & Dental trainees across Wales for the duration of their training programme. The Single Lead employer team, are part of NHS Wales Shared Services People & Organisational Development department, and work alongside Health Education Improvement in Wales and Host Organisations as part of a tripartite service level agreement (SLA). • NWSSP manages the Student Awards Services NHS Wales Bursary Scheme, which provides funding for healthcare students on NHS funded courses in Wales and Welsh domiciled medical and dental students within the UK. • The Learning and Development Team have strong links with the Universities in facilitating awareness of the roles available within NWSSP, to attract, train and retain a diverse workforce of the future, through promotion of careers fayres, etc and work placement schemes. • Recruitment Services in an All Wales Service within NWSSP, which facilitates close partnership working with industry partners such as NHS Jobs and TRAC as regards vacancy promotion and management.	Director of People & Organisational Development and Employment Services
7	Quality of clinical records is improved through implementing standards which enable re-use of the data for research	• NWSSP often receive request for information under the Freedom of Information Act 2000, which may be used for research purposes, specifically PCS information for pharmaceutical studies. We do not actively encourage using information for research purposes, however, as part of our duties under the Reuse of Public Sector Information Regulations we promote the process to follow for re-using information on our website.	Director of Primary Care Services Director of Finance and Corporate Services
Standard 3.4 Information Governance and Communications Technology Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	Safe and secure information systems are developed in accordance with legislation and within a robust governance framework	• NWSSP's information systems are supported through a Service Level Agreement (SLA) with Digital Health Care Wales (DHCW) who ensure that all electronic information systems are safe and secure in accordance with legislation. • We adhere to NWSSP own internal Records Management Policy and local Information Governance Protocols.	SLG

		• NWSSP has established arrangements for Information Governance to ensure that information is managed in line with the relevant law, legislation, regulations and Information Commissioners Office (ICO) guidance when required. • NWSSP Information Governance Steering Group (IGSG) monitor information governance compliance and report directly to the SLG, who assess and mitigate against information risks as part of its monthly review of risk management. • The Director of Finance and Corporate Services is the Senior Information Risk Owner (SIRO) in relation to information governance. • As NWSSP is hosted under Velindre University NHS Trust (VUNHST), our Caldicott Guardian is Dr. Jacinta Abraham, Medical Director. Ms Ruth Alcolado is NWSSP's Medical Director and also is considered to be an appropriate Caldicott Guardian. However, it must be noted that we are not in a position where we are subject to make clinical decisions in relation to patients (or complete the annual Caldicott assessment) and the Caldicott Guardianship does not apply to NWSSP as it would within a Health Board (secondary care) environment. • All requests received under the Freedom of Information Act and the provisions of Subject Access in line with the UK Data Protection legislation and are managed and co-ordinated through the Information Governance Manager and requests received relating to the Environmental Information Regulations are handled by the Environmental Management Team within Corporate Services, in accordance with the Environmental Management System (EMS) and the ISO14001:2015 Standard. • NWSSP complete an annual All Wales Information Governance self-assessment toolkit which is approved by the Information Governance Steering Group, reported on in SLG and endorsed by the Audit Committee. • NWSSP manages access control to systems and data through the active directory (NADEX), password control for various systems and encryption standards as dictated by DCHW. • All information governance breaches are required to be reported on to the RLDatix incident reporting software system. NWSSP adheres to its own IG Protocols, including an IG Confidentiality Breach Reporting Protocol. • NWSSP developed its own privacy impact assessments to ensure appropriate Data Protection and compliance by our Data Processors and to provide assurance to all stakeholders that confidentiality has been assessed as part of any new project or proposed change to data processing. • The Information Governance Steering Group (IGSG) comprises of Information Asset Owners who have collectively contributed to devising an Information Asset Register for NWSSP, which is monitored biannually. • ISO27001 Information Security and ISO 9001 Quality Management Standards attained for Procurement Services and Specialist Estates Services. • Policies and procedures are in place to highlight risks and escalate problems.	

		• Paper filing systems are minimal as we have introduced many paperless processes as we work on improving sustainability in the workplace and located in secure areas, protected from fire and away from bright light or risk of damage from water. Paper filing systems containing patient or person identifiable and business sensitive information are stored in safe, secure and lockable cabinets and housed appropriately. • Electronic systems cloud based and assessed to be a safe and secure areaof electronic file storage. • The safe storage of national systems and third party electronic systems hosted outside of the organisation all comply with legislation, guidance and audits. • Only authorised personnel can access sensitive data. Electronic records can only be accessed if authorisation has been given to access to files usually be way of password control and permissions granted by IT. • Clear desk guidance and audits highlight the importance of safe storage of paper-based records when the office is unattended. • Third party systems such as E-expenses are only used where they individually demonstrate an appropriate level of security. • All records relating to the Student Awards system are stored electronically and only staff that have been given the appropriate permissions are able to log onto the system and retrieve records. • Secure maintenance of records is demonstrated by compliance with system data definitions, data sets, user manuals and training. • Data accuracy is achieved where possible by utilising data verification tools and agreed end to end best practice processes. • Access to confidential data (e.g. workforce data through ESR) is securely controlled via user responsibility profiles linked to functional job roles. • Safe disposal/archiving of data is achieved by adopting end to end processes in line with the local archival protocol for Records Management. • Electronic systems are easily accessible to all appropriate staff with restricted access to folders/files containing patient or person identifiable information • Following the pandemic and the increased level of homeworking, Information Governance protocols including agile working and home based office working guidance have been rolled out across the organisation.	
2	Processes exist to operate and manage information and data effectively, to maintain business continuity and support and facilitate patient care and delivery	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Standard operating procedures exist and are regularly tested by both internal audit, and where appropriate, through Audit Wales, our external auditing body. • Periodic reviews take place within all services of the quality of records to ensure they are accurate and complete. Regular audits of systems are carried out within Primary Care Services ensuring all records are fit for purpose. • NWSSP has its own policy for creating, maintaining and destroying records including the Health and Social Care Records Management Policy 2022 (RMCoP) .	SLG

		Departmental protocols are in place with regard to creating, maintaining, monitoring and destroying records within all departments, in particular, Primary Care and Legal & Risk Services. • A protocol has been developed by People and Organisational Development in regard to the management of staff personal files. • Clear arrangements are in place for recording the receipt and return of all documents in relation to the Student Awards system. • To ensure information is easily retrievable, document naming conventions are in place to ensure ease of document retrieval. • All NWSSP records are Public Records under the Public Records Act and are kept in accordance with statutory provisions which include: o UK Data Protection legislation 2018 o UK General Data Protection Regulation (25 May 2018) (GDPR) o Freedom of Information Act 2000 o Public Records Acts 1958 o Health and Social Care Records Management Code of Practice 2022 o Lord Chancellor's Code of Practice on the Management of Records published by requirement of law under Section 46 of the Freedom of Information Act 2000 • The lengths of documentation retention periods are dependent on the type of record stored, its importance to the organisation and the legal requirements. Significant amounts of documentation within NWSSP contain identifiable (defined as patient, personal information). Robust mechanisms are in place ensuring the safeguarding of confidential information mean that confidential information is safeguarded. Procurement Services and Specialist Estates hold ISO 27001 Information Security management certification. • Confidential employee documents used for Payroll and Recruitment purposes are maintained for timescales consistent with the appropriate legislative body (e.g. HMRC, Disclosure and Barring Service, National Standards for Safe Recruitment). • When information is destroyed or archived, dependant on the nature of its destruction or archiving, whether it contains patient, personal or commercially sensitive information it is either shredded, or destroyed via confidential destruction processes. When contractors are used for disposal of confidential records, they are required to sign confidential undertakings and produce written certification as proof of destruction. • Confidential waste paper is bagged or boxed and placed in designated confidential waste containers for collection by an approved supplier/contractor, which is then shredded on site and repurposed into notebooks, etc (considering the sustainable life cycle of finite and scarce items). • NWSSP, along with all NHS organisations, have a legal responsibility to maintain records safely and securely under UK Data Protection legislation. Original copies of patient's records, which are requested under a data subject access request or	

		deceased records requested under the Access to Health Records Act, are not provided with original records (even if they have reached the end of the recommended retention period and are due for destruction) unless permission has been granted by the Lords Chancellor in accordance with s.3(6) of the Public Records Act. • Some records may be identified for transfer to the Public Records Office for permanent preservation or release to the public. When reviewing records for public release it is ensured that public records become available at the earliest possible time in accordance with the Freedom of Information Act (2000). • Transfer to the Public Records Office takes place by the time the records are 30 years old unless the Lord Chancellor gives permission for them to be retained for a longer period of time. • If records are found to contain information exempt under the Freedom of Information Act (2000), a schedule is prepared and submitted to the Public Records Office identifying the information precisely, citing the relevant exemptions and either an appropriate release date or a date at which a case for release could be reconsidered. • NWSSP policies and local practices on information management and information governance are issued to staff through intranet pages, staff communications, information governance steering group meetings, Q&A sessions, newsletters, local IG point of contact through the Information Governance Manager, posters on noticeboard, training sessions, etc. This provides staff with a source of information and ensures that the importance of effective Information Governance is signposted as broadly as possible and maintains a "culture of confidentiality" within the organisation. • As a hosted organisation, we are required to take cognisance of their GC 12 Business Continuity Management Policy and ensure that NWSSP has effective strategies in place for: o People – the loss of personnel due to sickness or pandemic; o Premises – denial of access to normal places of work; o Information Management and Technology (IM & IT) and communications/ICT equipment issues; and o Suppliers internal and external to the organisation. • NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify assess and implement applicable legislation and regulation requirements related to the continuity of operations, services as well as the interests of interested parties. At present there are local directorate procedures in place for ensuring business continuity arrangements are in place for key services, however the separate arrangements pose a significant risk as the is no "Resilience Lead" to monitor, co-ordinate and test business continuity plans. • The NWSSP Information Governance Manager completes an annual assessment on Information Governance using the toolkit that has been adopted across NHS Wales.	

		• In preparation for the Winter period, individual directorates have their own plans in place for staff and operational resilience specific to their areas (e.g. Health Courier Service has robust BCP in place to ensure effective front line delivery of services and an on-call rota to ensure effective communication outside of normal working hours). • There are also, robust "building continuity plans" in place for the main sites which are maintained and monitored by the Site Leads. In the event of building closures, following approval by the Director of Finance and Corporate Services, the home page of the website will be used to inform staff that access to the building is prohibited. This will be in addition to local communication through directorate managers, social media and the Building Manager's WhatsApp Group, which has been established in the event of a emergency communication being required. • Disaster testing and emergency scenario testing are periodically tested and undertaken, with key individuals (e.g. cyber attack). • Staff responsible for records management and specialist data management receive bespoke face to face Information Governance training (e.g. Primary Care Services). • Director of Finance & Corporate Services has received training on the role of the Senior Information Risk Owner (SIRO). • CSTF compliance is monitored through monthly Formal SLG meetings, including statistics in relation to the Information Governance module. • The nominated leads for Information Governance are: • As we are hosted under Velindre, our Caldicott Guardian is Dr. Jacinta Abraham, Medical Director. Ms Ruth Alcolado is NWSSP's Medical Director, we can also consider her as an appropriate Caldicott Guardian. However, it must be noted that we are not in a position where we are subject to make clinical decisions in relation to patients (or complete the annual Caldicott assessment). • Senior Information Risk Owner (SIRO) - the Director of Finance and Corporate Services within NWSSP. SIRO support is provided by the Head of Finance and Business Improvement and the Information Governance Manager. • Data Protection Officer (DPO) – the role of Data Protection Officer is undertaken by the Information Governance Manager. • Data Subject Access Request (DSAR) managed by the Information Governance Manager. • FOI – managed by the Information Governance Manager. • IT security/records management – the Head of IT manages the information security and records management. • Business Quality Manager in Procurement Services leads the ISO 27001 Information Security management certification at a number of its key sites. • Any information governance breaches are investigated thoroughly and consequences are determined through the severity of the incident and dealt with through the	

		Disciplinary Policy, as appropriate as well as internal/external reporting as necessary, mitigations and recommendations provided.	
3	Data and information are accurate, valid, reliable, timely, relevant, comprehensible and complete	• NWSSP ensure that its data is robust, accurate and timely and meets national standards through: o SLA with DCHW; o NWSSP's Information Governance Policy and protocols; o Standard operating procedures linked to our Key Performance Indicator embedded in Service Level Agreements with Health Boards/Trusts; and o Quality control processes in a number of transaction processes to ensure the validity, accuracy and timely delivery of services.	SLG
4	Information is used to review, assess and improve services	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is proactive in reviewing performance and utilising business intelligence to review its own service outputs. NWSSP is a member of the UK Benchmarking Group. • Health Courier Services (HCS) is a member of the NHS Transport & Logistics Best Practice Group which meets quarterly. The Group shares best practice, policy and documents and also undertake benchmarking exercises. Stakeholders utilise Primary Care data to assess, review and plan service developments. • The CSTF includes a mandatory module on Information Governance and the Information Governance Manager provides staff with information governance training using Microsoft Teams on a virtual basis, every 2 years, which ensures that staff can use information appropriately in accordance with the UK Data Protection legislation and other associated legislation and guidance. • NWSSP often receives requests for information under the Freedom of Information Act (2000), which may be used for research purposes, specifically PCS information for pharmaceutical studies. We do not actively encourage using information for research purposes, however as part of our duties under the Reuse of Public Sector Information Regulations we promote the process to follow for re-using information on our website. • When providing information to FOIA requests there is no confidential information provided. Information that may identify persons or commercial sensitive elements are exempted as the FOIA is not for sharing identifiable data and only Public Authority information in the spirit of openness and transparency. • Health and Safety, trends are analysed and objectives are set for a two year period, which are monitored and reported upon quarterly. • Environmental performance monitoring of the organisation's carbon footprint is undertaken on a monthly basis for each site within the scope of the EMS and ISO14001, assessed against objectives and targets and published annually. The EMS run on a cycle of continuous improvement; Plan, Do, Check Act. • Staff, customer and partner feedback, KPIs, and performance data is reviewed and acted upon accordingly by the relevant Service.	SLG

5	Information is shared with relevant partners using protocols when necessary to provide good care for people	• NWSSP has a data record sharing policy and processes in place and adheres to the Wales Accord on the Sharing of Personal Information (WASPI) and the seven (7) principles of the General Data Protection Regulation (GDPR) which are: o Lawfulness, fairness and transparency o Purpose limitation o Data minimisation o Accuracy o Storage limitation o Integrity and confidentiality (security) o Accountability • Partnership working arrangements are supported by appropriate and secure means of sharing identifiable information.	SLG

Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance

	Sub Criteria	Evidence	Responsible Person within each Directorate
1	Paper and electronic clinical record quality is improved through adoption of the Academy of Medical Royal Colleges standards for the clinical structure and content of patient records.	Not Applicable	-
2	Clear accountability for record keeping supports effective clinical judgements and decisions.	Not Applicable	-
3	There is effective communication and sharing of information between members of the multi-professional healthcare team and the patient	Not Applicable	-
4	Record keeping supports clinical audit, research, allocation of resources and performance planning.	Not Applicable	-
5	Evidence shows how decisions relating to patient care were made	Not Applicable	-
6	Identification of risks enables early detection of complications	Not Applicable	-

7	Record keeping supports the delivery of services, patient care and communications	Not Applicable	-
8	Records are designed, prepared, reviewed and accessible to meet the required needs	Not Applicable	-
9	Records are stored securely, maintained, are retrievable in a timely manner and disposed of appropriately	Not Applicable	-
10	Records are accurate, up-to-date, complete, understandable and contemporaneous in accordance with professional standards and guidance; and shared when appropriate	Not Applicable	-
11	People's personal records are regularly updated and available to them. To ensure confidentiality, they are kept secure and comply with the Data Protection Act 1998	• Individual directorates are responsible for managing identifiable information and for complying with the provisions of UK Data Protection Legislation, also taking account of the UK General Data Protection Regulations. • NWSSP has a Protocol for the Management of Personal Records. • Staff are required to keep their own personal information updated via ESR self-service. • NWSSP adhere to internal Information Governance Protocols on dealing with Data Subject Access Requests (DSARs) under the provisions of subject access under the UK General Data Protection Regulation (GDPR)/UK Data Protection legislation 2018. • The Information Governance Steering Group (IGSG) monitors compliance with the above and the Information Governance Manager prepares a quarterly report for SLG's consideration. The Information Governance Manager also prepares an Annual Report on Information Governance. • The Environmental Management Team manages requests made under the Environmental Information Regulations 2004 in accordance with the Environmental Management System (EMS) and ISO14001:2015 Standard in line with the Freedom of Information Act (2000).	Director of Finance and Corporate Services
12	Care, treatment and decision making is supported by structured, accurate and accessible patient records documenting the conversations between people and health professionals and the resulting decisions and actions	Not Applicable	-

	taken and reflects best practice founded on the evidence base.		

Theme 3 - Self Assessment Rating - Effective Care					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating				✓	

Theme 4 – Dignified Care

Standard 4.1 Dignified Care People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People are treated with respect, courtesy and politeness	Not Applicable	-
2	People are able to access free and independent advice so they can make choices about their care and lifestyle	Not Applicable	-
3	Individuals are addressed by their preferred name	Not Applicable	-
4	Welsh Language needs are responded to sensitively	Not Applicable	-
5	Confidentiality, modesty, personal space and privacy are respected especially in hospital wards, public spaces and reception areas	Not Applicable	-
6	People's feelings, needs and problems are actively listened to, acknowledged and respected	Not Applicable	-
7	All care is recognised as holistic and includes a spiritual, pastoral and religious dimension	Not Applicable	-
8	Information and care are always provided with compassion and sensitivity. Ensuring that people and their carers have the freedom to act and decide based on opportunities to participate and on clear and comprehensive information	Not Applicable	-
9	Consideration is given to people's environments and comfort so they may rest and sleep	Not Applicable	-

10	People are helped to be as comfortable and pain free as their condition and circumstances allow	Not Applicable	-
11	People are supported to be as independent as possible in taking care of their personal hygiene, appearance and feet and nails	Not Applicable	-
12	People are supported to maintain a clean, healthy, comfortable mouth and pain-free teeth and gums, enabling them to function as normal (including eating and speaking) and prevent related problems	Not Applicable	-
13	Continence care is appropriate and discreet and prompt assistance is provided as necessary taking into account peoples' specific needs and privacy	Not Applicable	-
14	People are supported to feel confident to talk through all aspects of their care including sensitive areas such as life expectancy. Advanced care planning, end of life care and addressing the needs of the dying and as good a death as practical for the individual and their family is a key part of dignified care.	Not Applicable	-
Standard 4.2 Patient Information People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People's rights and individual circumstances are respected so they have a voice and control, empowering them to make decisions that affect their lives	Not Applicable	
2	Welsh speakers are empowered to express their needs and they are able	Not Applicable	-

	to fully participate in their care as equal partners. Where needed people are provided with access a translator or a member of staff with appropriate language skills		
3	Health, personal and social care needs are assessed and set out in regularly reviewed plans of care	Not Applicable	-
4	Assistance or specialist aids are provided to those with speaking, sight or hearing difficulties, special needs such as memory problems or learning disabilities, enabling them to receive and respond to information	Not Applicable	-
5	People are consulted about any treatment and care they are to receive and opportunities provided to discuss and agree options	Not Applicable	-
6	People's personal records are kept safe regularly updated and available to them	Not Applicable	-
7	Time is taken to listen and actively respond to any questions and concerns that the individual or their relatives may have, treating their information confidentially	Not Applicable	-
8	Valid consent is obtained in line with best practice guidance; and assessing and caring for people in line with the Mental Capacity Act 2005, and when appropriate the Deprivation of Liberty Safeguards 2009	Not Applicable	-
9	Timely and accessible information is provided on people's conditions and care, medication, treatment and support arrangements	Not Applicable	-

Self Assessment Rating – Theme 4 - Dignified Care					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating	N/A	N/A	N/A	N/A	N/A

Comments:

Due to the largely non-clinical nature of services provided by NWSSP, the sub-criteria were deemed not applicable for the theme of Dignified Care.

Although, we note that we host the Medical Examiner Service within NWSSP, this is dealing with bereaved families relates to deceased individuals. The Medical Examiner Service is hosted by NWSSP and will provide an independent scrutiny of all deaths that are not investigated by the coroner. Scrutiny will be undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

Theme 5 – Timely Care

Standard 5.1 Timely Access All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People's health outcomes are monitored in order to ensure they receive care in a timely way	Not Applicable	-
2	All aspects of care are provided, including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with national timescales, pathways and best practice	Not Applicable	-
3	Conditions are diagnosed early and treated in accordance with clinical need	Not Applicable	-
4	Accessible information and support is given to ensure people are actively involved in decisions about their care	Not Applicable	-
5	There is compliance with the NHS Outcomes and Delivery framework relating to timely care outcomes	Not Applicable	-

Self Assessment Rating – Theme 5 - Timely Care					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations /**

				organisation / business	**business, and which others can learn from**
Rating	N/A	N/A	N/A	N/A	N/A
Comments: Due to the largely non-clinical nature of services provided by NWSSP, the sub-criteria were deemed not applicable for the theme of Dignified Care.					

Theme 6 – Individual Care

Standard 6.1 Planning Care to Promote Independence Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	People are supported to engage and participate in their care and feel valued in society	Not Applicable	-
2	People are treated with the understanding that they have the right to be who they are, to be understood, considered and recognised as an individual	Not Applicable	-
3	Sufficient time is available to support and encourage people to care for themselves, and supporting carers where individuals are unable to care for themselves	Not Applicable	-
4	Support is given to ensure that people have the right to make decisions about their life	Not Applicable	-
5	The care that people receive will respect their choices in making the most of their ability and desire to care for themselves	Not Applicable	-
6	Ongoing assessment and individual care planning involving all those relevant to the person's care, forms the basis of the plan of activities and care. This takes account of the person's requirements, strengths, abilities and potential	Not Applicable	-
7	Patients receiving secondary mental health services subject to the Mental Health (Wales) Measure 2010 must	Not Applicable	-

	have a statutory outcome focussed care and treatment plan that must be regularly reviewed		
8	Where possible, people are shown different ways of doing things to help them to be independent	Not Applicable	-
9	If appropriate, people are offered equipment to help them walk, move, eat, hear and see. This equipment is well maintained, and if provided for a specific person is kept for their own use	Not Applicable	-
10	People's ability to care for themselves is fostered and their NHS/care environment is as accessible, comfortable and safe as possible	Not Applicable	-
11	People are encouraged to be active taking appropriate exercise and/or recreation as far as their condition allows	Not Applicable	-
12	Healthcare workers are sensitive to people's linguistic needs and people will receive services through the medium of Welsh as a natural part of their care. People are shown respect for their cultural identity and are able to access Welsh language services without any obstacles, although not everyone responsible for their care will speak Welsh	Not Applicable	-
13	Public information will be easily accessible to ensure people take responsibility to access care appropriately	Not Applicable	-
14	There is effective transition from children to adult services	Not Applicable	-
15	Health, personal and social care needs are assessed and set out in regularly reviewed plans of care	Not Applicable	-

	agreed by the individual and the people caring for them. The plan is only shared with others with the service user's consent		
16	People are supported to get help, when they need it in the way they want it.	Not Applicable	-
17	Support is provided to develop competence in self-care and promote rehabilitation and re-enablement; and achieve effective partnership working with other services and organisations, including social services and the third sector	Not Applicable	-
18	Health services will work with community groups for example those who can help support people with protected characteristics.	Not Applicable	-

Standard 6.2 Peoples Rights
Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

	Sub Criteria	Evidence	Responsible Person within each Directorate
1	Needs of individuals are recognised and addressed whatever their identity and background, and their human rights are upheld	• NWSSP's Integrated Medium Term Plan (IMTP), Annual Review, Overarching Goals, Core Values, Strategic Objectives and Vision and Mission. • NWSSP Core Skills Training Framework (CSTF) modules mandated for all staff to undertake via the Electronic Staff Record (ESR) including Equality – Treat Me Fairly, Health & Safety, Fire Safety, Resuscitation, Information Governance, Infection Control, Safeguarding Children, Safeguarding Adults, Manual Handling, Violence & Aggression and Cyber Security. • Face to face and remote training courses and sessions are available in a variety of themes, including people management, stress awareness, Welsh language awareness, information governance, etc. • ESR learning modules offer a variety of courses online that staff can choose to undertake in addition to the CSTF modules mandated (e.g. Romani and Traveller Healthcare, etc.). • Health and Well-being Staff Partnership and associated offerings, resources, etc.	All

		o Equality, Diversity and Inclusion offering, including Staff Support Groups, Inclusion Network, LGBT+ Staff and Ally Network “Proud/Balch”, Disability Network, BAME Staff and Ally Network and Menopause Café, etc. o During the pandemic, we promoted Velindre’s Shielding Staff Support Network. • NWSSP are members of the Employers Network for Equality and Inclusion (ENEI). • NWSSP are participants in the All Wales Equality Leadership Group (ELG) promoting All-Wales approach to Equality, Diversity and Inclusion. • Personal data relating to equality and diversity is captured on the ESR system and staff are responsible for updating their own personal records using ESR Self-Service, including Ethnic Origin, Nationality, Country of Birth, Religious Belief, Sexual Orientation and Welsh language competencies. • Individuals’ specific needs identified are addressed, as required (e.g. Personal Emergency Evacuation Plans (PEEPs), providing suitable equipment, ensuring accessibility and facilitating reasonable adjustments. • As a non-statutory hosted organisation, we also benefit from being included in Velindre University NHS Trust’s Networks and Equality offerings and we comply with their Equality and Diversity Policy and associated All Wales Policies and guidance, available for staff to view on the intranet page, including Dignity and Work Policy, Raising Concerns (Whistleblowing) Policy and Standards of Behaviour Framework Policy, etc. • Equality, diversity and inclusion is embedded within the Performance Appraisal Development Review (PADR) process. • Working in partnership with Trade Union colleagues. • Equality Integrated Impact Assessments (EQIIAs) undertaken which capture Human Rights Act 1998, Protected Characteristics and the Equality Act 2010, Socio-Economic Duty and an integrated approach which also considers impacts for Health and Safety, Information Governance, Welsh Language, Modern Slavery Act 2015, Ethical Employment in Supply Chain and Well-being of Future Generations Act (Wales) 2015. o Assessments undertaken when considering changes to policies, practises or proposed service changes to policies, practices or proposed service change, where relevant. o Review Panel includes Subject Matter Experts, Senior Workforce Advisor and Trade Union representation • Trade Union representation for Shared Services Partnership Committee (SSPC) meetings, Staff Health and Well-being Partnership and Equality, Diversity and Inclusion Groups. • NWSSP provides a “Core Skills for Managers” Training Programme and the Managing Conflict module, includes an awareness session on the Dignity at Work Policy and Procedure.	

		• The NHS Jobs All Wales Recruitment Service, run by NWSSP, adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure that there are no discriminatory elements. • A recruitment and selection toolkit is available for managers which provides advice and guidance on the equality requirements of the recruitment and selection process, promoting equal opportunities. • Workforce data and KPIs are reported monthly at the Formal SLG meetings and published annually, via the Annual Review. • The rights of Welsh speaking members of staff are supported through the internal use of the Welsh Language Protocol. This encompasses a wide range of the requirements of the Welsh Language Standards. Although it's not a legal requirement to provide individual care packages for our staff for wellbeing through the medium of Welsh, we will support and seek providers that can support staff on wellbeing matters through the medium of Welsh, as we recognise that this supports wellness and the road to wellness by accessing staff support services through the medium of Welsh.	
2	Discrimination is challenged, equality and human rights are promoted and efforts are made to reduce health inequities through strategies, equality impact assessment, policies, practices, procurement and engagement	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Equality, diversity and human rights are incorporated into the governance considerations on the front cover for SSPC reports, which seeks to reduce health inequalities and promote fair and equal treatment. • Aligned to Well-being of Future Generations (Wales) Act 2015, considering the 7 well-being goals (in particular, a more Resilient Wales, a Healthier Wales and a more Equal Wales), the sustainable development principle (5 ways of working; long-term, prevention, collaboration, involvement and integration). • Equality and Human Rights are promoted the through Treat Me Fairly CSTF module, internal communication and training. • Equality and Diversity Policy follows the Older People's Commissioner Wales' Guidance issued under S12 Commissioner for Older People (Wales) Act 2006 (February 2013) - Best Practice Guidance on Assessing the Impact on Older People in Wales of Changes by Local Health Boards to Policy and Provision of Services. It also covers a how to recognise and uphold the rights of disabled people in accordance with the UN Convention on the rights of People with Disabilities, the UN Principles for Older People and the UN Convention on the Rights of the Child. • Procurement processes include Sustainability Risk Assessments being undertaken, which assesses Community Benefits, Value-Based Healthcare, Prudent Healthcare and a Healthier Wales, Well-being of Future Generations, Sustainable Development Principle (5 ways of working) and Ethical Employment in Supply Chain/Modern Slavery, amongst other strategic and Ministerial priorities and drivers/ enablers. • Our Director of People and Organisational Development and Employment Services is NWSSP's Ethical Employment Champion and signs a Statement to our commitment annually, which is published bilingually on our website and staff intranet.	All

		• Annual reviews of governance policies undertaken in line with the Forward Plan of Business, including the Raising Concerns (Whistleblowing) Policy at Audit Committee. • Staff support groups and networks and local initiatives such as the 'Show us your Rainbow' lanyard campaign, It Makes Sense and Pride Cymru Parade.	
3	Strategic equality plans are published setting out equality priorities in accordance with legislation	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • As a non-statutory hosted organisation, we adhere to Velindre's Equality and Diversity Policy, Standards of Behaviour Framework and Strategic Equality Objectives and contribute towards achieving goals and outcomes identified (e.g. through actions taken and projects delivered by our staff and Services). • We also participate in Policy Consultations in relation to Velindre, as our host organisation and have a central process for distributing these and collating NWSSP comments and feedback. • Our Director of Planning, Performance and Informatics is NWSSP's Equality and Diversity Champion.	All
4	Care is consistent whatever the age of the person being cared for, so that for example for younger people with serious illnesses should expect an efficient transition from child services to adult services with good communication between those agencies.	Not Applicable	-
5	The rights of children are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC)	• NWSSP does not offer the same services as Health Boards and therefore, there will be some gaps and areas in criteria, which will not be applicable, including Children's Services. However, this should in no way be interpreted as a lack of commitment. • Our host's policies are inclusive, where possible, on the Rights of the Child, including, Domestic Abuse Policy, Work Life Balance Scheme, Child Protection and Vulnerable Adult training. • Demonstrating support, dignity and respect of children via initiatives, such as Childcare Vouchers Scheme and School Holiday Childcare Subsidies. • Access to Employee Assistance Programme (EAP), which has a variety of resources and support mechanisms available to staff and their families, including modules relating to children.	All
6	The rights for older people in Wales are recognised in accordance with the Declaration of Rights for Older People in Wales and the UN principles for Older Persons.	• Our host's policies follow the Older People's Commissioner Wales' Guidance issued under S12 Commissioner for Older People (Wales) Act 2006 (February 2013) - Best Practice Guidance on Assessing the Impact on Older People in Wales of Changes by Local Health Boards to Policy and Provision of Services. It also covers how to recognise and uphold the rights of disabled people, in accordance with the UN	All

		Convention on the rights of People with Disabilities, the UN Principles for Older People and the UN Convention on the Rights of the Child.	
7	The spiritual and pastoral care needs of people and their carers are recognised and addressed	Not Applicable	-
8	People are encouraged to maintain their involvement with their family and friends and develop relationships with others, according to their wishes	Not Applicable	-

Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

	Sub Criteria	Evidence	Responsible Person within each Directorate
1	Health services and boards demonstrate how they are responding to user experience to improve services	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Service user experience is obtained from SSPC meetings and effectiveness surveys, Audit Committee meetings and effectiveness surveys, Service specific customer satisfaction surveys, quarterly review meetings (internal and external), IMTP peer review workshops, contract management (i.e. home oxygen contract, patient experience questionnaires, etc.) o Internally and more recently, staff feedback has been collated as regards active travel, agile working, accommodation and 'Tell us how it is" surveys. • NWSSP use a variety of communication channels to collate and seek feedback, including staff intranet, specific inbox, campaigns like "tell us how it is" and "you said, we did", online surveys, social media, etc. • Several of NWSSP's directorates use customer satisfaction surveys to assess service user's satisfaction with service delivery. This information is analysed by the individual teams and used as evidence as part of the Customer Service Excellence Assessments. • NWSSP acts upon service user experience and feedback from information received as regards concerns and serious incidents, as required and in accordance with the Complaints Management Protocol. • As a non-statutory hosted organisation, NWSSP does not produce its own Annual Quality Statement (AQS) and our services feature as part of the Velindre University NHS Trust AQS. • In addition, we publish an Annual Governance Statement within NWSSP, which is approved by the Audit Committee and is endorsed by the SSPC and Velindre Trust Board.	All

		• We welcome correspondence and feedback in both English and Welsh and all communications are issued bilingually, including all publications and Committee meeting papers published on our website. Staff have an option to promote this through the use of Cymraeg lanyards, safety pins and e-mail signatures. Letterheads also have a Cymraeg symbol to identify that we welcome bilingual correspondence.	
2	Partners are engaged in supporting and enabling people to be involved in the design planning and delivery of services	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP is committed to engaging with service users to support and enable people to be involved in the design and planning of services, including SSPC meetings, horizon scanning workshops, Audit Committee meetings, IMTP peer review, Managing Director and Committee Chair attend Board meetings with the Executive teams at each Health Board/Trust to gain a clearer understanding of their operational requirements, quarterly review meetings with Health Boards/Trusts, monthly professional peer group meetings, including the Directors of Finance Group, the Directors of People and Organisational Development and the Board and Deputy Board Secretaries Network, customer satisfaction surveys and feedback mechanisms, including post-project surveys. • NWSSP involves service users in the planning and delivery of services through its consultation process on the 3 year IMTP. NWSSP participates in peer review workshops facilitated by Welsh Government, which act as service user engagement events and provide an opportunity for Health Board's and Trusts to input to NWSSP's three-year planning process. • NWSSP are committed to treating both the English and Welsh language on the basis of equality and inclusion, and all external facing surveys and communications are issued in a bilingual format, in line with the requirements of the Welsh Language Standards and Act.	All
3	The patient's and carer's voice is heeded by health services and boards, including through the use of patient stories	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Due to NWSSP delivering mainly administrative, professional and technical (non-clinical) services, "patient stories" do not feature as part of the SLG or SSPC's agenda. However, NWSSP are proactive in listening and learning (core value) and engaging with service users and any patient stories concerning NWSSP's services are discussed at quarterly review meetings and then shared wider. • Welsh Infected Blood Support Scheme (WIBSS), hosted by NWSSP, and the associated public inquiry into infected blood, drew on patient stories and families of bereaved patients. • NWSSP recognise the impact on the population by the actions taken by our people and the services we provide, therefore we routinely collate 2 positive stories each month and circulate these to Welsh Government to highlight the organisation's impact on the wider population of Wales.	SSPC

		• We also publish case studies of projects and achievements in our IMTP and Annual Reviews to showcase our impact within NHS Wales and wider. We hold a case study library on our website and staff intranet, which boasts a wealth of highlights. • We also hold an Annual Staff Awards Recognition Ceremony, which puts case studies, delivering outcomes and impacts for the wider population of Wales in the spotlight staff being recognised for their contributions. Categories include health and well-being, environmental, Welsh language, team of the year, innovation, listening and learning, working together, taking responsibility, well-being of future generations, etc.	
4	Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Feedback has been addressed above, however, we do encourage Services to maintain a lessons learned log and following on from the pandemic response and recovery, the Adapt and Future Change Group authored a report on Lessons Learned, for the SLG's consideration in June 2020. Work continues to identify lessons learned from the pandemic response and recovery through the COVID-19 Public Inquiry Readiness Governance Group. • NWSSP's commitment to engaging with its stakeholders is demonstrated through attaining standards, certifications and accreditations within Services, such as Lexcel, STS Food Safety, ISO9001, ISO14001, ISO27001, Customer Service Excellence, etc. • Datix and the Once for Wales Concerns Management System capture lessons learned and this is used to record and manage investigations through to resolution, for all operational concerns, incidents and near misses across NWSSP's landscape. • Complaints Management is taken very seriously within NWSSP and there is a mechanism for feedback to be provided to the Managing Director for an independent review of any complaint within the gift of resolution by NWSSP, prior to being considered by the Public Services Ombudsman for Wales or the Pensions Ombudsman. • KPIs and performance data is scrutinised at Service specific quarterly review sessions, with NWSSP employing a Business and Performance Manager, within the Planning, Performance and Informatics directorate and the Head of Finance and Business Improvement within Finance and Corporate Services.	All
5	Service delivery improvement for all people is captured and demonstrated which includes, as a consequence, meeting statutory responsibilities for children and young people, equality and diversity, and the Welsh language	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Equality and diversity data held within ESR helps Managers within Services to identify and understand potential key equality issues across functions, including employment and service delivery areas. Where appropriate, we will use the findings to develop local equality objectives and shape initiatives, campaigns and use feedback to inform decisions.	All

		• Embedded within PADR process, CSTF ESR modules (mandatory and optional courses available, including Safeguarding Children, Safeguarding Adults, Equality and Violence & Aggression), All Wales Recruitment Services processes and the associated KPIs generated through these, which are reviewed at Formal SLG meetings on a monthly basis. • Employment Services hosts a Service Improvement Team who feed directly into the ESLG for areas such as payroll, pensions, student awards services, recruitment services, bursary, etc.	
6	It is clear how data reported in national surveys and audits are used and applied	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • Directorates have well established systems in place for collecting information from their customers, partners and stakeholders (interested parties), including customer satisfaction surveys, post-project surveys, Committee effectiveness surveys, NHS Wales Staff Surveys and NWSSP local staff and pulse surveys, etc. Survey results are reported to the SLG and Committees. Committee papers and minutes are published on the website in a bilingual format. • NWSSP has an established Velindre University NHS Trust Audit Committee for Shared Services, which meets four times a year, as part of the wider governance arrangements as a hosted organisation. The purpose of the Audit Committee is to advise and assure the SSPC and the Accountable Officer on whether effective arrangements are in place, regarding the design and operation of NWSSP's system of governance and assurance. This supports the SSPC in its decision making and in discharging its accountabilities for securing the achievements of NWSSP's objectives in accordance with the standards of good governance determined for the NHS Wales. • The composition of the Audit Committee includes an independent Chair and three other Independent Members (all of which are members of Velindre University NHS Trust's substantive Audit Committee), who each hold a specialist 'champion' role, beneficial to NWSSP (e.g. finance, safeguarding, legal, etc). The Committee comprises representatives from Internal Audit, Audit Wales, Counter Fraud, Chair of SSPC ,Chief Executive, Board Secretary/Director of Corporate Governance and Director of Finance from Velindre, Managing Director of NWSSP and the Director of Finance and Corporate Services. Standing agenda items on the agenda for Audit Committee includes the Corporate Risk Register, Counter Fraud, Internal Audit, External Audit and Governance Matters, including single tender actions, gifts and hospitality and contracting activity, such as tenders awarded. The Audit Committee provides the SSPC with an annual report on its activities and links in with the Head of Internal Audit Opinion.	All
7	There are processes in place that assure a good experience for people which include:	Not Applicable	-

	• Assessing and evaluating service user experience, especially for those who are vulnerable • provision for people who are less able to speak for themselves • delivering and measuring improvement • using patient feedback to influence/drive changes to service provision and delivery; • recognising the spiritual, pastoral and religious dimension of care		
8	There is compliance with legislation and guidance to deal with concerns, incidents, near misses, and claims as set out in the "Putting Things Right" arrangements	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • in relation to Putting Things Right, NHS Wales aims to provide the very best services and the vast majority of people are happy with the service they receive. Sometimes though, things might not go as well as expected. When that happens, we need to look at what went wrong so we can try to make it better. Some cases might need further investigation under the redress arrangements. • Redress is a range of actions that can be taken to resolve a concern where the organisation might have been at fault in causing some harm. Redress can include a written apology and explanation of what happened, an offer of treatment or rehabilitation to help relieve the problem and/or financial compensation. • Solicitors within Legal and Risk Services (LARS) offer advice and assistance in identifying whether there is a qualifying liability in a concern and provide legal support to quantify the financial recompense and help to obtain independent expert evidence. LARS also maintain the Lexcel accreditation. • NWSSP's Complaints Management Protocol is underpinned by commitment to the delivery of high-quality services to its customers and takes complaints and concerns seriously. We believe in the value of learning from complaints to develop and strengthen our services (as per the Gift of Complaints). o The Protocol is aligned with the requirements of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations (2011); o Putting Things Right arrangements; o Velindre University NHS Trust Handling Complaints Policy; and	All

		o Welsh Government's "Review of Concerns (Complaints) Handling with NHS Wales – "Using the Gift of Complaints" report, which made more than 100 recommendations on strengthening the NHS complaints process. • The Complaints Management Protocol incorporates specific guidance on identifying if a complainant is to be categorised as vexatious and how such complaints are to be managed. It also raises awareness for members of the public on how NWSSP deals with all kinds of complaints, as published on the NWSSP website. • The Complaints section of the website provides information on how to make a complaint and attaches a complaints leaflet. • The Procurement Services directorate also have their own in-house complaints procedure for procurement related issues.	
9	Concerns are reported, acted upon and responded to in an appropriate and timely manner and are handled and investigated openly, effectively and by those appropriately skilled to do so	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • The protocol includes dealing with "issues/early resolution complaints" in the first instance, which empowers staff 'nip concerns in the bud', to ensure swift resolution of any issues arising, at source. • Issues Form devised to ensure lessons learned are captured, in addition to the root cause of concerns. • The process for dealing with Complaints is set out within the Complaints Management Protocol which contains a flow chart to help staff identify the correct process for handling complaints, and includes key timescales for acknowledging and responding, etc. • Our core Complaints Management Team sits within Corporate Services and includes the Corporate Services Manager, Head of Finance and Business Improvement and Corporate Services Project Manager, which hold professional CIPFA qualifications in Corporate Governance, which ensures an appropriately skilled team to triage concerns and manage their investigation with the wider Services and local teams, as appropriate. • NWSSP complies with its own targets for responding to complaint, namely an acknowledgement is issued within 2 working days and we aim to provide a full response within 30 days, where appropriate. Should we have cause to deal with the Coroner's Office, the Public Services Ombudsman for Wales (PSOW) or the Health and Safety Executive (HSE) Information Commissioner's Office (ICO), for example, then we would ensure adherence to their performance targets and professional standards. • Datix and the Once for Wales Concerns Management System also applies to local staff concerns and records incidents and near misses for investigation, e.g. violence and aggression, information security, operational issues, etc.	All
15	Patients, service users and their carers are offered support including	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.):	Managing Director

	advocacy and where appropriate redress	• The Welsh Risk Pool (WRP) within LARS administers the risk pooling arrangement for NHS Wales, for losses and special payments over £25,000. The core functions include: o Reimbursing members for losses in excess of £25,000 upon receipt of confirmation that proportionate action has been taken to learn lessons; o Administering the arrangements for the ongoing payments of claims settled under a periodical payment order; o Undertaking of financial modelling to forecast financial trends in claims against NHS Wales; o Annual assessments of organisational arrangements for the management of Concerns, Claims and their Learning from events; o Assessments of clinical areas considered to be at risk from litigation; o Themed work in respect of high risk areas; o Supporting NHS Wales in the quality and safety agenda through the provision of information, education and training and attendance at National level groups (e.g. National Quality and Safety Forum); and o Provision of a Claims Management function for former Health Authority claims. • WRP work with the Health Boards and Trusts throughout the life of the claim and maintain with staff throughout the management of the concern/case. Both LARS and WRP are proactive in obtaining customer/service user feedback in relation to their work.	
16	Health services are open and honest with people when something goes wrong with their care and treatment	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): • NWSSP are open and transparent in sharing our governance procedures and complaints handling process, with information being available on the website and staff intranet, in an accessible and bilingual format.	Managing Director
17	Appropriate support is provided to health staff and learning and services improve through sharing lessons from local and national reviews	In addition to the above evidence provided (IMTP, Annual Review, EQIIAs, Policies, etc.): NWSSP utilise information gained from national audits and reviews to assist in identifying developments and improvements for NWSSP' services (e.g. Audit Wales publications, Welsh Government publications, Information Commissioner Reports, Public Services Ombudsman for Wales Reports, Future Generations Commissioner Reports, Welsh Language Commissioner Reports, Internal and External Audit Reports.	Managing Director

Self Assessment Rating – Theme 6 - Individual Care					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations /**

	what / where we need to improve	**demonstrate meaningful action.**		**throughout the organisation / business**	**business, and which others can learn from**
Rating				✓	

Theme 7 – Staff and Resources

Standard 7.1 Workforce Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.			
	Sub Criteria	**Evidence**	**Responsible Person within each Directorate**
1	Health services work with partners to develop an appropriately skilled safe and sustainable workforce by: • having effective workforce plans which are integrated with service and financial plans; • meeting the needs of the population served through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language; • promoting the continuous improvement of services through better ways of working; • enabling the supply of trainees, students, newly qualified staff and new recruits and their development; • ensuring plans reflect cross organisational/regional/	People & Organisational Development (POD) In May 2021, the POD service went through several changes, intended to align work more closely to staff by improving the service and support provided to the organisation. In order to be the best at what we do we need to be consistently delivering the best and we will achieve this by working within the NWSSP values which are: • Listening and Learning to constantly improve the quality, effectiveness and efficiency of all we do. • Working Together with colleagues, customers and suppliers. • Taking Responsibility for decisions and making things happen. • Innovating to encourage continuous improvement. Our work will be dedicated to ensuring we are: • An organisation that has great values that are put into practice, and where trust and honesty is implicit in everything we do. • An organisation that learns, one where it is safe to make mistakes, where blame is replaced by opportunity. • An organisation that is adaptable; agile and flexible. • An organisation that cares for, respects and values its people, its customers, and its partners, one where its people, its customers, and its partners feel cared for, respected and valued. • An organisation where everything is aligned to people. People and Organisational Development Plan was developed and launched in conjunction with the IMTP planning cycle. Closely integrated and linked with financial and service plans, as set out in the Annual Plan and IMTP. Case studies of progreThe Plan seeks to define our intention and commitment to become an Employer of Choice. In this, we specified our desire for our people to be engaged, to be connected to and share in our	Director of People & Organisational Development and Employment Services

	all Wales workforce requirements where appropriate.	purpose; to feel enriched, empowered, and inspired; and to feel they are supported and enabled to make a difference for the people of Wales. Having found our purpose and redefined our People and Organisational Development function, we identified seven strategic priorities within our People and Organisational Development plan: 'THIS IS OUR NWSSP: Our People, Our Organisation, Our Plan': *1. Organisational Design* *2. Organisational Development* *3. Resourcing* *4. People Insights and Analytics* *5. Employee Relations* *6. Welsh Language* *7. Service and People Excellence* As the first year of the plan was designed as a discovery phase for each of these areas, 2022-23 will see us design and implement several programmes to support the development of a high-performing organisation, increasing its effectiveness and facilitating personal and organisational growth and well-being. Within each of our strategic priorities, we have aligned our planned work to the Ministerial Priorities and wider programme of the Welsh Government. The support, hard work, dedication and commitment of our staff has been fundamental to the progress that we have achieved in maturing as an organisation. The structure up of the POD directorate includes Business Partnering Team, Organisational Development Team, People Development Team, People Services and Planning Insight Team, Single Lead Employer, Bank and Agency, ESR Support and Digital Workforce. Welsh language is a key priority within the Plan and each vacancy is screened to consider if it should be Welsh essential or desirable in its nature. All job adverts and job descriptions are translated so they are available bilingually, as are all of our communications and publications. Integrated with the Well-being Goals of Wales having a thriving culture and Welsh language, we encourage staff to converse Welsh in the workplace and wider and hold regular Welsh language taster sessions and promote free courses to learn the language. Staff who speak or are learning to speak welsh are provided with a Dysgu badge or lanyard. We also encourage customers and partners to communicate with us in the medium of Welsh and promote this with footers on letters that are issued and email signatures. The Core Skill Training Framework (CSTF) contains a number of mandatory training modules that new starters must undertake for compliance and competency assurance. The modules are required to be undertaken to refresh learning at different intervals	

		between 1 to 3 years. Modules include fire safety, resuscitation, manual handling, information governance, cyber security, safeguarding, infection control, etc, CSTF compliance is monitored through monthly Formal SLG meetings and local team meetings. Personal Development Appraisal Reviews (PADRs) are also reviewed at monthly Formal SLG meetings and local team meetings and the PADR process is linked to staff pay progression and the core values of the organisational, as well as key strategic objectives. The PADR process encourages growth mindset, CPD and further training and education. This process is critical in ensuring that the work objectives of all NWSSP staff are aligned to corporate objectives and NWSSP's Core Values. In addition this process is used to inform an assessment of individual and organisation training and development needs to inform ongoing investment priorities. • To support the reporting of organisational compliance NWSSP uses ESR functionality to provide Managers with Business Intelligence reports which includes: o Number of PADRs conducted o Staff who are compliant with statutory and mandatory requirement o Competencies and professional standards for individual staff The ESR system provides a wealth of learning resources for staff to undertake, which are optional, in addition to the CSTF modules for all levels of the organisation and roles. The People Development function promotes in-house training and advertises a number of free courses and work based learning paths for staff to upskill and further their continuous professional and personal development. We offer a range of learning programmes and development pathways for our leaders, managers and staff. Other sources of evidence to support this Standard include: • Strategies – including Health and Well-being, Recruitment and Retention, etc • Library of workforce policies and corporate policies that underpin the POD function, including All Wales policies, Velindre policies and NWSSP protocols and guidance (e.g. Standards of Behaviour Framework, etc). • Integrated Medium Term Plan • Annual Plan 2022-23 • Annual Review • People and Organisational Development Plan • Welsh Language Awareness • Learning Hub on the intranet • Health and Well-being Centre • SLE model on-boarding	

		• All Wales Collaborative Bank • Digital Workforce Partnership working with the Trades Unions is well established through Local Partnership Forum (LPF) and associated sub groups. NWSSP and its Senior Leadership Group (SLG) work closely with the LPF members on a wide range of corporate and strategic issues. This includes engagement in all aspects of organisational change, reorganisation, restructuring and relocation. Trades Unions are represented on a variety of subgroups established to manage change initiatives. Staff competency for Welsh Language is recorded in the Electronic Staff Record and monitored through the PADR process and reported at NWSSP SLG. Staff are responsible for updating their own personal information within ESR Self-Service. NWSSP is hosted by Velindre University NHS Trust and such is governed by the organisation's employment policies. However, NWSSP has reviewed the Velindre Study Leave Policy and has developed and published a revised protocol that is appropriate for the staff groups employed within NWSSP to ensure equity and access. Mechanisms have been established to ensure that these staff maintain appropriate professional registration and receive appropriate professional support when required. Registrations and DBS are recorded on ESR to ensure compliance visibility. Transactional services have developed a number of performance KPIs which provide information on relative workforce efficiency and performance. Where recruitment and retention challenges exist, service specific strategies continue to be implemented as an ongoing priority including strengthening relationships with local universities, work based degree opportunities and utilisation of bank and agency workers can be used as a short term solution to challenges. The vacancy control process allows an executive review of all posts recruited into NWSSP, and prompts managers to ensure they are reviewing their skill mix and recruitment requirements.	
2	The workforce: • have all necessary recruitment and periodic employment checks and are	Job descriptions are formed and assessed through the Job Evaluation process which details the minimum standard of qualifications, experience, knowledge etc that are required for the post. Recruitment is then undertaken against these requirements. Consistency checking training has also taken place. We operate a CAGE system which provides increased safety from an information governance perspective.	Director of People & Organisational Development and Employment Services

	registered with the relevant bodies; • are appropriately recruited, trained, qualified and competent for the work they undertake; • act, and are treated, in accordance with identified standards and codes of conduct; • The workforce: are able to raise, in confidence without prejudice, concerns over any aspect of service delivery, treatment or management; • are mentored, supervised and supported in the delivery of their role • are dealt with fairly and equitably when their performance causes concern; • are provided with appropriate skills, equipment and support to enable them to meet their responsibilities to consistently high standards	Recruiting Managers are required to undertake the appropriate Recruitment and Selection Training. This training can be accessed via ESR and there is also a suite of guidance that recruiting managers can access on the staff intranet. The Standard Operating Procedure for the safe recruitment and selection of staff has been agreed between NHS Organisations and NWSSP Recruitment Services and it complies with current employment legislation, NHS Employers Pre Employment Check Standards and best practice. The Recruiting Managers' Pack contains important information regarding the recruitment process including Pre Employment Checks. Following interview, offers of employment are conditional and subject to the following pre-employment checks: • Satisfactory references • An Occupational Health Assessment • A Disclosure and Barring Service check (where applicable) • Original essential qualifications (where applicable) • Professional Registration check (where applicable) • Evidence of right to work in the UK • Evidence of identity Recruitment checks are recorded on ESR and can be monitored through the Business Intelligence module of the Electronic Staff Record centrally, by local managers and by staff themselves. At the interview stage, all candidates are required to bring proof of identity and proof of essential qualifications specified in the person specification. The successful candidate will be required to attend a face-to-face pre-employment document check meeting with Recruitment and produce original documentation. Demonstration of CPD is a standard and ongoing requirement for qualified practitioners in any field to maintain membership of their professional body. There are appropriately qualified staff across all functions of NWSSP who hold membership with their professional bodies. Staff are encouraged to maintain their Professional & Technical Register within ESR which reflects the professional standards of the organisation. These include: ▪ Chartered Institute of Purchasing and Supply (CIPS) ▪ Association of Accounting Technicians (AAT) ▪ The Law Society ▪ Chartered Institute of Personnel and Development (CIPD) ▪ Chartered Institute of Internal Auditors ▪ Chartered Institute of Management Accountants ▪ Institute of Healthcare Management (IHM) ▪ Institute of Healthcare Engineering and Estate Management (IHEEM)	Director of Primary Care Services

		▪ Royal Institute of Chartered Surveyors (RICS) ▪ Chartered Institute of Building (CIOB) ▪ Chartered Institution of Building Services Engineers (CIBSE) ▪ Institute of Engineering and Technology (IET) ▪ Royal Institute of British Architects (RIBA) ▪ Chartered Management Institute (CMI) ▪ Institute of Fire Engineers (IFE) ▪ Chartered Institute of Financial Accountants (CIPFA) ▪ Association of Certified Chartered Accountants (ACCA) ▪ The Institute of Chartered Accountants (ICAEW) ▪ General Medical Council (GMC) ▪ Nursing and Midwifery Council (NMC) All staff are required to have an annual Personal Appraisal Development Review to help them understand what is expected of them in their role through honest and constructive feedback on role requirements and individual performance. Agreed work and performance objectives are regularly reviewed and discussed. The NHS Wales Pay Progression policy has been implemented within NWSSP and applies to all members of staff on NHS Terms and Conditions of Service and must be used in conjunction with the PADR/Appraisal principles. The policy sets out the procedure to be followed to deal with annual incremental reviews. To support the implementation of the NHS Wales Pay Progression Policy, NWSSP has developed measurable criteria to form a suite of core organisational objectives which will apply to all NWSSP staff. These core objectives reflect NWSSP's values – Taking Responsibility; Listening and Learning; Working Together and Innovation. Staff also be have work related objectives during their PADR discussions with their line manager. Pay Progression audits have been undertaken on a sample of staff who were due to receive their increments to ensure that the NHS Wales Pay Progression Policy is being adhered to and being implemented fully. The organisation's PADR compliance is recorded and reported on monthly to the SLG and local senior team meetings for each service. This is monitored along with the organisation's core objectives of entering sickness absence in a timely manner and completing statutory and mandatory training. Our Current training provision is vast, continuously improving and includes Business Administration, Business Improvement, Customer Service, Warehousing & Distribution, Team Engagement, Coaching and Mentoring, ILM, IQT, PADR Skills for Managers, People Management Skills, Sickness Absence, Stress Awareness, Mindfulness, etc.	

		All staff are required to undertake the Core Skills Training Framework, the minimum requirement for statutory and mandatory training consisting of ten modules. The Electronic Staff Record (ESR) is used to monitor and manage compliance. When performance concerns arise, the Capability Policy and Procedure is instigated; this promotes the fair and equal treatment of all employees. Formal capability issues are supported and monitored by People and Organisational Development. NWSSP staff are required to comply with the provisions of the employing organisation, Velindre NHS Trust, Standards of Behaviour Framework Policy. Failure to adhere to the requirements could result in disciplinary action. NWSSP is committed to honesty, openness and probity in all its activities. The Raising Concerns (Whistleblowing) Policy provides a framework for raising concerns and provides guidance for staff on how to manage and address particular situations. Staff who have concerns relating to their employment relationship have access to the Grievance Policy and Procedure. This provides for informal and formal resolution on an individual or collective basis. Staff can also raise concerns through their trade union representative. The Local Partnership Forum meets bi-monthly and local representatives are able to feedback to their union so that these concerns can be raised, if appropriate, at Partnership Forum. **'**Hearsay' is a forum designed to give staff the opportunity to escalate any queries or rumours they might have about the NWSSP, how it operates and plans for the future. Queries are responded to within 48 hours. The NWSSP People and Organisational Development 'HR Contact Point' -an email service which provides practical and proactive advice regarding HR issues/concerns for all staff in a timely manner PCS plays a role on assuring professionals (Doctors, Dentists, and Opticians) are assessed prior to being accepted on to Health Board Performers lists. Pharmacist are required to be accredited for providing advanced services and are included in the NWSSP All Wales Pharmacy database.	
3	The workforce is provided with appropriate support to enable them to: • maintain and develop competencies in order to be	In addition to the above evidence (IMTP, Annual Plan and Review, EQIIAs, Policies, etc): PADRs are completed within 3 months of a new starter joining the organisation and each member of staff must complete their PADRs annually. The figures on PADRs are monitored through ESR and by local teams and formally at SLG meetings on a monthly	Director of People & Organisational Development and Employment Services

	developed to their full potential; • attend induction and mandatory training programmes • have an annual appraisal and a personal development plan • develop their role; • demonstrate continuing professional development • access opportunities to develop collaborative practice and team working • work closely together, preventing duplication of effort and enabling more efficient use of resources.	basis. The PADR process is linked to pay progression (NHS Wales Pay Progression Policy) and the organisation's core values and key strategic objectives to ensure that roles are aligned to strategic priorities. A comprehensive training plan has been rolled out across all parts of NWSSP to support staff and managers in undertaking this process. The plan includes: • Understanding the new PADR process awareness sessions • Skill based training for new Managers • Maximising the functionality of ESR • Developing Service areas ESR Champions The Electronic Service Record, Online Learning Management continue to be updated with all PADR records which will allow us to monitor compliance with the target. Managers and staff are also able to access their PADR records through their self service access. The Core Skill Training Framework (CSTF) contains a number of mandatory training modules that new starters must undertake for compliance and competency assurance. The modules are required to be undertaken to refresh learning at different intervals between 1 to 3 years. Modules include fire safety, resuscitation, manual handling, information governance, cyber security, safeguarding, infection control, etc, CSTF compliance is monitored through monthly Formal SLG meetings and local team meetings. In 2014, the NHS Wales Core Competence Framework for Managers and Supervisors was launched. The Framework is a tool that has been designed to help individuals identify the behaviours, skills and knowledge that they need to do their job to the highest standard. The People and Organisational Development team continue to deliver its core skills for managers programmes. The programmes consist of a series of workshops that all managers are required to attend to ensure they have the core skills, competencies and knowledge required to enable them to manage their staff in line with policies, fairly, consistently and effectively and include management behaviours in addition to relevant case studies/scenarios on: • Managing Sickness Absence • Managing Capability • Managing Conflict • Disciplinary • Grievance The implementation of effective engagement strategies for both staff and customers is an ongoing challenge. Participation in the NHS Wales Staff Survey has given us a benchmark to assess and monitor progress against a baseline, in addition to NWSSP issued staff	

		surveys and feedback / suggestions sought from staff, such as the 'you tell us, we did' campaign. Health and well-being is a vital part of the engagement agenda and we have Champions to engage teams locally, working to the Health and Well-being Staff Partnership. There is a wealth of resources and support available to staff on well-being and mental health and this is comprehensively discussed within the Module of Staying Healthy.	

Self Assessment Rating – Theme 7 – Staff and Resources					
Assessment Level	**1** **We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve**	**2** **We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.**	**3** **We are developing plans and processes and can demonstrate progress with some of our key areas for improvement**	**4** **We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business**	**5** **We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from**
Rating				✓	

QUALITY SAFETY & PERFORMANCE COMMITTEE

TRUST BOARD ACCOUNTABILITY CONDITIONS & IMTP 2022/23 QUARTERLY ACTIONS PROGRESS

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	Carl James, Director Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director Strategic Transformation, Planning and Digital

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	Approved

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Govt Review Meeting)

1. SITUATION/BACKGROUND

1.1 The Integrated Medium Term Plan 2022-2025 was approved by the Minister for Health and Social Service in July 2022. Integral to the IMTP was a range of Quarterly Action Plans to further delivery of the Trust's Strategic Aims, covering:

- Cancer Services
- Blood and Transplant Services
- Trust-wide Programmes
- Enabling Support Services

1.2 The approval was followed by a letter to Steve Ham from the Director General and NHS Wales Chief Executive, which set out some general comments regarding expectations regarding the Trust Board's role in the process and a series of Requirements and Accountability Conditions on which the approval was made.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Accountability Conditions have been taken from the Director General and NHS Wales Chief Executive's letter and are set out in the Accountability Conditions Monitoring Document (**Appendix A).** The template outlines, at a high level, the key quarterly actions proposed to ensure full compliance with both the general and the VUNHST specific accountability conditions.

2.2 The General Accountability Conditions include a requirement to provide quarterly progress reports on IMTP Actions for 2022/23 to Trust Board and Welsh Government IQPD monitoring meetings. To this end, IMTP Quarterly Actions Progress Monitoring templates have been prepared for cancer, blood, support services and Trust-wide programme IMTP actions in **Appendices B, C, D and E** respectively.

2.3 The purpose of this paper is for QSP Committee review and agree the proposed ways in which the conditions will be fulfilled in Appendix A and to review the progress updates provided by service leads against their specific IMTP actions for Q1 and Q2 in Appendices B to E.

2.4 The above review will inform the version of this paper and supporting Appendices to be submitted to the November Trust Board.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The QSP Committee is asked to ENDORSE the paper which sets out the progress made in delivering the requirements set out in the Accountability Conditions and the IMTP 2022 – 2025.

Integrated Medium Term Plan 2022 – 2025 Accountability Conditions Letter Monitoring Document

Accountability Conditions (Judith Paget Letter dated 22/07/22)	Quarterly Actions Progress to comply with IMTP Accountability Conditions			
	Q1	Q2	Q3	Q4
General comment from Approval Letter: Expect the Board to scrutinise the plan and that progress is monitored effectively over the forthcoming year, in particular against the Ministerial Priorities set out in the NHS Planning Framework, the Minister's delivery measures and the specific accountability conditions for Velindre NHS Trust	Quarterly monitoring reports via QSP Committee and Trust Board Reports and cover papers to ensure there is explicit clarity on progress against: - Ministerial Priorities - Ministers Delivery Measures - Specific Accountability Conditions	Quarterly monitoring reports via QSP Committee and Trust Board Revised Performance Management framework to track expected outputs and benefits of the IMTP		
General comment from Approval Letter: Where necessary, any risks or challenges that need to be further addressed will need to be discussed and agreed at your Board and communicated to Welsh Government via the routine governance arrangements (e.g., IQPD meetings or quarterly reporting against your IMTP). Where this necessitates any	Routine/regular reporting against IMTP delivery Chair of QSP Committee and Trust Board Chair focused on IMTP delivery. Risks and issues registers routinely discussed and minuted	Regular discussion at IQPD meetings on any emerging risks/issues that are material to delivery of the IMTP Routine/regular reporting against IMTP delivery		

material changes to your IMTP in year will require you to advise me of these changes through an Accountable Officer letter.	– which will be appropriately recorded in the minute. Strategic organisational risks identified/discussed via the Trust Board Assurance Framework at Strategic Planning Committee and Trust Board	Strategic organisational risks identified/discussed via the Trust Board Assurance Framework at Strategic Planning Committee and Trust Board Revised Performance Management framework to track expected outputs and benefits of the IMTP		
General requirement – 'five ways of working and sustainable development It is essential that your organisation continues to build on the progress made to utilise the five ways of working, sustainable development principles, to deliver your integrated plan. The organisation should ensure its well-being objectives are consistent with and continue to be supported by its planning arrangements.	The Well-being of Future Generations Act and 'Five Ways' are the 'golden threads' that run through the Trust's approach. Complete strategic refresh achieved and approved by Trust Board includes: Trust 10 year strategy 'Destination 2032' framed upon the WBFGA. Also includes new	Major service developments and infrastructure planned against the WBFGA and 5 ways of working. Significant examples e.g. Design of new Velindre Cancer Centre (electric hospital; enhanced bio-diversity) achieved through long-term; partnership working. Hefyd community benefits programme e.g. social prescribing		

	sustainability, digital, people and estates strategy	through partnership with Ray of Light; develop local arts strategy; local engagement of school children with tee pee etc Outline business case for refurbishment of Welsh Blood Service Llantrisant – built upon partnership; decarbonisation benefits. Research programme with local universities (PhDs; MSc) generating new evidence on sustainability in infrastructure/design; PROMs/PREMs; social value/prescribing etc		
General requirement – IMTP The IMTP must be published on public facing Trust website.	This action is included in the SOP for the Planning Team.	IMTP updated on website 22nd September		

General requirement – Quarterly progress report on IMTP Action plans to IQPD There should be reporting against the key milestones associated with that quarter, any slippage against the plan, next milestones and the mitigation of any new/emerging risks.	Process in place to provide quarterly updates to EMB and Trust Board which will include escalation of any emerging risks etc.	IMTP 2022/25 Quarterly Progress reports submitted to Welsh Government as part of the Integrated Quality Performance Delivery (IQPD) meetings Chaired by Nick Wood.	Upcoming IQPD meetings with Welsh Govt: • IQPD 4th October – Q1 progress plus early feedback on Q2	IQPD 7th December (TBC) – Q2 and Q3 progress reports
General requirement – Quarterly Minimum Data Set (MDS) refresh The MDS must be refreshed on a quarterly basis.	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies
Cancer Care Services				
a) Demonstrate how key attributes of the quality statement for cancer are being taken forward	D&C modelling undertaken for SACT and treatment planning taskforce established with Improvement plans developed for SACT and RT Constant review of quality of services (quality, safety, experience	Modelling complete SACT/RT initiatives commenced Audit of clinical Harm review SOP in place Contingency plan for Linac upgrade to be developed New linac procured and installation works commenced	RT back in balance Contingency plan in place to support Linac upgrade SACT back in balance	SACT position sustained & to be reflected in IMTP 2023-2026

b) Demonstrate how access to cancer treatment is contributing to achievement of the suspected cancer waiting time target for the region.	QA20 HB monthly ops meetings in place to monitor pathway issues and opportunities for improvement	Group established with CVUHB/CTMUHB to look at lung patient pathway in line with 62-day target. Terms of Ref agreed. Audit undertaken New linac procured and installation works commenced	Continue improvement actions review of lung pathway. Review referral pathway into VCC process to minimise delays for first appointment.	Implement improvements for Q3 review.
c) Demonstrate what mental health support is being provided to patients.	Psychology, Counselling and Supportive Care services already in existence. Health Needs Assessments undertaken. Services include programmes of care for self-management eg fatigue etc. Referral pathways and SOP's in place for referral to specialist services. Range of services to support children including visits to VCC to see treatment areas, bereavement support in conjunction with City Hospice and a range	Ongoing As Q1	Ongoing As Q1	Ongoing As Q1 & to be reflected in IMTP 2023-2026

	of books developed by VCC.			
Workforce				
a) Demonstrate workforce intelligence that has identified key workforce risks and workforce planning that includes actions to address these key risks.	Triangulation of workforce and finance risks approach Workforce risk review on risk register and Trust Assurance Framework risks.	Key workforce risks and issues identified and discussed. Programme of work underway including workforce shape/supply; retention/recruitment Development of OD change programme Building Our Future Together to support workforce well-being and change		
New Velindre Cancer Centre				
a) Demonstrate effective management oversight of the development and transition to the new Velindre Cancer Centre (nVCC), Radiotherapy Satellite Centre (RSC) and Integrated Radiotherapy Solution (IRS).	IRS procurement finalised and transition to implementation began. Transition programme and commenced Transforming Cancer Services Programme Board in place	**IRS** IRS business case awaiting Ministerial approval IRS monthly transition programme board in place **RSC** RSC business case awaiting Ministerial approval	IRS contract signed with successful provider finalised. Links provided to construction teams for nVCC and RSC to begin planning for phase 2 and 3 of IRS implementation. WG approval scheduled for IRS and RSC	Key deliverables and work streams of phase 1 IRS implementation in progress. Maintain links to programme leads of nVCC and RSC. Transforming Cancer Services Programme Board in place

	Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Links with programme leads for nVCC and RSC. **<u>nVCC</u>** nVCC successful bidder identified – financial close target March 2023 Transforming Cancer Services Programme Board in place Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Transforming Cancer Services Programme Board in place Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group

Commissioning					
a) Demonstrate leadership in the further development of the networked clinical model, including the Nuffield recommendations	Continuing to support/service the Cancer Collaborative Leadership Group (CCLG) Good progress made regionally on implementing the Nuffield Trust recommendations;- **Acute oncology** service: phase 1 being delivered. LHBs/Velindre recruitment of posts **V@UHW Research Hub**: initial infrastructure in place and research strategy approved **V@UHW unscheduled care:** pathways revised and various actions taken to enhance quality of delivery **V@outreach**: Operational plans in place to return services across LHBs post covid	Acute oncology service: phase 1 being delivered: launch of cancer of unknown primary (CUP) service and outreach oncology model **V@UHW Research Hub**: tender out to identify partner to develop investment strategy and identify research partners **V@outreach**: Re-scoping of requirements for outreach with CTM /Aneurin Bevan to align strategic cancer developments	CCLG: proposal developed for pilot of whole system approach across 3 tumor sites. On CCLG agenda Nov 2022 meeting		

b) Secure agreement to the new commissioning model for radiotherapy with partner organisations	Complete LHBs approved IRS and RSC business cases			
Finance				
a) Demonstrate action is being taken to mitigate exceptional costs throughout the year.	Finance reports to QSP and Trust Board Trust represented on Energy Price Risk Management Group led by NWSSP	Finance reports to QSP and Trust Board Trust represented on Energy Price Risk Management Group led by NWSSP		
b) Demonstrate action is being taken to mitigate COVID costs throughout the year as the pandemic response continues	Finance reports to QSP and Trust Board Regular divisional finance performance reviews to monitor and manage Covid costs.	Finance reports to QSP and Trust Board Reduction of £0.112m in forecast Covid costs reported in M5		
c) Risks to delivery of saving plan delivery must be reduced to increase confidence in the plan - to be monitored by FDU on a quarterly basis.	Finance reports to QSP and Trust Board Monthly reporting and meetings with FDU in place to review financial position and savings plan.	Finance reports to QSP and Trust Board Monthly reporting and meetings with FDU in place to review financial position and savings plan.		
d) Ensure clear agreements are in place with commissioners to support delivery of COVID recovery and required activity.	LTAs issued to LHBs Monthly meetings in place for Collective Commissioning Group to monitor financial performance of LTAs	LTAs signed by VUNHST and LHBs Monthly meetings in place for Collective Commissioning Group to monitor financial performance of LTAs		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	**1.** SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24)	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led are model for SACT	New nursing staff in post and trained	Commence booking service review.	Task and finish group established with work plan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to be undertaken with a view to releasing SACT capacity.	Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH. Recruitment campaign has been successful. Discussions ongoing with Executive Director of Nursing and Chief Operating Officer regarding workforce plan.	
		Finalise interim facility plan at Neville Hall Hospital.	Work with ABUHB to identify appropriate	Review workforce requirements to support interim service	implement plan to support interim NHH model	Initial accommodation challenges at NHH resulted in a re-focus to expand capacity at PCH. NHH are continuing to explore options which VCC will	Data modelling of geographical flows underway to determine level of demand.	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
			accommodation	model across PCH and NHH		need to consider as fit for purpose. Expansion to either/both is subject to staffing capacity modelling and resourcing.		
		Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing	Implement staffing review agreed actions.	Develop business case for SACT Consultant Nurse/ Pharmacist.		Substantial readiness work undertaken throughout Q1. However, RCC went into liquidation June and therefore objective has to be withdrawn.		

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		Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to include review staffing model and assess workforce options.	Review of booking clerk capacity to be undertaken	Review of nursing capacity to be undertaken review of pharmacy capacity to be undertaken	Review pharmacy capacity to be completed	Task and finish group established with workplan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to be undertaken with a view to releasing SACT capacity.	Performance relative to key performance indicators improving during quarter 2. SACT task and finish group continue to meet, nurse modelling completed, pharmacy review commenced. Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH.	
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain		RCC has gone into liquidation therefore this option is withdrawn Discussions are currently underway with the new		

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				palliative scenarios.		private provider around contrating options for RCC.		
		Begin project to increase Linac capacity to 80 hours (73 currently)	Implement 80 hours Linac capacity	Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4	Linac capacity increased to 75 hours from July. Further expansion to 76 hours planned to take place at beginning of October. Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4.	

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		Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand.	Brachytherapy action plan delivery business case potentially here as will need to follow the action plan from the peer review and workforce review			Peer Review complete and action plan in development.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a maximum of 78 patients per year. Following benchmarking exercise undertaken with the Clatterbridge Cancer Centre a capacity and workforce review and gap analysis of gynae service ahead of the development of a service development business case for submission to WHSSC in late 2022/23.	
		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative			Medical decision required on alternative treatment options trial capacity specifically		

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			treatment approaches			detailed in service capacity plan		
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.				IRS updated paper approved by to Executive Management Board September with plan for first linac replacement. Radiotherapy recruitment complete, medical physics underway	
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical	Programme to review efficiency of existing pathways continues including	Develop standard operating procedures for pathway management, building on	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal	Implement agreed pathway and workforce models developed to meet COSC	Requires VCC wide response linked to demand profile and pathway development. Requires medical leadership and decision making to implement improved ways	Pathway and practice review on a site by site basis progressed (led by Dr Tom Rackley). Process intended to identified and scale good practice/learning, to	

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	treatment developments	reduction in variation in ways of working /action plan developed.	those developed in Lung Pathways and emerging themes/challenges with SST leads.	pathways with SST leads.	target requirements.	of working identified from initial pathway work. This manual data capture to deliver gap analysis. Support commissioned through Improvement Cymru for pathway development/review. VCC actively involved in the Wales Cancer Network Lung cancer pathway review. All Site Specialist Teams (SST's) have now undertaken one deep dive session.	identify and address systemic issues via the Radiotherapy Management Group and other groups. Data analysis undertaken to identify trends in breaches, missed appointments and cancellations to determine areas for improvement. Further support commissioned through Improvement Cymru for pathway development/review. VCC actively involved in the Wales Cancer Network Lung cancer pathway review.	

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							All Site Specialist Teams (SST's) have now undertaken one deep dive session.	
		Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision)	Engage with WHSSC on PRRT service to deliver patient benefit	PRRT business case if able to progress	Finalise business case and Delivery of PRRT plan	Service specification required from WHSSC. Initial WHSSC response to open service Q1 2023.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled to begin in autumn 2022.	

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		Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners remains in place. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy developments prioritisation completed a number of years ago so needs to be reviewed radiotherapy	New quarterly meeting instituted between VCC and WHSSC to review specialist services and inform planning and development work. ToRs of VCC Collective Commissioning Group reviewed and governance and reporting links strengthened. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy	

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							developments prioritisation completed a number of years ago so needs to be reviewed.	
	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre-pandemic work. (interdependent with	The transformation objectives for the SSTs and Outpatient workforce will continue as previously	Deliver transformation programmes- estate, pathways and workforce	Deliver transformation programmes- estate, pathways and workforce	Transformation programme structure in place with reporting into Velindre Futures. A draft high level outpatient work programme has been developed has been discussed with further work progressing on providing more details	SST reviews commenced July and continuing into August 2022. Draft Outpatient Work Programme developed in collaboration with the Medical Directorate. This has been reviewed, feedback provided, plan	

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		radiotherapy projects)	described in quarter 1.			plans. The transformation programme is built upon the National aims and objectives. The programme is interdependent upon all other services.	to be adjusted and submitted for final approval. Performance Management Framework will include National tagrets regarding outpatient services.	
		Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinar						

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		y workforce model.						
		Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing more efficient				**OPD** capacity and demand plan under development. Nursing establishment review completed leading to a review of skill mix leading to advertisement of band 4 apprenticeship nursing roles which is the first of its type at VCC.	**RACH I THINK THIS IS AMBER/RED AS HAVENT SEEN MUCH EVIDENCE OF A ROBUST PLAN ACROSS THE SERVICE**	
						· Upskilling of HCSW's		
						· All trained nurses to complete SACT passport to support the demand for injectables		

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		ways of working						
		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Utilisation of virtual consultations has continued and is firmly embedded in to service, via telephone and video conferencing technology. Virtual group sessions have also been introduced and further extended within the Therapies service. Positive feedback received from Welsh Government on use of virtual technology. Usage data is monitored by the Outpatient Management Group.	Utilisation of virtual consultations has continued and is firmly embedded in to service. Welsh Government refers to Velindre Cancer Centre as an 'exemplar' due the rapid transformation and modernisation of outpatient appointments and group sessions.	

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						Phlebotomy services continues function at an activity rate of an average of 100 patients per day with activity aligned to an increase in SACT. Electronic test requests are completed and issued to patients (excluding patients under Cardiff and Vale University Health Board as Velindre Cancer Centre is contracted to undertake this service) to attend their local primary or secondary care service for pre clinic bloods, however, it is noted that a number of GP practices have refused to complete 'hospital bloods'. The scale of this is under review.	The ratio of face to face/virtual consultations is continually monitored by the Outpatient Management Group.	

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		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient Nursing Team and Reception Staff have implemented extended working hours from 08:00 to 18:00 hours to provide support to meet increased demand. Feedback from the SST deep dives and discussions with the Medical Directorate Manager are underway in respect of demand/request for evening/weekend working without the outpatient department. Weekend working is in place and fully established for phlebotomy during bank holidays. Opportunities to increase activity within the Outpatient Treatment Room are under discussion.	Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department (within the Outpatient Treatment Room). Discussions remain on-going in relation to further opportunities.	
		Provide increased capacity incl. at evenings/week ends to meet demand initially while the more fundamental pathway changes and						

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		ways of working are introduced pending service improvement efficiency delivery.						
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementation of the 'supported self-				Patient pathways under review by each SST and explored during deep dive sessions. The Cancer Centre has commenced a PSA self-management project with the view to extending self-management models across other sites.		

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		management' model						
		Re-commence the pre Covid Outreach Clinics	outreach project group to be reestablished outreach project manager to be appointed	review of data assumptions and workforce requirements to support outreach clinics identification of gaps to support service delivery		Most outreach clinics have been repatriated. The remaining clinics are mainly within Aneurin Bevan University Health Board and have been escalated for resolution.	Engagement with Aneurin Bevan UHB undertaken to address key challenges currently being worked through to progress the return the remaining oncology clinics to Neville Hall and Royal Gwent Hospitals.	

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Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5. Digital Health Care Record (CANISC Replacement)	Finalise development	Testing and training	Commence Go Live Phases– dry run	Review impact of implementation on operational delivery	DHCW have delivered much of the software as outlined in the re-profiled plan. There are elements of the individual developments that require further work. VCC along with colleagues from across the wider NHS Wales Oncology service are continuing to work closely with DHCW to resolve these issues and find a solution that aligned with both national and local requirements.		
		Functional testing	Operational Go Live planning	Dry run weekend planned Complete Go Live	Plan phase 2	All required functional testing has been completed and the data migration plan is on schedule to compete the final sign off in Q3. The		

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		User Acceptance Testing	Go Live readiness assessment	review impact on service delivery and lessons learned		training plan was completed in readiness for the operational review. Implementation and operational readiness planning commenced as planned, these will be refined as the organisation moves toward the go-live scheduled for November 2022.		
			Go Live run through					
		Data Migration	SOP development					
		Operational service change planning						
		Training sign off						
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter.	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	Project team evaluations concluded in April 2022.	Engagement with Varian continued. Negotiation with Elekta to ensure ongoing maintainance of machines undertaken and commitment of expenditure papers developed for	
						Minimum Threshold Scored Questions (MTSQ) and Pricing clarifications		

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						developed by the team, were issued and responses received from bidders were subsequently reviews for final evaluation	consideration by the Trust Board.	
			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Draft Procurement outcome report was developed for mid-April with a Legal review scheduled.		
			Receive vendors detailed implementation plans			Work was ongoing with the team for drafting approvals and to finalise OBC/FBC including agreement of resource for implementation, risk and benefit owners to ensure alignment and a smooth transition from procurement to implementation transition		

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					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Multiple legal reviews for finalisation of the IRS Procurement Outcome Evaluation Report were scheduled and attended by the team. Development of Alcatel report with the legal team for issue to bidders on procurement award outcome was developed for Board approval		
						Issued to bidders following SRO approval in early June		
					Plans for Satellite and nVCC confirmed			
						June		
						IRS Contract development was ongoing with the support of Legal for finalisation of the contract. Meetings were scheduled throughout July & August		

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						to finalise the IRS contract with Varian		
		Appoint Radiation Services Programme Manager to lead implementation and commence design of 1st bunker.	Prepare recruitment of IRS implementation posts.	Recruit to IRS implementation posts		Actions on track managed through IRS Implementation programme Board	Actions on track managed through IRS implementation programme board.	

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		Establish Shadow Implementation Board		Commence formal IRS implementation – shadow implementation board stands up as a formal board.			The shadow IRS implementation board continues to meet with good engagement between the procurement team and the implementation team.	
	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	ANP Lead Nurse has recently completed an Establishment Review of the ANP workforce to ensure appropriate staffing levels and skill mix for the AOS service going forward.	Ongoing recruitment within the ANP team to ensure appropriate staffing levels and skill mix. Dedicated ANP to provide outreach clinical support for teams.	
	8. Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS.	Continue to review the unscheduled care patient pathway aligned to the VCC element of AOS.			Work continues with regional AOS teams to develop robust AOS model. Ongoing work to improve lunchtime AOS meetings with Health Boards. Work also ongoing with service leads to discuss the model	Work being progressed via the Clinical Model Review Group led by Annie Evans. Presentation to the Integrated Care Operational Group by	

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						for Unscheduled care and a VCC Clinical Model Review Group established and action plan developed.	Annie Evans to define next steps.	
		Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity	Immunohematology Service- further pathway work with HBs	Immunohematology Service- grow service delivery	Nursing team and administrator is in post (in line with funding), the 0.2 BI post remains outstanding and has been escalated to Cath O'Brien/Rachel Hennessy for decision.	Immunotherapy Toxicity Service launched early September. Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	
						Modelling of the new service, Standard Operating Procedures, clinical guidelines and the patient IO pathway is under review;	An IO data application (with associated DPIA) has been developed by BI, this has been tested throughout September before handed to Digital;	

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						Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	IO Intranet and Internet page have been set up and are in process of being populated in line with service developments/guidance document sign off;	
						An IO data application (with associated DPIA) has been developed by the Business Intelligence Team. This will be user acceptance tested via the pilot stage – awaiting confirmation that digital will support this App;	A suite of clinical guidelines/pathways has been issued to interested parties for feedback.	
						Scrutiny agreed in July to advertise 3 of the 7 funded Consultants sessions externally:		
						A pilot of the IO service will commence 16th August 2022 to test virtual		

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						scenarios in readiness for proposed launch of service early September 2022.		
		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Recruitment of nursing and therapies staff (bid funded) is complete. The Ambulatory Care Operational Policy and the Weekend Working Standard Operating Procedure have been finalised and proceeding through approval process. Patient Experiences (PREMS) and Patient Outcomes (PROMS) continue to be captured via the CIVICA Patient Experience system, following rollout of handheld devices and the App.	Excellent progress made as defined in quarter 1. All staff now in place and extended days implemented. Sunday opening commenced in July and is working well.	

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						An end-to-end process review of data capture within Integrated care is ongoing with service leads and service improvement to allow for more accurate, consistent and sustainable data capture. RD&I preparing to expedite a Head and Neck Patient Support Unit peer review; Sunday extended hours have commenced. Lessons learnt are being captured as a 'plan, do, study, act cycle in readiness for extension of Saturday hours from August 2022.		
			Deliver requirements of national projects e.g.			As above		

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			Immuno Oncology					
	9. Palliative Care	Review Cancer Associated Thrombosis clinic service: establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of Chronic pain service. Preparing the move from CANISC (no solution yet identified).	Initial meeting to re-establish Cancer and Hospital Acquired Thrombosis Group held. Draft terms of reference developed to progress the finding of the April 2022 All Wales HAT audit.. This will include review of the CAT clinic.	
	10. Key Treatment Development– IMN SABR Lutetium PSMA HDR Brachytherapy	Finalise the priority of implementation of key treatments where external funding is required and agree timescales.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Capacity paper to Executive Management Board in December 2021 confirmed no additional capacity available, and loss of capacity will occur during essential major change programme delivery - DHCR / IRS implementation / RSC / nVCC.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled to begin in autumn 2022.	

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						Risk and Harm impact assessments will be required when extra capacity above core commissioned activity is required to implement to change / amend pathways for new service provision.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a putative maximum of 78 patients per year.	
	Clinical team priorities – gaps in servie therapies access to trials research MDT attendance/cover arrangements							

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		Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Apply 'Just do it' criteria where appropriate for clinical team	Apply 'Just do it' criteria where appropriate		Not applicable no extension / service changes yet agreed through triumvirate risk assessment		
		Finalise the priority of clinical team priorities.	Begin development of implementation plans for clinical team priorities requiring support/wider discussions.	Continue the development of implementation plans for clinical team priorities requiring support/wider discussions.		No response provided		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
	11. Radiotherapy Satellite Centre	Support Strategic case development and review of FBC.	FBC approval- WG implement Arts strategy for RSC operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment project board, project team meetings	operaitonal model delivery plan preparation	Managed through IRS Implementation Board	Managed through IRS Implementation Board	
		Workforce Plan.						
		Finance case.						
		IRS alignment and FBC.						
		FBC scrutiny and approval by service lead and through Boards						

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Not started – interdependency required for radiology demand for pathway changes Treatment pathways requires completion and sign off to assess demand requirement	Commissioning of refurbished MR scanner completed. Fully operational.	

	13. Patient treatment helpline	Implement new handover arrangement into SACT service.	Develop action plan to address issues identified and changes required.	Implement actions identified.	Implement associated workforce or training plans	No response provided	SACT Treatment Helpline handed over to SACT and MM Directorate. Review of why the helpline is currently being accessed towards near end of completion with view of Options appraisal being presented Autumn 2022. Initial work to stabilise the platform for recording calls completed. Further work to be considered in conjuntion with digital teams, including functionality of the telephony system	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.,	Implement any identified telephony systems to allow signposting to all areas.	Roll out new system and ways of working			
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel	Commence establishment of Patient Engagement Hub and Patient Leadership Group	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	New strategy approved Trust Board in May 2022. Final documentation and infographic have been finalised. Funding has been agreed for Patient Engagement Manager which is due to be advertised in late July 2022.	Pilot of new CIVICA engage platform to enable establishment of patient panel to commence autumn 2022.	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Implement patient panel management software programme	Establish initial Patient Engagement activity for Velindre Futures projects				Launch and recruitment plan also for early autumn 2022.	
	15. Establish Primary Care project under Velindre Futures					Task and finish group to be established to scope of project and associated actions. The original IMTP did not include any objectives so will be added retrospectively.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
Strategic Priority 4: To be an international leader in research, development, innovation and education	16. R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case and costs	Establish Governance Arrangements for the Hub.	**<u>Progress the clinical scientist and clinical academic business cases.</u>**	New south-east Wales Prehab2Rehab collaborative group formed. Inugral meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	
						· Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the Velindre Charitable Funds committee and the plan will be to secure match funding by Cardiff University. The business case is currently going through Cardiff University processes.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
						· A number of posts are going through recruitment and selection; these include a Band 8a Senior Nurse (12 months secondment), a Band 6 nurse and a Clinical Research Fellow.	-	
						<u>Business case costing and funding agreements in place.</u>		
						· ECMC, Cardiff's 5year renewal bid to CRUK (2023-2028) was submitted on the 30th June. If successful, the ECMC bid includes some research nurse capacity that will support the research delivery within the Hub.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
						· WCRC's bid was submitted to HCRW for the next 2 years (2023-2025). Included in the bid were Clinical Research Fellows that would support the Hub as well as undertake postgraduate training. Also included were other opportunities to build further collaboration with Cardiff University and VUNHST. WCRC is awaiting initial feedback from HCRW.	-	
						· An approach has been made to HCRW regarding the additional 3.6 WTE posts. Both VUNHST and CVUHB are supplying further information with regard to this request.		

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
						Establish Governance Arrangements for the Hub.		

						The Head of R&D and her team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. Areas of focus will be managing activity coming into the JRO that will be delivered through the hub. The Early project review process, which has been established to manage projects from CU and CV UHB, to undertake an early assessment of their projects by the JRO team to iron out any potential issues in setting up projects continues with VUNHST now contributing to the process development to ensure alignment. The intention is to ensure synergy in a streamlined process to		

						speed up the setup process and expand capacity to deliver contracts more quickly. The Research Governance Groups will move to a joint Research Governance Group within the JRO with Velindre included as required, bringing organisational governance together. This work also includes the development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of Understanding (MOU) between the three organisations. The JRO memorandum of understanding is currently still in draft and between C&VUHB and CU only. Work on this agreement has been on hold pending the appointment of the JRO's new Partnership and		

						Business Development Manager who is expected to join the JRO soon. The Head of R&D and the Senior Research Contracts manager will work with the JRO to ensure that the further development of the MoU will include the Trust's requirements. Work on the Heads of Terms agreement has commenced and it was requested by the Cardiff Cancer Research Hub Project Board at their meeting of 6 July 2022 that this document should be finalised for their next meeting in October 2022.		
						Project Board established to take place in September 2022. Awaiting further detail via the National	-	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
						TrAMS model to better inform potential impact on VCC.		
						VCC Therapies Team are working collaboratively with Health Board partners to progress prehabilitation programme. Participating in newly established South-East Wales Prehab 2 Rehab Collaborative which aims to support a system wide transformation, initiated and delivered closer to the patient's home. Participation within the collaborative will help define the service delivery need for VCC in conjunction with the work happening in our partner organisations.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
	17. TrAMS	Establish VCC programme board and supporting sub groups: - clinical serices model - clinical trials via Trams - workforce and staff impact - finance incl private pt impact	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	A strategic workforce programme group has been established, and this group will work to provide strategic direction to the VCC Senior Leadership Team regarding the workforce modernisation. Much of the initial phase of this work will involve benchmarking with other UK and International Cancer Centres to identify best practice models and ways of working	Project Board established September 2022. national TRAMS Service Model awaited.	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
	18. Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and scope development plan.	Review funding streams and commissioning models to facilitate prehabilitation service development.	Continue participation in regional service	Bring forward proposals for therapies development	Workforce planning owned by service leads review with Health Education Improvement Wales on 'route 2' role extension training planned for September 2022.	New south-east Wales Prehab2Rehab collaborative group formed. Inugral meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	
	19. Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach - 'Stabilise and Modernise' Finalise proposals for revised clinical	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	Network SCP Project Manager leading review of referral pathways with lung cancer National project used as a pilot site.	Value business case to support development of new non-medical outliner roles developed.	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		leadership arrangements.	to 'kick start' the workforce Advanced Practice Radiographers and Therapeutic Radiographers					
	20. Single Cancer Pathway	Focus on front end of the pathway for all tumour sites:	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway:	Commence Action plan implementation.	SCP Project Manager requested to review data and current process with regard to referral management. Work programme and project plan awaited.	Work initaited to focus on earlier part of VCC pathways (MDT management, referrals, initial outpatient appoinments, etc). Work designed to identify and address issues and to inform future work to standardise working practices.	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Aims to Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		Joint improvement project agreed with CTUHB regarding referral management.		
		Timely receipt of all diagnostic test results and treatment pre-requisites prior to MDT.		Identify touch points along pathway and potential bottlenecks		Pathway development required to manage implementation of COSC measures.		
		Improve patient outcomes by early genomic testing where indicated.		Measure how currently delivering against the National Optimal		No response received with regard to genomic project.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Develop training plans		Pathways (NOP)				
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer	21. Engagement with HB's	Agree terms of reference and priorities for joint working with each HB.	Share patient pathway challenges in developing improvement plans.				Monthly meetings established with Cwm Taf Morgannwg, Aneurin Bevan and Cardiff UHBs. Standardised agendas and datasets agreed. Regular discussions around outreach facilities	
		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.					

KEY:

BLUE	Action successfully completed with benefits being realised
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

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	**1.** Develop and introduce Plasma For Fractionation - Medicine Service Model for Wales.	Scope service need. Project group established.	Business case to Welsh Governmen t.	Develop draft service model.	Service model approved.	**Q1** Waiting for Welsh Government to set up program for Plasma for Medicines/Fractionation which will direct the WBS plans for collection. **Q2** UK wide MOU agreed with Welsh Govt - not yet received by Department of Health	
	2. Develop and implement Donor Strategy.	Scope service need. Project structure established. Draft strategy produced.	Consultatio n on strategy.	Implementatio n plan developed.	Implementation of eDRM phase 1 to support delivery of implementation plan.	**Q1** Scoping best practice, developing evidence to support strategy. **Q2** Strategy continues to be under development.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Develop and implement WBMDR strategy.	Scope service need project structure established draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation commence.	**Q1** Workshop completed, formal strategy for service being progressed. **Q2** Strategy for sustained growth and retention of the stem cell donor panel is being progressed. Recovery Plan being developed to support increased bone marrow volunteer recruitment.	
	4. Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose.	Establish project structure review service models to meet need & undertake service/data review in light of COVID and proposed contract variation.	Undertake service/data review in light of COVID and proposed contract variation.	Complete OCP process in relation to service model.	Complete OCP process in relation to service model.	**Q1** Project structure, data review & OCP not yet completed work is ongoing. **Q2** OCP concluded and agreed with union partners – implementation being phased.	
SP2: Meet the patient demand for	**5.** Introduction of 'live connectivity' to allow 'real-time' information	Scope opportunities for digital	Establish technology solutions.	Identify resources to support	Implementation commence.	**Q1** Health Technology Wales report in support of proposal. Business case submitted to WG	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
blood and blood products through faciltiating the most appropriate use across Health organisations	to be shared WBS, laboratories and health board transfusion/clinical teams.	technology to support sharing real time data and transfer of goods between WBS and customers.		implementation.		awaiting final agreement. Will introduce in alignment with LINC programme 2023 – 24. **Q2** Ongoing project in collaboration with Cardiff & Vale HB leading on application to Welsh Government for funding to support electronic blood management system.	
SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services	**6.** Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.	Confirm role of WBS with Welsh Government establish project structure.	Complete OCP process in relation to service mode.	Establish workforce model.	Implementation.	**Q1** Project and T&F groups established and working towards implementation on 30/05/2022. Hep B core testing implemented on 30/05/22. Project group meetings and stock swap out ongoing. **Q2** Stock swap out completed, all blood components in WBS and Health Boards now Hep B core negative. This element of the Hep B Core project is now completed.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						Lookback pathway for patients has been drafted -yet to be agreed at All Wales level	
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	**7.** Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification.	Undertake procurement.	Undertake procurement.	Complete USR procurement.	**Q1** URS in progress. First draft of business case complete and circulated for comment. **Q2** WBS Local Deployment Board established. 9-month delay in design phase of Citadel system. This will have significant impact on the national deployment timelines. Discussions ongoing.	
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	**Q1** Initial Programme Board meeting held 06/06/22, internal project group being formed. **Q2** Project groups in progress.	
SP5: Provide, services that are environmentally	**9.** Establish a quality assurance modernisation programme to develop and	Project to be scoped. Project structure established.	Develop implementation plan.	Take forward implementation.		**Q1** No formal project scope and structure developed to date. **Q2**	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
sustainable and benefit our local communities and Wales	implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology.	Phased work plan.				Tender being prepared for the renewal of the WBS Quality Management System. SMT paper being prepared for the utilising of electronic signatures been approved. Preparation activities including trialling different formats taking place. Presentation made to SMT with a positive feedback, individual departments now being engaged. Formal project plan to be initiated in Q3/Q4.	
	10. Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions.	Submit OBC for Talbot Green infrastructure Project	Procure support to develop FBC.	Appoint Healthcare planner to develop FBC.	FBC submitted to Welsh Government.	**Q1** OBC in development not yet approved. **Q2** Work underway to understand phasing in light of Laboratory Modernisation Programme and Plasma for Medicines and the impacts on this programme.	
SP6: Be a great organisation with great people	**11.** Develop a sustainable workforce model for WBS which provides leadership,	Engagement with teams in relation to review of Clinical	Developme nt of service model paper to be developed	Development of service model paper to be	Implementation plan developed.	**Q1** Delivery plan yet to be developed. SMT training need before creating their workforce plan. Initial plans to meet to be	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
dedicated to improving outcomes for patients and donors.	resilience and succession planning.	Services. Review of Facilities model. Review of BI.	for approval.	developed for approval.		shaped & involve key stakeholders. Plan also dependent on resolving SMT structure, which relies on interim staff being resolved. **Q2** Discussions on this to take place during SMT Away Day. By Q3 a proposed SMT structure following consultation to be in place. New workforce model anticipated to be ready Q1/2 2023.	
	12. Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS.	Scope programme of work. Establish project structure.	Develop implementation plan.	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab.	Funding secured.	**Q1** Project structure in development. **Q2** Work underway to understand alignment of this programme and Talbot Green Infrastructure Programme.	
	13. Lead the All Wales approach to implementation of Welsh Government	Secure funding review structure and develop	Clinical lead appointed. Implementa	Implementation of work plan.	Implementation of work plan.	**Q1** Programme funding has been secured from Welsh Government until March	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	Statement of Intent for Advanced Therapies.	work plan 2022/23.	tion of work plan.			2023. The Programme's structure was reviewed, updated and implemented by the Advanced Therapies Programme Board with the introduction of a more streamlined governance process and two new working groups. **Q2** Advertisement for Clinical Lead took place in August, but the role was not recruited into. Options are being considered. Implementation of the new workplan is currently underway after Programme Board agreement in Q1.	
	14. Support UK Infected Blood Inquiry and delivery of its Terms of Reference.	IBI continues	IBI continues	IBI continues	IBI continues	**Q1** Work ongoing. **Q2** IBI is continuing to hear evidence, which will continue until the end of the year WBS is preparing a final written statement in relation to recommendations and conclusions they would like the Chair of the IBI to consider	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						WBS is working with the other UK Blood Services in relation to the final written statement and recommendations.	

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AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Trust-wide Programmes IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Meeting requirements of the Quality & Engagement Act (2020)	1. Finalise and Implement the Trusts Quality Framework	Finalise the Trust Quality Framework & Gain Board approval. Develop clear implementation plan.	Commence implementation of the framework		Formally review framework implementation	Quality & Safety Framework approved by Board in July 2022. Implementation commenced	
	2. Develop integrated Quality Hubs – Trust wide Hub and two divisional Hubs	Commence Hub development	Establish integrated Quality & Safety Hubs – Corporate/ VCC & WBS Establish Operational Quality	Hubs to be fully operationalised & all Hub members to receive required training	Review formally the functioning of the Hubs & reporting lines	Quality Hub development underway – Corporately, within WBS & VCC	
	3. Establish Core Trust wide Quality & Safety Team that is 'fit to deliver' new legislation	Complete OCP & appoint into posts	Ensure all QS Team members received training & competency assessments	Review Team in line with Duty Quality & Duty Candour statutory guidance requirements		Quality & Safety Team OCP completed and recruitment into posts has commenced	

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	4. Fully implement Duty of Quality requirements	Review Draft Duty of Quality guidance – develop Gap analysis plan	Develop clear Trust wide, divisional & hosted organisation implementation plan	Agree and commence implementing revised Duty of Quality reporting	Implement Duty of Quality requirements in shadow form Ensure all Trust Incident, concerns policies are revised	Quality & Safety Team OCP completed and recruitment into posts has commenced	
	5. Fully implement Duty of Candour requirements	Review Draft Duty of Candour guidance – develop Gap analysis plan	Develop clear Trust wide, divisional & hosted organisation implementation plan	Agree and commence implementing revised Duty of Candour reporting	Implement Duty of Candour requirements in shadow form Ensure all Trust Incident, concerns policies are revised	Quality & Safety Team OCP completed and recruitment into posts has commenced	
	6. Plan for & implement the new Quality Standards (replacing H&CS)			Review the proposed new Quality Standards and undertake a relevance & impact assessment	Develop a Duty of Quality standards implementation plan and reporting mechanism	There are national delays in drafting revised quality standards – alignment to 6 domains of quality and high level mapping only to date – Trust cannot currently plan due to delay	**National delay**

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	7. There are clear service delivery to Board Quality metrics	Clinical quality metrics for the VCC to be determined incl. data definitions and sources to be agreed	How services will assess 'what good looks like' to be determined and required metrics agreed	Commence service level to Board hierarchy quality outcome reporting	Commence implementation of the new Duty of Quality & Candour quality metrics – through robust integrated business systems	Quality metrics for VCC still under development. SST reviews done across VCC to define 'what good looks like'	
Strategic Priority 2: Placing Quality & Experience at the Centre of the organisation	8. Real time patient / donor feedback is captured at source and used in all areas of the Trust	CIVICA to be rolled out within WBS Formal review of VCC implementation to date to be undertaken	Infrastructure to be in place for CIVICA outputs to be reviewed at all level of the Trust and used as an improvement tool	You Said …. We did…. In respect of patient / donor feedback to be in place across all parts of Trust	CIVICA patient engagement system to be implemented	CIVICA implemented within both VCC & WBS – the volume of feedback needs to considerably increase within VCC	
	9. Develop & Implement Trust Quality Management system with integrated learning & improvement	Formal review of Trust improvement capability Undertake targeted work across Divisions regarding the implementation of the learning & action modules in Datix	Plan to be agreed & implemented to address any improvement capability gaps identified	Establish meaningful automated mechanisms for sharing improvements and learning Audit the use of learning & action modules in Datix	Collate and review outcomes of all quality improvement activities	Trust engaging with Improvement Cymru to explore the feasibility of implementing Quality as an organisational design	

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		Q1	**Q2**	**Q3**	**Q4**		
	10. Trust has robust mechanisms in place for capturing patient & Donor outcomes across all services , ensuring learning and improvement mechanisms are in place & appropriately reporting	Review systems and mechanisms in place across all services to capture patient / donor outcomes to develop baseline position. Including how outcomes are recorded, reported and used to inform service developments / changes.		Undertake service benchmarking and national / best practice standards in respect of patient / donor outcome measures.	Formal review of Outcome metrics and reporting to be undertaken. Any gaps across services to be identified and reported to EMB	Infrastructure for PROMS being taken forward through the Trusts Values Based Health Care work – digital solution procured	
Strategic Priority 3: Trust is clinically & scientifically led organisation	11. Robust multi-professional clinical leadership across all areas of the organisation	Review current multi- professional clinical leadership infrastructure make recommendations for any enhancements		Review current clinical leadership development opportunities and develop a clinical leadership pathway		Work well underway	

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	12. Establish a Clinical & Scientific Strategic Board to drive the organisation, lead on values based healthcare, the national clinical plan requirements and the development of the Trust Clinical & Scientific Strategy	Establish Clinical & Scientific Strategy Board with external 'critical friend' support	Agree Values based healthcare priorities and agree implementation plan Agree clinical priorities aligned with national clinical plan		Finalise and have approved the Trust Clinical & Scientific Strategy	Release of resources to facilitate the establishment of the CSSB are under discussion	

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	13. Top of license working with appropriate support & admin infrastructure	Undertake a comprehensive clinical workforce review – expanding on opportunities for enhancing non-registered workforce, clinical apprentices and top of license working within a robust framework of clinical competencies. Embedding workforce resilience across all clinical workforce reviews.					
	14.Optimisation of multi-professional advanced practice	Agree, in line with national advance practice framework a Trust Multi Professional Advanced Practice framework aligned across patient / donor pathways			Develop a clear advanced practice workforce plan (aligned with clinical workforce plan)		

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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Strategic Priority 1: Creating Wider Value: our organisational approach	1. Ensure sustainability is embedded into our organisational conscience and decision-making	Sustainability strategy	Engagement events				
		Partnerships with Future Generations Office		Best practice shared via attendance at All Wales Environmental Management Meetings	Partnerships with industry leads to deliver seminars to staff		
	2. Improve life for people who lives in the communities we serve	Regional Arts Partnership Launched	Inaugural Regional Arts Collaboration Event				
Strategic Priority 2: Sustainable Care Models	3. Improve the environment sustainability of our care pathways			Pharmaceutical packaging return initiatives			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**								
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	4. Maximise the use of technology and digital services to reduce the environmental impact of care	Digital Strategy Launched	Continued use of Attend Anywhere		Addressing Digital Exclusion through outreach	Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery. Attend Anywhere needs further adoption and team are following up with TEC Cymru to explore additional support that can be put in place. On track for Digital Inclusion work in Q4 (Post DH&CR) with support from Digital Communities Wales.	
	5.Collaborate with patients, donors and our partners to deliver models of care that reduce site visits for the provision of care at home		Engagement events promoting our sustainable future		Promote benefits of digital appointments	Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery.	

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	or closer to home						
Strategic Priority 3: Eliminating Carbon	6. Be a Net Zero carbon organisation by 2030	LED lighting upgrades at VCC		Upgrading emergency lighting systems to LED			
		Building Management System Upgrades for all sites	Metering Strategy implementation	Review site optimisation against metering strategy	Refine and review Metering Strategy against progress	Ongoing discussions and planning in line with Decarbonisation Action Plan	
Strategic Priority 4: Sustainable Infrastructure	7. Reduce environment impact of building works during design, refurbish construction,			Talbot Green Full Business Case developed	Talbot Green Full Business Case developed		
				Sustainability guidelines developed for all capital projects			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	operation & decommissioning stages				Radiotherapy Satellite Centre construction		
Strategic Priority 5: Transiton to a Renewable Future	8. Reduce consumption of energy by 70% and reduce water usage year on year	Undertake site optimisation study of Building Management System	Metering Strategy	Target consumption 'hotspots' as identified in the site optimisation & metering strategy	Target consumption 'hotspots' as identified in the site optimisation & metering strategy	Ongoing discussions and planning in line with Decarbonisation Action Plan	
	9. Transition to purchasing 100% of our energy from renewable sources by 2027	Purchasing green electricity					
Strategic Priority 6: Sustainable Use of Resources	10. Reduce our waste by 26% by 2025 and 33% by 2030 aligning with the Welsh Government Beyond Recycling targets	Introduce reusable items in canteen (pending IP & C guidelines)		Review waste at donor clinics and source reusable alternatives			

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	11. Achieve 'zero waste to landfill' by 2025		Introduce recycling schemes for WEEE			Specific WEEE waste stream initiative not implemented in Q2, will be investigated in Q3/4	
	12. Have 70% of our waste recycled by 2025		Recycling campaigns		Recycling campaigns		
Strategic Priority 7: Connecting with Nature	13. Improve the well-being of our patients, donors and staff connection with the	Green Social Prescribing Collaboration	Green Social Prescribing Collaboration				

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	natural environment						
	14. Increase biodiversity by protecting and enhancing natural assets	Reduction of Mowing	Sewing wildflowers		Removal of invasive species		
	15. Maximise the quality and benefits from our green spaces	Install Nature Notices	Nature Walk at Talbot Green		External audit, 3 years after our baseline (as mandated in the Environment (Wales) Act 2015)		
Strategic Priority 8: Greening our Travel and Transport	16.Decarbonise our transport and travel operations	Launch Travel Plan across all sites	Events / Promotion of Travel Plan		All Wales Travel Charter		
			Pilot of Electric Vehicle Fleet at Welsh Blood Service	Electric Vehicle Charging Port at VCC			
	17.Encourage sustainable	Next Bike Reopening and	Cycle Confidence Events held in	Promotion of local cycle routes			

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	and active travel wherever possible seeking to reduce business mileage by 70%	promotional video / communication campaign to relaunch	partnership with Cardiff Council				
			Promotion of 'Park and Stride ,	Departmental competitions		Promotion not taken forward to date – other Travel related initiative introduced included Cycle Confidence / Cycle to Work scheme / Electric Vehicle Fleet Solutions	
	18. Provide more care and services at home or closer to home	Launch of Digital Strategy				Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery.	
Strategic Priority 9: Adapting to Climate Change	19. Assess and understand the impacts of climate change on our services		Create Climate Change Adaption Toolkit		Monitor risk of Climate Change	Research into industry leading Toolkits undertaken.	

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	and communities						
	20. Ensure infrastructure services, procurement activities and local communities are well prepared to mitigate and manage climate change						
Strategic Priority 10: Our people as Agents for Change	21. Support staff to develop the knowledge and skills to improve sustainability	Targeted Environmental Awareness training action plan	Event – NHS Sustainability Day for Action		Promotion of Agile Working and environmental benefits of digital working		

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	at work and home.						
	22. Empower staff to make sustainable choices in the services we provide which improve their well-being	Review and refresh of Sustainability webpages to signpost	Promotional Campaigns	Creation of 'Green Champions'	Regular Communications		
			Well-being Sustainability Pop Up event at WBS	Well-being Sustainability Pop Up event at THQ			
Ministerial Priority - Emissions reported in line with the Welsh Public Sector Net Zero Carbon	23. 16% reduction in carbon emissions by 2025 against the 2018/19 NHS Wales				Monitoring return	Return submitted to Welsh Government for financial year 2021 -22	

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Reporting Approach	baseline position						
Ministerial Priority - Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan	24. Evidence of improvement				Monitoring return	Return submitted to Welsh Government for April – September 2022.	

Value-based Healthcare IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Culture, socialisation and education	1. Develop Strategy & Implementation Framework	• Complete Capacity & Maturity Self-Assessment process & evaluate to inform Strategic priorities & objectives • Engage with staff to understand what value means for them • Develop Communication engagement & training education plan (Velindre Futures & WBS Modernisation) • Patient Engagement policy implemented, for a co-design approach with future work streams	• Engage with staff to understand what value means for them • Use maturity self-assessment and engagement with staff to develop and agree Trust VBHC Strategy & Plans and integrate into Velindre Futures (VF) & WBS service modernisation • Agree strategic priorities & objectives			Actions completed: • VBHC Strategic priorities and implementation plan developed • Exec Directors have completed Capacity & Maturity Self- Assessment process which has been used to identify the strategic priorities & objectives • Initial engagement with Executive Management Board (EMB) and Velindre Futures Board around value • VBHC strategic priorities and objectives agreed by EMB and Board as part of IMTP Actions outstanding: • Wider staff engagement around value as part of the Building Our Future Together Programme • Development and roll out of a value communication and training & education plan	

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	2. Implement Resources & Governance	• Develop & submit bid to WG VBHC fund identifying infrastructure (Project Management, Digital, BI etc) and key areas of value driven service improvement resource requirements				Actions completed: • Successful bid to WG VBHC Fund to establish a Value Intelligence Centre which will include implementation of a PROM collection system (using the National Framework) • Value Intelligence Centre resource to support provision of infrastructure across all SST's to provide a systematic trust wide approach to reviewing Trust clinical pathways against best practice to identify areas of improvement, provide clinical leadership time, provide data to identify unwarranted variation and waste, develop dashboards bringing together activity, clinical audit, resources, PLICS, PROMs data to support value improvement	
	3. People development	• Baseline assessment of capability & expertise and	• Key staff to attend VBHC courses, e.g. Executive	• Principles of VBHC to be communicated well and clearly		Actions completed: • Initial assessment of capability & expertise	

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		key posts identified to support work programme • Develop Communication engagement & training education plan (Velindre Futures & WBS Modernisation)	education, masterclasses or the Mid Wales Bringing Value to Life education course	across the Trust		identified that the Trust had no VBHC capability & expertise. A key aspect of the VBHC bid to WG Value Fund was to enable the Trust to recruit the capability & expertise • A number of Trust staff attended the Hywel Dda VBHC course • Executives have been informed of the availability of the Bringing Value to Life education courses. Two Executives have attended this course Actions outstanding: • Key posts identified to support work programme were included in the successful VBHC funding bid to WG. Recruitment to these posts will be progressed over Q3 & Q4 • A communication engagement & training education plan has not yet been developed. This will be one of the roles of the Head of VBHC post to be	

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						recruited from WG funding for infrastructure. JD developed and recruitment process to commence in Q3	
	4. Active membership of the Value in Health Strategy Group and implementation of key learning from National Programme	• Meet with National Team to discuss and agree Trust priorities and support required • Seek learning from HBs on their VBHC implementation to avoid mistakes / pitfalls how they have overcome data/info gaps • Continue partnership working across SE Wales region to develop whole system pathways, e.g. AOS, prehab				Actions completed: • DoF attends the Value in Health Strategy Group and shares learning within Trust to facilitate implementation where relevant • DDoF attends the Value in Health operational group for areas of learning and seek support from HBs / Trusts that have been implementing VBHC for many years • Trust Directors met with Value in Health Team in August to share its planned approach to VBHC, understand the National Value in Health Strategy around VBHC and agree approach to joint working and priorities for Velindre Trust • Trust has had further meetings and communication with	

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		• Linking in with the Mid/North Wales Network to learn from them				National team seeking support to progress a number of objectives / actions in this plan	
	5. Integrate VBHC principles into existing governance structures internally & externally	• Build culture of Value in way Trust works • Raise awareness of VBHC / Prudent principles through Divisions e.g. Velindre Futures, TCS Programme, Clinical Advisory Group, WBS Lab Modernisation • Highlight VBHC central to recovery plan & National Clinical Framework	• Seek views on and agree strategic priorities & objectives • Through CCLG & HB Cancer Boards reinforce added value of AOS and explore further opportunities to add value across cancer pathways			Actions completed: • VBHC is included as one of the projects with the Trust "Building our Future Together" Programme led by the Chief Executive • The AOS service development agreed with HB's in SE Wales has been used as an example of delivering Value in practice across the cancer pathway • Initial awareness of VBHC / Prudent principles undertaken with EMB & Velindre Futures, but further work required to spread more widely • VBHC principles have been embedded in the ToR of the recently establish Trust Integrated Quality & Safety Group Actions outstanding:	

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						• Recruitment to the Head of VBHC and other infrastructure posts will commence in Q3 & Q4 enabling work to commence to build a culture of Value in way Trust works and carry out further work required to raise awareness of VBHC and prudent healthcare across the Trust to spread more widely	
Strategic Priority 2: Measurement of Outcomes & Cost in a meaningful way	6. VBHC Cancer SST Dashboard Development	• Commencement of the SST transformation programme, with an introduction to the VBHC approach to the SSTs (including 'supported self-management' and scrutiny around patient follow up pathways and review of data requirements,	• Review how the National Lung Dashboard can be used with the Trust	• Commence development of a Trust Lung dashboard bringing together clinical audit data, PROs / PREMs data and patient level cost data	• Commence development of Breast Dashboard	• All the actions to develop Cancer SST Dashboards to provide teams with data to highlight unwarranted clinical variation, waste, pathway inefficiencies etc have been delayed pending the establishment of the VBHC Intelligence Centre team. Recruitment to posts within this team has commenced with the Head of VBHC being a key role to provide the focussed leadership and management necessary to drive forward the VBHC objectives. Alongside recruitment of the posts that the WG VBHC	

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						funding will provide, support is being sought from HB VBHC teams and the National Team as well as consideration of procuring expert support to provide Business Intelligence input in the interim	
	7. Create and connect a digital cancer services community in South East Wales	• Baseline assessment: Survey staff who have direct patient contact to identify PROM & PREM data collection and assess the proportion of data that is patient identifiable • Ensure patient engagement plans include improving digital literacy, access and engagement on PROMs • Engaged in national	• Develop plan to digitise existing data collection into data Warehouse • Urology SST PROMs data which will be expanded and included in data Warehouse to enable use across the Trust on value assessment	• Implement pilot for patient portal included in IRS procurement (PROMs & PREMs data collection)	• Collection of PROMs & PREMs for Radiotherapy patients via IRS patient portal	Actions completed: • Shared specification for PROM software procured as part of the IRS with the Nation Value in Health Digital lead for assessment against National specification • PhD Student currently producing baseline of PROM collection across the Trust and assessment of proportion of patient identifiable data. Main area of collection is using My Health Record software in Urology SST for prostate patients as a pilot Actions outstanding: • Once the additional VBHC infrastructure staff are recruited into BI & Digital work to digitise existing	

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		procurement for Prom Collection				PROM collection into the Trust data warehouse can commence as well as roll out of the use of My Health Online into other SST's • Need to liaise with patient engagement leads to ensure plans include improving digital literacy, access and engagement on PROMs • The implementation of the patient portal pilot procured as part of the IRS are identified for Q3 & Q4, but this will be dependent on the available resources from Varian the IRS supplier according to the detailed implementation plan for the IRS and recruitment by the Trust into the VBHC infrastructure posts	
	8. Allocation and distribution of resources in order to maximise outcomes	Scope work required to map costs to pathways for each cancer area / SST	• Engage with clinical teams on cost - share patient level costing data with each SST • Develop a plan for integration of PLCS/New warehouse			• All the actions to review and realign the allocation and distribution of resources to maximise outcomes have been delayed pending the establishment of the VBHC Intelligence Centre team. Recruitment to posts within this team has commenced with the Head of VBHC	

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			costing system to automate costing of pathways against outcomes. • Develop plan for PROMS/PREMS to the whole costed pathway • Engagement with clinical teams where costs of pathways and treatments are not already available or require updating			being a key role to provide the focussed leadership and management necessary to drive forward the VBHC objectives.	
	10. Commissioning for outcomes	• Benchmark against the NHS England specialist commissioning outcomes for cancer for a baseline assessment and to identify early opportunities.	Working with National VBHC Programme Scope out project for planning and commissioning for cancer outcomes	Start work with clinicians & commissioners to develop a contracting framework that funds based on outcomes		Actions completed: • Fed into the National Funds Flow group about undertaking an assessment of approaches to inclusion of outcomes as part of the payments mechanism in LTAs between commissioners and providers. The National Group will consider commissioning for outcomes as part of their overall remit	

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		• Participate in procurement of an All Wales benchmarking tool to ensure it includes cancer services.				• Trust Cancer services are included in the benchmarking tool procured by the FDU from KPMG . Actions outstanding: • Work with clinicians to agree outcome measures for a contracting framework will commence once the VBHC infrastructure team is recruited and the work form the National Funds Flow Group has been shared	
Strategic Priority 3: Prudent Healthcare & Service Prioritisation	11. VCC: USC / Acute oncology service & outpatient improvement	• Commence On-site & virtual oncology support to HBs • Commence MUP/CUP clinic • Commence Toxicity Clinic (SDEC bid) • Finalise the Unscheduled Care pathways with the 3 LHB • Commence phase 2 of the 24/7 Helpline Transformation	• Develop plans to establish a 24/7 critical care outreach service at VCC to improve pathways and reduce need for urgent transfer of patients to HBs • Integration, enhancement & expansion of access to Ambulatory care services (SDEC bid)			Actions completed: • Enhanced AOS commenced with on-site & virtual oncology in HBs • MUP/CIP clinic commenced • Toxicity Clinic commenced • Integration, enhancement and expansion of the Ambulatory Care services has been commenced Actions outstanding: • USC pathway work with three main HBs remains ongoing • Phase 2 of helpline transformation not yet commenced as will require	

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		– triaging of patients to the 'right place. First time. • Continue with the Outpatient modernisation / Transformation programme, review of SST pathways, maximising digital opportunities				support from the VBHC team wants recruited • Review of SST clinical pathways has commenced as part of the SST Deep Dive reviews, however detailed work will commence once the VBHC Infrastructure team are recruited to support the work	
	12. VCC: Radiotherapy service improvement	• Submit business cases to Commissioners for investment in prioritised list of new RT techniques • Commence Radiotherapy workforce modernisation and 'fit for the future' planning	• Commence Implementation of new radiotherapy techniques as per prioritisation list (if funded)	• Increase proportions of IMRT/VMAT (3D Plans) • implementation of new IRS – equipment upgrades and new Software for existing fleet @ VCC • Working with IRS supplier commence changes to workflow, automated planning	Consider options for introduction of further accelerated pathways: ▪ trials with reduced fractionation ▪ treat patients with best practice waiting times	Actions completed: • Cases for RT priorities submitted to commissioners and are being discussed through commissioners group • Proportion of 3D planning has increased and implementation of the IRS will enable further opportunity for 3D planning • Hyperfractionation (reduced fractions at higher dose) has been implemented for breast and some prostate treatment Actions outstanding:	

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		Q1	**Q2**	**Q3**	**Q4**		
						• IRS implantation has been delayed since the actions within the IMTP were developed so the RT workflow work with the IRS supplier is now anticipated to commence in 23-24 •	
	13. VCC:SACT service improvement	• Review 3year capacity plans for best value options between internal & outsourced are maximised • Resource work to progress agreement on TCS outreach service model infrastructure • Evaluate options of a 'Velindre Medicines at Home' service model • Commence workforce planning and modernisation	• Review SACT treatment algorithms / pathways to ensure standardised approach audited against NICE recommendations & benchmarked with other cancer certes • Review how work Trust is involved in on Genomics can be used for new drugs.	• Review of the impact of immunotherapy agents on activity and patient flow and recommend pathways changes for improvement	• Develop a plan to produce a Genomics dataset to aid review of SACT NICE drug use and assist in clinical trial matching	Actions completed: • Work undertaken within SACT service to map out processes and available capacity based on staff time and skills to meet workload demand. This work has identified areas of improvement that will add value. • Outsourced capacity through the Rutherford Cancer Centre not an option since the company went into liquidation. Additional internal capacity has been created in Prince Charles Hospital outreach facility at significantly better value • Discussions ongoing with AB UHB around the re-establishment of outreach SACT capacity at Nevill Hall	

Value-based Healthcare IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverable/ Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		– includes links Cancer SST				• Discussions with HB's around longer term approach to TCS SACT outreach service model has recommenced Actions outstanding: • All the other actions identified are on hold pending the recruitment of the VBHC infrastructure team which will review and reset realistic timescales and prioritise areas of greatest value	
	14. WBS: Lab modernisation Programme	• Commence work to agree value adding outcomes of Lab Modernisation				• Laboratory Services Modernisation Programme established within WBS that has been established to review and develop service processes, practices, and workforce requirements to support an efficient and effective service model across all laboratories in WBS. • OBC for capital investment to improve the WBS estates infrastructure as an enabler to the service modernisation	

Value-based Healthcare IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
						is being finalised for submission to WG.	
	15. Implement prudent healthcare principles	• Engage with clinical teams around prudent healthcare to reduce unwarranted variation, activity of limited value, and prioritise standardisation of best practice • Include this within the Cancer SST Transformation 'deep dives and opportunities for pathway refinement e.g. ceasing any follow up	Seek clinical agreement to adopt ICHOMs Standards for non-surgical oncology: Lung, Breast, Advanced & Localised Prostate, and Colorectal	• SSTs review & and formally adopt • SST develop plans for implementation of standard	SSTs commence implementation of standards	• This work has been delayed pending recruitment of the Head of VBHC and other posts that will create a Value Intelligence Centre to provide the information to clinical teams around unwarranted variation, activity of limited value and potential clinical pathway improvement to best practice	
	16. Implement a prioritisation process	• This will be included as part of the Cancer SST transformation programme	• Agree a robust, transparent and data driven prioritisation process to make it clear why choices are			• Initial work commenced to shape an invest / dis-investment prioritisation process based on data demonstrating value i.e. resources consumed relative to outcomes	

Value-based Healthcare IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
		and the 'deep-dives'.	made across all levels in VUNHST				
Ministerial Priority - Report detailing evidence of NHS Wales embedding Value Based Health and Care within organisational strategic plans and decision making processes	17.Evidence of activity undertaken to embed a Value Based Health Care approach				Monitoring return	• Separate return provided on 20th Sep 2022 covering 1 Apr '22 – 31 Aug '22	
Ministerial Priority - Agency spend as a percentage of the total pay bill	18. 12 month reduction trend	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	• Separate return provided on 20th Sep 2022 covering 1 Apr '22 – 31 Aug '22	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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Strategic Priority 1: ***The Trust will drive forward the implementation of its Cancer Research and Development Ambitions***	The implementation of immediate term plan for the Cardiff Cancer Research Hub (a tri-partite development between the Trust, Cardiff & Vale UHB and Cardiff University) to use existing Cardiff & Vale UHB facilities for intermediate to high-risk research studies that cannot be delivered at Velindre Cancer Centre.				Complete the implementation of the immediate term plan (first 18 months) for the Cardiff Cancer Research Hub that utilises existing C&V UHB facilities.	**Cardiff Cancer Research Hub** • The shared cancer research priorities have been agreed by all Tripartite partners. These priorities act as the building blocks of the Hub, providing a clear direction when applying for grants and developing further partnerships. • Delay in identifying the infrastructure requirements for the Hub which is being addressed with C&VUHB and VUNHST colleagues • A number of posts are going through recruitment and selection; these include a Band 8a Senior Nurse (12 months secondment) due to start November 2022, and a Band 6 nurse and a Clinical Research Fellow.	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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						Governance Arrangements for Cardiff Cancer Research Hub • The Head of R&D and the R&D team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. • Areas of focus are: 1. Managing activity coming into the JRO that will be delivered through the hub. 2. The development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of Understanding (MOU) between the three organisations. 3. The Head of R&D and the Senior Research Contracts manager are working with the JRO to ensure that the further development of the MoU will include the Trust's requirements. Work on the Heads of Terms agreement	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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						has commenced is expected to be discussed at the next Cardiff Cancer Research Hub Project Board meeting.	
	The development and implementation of the intermediate term plan for the Cardiff Cancer Research Hub to provide a focal point and facility for delivering intermediate to high risk research studies, translational research and allow opportunities for education and training.					Expected to Complete the implementation of the intermediate term plan (following 30 months) for the Cardiff Cancer Research Hub, in 2024/25. The Trust has gone out to tender to commission and Investment Strategy for the Hub on behalf of the Tripartite partners. We are awaiting results of this tender	
	Establish Clinical Academic posts in cancer research to strengthen our			One post appointed		**Clinical Academic Post** • Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the Velindre Charitable Funds committee	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**								
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	links with Academic Partners and enable translational research					and the plan will be to secure match funding by Cardiff University. The business case is current going through Cardiff University processes. • Discussions are ongoing regarding additional Clinical academic posts in partnership with funding the Wales Cancer Research Centre and Cardiff University.		
	Maximise R&D&I opportunities in radiotherapy associated with the development of nVCC and the radiotherapy research bunker				Ongoing/ continuous	**IRS Radiotherapy Bunker** • A Radiotherapy R&D Group has been established to oversee activities and membership will include all key internal stakeholders. • The group will consider and prioritise all proposals for submission to the IRS Joint R&D Committee that will be formed, in partnership with Varian, post contract signature. **Radiotherapy Research** A group has been set-up to discuss capacity issues in the core Radiotherapy service and the impact on radiotherapy research. The aim is to define the issues and identify possible		

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
						solutions. The group includes senior colleagues from medical physics, radiography, and medics	
	Further investment in the capacity and capability to support multi-disciplinary research to ensure that the Trust can grow its capacity to deliver clinical research to patients.		Identify the local clinical support services that require further investment in capacity and capability to support research	Develop a plan defining the future investment in capacity and capability to support research.	Initiate a programme of investment in capacity and capability of local clinical support services to provide resource to research studies.	**Nursing and Allied Health Professional & Clinical Scientist's Research** • RD&I Database under development, to capture all research and innovation conducted by Nurses, AHPs, and Clinical Scientists. • Aimed at Nurses, AHPs, and Clinical Scientists a RD&I staff survey is in development with the aim of ascertaining a baseline of the research and innovation projects that are being conducted across VUNHST, identifying RD&I understanding and educational needs. **Training and Education** • The team are developing a 'Dragons Den' workshop for an upcoming Velindre Nurse conference to be held in March 2023. The workshop will address a specific research proposal and the panel will raise questions to highlight areas	

Research Development & Innovation IMTP Strategic Priorities Service Delivery Framework 2022/23							
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						researchers need to address such as governance and ethics.	
Strategic Priority 2: ***The Trust will maximise the RD&I ambitions of the Welsh Blood Service.***	WBS will continue to grow the RD&I opportunities partnerships to realise the significant potential of Component Development Lab.				Ongoing/ continuous		
Strategic Priority 3: ***The Trust will implement the Velindre Innovation Plan.***	©Velindre Innovation Plan will be Implemented	New RIIC guidelines implemented		Innovation MDT established and linked to the Cardiff MDT	Core Team Established	**Research, Innovation, Improvement and Coordination (RIIC)** • New guidelines for the RIIC hubs were published in March by the Welsh Government. The team at Welsh Government, after wide consultation changed the very broad focus of the RIIC hubs to clearly supporting innovation infrastructures. Also moving away from networking to delivering collaborative innovation projects with significant	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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						outcomes for patients. The new hubs would be Regional Innovation Coordination Hubs (RICH). The implementation has been completed after discussion across key areas of the service and within the RD&I team. This resulted in the submission of the RICH plan and funding of £75k for 2022/23, to the Innovation Team in the Welsh Government.	
Strategic Priority 4: *The Trust will maximise collaborative opportunities locally, nationally and internationall y*	Formalise the Cardiff Cancer Research Hub partnership					Expected to complete the establishment of an MOU/Heads of Terms arrangement with partners to facilitate partnership working in the Tripartite Cardiff Cancer Research Hub in 2023/24. Current progress is described in "Governance Arrangements for Cardiff Cancer Research Hub" under **Strategic Priority 1: *The Trust will drive forward the implementation of its Cancer Research and Development Ambitions***	

Research Development & Innovation IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	Maximise R&D opportunities at the Velindre satellite unit at Nevill Hall Hospital				Ongoing/ continuous	Expected to complete the development of a plan to maximise research, development & innovation opportunities in radiotherapy associated with the radiotherapy satellite unit at Nevill Hall Hospital in 2023/24.	
	Development & implementation of "Velindre@" Programme, with research facilities at Aneurin Bevan UHB, Cwm Taf Morgannwg UHB, as well as within the Cardiff Cancer Research Hub at CV UHB, forming a South East Wales research network increasing opportunities for donors/patients to access research studies across the region.				Complete the development of "Velindre@" Programme implementation plan.	**Velindre @ Programme** Dialogue around building on research opportunities continues between VUNHST and ABUHB with a key meeting scheduled on November 2022, where increasing trial activity and developing collaborative working will be discussed.	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**								
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<u>Cross-cutting themes across Strategic Priorities 1-4 above</u>	Implementation of programmes, complementing existing training opportunities that enable and support Trust staff to develop, deliver and manage research portfolios.			Review of existing training opportunities to develop an implementation plan for a complementary programme Trust staff to develop & deliver research		**Training Programme & Opportunities** Work continues to identify existing training and develop an implementation plan to ensure the Trust can provide/promote a staff training programme for research & development		
	Further investment in the research delivery and governance teams to make sure that studies are optimised to facilitate effective and timely recruitment and delivery.	Continue the development and implementation of staffing plans for the research delivery and governance teams (identified in 2021/22) to facilitate timely recruitment	Complete the appointment of senior staff in the research delivery team and to support the delivery of the Cardiff Cancer Research Hub	Complete the implementation of changes to the structure of the research delivery team administrative structure.		**Reorganisation of Trust Research Delivery team** • Work continues on plans to improve/change the administrative structure, roles and responsibilities of the research delivery team is ongoing with support from Trust Workforce & Organisational Development, as appropriate.		
	The development and implementation of clinical information systems to identify donors/patients eligible to take		Complete the R&D contribution to the Trust's implementation of the Digital Health & Care Record in line with the Trust's project schedule.		Complete a review of clinical information systems available (in conjunction with partner stakeholders, i.e. DHCW and HCRW)	**Delivery of the Digital Health and Care Record system** • The R&D delivery staff continue to support the Trust's Digital Health and Care Record development programme. Although delayed the system is expected to go live in November 2022. Staff		

Research Development & Innovation IMTP Strategic Priorities Service Delivery Framework 2022/23								
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	part in research studies.				to identify research study participants.	continue to contribute to the design of the dataset for the capture of research study data in line with regulatory body and study Sponsor requirements.		

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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Implementation of an Enhanced Acute Oncology Service in South East Wales	Implementation of MUO/CUP Service	Recruitment process for MUO/CUP nurse and AOS Co-ordinator MUO/CUP service governance and SOP structures developed	MUO/CUP nurse and AOS Co-ordinator in post MUO/CUP clinic and MDT to commence	MDT Service Review	MDT Service Review	MUO /CUP nurse appointed and in post. AOS co-ordinator due to be appointed in quarter 4. MUO / CUP service to open for referrals on 7th November 2022. First MUO / COP scheduled for 17th November 2022. First MUO / CUP service scheduled for 21st November 2022.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	Enhanced Digital Services to Support AOS	Recruitment of Regional posts	Regional development of data capture t	Ongoing Digital Developments		Recruitment of regional digital posts completed and due to start in quarter 3. Data capture moved to quarter 3.	
	Specialist Oncology Support Within Health Boards	Task & Finish Group implemented to support the PSDA pilot of virtual morning support for LHB's.	Ongoing review of virtual support via T&F group			Task and finish group established and meeting on a regular basis. Enhanced virtual lunchtime sessions implemented. Full implementation now planned for quarter 4.	
	AB & CTM Specialist Oncology/Recruitment	AB to support the development of 7 specialist oncology sessions (2/7 to be filled) AB CNS Recruitment process to start CTM Implementation plan to commence	3/7 of AB specialist oncology sessions to be filled AB CNS recruitment to be completed 2/6 of CTM specialist oncology sessions to be filled	5/7 of AB specialist oncology sessions to be filled 4/6 of CTM specialist oncology sessions to be filled	7/7 of AB specialist oncology sessions to be filled 6/6 of CTM specialist oncology sessions to be filled	ABUHB have requested a revised model, which prioritises virtual support due to the number of sites from which they operate. These will commence in quarter 3. Implementation at CTMUHB has been delayed. However, joint meetings have been implementation to develop mitigating actions and a revised plan.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	CAV Specialist Oncology	2/5 of specialist oncology sessions to be filled	3/5 of specialist oncology sessions to be filled	4/5 of specialist oncology sessions to be filled	5/5 of specialist oncology sessions to be filled	1 additional oncology session has been filled. A plan has been developed to provide 2 more additional oncology sessions in December 2022. A plan has been developed to provide the final 2 additional oncology sessions.	
	Recruitment – CAV	All local CAV positions fully recruited and in post (CNS, AHP's, Admin) Confirmation of AOS clinical sessions in CAV being secured	CAV clinical sessions to be in post.			AHPs (excl 0.5 WTE) in post. CNS to be in post during quarter 3. Clinical sessions recruited.	
	Hot Clinic - CAV	Twice weekly Hot Clinics held at UHW and UHL to commence.	Review of hot clinics and development as per available outpatient space	Ongoing service review and development	Ongoing service review and development	Review currently being undertaken in line with agreed actions.	
	AB Ambulatory Clinics	Planning for AB ambulatory hot clinics to commence	Local ambulatory clinics to commence at Royal Gwent	Ongoing service review and development	Ongoing service review and development	An Implementation Board has been established. However, there have been challenges in recruitment	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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						which has resulted in delays to full implementation.	
Implementation of an Enhanced Unscheduled Care Service in South East Wales	Agreed model of care for acutely unwell patients and those requiring unscheduled care	Agreed model of care including pathways, acceptance criteria, facilities and workforce model for acutely unwell patients and those requiring unscheduled care		Joint operational clinical guideline for unscheduled care	Agreed shared key performance metrics to monitor and manage the quality of the service	A model of care has been developed. However, it has yet to be agreed and approved by both organisations. This is now planned for quarter 3.	
		Finalisation implementation guidance	Service review	Service review	Service Audit	As the model of care has yet to be agreed it has not been possible to proceed with this action.	
	Shared key performance metrics to monitor and manage the quality of the service	Finalisation and implementation of performance metrics	Service review	Service review	Service Audit	As the model of care has yet to be agreed it has not been possible to proceed with this action.	
	Patient experience survey	Patient focus group	Ongoing collection of data	Ongoing collection of data	Ongoing collection of data	It has been agreed between C&VUHB and VUNHST to revise this action.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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						A joint meeting has been held and it has been agreed to collect data from quarter 4.	
Implementation of a Tripartite Cancer Research Hub	Implement Phase 1 of the Clinical Service Model	Clinical Model and Service Specification approved by tripartite partners	Funding strategy developed & approved by tripartite partners	Full implementation of Phase 1 completed	Benefits realised for South East Wales Cancer patients	Clinical Model and Service Specification approved by tripartite partners. Funding strategy initiated and seeking external support to complete. This will mean that this action will not be completed until quarter 3. In parallel a business case to support the required investment will be developed in quarter 3.	
	Implementation of Phase 2 of the Clinical Service Model			Phase 2 capital and revenue requirements agreed with tripartite partners	Phase 2 Business Case approved by tripartite partners	Phase 2 business case cannot be completed until phase 1 business case has been implemented. Phase 2 business case re-profiled for submission in quarter 1 2023 / 2024.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	Implement Phase 3 of the Clinical Service Model					Not applicable – no actions required during 2022 / 2023.	
Development of Enhances Haemato-oncology Services in South-East Wales	Implement agreed Haemato-oncology Service Model in South-East Wales	Agree shared pathways for Haemato-oncology patients in South East Wales	Development of acceptance criteria and clinical pathways	Agreed performance metrics to monitor quality of the service Agreed workforce and operational model across South East Wales	Implementation of agreed Haemato-oncology service in South East Wales	Model yet to be agreed between Velindre and Health Boards. In response joint workshops have been organised between all parties with a revised action plan due to be agreed in quarter 3.	
Ministerial Priority - Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational	Delivery of Foundational Economy initiatives and/or evidence of improvements in decision making process				Monitoring return	Not applicable – no action required until quarter 4.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
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Economy in Health and Social Services 2021-22 Programme							

KEY:

BLUE	Action successfully completed with benefits being realised
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

Support Services Functions IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

Digital IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	Utilise digital technology to reduce unnecessary workload and risk through improving efficiency and reducing waste (transition to cloud-hosted services).				Scoping exercise to identify potential candidates for transition to cloud platform.	Digital Strategy approved and Digital Programme being established for delivery. Cloud-first is now the assumption for new digital systems. On track to identify candidates in Q4.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	Enhance existing Trust-wide telephony infrastructure to support current and emerging service needs, to include replacement of existing call centre software.				Scoping Procurement Deployment	On track with plans for Q4 to introduce SIP Telephony into VCC, and a common call recording platform Trust wide.	
	Explore opportunities to utilise AI / machine / automation learning to support business processes.				Establishment of PoCs / pilots. Commence set up of RPA service.	Robotic Process Automation pilot is being scoped and looking to re-use examples from other HBs with Finance being the pilot area. AI / Machine learning will follow in Q4 as part of the Digital programme following the DH&CR rollout in Q3.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
	Develop 'digital first' culture across VUNHST, through development of workforce capability and digital literacy.					Digital Strategy approved and Digital Programme being established for delivery, including the Digital Organisation theme. Delivery approach and timescales needs to be agreed alongside other Trust priorities. Continued engagement with Digital Communities Wales for digital inclusion activities.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
	Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach.					Staff education programme is in place as part of mandatory training plans. Phishing simulation is actively used and results reported as Trust KPI. Cyber Security technical controls continue to be strengthened although technical debt will still be present in the infrastructure for a considerable period. Global supply chain is currently impacted for security devices (e.g. firewalls) causing delays in introducing technical controls.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	Establish a platform, through which Velindre staff and patient/donor-facing services can be accessed.				Establish development platform / approach.	Digital Strategy approved and Digital Programme being established for delivery which includes patient/donor apps. We are contributing to the Digital Services for Patients and Public (DSPP) programme as the entry point for Donors and Patients. Commitment for our services to be available needs to be established with the programme. PSA tracker app to be launched in Q3	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Create income-generation opportunities through the deployment of VUNHST-developed applications / digital services to other organisations.		WBS Appts. System (NIBTS, HCRW).		Explore other income-generation options.	Proposal for providing the WBS Appointments system for NIBTS has been scoped and planned for Q3. On track for wider review in Q4.	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Wellbeing	Empower staff to maintain their physical and mental wellbeing in line with an agreed Health and Wellbeing Framework as developed by the Healthy and Engaged Steering Group	Review/renew information available supporting mental and physical health and wellbeing Provide information and training in holding wellbeing and attendance conversations Incorporate HEIW health and wellbeing framework into VUNHST approach and agree framework for 2022-23	Involve staff in developing peer support network, building on Mental Health First Aid skills Involve staff in the agile working project to achieve relevant work/life balance arrangements	Offer flexible career opportunities to meet changing needs Review usage of VCC and WBS wellbeing rooms and resources	Measure progress with health and wellbeing using NHS Staff Survey and listening events	New pages launched on the intranet setting out information to support mental and physical health and wellbeing. Information issued on holding wellbeing and attendance conversations. Training being developed for delivery in Autumn 2022. HEIW HWB website is embedded in VUNHST approach. Mental Health First Aiders meet regularly as a network and are working with the Staff Psychologist to develop peer support. Agile Working Project has two staff engagement session in October 2022.	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	VUNHST develops its compassionate, values-led culture where staff are empowered, involved and engaged.	Embark on a 12 month project refreshing and embedding a positive and relevant code of values for the Trust.	Continue with Values project	Continue with Values project	Measure progress with Values project and move to next stage	The Values project has been approved by EMB and is now part of the Building our Future Together work. Culture and Values interviews have taken place with Board members. Staff surveys to be launched. Summary report due in December	
	Promote a culture of true inclusivity, fairness and equity across the workforce.	Agree an Equality, Diversity and Inclusion plan and a Welsh Language Plan for 2022-23 Develop metrics to track progress of plans. Develop a plan to ensure compliance with Welsh Government Race Equality Action and LGBTQ+ Action Plans	Focus on addressing pay gaps across protected characteristics Establish mechanisms for staff to speak up and be heard	Grow networks and groups for staff to be actively involved in develop an inclusive, bi-lingual culture	Reflect on feedback from staff survey and ask staff what is important for 2023-24	Plan for ED&I is part of the agenda for the Healthy and Engaged Steering Group. This needs to be drawn out as a standalone document. Plan for Welsh Language is drawn from the Quarterly RAG rating against the Welsh Language Standard. Actions are taken by WBS, VCC and Corporate into three individual action plans. The Trust has established a steering group to develop the action plan for Anti-racist Wales which will be submitted in December 2022. Guidance has not yet emerged from Welsh Government	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
						regarding the LGBTQ+ action plan. The Gender Pay Gap for 2022 has been measured and discussed at EMB and LPF. A more detailed action plan is currently in development, including the use of staff networks. Work in Confidence has been re-launched and advertised as a means of speaking up. The Trust is working with partners on devising an All Wales approach to Speaking Up.	
Supply and Shape/Attraction and Retention	Develop effective people plans having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence	Further embed our workforce planning process and toolkit Review hard to fill roles ensuring robust recruitment and retention plans	MDT training pathways mapped to maximise opportunities for transformation Ongoing management of Apprenticeships, Graduate trainees	Introduction of Physicians Associate roles Introduction of the Delegation Frameworks	Review and evaluate plans to ensure delivery	MDT Deep dives have been undertaken in Divisional areas to assess service models. Workforce modelling tool purchased to model future workforce – example workforce models to be discussed in October. Apprenticeship strategy agreed and active promotion of apprenticeship in place and targeted at hotspot areas of	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	based care and support patient and donor wellbeing					recruitments. Linking with University and HEIW to support graduate training schemes	
Education and Learning	Develop a competent, capable and caring workforce	Assurance of safety through 85% compliance on Statutory and Mandatory Training Refocus the Education and Training Steering Group to promote the objectives of the People Strategy and launch a Training and Development	Working with HEIW, maintain provision of the Trust Inspire Management Programme. Further develop follow-on activities that are flexible and support 'just for me, just in time' development	Utilise the NHS Staff Survey to improve digital literacy across the workforce. Re-launch the Virtual Reality education projects, in collaboration with Swansea University to provide virtual reality fire training to improve compliance	Conduct evaluation of the Training and Development plan including satisfaction, learning and application to the workplace.	Stat and Mandatory training is closely monitored and action taken where figures dip below 85%. The Education and Training Steering Group has been refocused around the Education Strategy and the People Strategy. The Training Plan has been drafted. Inspire has continued to be offered in line with demand (now in its 5th cohort). Other development options are regularly discussed on a 'just for me, just in time' basis	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		plan owned by stakeholders throughout the Trust					
Leadership and Succession	Provide effective leadership development	Undertake a baseline review and evaluation of current leadership offers Ongoing provision of bespoke offers, in liaison with HEIW	Produce an options appraisal on leadership development for the Trust	Build on our partnerships in academia and Health Education and Improvement Wales to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses		An evaluation of Inspire is underway and a review of leadership development is taking place as part of Building our Future Together. This will outline the leadership development options for the Trust.	
	Promote a coaching culture at all levels to encourage compassionate leadership behaviour	Undertake a baseline review of skills, capabilities and activity across the Trust	Develop a coaching and mentoring network in the Trust Deliver skills development for potential coaches and mentors, line managers and all staff	Link the Trust network with All Wales networks and external bodies, as relevant. Create culture of continuous learning.		Data relating to coaches and mentors is being collated to understand the skills and capabilities we hold. Links have been made with other Health Boards for reciprocal coaching as and when required	
	Establish a Talent Management process to spot and	Contribute to the HEIW Talent Management Programme, April to July 2022	Apply next steps in HEIW programme	Review appraisal and recruitment to make space for talent management discussions	Encourage staff to identify their personal and professional aspirations and	VUNHST fully participated in the HEIW Talent Management Programme. The learning from this programme is being	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		Q1	**Q2**	**Q3**	**Q4**		
	manage talent at all levels	Undertake HEIW diagnostic of organisation readiness for Talent Management process			take control of their careers	reviewed for applying to Trust practices.	
Ministerial Priority - Overall staff engagement score	Annual improvement				Monitoring return	• The Healthy and Engaged Steering Group has been established with an Executive Lead to drive improvements in health, wellbeing and inclusion. This brings together Divisional and professional leads to develop strategies to improve working lives. There is an annual work plan	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						linked to the People Strategy. • The values and culture of the organisation are being reviewed within the Building Our Future Together work to create positive and constructive working conditions for all. • A new Wellbeing Hub opened in Velindre Cancer Centre in May 2022 offering support to staff from all areas of the Trust. • A Staff Psychologist is coming into post	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						in September 2022 to develop a culture of psychological health and wellbeing across the Trust. • The Work in Confidence platform is in place for staff to raise concerns anonymously. • Staff communications have improved with the weekly newsletter being supplemented by News and Events on the new intranet from June 2022. • An Agile Working Group has	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						developed principles for Hybrid Working and will be establishing processes and practices that balance employee and service requirements. This group has undertaken a number of wellbeing engagement sessions to understand the impact of home working on individuals. • Executive Equality Ambassadors established for all	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						protected characteristics.	
Ministerial Priority - Percentage of staff who report that their line manager takes a positive interest in their health and well-being	Annual improvement				Monitoring return	• Listening events with leadership and management teams have taken place regarding health and wellbeing. • The wellbeing focus within our leadership and management development programme has been increased.	
Ministerial Priority - Percentage compliance for all completed level 1 competencies of the Core Skills and	Target 85%	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Compliance met Monthly reporting and assurance via Executive Management Board	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		Q1	**Q2**	**Q3**	**Q4**		
Training Framework by organisation							
Ministerial Priority - Percentage of sickness absence rate of staff	12 Month Reduction Trend	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Sickness rates above 6% A range of health and wellbeing interventions in place and promoted through the Trust and in areas of high sickness Data triangulation utilised to understand reason for low compliance WOD working with management to establish an improvement trajectory in areas on high absence	
Ministerial Priority - Percentage headcount by organisation who have had a Personal Appraisal	Target 85%	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Compliance circa 65% Plans in place in areas of low compliance Data triangulation utilised to understand reason for low compliance WOD working with management to establish an	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
Development Review (PADR)/medical appraisal previous 12 months (including doctors and dentists in training						improvement trajectory in areas on non-compliance	

Estates IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Safe and High Quality Estate	Address IP&C Related Concerns raised through Audit.	Prioritise Action Plan	Tender Works	Delivery	Delivery	Closed out.	

Estates IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Maintain compliance with HTM and legislation, Estates Action Plan	Prioritise Action Plan	Tender Works	Delivery	Delivery	Action Plan complete, a high percentages of actions have been closed out. Change is approach to manage these outputs through the various Safety Groups (Vent, Water, Electric, IP&C, Med gas). Reports issued to Quarterly H&S Board	
	Complete works identified under fire safety	Commence PFP Works Continue with Fire door replacement Continue Emergency Lighting Installation Conduct fire damper tender	Complete Fire door replacement Complete Emergency lighting Complete works	Complete PFP Works	Review	Compartmentation remedial works at VCC commenced in September 2022 with scheduled completion by December 2022. Compartmentation works for WBS HQ will follow with scheduled completion by March 2023. Fire door replacement work at VCC underway with scheduled completion by March 2023. Fire door replacement works at WBS to commence and continue in tandem with scheduled completion by March 2023.	

Estates **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						Emergency lighting has been procured with installation programme due to commence all works to be completed by end of January	
Healthy Buildings and Healthier People	Deploy new technologies working with SES to improve air quality	Research	Trail	Evaluate	Issue paper to EMB	This work has stalled due to resource requirements to manage works. Estates Recruitment to be completed Q3, this will be picked up and actioned.	
	FF Ward Ventilation	Develop Board paper	Commence Design	Complete Design	Tender	Paper to be submitted to September Board. Recommendation to proceed with a revised solution.	
	Decoration Plan to address areas below cat B	Compile prioritised List of Area	Tender works 2022/23	Delivery	Delivery	Plan complete, finance required to support	
Minimise our Impact	Target reduction in Utility	Develop metering strategy	Metering Strategy implementation	Review site optimisation against metering strategy	Refine and review Metering Strategy against progress	Application for funding to WG BMS Metering almost complete	
	Be a Net Zero carbon	LED lighting upgrades at VCC		Upgrading emergency lighting systems to LED	insert text	Slight delay to project due to funding reallocation to	

Estates **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
	organisation by 2030	Building Management System Upgrades for all sites				support IRS. Construction due to commence Q3 Building Management System Upgrades complete optimisation of controls ongoing to be completed end Q3	
	Reduce the environmental impact of building works during design, refurbish construction, operation and decommissioning stages	Update standard tender small works documentation to include sustainable option appraisal	Implement and monitor	Talbot Green Full Business Case developed Sustainability guidelines developed for all capital projects	Talbot Green Full Business Case developed	Estates annex complete. This process has highlighted the need to revisit delivery of works as outlined in the PBC works underway to update documentation All tendered works both major and minor include a 15 % weighting to assess sustainability as standard	
Using our Estate to Deliver the Maximum Benefit and Social Value	Achieved through new build programme						

Estates IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables /Objectives	Key Specific Actions and 2022/25 Timescales				Quarterly Progress Update for Q 1 & 2	Progress Rating
		2022/23					
		Q1	Q2	Q3	Q4		
to the Community							

KEY:

BLUE	Action successfully completed with benefits being realised
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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

QUALITY, SAFETY & PERFORMANCE COMMITTEE ANNUAL EFFECTIVENESS SURVEY

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science & Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
~	~	~

1. INTRODUCTION / SITUATION

Like other healthcare organisations across the UK managing many short and long term risks, Velindre University NHS Trust is required to be resilient and agile to a number of challenging pressures, as the Trust continues to provide essential services against the ongoing backdrop and response to COVID 19. This has created an environment where the Quality, Safety & Performance Committee is operating in a highly challenging context, and needs to be dynamic and responsive to the changing risk profiles and demands of the organisation. This also provides an opportunity to identify how it can most proactively work on behalf of and with the Board.

Within this context, the Committee's Annual Effectiveness Survey, provides a tool for the Quality, Safety & Performance Committee to assess its effectiveness against more than just the basic requirements: it provides the opportunity to seek aspects of good practice to give the Committee and the Board greater confidence and assurance on how it can best meet the requirements of its role.

This report provides the Committee with the results of the effectiveness survey and the Committee is asked to:

a. **DISCUSS & REVIEW** the results of the Quality, Safety & Performance Committee Annual Effectiveness Survey (November 2021 – October 2022).
b. AGREE what actions should be taken, including areas of prioritisation and timescales for delivery**.**

2. BACKGROUND

In September 2020, the Trust Board approved a new Board & Committee model resulting in the move from a top line nine committee model to a five committee model. Amongst a number of key changes, the revised model resulted in the establishment of a newly formed Quality, Safety and Performance Committee, encompassing the remit of the previous:

- Quality & Safety Committee
- Workforce & Organisational Development Committee
- Planning & Performance Committee
- Digital & Information Governance Committee

A key aim of the new Quality, Safety & Performance Committee was to bring information together across a number of key areas to enable the integration of, quality, safety and

performance reporting, together with finance, digital and workforce, facilitating more effective oversight and holistic assessment of work being undertaken across the Trust, to triangulate information and promote enhanced scrutiny and assurance.

The Quality, Safety & Performance Committee's inaugural business cycle concluded on the 31st October 2021. As part of the Committee's ongoing commitment to continuous review and improvement and its key role in the development and monitoring of the Quality, Safety & Performance governance and assurance framework, it reported on the results of its first Annual Effectiveness Survey in November 2021. The results of this survey are attached in ***Appendix 1***, together with the results of this year's Annual Effectiveness Survey, to provide a clear and transparent baseline and enable a full assessment of how the Committee has continued to develop and evolve as it matures following the conclusion of its second year of operation.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Quality, Safety & Performance Committee Annual Effectiveness Survey Methodology

The Quality, Safety & Performance Committee Annual Effectiveness Survey (November 2021 – October 2022) consisted of nineteen questions administered via an online survey platform. The survey questions from the Committee's first reporting year were retained (with the inclusion of one additional question i.e. Q.19 ref. ***Appendix 1***), to provide a clear benchmark for performance. The questions were designed and selected to gain valuable feedback and harness the opinion of both '**Members'** and **'Regular Attendees',** to ascertain their views with respect to the Committee's second year of operation.

All questions were posed in a structured format with survey respondents invited to provide a reason / supporting comments for each question. The questionnaire was designed to require respondents to answer each question before enabling them to progress onto the next question. No personal data was collected in the completion of the survey questionnaire; hence, all responses are anonymised.

3.2 Findings

16 people were asked to complete the survey and 12 responses were received, giving an overall completion rate of 75%. The full survey results are reported in ***Appendix 1.*** Following a review of the findings a number of key themes have emerged including:

- Need for ongoing continual review of the Committee Cycle of Business to ensure clear alignment with the Trust risk based priorities, enable focused discussion across the breadth of the Committee's remit, adapt time allocated for discussion of each agenda item in an agile way and facilitate effective governance and assurance arrangements by the Committee on behalf of the Board.
- Establish clear protocol and guidelines on how reports should be presented during Committee meetings.
- Increase overall compliance with deadlines set across all Committee papers received to ensure and enable the 7 day pre-meeting publication deadline.
- The quality of papers received is improving, however overall quality and level of detail requires further development to support effective reporting and engineer more effective triangulation for the effective operation of the Committee.
- Clearer utilisation of the Consent Agenda to support the effective operation of the Committee.
- Need to strengthen Business Intelligence arrangements underpinning Committee reporting across the Trust.
- Clear evidence of increased transparency in reporting through the year with significantly reduced Private (Part B) Committee meetings.

The key themes outlined above, together with the results of the overall findings reported in ***Appendix 1,*** will help inform and reinforce key areas of focus for the coming year and a number of actions to be taken, including areas of prioritisation and timescales for delivery, as set out in ***Appendix 2.***

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

a. **DISCUSS & REVIEW** the results of the Quality, Safety & Performance Committee Annual Effectiveness Survey (November 2021 – October 2022) outlined in ***Appendix 1***.

b. AGREE what actions should be taken, including areas of prioritisation and timescales for delivery outlined in ***Appendix 2*****.**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1:

Quality, Safety & Performance Committee Annual Effectiveness Survey

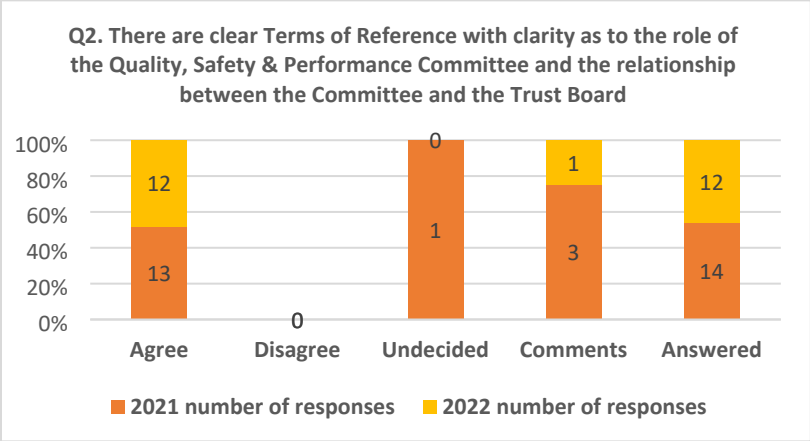
(November 2021 – October 2022)

Survey question 1

Question 1 asked survey respondents to indicate if they were a **'Member'** of the Quality, Safety & Performance Committee i.e. Independent Member or a **'Regular Attendee'** of the Committee.

In both 2021 and 2022 100% i.e. all 4 '**Members**' responded to the survey. In the Committee's first year of operation, there were a total of 16 **'Regular Attendees'**. This included representatives of independent and partnership organisations and our regulators including, Healthcare Inspectorate Wales, Audit Wales and the Community Health Council. 10 **'Regular Attendees'** responded to the survey in the Committee's first year, providing an overall response rate of 62.5% by the Committee's **'Regular Attendees'**. In the Committee's second year of operation there were a total of 12 '**Regular Attendees**', 8 of whom responded to the survey, providing an overall response rate of 66.6% by the Committee's '**Regular Attendees**'.

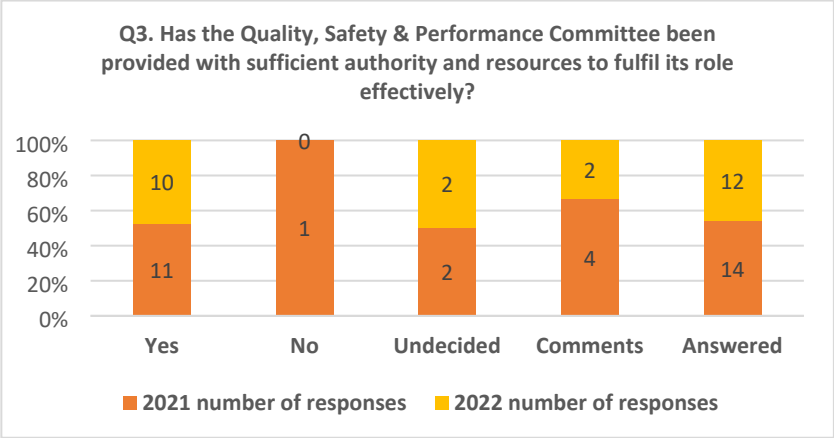
Survey question 2



In 2021, 14 responses were received, 92.86% (13) of the responses agreed and none disagreed, 7.14% (1) was undecided and 3 made further comments on the question, while in 2022, 12 responses were received, 100% of the responses agreed none disagreed and 1 comment was made.

COMMENTS 2022	
1	Recently updated as far as I'm aware.

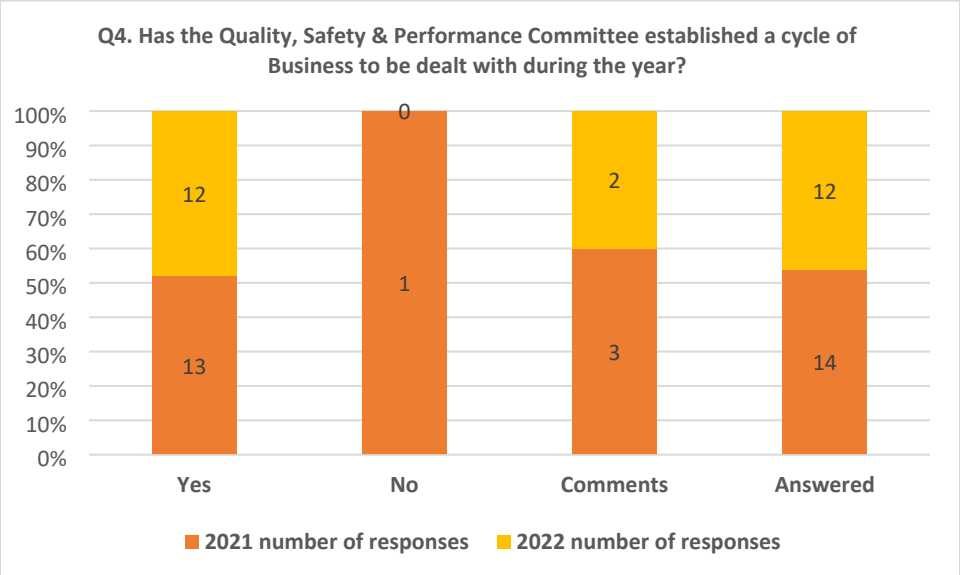
Survey question 3



In 2021, 14 responses were received, 78.57% (11) answered affirmatively, 7.14% (1) disagreed, 14.29% (2) were undecided, and 4 comments were made, while in 2022, 12 responses were received, 83.33% (10) were affirmative, none disagreed but 16.67% (2) were undecided and 2 comments were made.

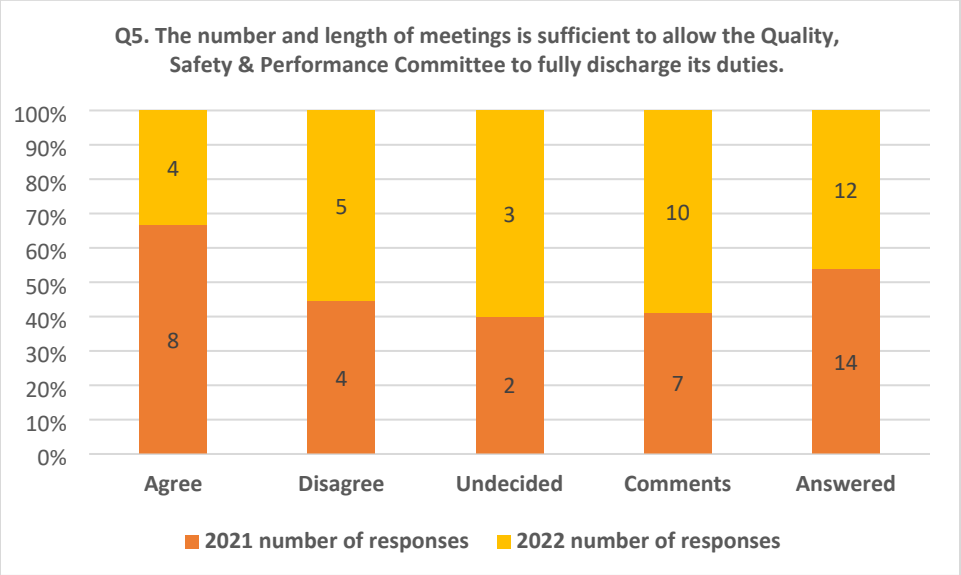
COMMENTS 2022	
1	It's not clear what its authority is.
2	Unable to comment.

Survey question 4



In 2021, 14 responses were received, 92.86% (13) answered in agreement, 7.14% (1) disagreed and 3 comments were made while in 2022, 12 responses were received, 100% answered in agreement and 2 comments were made one of which however indicated that they were unsure.	
COMMENTS 2022	
1	I am unsure.
2	The cycle of business had been established but is being reviewed again to ensure the risk -based priorities are escalated onto the cycle of business and some based on levels of assurance de-escalated into less frequent basis. The requirements of the Health and Social Care Act will be a key influencer on the cycle of business and the formation of Quality Hubs a key influence on the evidence required in papers and again influence the cycle of business as we go forwards.

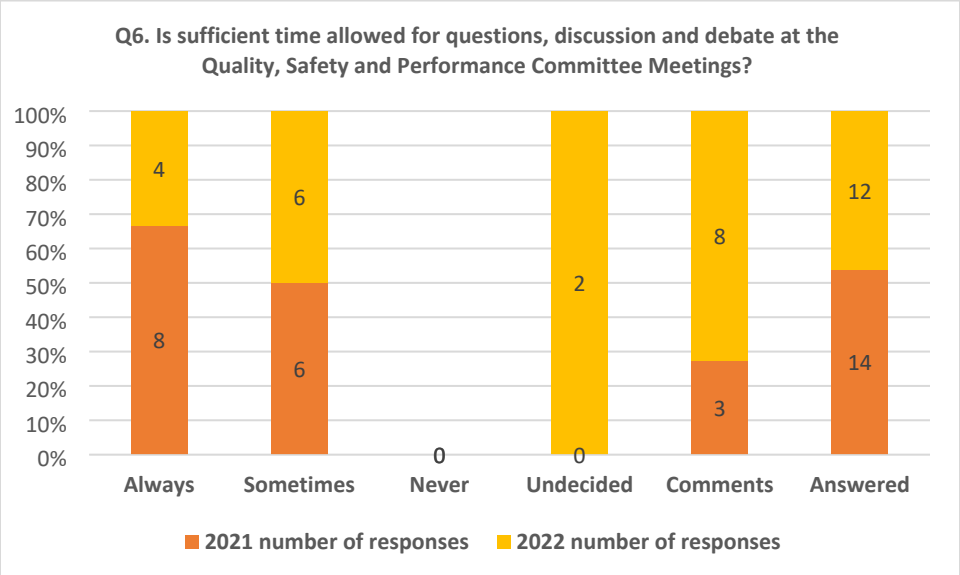
Survey question 5



In 2021, 14 responses were received, 57.14% (8) answered in agreement, 28.57% (4) disagreed, 14.29% (2) were undecided and 7 comments were received, while in 2022, a total of 12 responses were received, 33.3% (4) were in agreement, 41.67% (5) disagreed, 25% (3) were undecided and a total of 10 comments were received.	
COMMENTS 2022	
1	The agendas are very full and sometimes one feels that more time could be spent on certain items - I'm not sure, for example, that we have adequate time to get adequate assurance of where we are with the Future Generations Act.
2	Some of the reports presented are extremely detailed and lengthy. This means that meetings can over-run and some papers towards the end of the meetings do not get the scrutiny they deserve. Clear expectations are needed around the content, level of detail and length of reports, to ensure that there is sufficient time in the meeting to scrutinise and provide assurance.
3	The meetings are too long and requires too much detailed information.
4	Generally, agree with the statement in terms of frequency. In terms of discharging its functions the agenda is detailed and there is a lot of papers to digest.
5	The business of the Committee is vast (possibly too much breadth/depth). This results in the meetings being too long generally.
6	The breadth of the areas the QSP Committee is responsible for makes it difficult to fully discharge its duties within the no. of meetings. Some of this risk is mitigated through additional assurance IMs gain through other meetings with Officers.
7	There are too many items for the length of meetings, meaning some important issues get rushed most meetings.

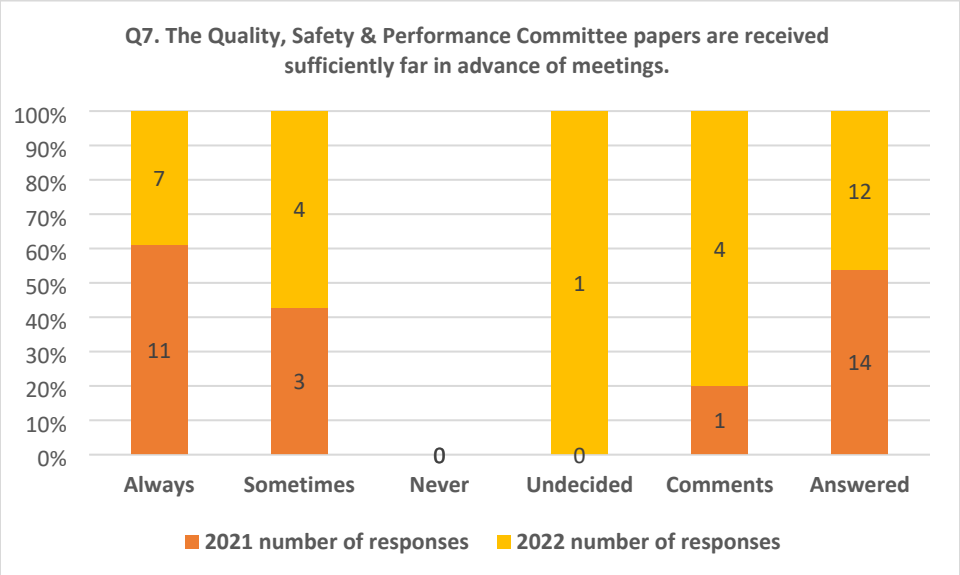
8	The presentation of papers can be too lengthy. Papers are read in advance and therefore little presentation required. Time should be allocated to discussion, debate, challenge, and decision making. Papers need to be more succinct and written with a clear purpose in mind.
9	The key issue for the Committee is how it is able to discharge its duties with the range of issues it is required to cover. There remains a risk that within the time constraints and frequency of the meetings that issues are missed from papers or the discussion in the need to cover the agenda. This is not helped by the lack of infrastructure sitting underneath QSP, so I know this will change over the next few months. The issue of the quality of the narrative needing to change (in papers) in order to enable the Committee members to discuss the key salient points, understand the risks and actions being taken to mitigate those risks and timescales required is key. The agenda items/ CoB will be influenced by the Quality Hub considerations going forward and then more succinct and salient papers will enable clear discussion going forward.
10	The potential areas to be covered under this agenda is too broad.

Survey question 6



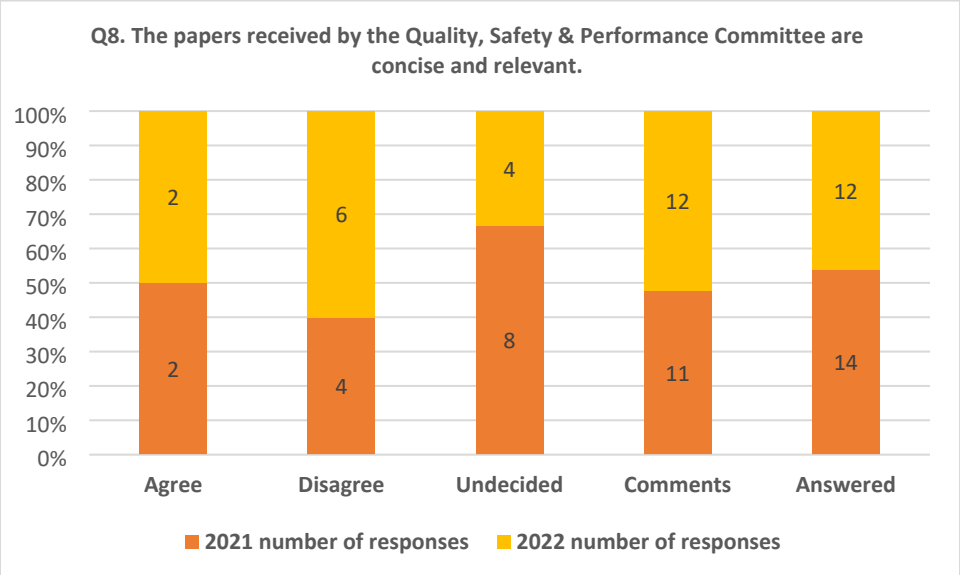
In 2021, 14 people responded, 57.14% (8) agreed with the question, 42.86% (6) believed sufficient time is allowed sometimes, none disagreed, and 3 comments were received, while in 2022, 12 responses were received, 33.33% (4) were in agreement this was always the case, 50% (6) felt this was sometimes the case, 16.67% (2) were undecided and a total of 8 comments were received.	
COMMENTS 2022	
1	Some items could come to the Committee more often, but because of the busy agenda they don't come as often as they might.
2	See above response to question 5, where meetings have tended to overrun, discussion and debate can have occasionally been curtailed.
3	The patient/donor story is very important but doesn't receive as much time and attention as it could.
4	Discussion and debate are encouraged and positive. The difficulty is the size of the agenda doesn't always allow for discussion / can be tight.
5	As per comment regarding the number and length of meetings it is difficult given the breadth of areas the Committee is responsible for to always devote sufficient time to each agenda item.
6	Previous comment to question 5 applies - sometimes things are rushed.
7	This sometimes results in the Committee overrunning due to time also afforded to talk through papers.
8	Whilst recognising the response to the previous question 5, then all members and attendees are provided with sufficient time for questions and debate.

Survey question 7



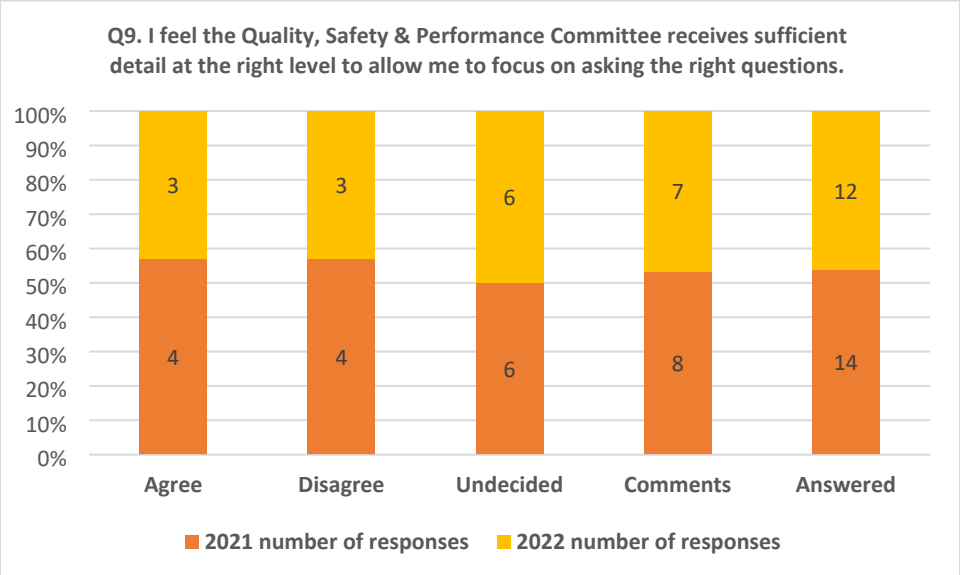
In 2021, 14 responded, 78.57% (11) agreed that papers are received in advance of meetings, 21.43% (3) said sometimes, and only 1 comment was received, while in 2022, 12 responses came in, 58.33% (7) agreed, 33.33% (4) disagreed, 8.33% (1) was undecided and 4 comments were made.	
COMMENTS 2022	
1	I don't receive the papers so am unsure.
2	Timetable for delivery can be a challenge, but cycle of business/reporting etc. appear to be getting better.
3	Some are, and some come much later than the "week before" deadline.
4	There have been some variances to the 7 day provision of papers but most of the time these are provided on time.

Survey question 8



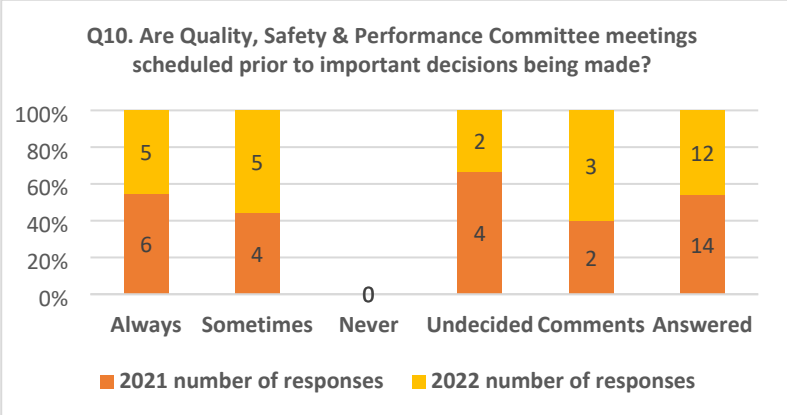
In 2021, 14 responses were received, 14.29% (2) agreed, 28.57% (4) disagreed, 57.14% (8) were undecided, and 11 comments were received, while in 2022, 12 responses were received, 16.67% (2) agreed, 50% (6) disagreed, 33.33% (4) were undecided and 12 comments were received.	
COMMENTS 2022	
1	The quality of the papers has significantly improved, a little way to go - but the work is underway.
2	This is true most of the time. There is noticeable improvement in the quality and relevance of papers.
3	See above comment, some papers are extremely lengthy and detailed.
4	There is often too much detail in the papers and required of the services which places an additional burden on already busy clinical staff, the infrastructure to support business intelligence/data is not robust enough.
5	Some papers are lengthy there may be opportunity to make them more concise.
6	There are too many papers that are voluminous in length with far too much detail in.
7	The papers produced for the Committee have improved and are more concise and relevant, but there is further work that can be done to improve this.
8	Generally, agree - there are occasional QA issues, but these are not as frequent now.
9	Quality of papers are slowly improving. Further working required in writing for a purpose and intended audience
10	The comment to previous questions covers this point to some degree and will be enhanced by the Quality Hub consideration and papers, so that the distillation of actions and narrative can be clear as to what the Quality and Safety risks are, and actions being taken to mitigate and improve the patient experience.
11	There is too much detail in the papers.
12	Some papers are inaccurate or need updating as this meeting is in the public domain it is important that papers are correct from a public point of view.

Survey question 9



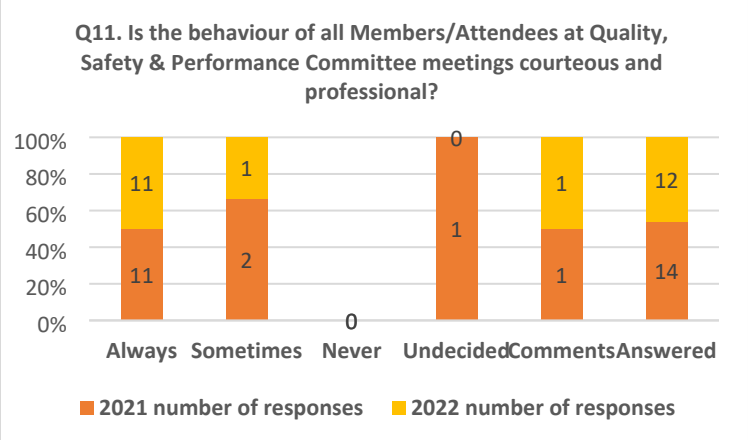
In 2021, 14 responses were received, 28.57% (4) agreed, 28.57% (4) disagreed, 42.86% (6) were undecided and 8 comments were received alongside responses, while in 2022, 12 responses came in, 25% (3) agreed, 25% (3) disagreed, 50% (6) were undecided and a total of 7 responses were received.	
COMMENTS 2022	
1	Mostly, but again the way the papers are now being prepared - going in the right direction.
2	Often there is more detail requested then necessarily needed for the function of this Committee.
3	The reports are far too detailed which means that the committee are drawn into lots of detail.
4	Can be too much detail in Committee which inevitably allows the Board to dip into the operation would be my observation.
5	Part of the improvement in papers has been to ensure they contain the right level of detail to highlight the key risk and actions to provide assurance and enable members to focus on asking the right questions. However, there is further work that can be done to improve this.
6	Sometimes too much information provided and too many details. Much greater analysis and 'so what' required in papers.
7	Covered in previous points.

Survey question 10



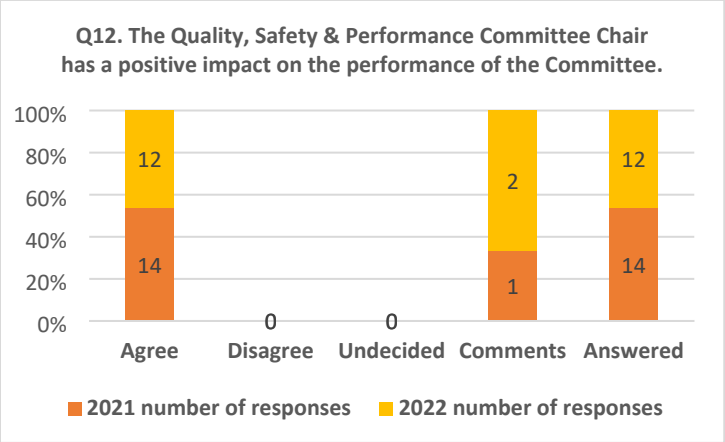
In 2021, 42.86% (6) people agreed to the question, 28.57% (4) people said otherwise, 28.57% (4) were undecided and 2 comments were made, a total of 14 responses were received, while in 2022, 12 responses were received, 41.67% (5) people agreed, 41.67% (5) disagreed, 16.67% (2) were undecided and 3 comments were received.	
COMMENTS 2022	
1	It is not clear what the link between important decisions and the QSP meeting is.
2	Can't comment on this.
3	Not sure I understand the question? From a governance perspective and covered in the TOR then e.g., papers required before Board approval are scheduled prior to decisions required.

Survey question 11



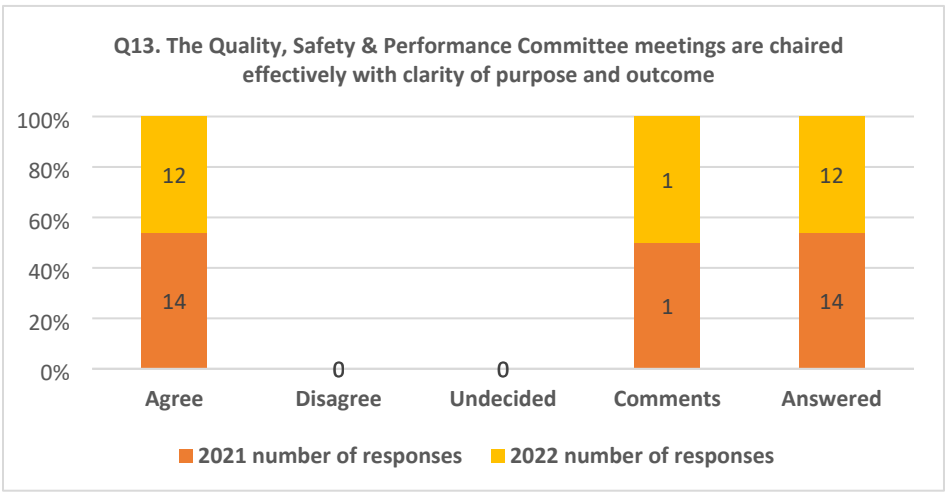
In 2021, 14 people responded, 78.57% (11) people agreed that the behaviour of members is always courteous, 14.29% (2) people said they are only sometimes courteous, 7.14% (1) was undecided and 1 comment was received. In 2022, 12 people responded, 91.67% (11) agreed, 8.33% (1) disagreed and 1 comment was received.	
COMMENTS 2022	
1	The meeting can sometimes feel quite intimidating and overly challenging by some individuals.

Survey question 12



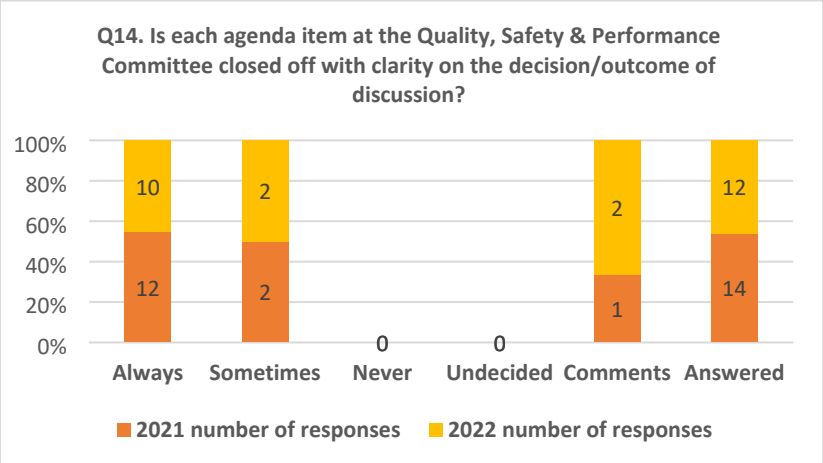
In 2021, 14 responses were received, 100% agreed and only one comment was received, while in 2022, 12 responses were received, 100% were also in agreement and 2 comments were received.	
COMMENTS 2022	
1	This is the case with the new Chair.
2	Committee is Chaired very well.

Survey question 13



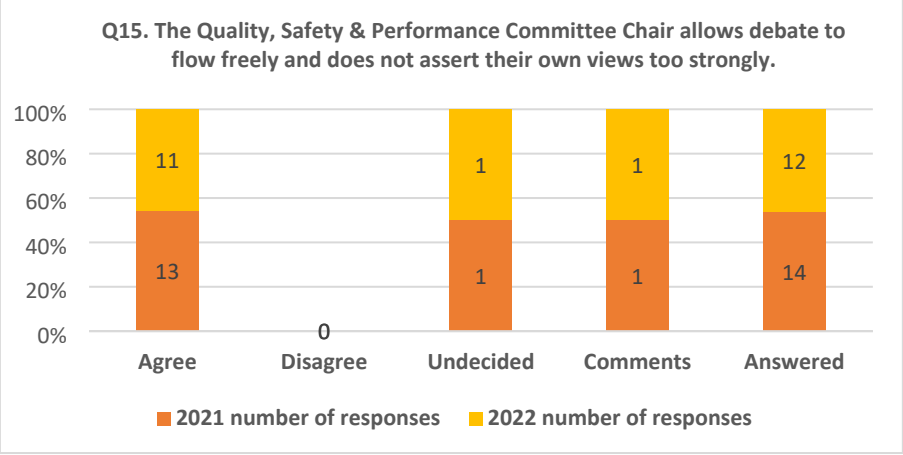
In 2021, 14 responses were received, 100% agreed and only 1 comment recorded, while in 2022, 12 responses were received, 100% were also in agreement, and 1 comment was recorded.	
COMMENTS 2022	
1	Currently yes

Survey question 14



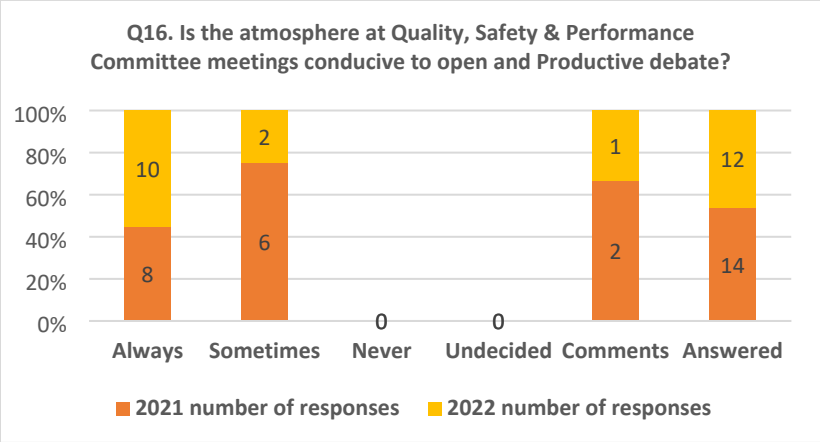
In 2021, out of 14 responses, 85.71% (12) agreed, 14.29% (2) disagreed and one comment was received, while in 2022, 83.33% (10) responses agreed out of 12 and 16.67% (2) disagreed and two comments received.	
COMMENTS 2022	
1	This is not always clear.
2	The consent agenda is somewhat confusing for the public as these are noted, whilst it is accepted that documents can be pulled into the main agenda this can become very disjointed on occasions.

Survey question 15



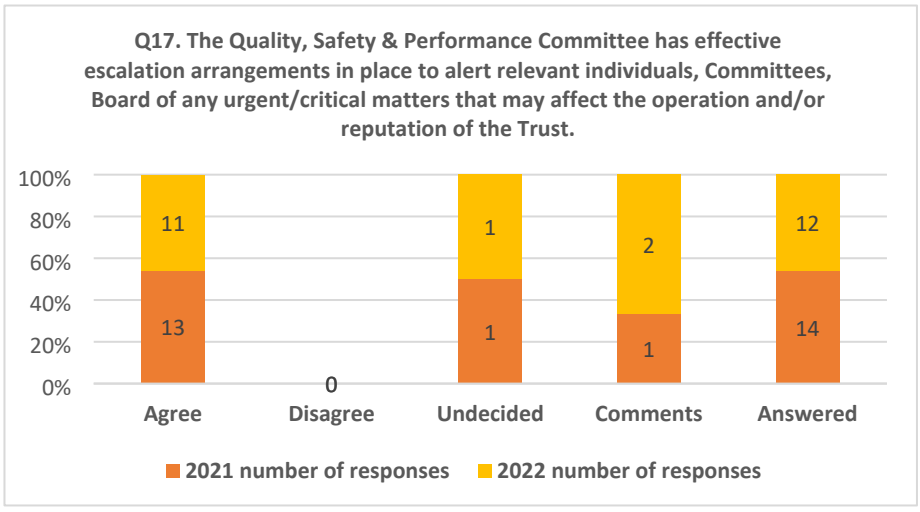
In 2021, 14 responses were received, 92.86% (13) agreed, 7.14% (1) was undecided with one comment received, while in 2022, 12 responses were received, 91.67% (11) responses agreed, 8.33% (1) was undecided and one comment was received.	
COMMENTS 2022	
1	Definitely.

Survey question 16



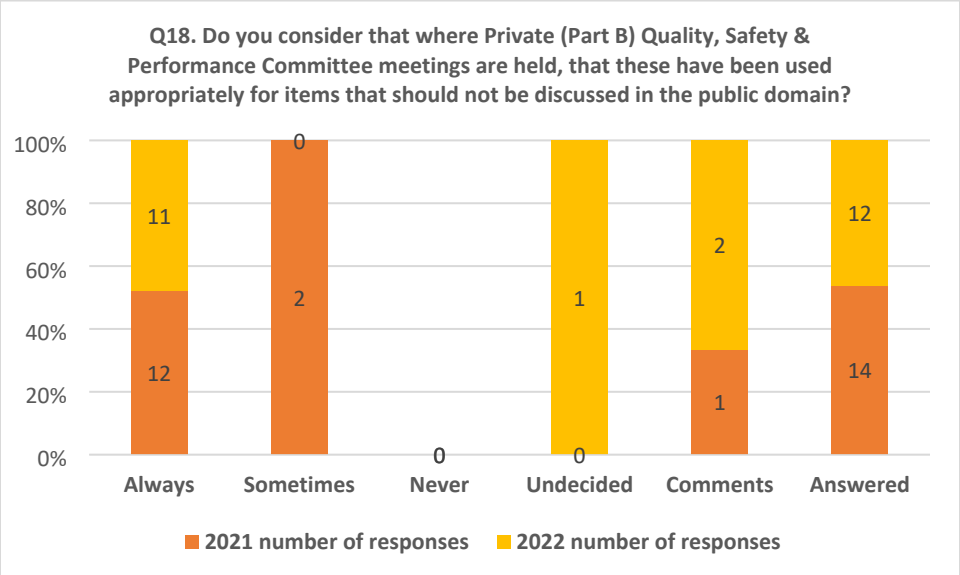
In 2021, 57.14 (8) out of 14 responses agreed, the other 42.86% (6) disagreed while in 2022, out of 12 responses, 83.33% (10) agreed and 16.67% (2) disagreed.	
COMMENTS 2022	
1	It can feel stressful and intimidating.

Survey question 17



In 2021, 92.86% (13) answers agreed and 7.14% (1) was undecided also in 2022, out of the 12 responses 91.67% (11) agreed and 8.33% (1) was undecided.	
COMMENTS 2022	
1	Although I have not seen these in operation.
2	The Committee works well within current arrangements. It would be strengthened with a clearer performance accountability framework and clear information/metrics at the Committee.

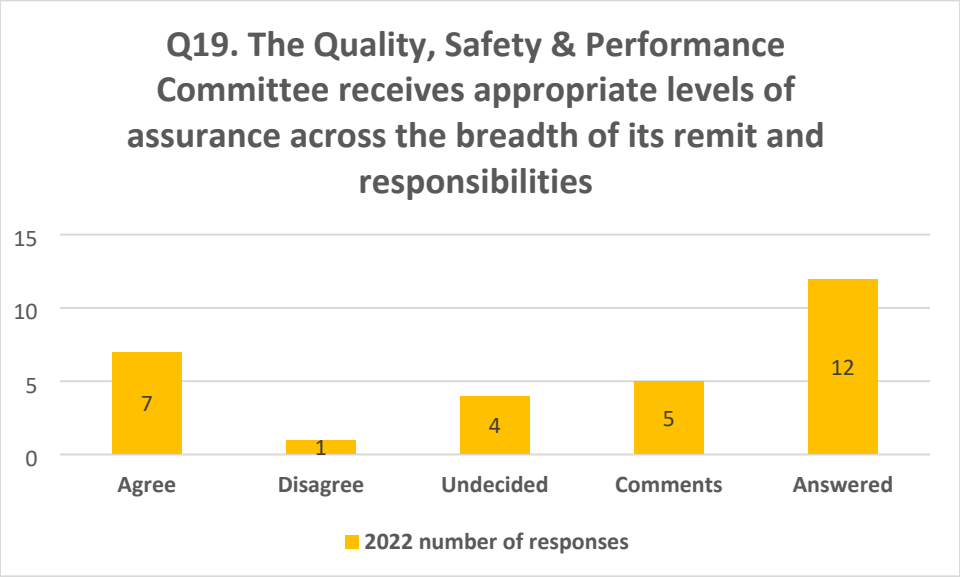
Survey question 18



In 2021, out of 14 responses, 85.71% (12) agreed, 14.29% (2) disagreed and one comment was received while in 2022, 91.67% (11) responses agreed, 8.33% (1) was undecided and 2 comments were received.	
COMMENTS 2022	
1	Definitely.
2	The number of private items considered over the last 12 months has reduced appropriately reflecting a more open culture

Survey question 19

Note: – additional survey question introduced for Committee Survey (November 2021 – October 2022)



In 2022, of all 12 responses, 58.33% (7) agreed, 8.33% (1) disagreed, 33.33% (4) were undecided and 5 comments were received in total.	
COMMENTS 2022	
1	There could be room to expand on the various legislation that the Organisation must meet and ensure that there is assurance on all areas.
2	It isn't made clear.
3	In the main I believe so. However, the breadth of the remit is massive and could lead to key matters being missed or not being able to gain assurance.
4	The breadth of the areas the QSP Committee is responsible for makes it difficult to ensure it receives appropriate assurance across all areas at each meeting, but over a year it should be possible to ensure assurance is obtained across all areas.
5	The levels of assurance are being actively discussed to address this point as there are no current recognised levels of assurance agreed by the Board to utilise at Committee and Board level- Board development discussion.

APPENDIX 2

Quality, Safety & Performance Committee Annual Effectiveness Survey:

Recommendations Action Plan

Required Outcome	Required Action	Action Lead	Delivery Timescale
Committee Cycle of Business aligned to National, legislative and Trust risk based priorities.	Continual review of Committee Cycle of Business via ongoing regular engagement with Executive & Service Leads	Executive Director of Nursing, AHPs & Health Science, Head of Corporate Governance, QSP Business Support Officer	March 2023 *(minimum annual basis thereafter)*
Committee receives robust, succinct and appropriate data and information	Effective automated electronic Business Intelligence system to be in place to feed Committee through robust triangulated dashboards PMF reports.	Chief Operating Officer	March 2023
Clear and effective presentation of reports at Committee.	Establish clear protocol and guidelines on how reports should be presented during Committee meetings.	Corporate Governance Manager	January 2023
100% compliance with paper deadlines to achieve 7-day pre-Committee papers publication.	Zero Tolerance to late papers except new papers not predicted in response to situations that arise.	Corporate Governance Team	January 2023 *(every meeting thereafter)*
Clear, high quality papers / reports provided for Committee	7 steps of assurance work, Next steps to report writing training Revised committee paper template	Director of Corporate Governance & Chief of Staff	March 2023
Effective utilisation of the Consent Agenda.	Full review of use of Consent Agenda with supporting Procedure.	Director of Corporate Governance & Chief of Staff	March 2023

Quality, Safety & Performance Committee

AMENDMENT TO STANDING ORDERS – SCHEDULE 3

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science & Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	ENDORSED

ACRONYMS	
SO	Standing Orders
ToR	Terms of Reference

1. SITUATION

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

The purpose of this report is to outline the required changed to the Trust Standing Orders – **Schedule 3,** resulting from the Annual Review of the **Terms of Reference and Operating Arrangements** in respect of the **Quality, Safety & Performance Committee**, (ref. ***Appendix 1 [no track changes] & Appendix 2 [with track changes],*** and is seeking formal **ENDORSEMENT** by the Quality, Safety & Performance Committee prior to submission to Trust Board.

2. BACKGROUND

The amendments detailed in this report have been agreed via collaborative engagement with the wider Executive Management Team in conjunction with effective oversight and review by the Chair of the Quality, Safety & Performance Committee.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Summary of Amendments

The revised Terms of Reference and Operating Arrangements for the Quality, Safety & Performance Committee are set out in ***Appendix 1 & 2,*** with the latter inclusive of track changes for ease of reference and transparency. The proposed amendments include the following key changes summarised below:

Terms of Reference & Operating Arrangements	**Summary of Amendments**
Quality, Safety & Performance Committee	**Section 3:** - Addition of **Duties of Quality and Candour** to the Quality Management System the Trust already has in place. - Addition of **Integrated Quality & Safety Group** to **Sub Committees,** to provide triangulation and analysis of outcomes of the Quality Management System and Divisional

Terms of Reference & Operating Arrangements	Summary of Amendments
	Quality Hubs to the Quality, Safety & Performance Committee. **Section 3 *additional*:** - Highlighted items within the **Delegated Powers and Authority** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board; o Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board; o Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015. **Section 4:** - Addition of **Deputy Director of Organisational Development and Workforce** to attendees of the Quality, Safety & Performance Committee. - Amendment of job title of **Quality & Safety Manager** to **Head of Quality, Safety & Assurance**. **Section 6:** - Highlighted items within the **Relationships & Accountability** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o **6.4** – The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance. o The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the amendments to the Trust Board Standing Orders – **Schedule 3** as outlined in section **3** of this report, and included in ***Appendix 1 & 2.***

Subject to formal **ENDORSEMENT** by the November Quality, Safety & Performance Committee, the revised Terms of Reference will then be received at the next meeting of the Trust Board Audit Committee for formal **ENDORSEMENT** and recommendation to the Trust Board for **APPROVAL**.

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.
- Integrated Quality & Safety Group.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

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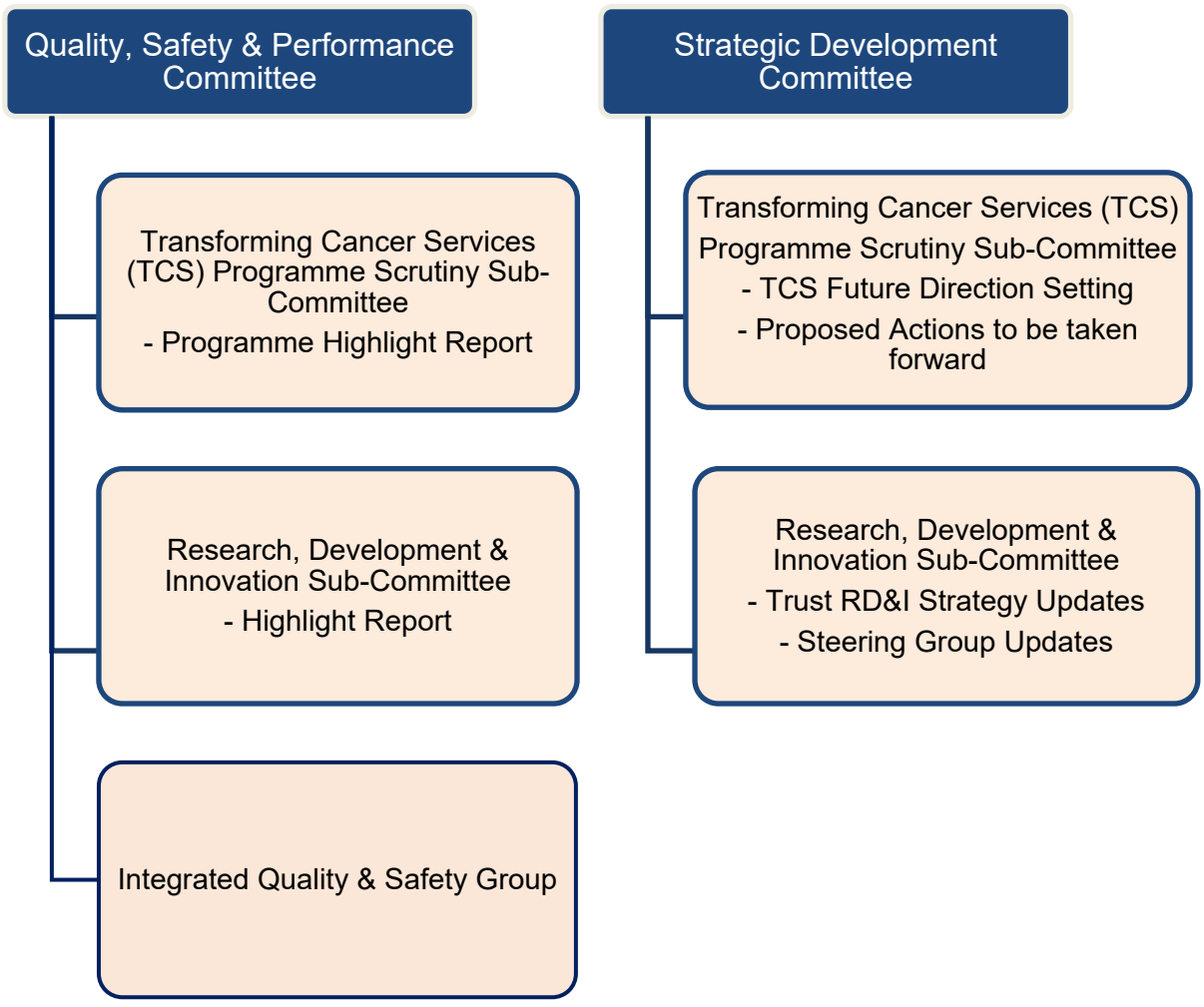

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One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

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- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of OD & Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality, Safety & Assurance
- Head of Corporate Governance

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

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Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

  Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

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

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

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7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

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10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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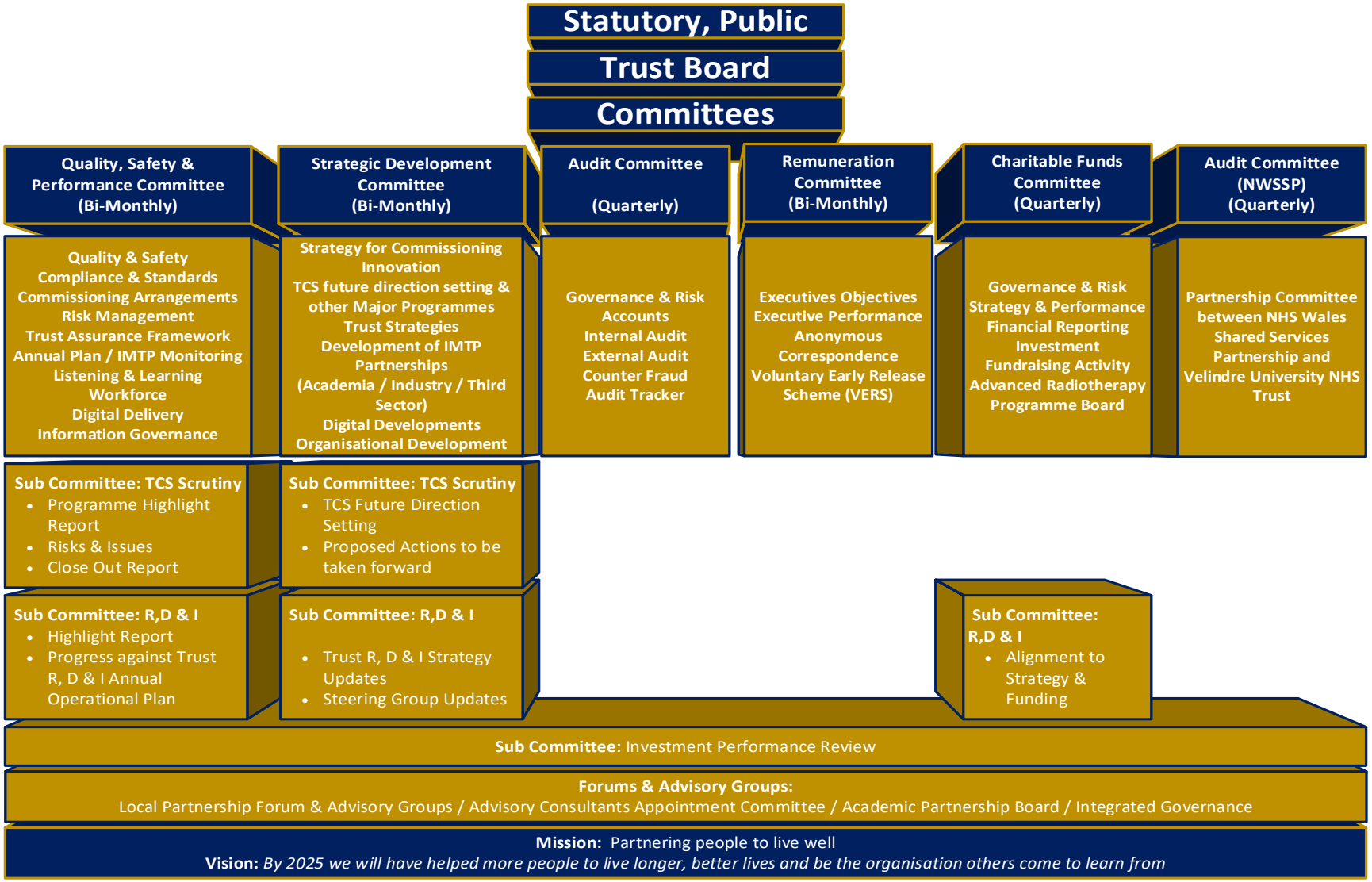

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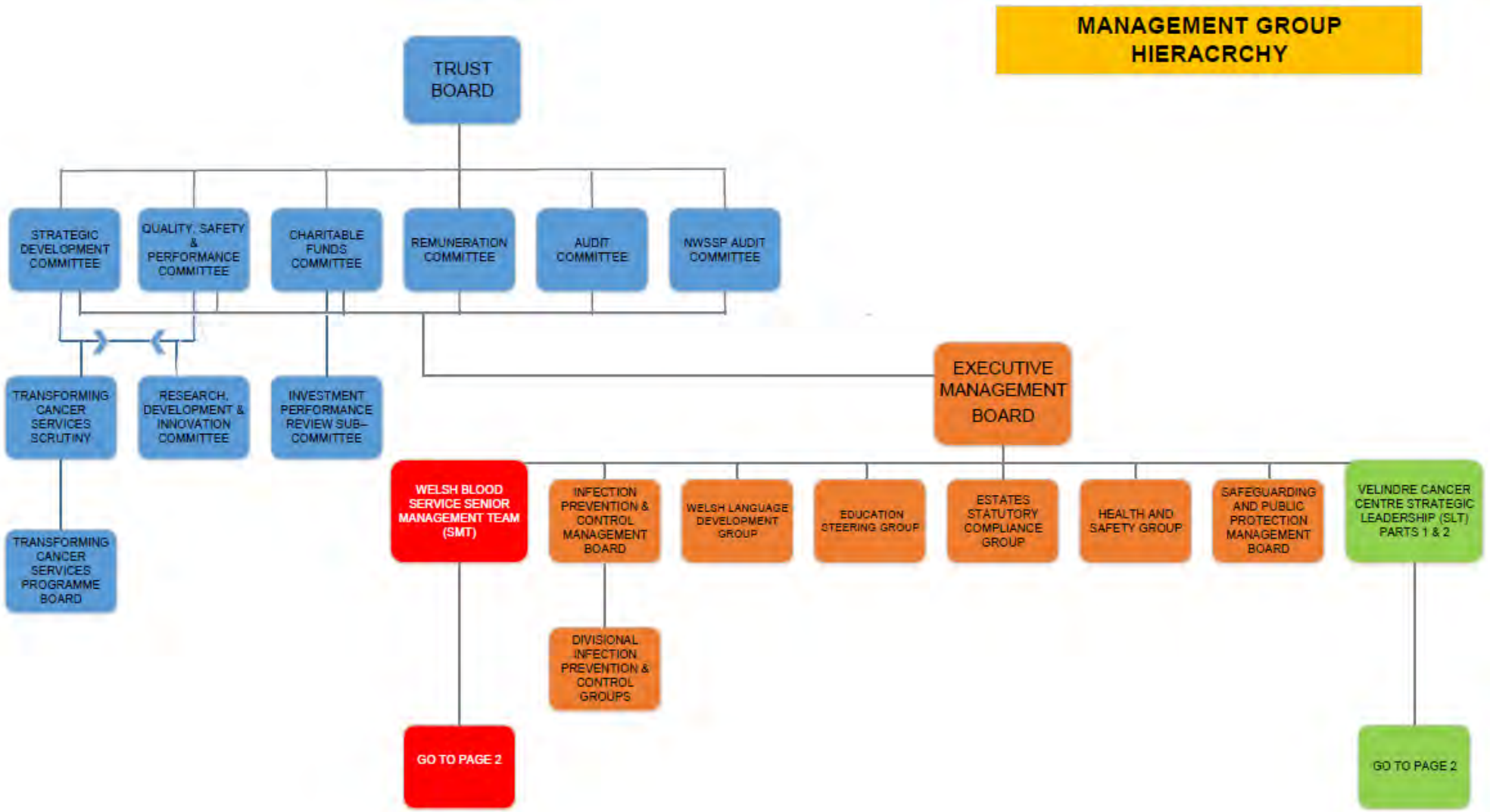

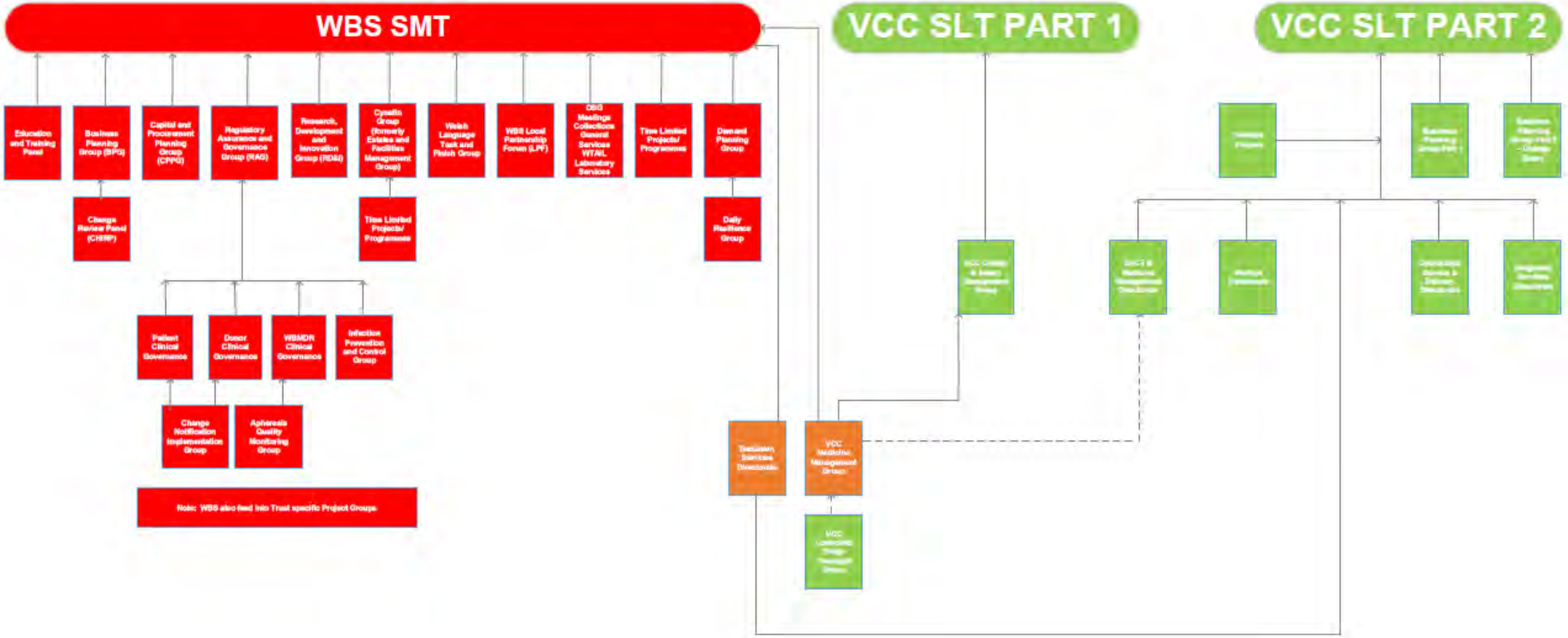
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Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 20221
Approved:	January 2022
Next Review Due:	October 2022March 2023

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects ~~of~~ regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

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3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;
- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;
- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.
- Monitor the Trust's sustainability activities and responsibilities;
- Monitor progress against cost improvement programmes;
- Monitor and review performance against the Trust's Assurance Framework.
- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;
- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;
- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;
- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.
- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;
- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;
- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;
- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

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Access

3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

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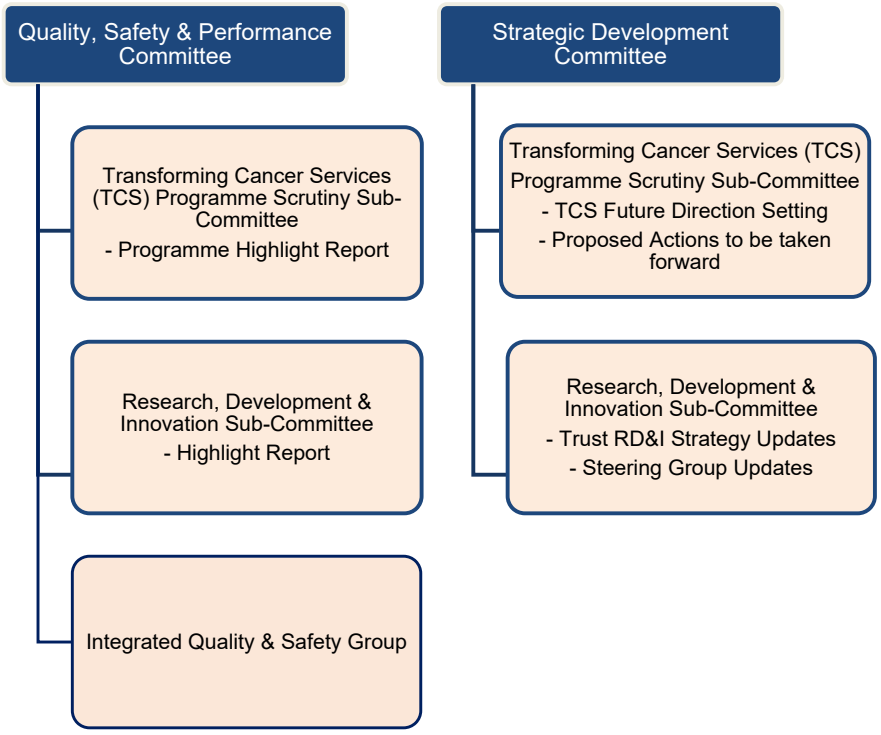

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Commented [KP(-EP2]: Addition by Sarah Morley

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Commented [KP(-EP3]: Changes made by Sarah Morley

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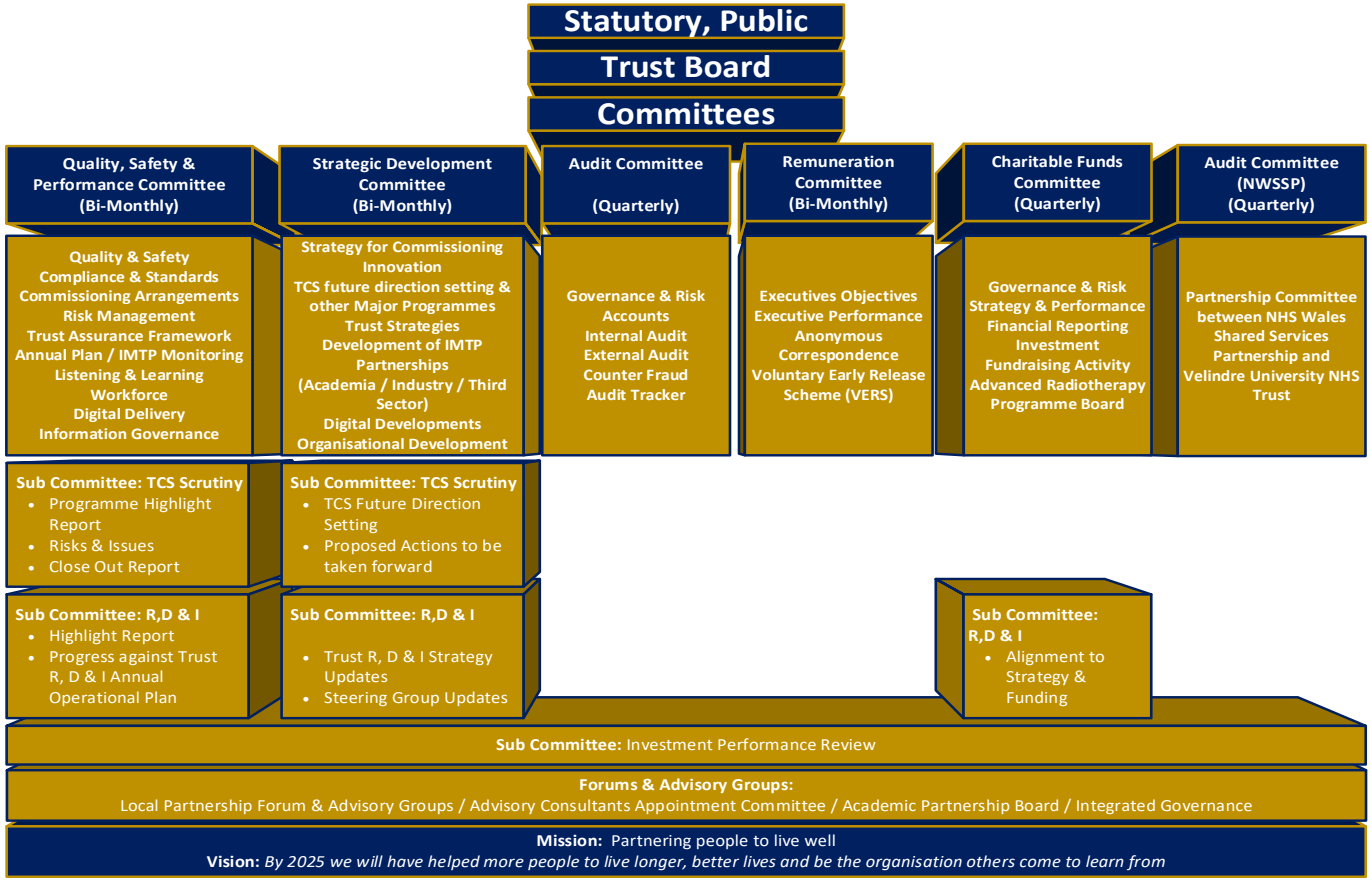

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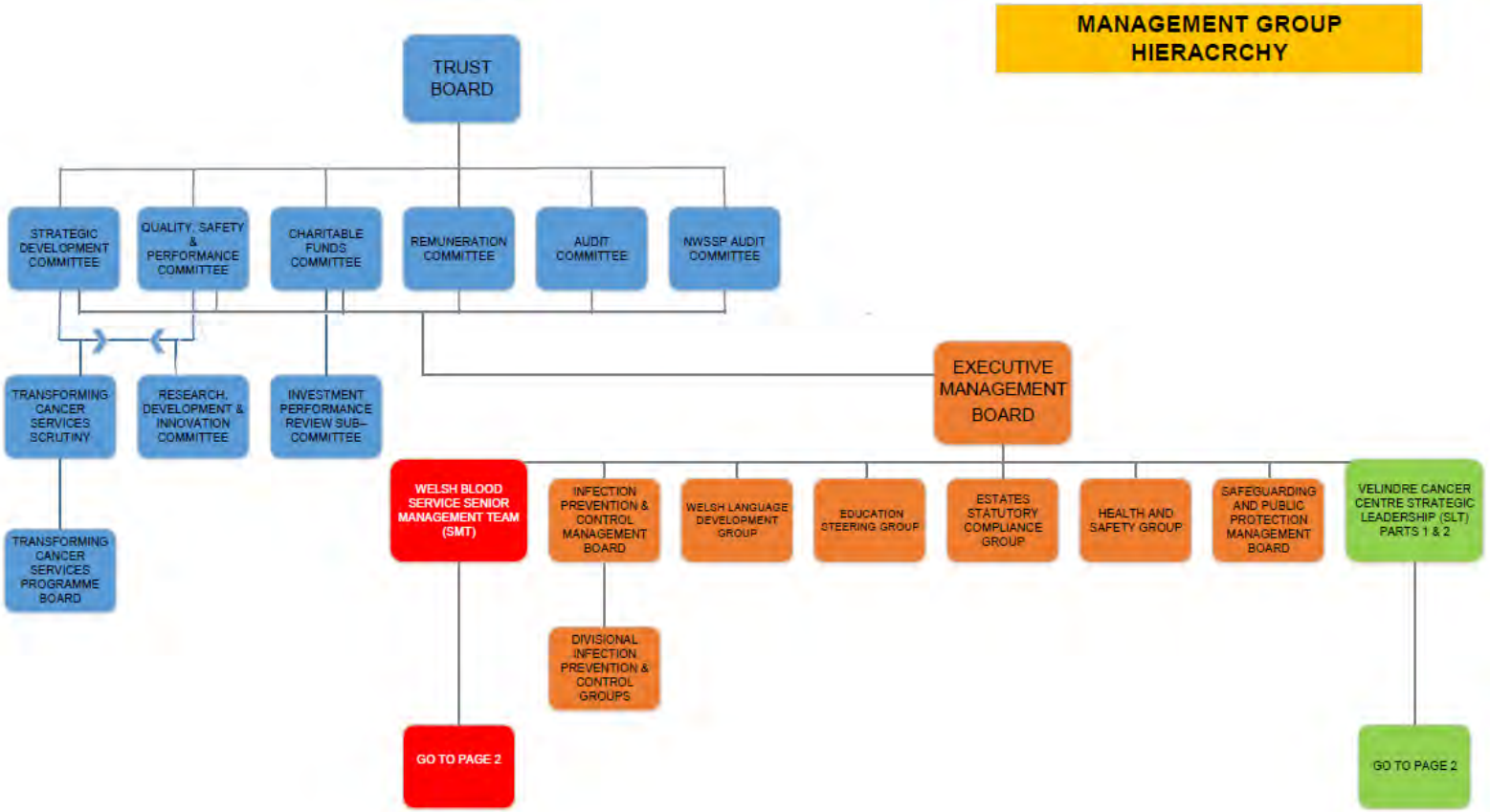

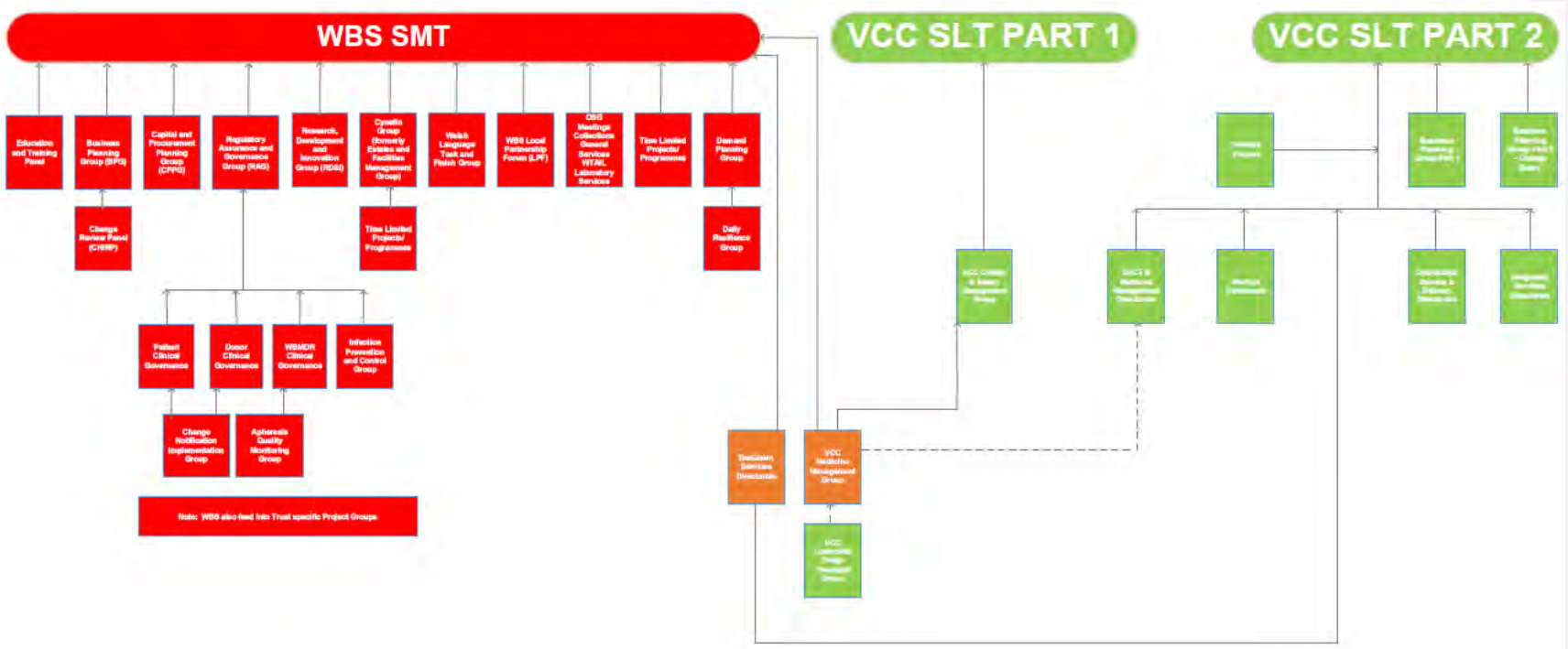
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QUALITY, SAFETY & PERFORMANCE COMMITTEE

QUALITY, SAFETY & PERFORMANCE COMMITTEE CYCLE OF BUSINESS

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science Supported by, Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	ENDORSEMENT

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	ENDORSED

1. SITUATION

The purpose of this paper is to seek **ENDORSEMENT** by the Quality, Safety & Performance Committee for the proposed amendments to the Committee Cycle of Business.

2. BACKGROUND

The Quality, Safety & Performance Committee Cycle of Business is reviewed annually. The cycle of business has been reviewed throughout the month of October 2022 and the amendments detailed in this report have been agreed via collaborative engagement with the accountable Executive Directors and Service Leads across the Trust that span all portfolios within the agreed remit and responsibilities of the Quality, Safety & Performance Committee.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Review

This review of the Committee work programme has been undertaken as part of the current formal annual review cycle since the Committee was first established in November 2020. It builds on the amendments previously agreed by the Committee via its regular ongoing review and commitment to continuous improvement.

A further formal review will be undertaken in March 2023. The purpose of which is to serve a number of key factors:

i. to enable the revision of the annual reporting cycle in line with the financial reporting year and support the preparation of the Trust Annual Governance Statement.
ii. incorporate any outputs and recommendations arising following the establishment of the Trust Integrated Quality & Safety Group.
iii. reflect the reporting requirements of the new Duty of Quality and Duty of Candour when these come into force as a statutory requirement.
iv. the ongoing review of the Trust hosted organisations' reporting requirements, in line with the standards required for good corporate governance. Discussions continue in relation to items to be included on the Cycle of Business.

3.2 Proposed amendments to the Cycle of Business

The amendments proposed to the Quality, Safety & Performance Committee Cycle of Business at this stage of the formal review process, have been incorporated into the work programme (***Appendix 1***).

For ease of reference the proposed changes are summarised below:

- ***Annual Reports:*** All Trust wide Annual Reports within the remit of the Quality, Safety & Performance Committee will be received at the July 2022 Committee

meeting each year. This will ensure that Annual Reports are able to accurately reflect the full financial reporting period and will facilitate full year triangulation. The Trust Finance Report, Performance Report and Staff Story are the only additional items of business to be received as standard at the July Committee meeting, to ensure adequate time is afforded to each of the Annual Reports, with the exception of any matters of business for escalation or externally driven.

- ***Items currently reported not captured:*** The triangulated ***Workforce & Organisational Development Performance Report / Financial Report*** has been received by the Quality, Safety & Performance Committee as a standard item of business since **March 2022**, however, this was not previously detailed on the Committee work plan. As such, this has now been formally incorporated into the Cycle of Business to reflect the agreed established arrangements.

- ***New items of business:*** A number of key reports, not previously reported to the Quality, Safety & Performance Committee, have been identified for inclusion in the work plan (outlined below), to ensure effective oversight and governance arrangements in line with the Committee's remit and responsibilities:

Proposed New Item of Business	Report Frequency	Report Purpose
• Staff Story	• Annual	• Provide a staff experiential oversight for Committee members
• Trust-wide Workforce Performance Management Framework (PMF) Report	• Each meeting	• For Assurance
• Business Continuity & Emergency Planning	• Bi-annual initially (i.e. January 2023 and July 2023), reducing to annually thereafter.	• For Assurance
• Private Patient Improvement Plan	• Bi-annual	• For Approval (Nov 2022) • For Assurance (post Nov 2022)
• Anti-Racist Wales Action Plan	• Bi-annual	• For Assurance
• Annual Information Governance Report	• Annual	• For Assurance
• Patient Nosocomial Transmission Review Update	• Quarterly	• For Assurance

• **Clinical & Scientific Strategic Board Highlight Report	• Bi-annual	• For Assurance
• Annual Risk Summary	• Annual	• For Assurance
• Freedom of Information Requests Annual Report	• Annual	• For Assurance
• Communications Annual Report	• Annual	• For Assurance
• Value-based Healthcare	• Bi-annual	• For Assurance
• Sustainability Report (including decarbonisation)	• Bi-annual	• For Assurance
• Annual Report Workforce & OD (inc. Workforce Planning)	• Annual	• For Assurance

** *Predicated on the availability of required support resource.*

- ***Frequency of reports:*** The frequency with which a number of reports are to be received by the Quality, Safety & Performance Committee has been reduced to facilitate and ensure a more targeted and focused approach, namely:

Existing Reporting Frequency	**Revised Reporting Frequency**
• Infected Blood Inquiry ***(Quarterly)***	• Infected Blood Inquiry ***(Bi-annual or by exception)***
• Highlight Report from the Trust Estates Assurance Group • ***(Quarterly)***	• Highlight Report from the Trust Estates Assurance Group ***(Bi-annual)***
• Professional Nursing Update Report ***(Quarterly)***	• Professional Nursing Update Report ***(Bi-annual)***
• Highlight Report from the Trust-wide Safeguarding & Vulnerable Adults Group (SVAG) ***(Quarterly)***	• Highlight Report from the Trust-wide Safeguarding & Vulnerable Adults Group (SVAG) ***(Bi-annual or by exception)***
• Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG) ***(Quarterly)***	• Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG) ***(Bi-annual or by exception)***

- ***Revised reporting categories:*** All items of business to be reported to the Quality, Safety & Performance Committee will be assigned to one of the following reporting categories to more accurately reflect the nature and purpose of the report:

  - Annual Report
  - Highlight Report

- Exception Report
- Assurance Report

- ***Balance of Reports:*** A review of the balance of reports received at each meeting across the Committee work plan has also been undertaken as part of the review process to ensure adequate time is afforded to each report received to support the effectiveness of the Committee working arrangements.

- ***Removal of previous items of business:***

  - **Consent Audit Report and Compliance with the NHS Wales Consent Policy** – It has been agreed that Consent will now be included within the Trust Clinical Audit Report.
  - **Annual Assurance Report from the Medical Gas Group (MGG)** – This will now be included in the Medicines Management Group (MMG) Assurance Report.
  - **Medical Workforce Annual Report** – To be replaced with Workforce Planning Annual Report.
  - **Trust Travel Survey -** This report is no longer relevant to the Committee's Terms of Reference.

  Going forward, the **GOLD Command Highlight Report, Test, Trace & Protect Cell Highlight Report and COVID Vaccination Programme Highlight Report** will be included by exception only, when required.

3.3 Further Areas for Review

A number of additional areas have been identified that will be progressed over the next phase of the review programme to inform and underpin the Quality, Safety & Performance Committee Cycle of Business, this included but will not be limited to the following:

- The quality and level of detail of reports received by the Quality, Safety & Performance Committee with a focus on assurance and escalation.
- Review of relevant statutory responsibilities.
- Review of the Divisional Committee performance reporting formats.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the proposed revisions to the Quality, Safety & Performance Committee Cycle of Business outlined in section **3.2** and **NOTE** the additional work to be undertaken outlined in section **3.3** to support and underpin further review as part of our commitment to continuous improvement.

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
DONOR / PATIENT / STAFF STORY										
Welsh Blood Service Donor Story	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Quarterly	✓		✓			✓
Velindre Cancer Service Patient Story	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Quarterly		✓		✓		
Staff Story	Executive Director of Organisational Development & Workforce (Sarah Morley)	Variable	Public	Annual					✓	
DIVISIONAL / DIRECTORATE REPORTS										
Welsh Blood Service Quality Safety & Performance Divisional Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Quarterly	✓		✓			✓
Velindre Cancer Service Quality Safety & Performance Divisional Report	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Quarterly		✓		✓		
Digital Service Operational Report	Director of Transformation, Planning & Digital (Carl James)	Deputy Chief Digital Officer (Carl Taylor)	Public	TBC						
PERFORMANCE REPORTS										
Welsh Blood Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Each Meeting	✓	✓	✓	✓	(by exception)	✓
Velindre Cancer Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Each Meeting	✓	✓	✓	✓	(by exception)	✓
Workforce & Organisational Development Performance Report/Finance Report	Executive Director of OD & Workforce (Sarah Morley) Executive Finance Director (Matthew Bunce)	Deputy Director of OD & Workforce (Susan Thomas) Deputy Director of Finance (Chris Moreton)	Public	Each Meeting	✓	✓	✓	✓	(by exception)	✓
Trust-wide Workforce Performance Management Framework (PMF) Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Each Meeting	✓	✓	✓	✓	(by exception)	✓
Finance Report	Executive Director of Finance (Matthew Bunce)	Head of Financial Reporting (Steve Coliandris)	Public	Each Meeting	✓	✓	✓	✓	✓	✓

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
MEDICAL & RESEARCH DEVELOPMENT										
Assurance Report Medicines Management Group (including Medical Gases & CDs)	Executive Medical Director (Jacinta Abraham)	Head of SACT and Medicines Management (Bethan Tranter)	Public	Bi Annually	Highlight Report (last received moving to Assurance Report)		✓			✓
RD&I Sub Committee Highlight Report	Executive Medical Director (Dr Jacinta Abraham)	Head of Research & Development (Sarah Townsend)	Public	Quarterly	✓	✓		✓		✓
QUALITY, SAFETY & ASSURANCE										
Highlight Report from the Trust-wide Infection Prevention & Control Management Group	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention & Control (Hayley Jeffreys)	Public	Quarterly	✓		✓			✓
Highlight Report from the Trust-wide Safeguarding & Vulnerable Adults Group (SVAG)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Groups (Tina Jenkins)	Public	Bi Annually (or by exception)	✓			✓		
Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Bi Annually (or by exception)	✓			✓		
Datix Project Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Incorporate in Quality Report after Jan 2023		✓				
Medical Devices Report	Chief Operating Officer (Cath O'Brien)	(Tim Register)/(Jignesh Raiyani)/(Peter Richardson) TBC	Public	Bi Annually		✓			✓ (Annual)	
Infected Blood Inquiry Proceedings	Chief Operating Officer (Cath O'Brien)	Business Support Officer (Suzanne Jones)	Public & Private	Bi Annually (or by exception)	✓			✓		
Putting Things Right Report (inc. Incidents, SIs, Complaints, Compliments, Claims & Patient Experience)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Quarterly	✓		✓	✓		✓
Quality & Safety Framework	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Public	Bi-Annually	✓			✓		
Value based Healthcare	Executive Director of Finance (Matthew Bunce)	Deputy Director of Finance (Chris Moreton)	Public	Bi-Annually			✓			✓

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
Private Patient Improvement Plan	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Bi-Annually	✓			✓		
Radiation Protection and Medical Exposures Strategic Group Highlight Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually	✓			✓		
Medical Examiner's Service & Mortality Framework Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually			✓			✓
Patient Nosocomial Transmission Review Update	Nicola Williams (Executive Director of Nursing, Allied Health Professionals & Health Science)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Quarterly		✓		✓		✓
Business Continuity & Emergency Planning	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser) (both divisions)	Public	Bi-Annually (Annually from July 2023 onwards)		✓			✓ (Annual)	
STRATEGIC TRANSFORMATION, PLANNING & ESTATES										
Highlight Report from the Trust Estates Assurance Group	Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Estates, Environment & Capital Development (Jason Hoskins)	Public	Bi-Annually			✓			✓
Sustainability Report (inc. decarbonisation)	Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Bi-Annually		✓				
Transforming Cancer Service (TCS) Programme Scrutiny Sub Committee Highlight Report	Director of Strategic Transformation, Planning & Digital (Carl James)	Business Support Officer (Jessica Corrigan)	Public & Private	Each meeting	✓	✓	✓	✓	✓	✓
WORKFORCE										
Anti-Racist Wales Action Plan	Executive Director of Organisational Development & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Bi-annually	✓			✓		
Gender Pay Gap Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually		✓				
Annual Equality, Diversity & Inclusion Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually				✓		

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
ANNUAL REPORTS										
Medical Education Governance Framework	Executive Medical Director (Dr Jacinta Abraham)	Interim Medical Business Manager (Nicola Hughes) Louise Hanna	Public	Annually					✓	
Trust Clinical Audit Annual Report	Executive Medical Director (Dr Jacinta Abraham)	Clinical Audit Manager/Head of Quality Assurance (Sara Walters/Peter Richardson)	Public	Annually					✓	
Trust Clinical Audit Plan	Executive Medical Director (Dr Jacinta Abraham)	Clinical Audit Manager/Head of Quality Assurance (Sara Walters/Peter Richardson)	Public	Annually				✓		
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Nursing for Professional Standards & Digital (Anna Harries)	Public	Annually					✓	
Annual Quality Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Quality & Safety (TBC)	Public	Annually					✓	
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention Control (Hayley Jeffreys)	Public	Annually					✓	
Safeguarding & Public Protection Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Groups (Tina Jenkins)	Public	Annually					✓	
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality Safety, & Assurance Manager (TBC)	Public	Annually					✓	
Annual Performance Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Planning and Performance (Jason Hoskins)	Public	Annually					✓	
Annual Estates Update	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually					✓	
Annual Sustainability Report (inc. decarbonisation)	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually					✓	

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
Health & Safety Annual Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Health & Safety Manager (Helen Jones)	Public	Annually					✓	
Local Partnership Forum Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually					✓	
Annual Report Workforce & Organisational Development (inc. Workforce Planning)	Executive Director of OD & Workforce (Sarah Morley)	TBC	Public	Annually					✓	
Welsh Language Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually					✓	
Professional Registration/Revalidation	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Consultant Clinical Oncologist (Mick Button) / Head of Nursing for Professional Standards and Digital (Anna Harries)	Public	Annually					✓	
Patient & Donor Experience Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Annually					✓	
Committee Annual Report for Trust Board	Director of Corporate Governance and Chief of staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually					✓	
Annual progress report – Cyber Security Strategic Plan	Director of Transformation, Planning & Digital (Carl James)	Deputy Chief Digital Officer (Carl Taylor)	Private	Annually					✓	
Annual Information Governance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public						✓	
Clinical & Scientific Strategic Board Highlight Report	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	TBC	Public	Bi-annually TBC						

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
Communications Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Assistant Director of Communications (Non Gwilym)	Public	Annually					✓	
Annual Risk Summary	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Annually					✓	
Freedom of Information Requests Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Communication and Compliance Officer (Julie Mann)	Public	Annually					✓	
Information Governance Assurance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public	Quarterly		✓		✓		✓
PROFESSIONAL REGULATION										
Professional Nursing Update Report	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Nursing Professional Standards & Digital (Anna Harries)	Public	Bi-Annually			✓			✓
INTEGRATED GOVERNANCE										
Health & Care Standards / Quality Standards	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Quality, Safety & Assurance (TBC)	Public	Bi Annually	✓			✓		
Trust Risk Register (Board level reporting threshold & TAF)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Each meeting	✓	✓	✓	✓	✓	✓
Freedom of Information Requests (IG & IM&T)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Communication and Compliance Officer (Julie Mann)	Public	Bi Annually	✓			✓		
Trust-wide policies and procedures for approval	Executive Policy Lead (various)	Policy Lead (various)	Public	Each meeting (as required)	✓	✓	✓	✓	✓	✓
Trust-wide policies and procedures compliance report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Each meeting (as required until backlog cleared)	✓	✓	✓			

Quality, Safety & Performance Committee Cycle of Business 2022-23 (commencing November 2022)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2022	Jan 2023	Mar 2023	May 2023	Jul 2023	Sep 2023
COMMITTEE EFFECTIVENESS										
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually			✓			
Committee Cycle of Business	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually			✓			
Committee Effectiveness Survey Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually			✓			
Hosted Organisations (e.g. NHS Wales Shared Services Partnership (NWSSP) TBC										
Ad-hoc reports by exception (dependent on external schedules) e.g. COVID-19, staff surveys, inspection reports, internal audit and Audit Wales reports, internal high level task & finish work e.g. Occult Hepatitis B										

QUALITY, SAFETY & PERFORMANCE COMMITTEE

WORKFORCE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Chris Moreton, Deputy Director of Finance Susan Thomas, Deputy Director of W&OD
PRESENTED BY	Matthew Bunce, Executive Director of Finance Sarah Morley, Executive Director of Organisational Development and Workforce
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance Sarah Morley, Executive Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		

ACRONYMS	
IMTP	Integrated Medium Term Plan
ED&I	Equality, Diversity & Inclusion
HB	Health Board
LTA	Long Term Agreement
TOIL	Time off in Lieu

WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the key workforce and associated financial risks that the Trust is currently facing and that might crystalise in 2022-23, together with the required management action to ensure risk mitigation and performance improvement.

1.2 The paper is structured under the risks identified within the key People strategy themes of Workforce Supply and Shape; Wellbeing; Attraction and Retention. Each theme and section of the report will be structured as follows:

1.2.1 Key Workforce and Associated Financial Risks

1.2.2 Actions to be taken to address WOD and Financial Risks

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Workforce Supply and Shape

Key issues currently and expected to continue through 2022-23 are:

2.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: In response to service demand, traditional staffing models cannot deliver service need, the shape of the workforce has to change. This may require finance to be allocated across different teams and different staff groups. The Trust has key hotspot areas in diagnostic radiation services, nuclear medicine, SACT Nursing and medical oncology.

Financial risk: The financial risk associated with workforce planning 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 as funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners.

The full year pay budget is £74.072m based on 1,561 WTE.

As at Sep 2022, the current staff in post is 1,440WTE. The number of vacancies is 121 WTE, which represents 7.8% vacancy rate. The vacancy gap is largely being met by the use of agency staff and overtime, which is reported on further in section 3, Attraction and Retention.

Vacancies throughout the Trust remain high, however a number of posts in both VCC and WBS have been appointed at risk in response to Covid. There has also been forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. Work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The supply of staff, due to the funding streams supporting a number of projects over the years, has resulted in a significant number of staff (c185) on fixed-term contracts

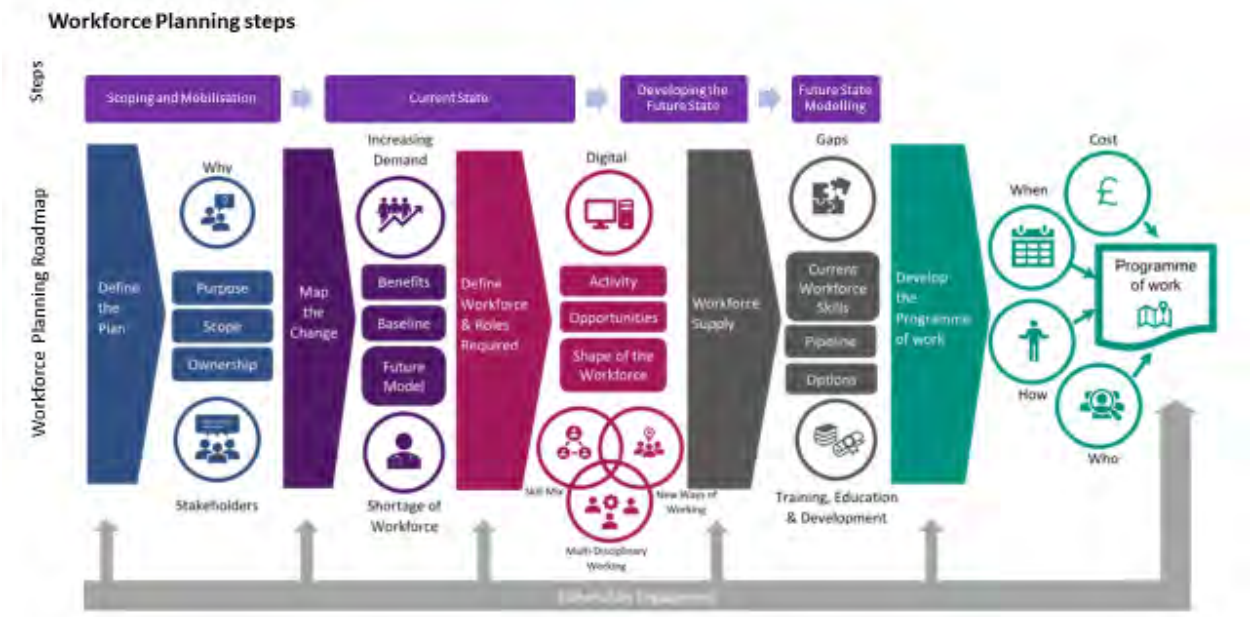
- Initial cleansing of data has been completed which has reduced the number of contracts from 185 to 122
- Ongoing work is taking place with divisions, however the nature of the funding streams impact on contract provision

The Trust has reported a cumulative year-to-date spend of £37.608m on pay against a budget of £38.073m resulting in an underspend position of £0.465m as at September 22. The pay costs include the costs of agency staff and overtime.

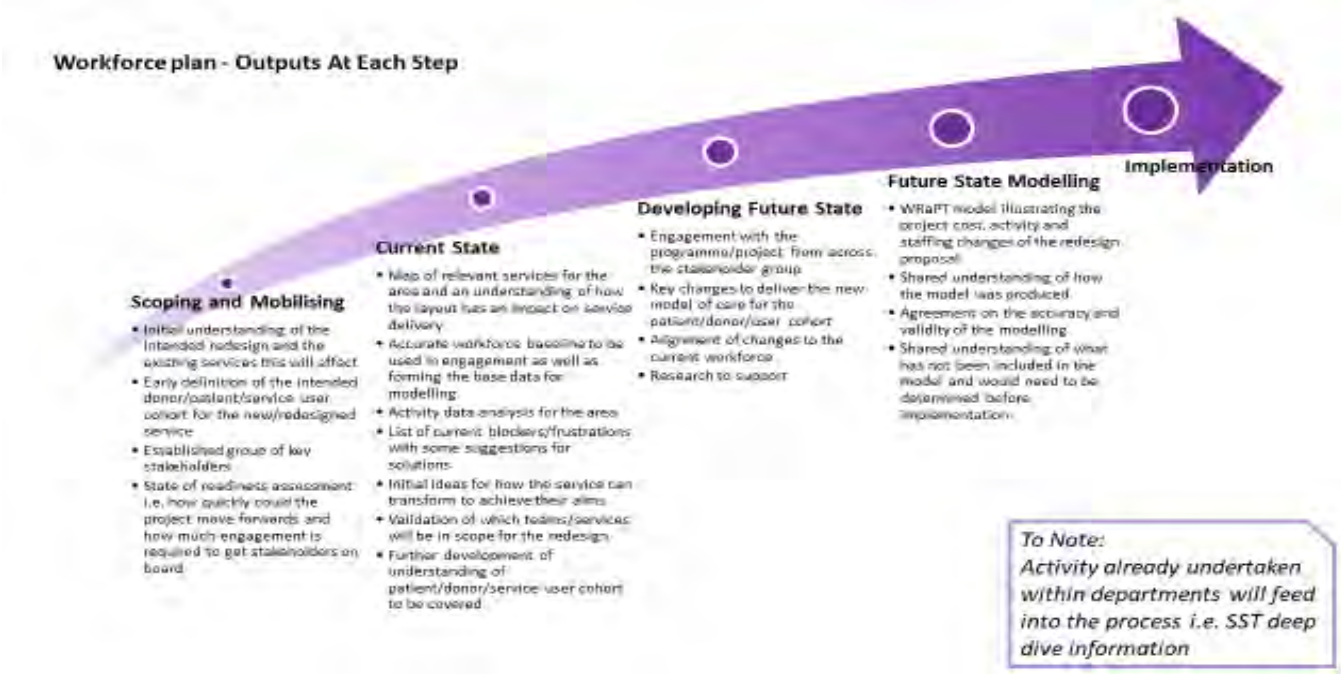
2.1.2 ***Actions taken to mitigate WOD and Finance Risks related to Workforce Supply and Shape***

Using the nationally agreed Workforce Planning (WP) Principles (Appendix A), the Trust are taking forward a number of projects, focused on hotspot areas, to address the need to change the workforce model. The planning principles have been adopted into a Work plan, utilizing the Workforce Repository and Planning Tool with actions and timescales as noted below.

Workforce planning steps based on the Workforce planning principles



Workforce plan – utilizing the Workforce Planning Repository Tool



Current Projects - Status

	1. Scoping and Mobilising	2. Understanding current state			3. Developing your future state	4. Modelling your future state	5. Implementation
Planning indicative timescale	4 weeks	4 weeks			3 weeks	3 weeks	1 week
Hotspot teams	Initial Scoping Meeting	Workforce Data (i.e. current workforce delivering the service)	Activity Data (i.e. what activity is being undertaken)	Driver Data (i.e. how long it takes to complete a task)			
Technical Services	TBC	Nov – Dec 2022			January 2023	February 2023	February 2023
SST's	TBC						
CNS	26th October						
Medical Directorate	11th November						
Therapies	TBC						
SACT	TBC						

*Timeline dependent upon wider project activity and service availability

Scoping meeting to be confirmed by w/c 6th November

- In the interim the finance team are working with W&OD to support departments to implement alternatives to agency where possible, such as establishment of Bank staffing and agreeing overtime.
- The W&OD and Finance Team has conducted Quarterly performance reviews with each Directorate within WBS and VCC. The focus of these meetings has been on understanding the workforce challenges and associated financial considerations, supported by quantitative analysis. This analysis targets the gaps between budgeted workforce and the available operating workforce factoring the impact of investments, vacancies, sickness, maternity, facilitating targeted recruitment and management action. Action plans are in place to address gaps relating to sickness. The Workforce Performance report notes the actions taken to address sickness hotspots. The vacancy gaps are addressed via the Attraction, Recruitment and Retention group. Page 8 of this report highlights actions.

2.2 Wellbeing

2.2.1 Key Workforce and Associated Financial Risks

Key workforce risk: The COVID pandemic has driven in generally higher levels of sickness absence compared to pre-Covid. The main reason for absence remains stress and anxiety. The Trust, throughout COVID, has provided a raft of wellbeing interventions to support staff and the Workforce teamwork with hotspot areas to ensure targeted interventions are provided – Please refer to September Workforce Monthly Performance.

Financial risk: The cost of sickness is reflected as an indicative productivity/ efficiency loss. The indicative productivity loss and cost for the last 12 months related to sickness is £2.114m, which is 24,274 days. High levels of sickness may also increase the need to use more staff through agencies and to therefore incur the associated costs. This risk is reported under the Attraction and Retention section below. Reduction in sickness absences rates has a direct impact on reducing the variable pay bill.

2.2.2 Actions taken to mitigate Workforce ad OD and Finance Risks related to Wellbeing

In addition to the raft of physical and mental wellbeing resources available to staff the following actions are being undertaken, monitored via the Healthy and Engaged Steering group, to support staff's financial wellbeing:

- The contract for an Employee Assistance Programme with Workplace Options was renewed from April 2022 and now runs until March 2024. This gives staff access to information and support in relation to managing money
- Salary Finance provide a service to all NHS Organisations in Wales including help and support with budgeting and the ability to provide a loan repaid through salary deductions. Links to their services are available on the intranet.
- A series of weekly Drop-in Sessions on a Monday from 14 November 2022 onwards has been established for staff
- Contact has been made with the government's independent Money and Pensions Service and their resources, branded Money Helper, have been added to the intranet

- The Trust has cited Financial Wellbeing as one of their top three wellbeing issues in the HEIW Health and Wellbeing Network. A session on Pension and the Menopause was held on 18 October 2022 for all NHS Organisations in Wales.
- The Trust advertised the NHS Pension webinars in July 2022, which gave information about the scheme and how to access the Annual Benefit Statements.
- The Trust ran the childcare subsidy scheme over the summer holidays and it was accessed by 35 staff with a total of £7,750 paid out to support childcare costs in 2022

3. Attraction and Retention

3.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: The Trust is currently carrying 121 WTE vacancies as at the end of September 2022. An Attraction and Retention plan has been developed with targeted specific interventions in hotspot areas together with work ongoing with regional partners to develop regional interventions. For further details refer to the Trust Attraction and Retention Plan in Appendix C.

Financial risk: The cost is reflected in the pay costs through use of agency and overtime and provision of TOIL.

The cumulative spend year-to-date as at September 2022 on measures to bridge the vacancy gap include:

- Agency spend £787k (£185k directly related to Covid)
- Overtime spend £247k

The 2022/23 full year forecast outturn for Agency spend is circa £1,465k (£346k Covid related) compared to £1,906k 2021/22, which is a £441k (23%) expected year-on-year reduction.

Based on the full year 2022/23 cost forecast, £440k is estimated to be premium cost that could be saved if the Trust were able to recruit permanently rather than utilise Agency.

*3.1.2 **Actions taken to mitigate Workforce and OD and Finance Risks related to Attraction and Retention***

The Trust has established a Recruitment, Attraction and Retention group to address the issues related to its key recruitment and retention hotspots. Three Action Groups related to improving marketing for hotspot areas, streamlining the process around recruitment and working with national colleagues to ensure a better user experience and turnaround time for recruitment have been established. These are particularly aligned to hotspot areas.

Marketing

The marketing sub group have completed and sent over the final storyboard idea for the Trust wide attraction video called 'This is Velindre'. Additionally, SACT, Medical Physics and Collections Nursing have developed more bespoke storyboards for their area's having been supported by the Velindre Fundraising team to develop their brand. Filming of these videos is now required

Process:

- A recruiting manager's toolkit is in development on the new Intranet, making it easier for managers to find information they need to prepare for recruitment.
- The Recruitment Modernisation programme sets out a number of changes, such as

    - Further streamlined approach to the internal employment check process
    - Implementation of ID checking software
    - Utilising Robotics Process Automation for manual tasks
    - Agreeing a provisional start date at offer stage, subject to certain employment checks
    - Removal of the unconditional offer letter
    - The Trust are keen to maximise the benefit of giving appointees a proposed start date in their offer letter, which will allow an appointee to work their notice alongside pre-employment checks being processed.

- The new scrutiny process has been tested over the last 3 months for VCC and WBS and has worked well. The Process task and finish group have drawn up an

SBAR for this to now be rolled out across the Trust on a permanent basis, aligning Velindre to what other NHS organisations do for vacancy authorisation. This is currently with EMB for approval.

Retention:

- The first survey on retention is being piloted with WBS labs in September 2022 with the expectation this will be rolled out across the Trust to understand the Turnover issues

In addition, the first draft recruitment policy being reviewed by partnership colleagues currently for progress through the policy work being undertaken across the Trust.

4. Measures to Monitor Improvement

To address improvement the following Key Performance Indicators are being reviewed monthly:

WOD Risk	Hotspot Risk Areas – Reviewed and Updated monthly via Service and Workforce Performance reports	Key Performance Indicator
Supply and Shape	Monthly Performance reports to address and monitor improvement trajectories	Fixed term contracts reviewed
Wellbeing		Sickness Absence Rates Indicative productivity loss (Hrs.) and cost (£)
Attraction and Retention		Vacancy Rate Vacancy turnover rate Agency spend

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Covid staff costs that may not be fully covered by WG or Commissioner income Ongoing premium cost of agency

5. RECOMMENDATION

a. The Quality, Safety and Performance Committee is asked to **NOTE and CONSIDER** the workforce risks, opportunities and associated financial impacts as outlined within the contents of the report.

Appendix A

Workforce Planning Principles

Agile, workforce will work flexibly and across traditional professional, physical, psychological, Organisational and geographical boundaries

Transformative, embrace opportunities for workforce transformation because of changes within digital, technological and medical advances

Intelligence Led, information and analysis that will support intelligence-based decision making.

Health and Wellbeing focus, ensuring the psychological wellbeing of staff and that staff are only required to work within their level of competence

ED&I Focus, reflective of the population and that workforce demographics are considered including ageing workforce, gender balance, flexible and part-time working and inclusivity

Welsh Language Considerations, Welsh language legislation will be considered as part of all workforce plans

Sustainable, appropriately skilled and competent multi-disciplinary team members are enabled to undertake tasks rather than traditional roles. Plans to be resilient and workforce deployed effectively

MDT Focus, workforce plans will have a clear scope and assumptions will be clearly stated. This will ensure that the outcomes of the planning are robust, feasible, affordable and that they will be supported

Whole System, Safety, quality and affordability will be equal key cornerstones of workforce planning.

Co-Produced, strong engagement and collaboration with key stakeholders to ensure that all plans are co-produced and that any actions are owned and agreed at the outset.

Consistent Approach, the development of a workforce plan will be based on the Six Step Methodology adopted across NHS Wales

Clearly Defined, workforce plans will have a clear scope and assumptions will be clearly stated.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 30 SEPTEMBER 2022 (M6)

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	26.10.2022	NOTED

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales
QSP	Quality, Safety & Performance Committee

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of September 2022.

1.2 This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.335	5.954	23.063
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.9%	95.4%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of September 22 is an underspend of **£0.002m**, with an underachievement against income offset by an underspend within both Pay and Non Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid and decreased activity. The Trust is expecting to receive WG funding to cover during the first 6 months of the year, with strategic plans having been put in place to mitigate the risk exposure during the latter part of the year.

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

Two saving schemes relating to service redesign and supportive structures currently remain RAG rated amber and whilst contingency plans have been put in place which are non-recurrent in nature it is still important that those schemes that have not yet gone live are reviewed at divisional level with a view to implement before the end of the financial year.

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs along with the Exceptional National cost pressures will be fully reimbursed by both WG and the Trust Commissioners, that all other planned additional income is received, and the savings targets are achieved.

2.3 PSPP Performance

During September '22 the Trust (core) achieved a compliance level of **93.9%** (August 22: 96.31%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.4%** as at the end of month 6, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

A task and finish group has recently been established to target key areas of underperformance and ensure that the target continues to be achieved during 2022-23.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding 2022/23			
	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.225		0.225
PPE	0.070		0.070
Cleaning	0.407		0.407
Other Covid Response	0.261		0.261

Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261
	0.963	**3.906**	**4.869**

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.869m, with £0.963m being recognised although not confirmed for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £4.869m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5 Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

At this stage only unavoidable costs pressures are being considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure and Exceptional National cost pressures will be funded by WG and / or Commissioners.

2.6 Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.906m, which has been invested in securing additional capacity, has not been agreed by Commissioners.

The Trust has received signed Long Term Agreements (LTA's) from our Commissioners. However, the funding for Planned care & Covid backlog capacity remains a risk as the marginal income that the Trust is forecast to receive will not cover the additional costs being incurred.

The expectation at this stage is that Covid response costs will be funded from WG, however the Trust has not yet received formal confirmation.

Savings

Due to the ongoing pandemic and the potential inability to enact two of the Trust savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully achieved which will have a recurrent impact on the Trust position. Those schemes with risk of delivery are being reviewed at divisional level with a view to ensure delivery before the end of the year.

TCS

A non-recurrent revenue funding request of £0.104m has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC project. This was presented to EMB Run on 1st July and agreed. Latest forecast requirement currently stands at £0.133m which reflects additional Judicial fees of £0.029m (total to date £0.043m).

The revenue financial information provided within the main body of the report and the TCS Programme Board paper differ slighlty which is due to both a timing difference, and the authorisation of budget virements from the Core Trust to the TCS Programme.

Pay Award

The Trust has been informed that the pay ward will be paid on actual staff in post which will exclude both vacancies and incremental drift. This is expected to leave a funding gap of between circa £0.500m and £0.700m which is required in order to support the full Trust staff establishment.

Other Exceptional National Cost Pressures

The Trust is anticipating full funding for the additional Employers NI has reduced to (£0.339m) following the decision to reverse the increase.

The incremental increase in energy prices has significantly decreased to £0.898m following the introduction of the price cap.

All other financial risks are expected to be mitigated at divisional level, however there is a risk that operational cost pressures may materialise during the year which is beyond divisional control or the ability to be managed through the overall Trust funding envelope.

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget, however there is potential risk of an underspend on the nVCC Enabling works with update on spend and funding requirement being provided to WG by the end of October.

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, WBS Hemoflows, Scalp Coolers, VCC Outpatients & Ventilation and Plasma Fractionation.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of September 2022 is an underspend of £0.002m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

QSP is asked to **NOTE**

4.1 the contents of the September 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for September 2022 attached as **Appendix 1**.

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED SEPTEMBER 2022/23

QUALITY, SAFETY & PERFORMANCE COMMITTEE 10/11/2022

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 2022-23.

2. Background / Context

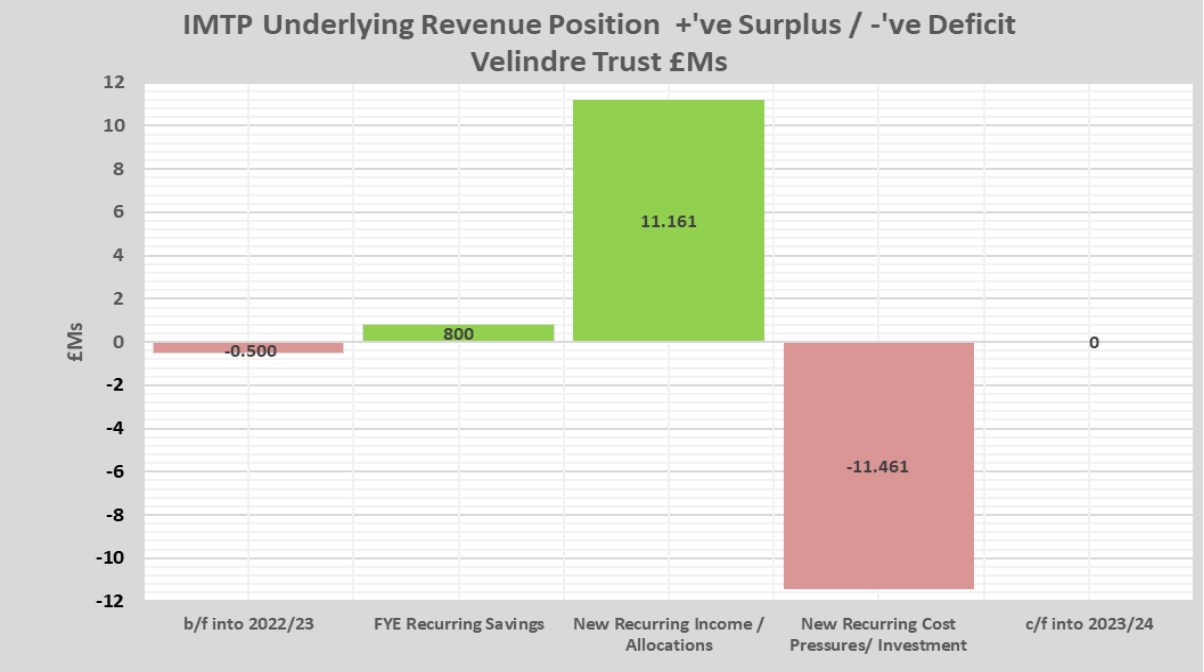
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of **-£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 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 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	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	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.335	5.954	23.063
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.9%	95.4%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.002)m overspend for September '22, with a cumulative position of £0.002m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at September '22 is **£23.063m**. This represents all Wales Capital funding of **£21.069m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to September'22 of £5.954m and is forecasting to remain within its CEL of £23.603m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m September 2022
Discretionary Capital	1.454	0.000	1.454
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-3.372	20.530
Total CEL	**25.856**	**-2.793**	**23.063**

With WG agreement, slippage on the TCS Programme has led to £3.372m Capital funding being pushed back into 2023/24, reducing the WG Capital allocation to £20.530m for this financial year.

PSPP

During September '22 the Trust (core) achieved a compliance level of **93.9%** (August 22: 96.31%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.4%** as at the end of month 6, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23, with contingency plans having been put in place to support under delivery on those schemes still rated amber.

Revenue Position

Cumulative				Forecast		
£0.002m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(86.875)	(86.442)	(0.433)	(179.442)	(178.753)	(0.689)
Pay	38.073	37.608	0.465	74.072	73.700	0.372
Non Pay	48.802	48.832	(0.030)	105.371	105.053	0.318
Total	**0.000**	**(0.002)**	**0.002**	**0.000**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of September 2022 is an underspend of **£0.002m**, with a Pay underspend offsetting an Income under achievement.

The Trust is reporting a year end forecast breakeven position, however this assumes that all additional Covid-19 costs, along with the Exceptional National cost pressures will be fully reimbursed by both WG and the Trust commissioners, that all other planned additional income is received, and the planned savings targets are achieved during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income underachievement to September is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans being put in place to support recovery in the latter part of the year.

Pay Key Issues

The total Trust vacancies as at September 2022 is 121wte, VCC (67wte), WBS (32wte), Corporate (6wte), R&D (7wte), TCS (2wte) and HTW (7wte).

The total pay award for 2022/23 which is required to cover the core Trust full establishment including vacancies and increments is expected to be circa £3.4m. The Trust is currently working on the assumption that this will be fully funded by WG, although expectation is that the Trust will only receive funding for actual staff in post (excluding vacancies) which will leave a funding shortfall of between circa £0.500m - £0.700m.

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding requirement of circa £0.339m (previously £0.551m) until the 6th November the date that the increase will be reversed is currently expected to be secured from WG through the recognition of the Exceptional National Cost pressures however remains a risk.

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

Non Pay Key Issues

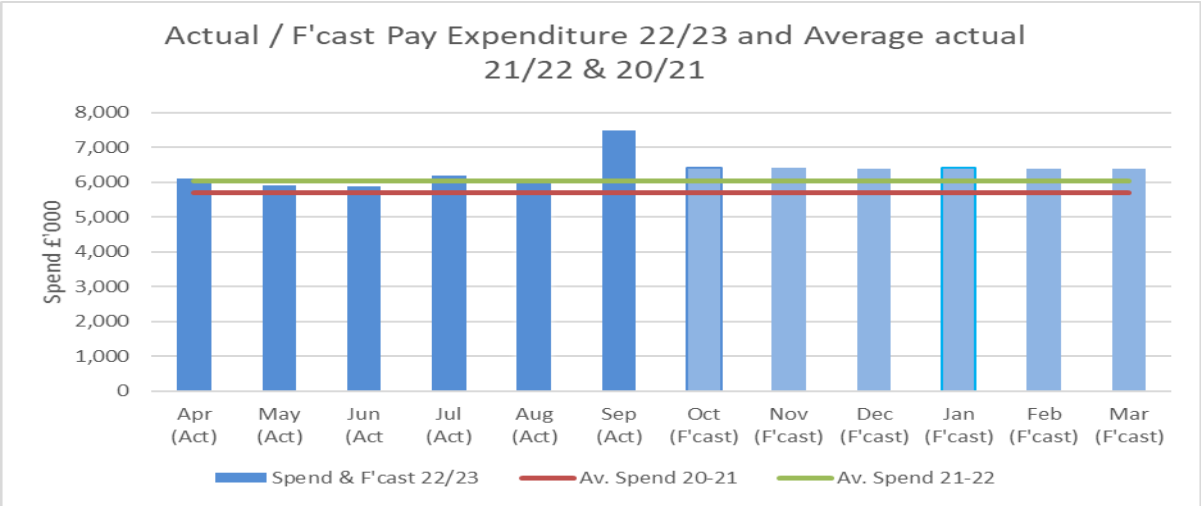
The expected increase in energy prices as significantly reduced to circa £0.898m August (£3.016m) which is following the introduction of the price cap. The stepped increase has been recognised as an Exceptional National cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23, although this is yet to be confirmed.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

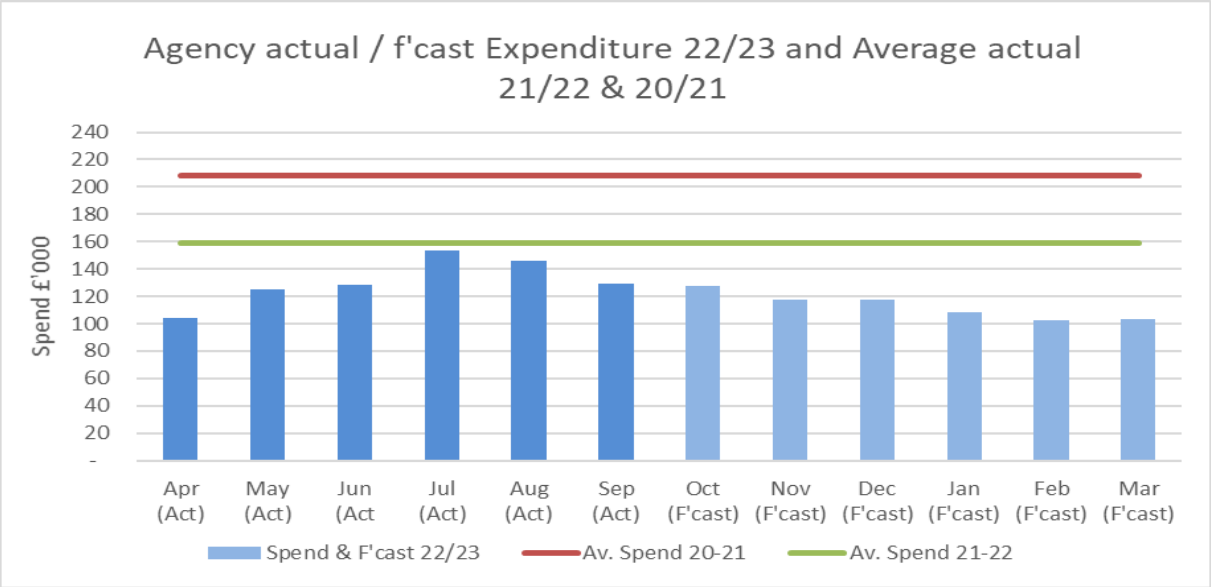
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

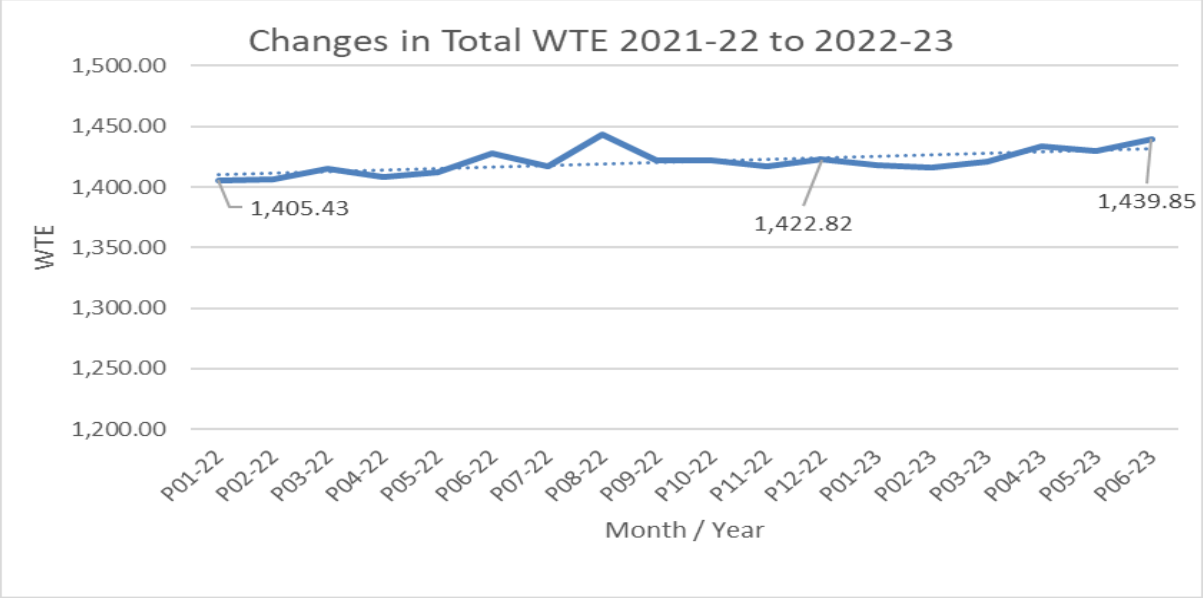
4.2 Pay Spend Trends (Run Rate)

The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels largely due to the reduction of agency staff that was previously recruited to support Covid. It is hopeful that further reductions will be generated through the recruitment into vacancies.



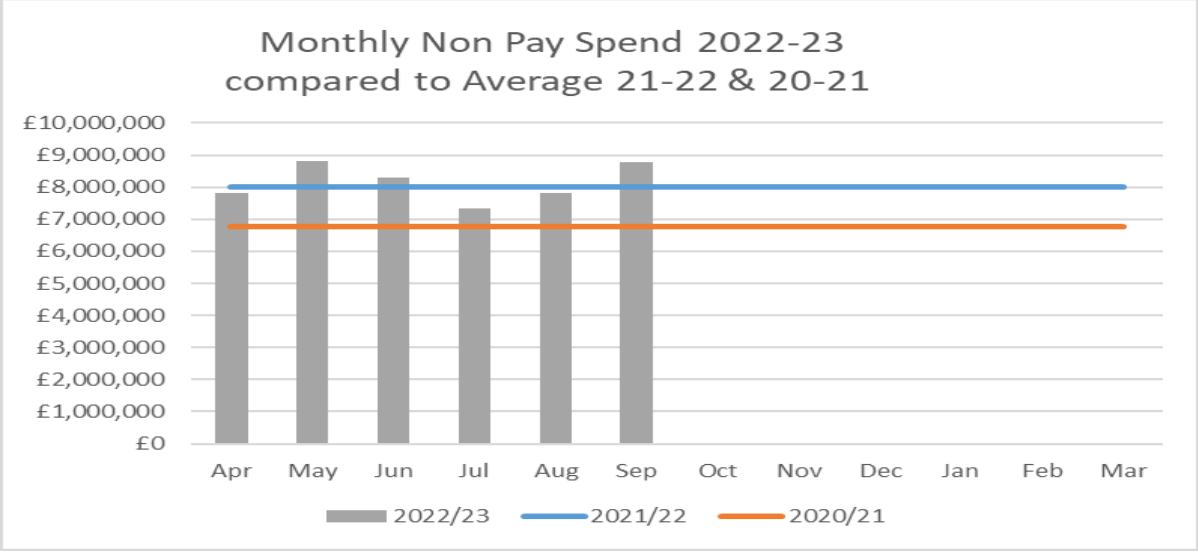
The spend on agency for September 22 was £0.129m (August £0.146m), which gives a cumulative year to date spend of **£0.787m** and a current forecast outturn spend of circa **£1.465m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of September is £0.185m and forecast spend is circa £0.346m (£0.826m 2021/22).





4.3 Non Pay

Non-pay 21/22 (c£96m) av. monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.1m which is currently in line with 21/22 expenditure.



4.4 Covid-19

The latest forecast funding requirement as at 30th September in relation to Covid for 2022-23 has been further revised down to £4.869m (August £5.022m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.869m total Covid requirement £0.963m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.906m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend/ Funding 2022/23

	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.225		0.225
PPE	0.070		0.070
Cleaning	0.407		0.407
Other Covid Response	0.261		0.261
Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261
	0.963	**3.906**	**4.869**

The latest forecast spend and funding requirement from WG has decreased by a further £0.153m from £1.116m reported in August to £0.963m. The reduction is due to further utilisation of PPE with current stock levels expected to last until the end of the financial year based on the review of daily usage.

WG funding has been assumed for programme related Covid costs of £0.295m (Mass Vaccination and PPE), along with other Covid response funding of £0.667m in relation to ongoing cleaning, increase in workforce costs, and other support costs per letter received from Judith Paget dated 14th March 2022. The Trust has received funding for QTR 1 costs in relation to Mass Vaccination and PPE.

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly since. The Trust has already invested £2.943m in additional capacity. Following news that The Rutherford has gone into liquidation, the funding previously required for outsourcing has significantly reduced (by the full £4.150m). In response the Trust is has now established additional outreach Capacity at Prince Charles Hospital (from October) for SACT with forecast additional cost above that already invested in Covid capacity of circa £0.261m and has developed plans for Radiotherapy capacity internally looking to weekend working which will require WLI and enhanced pay rates. The full cost of this additional capacity is currently still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial risk to the Trust

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

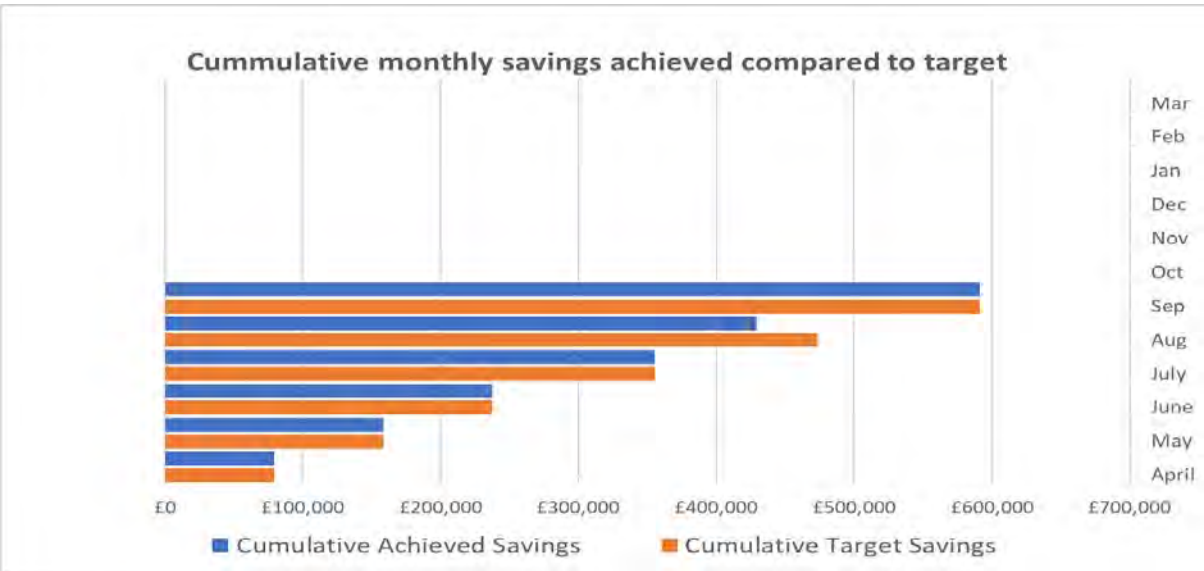
Currently two of the schemes relating to service redesign and supportive structures are still RAG rated amber which are those that continue to be impacted by Covid during 2022-23 and have underachieved by £0.066m year to date.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore the date expected to go live has been pushed back further to January.

Contingency measures have been put in place on the basis that these savings schemes will not be fully achieved this year, however these are non-recurrent in nature. **It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved that alternative schemes are implemented to ensure that the savings target is met for 2022-23. Consideration should also be giving to the impact of not achieving recurrent savings may have on next year's financial position.**

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	**700**	**292**	**226**	**(66)**	**566**	**(134)**
			77%		**81%**	
WBS TOTAL SAVINGS	**500**	**250**	**250**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**50**	**50**	**0**	**100**	**0**
			100%		**100%**	
TRUST LEVEL TOTAL SAVINGS			**66**	**66**	**134**	**134**
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**592**	**526**	**(66)**	**1,300**	**0**
			89%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	50	50	0	100	0
Laboratory & Collection Model (WBS)	Green	50	25	25	0	50	0
Laboratory & Collection Model (WBS)	Green	50	25	25	0	50	0
Stock Management (WBS)	Green	100	50	50	0	100	0
Stock Management (WBS)	Green	150	75	75	0	150	0
Procurement - Supply Chain (WBS)	Amber	50	25	25	0	50	0
Service Redesign (VCC)	Amber	100	33	0	(33)	33	(67)
Supportive Stuctures (VCC)	Amber	100	33	0	(33)	33	(67)
Procurement - Supply Chain (VCC)	Green	50	25	25	0	50	0
Bank Interest (Trust - In Year)	Green		0	33	33	67	67
Vacancy Factor (Trust - In Year)	Green		0	33	33	67	67
Total Saving Schemes		**750**	342	342	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	25	25	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Geen	50	25	25	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Amber	150	50	50	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	50	50	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	100	100	0	200	0
Total Income Generation		**550**	250	250	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**592**	**592**	**0**	**1,300**	**0**
				100%		**100%**	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£m
Recurrent Reserves Available for investment	1.241
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.131)
Emergence of Slippage against Recurrent Reserves Commitments	
Remaining Balance	**0**

Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23	£m
Non-Recurrent Reserves Available for investment	1.471
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
New Commitments	(0.067)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that both the Exceptional National costs pressures and all Covid related expenditure is funded.

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings - *Risk £0.066m, Likelihood - Low*

The Trust as part of the IMTP identified £1.300m of Savings and Income Generation to be achieved during 2022/23. Due to the ongoing pandemic and impact on sickness levels that remain significantly above pre Covid levels at this stage the Trust is unable to implement service redesign and changes to supportive structures, therefore there is a risk that the savings target against these schemes may not be fully achieved. The Trust will continue to review the savings schemes with a view of ensuring delivery, though contingency plans have now been developed in order to support any underperformance.

The conclusion of the Microsoft 365 National Deal led to a £0.157m (incl. VAT) in-year cost pressure, which will be assigned as a Cost Improvement Programme to the Digital Services Team. This includes the standing down of legacy IT infrastructure which is not required due to the MS 365 deal.

Covid Funding via Commissioners – *Risk £500k, Likelihood - Medium*

The Trust continues to have discussions with its commissioners who recognise our Covid funding requirement, however they have not committed to providing the full funding ask of £3.906m. Commissioners have all stated that any funding required to cover additional Covid recovery costs will only flow through the LTA under the national funds flow mechanism. This mechanism whilst providing enhanced income protection over the normal LTA would not cover the additional costs of premium rates through enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity will remain a risk for the Trust.

Other C-19 Response Costs – *Risk £0.963m, Likelihood - Medium*

Following further Covid de-escalation related activity and a review of operational costs in line with the updated guidance, the latest forecast spend and funding requirement from WG has reduced by a further £0.153m from £1.116m reported in August to £0.963m.

Other Exceptional National Cost Pressures – *Risk £1.237m - Medium*

The Trust is still anticipating full funding for the Employers NI increase and the incremental increase in Energy prices. The Employers NI costs have reduced from £0.551m to £0.339m following the Government announcement that the increase will be reversed from the 6th November. The incremental increase in Energy prices has significantly reduced from £3.016m in August to £0.898m following the introduction of the price cap and reflects the latest forecast provided by NWSSP Colleagues during October.

Pay Award – *Risk £0.500m - High*

The Trust has been informed that the pay ward will be paid on actual staff in post which will exclude both vacancies and incremental drift. This is expected to leave a funding gap of between circa £0.500m and £0.700m which is required in order to support the the full Trust staff establishment.

Management of Operational Cost Pressures – *Risk £0.250m, Likelihood - Low*

Cost pressures that have / will surface through the year 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 pressures may materialise beyond divisional control or be able to be managed through the overall Trust funding envelope.

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 £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - project costs	2.089	1.709	0.000	0.380	2.883	-0.794
nVCC - Enabling Works	18.441	3.362	0.000	15.079	17.647	0.794
Canisc Cancer Project	0.579	0.450	0.000	0.129	0.579	0.000
Fire Safety	0.500	0.051	0.000	0.449	0.500	0.000
Total All Wales Capital Programme	21.609	5.572	0.000	16.037	21.609	0.000
Discretionary Capital	1.454	0.382	0.000	1.072	1.454	0.000
Total	23.063	5.954	0.000	17.109	23.063	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at September 2022 was £23.063m. This includes All Wales Capital funding of £21.609m, and discretionary funding of £1.454m. The approved CEL has been reduced by £3.372m to reflect the latest forecast requirement on the nVCC Enabling works project for 2022/23. Following agreement with WG the £3.372m will be re-provided to the programme during 2023/24.

WG colleagues have been notified of an additional request to move £0.794m (previously £0.450m) from the nVCC enabling works to support the additional costs associated with the nVCC project fees and advisory activities. In addition, there is a further potential risk of underspend on the nVCC Enabling works with an update on spend ad funding requirement being provided to WG by the end of October.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

The discretionary allocation has ringfenced £0.434m to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may be reimbursed for the costs incurred in supporting the procurement phase of the scheme once the IRS FBC is approved.

The Trust is working collaboratively with Commissioners to progress the IRS FBC through the governance structures of each organisation in order to secure the funding requirements to deliver the solution. The Trust has required the need to place an order with the provider ahead of contract signature to allow the provider to secure the available resource within its supply chain.

Whilst there is a reduction in availability of Capital funding this year, WG colleagues have indicated that they are keen for organisation to continue to develop capital proposals should additional funding become available later in the financial year.

A list of prioritised bids to try and secure any WG yearend Capital opportunities have been endorsed by the Capital planning group for approval by EMB at today's meeting.

Whilst the financial position is challenging it is expected that capital requirements will be managed through the Trust discretionary allocation during 2022/23 or additional funding will be agreed and secured from WG.

Performance to date

The actual cumulative expenditure to September 2022 on the All-Wales Capital Programme schemes was £5.572m, this is broken down between spend on the nVCC enabling works £3.362m, nVCC project costs of £1.709m, Canisc Cancer Project £0.450m, and fire safety £0.051m.

Spend to date on Discretionary Capital is currently £0.382m leaving a remaining balance of £1.072m as at the 30th September.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

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.

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M
1	WBS HQ	34.125*	FBC being developed	1.016	12.808	9.996	4.434	5.215	0.608	0.048
2	IRS	46.921*	FBC has been approved by HBs and awaiting final approval from WG	7.453	9.533	22.832	7.103	0.000	0.000	0.000
3	Hemoflows	0.224	SBAR being Completed	0.224	0.000	0.000	0.000	0.000	0.000	0.000
4	Scalp Coolers	0.250	SBAR being Completed	0.250	0.000	0.000	0.000	0.000	0.000	0.000

*Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

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 22	Closing Balance End of Sep-22	Movement from 1st April Sep-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	150.510	7.37	155.420
Intangible assets	8.667	7.803	(0.864)	8.200
Trade and other receivables	1,092.008	1,303.720	211.71	1,303.720
Other financial assets	0.000	0.000	0.00	0.000
Non-Current Assets sub total	1,243.811	1.462	0.22	1.467
Current Assets				
Inventories	65.207	54.503	(10.704)	54.503
Trade and other receivables	540.227	265.860	(274.367)	294.287
Other financial assets	0.000	0.000	0.00	0.000
Cash and cash equivalents	30.404	52.234	21.83	18.500
Non-current assets classified as held for sale	0.000	0.000	0.00	0.000
Current Assets sub total	635.838	372.597	(263.241)	367.290
TOTAL ASSETS	1,879.649	1,834.630	(45.019)	1,834.630
Current Liabilities				
Trade and other payables	(277.601)	(227.480)	50.12	(227.480)
Borrowings	0.00	0.00	0.00	0.00
Other financial liabilities	0.00	0.00	0.00	0.00
Provisions	(341.123)	(342.901)	(1.778)	(342.901)
Current Liabilities sub total	(618.724)	(570.381)	48.34	(570.381)
NET ASSETS LESS CURRENT LIABILITIES	1,260.93	1,264.25	3.32	1,264.25
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.00	(7.336)
Borrowings	0.00	0.00	0.00	0.00
Other financial liabilities	0.00	0.00	0.00	0.00
Provisions	(1,094.206)	(1,091.599)	2.61	(1,091.599)
Non-Current Liabilities sub total	-1,101.542	-1,098.935	2.61	-1,098.935
TOTAL ASSETS EMPLOYED	159.383	165.314	5.93	165.314
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.00	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.93	118.911
Retained earnings	15.466	15.471	0.01	15.469
Other reserve	0.000	0.000	0.00	0.000
Total Taxpayers' Equity	159.383	165.316	5.933	165.314

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 £5m of stock had been purchased by NWSSP and an additional £2m 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.

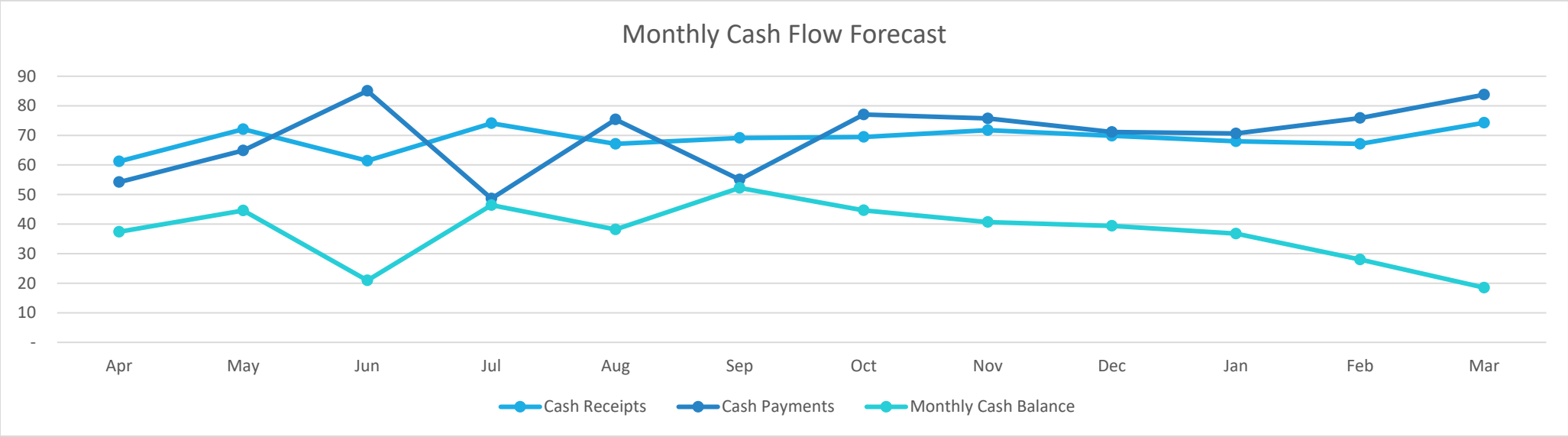
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place later this year but will be dependent on the stock being released.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however by the end of this financial year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

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	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	41.602	40.388	40.100	40.000	39.725	35.218	472.267
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	24.620	28.155	24.468	24.458	24.187	24.982	279.069
3	Short Term Loans													0.000
4	PDC				5.928								8.596	14.524
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.015	0.015	0.015	0.015	0.015	0.015	0.290
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	3.223	3.190	5.271	3.520	3.183	5.447	59.286
8	TOTAL RECEIPTS	**61.197**	**72.074**	**61.403**	**74.090**	**67.121**	**69.127**	**69.460**	**71.748**	**69.854**	**67.993**	**67.110**	**74.258**	**825.435**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	32.962	32.971	32.942	32.976	32.970	33.478	372.433
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	42.570	39.288	35.638	33.760	40.496	41.331	433.131
11	Short Term Loan Repayment												7.000	7.000
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.513	3.458	2.551	3.898	2.402	1.952	24.776
15	Other items													0.000
16	TOTAL PAYMENTS	**54.205**	**64.889**	**85.042**	**48.623**	**75.361**	**55.063**	**77.046**	**75.716**	**71.131**	**70.635**	**75.868**	**83.762**	**837.340**
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	-23.639	25.467	-8.240	14.064	-7.586	-3.969	-1.277	-2.642	-8.757	-9.503	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	44.648	40.679	39.402	36.760	28.003	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	44.648	40.679	39.402	36.760	28.003	18.500	



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	(18.238)	(18.238)	(0.000)	(37.280)	(37.280)	0.000
RD&I	(0.289)	(0.288)	(0.000)	0.323	0.323	0.000
WBS	(10.097)	(10.098)	0.000	(20.303)	(20.303)	0.000
Sub-Total Divisions	**(28.624)**	**(28.624)**	**(0.000)**	**(57.259)**	**(57.259)**	**0.000**
Corporate Services Directorates	**(5.177)**	**(5.174)**	**(0.003)**	**(10.337)**	**(10.337)**	**0.000**
Delegated Budget Position	**(33.801)**	**(33.798)**	**(0.003)**	**(67.597)**	**(67.597)**	**0.000**
TCS	(0.280)	(0.280)	0.000	(0.556)	(0.556)	0.000
Health Technology Wales	(0.034)	(0.033)	(0.000)	(0.048)	(0.048)	0.000
Trust Income / Reserves	34.115	34.113	0.002	68.200	68.200	0.000
Trust Position	(0.000)	0.003	(0.003)	0.000	0.000	0.000

VCC

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**33.792**	**34.070**	**0.278**	**71.793**	**71.793**	**0.000**
Expenditure						
Staff	**22.540**	**22.430**	**0.110**	**43.884**	**43.884**	**0.000**
Non Staff	**29.490**	**29.878**	**(0.388)**	**65.189**	**65.189**	**0.000**
Sub Total	**52.030**	**52.308**	**(0.278)**	**109.073**	**109.073**	**0.000**
Total	**(18.238)**	**(18.238)**	(0.000)	**(37.280)**	**(37.280)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of September 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 6 represents an overachievement of **£0.278m**. This is largely from an increase in activity from providing SACT homecare and the additional VAT savings, an over achievement on private patient income due to drug performance, which is above general private patient performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.392m.

VCC have reported a year to date underspend of **£0.110m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly within Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£0.585m to end of September, £0.159m being directly related to Covid). Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures, however with social distancing measures reducing a review of service model is being undertaken which considers both recruitment requirement, but also additional ambulatory care to help reduce inpatient flow.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led is currently still being partly covered by Jnr Dr's with transition to nursing having started from August.

Early recruitment to the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.260m.

Non-Staff Expenditure at Month 6 was **£(0.388)m** overspent. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs. The affect from the increase in price for utilities is included as an exceptional national costs pressure with the expectation that the costs will be funded by WG.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**13.082**	**12.558**	**(0.524)**	**23.730**	**23.160**	**(0.570)**
Expenditure						
Staff	**8.580**	**8.588**	**(0.008)**	**16.971**	**16.942**	**0.029**
Non Staff	**14.599**	**14.068**	**0.532**	**27.062**	**26.521**	**0.542**
Sub Total	**23.180**	**22.656**	**0.524**	**44.032**	**43.463**	**0.570**
Total	**(10.097)**	**(10.098)**	0.000	**(20.303)**	**(20.303)**	**0.000**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of September 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.524)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation from plasma sales to research is not achieving desired levels, contract award for increased selling price for new supplier is to be awarded on 1st October and secondary supplier expected from February, however volume of product to sell remains low and a risk. Transitional operating sites for Bone Marrow and

increasingly curtailed procedures is resulting in activity being considerably lower than target. Assumed WHSSC income for supressed income is reflected within the non-pay position.

Staff reported a small year-to-date overspend of **£(0.008)m** to September. Overspend from posts supported without identified funding source which includes advanced recruitment and service developments have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. WG bid has been submitted to support Plasma Fractionation staffing costs.

Work is still underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff underspend of **£0.532m** is largely due to reduced costs from suppressed activity underspends on Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance. Bone Marrow underspend reflected to contra income underachievement.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.497**	**0.537**	**0.039**	**0.974**	**0.991**	**0.017**
Expenditure						
Staff	**4.577**	**4.401**	**0.177**	**9.002**	**8.840**	**0.162**
Non Staff	**1.097**	**1.310**	**(0.213)**	**2.310**	**2.488**	**(0.178)**
Sub Total	**5.675**	**5.711**	**(0.036)**	**11.311**	**11.328**	**(0.017)**
Total	**(5.177)**	**(5.174)**	0.003	**(10.337)**	**(10.337)**	**0.000**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of September 2022 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates which will be utilised to support the WRP contribution which is now expected to become recurrent in nature.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £0.100m divisional savings target.

Non pay overspend is **£(0.213)m** as at month 6 largely relates to the divisional savings target £(0.078)m as at end of September which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates. Other large pressures include the increased running costs for the hospital estate with work still ongoing to understand the total cost for 2022-23.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.128**	**1.028**	**(0.100)**	**3.190**	**3.054**	**(0.136)**
Expenditure						
Staff	**1.347**	**1.239**	**0.108**	**2.684**	**2.503**	**0.181**
Non Staff	**0.070**	**0.077**	**(0.008)**	**0.183**	**0.183**	**(0.045)**
Sub Total	**1.416**	**1.316**	**0.100**	**2.867**	**2.686**	**0.136**
Total	**(0.289)**	**(0.288)**	(0.000)	**0.323**	**0.368**	**0.000**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of September 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Staff vacancies are offsetting the innovation income target with the stretched target for this year currently proving to be difficult to meet.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.280**	**0.280**	**0.000**	**0.556**	**0.556**	**0.000**
Non Staff	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Sub Total	**0.280**	**0.280**	**0.000**	**0.556**	**0.556**	**0.000**
Total	**(0.280)**	**(0.280)**	0.000	**(0.556)**	**(0.556)**	**0.000**

TCS Key Issues

The reported financial position for the TCS Programme at the end of September 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

TCS will achieve breakeven on the assumption that the Trust reserves again supports the forecasted non-pay costs of £0.030m, along with associated costs of the judicial review which is currently expected to be £0.043m.

The TCS report assumes budget for the above Trust reserves allocation and pay award which is pending formal approval along with previously approved funding, therefore the report reflects inflated figures to what is currently in the Trust ledger.

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	**0.832**	**0.706**	**(0.126)**	**1.664**	**1.664**	**0.000**
Expenditure						
Staff	**0.748**	**0.669**	**0.079**	**1.476**	**1.476**	**0.000**
Non Staff	**0.118**	**0.070**	**0.048**	**0.235**	**0.235**	**0.000**
Sub Total	**0.866**	**0.739**	**0.127**	**1.712**	**1.712**	**0.000**
Total	**(0.034)**	**(0.033)**	(0.000)	**(0.048)**	**(0.048)**	**0.000**

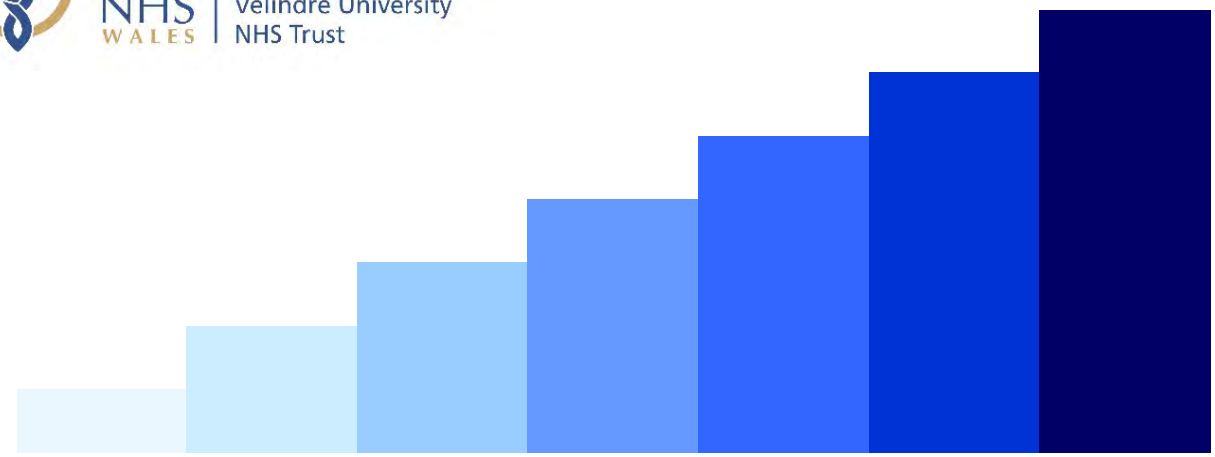
HTW Key Issues

The reported financial position for Health Technology Wales at the end of September 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG.

Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo

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



TCS PROGRAMME FINANCE REPORT 2022/23

Period Ending September 2022

Presented to the
TCS Programme Delivery Board on
13th October 2022

Contents Page

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 2022/23, outlining spend to date against budget as at Month 06 and the current 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 2022/23 as at 30th September 2022 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	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£5.234m	£20.964m	£20.964m	£0
Revenue	£0.311m	£0.704m	£0.704m	£0
Total	**£5.544m**	**£21.668m**	**£21.668m**	**£0**

2.2 The Programme is currently forecasting an overall breakeven position for capital and revenue expenditure for the financial year 2022/23. The Enabling Works forecast position reflects an under-spend of £0.794m, which will support the nVCC Project. The financial support will be provided from the Enabling Works QRA and does pose a low financial risk for the Enabling Works Project. The approach needs to be agreed with WG.

2.3 Following a review in August 2022, WG have agreed a virement of £1.472m of the Enabling Works Project capital funding from 2022/23 into 2023/24. This reduces the overall capital funding for 2022/23 to £21.648m. The Project will make an assessment to 'slip' funding into 2023-24 as per agreement with WG. To date the EW Project has undertaken the following adjustments into 2023-24:

- Adjustment of £1.9m in May 22 – delay in Enabling Works Project
- Adjustment of £1.472m in August 22 – delay in the Asda works

2.4 Provisional pay award revenue funding of £0.020m was provided to the Programme in September 2022 from the WG allocation to the Trust. The revised revenue budget is now £0.704m for 2022/23, and the overall budget has increased to £21.668m for this financial year.

2.5 There are currently two financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities; and

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage.

2.6 These risks have mitigation plans in place or being developed by the relevant Project Teams. There are currently no other financial risks for the TCS Programme.

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 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from 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 and £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2022/23 is £20.964m capital and £0.684m revenue, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1 There is a revised Capital Expenditure Limit (CEL) from WG of £18.441m for the Enabling Works Project and £2.089m to support the nVCC Project in 2022/23.

4.2 WG funding for the Integrated Radiotherapy Solution Procurement (IRS) Project was utilised in previous years, therefore no CEL has been issued for this Project in 2022/23. The capital funding requirement of £0.434m will be provided from the Trust's discretionary capital allocation.

4.3 The capital position as at 30th September 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against an overall budget of £20.964m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£3.350m	£18.441m	£17.646m	£0.794m
nVCC Project	£1.719m	£2.089m	£2.883m	-£0.794m
IRS Procurement Project	£0.165m	£0.434m	£0.434m	£0
Total	**£5.234m**	**£20.964m**	**£20.964m**	**£0**

4.4 The forecast overspend of £0.794m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.794m.

5. REVENUE POSITION

5.1 Revenue funding for the Programme Management Office (PMO) and the Service Development & Transformation (SDT) Project continues to be provided by the Trust and the NHS Commissioners.

5.2 To date, the Trust has ring-fenced £0.073m revenue funding for the nVCC Project, as no revenue funding has been provided by WG this year. Formal delegation of this budget is pending.

5.3 In September 2022, the annual NHS pay award was implemented, back dated to April 2022. As such, a provisional pay award of £0.010m was provided to the PMO and another £0.010m to the SDT Project from the assumed WG allocation to the Trust. These will be confirmed in October 2022 following a mid-year review of revenue pay and non-pay budgets and forecast spend.

5.4 The revenue position as at 30th September 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a revised budget of £0.704m.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.114m	£0.310m	£0.310m	£0
nVCC Project	£0.049m	£0.073m	£0.073m	£0
SDT Project	£0.147m	£0.321m	£0.321m	£0
Total	**£0.311m**	**£0.704m**	**£0.704m**	**£0**

6. CASH FLOW

6.1 This update is currently being developed.

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 In 2022/23, the PMO has been allocated £0.060m from the phased funding of £0.250m for the Strategic Transformation Programme from 2021/22 to 2023/24 to support the transition between Programmes. This additional funding was released in May 2022, increasing the total revenue funding from £0.240m (Commissioners' funding) to £0.300m for 2022/23.

7.3 In September 2022, provisional pay award funding of £0.010m was allocated to the PMO, resulting in a revised budget of£0.310m for this financial year.

7.4 There is no capital funding requirement for the PMO in 2022/23.

7.5 The revenue position for the PMO as at 30th September 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.112m	£0.293m	£0.293m	£0
Non Pay	£0.002m	£0.017m	£0.017m	£0
Total	**£0.114m**	**£0.310m**	**£0.310m**	**£0**

7.6 There are currently no financial risks relating to the PMO.

Enabling Works Project

7.7 A CEL of £18.441m has been provided by WG for the Enabling Works Project in 2022/23. This is a revised amount from the £21.813m CEL initially allocated in 2022/23 from the total capital funding for the Project of £28.089m. An overall virement to date of £3.372m into 2023/24 has resulted in the current revised CEL.

7.8 The Project's financial position for 30th September 2022 is shown below, with a further breakdown provided in Appendix 3. The forecast position reflects an underspend of £0.793m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.109m	£0.220m	£0.219m	£0.001m
Non Pay	£3.241m	£18.221m	£17.428m	£0.793m
Total	**£3.350m**	**£18.441m**	**£17.646m**	**£0.794m**

7.9 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities. The Project will review and confirm to WG in October 2022 the funding required in 2022/23 to deliver the Project. Any further slippage after this point will be managed by the Trust's Capital programme or returned to W with no reprovision.

New Velindre Cancer Centre Project

Capital

7.10 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL of £2.089m in 2022/23.

7.11 The capital financial position for the nVCC Project for 30th September 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.794m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.631m	£1.413m	£1.326m	£0.087m
Non Pay	£1.088m	£0.676m	£1.557m	-£0.881m
Total	**£1.719m**	**£2.089m**	**£2.883m**	**-£0.794m**

7.12 There is a financial risk relating to increased advisory fees in the range of £0.100m to £0.200m required to conclude the tender evaluation stage and Successful Participant to Financial Close stage. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

7.13 No revenue funding has been provided for the nVCC Project by WG in 2022/23. Therefore the Trust has ring-fenced a revenue budget of £0.030m for nVCC Project Delivery, and a further £0.043m for the Judicial Review Matter. Formal delegation of both budgets is pending.

7.14 The revenue financial position for the nVCC Project for 30th September 2022 is shown below, reflecting a forecast breakeven spend against a budget of £0.073m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.016m	£0.030m	£0.030m	£0
Judicial Review	£0.033m	£0.043m	£0.043m	£0
Total	**£0.049m**	**£0.073m**	**£0.073m**	**£0**

7.15 Following the closure of the Judicial Review matter, the budget and forecast spend for this matter will be reviewed once of any outstanding and final fees have been presented to the Project.

7.16 There are currently no financial risks relating to the nVCC revenue expenditure.

Integrated Radiotherapy Solution Procurement Project

7.17 Due to a delay in the procurement process, the IRS Project has been extended to September 2022. This has resulted in an additional capital requirement of £0.434m in 2022/23, which has been ring-fenced by the Trust from its 2022/253 discretionary capital allocation.

7.18 There is no revenue funding requirement for the Project in 2022/23.

7.19 The capital position for the IRS Project for 30th September 2022 is outlined below, with a breakeven position forecast for the year.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.072m	£0.072m	£0.081m	-£0.009m
Non Pay	£0.093m	£0.362m	£0.353m	£0.009m
Total	**£0.165m**	**£0.434m**	**£0.434m**	**£0**

7.20 Closure of the Project is expected in October 2022, at which time any unused funding will be returned to the Trusts discretionary capital allocation.

7.21 There are currently no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation Project

7.22 The SDT Project has received revenue funding of £0.131m from the Trust and £0.180m funding from the NHS Commissioners' contribution to support pay and non-pay costs in 2022/23.

7.23 In September 2022, provisional pay award funding of £0.010m allocated to the Project, resulting in a revised budget of£0.321m for this financial year.

7.24 There is no capital funding requirement for the Project in 2022/23.

7.25 The SDT Project revenue position as at 30th September 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.147m	£0.298m	£0.298m	£0
Non Pay	£0.000m	£0.023m	£0.023m	£0
Total	**£0.147m**	**£0.321m**	**£0.321m**	**£0**

7.26 There are currently no financial risks relating to the SDT Project.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently two financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities; and
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage.

8.2 These risks have mitigation plans in place or being developed by the relevant Project Teams.

8.3 There are currently no other financial risks for the TCS Programme.

9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being developed.

APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 30th September 2022

CAPITAL	Year to Date			Financial Year		
	Budget Sep-22	Spend Sep-22	Variance Sep-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	104,388	104,281	107	208,776	210,475	-1,699
Project 1b - Enabling Works FBC	109,872	109,002	870	219,744	218,600	1,144
Project 2a - New Velindre Cancer Centre OBC	621,394	526,303	95,091	1,203,913	1,115,688	88,225
Project 3a - Radiotherapy Procurement Solution	72,101	71,854	248	72,101	80,934	-8,832
Capital Pay Total	**907,755**	**811,440**	**96,315**	**1,704,534**	**1,625,696**	**78,838**
NON-PAY						
nVCC Project Delivery	37,470	34,742	2,728	84,000	84,000	0
Project 1b - Enabling Works FBC	3,606,141	3,240,755	365,386	18,221,033	17,427,861	793,171
Project 2a - New Velindre Cancer Centre OBC	592,311	1,053,630	-461,319	592,311	1,472,950	-880,639
Project 3a - Radiotherapy Procurement Solution	250,487	93,304	157,183	361,899	353,066	8,832
Capital Non-Pay Total	**4,486,409**	**4,422,431**	**63,978**	**19,259,243**	**19,337,878**	**-78,635**
CAPITAL TOTAL	**5,394,164**	**5,233,871**	**160,293**	**20,963,777**	**20,963,574**	**203**

REVENUE	Year to Date			Financial Year		
	Budget Sep-22	Spend Sep-22	Variance Sep-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	115,519	112,342	3,177	292,993	292,993	0
Project 6 - Service Change Team	146,001	147,124	-1,124	298,390	298,390	0
Revenue Pay total	**261,519**	**259,466**	**2,053**	**591,383**	**591,383**	**0**
NON-PAY						
nVCC Project Delivery	16,338	16,412	-75	30,000	30,000	0
nVCC Judicial Review	32,956	32,956	0	43,417	43,417	0
Programme Management Office	3,000	1,626	1,374	17,007	17,007	0
Project 6 - Service Change Team	11,305	133	11,172	22,610	22,610	0
Revenue Non-Pay Total	**63,599**	**51,128**	**12,471**	**113,034**	**113,034**	**0**
REVENUE TOTAL	**325,118**	**310,594**	**14,524**	**704,417**	**704,417**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.310m**
Commissioner's funding (April 2022)		£0.240m
Year 1 Trust revenue funding for Strategic Transformation (April 2022)		£0.060m
Pay Award Funding (September 2022)		£0.010m
Enabling Works OBC	**£18.441m**	**£0m**
2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£21.813m	
Virement of funds from 2022/23 to 2023/24 financial year (May 2022)	-£1.900m	
Virement of funds from 2022/23 to 2023/24 financial year (August 2022)	-£1.472m	
New Velindre Cancer Centre OBC	**£2.089m**	**£0.073m**
2022/23 CEL from Welsh Government funding for nVCC OBC (March 2021)	£2.089m	
Trust revenue funding for nVCC Project Delivery (May 2022)		£0.030m
Trust revenue funding for Judicial Review matter (May 2022)		£0.014m
Additional Trust revenue funding for Judicial Review matter (June 2022)		£0.029m
Integrated Radiotherapy Procurement Solution	**£0.434m**	**£0m**
Trust Discretionary Capital Allocation (June 2022)	£0.434m	
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.321m**
Commissioner's funding (April 2022)		£0.180m
Trust Funding (April 2022)		£0.131m

Description	Funding Type	
	Capital	Revenue
Pay Award Funding (September 2022)		£0.010m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£20.964m**	**£0.704m**

APPENDIX 3: Enabling Works Project Budget and Spend 2022/23 as at 30th September 2022

Description		Year to Date Budget Sep-22 £	Year to Date Spend Sep-22 £	Year to Date Variance Sep-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		109,872	109,002	870	219,744	218,600	1,144
Pay Capital Total		**109,872**	**109,002**	**870**	**219,744**	**218,600**	**1,144**
NON-PAY - PROJECTS							
EF01	Construction Costs	0	51,662	-51,662	0	51,662	-51,662
EF02	Utility Costs	62,576	62,576	0	1,850,895	1,850,895	0
EF03	Supply Chain Fees	293,057	292,557	500	596,047	596,047	0
EF04	Non Works Costs	80,753	182,826	-102,073	495,847	618,920	-123,073
EF05	ASDA Works	297,743	275,023	22,720	4,570,654	4,547,934	22,720
EF06	Walters D&B	2,247,249	2,247,249	0	8,735,418	8,735,418	0
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	153,000	21,000
EFQR	Quantified Risk	624,763	165,237	459,526	1,351,828	456,281	895,547
EFQS	QRA - SCP	0	0	0	454,080	454,080	0
EFRS	Enabling Works FBC Reserves	0	-36,375	36,375	-7,736	-36,375	28,639
Enabling Works Project Capital Total		**3,606,141**	**3,240,755**	**365,386**	**18,221,033**	**17,427,861**	**793,171**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**3,716,013**	**3,349,757**	**366,256**	**18,440,777**	**17,646,461**	**794,316**

APPENDIX 4: nVCC Project Budget and Spend 2022/23 as at 30th September 2022

Description	Year to Date Budget Sep-22 £	Year to Date Spend Sep-22 £	Year to Date Variance Sep-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership	104,388	104,281	107	208,776	210,475	-1,699
Project 2a - New Velindre Cancer Centre OBC	621,394	526,303	95,091	1,203,913	1,115,688	88,225
Pay Capital Total	**725,782**	**630,584**	**95,198**	**1,412,689**	**1,326,163**	**86,526**
NON-PAY						
nVCC Project Delivery	**37,470**	**34,742**	**2,728**	**84,000**	**84,000**	**0**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	592,311	1,014,771	-422,460	592,311	1,431,271	-838,960
VC10 Legal Advice	0	2,460	-2,460	0	2,460	-2,460
VC11 S73 Planning	0	99,918	-99,918	0	99,918	-99,918
VCRS nVCC Reserves	0	-63,518	63,518	0	-60,698	60,698
nVCC Project Capital Total	**592,311**	**1,053,630**	**-461,319**	**592,311**	**1,472,950**	**-880,639**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**1,355,563**	**1,718,956**	**-363,393**	**2,089,000**	**2,883,113**	**-794,113**

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

September 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness
- Hotspots identified, with in month actions to explain improvement trajectory work in relation to sickness

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Sept-22	Aug22	
PADR	71.24%	70.45%	85%
Sickness	6.31%	6.46%	3.54%
S&M Compliance	85.49%	85.10%	85%

Workforce Dashboard

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63
Research, Development & Innovation	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00
Transforming Cancer Services	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50
Velindre Cancer Centre	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50
Welsh Blood Service	77.93	77.52	82.19	83.06	83.73	81..75	78.44	78.16	79.26	77.53	76.90	77.86	79.27
Velindre Organisations	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	71.36	74.54	72.32	74.40	72.17	73.64	74.51	73.48	74.31	74.41	73.06	71.95	73.84
Research, Development & Innovation	86.25	84.89	84.58	85.83	84.26	80.42	80.21	80.23	79.56	82.95	81.09	80.22	84.77
Transforming Cancer Services	82.50	82.86	83.33	81.43	77.86	77.39	77.39	78.64	80.91	76.96	75.65	75.42	77.20
Velindre Cancer Centre	82.89	83.11	84.91	84.93	84.73	84.18	84.88	85.17	85.46	85.22	84.68	84.39	85.01
Welsh Blood Service	92.21	92.54	93.36	93.56	93.78	92.02	92.30	92.19	92.44	93.17	91.72	92.19	91.33
Velindre Organisations	84.95	85.10	86.06	86.40	85.97	85.26	85.77	85.76	85.08	86.20	85.27	85.10	85.49

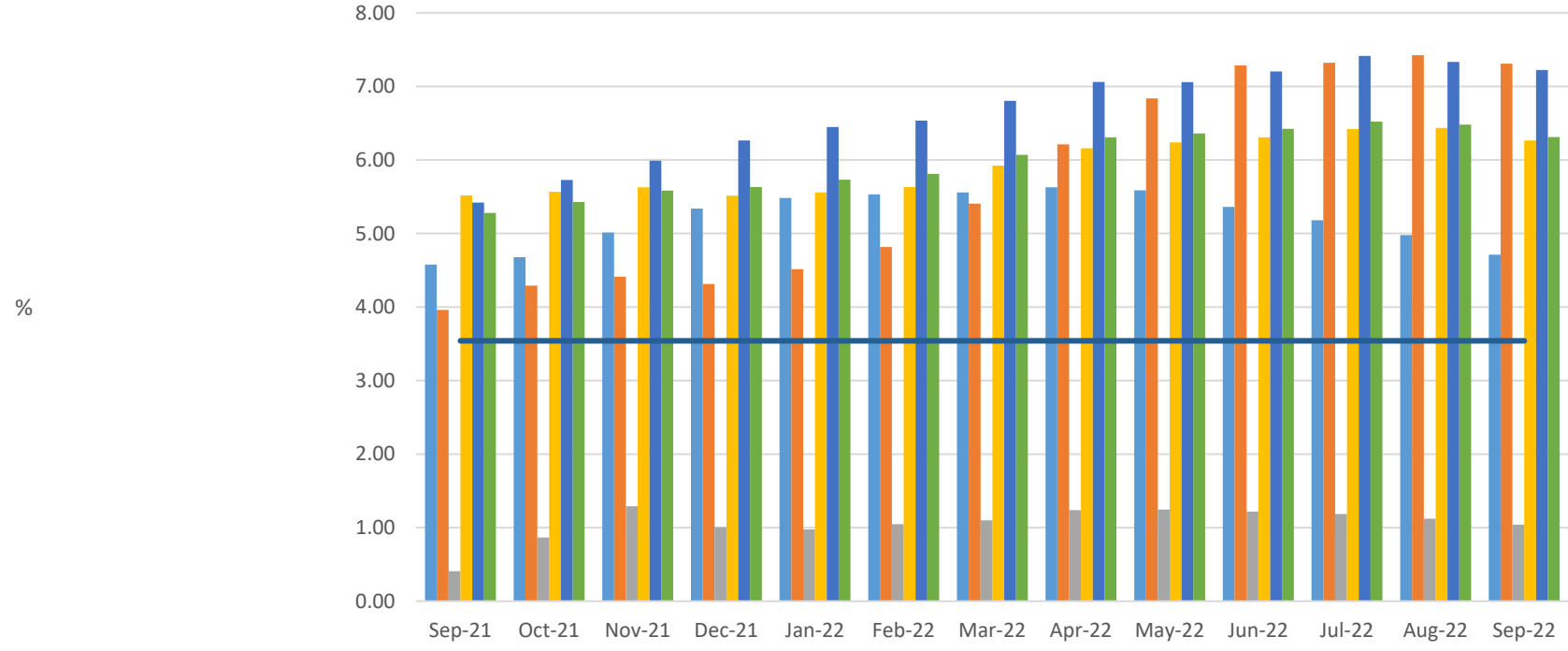
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.18	4.98	4.71
Research, Development & Innovation	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.31
Transforming Cancer Services	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18	1.12	1.04
Velindre Cancer Centre	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.31	6.42	6.43	6.26
Welsh Blood Service	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41	7.33	7.22
Velindre Organisations	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.52	6.48	6.31
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

Monthly Sickness Rolling Covid Only Absence %	0.00		0.01% - 0.49%		0.50 % & Above								
Sickness Leave Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	1.34	1.46	1.57	1.64	1.71	1.73	1.69	1.66	1.63	1.57	1.54	1.48	1.36
Research, Development & Innovation	0.43	0.43	0.53	0.66	0.87	1.08	1.33	1.59	1.68	1.96	2.22	2.48	2.58
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Velindre Cancer Centre	0.85	0.86	0.84	0.73	0.82	0.89	1.07	1.17	1.16	1.22	1.31	1.30	1.25
Welsh Blood Service	0.36	0.39	0.38	0.36	0.38	0.42	0.61	0.79	0.85	0.94	1.12	1.15	1.11
Velindre Organisations	0.72	0.75	0.74	0.70	0.77	0.83	0.99	1.10	1.12	1.18	1.29	1.29	1.24

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	0.03	0.09	0.09	0.09	0.09	0.10	0.10	0.12	0.13	0.14	0.14	0.14	0.14
Research, Development & Innovation	0.92	1.08	1.25	1.37	1.57	1.62	1.69	1.89	1.89	1.82	1.75	1.55	1.36
Transforming Cancer Services	0.55	0.54	0.41	0.25	0.08	0.07	0.07	0.07	0.07	0.06	0.05	0.02	0.02
Velindre Cancer Centre	0.48	0.53	0.57	0.61	0.66	0.67	0.73	0.79	0.79	0.81	0.81	0.78	0.74
Welsh Blood Service	0.59	0.59	0.58	0.56	0.53	0.51	0.49	0.50	0.48	0.47	0.43	0.40	0.38
Velindre Organisations	0.49	0.53	0.55	0.56	0.58	0.59	0.61	0.65	0.65	0.65	0.64	0.61	0.57

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	0.01	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.05	0.07	0.08	0.08	0.09
Research, Development & Innovation	0.13	0.15	0.10	0.15	0.20	0.20	0.21	0.30	0.30	0.31	0.31	0.24	0.24
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.69	0.71	0.64	0.65	0.70	0.69	0.75	0.83	0.85	0.88	0.89	0.90	0.85
Welsh Blood Service	0.67	0.67	0.68	0.65	0.63	0.61	0.59	0.63	0.69	0.69	0.68	0.64	0.52
Velindre Organisations	0.59	0.60	0.56	0.56	0.58	0.57	0.60	0.65	0.68	0.70	0.71	0.69	0.63

Sickness Data – The Figures



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.18	4.98	4.71
Research, Development & Innovation	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.31
Transforming Cancer Services	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18	1.12	1.04
Velindre Cancer Centre	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.31	6.42	6.43	6.26
Welsh Blood Service	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41	7.33	7.22
Velindre Organisations	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.52	6.48	6.31
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

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	September Figure	Hotspot	%	Comment
Sickness absence (3.42%)	**6.46%** ↓	6.31%	**Welsh Blood Service (7.33%)**		
			Collections	9.64%	Decrease from previous month (11.99%)
			Laboratory Section	3.85%	Decrease from previous month (8.43%)
			Quality Assurance Section	2.69%	Decrease from previous month (4.76%)
			Velindre Cancer Centre (6.41%)		
			Radiotherapy	9.63%	Increase from previous month (8.85%)
			Outpatients	7.04%	Decrease from previous month (11.99%)
			Operational Services	7.27%	Increase from previous month (6.74%)
			Information Section	7.88%	Decrease from previous month 10.75%)

QUALITY, SAFETY AND PERFORMANCE COMMITTEE (QSP)

SEPTEMBER 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jeff O'Sullivan, Planning and Performance Manager Alan Prosser, Director WBS Amanda Jenkins, Head of WOD
PRESENTED BY	Cath O'Brien, Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	12.10.22	Reviewed and Noted
VCC SLT	19.10.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	19.10.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	20.10.22	Reviewed and Noted
EMB RUN	26.10.22	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
QSP	Quality, Safety & Performance Committee
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
RCC	Rutherford Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to QSP with respect to Trust-wide performance against key performance metrics through to the end of September 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(*appendix 3).*** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.1 Velindre Cancer Centre:

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing and varying as health boards undertake additional activity to address their longest waiting patients.

Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work underway supported by activity plans to maximise efficiency and productivity to demonstrate the most effective use of resources.

Below we outline the details of the factors influencing performance in September 2022,

A number of immediate actions have been implemented as part of the ongoing capacity task force groups established in Radiotherapy and SACT. This includes incremental release of capacity through changes in practice and identifying options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

Radiotherapy Waiting Times

Overall referrals to radiotherapy for September (364) were above than those received in August (322).

There are also significant challenges associated with the fragility of the equipment due to its age of the equipment and the risk of potential breakdown, especially as we increase usage. The replacement programme that has commenced in October is essential in addressing this risk.

We have observed higher than planned referrals for breast cancer patients as health boards are commencing a range of activity to target the increasing patient referrals for diagnosis for patients with suspected breast cancer and increase activity in the initial parts of their treatment pathway. Variation in referral patterns occurring is also a challenge as health board undertake focused activity within specific specialist areas.
Capacity to treat breast patients has been compounded due to the configuration of the linear accelerator (LINAC) fleet at VCC, which means specific tumour sites such as breast, cannot be treated on all machines. This is being addressed through configuration changes to all LINAC to facilitate additional capacity during September which will impact on capacity in October.
Challenges also remain in relation to provision of specific Brachytherapy capacity and Medical Physics capacity. This is being addressed through the commissioning of additional service capacity, delivery of which is being planned and is reliant on

A gradual increase in LINAC capacity by 8% is underway, increasing from 73.5 planned hours in June to 76.5 hours in September and 79.5 planned in October. This is being supported through a temporary increase in staffing hours and reallocation of roles, whilst we continue to induct the recruited staff that started in recent months. This staff group will be fully operational in January.

Patient receiving radical radiotherapy within 28 day

Of the 214 patients who were referred for treatment with radical intent. 27 did not begin treatment within 28-days (performance rate of 87%). The target is 98%. This is a 50% reduction from the breach number in August (55).

We have analysed the breach data at an individual patient level to determine why this occurred.

24 of the 27 of breaches in September were attributed to a lack of sufficient treatment capacity for patients referred with breast cancers. Previously defined operational plans to secure sufficient breast treatment capacity in anticipation of the final decommissioning of one of two linear accelerators, relied on capacity from the Rutherford Cancer Centre (RCC). The closure of the RCC has presented capacity challenges which have been further compounded by the upturn in referrals noted above. As identified above , the radiotherapy service is delivering a plan which will introduce a greater degree of flexibility, extending and improving the capability of the various LINAC, ensuring that more patients with breast cancers can undergo treatment on more machines than has been the case in the past.

SACT Waiting Times

Performance against the non-emergency time-to-treatment target has continued to improve, and has risen to 89% from 77% last month. Breach numbers have also reduced from 92 in August to 36 in September.

A taskforce is in place to identify short to medium term options to address shortfall in capacity and to deliver productivity and efficiency gains alongside additional resources being deployed. This work is ongoing but has already resulted in the highest ever recorded SACT delivery figures for August (2501) and September (2544).

A redistribution of patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics established from August for a three-month period to expand capacity have now ceased, coinciding with the reopening of SACT chairs in the Prince Charles hospital setting commencing in October. Internal support is being provided from nursing within other departments as required to maintain activity.

Therapies

A number of our therapy teams are having recruitment and retention challenges and this has resulted in a small number of waiting times breaches (3), particularly where there is specialist provision or low resilience through small or single handed services and teams. This has also been compounded by levels of maternity absence which cannot always be covered. All actions that can be taken to support service delivery are being undertaken.

Other areas

Falls

During September 2022, there were 3 Velindre falls affecting 3 patients on first floor ward. 2 were deemed unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

Pressure Ulcers

During September 2022, there were 4 Velindre acquired pressure ulcers affecting 3 patients on first floor ward. All were deemed unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

Healthcare Acquired Infections

No Healthcare Acquired Infections (HAIs) were reported in September 2022.

SEPSIS bundle NEWS score

13 patients met the criteria for response to sepsis and all 13 received antibiotics within 1 hour where appropriate = 100% compliance.

9 of the 13 patients went on to receive a diagnosis of sepsis and all 9 patients received all 6 elements of the SEPSIS bundle within 1 hour = 100% compliance.

Delayed Transfers of Care (DTOC's)

There was no Delayed Transfers of Care reported in September 2022.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups, which is testament to a concerted effort by all staff working in the supply chain operation.
This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated.

2.2.1 Quality

At 98%, Quality Incident Records closed within 30 days continues to exceed target (90%) for September. There were no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no SHOT incidents were reported during the month. No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics.

All 6 informal concerns received were managed within 2 working days as required by Putting Things Right (PTR) regulations. At 96.5% donor satisfaction continues to remain above target.

2.2.2 Recruitment of new Bone Marrow Volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) is below target (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we

typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% in eligible donors).

A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers, avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan, which is expected to start to deliver results in Quarter 1 2023.

2.2.3 Reference Serology

In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance.

A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric.

2.2.4 Time Expired Platelets

Time expired platelets did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September.

Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in November to implement the recommendations.

2.2.5 Manufacturing Efficiency

Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales.

This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the performance management reporting framework.

2.2.5 New Blood & Apheresis Donors (Quarterly Reporting)

Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies.

A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors.

As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.

3 WORKFORCE

3.2.3 PADR

Trust Wide 71.24%, increase on previous month (Target 85%)
WBS 79.27%, increased compared to last month
VCC 71.50%, increased compared to last month

Sickness Absence

Trust wide 6.31%, sickness rates decreased compared to last month. (Target 3.54%)
WBS 7.22%, sickness rates decreased compared to last month
VCC 6.26%, sickness decreased compared to last month.

3.3 Statutory & Mandatory Compliance

Trust Wide 85.49%, above target (Target 85%)
WBS 91.33%, above target but decrease on previous month
VCC 85.01% above target and increase on previous month.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 QSP is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC September PMF Report
2. WBS September PMF Report
3. Workforce Monthly September PMF Report

QUALITY SAFETY AND PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	PETER RICHARDSON, HEAD OF QUALITY ASSURANCE AND REGUALTORY COMPLIANCE, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality and Regulatory Compliance
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Regulatory Assurance and Governance Group	31/10/22	Noted and discussed
WBS Senior Management Team	09/11/22	Noted and discussed
Executive Management Board	24/10/22	

ACRONYMS	
WBS	Welsh Blood Service
WTAIL	Welsh Transplant and Immuno-genetics Laboratories
MHRA	Medicines and Healthcare products Regulatory Agency
RAGG	Regulatory assurance and governance group
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action
SABRE	Serious Adverse Blood Related Event

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period June to September 2022

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

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

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between June and September 2022, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements.

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises :

- Key performance outliers and associated actions to resolve
- Key quality and safety related indicators and remedial action identified
- Feedback from Donors and the responses to it.
- Regulator and Audit Feedback, assurance and learning themes
- An outline of key service developments in WBS

3.1 Triangulated Analysis

The report provides assurance to the Quality, Safety and Performance Committee that WBS is continuing to meet its Quality, Safety and Performance standards. The report summarises for the reporting period June to September and updates where possible for the month of October 2022.

- All clinical demand was met for red cells and platelets although some stock was imported during early July when the service was in blue alert given a combination of constraints in blood collection.
- WBS rallied towards the end of July and was able to increase collection capacity which has been sustained to date through a combination of measures including, staff volunteers and increasing chair capacity.
- More recently, WBS has been able to support other UK blood services (Celtic Nations) who have not been able to recover and sustain their stock holding as fast as in Wales. The UK position on blood supply remains fragile and was exacerbated by NHSBT in England declaring an Amber alert for all Blood groups on October 12th for a minimum 4 week period.
- As a consequence of the nationwide publicity on Amber alert for blood 2,000 additional donors registered with WBS within two days, allowing the service to open up its December clinic schedule.
- In addition, our collection teams were able to maximise their clinic capacity to build stock, which has allowed WBS to provide mutual aid support to the Northern Irish Blood Transfusion Service.
- The Human Tissue Authority inspected the Talbot Green site and the new Velindre Cancer Centre stem cell collection facility in early October. Both sites have been reaccredited with no major observations raised.
- Closure of quality incidents within the required 30 days has stabilised and achieved 98% for the whole reporting period, significantly above target.
- During the period 1 Serious Adverse Event (SAE) was reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- Reference Serology turn-around times remain below the target.
- 12 concerns were reported, 10 were managed within timeline as early resolution as detailed in the table below. Two formal complaints were dealt with and closed within 30 days.
- In response to Donor Feedback and the removal of Covid-related restrictions allowing the return to use of mobile collection clinics as well as smaller local

venues, the planning team have worked to improve the availability of clinics closer to where donors live.
- Overall donor satisfaction continues to exceed target at 96.5%.

3.2 Key Actions / Areas of focus during next period

Quality and safety and patient experience remains at the heart of our service during this period in all aspects of service delivery as well as the well-being of our staff. During the period October to December 2022 the following areas will be a priority:

- Continue to monitor and sustain blood stocks, whilst continuing to pursue prudent use across NHS Wales.
- Complete the action plan to address the observations from the HTA Inspection at Talbot Green and Velindre Cancer Centre.
- Implement the strategy to increase both the number and diversity of bone marrow donors.
- Implement the recommendations arising from the review of platelet collection and manufacture.
- Continue to implement SABTO recommendations regarding testing and lookback for Occult Hepatitis B infection.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources

	• Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

5. RECOMMENDATIONS

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

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

June to September 2022

INTRODUCTION

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

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

1. Safety

1.1 Safety Incidents linked to donors are reported into the Donor Clinical Governance Group and scrutinised at the Regulatory Assurance and Governce Group (RAGG), These include failed venepuncture where a needle is not properly sited in a vein, and part bags where a donation stops before the full quantity is collected.

All of these measures have remained at low levels and within tolerance during the reporting period:

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

- **Good Manufacturing Practice (GMP) Incidents**, in which our routine process monitoring and checking identifies non-compliance with expected processes or outcomes and responds to prevent further processing or harm to patients. These are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS) in line with regulatory standards.

  There were 101 GMP incidents occurring between June and September 2022 reported via QPulse. All of these incidents were closed within 30 days

- **Incidents which may lead to redress or could result in harm to donors, patients or staff** – these are reported in Datix Once for Wales (OfW) for consistency across the trust.

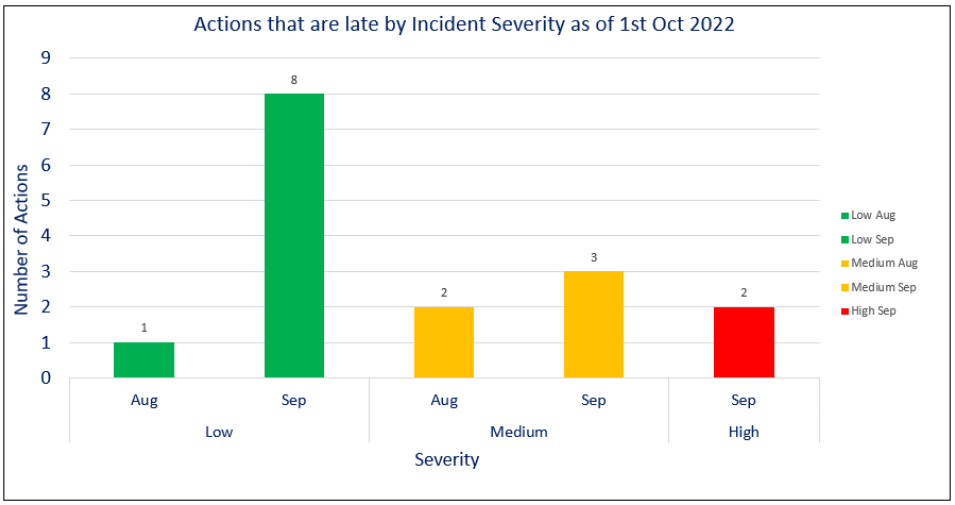
There were 31 incidents reported via Datix (OfW) that could potentially affect the quality and safety of blood/blood components, however, coding of the events within the Datix (OfW) system remains a challenge for easily identification of such incidents so these have not been included in the pie chart detailing incident by category. 29 of these incidents (94%) were closed within 30 days and the remaining 2 have now been closed.

1.3 Areas of concern:

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

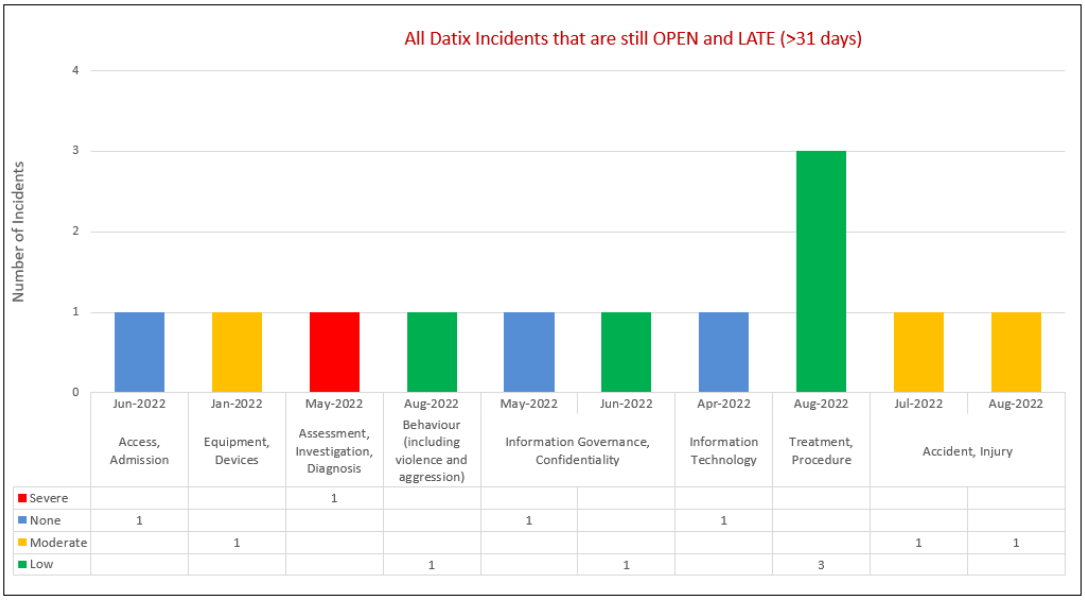
- Main categories of incidents were Blood Pack Incidents, Laboratory Errors, Quality Monitoring and Equipment Problems.
- Main locations of incidents were within Distribution (Hospital Services), Manufacturing Laboratory, WTAIL Serology and QA Laboratory
- One incident (INV-389) has a significant risk rating: Frequency converter error in manufacturing laboratory centrifuges due to an ongoing electrical issue. The impact on affected components has been assessed and RAGG has recorded a decision that components remain suitable for patients refer to RAGG Decision log.

In terms of severity, corrective actions that are late in QPulse at the end of the rolling period were:



Note: Two high scoring actions are associated with the completion of the MHRA inspection action plan

It should be noted that within Datix Cymru at the end of the reporting period there were still 12 incidents that had been open more than 31 days, 8 of these have since been closed.



	Jun-2022 Access, Admission	Jan-2022 Equipment, Devices	May-2022 Assessment, Investigation, Diagnosis	Aug-2022 Behaviour (including violence and aggression)	May-2022 Information Governance, Confidentiality	Jun-2022 Information Governance, Confidentiality	Apr-2022 Information Technology	Aug-2022 Treatment, Procedure	Jul-2022 Accident, Injury	Aug-2022 Accident, Injury
Severe			1							
None	1				1		1			
Moderate		1							1	1
Low				1		1		3		

In the 3 months to the end of September 2022, 98% of reported incidents were investigated and closed within 30 days (including GMP incidents reported via Datix OfW). This is an improvement in performance compared with previous report (92%).

The number of incidents not closed within the required timeframe has reduced from 8 in the previous three-month rolling period to 2 in this three-month reporting period. Further to the findings by the Medicines and Healthcare Products Regulatory Agency (MHRA) audit in June, all incidents regardless of severity now have a root-cause assigned before the incident is closed.

1.4 Regulatory Inspections

1.4.1 The Welsh Blood Service was inspected by the Human Tissue Authority (HTA) in early October. This included the first inspection of the stem cell collection facility at Velindre Cancer Centre. No major or critical observations were raised by the inspectors and WBS has successfully maintained registration with the HTA.

1.4.2 United Kingdom Accreditation Service (UKAS) inspected the Talbot Green site twice in early October. No critical observations were raised and accreditation to ISO 15189 and ISO 17043 has been maintained.

1.4.3 The MHRA have now confirmed their acceptance of the action plan in response to the findings of the inspection in June, WBS has received the renewal of their Wrexham Blood Establishment Authorisation for two years, and a certificate of compliance to Good Distribution Practice valid for five years. All actions are now complete, with the exception of the retrospective review of low-severity incidents to assign root causes. This work is expected to be complete before Christmas 2022 in line with the agreed action plan.

1.5 Serious Incidents Reportable to Regulators

1.5.1 There was one serious incident reported to MHRA via the SABRE portal in July, regarding a critical freezer alarm that was cleared without appropriate action to quarantine the stock. A full root cause analysis investigation has been undertaken and whilst there was a theoretical potential for blood products to be affected it has been determined that the temperature excursion was sufficiently minor for products stored in the affected freezer to be released for use. The procedures for dealing with out of hours temperature excursions have been rewritten to give clearer instructions on when products must be quarantined pending release by the Responsible Person or Medical Director.

1.5.2 There was one serious incident reported to the Human Tissue Authority in August 2022. This related to a donor who developed tachycardia whilst undergoing stem cell apheresis and was hospitalise as a precaution. A review of the patient's medical records revealed the likely cause of the tachycardia to be a sub-clinical infection. On this basis the HTA have deemed the Welsh Blood Service not to be at fault and advised that there was no need to report this incident.

1.6 15 Step Challenge Action plans (see attached appendices)

1.6.1 The action plan arising from the 15-step Challenge visit to the North Wales Caolelciton team in August is complete from an operational perspective. There are two remaining actions which require a digital solution, 1 relating to network connectivity for collections staff which is part of a longer term ambition to roll-out cellular connectivity, and 1 relating to the use of QR codes to help donors provide online feedback about their experience which will be complete by the end of Q3 2022/23.

1.6.2 The action plan arising from the 15-step Challenge visit to the transfusion laboratories at Talbot Green has identified a number of improvments relating to cleaning procedures and schedules, exchange of protective clothing and staff compliance with hand hygeine standards for clinical staff whch have been incorporated into stanfard operating procedures. An observation about limiting the use of paper records will be incorporated into a wider trial of the use of electronic signatures planned for Q3 and Q4 2022/23.

2. Effectiveness

2.1 Blood Supply

In June, July and early August WBS continued to experience shortages of blood components but after to a focussed effort and re-alignment of resources to support the collections teams, has recovered it's stocks to optimum levels across all blood groups.

WBS has also continued to work closely with hospitals across Wales to promote appropriate use of Blood and reduce the stock levels held in hospital blood banks.

Severe shortages are still affecting other parts of the UK, with NHSBT in England declared an amber alert on all Blood group in October. WBS has been able to support other UK blood services with exports of blood components under mutual aid agreements without risking their own stock levels which is testament to the blood supply chain staff across Collections and laboratories and the generosity of our donors.

2.2 Bone Marrow / Stem Cell collections

Following sustained drops in the number of donors recruited to the Welsh Bone Marrow Donor Registry (WBMDR), and resulting drops in the number of Welsh donors matched for transplant, a review of the donor recruitment and retention strategy is underway. Key activities include:

- Re- planning for bone marrow donor recruitment activities as part of routine collections clinics with our return to schools, colleges and universities.
- Focussing collection teams on identifying potential donors and promoting bone marrow donation where appropriate.
- Investing in paid social media advertising and in-person recruitment activities.
- Utilising existing community partnerships, such as the Cardiff Devils, Football Association of Wales and local sports clubs, to promote bone marrow donation.
- Continuation of existing recruitment activities at fresher's fairs and via oral swabs for non-blood donors.

A comparison of donor utilisation between the four bone marrow registries active in the UK shows that WBMDR provides more donations per 10,000 registered donors than any of the other UK registries. This demonstrates the high quality of services provided but underlines the critical importance of growing the panel of donors in Wales.

2.3 Audit Summary

There were 17 internal audits scheduled for completion between June and September.

- 15 audits have been conducted as planned
- 2 audits have carried over into Q3r, the risk from late completion has been assessed as low as this activity as they cover areas already inspected by the HTA and UKAS

15 Audits Conducted / Started within schedule	Findings/Non-Conformances
x7 - Procedural Audits **x3 - ISO 15189 Audits** **x1 - ISO 17043 WASPS – Audit has commenced and is ongoing - approximately 3 months to complete** **x4 - HTA Internal**	**Major Findings/Categories:** **x 2 – Procedural** **Minor Findings/Categories:** **Documentation Error** **Procedural** **Data Integrity/ALCOA+** **Training**

x2 Procedural Audits carrying over into next quarter
Slippage due to auditor/auditee availability.

Risk by late completion: Low
Audits carrying over have been subject to external (3rd Party) and other internal (1st Party) audits throughout 2021 - 2022

3. Service-User Centred

3.1 WBS invites every blood donor to complete a feedback survey in the month after their donation. This is available online, by text message or by completion of a feedback form. The feedback highlights are:

a. During The period June to September 2022, 3809 responses were received (17.9% response rate)
b. Donor satisfaction for those who had successfully donated was:
   - Overall (3439) 96.5%
   - N.Wales (715) 95.1%
   - S.Wales (2769) 96.2%

c. Donor satisfaction for every respondent, including incomplete donations was:
   - Overall (3715) 93.8%
   - N.Wales (719) 95.1%
   - S.Wales (2996) 93.5%

d. In total 3077 donors scored themselves as ‘Totally Satisfied’ and were invited to provide more details.

e. Out of 34,962 donation attendances in June to September 2022, 57 donors (1.5%) described themselves as 'Dissatisfied' or 'Totally Dissatisfied' and were invited to provide more details. The responses are analysed and followed up by the Collections Leadership team through their monthly operational service group:

3.2 Changes in response to Donor Feedback

A continuing theme from Donor Feedback is the lack donation of clinics closer to where donors live. The planning team have taken advantage of the removal of COVID-related restrictions and the return to use of mobile collection clinics to improve the geographical spread of clinics for the rest of this year and into 2023:

Theme	Response
'Llandeilo is not regular anymore'	Has now returned to 2 rotations, same as pre covid
'I Live in Ebbw vale where there used to be frequent clinics but now, I travel to Newbridge or Pontypool'	Ebbw Vale Venue unsuitable with no suitable alternative– with re introduction of Trailers, will be able to return to Tesco Ebbw Vale.
'Struggle to commit in advance too far in advance. By the time I can all the appointment slots are gone. I also have to travel miles! I keep being offered Denbigh! (40 mins minimum). I ended up at Prestatyn this time (30mins). There appear to be no venues in Colwyn Bay or Rhos. Craig y Don & Llandudno Junction business park are infrequent'	No suitable venues, extensive scoping conducted by Planning and NW team but to no avail – Llandudno Junction is difficult to book but does have 3 rotations.
'More out of town donations in areas easy to park – Roath'	New venue secured – St Peters Ruby club, Roath, ample parking and 6 chair capacity
'Lampeter is my nearest clinic. I had to travel an additional half hour to get to Aberaeron. This is fine in summer, but I won't be doing it in the winter'	Lampeter booked for 2 rotations for 2023 –clinic booked for Feb to cover the winter months, also April, Sept and Nov booked 2023
'No access to clinic close to home (Heath) except UHW very sporadically'	16 clinics booked on UHW 2023 (pre covid 6)

'You no longer have a clinic in Ammanford, therefore I have to travel to donate'	clinic booked 28/10/22 – will return on a bi-monthly rotation as pre covid.
'Was really hot - after giving blood I felt lightheaded so had to sit in chair. (Record time 6mins 17 now I know, haha) This guy at coffee table also asked for a cold drink as he didn't feel right. As I was leaving a woman collapsed to the floor luckily worker was able to catch her - staff amazing btw' -	All teams issued with fans – extreme hot temperatures on that day.
'Would be nice to see more sessions given so that more donations can be given Ystradgynlais'	This panel has increased to 4 rotations and a clinic is held at the venue every month –this used to be 2 rotations pre covid.

3.3 Concerns

3.3.1 In the period June to September 2022, 12 concerns were reported, 10 were managed within timeline as early resolution as detailed in the table below. two formal complaints were dealt with and closed within 30 days.

Month	Early Resolution	Formal	You Sa	We Did
July	4	0	1, A donor raised concerns around the positioning of the clinic screening booths and trailing electrical cables whilst visiting the donation venue for a non-donation related event. resulting in the potential breach of confidential and trip hazard.	1, The Operational Manager has reviewed complainants concerns and as a result is developing a new master venue layout plan, to ensure the reconfiguration of screening area.
			2, A donor is unhappy he has active deferral on his record due to a technical glitch in the WBS computer system.	2, Specialist Nurse in Donor Care in collaboration with the IT department have ensured donor a configuration update is planned for the 21st of August 2022.
			3, A donor was unhappy to be turned away from session for being later for appointment.	3, The Operational Manager discussed concern with donor, who admitted he was 15 minutes later and not the 5 minutes he had originally declared. Operational Manager explained the donor's appointment ran into the team's lunch time so were unable to accept him. Donor was offered alternative appointment after lunch but was unable to accept. Donor appreciated call back and has since booked another appointment.
			4, A donor and his wife were unhappy they were turned away from the donation session upon due to their age.	4, The WBS Medical Director has reviewed donors' complaint and as a result the donor and his wife are now able to donate. An updated process is in place to actively identify and contact donors from the age of 69.5 who

				are not regular donors to make them aware of the donation guidelines for the age group.
August	2	0	Donor raised concern about the difficulty he is having booking a suitable appointment to donate blood. Donor finds it difficult to commit to an appointment time due to his occupation as a farmer	Working in collaboration with Clinic Lead, donor was contacted and has been offered the opportunity as a walk-in donor at a time that suits him to donate. Donor very happy with outcome of conversation
			Donor unhappy with staff member using left arm, despite her stipulating the right arm has the more suitable vein for donation	Operational Manager discuss concern with donor, measure put in place to record preferred arm choice for donation on donor's record. Donor happy with outcome of conversation and will make another suitable appointment
September 2022	6	0	Donor unhappy he was asked to wear a face mask when on donation session.	Operation's Manager to remind Staff it is not an essential requirement for donors who attend session to donate blood to wear a face mask.
			Donor unhappy to be turned away from session due to attending with her 7-Month-old baby.	Operations Manager discussed concern with Clinical Governance team & Advanced Practitioner to establish a consistent approach to advice donors who attend session with children.
			2 X Donors unhappy they attended separate donation clinics that had been cancelled due to issues out of WBS control	DCC Manager investigated concern and found processes were followed and a voicemail and email were sent to the Donors. There is no mobile number attached to one donor record so an SMS message could not have been sent
			Donor raised concern he was unable to have his daughter translate the blood donation information for him throughout the process.	Full explanation given to donor by Clinic and Specialist Nurses. Donor understands spoken English better than written English. During conversation on session, it was evident donor did not understand the consequences of donation. Following subsequent conversation with donor by Specialist Nurse in Donor Care the donor was happy with the outcome of conversation held.
			Donor unhappy with a particular member of staff, donor felt he was an inconvenience to staff member.	Operational Manager discussed concern raised with staff member and clinic Nurse, neither could recall any issues on the day. Staff member has worked across the collection teams for over 19 years without any reason for concern.

4. Timeliness

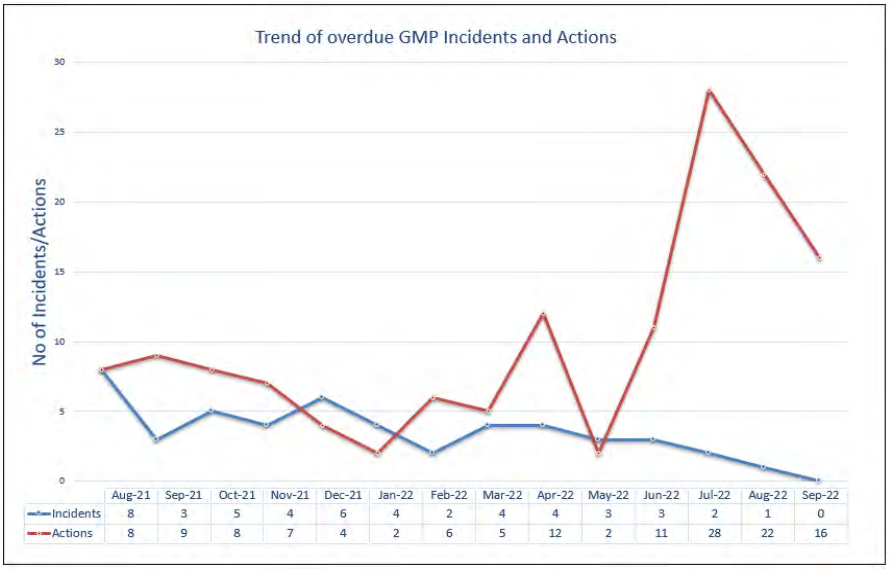
4.1 Reference Serology Turn-around times

The RCI laboratory has been experiencing workload and staffing pressures, which have been affecting the turnaround times of non-urgent testing requests as well as adding sustained pressure to both the routine staff and the on call system.

Referrals continue to be prioritised based on clinical need and all Compatibility Testing is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, therefore the tests are prioritised to ensure patient care is not affected. The service has submitted a case to Welsh Health Specialised Services Committee for consideration given sustained activity increases.

4.2 Overdue activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year. Incident closure has improved over the reporting period, but there was a significant increase in overdue corrective actions following the re-prioritisation of resources to support blood collections in June and July. From September, operational teams have been focussed on review and follow up of these actions and the trend is expected to continue downwards as a result.



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Incidents	8	3	5	4	6	4	2	4	4	3	3	2	1	0
Actions	8	9	8	7	4	2	6	5	12	2	11	28	22	16

4.3 Areas for concern:

There are no quality deviations (incidents) more than 3 months overdue.

There were 2 overdue actions recorded in QPulse, at the end of May 2022. Both actions have since been closed.

Analysis of incidents reported via Datix Once for Wales (OfW) has identified 5 incidents which were overdue for completion at the end of September. Four of these incidents have

been followed up with the teams concerned and closed, one item remains open pending completion of an independent investigation which is expected to report by November 4th. There was no adverse impact on safety as a result of delayed closure.

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

5. Equity

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

Recent donor feedback indicates that some donors are still travelling large distances to donate and indicate a need to return to some of the more remote locations that we have not been abe to use as a result of restrictions from the Covid 19 pandemic. WBS has expanded the clinic plans aiming to reflect a return in forthcoming months to wider coverage akin to the pre-pandemic collection model but develioping this further to ensure we learn from experiences during the pandemic and reflect changes in donor behaviour, for example working from home.

6. Efficiency

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

Collection productivity has improved over the period to 1.22 in September but continues to be below target. The removal of Covid and Infection Prevention Control (IPC) measures have contributed to this as well as the activities to increase blood collection over the summer period and more recently.

Mobile donor vehicles were reintroduced to service in August, further contributing to collection capacity and efficiency.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency has fluctuated from 377 in June, peaking at 415 in August but dropping back below target in September. This increase was driven by increased blood collections but has been adversely impacted by the need to increase manufacture of fresh

frozen plasma and cryoprecipitate to support stock replacement under the occult Hepatitis B project. Frozen components are more labour-intensive to manufacture.

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses for June to September have increased slightly to fluctuate between 0.1% and 0.2% but remain below tolerance.

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry for June to September 2022 remains extremely low and within target. The low stock position over the summer has increased stock turnover keeping time-expiry low, but as stock levels improve there has been a small increase in time-expired stock to 0.4% in the blood groups where demand is less predictable.

6.5 Time Expired Platelets (Target 10% expired)

Platelet expiry remained above target during June to September 2022, peaking at 30% in August. It should be emphasised that the majority of date-expired platelets come from whole blood collections rather than apheresis, the donation is therefore only partially wasted.

A review of the platelet strategy has concluded identifying 2 areas where quick wins are possible. A task and finish group has been set up to review clinic times/days in consultation with donors, to better match daily demand and increase the available shelf life of stock at the time of issue. There is a separate work stream underway to develop a statistical demand prediction tool to inform daily decisions on pooled platelet manufacture.

Welsh Blood Service Monthly Report
September 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups, which is testament to a concerted effort by all staff working in the supply chain operation. This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated.

At 98%, Quality Incident Records closed within 30 days continues to exceed target (90%) for September. There were no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no SHOT incidents were reported during the month. No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics. All 6 informal concerns received were managed within 2 working days as required by Putting Things Right (PTR) regulations. At 96.5% donor satisfaction continues to remain above target.

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) is still below target (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% of eligible donors). A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers, avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan, which is expected to start to deliver results in Quarter 1 2023.

2 stem cells were collected out of the 5 planned (2 collections were cancelled by the Transplant Centre and 1 donor failed medical evaluation). The pandemic has impacted on unrelated donor stem cell transplants globally, reducing the number of stem cell collection requests received. A review, re-appraising the existing collection model and its ambition, will culminate in the development of the WBMDR 5 year strategy outlining a structured recruitment strategy enhancing the collection of stem cells.

In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance. A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric. Compatibility testing (47% of referrals) continues to meet clinical target and all time critical tests are being completed on time.

Time expired platelets did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September. Given the variability of expired platelets over the past 12 months, the service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in Noveber to implement the recommendations.

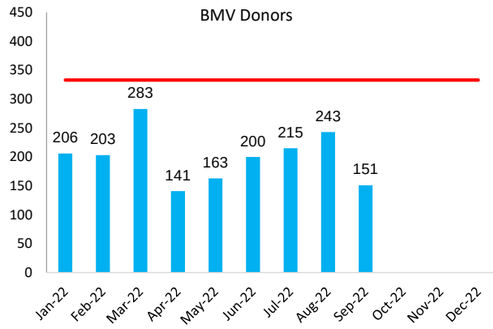
Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales. 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. New staff have been recruited to vacancies in the department.

Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies.
A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors. As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.

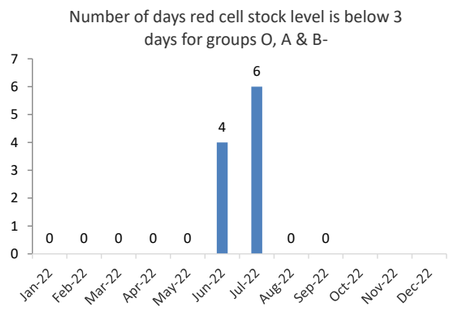
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE **(Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

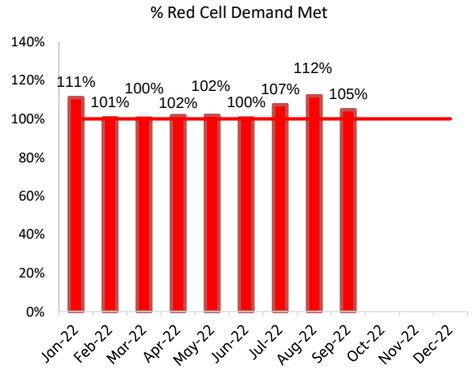
Monthly Reporting



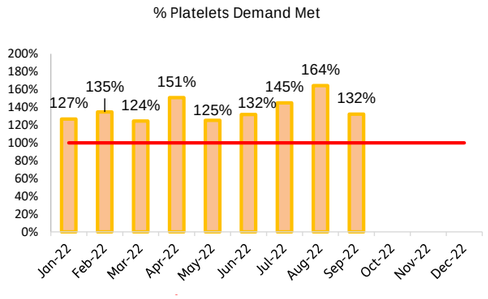
Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% in eligible donors).	A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan. Existing promotional activity plans continue and include WBMDR staff attending school six forms, colleges and university fresher's fayres. Profiling bone marrow donor recruitment on social media and on the WBS website continues in earnest. The WBMDR five year strategy, re-appraising the existing collection model and its ambition, is in development.	Quarter 1, 2023 Ongoing Quarter 3



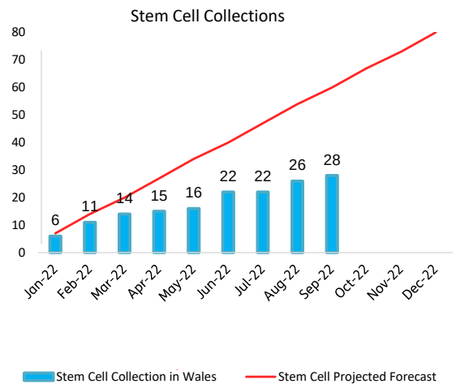
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
During September, the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+). Stock levels are satisfactory across all groups.	The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



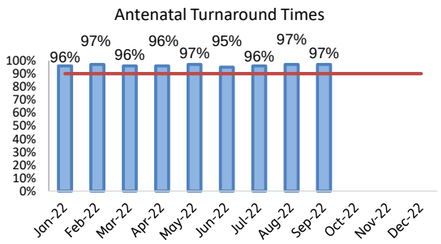
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups. This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated. Demand in September (full weeks) averaged at 1401 units per week.	The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain.	Reviewed daily to support responses to changes in demand.



Monthly Target: 100%	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met. For September, platelet demand was 155 units per week on average, which is up from August's weekly average of 149. Note: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.	Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. The service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in Q3 to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Reviewed daily Quarter 3

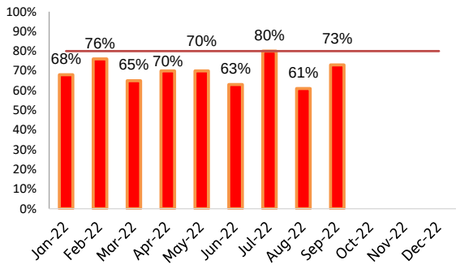


Annual Target: 80 (ave 7 per month)	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
2 stem cells were collected out of the 5 planned (2 collections were cancelled by the Transplant Centre and 1 donor failed medical evaluation). The pandemic has impacted on unrelated donor stem cell transplants globally, reducing the number of stem cell collection requests. In addition, the Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.	Currently, 2 requests for stem cell products are due for collection in October with a further 2 waiting to be booked and 2 collections for November. The WBMDR five year strategy, re-appraising the existing collection model and its ambition, is in development.	Quarter 3



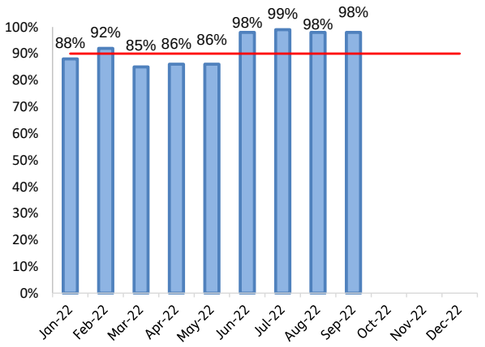
Monthly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Efficient and embedded testing systems are in place. Continued monitoring and active management remains in place, maintaining high performance against current target.	Business as Usual, reviewed daily

Reference Serology



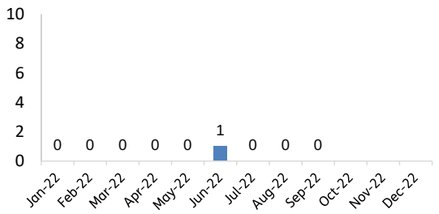
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance. Compatibility testing (47% of referrals) continues to meet clinical target and all time critical tests are being completed on time. At 229 the volume of testing requests has reduced slightly compared to Average 226/month for 2021 and 181/month in 2020.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. The service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need. A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric. Validation the new automated analyser, which will improve efficiency, remains on schedule to be completed in the Autumn.	Quarter 3

Quality Incidents closed within 30 days

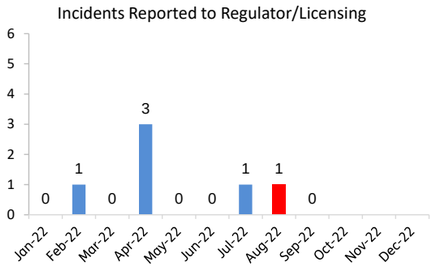


Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 98%, Quality Incident Records (recorded in DATIX & QPulse) closed within 30 days has met target (90%) for the three-month rolling period to September (QPulse at 100% and 94% for Datix). All QPulse incidents that have been 'Accepted' as GMP incidents have been risk assessed, investigated and CAPA assigned.	New reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The process has been revised to address the findings of the MHRA inspection and ensure that all low and moderate risk incidents have root cause assigned. The progress of actions to address incidents is closely monitored. The QA team continue to send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines .	Continue with close monitoring and early recognition of potential timeline breaches.

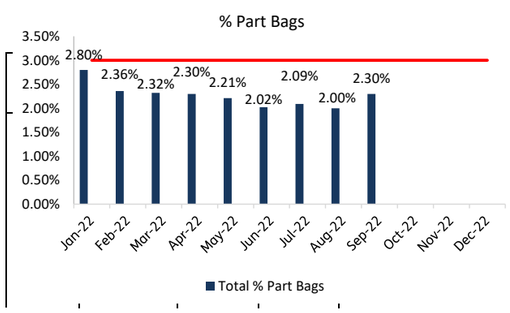
Critical Findings



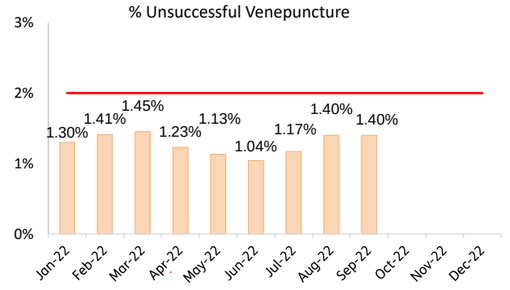
Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no major findings during the UKAS 17403 Surveillance Audit (29-30 Sep). There was one minor finding on the time period related to the review of documentation, and one recommendation relating to the process for capturing and recording non-conformances.	Significant progress is being made against the MHRA action plan arising from the North Wales inspection in June.	Completion of all action plans for external audits is monitored via the monthly RAGG meeting.



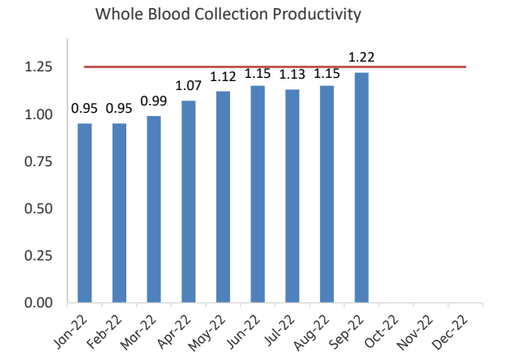
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no adverse event reports submitted to the MHRA in September and no adverse event reports were submitted to the HTA. Also, no SHOT incidents were reported during the month.	Completion of CAPA, in respect of SABRE reports, is monitored via existing processes. Note: A suspected serious adverse event involving a stem cell donor was reported to the Human Tissue Authority in August. Following a review of information relating to the donor, the HTA has deemed that this incident is most likely to have resulted from a localised chest infection and not from the donation procedure itself. As a result it does not meet the criteria for a Serious Adverse Event (now marked in red in bar chart).	Progress of completion of the Datix investigation is monitored via monthly QA metrics reporting.



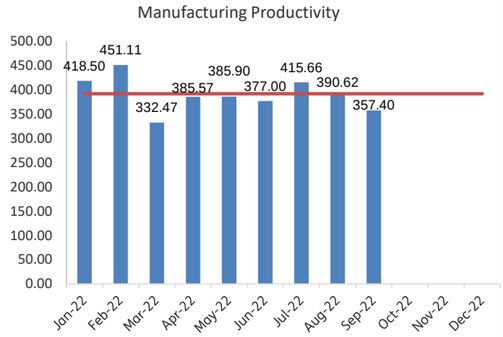
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains within the required tolerance level (3%) at 2.30% during September. Analysis of the part bag rates shows that the only breach for September was the Mobile Donation Clinics (MDCs) with a rate of 4.5%. MDCs were taken out of service in March 2020 due to Infection, Prevention and Control measures during COVID and were re-introduced in September on a phased basis. Some teething problems have contributed to the breach in tolerance for September for the MDC (e.g. wrong appointment grid being used, some 'make ready' changes introduced, new staff deployed onto MDC). Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).	The majority if the issues identified on the MDC were resolved immediately. Work is ongoing to support staff as they re-familiarise themselves with working in an MDC environment. Part bags rates for MDCs will be closely monitored throughout October.	Continued close monitoring and trend analysis and intervention where required



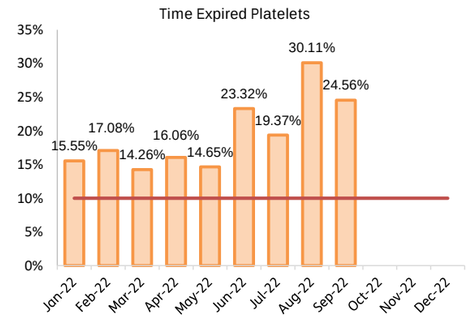
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains constant and within the required tolerance (2%) at 1.40%. Analysis of the FVP rates shows that the majority of teams have no breaches for September. The exception is Bangor with a 3.4% FVP rate. (10 FVP's - 294 donors bled).	Work is ongoing to identify any potential trends on the Bangor team.	Continued close monitoring and trend analysis and intervention where required.



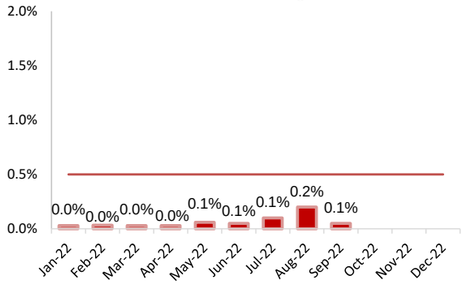
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Collection efficiency was just below target in September at 1.22 but has moved closer to the target of 1.25 and is the highest it has been this year. There has been a steady increase in performance as we transition from the COVID model to the future model. This is attributable to a number of factors: 1. Growth in appointment uptake %. 2. Targeted DNA messaging. 3. Reintroduction of 10 chair clinics (due to removal of physical distancing). 4. Pilot study to map overbooking opportunities against specific DNA patterns. 5. Completion of training of new staff which improves flow and staff utilisation.	A pilot study is ongoing to review the impact on donor experience when booking donors into identified non attendance gaps, 'overbooking' or supporting 'controlled walk ins' at carefully selected clinics. Donor experience has been reviewed for September and there were no adverse incidents identified to date. It will be reviewed again in October to ascertain any trends emerging as part of the pilot study before considering if the pilot becomes business as usual. In addition, modifications to the 6 chair mobile donations units are now complete and the units have returned to communities in September. Mobile units will now form part of the planning process with the intension of full utilisation in the new year. Work is ongoing with local businesses to return to work place donor sessions. This is dependent on pre COVID models of working in each business due to staff now working from home.	October



Monthly Target 392	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Actions(s) bring taken to improve performance**	**By When**
Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales. NB. This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.	New staff have been recruited to vacancies in the department. 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.	Quarter 4

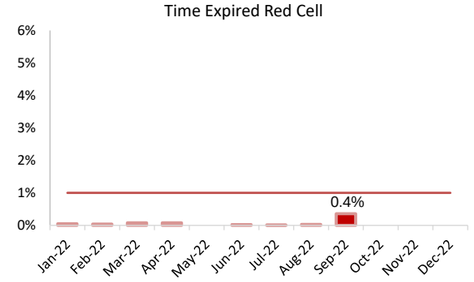


Monthly Target: Maximum 10%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September. Platelet production is currently set at 180 units per week in September.	Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in November to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Quarter 3



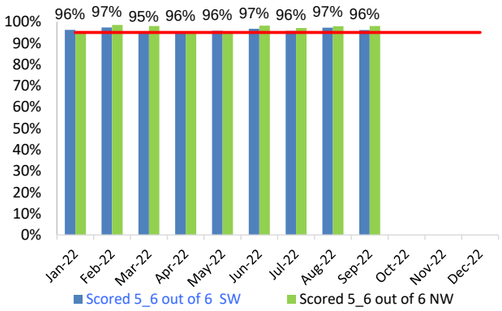
Monthly Target: Maximum 0.5%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were low at 0.05% and remain within tolerance of below 0.5%. The losses were (units): M&D Heat sealer : 1 unit M&D Operator - Automated Blood Press : 2 units These levels are well within tolerance and represent good performance. The monthly controllable losses should be considered against total production of approx. 1500 units per week.	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly

Time Expired Red Cell



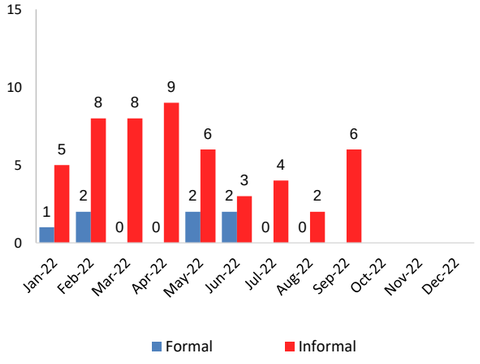
Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric remains within the target and there are no concerns around expiry of red cells. COVID challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell Shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

Donor Satisfaction

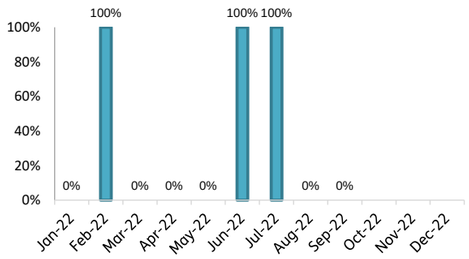


Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96.5% donor satisfaction continues to be above target for August. In total there were 1,103 respondents to the donor survey (some of which are non attributable).	Findings are reported to the Collections management team at the monthly Collections meeting to address any actions for individual teams.	Business as usual, reviewed monthly

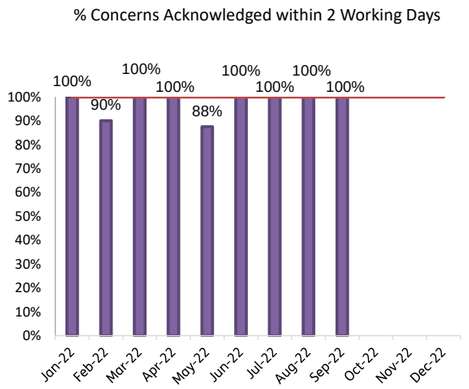
Number of Concerns Received



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics. 6 concerns (0.08%) were reported and closed as early resolutions in September. The concerns raised included: * Donor unhappy he was asked to wear a face mask when on donation session. * Donor unhappy to be turned away from session due to attending with her 7 month old baby. * 2 x donors unhappy they attended separate donation clinics that had been cancelled due to issues out of WBS control. * Donor raised concern he was unable to have his daughter translate the blood donation information for him throughout the process. * Donor unhappy with a particular member of staff, donor felt he was an inconvenience to staff member.	Each concern was dealt with as an early resolution and closed within the required timescale. Actions taken to resolve the concerns included: * Operation Managers to remind staff it is not an essential requirement for donors who attend session to donate blood to wear a face mask. * Operation Manager discussed concern with Clinical Governance team & Advanced Practitioner to establish a consistent approach to advise donors who attend session with children. * DCC Manager investigated concern and found processes were followed and a voicemail and email were sent to the Donors. There is no mobile number attached to one donor record so an SMS message could not have been sent. * Full explanation given to donor by Clinic and Specialist Nurses. Donor understands spoken English better than written English. During conversation on session, it was evident donor did not understand the consequences of donation. Following subsequent conversation with donor by Specialist Nurse in Donor Care the donor was happy with the outcome of conversation held. * Operational Manager discussed concern raised with staff member and clinic Nurse, neither could recall any issues on the day. Staff member has worked across the collection teams for over 19 years without any reason for concern.	Business as usual, reviewed daily



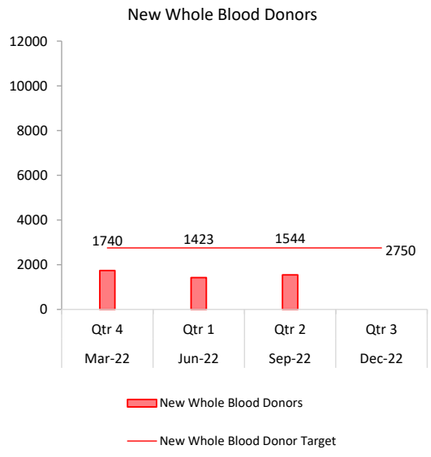
Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No formal concerns were received during September 2022. All concerns are being monitored and actioned as appropriate. * Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor formal complaint response progress, and 30 day target compliance.	Business as Usual



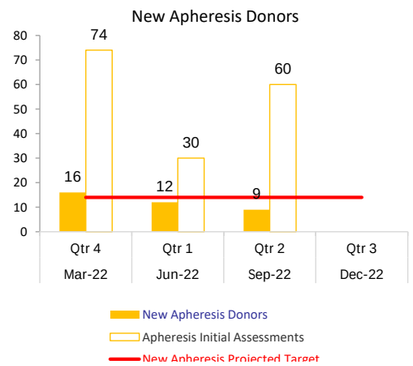
Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All concerns received in September 2022 were managed within 2 working days as required by Putting Things Right (PTR) regulations.	Continue to monitor this measure against the 'two working day' target compliance. Timescale requirements communicated to all involved in concerns management.	Ongoing, reviewed daily

Quarterly Reporting

Equitable and Timely Access to Services



Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies. A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors. As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.	Whilst the UK blood stocks position remains unstable, with NHSBT in amber alert status, WBS has continued to grow all blood type stocks throughout September. This allows the Donor Engagement team to rebalance existing donors with new donors, while stocks remain at stable levels. The return of donation vehicles, re-introduction of business sessions and recommencement of University/College venues is expected to result in an increase in new donors. A pilot study to review the impact on donor experience when booking donors into identified non attendance gaps, which includes 'overbooking' or supporting 'controlled walk ins' at carefully selected clinics has started in August, results are positive to date. The future clinic model is being reviewed.	Ongoing, staffing reviewed daily, venue plan reviewed monthly.

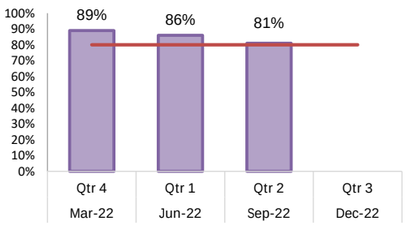


Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were 4 new apheresis donors in September, five short of the quarterly recruitment target.	17 blood donors registered their interest in becoming apheresis donors following a recruitment drive undertaken in September by the Donor Engagement Team. These donors will be assessed in the coming weeks.	Ongoing monitoring

New Apheresis Projected Target

Safe and Reliable service

Turnaround Times (Deceased Donor Typing/Crossmatching)



Quarterly Target: 80%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Continue to monitor performance.	Quarter 3

Anti D & -c Quantitation

Quarterly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Continue to monitor performance.	Business as Usual

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE
Area visited - Laboratory Suite (Logging In Room, Manufacturing Laboratory, Platelet Laboratory)
Completed by: Stephen Pearce Date:07/07/22

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Improved warmth and professionalism of main (WBS) reception staff required, treating all visitors as though it is their first visit. Review staffing present and reinforce best practise and importance of the welcome all visitors receive. Explore options for customer service training for reception staff		Sarah Richards	28/10/2022	Audit and actions will be reported in to the General Services Operational Group (Governance route for Reception). Updates will also be provided to 15 step challenge co-ordinator.
Review white coat laundering & replacement processes that include assurance mechanisms that coats have been regularly washed / replaced as a number of coats hanging outside Manufacturing Laboratory were dirty. POL(S)-009 Laboratory Safety Procedures - this doesn't have a specific requirement to change laboratory coats every week - update Policy to include this requirement. Reinforce requirement to change laboratory coats with staff at Laboratory Meetings. Process for laundering laboratory coats is in place and staff have suffcient laboratory coats. Additional coats can be ordered if more are required by individual staff members.		Stephen Pearce	29/07/2022 On review POL(S)-009 has a requirement to change laboratory coats at least once per week - Complete Lab coat changes discussed at monthly laboratory meeting - Complete	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Ensure all laboratory staff (whilst working within laboratory settings) adhere to clinical staff all wales uniform policy requirements and hand hygiene standards including no nail varnish, acrylic nails and stoned rings and have long hair tied back. Specific health and safety requirements for Laboratory staff to be reviewed in line with clinical staff all Wales uniform policy requirements to ensure high standards of health and safety (including IP&C) are met.		Georgia Stephens	Ensure compliance with Health and Safety Legislation and consistent implementation of Trust H&S Policies throughout laboratories in the Welsh Blood Service.- Laboratory Specific Health and Safety Group.	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Relocation of storage racks / cabinets within Logging In Room from floor level required to allow for cleaning of whole floor. Low level racking may be required. Storage requirement for trays reduced by utilising trolleys to store trays. Liase with estates department to install low level racking (if possible)		Stephen Pearce	Metal racking on floor removed to allow cleaning of floor. Racking not purchased - alternative storage for trays used (movable trolleys with shelving) 29/10/2022	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Sink in Booking in Room needs replacing as cracked. This was identified in April 2021 prior to MHRA audit and a request for repair raised. It had not been followed up so it has be re raised with facilities/estates.		Stephen Pearce	Update 13-10-22 - This action is with Estates to replace the sink - expected date has been requested 29/10/2022 (Dependant upon rapair/replacement time)	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept).

Wipe down process required for dusty computer equipment in Laboratories and Logging In Room and removal of sticky residue left on surface from prior use of sellotape. Work surfaces cleaned of residue. Request to IT to discuss and agree cleaning method for desktop PC's with buildup of dust.		Stephen Pearce	29/07/2022 IT supplied a vacuum cleaner which was used to clean all the PC;s in M&D - this is scheduled for repeating on a 6 monthly basis (Complete)	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Review of cleaning standards / frequencies within Booking in Room as as floor had rubbish on it computers very dusty and there were cobwebs on light fittings. Request to IT to discuss and agree cleaning method for desktop PC's with buildup of dust. Review frequency and extent of cleaning for laboratory areas with facilities / cleaning staff.		Stephen Pearce	29/07/2022 IT provided vacuum to clean pc's. - complete Head of M&D to attend monthly cleaning audit with cleaning company and facilities -due AL this will take place in September 2022. 13-10-22 discussion with facilties/cleaners around some specific issues did not resolve some specific issues due to difficulties in cleaning high up delicate electrical items (lighting) - resolution may be acheved by moving to different lighting (sealed units) - this to be taken to estates group. Laboratories are swept daily and cleaned weekly by the cleaners. Work surfaces cleaned daily by laboratory staff.	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Review of cleaning schedule processes as the schedule on the notice board in laboratory had not been completed for the month of April. Cleaning record updated. Cleaning and recording is specified in SOP PRO-084 which defines daily and weekly cleaning tasks by room.		Stephen Pearce	Complete 06/07/22	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.
Consider a potential move to partial or complete paperless record storage for additional security. MHRA advice from audit at Wrexham was to keep (paper) primary records on site from at least the last audit. Method for electronic archiving of paper records in place. Move towards more electronic records would be welcome. WBS QA Systems are currently investigating use of electronic signatures compliant with regulatory requirements. Take suggestion into developments of the organisation.		Stephen Pearce	Raise with iHub for consideration as Service Improvement Use of electronic signatures is a longer term project so unable to give a by when date. No unaccompanied visitors allowed into the department. Access into laboratory is controlled by swipe access	Audit and actions will be reported in to the Laboratory Services Operational Group (Governance route for Manufacturing dept). Updates will also be provided to 15 step challenge co-ordinator.

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE

Area visited: Wrexham (WBS Collections Team)

Completed by: Sally Gronow Date: 12.10.2022

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Although information is included within pre-donation reading material, a visible board detailing who is in charge of the clinic, what uniforms mean and Welsh speaking staff would be beneficial in case donors do not read the material provided.	language laminate cards distributed to all teams with RN / Supervisor name and displayed on entry point. Due to capacity on WBS vehicles there is no capacity to store an additional display board.	Sally Gronow	Complete	
Clinical grids / staff numbers to be reviewed to ensure efficient use of staff time. Increase in donor numbers could also be considered to support blood supply required.	Daily 10:00 conference with operations and resource planning and logistics to review clinic plans to ensure clinics and staffing are maximised	Aiysha Tufail - RPL Manager	Complete	Barriers to performance discussed in daily resilience

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Review clinic venues to ensure that all possible space is being utilised to maximise chair capacity whilst maintaining COVID social distancing restrictions	All venue master risk assessments have been reviewed post covid to ensure full clinic utilisation Supervisor feedback venue form updated daily to identify if venue changes occur	Mark Jenkins	complete	
Staff to be provided with ID badge pull cords and asked not to wear lanyards given the IPC risks.	Lanyards ordered and distributed to all staff	Mark Jenkins	complete	

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Information to be available and easy to read at all clinics regarding how to make a suggestion, complaint and compliment. Additionally, inclusion of a 'You said….we did...' board detailing changes WBS has made following feedback from donors is required.	Monthly you said we did updates in operational strategic group. Interim Engagement and communications manager to update WBS internet site, donors will then have a QR code on donor session that will take them to the link to review.	Sally Gronow / Simon Cambell Davies	Jan-23	OSG / Internet
More visibility of Welsh speaking staff required, via appropriate uniforms / more visible badges.	all Welsh speaking staff have been issued with WBS Welsh speaking badges email to all Supervisors to check if any new badges need to be distributed	Brooke Winsper - Parry	complete	

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?
Staff reported WBS collections staff requiring an alternative way of organising mandatory & statutory training as currently they are required to complete during clinics and they advised there is insufficient time to do this, resulting in reduced compliance.	Current stat & man compliance is 80.2% request made via scrutiny to over establish collections to support staff with down time to complete training & PADR's	Sally Gronow	Scrutiny case - 18.10.2022	Collections OSG
Registered Nurses reported being unable to participate in professional or management meetings due to lack of appropriate devices/internet access. This has been requested previously to allow more active participation. iPADs made available to staff would make connection easier (fewer connection issues) and ensure they have an ability to dial into meetings at clinics as often there is no available computer or connection cannot be obtained and staff have to use their own phones.	RN's in North Wales have been issued with individual laptops. Connectivity issues raised with IT VERTO to be raised to highlight ongoing connectivity issues	Sally Gronow	Jan-23	BPG
Registered staff also concerned re the travel to clinic requirement on bus as this is usually the time when professional meetings are held - there will therefore need to be variations to this rule to allow registered staff to attend required professional meetings.	staff who are requested to join formal meetings while on session will be considered on an individual basis to support release	Collections Managers	as and when	

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (September 2022)

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			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page xx)	Actual	97%	96%	92%	78%	92%	92%	92%	87%	92%	83%	72%	77%	87%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page xx)	Actual	82%	82%	74%	84%	90%	90%	81%	79%	81%	83%	83%	85%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page xx)	Actual	97%	100%	85%	89%	100%	93%	88%	84%	88%	100%	100%	94%	93%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page xx)	Actual	98%	99%	99%	99%	94%	91%	71%	69%	61%	58%	66%	77%	89%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page xx)	Actual	100%	100%	86%	100%	100%	100%	83%	100%	100%	86%	100%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page xx)	Actual	53%	65%	65%	Data Collection (Paused)	Data Collection (Paused)	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)	70%	47%	57%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

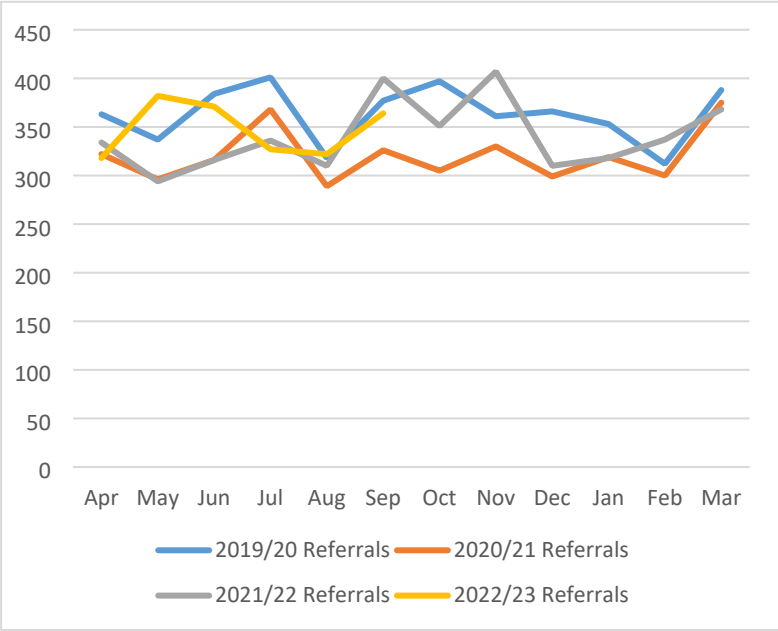
			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Did Not Attend (DNA) Rates	Actual	5%	5%	5%	3%	3%	3%	3%	3%	3%	3%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page xx)	Actual (Dietetics)	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%
		Actual (Occupational Therapy)	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
		Actual (Speech and Language Therapy)	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Pressure Ulcers (page xx)	Actual	1	1	0	1	0	1	1	0	0	1	0	0	4
		Unavoidable	1	1	0	1	0	1	1	0	0	1	0	0	4
		Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page xx)	Actual (Total)	2	3	1	4	3	2	9	4	1	1	2	1	3
		Unavoidable	1	3	1	4	2	2	9	3	0	1	2	1	2

			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Number of VCC Inpatient Falls (page xx)	Avoidable	1	0	0	0	1	0	0	1	1	0	0	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	4	0	0	1	4	1	1	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater than or Equal to Three Who Receive all 6 Elements in Required Timeframe	Actual	75%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections	Actual	0	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (E.Coli bacteremia)	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved

Radiotherapy Referral Trends – Overall

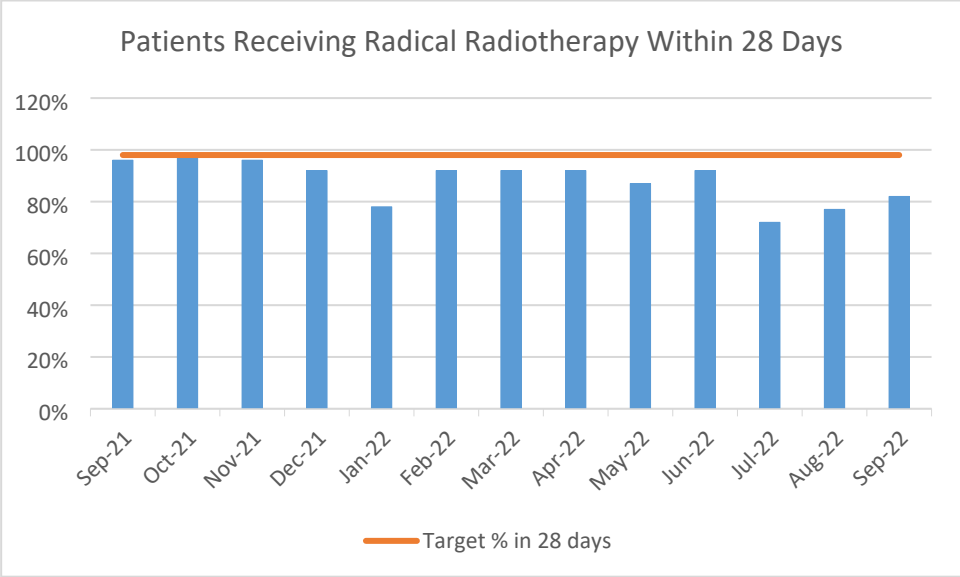


All Radiotherapy Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Referrals	363	337	384	401	318	377	397	361	366	353	312	388
2020/21 Referrals	322	296	316	368	289	326	305	330	299	319	300	375
2021/22 Referrals	334	294	316	336	310	400	351	407	310	318	337	368
2022/23 Referrals	318	382	371	327	322	364						

There was an increase in referrals in September, however this is in line with typical seasonal variation seen in previous years for the same period.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



Assessment of current performance - key points:
Demand for radiotherapy services has increased from August's referral number of 324 with 364 new patient referrals received in September. 214 patients were referred for treatment with radical intent. 27 did not begin treatment within 28-days (performance rate of 87%).

- 24 as a result of Linac capacity (breast)(all patients prioritised to minimise clinical significance)
- 2 required a rescan
- 1 as a result of the requirement for further diagnostic investigations prior to plan

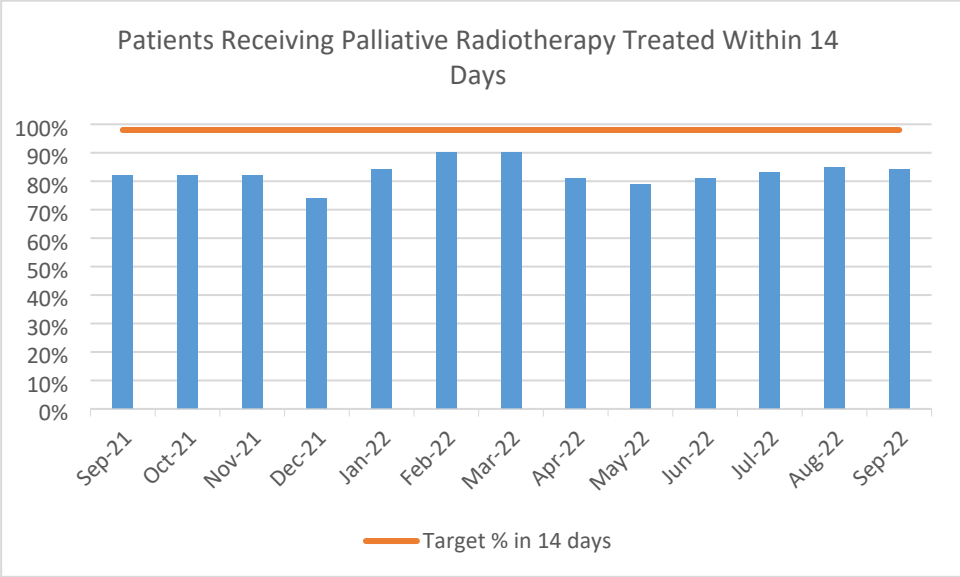
Treatment Intent	29- 35 days	36- 40 days	41- 45 days	46- 50 days	51 days +
Radical (28-day target)	14	10	0	1	2

The two patients waiting over 51 days are breast patients delayed due to capacity constraints and have been subject to clinical prioritisation.

Management of Breast patients continues to be a challenge. Initial plans for accommodating these patients included RCC. This has ceased to be an option. Significant work has since taken place to realign the LINAC fleet to allow breast patients to be treated on multiple machines.

	We are also managing a backlog of Basal Cell Carcinoma (BCC) skin patients, which has occurred due to single handed consultant and availability of DXR scanner capacity. Plans to address this include the ongoing increase to the number of additional ad hoc slots for patient treatments. From November, consultant sessions dedicated to management of these patients will increase from 3 to 4 weekly sessions to provide some sustainable capacity. All BCC patients are clinically prioritised. These patients are not reported under cancer waiting time standards. Fragility of the LINACs due to aged and associated potential for break down remains a significant risk to maintaining activity. **Key actions:** Plan in place for phased increase in LINAC capacity commenced July. This has been supported by extended working days and reallocation of resources. Three radiographers have been appointed and started in October. Further expansion is reliant on recruitment of additional staff and training. Advertisements are currently out to advert. Detailed work is taking place within the clinical teams to understand the trends associated with breaches. This will support a focused piece of work to address the areas of concern e.g. requests for re-scans and re-plans Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group for action as required.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



105 patients were referred for treatment with palliative intent. 16 did not begin treatment within 14-days (performance rate of 85%)

- 11 as a result of requiring a complex 3D plan all were treated within the locally agreed timeframe in compliance with the Wales time to radiotherapy metrics. This aligns with the anticipated COSC standards.
- 1 was as a result of change of treatment plan
- 1 was as a result of change of treatment modality
- 1 was as a result of treatment capacity on DXR,
- 2 were as a result of process failure,

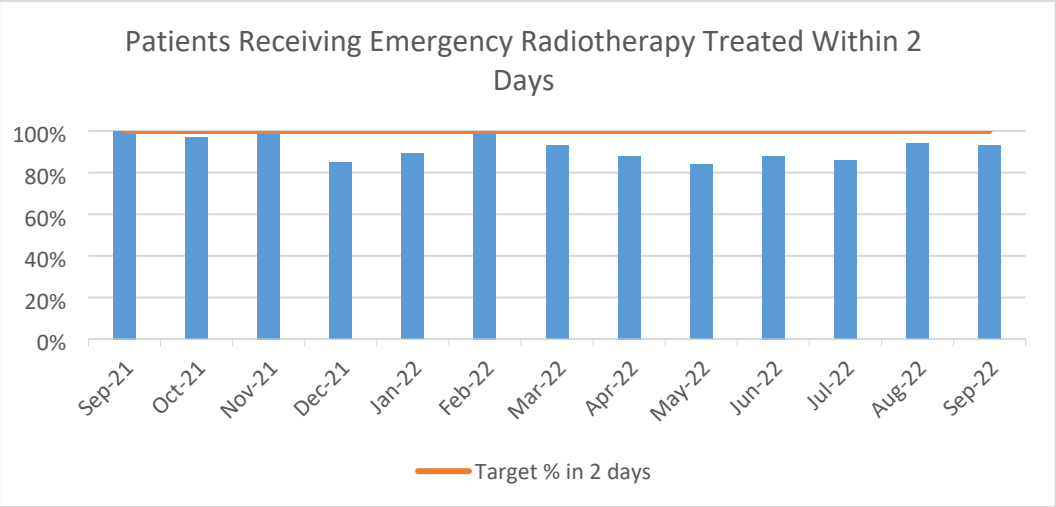
Treatment Intent	15- 20 days	21-25 days	26- 30 days
Palliative (14-day target)	13	3	0

Key Actions

Key actions are outlined in the 28-day section

In relation to 3D planning: A proposal is being developed following review COSC implications and an improvement programme to support delivery of the revised targets will need to be agreed as a priority (Quality Performance indicators QPIs)

Patients Receiving Emergency Radiotherapy Within 2-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



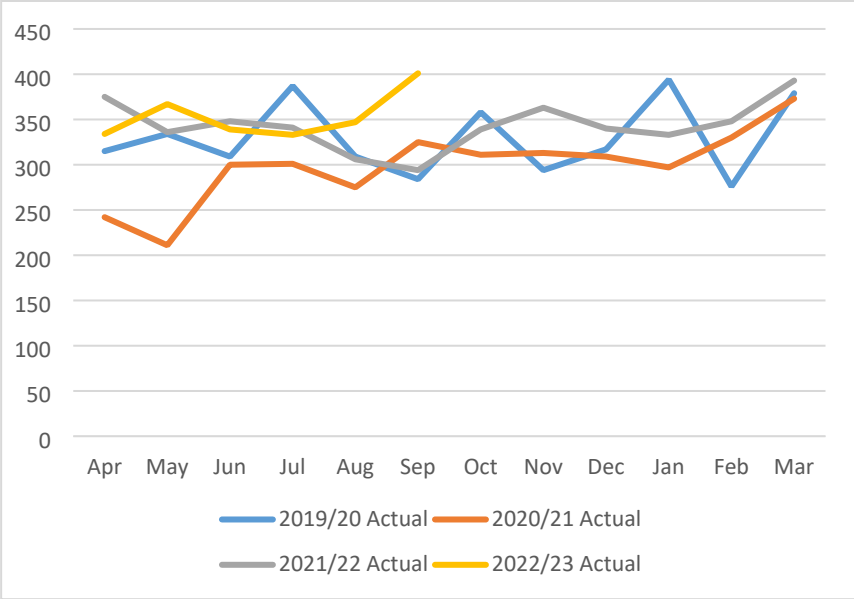
The number of patients scheduled to begin emergency radiotherapy treatment in September 2022 (28) was greater than the number scheduled to begin treatment in the previous month (17).

Treatment Intent	3-5 days	6-10 days
Emergency (2-day target)	2	0

28 patients were referred for emergency treatment. 2 did not receive treatment within 2-days of referral for emergency radiotherapy treatment (performance 93%).

Of these patients:
2 patients were treated within 3 days. This delay was as a result of Consultant request in relation to pathway management.

SACT Referral Trends – Overall

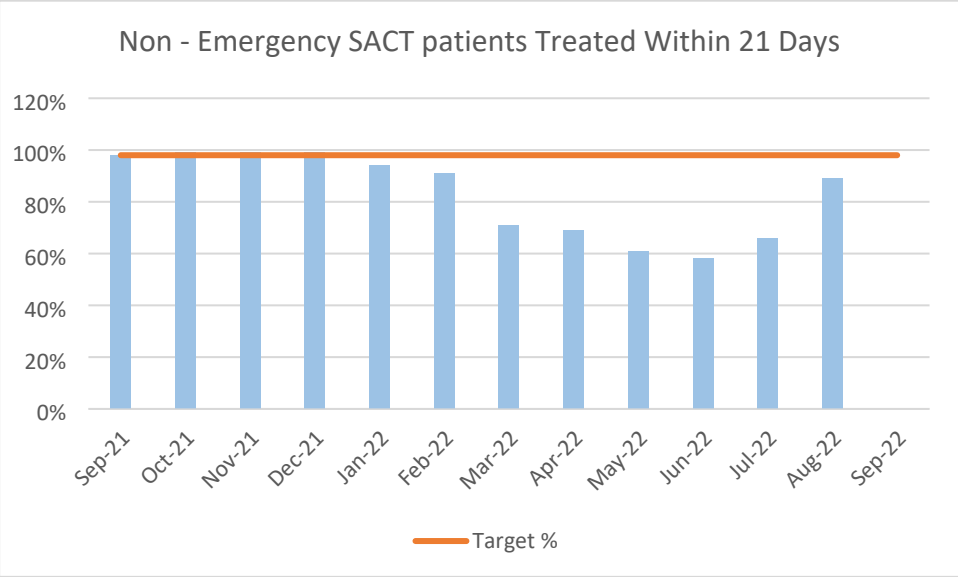


All SACT Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Referrals	315	334	309	387	309	284	358	294	317	394	276	379
2020/21 Referrals	242	211	300	301	275	325	311	313	309	297	330	373
2021/22 Referrals	375	336	348	341	306	294	339	363	340	333	348	393
2022/23 Referrals	334	367	339	333	347	401						

Referrals to SACT continue to increase, with referrals in September being the highest number in single month in the last 4 years.

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



Of 334 patients treated, 36 patients waited over 21 days = performance of 89%.

Intent / Days -	22-28	29-35	36-42	42+
Non-emergency (21-day target)	20	8	7	1

Performance has continued to improve, with breach numbers continuing to reduce from 92 in August to 36 in September.

The attendance record was broken again in September with 2544 SACT attendances, up from last month's high of 2501. The average for the April to July period was 2300.

Breaches within SACT are as a result of demand outstripping available.

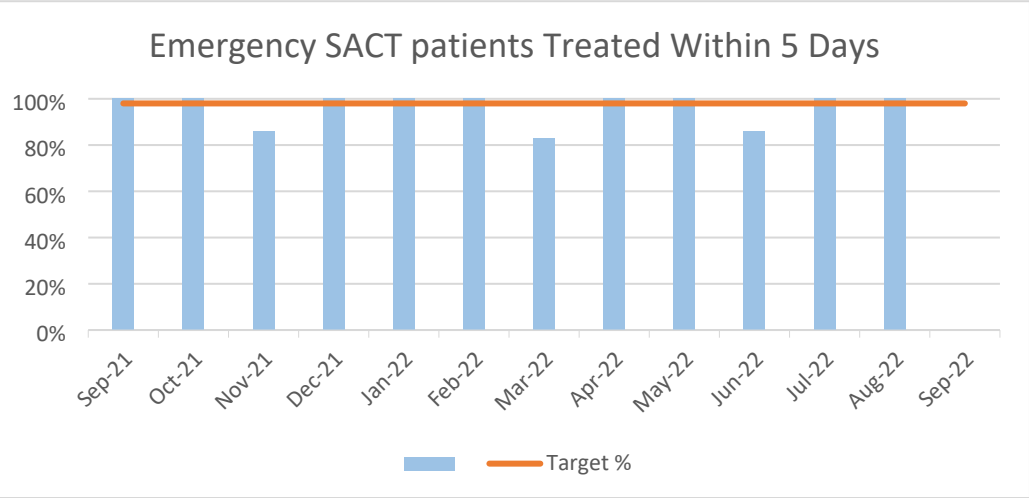
All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Daily escalation meetings continue and capacity needs are continually reviewed and change frequently throughout the day. The clinical priority process commenced on 20th December 2021.

All patients within a Clinical Trial are booked within the trial timeframes.

A review of the process for measuring and managing potential harm to patients as a result of longer waiting times has commenced, along with

	an audit of the application of the clinical prioritisation process to ensure patients at most risk are managed appropriately.
	Key Actions
	• Week commencing 10th October additional chairs to be supported in Prince Charles Hospital resulting in sustainable increase in activity. • Additional capacity continues to be provided from RD&I, and first floor ward. • Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision. • Treatment regimens which can be delivered in other clinical areas have been actioned and further are being explored to release capacity in the SACT clinic area. • Proposal has been developed to support re-introduction of activity within Neville Hall Hospital as part of an interim solution pending the work of the Outreach Project. • Process to monitor the weekly activity data to ensure activity levels continue to be maintained across all delivery points

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend

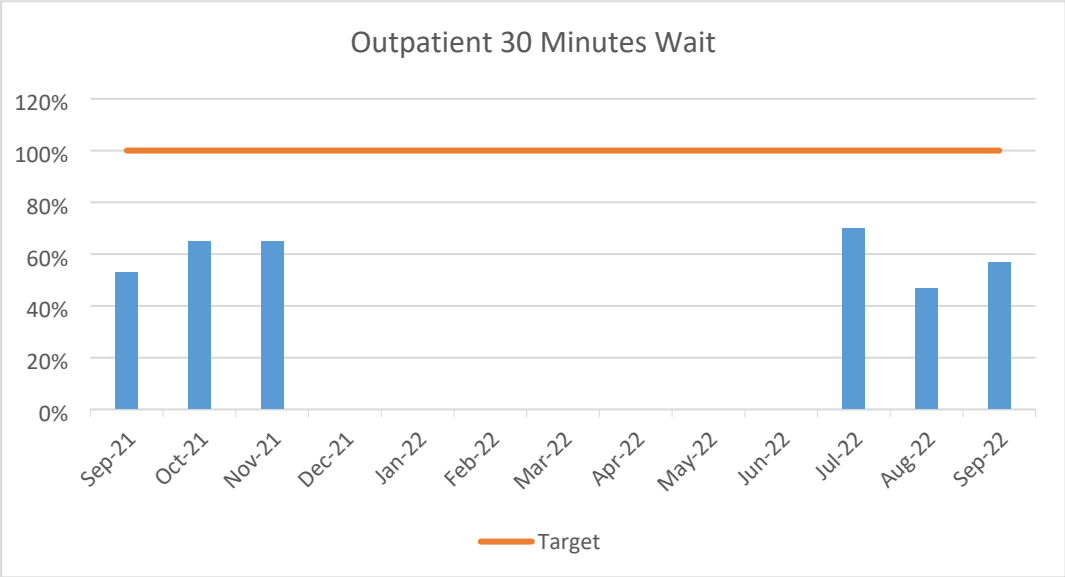


9 patients were treated in September who were referred for emergency SACT. All 9 patients were treated in target. Therefore 100% compliance with target.

Key Actions

- Continue to balance demand and ring fencing with capacity.

Outpatient 30 minute wait	
Target: 100%	**SLT Lead: Outpatient Manager**
Current Performance	Trend



Performance reported for Sep 2022 was 57%.

Monitoring of indicator reinstated but remains limited as only a snapshot of clinics at particular times.

The performance on patient waiting times has multiple influencing factors. This includes the delivery of "on the day" phlebotomy, variation in clinic management practice between clinical teams and increases in the number of patients requiring complex care. The Out Patient Programme is collating a wide range of actions to enable incremental improvements across the function. Currently the focus is on the implementation of DHCR. We are working with the Wales Cancer Network to scope pathway improvements.

Actions

Focus Groups to be established with patient involvement to define performance measures reflecting the entire patient experience at outpatients as part of the Trust wide PMF review.

Delivery of the Out Patient Programme.

Equitable and Timely Access to Services - Therapies

Target: 100%	SLT Lead: Head of Nursing

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

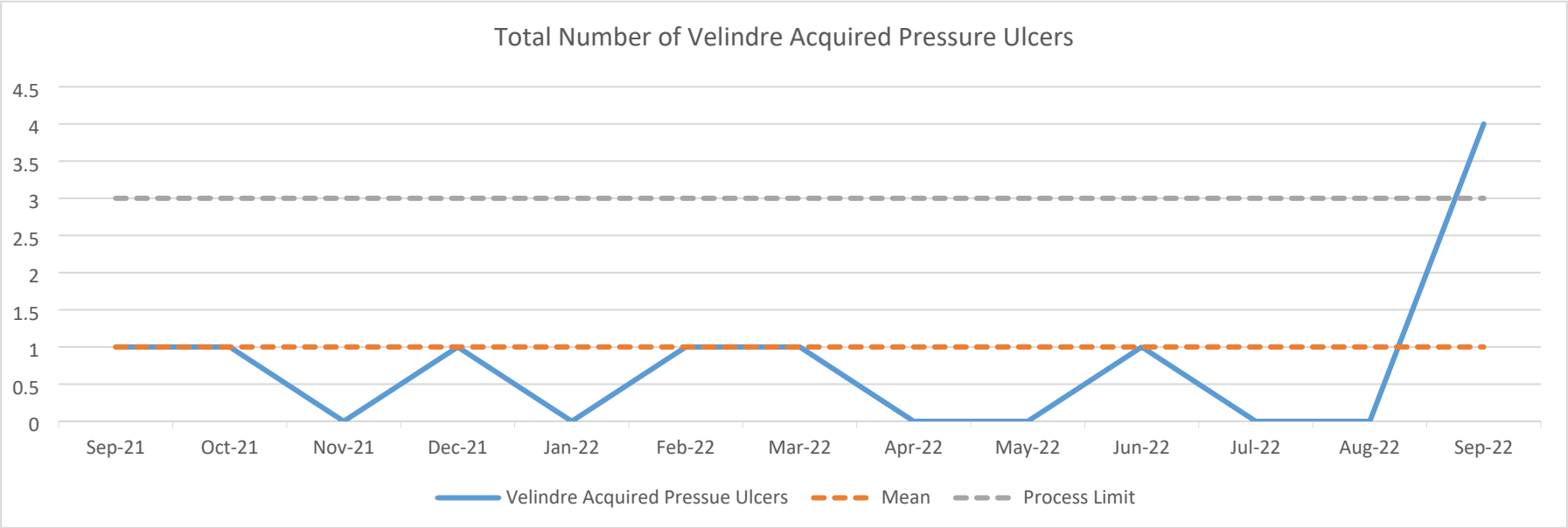
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%
OT	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
SLT	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%

Therapies had the following breaches: **IP's:** Dietetics = 1 breach for Dietetics (95%) - Workforce issues due to a new band 5 induction for inpatients. **OP's** (routine) Physiotherapy = 78% = 2 breaches, Locum is covering outpatients and had 2 weeks annual leave during this period. **OP's** (urgent) Speech and Language Therapy = 50% 1 breach due to workforce issues. Risk already raised due to recruitment problems and maternity leave x2	Actions: Departmental Leads continue to review recruitment and retention strategies and the use and cost of short term cover options.

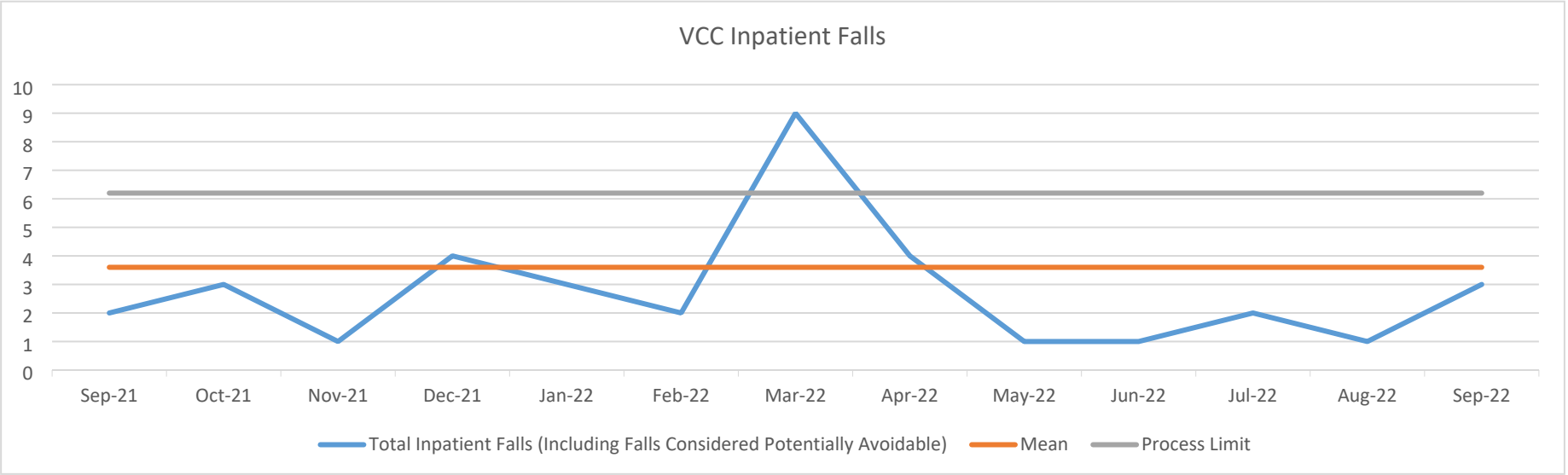
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Velindre Acquired Pressure Ulcers (Total)	2	1	1	0	1	0	1	1	0	1	0	0	4
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	0	0	0	1	0	0	1	0	0	0

Trend	Action
Proposed In September 2022 there were 4 Velindre acquired pressure ulcers affecting 3 patients on first floor ward. All three patients have been discussed at Scrutiny panel and all identified as unavoidable, however one case has been referred back to scrutiny as there were breaches in standards identified. The following themes were identified: firstly (2 out of 3 patients) where the timescale for the initial PU risk assessment being undertaken was delayed, and secondly 2 of the 3 patients were having to be nursed on their backs flat. ***Patient 1*** - (suspected deep tissues injury & grade 2) had all appropriate assessments and care, had capacity and was declining frequent turns and care on occasions despite risk based discussions. Patient, due to condition had to be nursed supine with neck brace on – pressure ulcers developed on heal and neck. ***Patient 2*** – (grade 2) slight delay in admission pressure ulcer risk assessment being undertaken (7 hours 45 mins after admission rather than within 6 hours) – deemed not to be contributory factors. All preventative measures in place and followed. Following identification of skin damage mattress changed to a new trial mattress and PU healed quickly. ***Patient 3***- (grade 2) – risk assessment 4 hour late in being undertaken due to care needs being prioritised. Patients condition was generally poor. Patient had to be nursed flat. There were delays in repositioning and on occasions re positioning was declined. Following review at EMB this case has been referred back to Scrutiny panel as this may have been preventable given breach in standards. A full review of the reasons behind both the delays in undertaking PU risk assessments and in the moving of patient 3 within identified timeframe is required by VCS.	Further review of patient 3.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

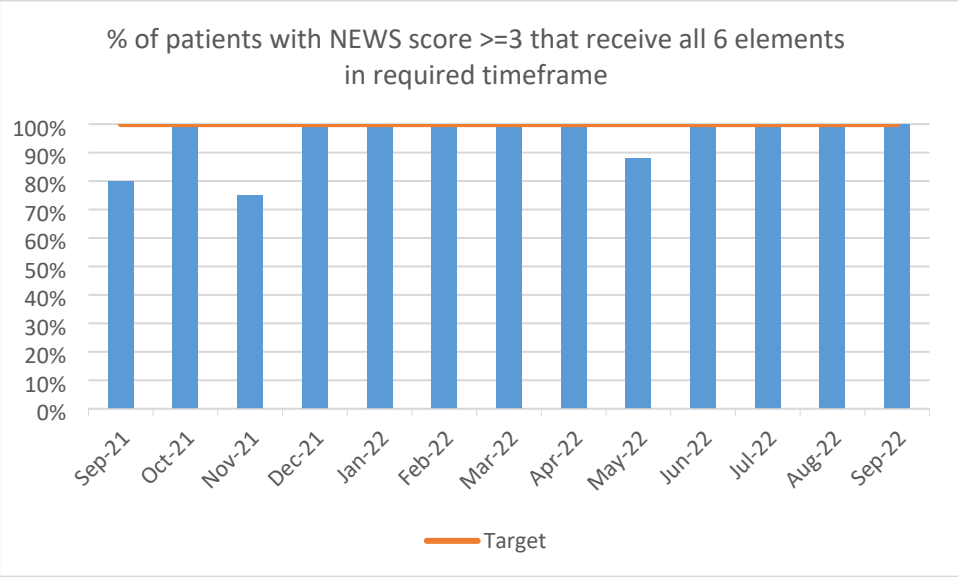


	Jul-21	Aug-21	Sep-21	Oct-21	Nov - 21	Dec - 21	Jan - 22	Feb - 22	Mar - 22	Apr - 22	May - 22	Jun - 22	Jul - 22	Aug-22	Sep-22
Total Inpatient Falls	3	4	2	3	1	4	3	2	9	4	1	1	2	1	3
Potentially Avoidable Inpatient Falls	0	0	1	0	0	0	1	0	0	1	1	0	2	0	1

Trend	Action
Patient 1 Patient was admitted to first floor ward The required admission assessments were complete the patient was not identified as risk of falls. The patient pressed the call buzzer, nurse attended and found patient on her knees at the edge of the bed. Post falls care plan was followed and the patient was assisted back to bed. No obvious injuries. **Outcome: UNAVOIDABLE** because the patient was not identified as at risk of falls and had no cognitive impairment but didn't use call bell. **Patient 2** Patient was admitted to first floor ward and was generally unwell and for consideration of Radiotherapy. All required admission assessments completed and falls reduction plan in place, patient was identified as risk of falls as unsteady on feet. Witnessed fall, patient reports attempting to stand to use zimmer frame and legs folded beneath him, patients legs leaking serous fluid and slipped on the wet floor. Falls care plans updated following the fall and Neurological observations completed as per falls policy. Referral made to Physiotherapist. **Outcome: UNAVOIDABLE** due to risk factors.	**Actions and Learning:**

Patient 3 Patient was identified as risk of falls and confusion. Patient admitted to ward late in the evening awaiting move to HB and only on the ward for a few hours overnight therefore, a physio assessment was not done. The patient could not be moved closer to the nursing station due to the ward acuity so the staff observed the patient within the ward. **Scrutiny Panel Outcome: AVOIDABLE -** Patient based on ward for short period awaiting ambulance transport, not obviously confused and not highlighted in handover from HB staff, on reflection enhanced supervision should have been provided and was provided post fall.	Feedback to staff on patient scenario and learning

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	
There were 0 DToC in September 2022	

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	Measure 23 % of patients who receive antimicrobial within 1 hour • 13 patients met criteria for response to sepsis - 13 received antibiotics within 1 hour where appropriate = 100% Measure 24 % of patients who receive diagnosis of sepsis & all 6 elements within 1 hour • 9 patient received diagnosis of sepsis - 9 received all 6 elements within 1 hour = 100% % of patients who receive antimicrobial within VCC clinical guidelines = 100% % of patients who receive correct investigations in accordance to VCC guidelines = 100%
	Actions
	Although not impacting in delivery of the bundle there is some improvement regarding completion of bundle paperwork required - this has been added to the department's safety huddles and local sepsis champions identified to assist with cascade of information.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
C.diff	0	0	0	0	1	0	1	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteremia	0	0	0	0	0	0	0	0	0	0	1	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
No cases reported for September	No specific action required.

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE

Area visited: Radiotherapy Department VCC

Date: 26th July 2022

in progress
completed
NA

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Tasks	Stage
Cleaning checklists required across all areas of the department - the detail which staff group are responsible for cleaning what & how often & a sign off process in place.	Welcoming and Caring	Sue Sheppard-Murphy and Sam Allen	30.9.2022 and procedure reviewed	Any concerns will be discussed directly with Sue Sheppard- Murphy when needed	Checkiists for clinical areas to be revised.- Domestics Cleaning checklist to be emailed to radiotherapy superintendents/DRSM and allow any issues to be addressed. **Outstanding issue: Windows to be cleaned**	
A full de-clutter is required.	Welcoming and Caring	Radiotherapy staff	30.09.2022	Radiotherapy operational meeting as required	Each area asked to declutter in regards to unlaminated posters and general. La6 refurbishment due 2022-2023 which will adress la6 declutter. In progess	
Radiotherapy walk arounds to be undertaken to assess against IPC Standards (using agreed IPC Tool), facilitated and attended by Radiotherapy manager until all standards / IPC standards addressed. Frequency should then be reduced to monthly. Walkaround team to consistently include: estates manager, facilities manager, radiotherapy manager & IPC.	Welcoming and Caring	Sue Sheppard-Murphy, Hayley Jeffreys, Nigel Hill, Sam Allen,Milburn Mounter, Rhidian Richard	ongoing		First walkaround on 23.8.2022. Second booked for 20.9.22 to discuss outstanding issues. Monthly walkarounds have continued	
Floor extremely uneven outside entrance to L5 - trip hazard - requires evening out to ensure it is safe until move to the new build.	Welcoming and Caring	Nigel Hill	31.10.22	Discussed at walkaround on 23.8.22	Estates team to link with contractors re timing frame and costs .Costs sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October.	
Flooring in toilet areas by la5 uneven	Welcoming and Caring	Nigel Hill- Estates team	13/10/2022	On action plan	Completed	
The no visiting signage to be removed and replaced with the agreed support arrangements (1 person can support)					All 'no visitors signs' have been removed. No new signs have been added as there are no current visitor restrictions in the Trust.	
The whole of radiotherapy department - in particular corridors and waiting areas requires painting as walls in some areas in a bad state of repair (breach IPC environmental standards).	Welcoming and Caring	Nigel Hill	31.10.22	Discussed at walkaround on 23.8.22	Estates team to link with contractors re timing frame and costs. .Costs sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October	

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments	
Cracked electric point (zone15/d11) to be r	Well Organised and Calm	Estates	17.08.2022		Raised by Sam Allen on the 16/8/2022.Rhidian responded and Estates will replace cover to make safe . Completed on the 17/8/2022	
A risk assessment in relation to the carpet in the main waiting room should be undertaken.	Well Organised and Calm	H+S department rep	31.08.2022	Quality meeting	Carried out on the 19/9/2022	
Clean linen cupboards to be installed within the Linac areas for gowns and 'green sheets' and appropriate locations for solied linen skips to be determined.	Well Organised and Calm	Sam Allen	30.09.2022		Sub waiting areas are where soiled linen bags are kept.Plastic boxes with lids to be procured for each changing room to store clean gowns. Clean Green sheets are stored inside the linac rooms	
Around main reception area details should be published bilingually regarding who is in charge that day.	Well Organised and Calm	Helen Payne	16.08.2022		Situated on the wall at radiotherapy reception	
A full review of all store cupboards to be undertaken using 'perfect ward' principles.	Well Organised and Calm	radiotherapy	1.01.23		Review undertaken abd all essential equipment or items are loctaed in the correct area	
An urgent review of storeroom in L6 needed and a review off all storage in line with 'productive ward' principles.	Well Organised and Calm	la6 Refurbishment business ca	2023		La6 refurbishment started on the 11/10/22 which will adress la6 declutter and IPC issues..	
All fans to be removed from throughout radiotherapy.	Well Organised and Calm	Sam Allen			Radiation Services use of fans Risk Assessment for non-clinical areas has been undertaken which premits the use of fans.	
Blinds in reception to be removed	Well Organised and Calm	Nigel Hill	30.9.22		Highlighted an IPC risk. Estates to cost scallfoldng to remove the blinds. Removed 11.10.22	

A review of all chairs in the department required - all dirty, damaged, tacky chairs to be condemned.	Well Organised and Calm	Sam Allen	31.10.22		6 chairs condemned and removed. Costs for additional chairs to be discussed. Procurement of 40 Chairs cost sent to Jeff osullivan and will be discussed by Jeff osullivan at SLT in October	
INFORMATIVE						
Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments	
Full review of signage throughout the department required. To ensure that only essential signage is in place, that they are bilingual and all laminated.	Informative	Radiotherapy Department	ongoing		In progess	
A full review of patient information to be undertaken across the dept. Including what is provided, how it is themed (e.g possibly by SST) and how made visible.	Informative	Radiotherapy Department	23.8.22		The department has all leaflets avialble for patients. General Macmillian booklets ie benefits, tiredness, stopping smoking are avaialble for patients.Patient information booklet/leaflet is stored under plastic sheeting – no change due to covid . No leaflets on display in sub-weight areas . Any leaflet that is needed is found by reception/radiographers. Site sepcific leaftets are given in consent cinic appointmets	
A review of drinks provision should be undertaken - plan in respect of café or moving vending machine to an area visible to all patients.	Informative	Sue Sheppard-Murphy.	31.9.22		Impact assessment on where the vending machine can go. No action taken- no area to put the vending machine in that isnt more appropraite than current area	
Clear signage required in public and visible area regarding how to raise a concern, compliment or suggestion. Including availabilty of CHC for support.	Informative	Claire Davies	31.10.22		Discussed at QSMG in regarsd to civica and haviung feedback from patients is Trust wide issue	
Feedback from patients/donors/staff						
Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Comments/Action	
A review of staff uniform wearing required to ensure that full uniforms are worn for all clinical staff and uniform standards are fully adhered to.	Feedback from patients/donors/staff	Sam Allen	31.12.22	Email Weekly update	Staff reminded in the radiotherapy email weekly update on the 18.8.22 to adhere to uniform policy including jewellery. Review Uniforms in department and to change to black scrubs in line with radioghraphers uniform policy	
Positive feedback mechanisms to staff required in relation to the extent to which their views have been taken into consideration in relation to the new build and if all views have not been adopted the rationale made available. In the event of patient pathway issues these need to be formally escalated through to the programme board.	Feedback from patients /donors/ staff	Andrea Hague /Jacqui Couch /Kate Hammond	14.9.22	Email Weekly update	Email sent to AH and JC to send an update for staff 18.8.22. Meeting on 24.8.22 between JC and SA. AH, JC and KH to develop communication to be sent to staff in radiotherapy via weekly update on the 16.9.22.Completed and add to weekly update 14.9.22	
IM requested understanding of the plan around utilisation of L6 given the current capacity / demand challenges and that it has been out of use for some considerable time.	Feedback from patients/donors/staff	Helen Payne	15.8.22	EMB Shape	Paper submitted and discussed on 15.8.22 at EMB Shape	
Patient feedback Zone in main reception & mini zones in Linac areas required - main reception to include CIVICA electronic Feedback point with large 'your feedback is important to us' type signage. Within area a Know how we are Doing Board is required with a 'You Said .. We did…' feedback.	Feedback from patients/donors/staff	Sam Allen/Claire Davies	1.12.22	Civia meeting	Purchase –noticeboard in department in reception for patient feedback - 1.9.22 Admin roles : Laminated and putting it up in treatment/pre-treatment. CRD/SA Responsibility to update every other month	
Relative had approval on support grounds to support relative on all visits to VCC. This had not been positively received within SACT and was regularly challenged in a non friendly manner.	Feedback from patients/donors/staff	Emma cunningham/Anna Burgess	18.8.22	Nursing staff meeting	Email sent to inform -vivien Cooper, Emma Cunnigham and Anna Burgess in SACT nursing 18.8.22	

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE					
Completed by: Matthew Walters			Date: 19/10/22		
WELCOMING AND CARING					
Action required	**Action taken (including additional context)**	**Strategic theme**	**Who will do this?**	**By when?**	**Where will it be reported?**
Ward paper signs are required to be laminated.	Ward manager made aware and this will be completed by November 22		Ward manager	Nov-22	
Ward relative's room flooring in bad repair	Estates team contacted for consideration of repair or renew, a capital request will be made based on the outcome of estates review		Estates	Nov-22	
All information Boards contained information that was significantly out of date.	Ward manager made aware, this has been addressed, and new information will be added to display boards		Ward manager	Nov-22	
Facilities for patients and relatives were not accessible to them on the day of the visit. The only Relatives' room was being used by staff as breakout room and sink contained lots of dirty dishes etc.	Ward manager made aware, and will request support from operational services staff to ensure that the Relative's room is clean and maintained appropriately.		Ward manager	Nov-22	
A Patient TV room was stacked full of storage.	Operational services have been contacted to arrange alternative storage of the air conditioning units and this now complete.		Operational Services	Oct-22	Complete
The Ward Manager (fairly new in post) advised that she was unclear of the full scope of her role and had not received induction, but learnt from the previous Ward Manager.	This situation arose due to the immediate need to move the previous ward manager to a role as senior nurse in outpatients. Full support is being given to the Ward Manager. Coaching has been arranged from a peer ward manager in a Health Board. Objectives have been set, regular 1-1s in place.		Senior Nurse	Oct-22	Complete
Staff advised that if there were some staff absent from duty then patients would not be admitted, rather sent to their Health Board. Staff could not describe an escalation process through to Divisional Director to put preventative mitigation in place.	The beds are now fully open to 32 and patients are admitted in line with the VCC Admission Criteria. The ward manager has implemented a Big 4 discussion every morning and the escalation process through to the divisional director is being discussed regularly. The ward staff are aware and where required escalate issues concerns to the ward manager and senior nurse.		Ward Manager Senior Nurse	Oct-22	
No welcome signs observed. No other languages outside of English and Welsh.	Ward manager made aware and has asked the band 6 clinical sister/charge nurses to lead on this as a team as one of their joint objectives.		Ward team	Nov-22	
The 'thank you messages' noticeboard outside the main doors to the ward could be replaced with a board specifying managers, titles, contact details and feedback station.	Ward manager made aware to create a board regarding the ward team and management structure with contact details.		Ward team Anna Harries	Nov-23	
Information about who the staff team is and who the ward manager is.	Ward manager aware that board is to be updated on each shift.		Ward Team	Nov-22	
The macerators both require attention.	Escalated to Estates team		Estates	Oct-22	Complete
Daily resuscitation trolley checks	Ward manager aware to monitor in partnership with Resus audits that are undertaken by the resus officer.		Ward Team	Oct-22	
The medication fridge was extremely dirty with sticky residue and hairs.	Ward manager is ensuring that staff perform daily inspection and cleaning of fridge when checking temperature		Ward Team	Nov-22	
Confirmation that bed mattresses / bars and area surrounding beds thoroughly cleaned between patients.	Ward manager aware that we should have a laminated cleaning checklist in each bed area		Ward Team	Nov-22	
No visible evidence of 'you said, we did...' or a patient feedback area. Process on how to complain and compliment.	Ward manager made aware that a patient feedback board should be updated to reflect our response to feedback. The process on how to complain or compliment is now visible in the ward area.		Ward Team	Nov-22	
Resuscitation trolley requires cleaning as part of daily checking process.	Ward Manager aware that cleaning of the resuscitation trolley is part of the daily checks and this has been added to the daily checklists.		Ward Team	Nov-22	
Cleaning schedules to evidence cleaning	Ward manager aware		Ward Team, Estates and Operational Services	Dec-22	
WELL ORGANISED AND CALM					
Action required		**Strategic theme**	**Who will do this?**	**By when?**	**Where will it be reported?**
PSAG (Patient Status at a Glance Boards) not fully completed - very few had EDD, no NEWS, falls risks etc. There were no symbols in use to indicate if patents had a cognitive impairment in PSAG board or bedside.	Ward manager aware that the PSAG board should be completed in full and has since implemented a system where the board is updated as a minimum in the morning handover and then throughout the shift if there are changes made. An electronic system would further support updating this information and this has been raised as part of the Digital requirements.		Ward Team	Dec-22	
There is equipment stored in the patients' TV room and also in corridors.	Ward manager aware. Will attempt to rationalise amount of equipment stored in rooms and corridors however space constraint is an ongoing issue and there is no designated storage area available in close proximity to the ward. This has been raised with operational services.		Ward Team	Dec-22	

Staff kitchen also contained staff personal possessions / clothing / bags / wallets. Not a secure area. Lockers available elsewhere. The cleaners' room door was jammed open (this had just a few weeks before been identified on an HIW inspection).	Ward manager aware. Staff to ensure that they store their possessions in the lockers in changing rooms. The cleaner's room door has been escalated via Operational services.		Ward Team Operational Services	Nov-22	
Clear signage to rooms, toilets etc. Dementia / cognitive impairment signage not in place.	Ward Manager will be working Supportive Care lead nurse to take forward dementia friendly signage and additional environmental changes that would benefit patients with cognitive impairment.		Ward Team Supportive Care Lead Nurse	Dec-22	
Fabric slatted blinds in place in some areas of ward - wipable blinds required.	Ward Manager aware and escalated to operational services.		Ward Team OP Services	Dec-22	
Feedback from patients/donors/staff					
Action required		Strategic theme	Who will do this?	By when?	Where will it be reported?
Staff morale appeared generally low	The senior nurse and ward manager would welcome some further discussion around the concerns/evidence in relation to this statement. Work around staff morale is already being actioned, there is now a staff morale champion, the employee of the month has been reinstated, team away days have been organised. VCC offers staff psychology, Bobath staff wellbeing centre.		Ward Team Senior Management	Nov-22	
There was a significant number of newly recruited staff requiring support has presented challenges, particularly now that bed numbers on the ward have increased (back to pre-pandemic level) from 22 to 32.	Recruitment is nationally a challenge. Staff are being supported with the reopening of a full ward and recruitment to support this model is currently being undertaken. The Band 4 Assistant Practitioner role is being considered for the inpatient ward.		Ward Team Senior Management	Jan-23	
Reports of newer staff struggling with multiple elements of the role unfamiliar to them. We were advised that new registered staff commencing on the ward did not have the required skills: ECG, Catheterisation, bloods, discharge etc.	Staff are being supported to learn the required clinical skills supported by the clinical educators. The ward manager is working with the clinical trainer to ensure that where staff arrive with skills from previous roles there are being encouraged to be signed off as competent without repeating training programmes. The Band 4 Assistant Practitioner role is being considered for the inpatient ward.		Ward Team Senior Management	Jan-23	
Staff felt that: dedicated discharge support to manage the POC, repatriation and complex discharge would help.	This has been in place previously resulting in a single point of failure and burnout for the individual in post. Consideration is being given to an agreement with HB for a rotational post from HB to VCC. The Band 4 Assistant Practitioner role is being considered to further support registered nurses for the inpatient ward.		Ward Team Senior Management	Jan-23	
More support and leadership required.	The current structure is robust and feels appropriate further information on this statement would be helpful to the senior nurse and ward manager. The inpatient ward leadership structure is formed of 1 Band 8a Senior Nurse, 1 Ward manager, 3 Night managers and 8 Band 6 Coordinators. Coaching is being organised for the ward manager to support further development.		Ward Team Senior Management	Nov-22	
Possible weekly remuneration for bank staff would facilitate current staff working extra shifts on ward on bank rather than agency shifts elsewhere.	This work was being taken forward with NHS Shared Services		Ward Team Senior Management	Dec-23	

QUALITY SAFETY AND PERFORMANCE COMMITTEE

2022 / 2023 QUARTER 2 PUTTING THINGS RIGHT REPORT

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NA

PREPARED BY	Jade Coleman, Quality, Safety & Assurance Manager
PRESENTED BY	Jade Coleman, Quality, Safety & Assurance Manager & Nigel Downes, Interim Deputy Director of Nursing, Quality and Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	Received and noted

ACRONYMS	
WBS	Welsh Blood Service
VCS	Velindre Cancer Service
SLT	Senior Leadership Team
Q&S	Quality and Safety
PTR	Putting Things Right

1. SITUATION

The 2022/2023 Quarter 2 Putting Things Right report is provided to the Quality, Safety and Performance Committee to provide a summary of concerns (complaints) and incidents received, themes and improvements made during the 1st July 2022 to the 30th September 2022. The paper provides **ASSURANCE** in relation to how the Trust is executing its responsibilities in relation to the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **NOTE** the report.

2. BACKGROUND

All NHS bodies in Wales must ensure that they have effective processes for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Velindre University NHS Trust is committed to ensuring the provision of an effective and timely process for responding to concerns. This ensures that concerns (including incidents) are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the Quarter 2 report:

- **31** concerns were raised during the Quarter, 13 Welsh Blood Service (WBS) (0.04% of total WBS contacts* (34920)) and 17 Velindre Cancer Service (VCS) (0.03% of total VCC contacts** (54095)). Overall percentage being 0.03% of contacts (89015), compares with 0.07% in Quarter 1.
- **84**% (27) of concerns were graded at level 1 (no or low harm) and 13% (4) grade 3 concerns raised – detail of which are contained of page 13 of this report.
- **65%** (20) of the concerns raised were managed via the Early Resolution process, and **35%** (11) were managed via the Putting Things Right process (formal).
- The Trust received **6** Covid related concerns (2 concerns related to WBS and 4 concerns related VCS).
- **100%** of the formal concerns raised were closed within the 30 working day timeframe, which is consistent with the previous quarter and exceeds the Welsh Government target of 75%.
- The top three themes of the concerns raised continue to be: Appointments, Communication, and clinical treatment.
- **510** incidents were raised during the Quarter – **445** from the Cancer Service and **64** from the Welsh Blood Service.
- **98%** of incidents raised were graded as no harm or low harm, with details of higher

graded incidents contained on page 20 of this report.

- There were **2** National Reportable Incidents submitted to Welsh Government relating to the Trust, details of which, are contained on page 15 of this report.
- There were **4** IR(ME)R incidents reported to Healthcare Inspectorate Wales.
- Formal investigation training has concluded for all key staff to strengthen comprehensive concern investigations.

4. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Yes
	Safe Care and Individual Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes
	The Putting Things Right legislative implications of the management of incidents across the Trust
FINANCIAL IMPLICATIONS / IMPACT	Yes
	Possible financial implications in the event of complaints and claims as a result of an incident and where errors have occurred or system failures are evident.

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **NOTE** the 2022/23 Quarter 2 Putting Things Right Report.

* WBS Contacts – had a contact with Welsh Blood Service and either attended a clinic or called the contact centre. This figure related only to blood donors and does not include platelet or bone marrow donor contacts. This figure covers all sessions in Wales, including East, West and North Wales sessions during the period.

** VCS Contacts – include: New Outpatients, Follow up Outpatients, Ambulatory Care attendances, SACT attendances, Radio-Therapy attendances, Radiology Examinations and Inpatient admissions. Not included: Therapies attendances, telephone helpline contacts, other calls with CNS or consultants, calls relating to appointments.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

Putting Things Right Report

Quarter 2

2022/2023

Learn it Lead it Live it

LEARN TODAY FOR A BETTER TOMORROW

Contents

Acronyms

VCS	Velindre Cancer Service
WBS	Welsh Blood Service
SLT	Senior Leadership Team
Q&S	Quality and Safety
PTR	Putting Things Right

Executive Summary

This is the Trust's Quarterly Putting Things Right report where the concerns raised and incidents reported during the quarter are presented within one overarching report. Due to sensitivities, a separate claims and redress report will be presented. This Quarter 2 report reflects the period 1st July 2022 to 30th September 2022. The key messages / highlights are:

- **31** concerns were raised during the Quarter, 13 Welsh Blood Service (WBS) (0.04% of total WBS contacts* (34920)) and 17 Velindre Cancer Service (VCS) (0.03% of total VCC contacts** (54095)). Overall percentage being 0.03% of contacts (89015), compares with 0.07% in Quarter 1.
- **84**% (27) of concerns were graded at level 1 (no or low harm) and 13% (4) grade 3 concerns raised – detail of which are contained of page 13 of this report.
- **65%** (20) of the concerns raised were managed via the Early Resolution process, and **35%** (11) were managed via the Putting Things Right process (formal).
- The Trust received **6** Covid related concerns (2 concerns related to WBS and 4 concerns related VCS).
- **100%** of the formal concerns raised were closed within the 30 working day timeframe, which is consistent with the previous quarter and exceeds the Welsh Government target of 75%.
- The top three themes of the concerns raised continue to be: Appointments, Communication, and clinical treatment.
- **510** incidents were raised during the Quarter – **445** from the Cancer Service and **64** from the Welsh Blood Service.
- **98%** of incidents raised were graded as no harm or low harm, with details of higher graded incidents contained on page 20 of this report.
- There were **2** National Reportable Incidents submitted to Welsh Government relating to the Trust, details of which, are contained on page 15 of this report.
- There were **4** IR(ME)R incidents reported to Healthcare Inspectorate Wales.
- Formal investigation training has concluded for all key staff to strengthen comprehensive concern investigations.

The report is presented in two parts:

- Part 1: Concerns, which are presented under the heading of the Trust's Concerns Pledge which can be viewed in ***Appendix 1***
- Part 2: Incidents for the Velindre Cancer Service and Welsh Blood Service

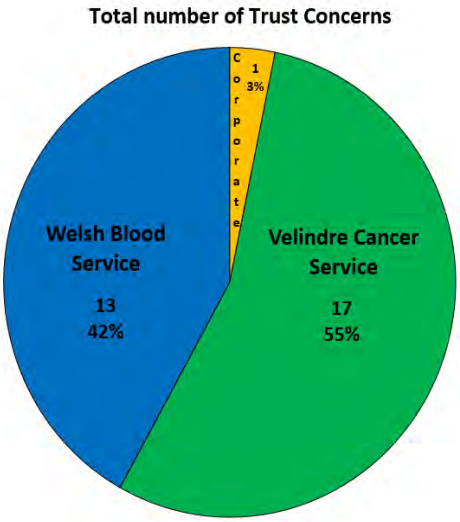
* **WBS Contacts** – had a contact with Welsh Blood Service and either attended a clinic or called the contact centre. This figure covers all sessions in Wales, including East, West and North Wales sessions during the period. This figure related only to blood donors and does not include platelet or bone marrow donor contacts.

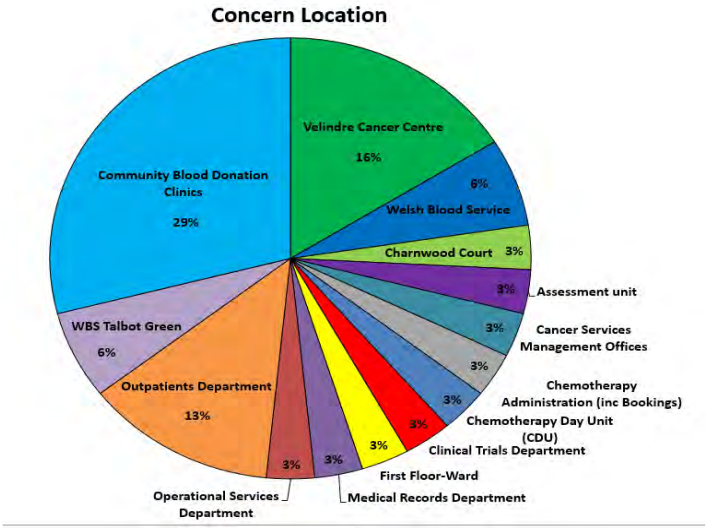
** **VCS Contacts** – include: New Outpatients, Follow up Outpatients, Ambulatory Care attendances, SACT attendances, Radio-Therapy attendances, Radiology Examinations and Inpatient admissions. Not included: Therapies attendances, telephone helpline contacts, other calls with Clinical Nurse Specialists or consultants, calls relating to appointments.

1. CONCERNS RECEIVED IN QUARTER 2

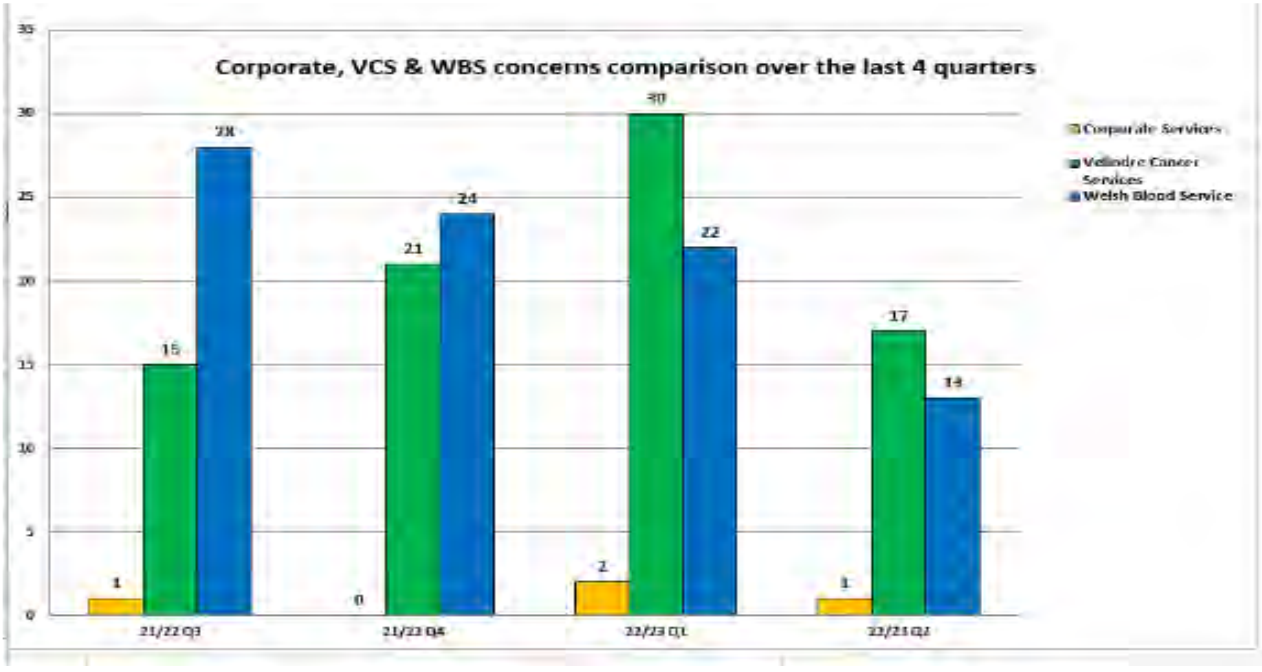
Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

31 concerns were received by the Trust during Quarter 2. 13 related to the Welsh Blood Service (0.04% of total WBS contacts* (34920)) and 17 to Velindre Cancer Service (0.03% of total VCS contacts** (54095)). The below pie charts outline where in the Trust the concerns originated, including a further percentage breakdown of concerns for each location:

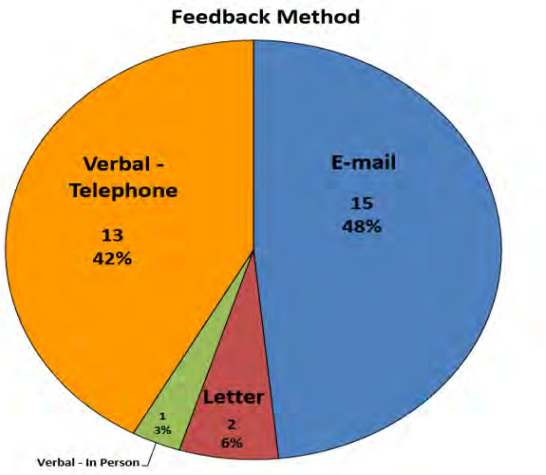




The overall number of concerns raised significantly decreased in the quarter by 19, with both Divisions reporting lower numbers of concerns raised. There appears to be 'normal variation' across the organisation in relation to numbers of concerns received. The chart below displays the concern numbers raised within each division & corporately over the last year.

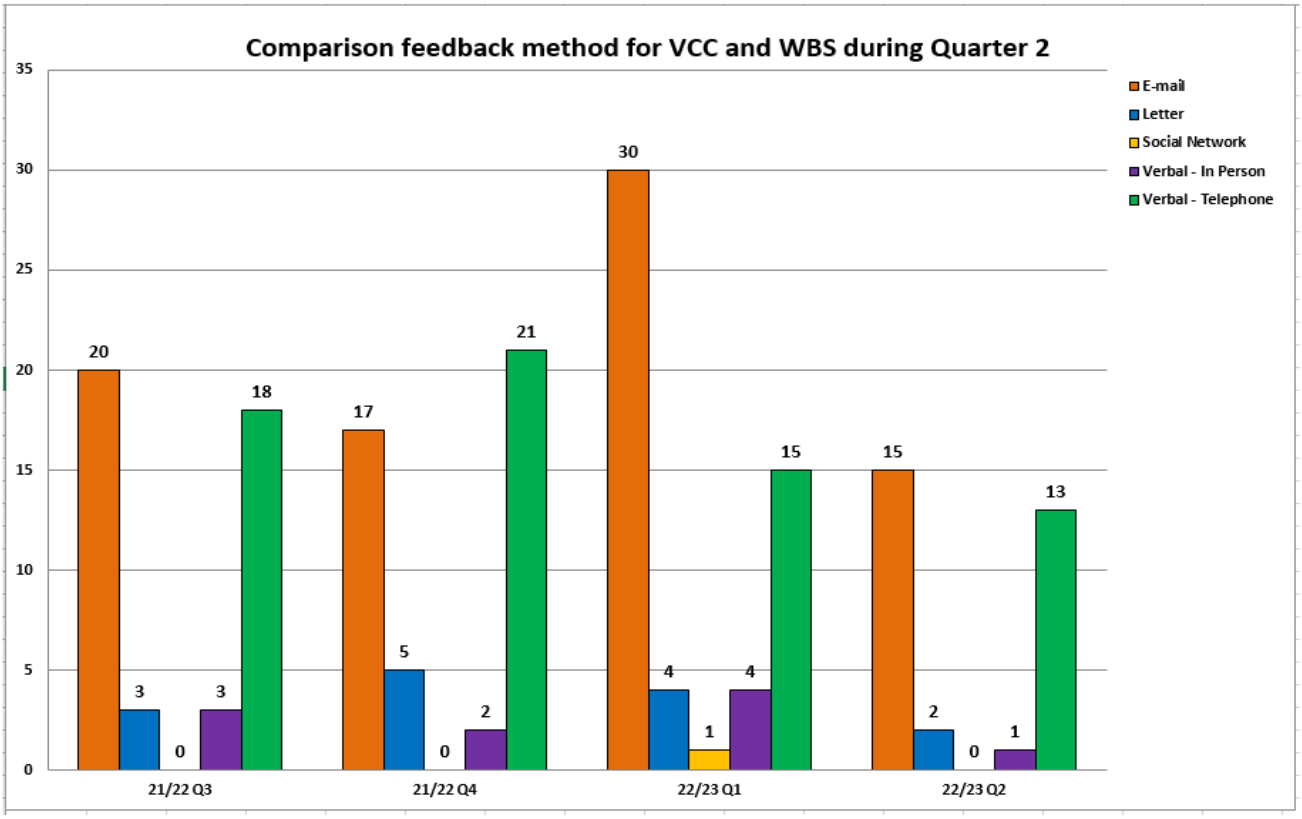


1.1 Method of receipt for concerns received in Quarter 2



48% of Trust concerns were received via email which remains the preferred method for raising concerns. The number / percentage of concerns being received via telephone is decreasing and via e-mails increasing.

The below bar graph further displays a quarterly comparison for the preferred feedback method over the last year:

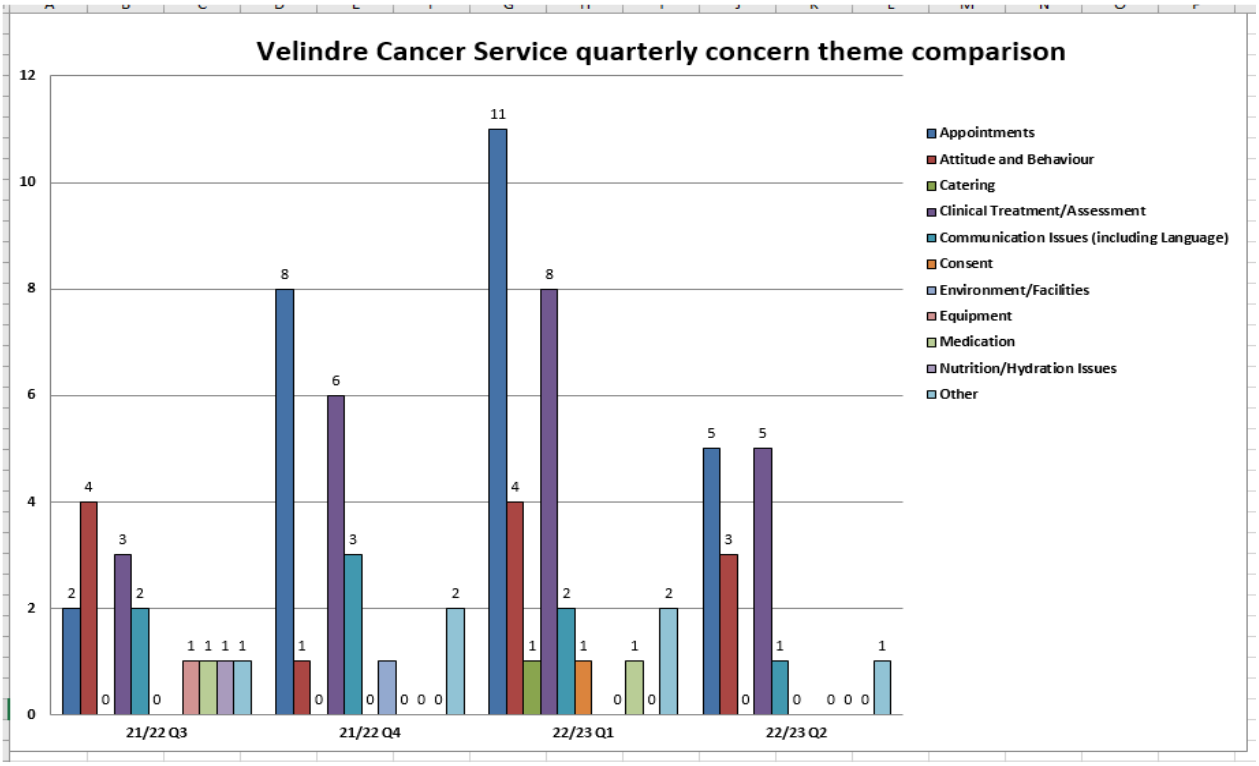


1.2. Thematic review of the concerns received in Quarter 2

The charts below outline a quarterly comparison for concern themes from each Division:

1.2.1 Velindre Cancer Service

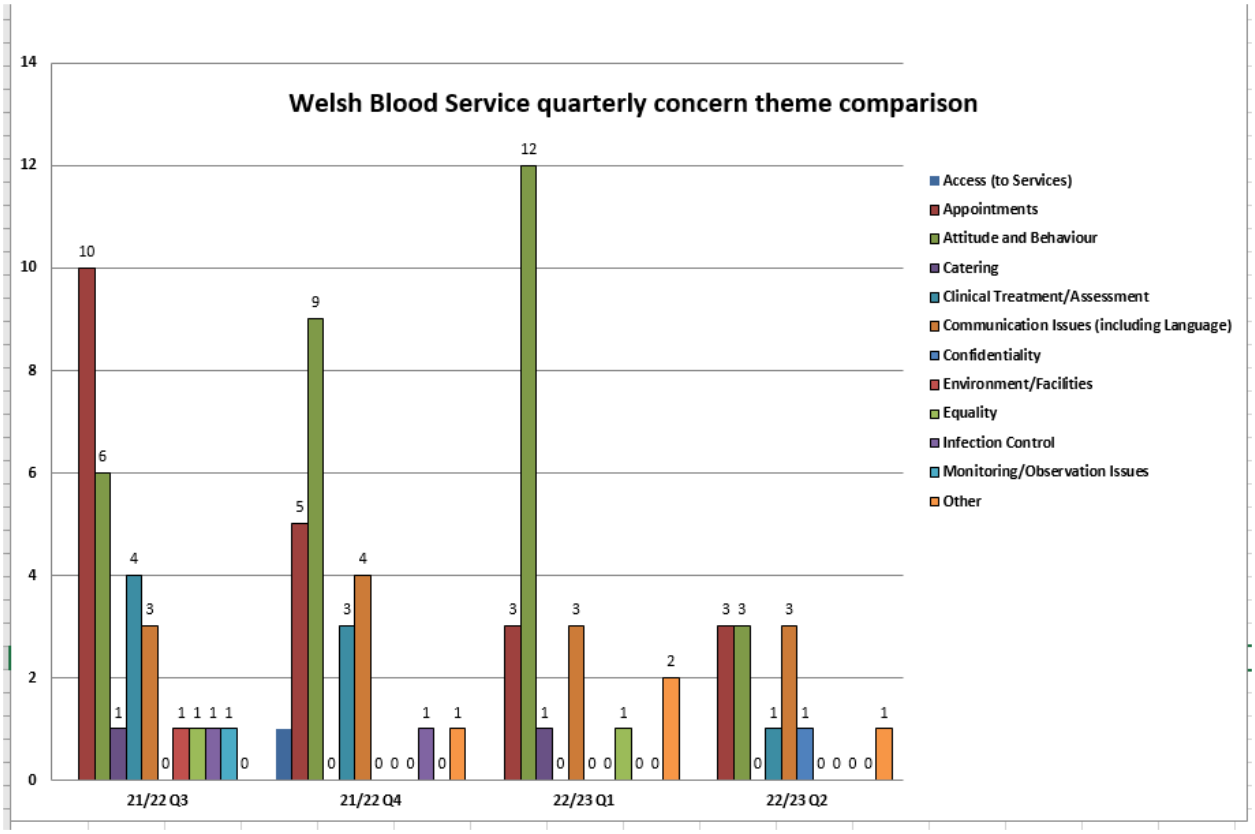
The bar chart provides a breakdown of the themes in relation to concerns raised at the Velindre Cancer Service over the course of the year:



During the quarter: appointment related concerns remain the highest reported at Velindre Cancer Service. The Cancer Service have recognised that these types of concerns are closely linked to the communication aspect of patient care, with some patients raising concerns regarding appointment delays and lack of communication for follow up appointments, including why appointments have been cancelled or re-scheduled at short notice. On recognising an evident theme in appointment related concerns, Velindre Cancer Service initiated an improvement project to focus on this area in order to enhance the systems and processes around appointments and follow up's which were mainly related to communication issues. The improvement project team continue to review and focus on the SACT booking centre process which will ensure patients are offered a choice of video or telephone (virtual) clinics and the offer of face to face clinic appointments when there is a clinical need and when Covid guidelines allow this to happen. The Improvement Project is also reviewing the process around booking clinic appointments following MRI and CT scans.

1.2.2 Welsh Blood Service

The bar chart provides a breakdown of the themes in relation to concerns raised at the Welsh Blood Service over the course of the year:



Attitude and behaviour is a recurring theme at the Welsh Blood Service and although remains one of the highest reported concerns that the Welsh Blood Service receive, the total number of concerns received relating to attitude and behaviour has significantly reduced during Quarter 2.

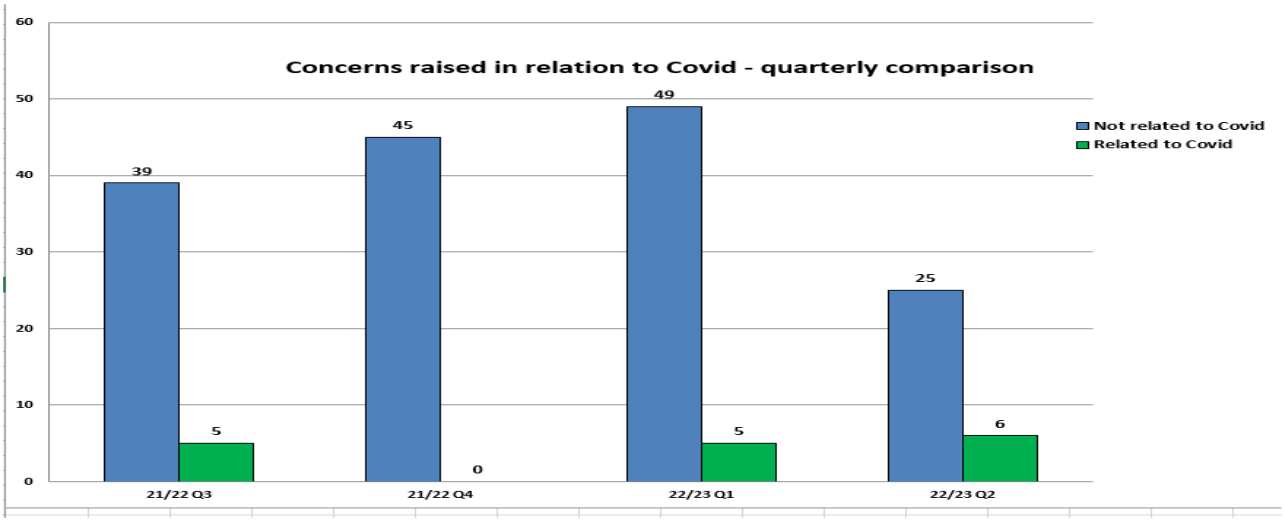
Following a review of these concerns a number of measures have been put in place to efficiently resolve complaints made relating to attitude and behaviour. This has included, a Clinic Lead Registered Nurse being available to support staff members and identify areas of concern. A number of team and individual meetings have taken place over the past few months to address behaviours and ways of working within the Collections team, as this is where the majority of concerns relate to. Senior operations managers have further addressed raising issues in real time in addition to developing action plans that coincide with ongoing monitoring of situations. Following this piece of work the Welsh Blood Service have started to see some encouraging outcomes with staff reporting they feel more positive and supported, this should improve morale and hopefully impact on a positive donor experience.

1.3 COVID related concerns

There were **6** Covid related concerns reported during Quarter 2 for the Trust.

The six concerns raised in quarter 2 related to:

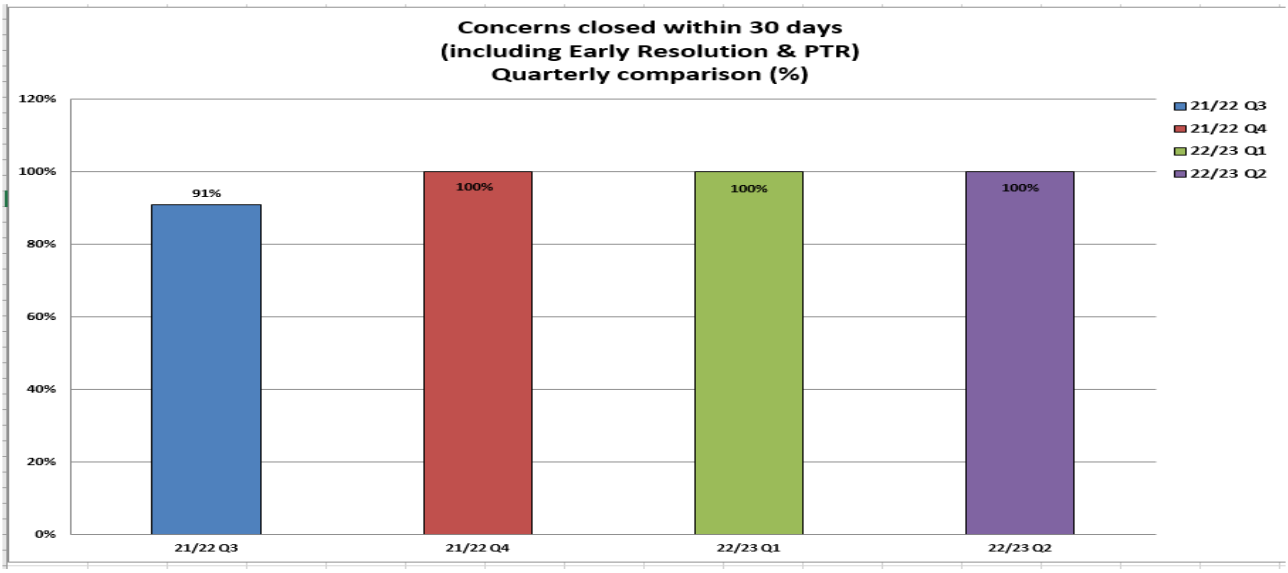
- Two concerns raised at the Welsh Blood Service, relating to wearing face masks *and* the cancellation of an appointment.
- Four concerns raised at Velindre Cancer Service, relating to the cancellation of two outpatient appointments, communication and treatment during the Covid pandemic and, the lasting effect from an Astra Zenica injection given to a patient whilst taking part in a trial.



1.4 Concerns investigated and closed during the Quarter

Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day.
Responses required under PTR will be provided within the legislative timescales.

All concerns raised during the Quarter 2 were also closed during the Quarter. **65%** were closed as an Early Resolution, and **35%** under the Putting Things Right regulations (formal). **100%** of formal concerns were closed within the 30-working day requirement.



The percentage of complaints resolved as early resolution reduced by 19% during Quarter 2, which signifies the increase reported in Quarter 2 for concerns managed under the Putting Things Right Regulations. Strong communication channels between Corporate, Velindre Cancer Service and Welsh Blood Service ensure we continue to drive early resolutions for concerns at source and the management of concerns continues to be largely due to the robust handling Concerns processes implemented within each Division and supported by dedicated complaints managers at the Cancer Serviceand Welsh Blood Service. Efficient initial reviews of concerns enable each Division to swiftly resolve concerns received and decide quickly whether a Putting Things Right investigation is required. Clear defined roles and responsibilities have essentially created a strong link between the Corporate Quality & Safety Team, Velindre Cancer Service and Welsh Blood Service.

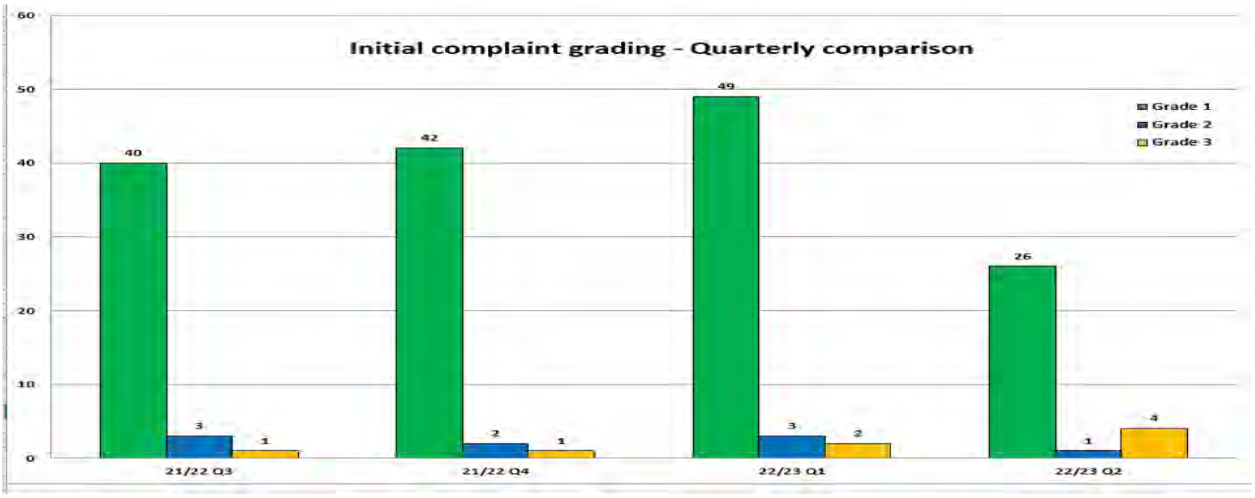
1.5 Level of investigations undertaken

Concerns will be assessed to determine the level of investigation required
Undertake robust investigations by trained staff
Being open and transparent throughout the investigation

Provide an apology where required and confirm what has been done to Put Things Right
Redress will be considered where appropriate
Offer concerns meetings and details of the Public Services Ombudsman Wales

All concerns are graded upon receipt (complaints grading table included as **Appendix 1).** All concerns graded level 2 – 5 undergo an assessment of harm to determine whether the Trust has breached its duty of care, whether a qualifying liability in tort exists and to ensure that the appropriate level of investigation is undertaken. Relevant cases are discussed at the Trust's Putting Things Right Panel. During the quarter **84%** (26) of all concerns initially received were graded as level 1, 3% (1) grade 2, and 13% (4) grade 3.

Trust concerns graded as level 1 should be resolved as an Early Resolution. If this is not achieved they should be transferred into a formal (PTR) concern. During the quarter **26** concerns were initially graded as level 1 on receipt and, **20** concerns were resolved as an Early Resolution, suggesting **77%** of grade 1 concerns were resolved within 2 working days via the Early Resolution process. All other concerns raised were managed under the Putting Things Right Regulations.



On completion of all Quarter 2 investigations, the Trust subsequently recorded 27 (87%) grade 1 concerns however, Quarter 2 saw an increase in higher graded concerns, recording four grade 3 concerns during the quarter and related to:

- The lasting effect from an Astra Zenica injection given to a patient whilst taking part in a trial.
- Three concerns raised where a lack of robust investigation into patient symptoms, early discharge and communication issues contributed to the deterioration of the patient.

1.6 Quality of investigations undertaken

1.6.1 Public Service Ombudsman: During the quarter:

- As of the 30th September 2022 the Trust had 6 open Public Service Ombudsman Cases.

- The Trust received two new Ombudsman cases (case information below):
  - ***Case 1:*** Failing to start treatment immediately after confirmation of diagnosis of lung cancer. Medical records were reviewed and comments sought from the patient clinicians to support the detail contained within the response sent to the Ombudsman. The Trust await feedback from the Ombudsman.
  - ***Case 2:*** Unavailability of Consultant Oncologist delaying patient referral. Medical records were reviewed and comments sought from the patient clinicians to support the detail contained within the response sent to the Ombudsman. The Trust await feedback from the Ombudsman.

- Two Ombudsman cases remained under investigation (case information below):
  - ***Case 1***: Failure to discuss prognosis and thereafter to discuss treatment options
  - ***Case 2:*** Missing property of a patient being treated Velindre Cancer Centre

- There were no Ombudsman cases closed during the quarter. The Trust await further correspondence from the Ombudsman following the review of Trust evidence provided in relation to the above 4 cases.

- The Trust met all Ombudsman action deadlines.

1.7 Learning

Identify and implement learning from concerns raised
Updating patients and donors as to how learning has improved services

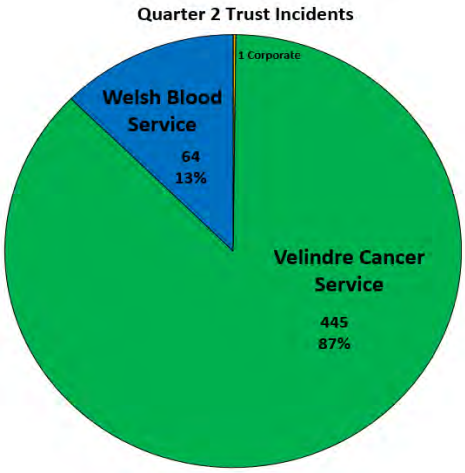
Through the investigation and management of concerns, the Trust continues to closely monitor every concern that is received which helps to identify areas for service

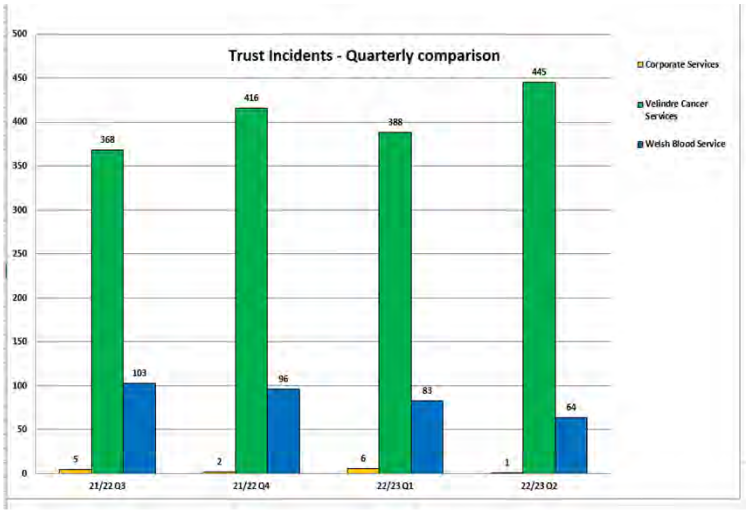
improvement. The Divisions have mechanisms in place to share learning from complaints, and for monitoring the implementation of recommendations and actions. Work continues across both Divisions to better understand the feedback being received in relation to attitude and behavior and the treatment that patients receive. Work continues to review the access to clinical treatment to ensure timely access and equitable care.

Velindre Cancer Service
Following concerns raised relating to the SACT treatment helpline further enhanced training has been identified including additional telephone triage training. A full review of the helpline, how it functions and the staffing model has been escalated to the Senior Leadership Team and Executive Management Board.
Following a concern raised relating to decisions made around treatment pathways, all staff have been reminded that it is their responsibility to check suitability for cancer treatments, including any relevant medical history or conditions, and to follow up on the results of any test samples they request, particularly when prescribing SACT.
As a result of behaviours identified whilst treating patient's and communicating with families, clinicians have time to reflect on concerns raised they are directly involved in, to help guide future practice in managing patients in the future.
Welsh Blood Service
Following a complaint raised around the positioning of the clinic screening booths and trailing electrical cables the Operational Manager has reviewed complainants concerns and as a result is developing a new master venue layout plan, to ensure the reconfiguration of screening area.
Active deferral on Donor records due to a technical glitch in the Welsh Blood Service system led to a Specialist Nurse in Donor Care working in collaboration with the IT department to ensure a configuration update was planned for August 2022.
Working in collaboration with the Clinic Lead, a donor was contacted and offered the opportunity as a walk-in donor, to aid a time that best suited him. This followed repeatedly being unable to book a suitable appointment to donate blood due to his occupation as a farmer.

2. QUARTER 2 INCIDENTS

510 incidents were reported during Quarter 2, which is an increase in incidents raised in comparison to the previous quarter, where 475 were recorded. A further breakdown is provided throughout the report and looks specifically at Velindre Cancer Service and Welsh Blood Service incident data. 1 Corporate related incident was raised relating to an information governance issue.





2.1 Nationally reportable Incidents

2.1.1 Incidents Reported during Quarter

There were **two** National Reportable Incidents reported (both relating to Velindre Cancer Service) during the quarter and are currently under investigation, the detail is included below:

- A breach of duty identified where there has been a possible preventable death following contact with the SACT (systemic anti-cancer treatment) helpline. A full investigation is currently underway.

- Following a patient attending the Nuclear Medicine Department for their third planned administration of Radiotherapy as part of their metastatic prostate cancer treatment, a quantity of Radiation was possibly exposed to the soft tissue in the region of the administration site. A full investigation is currently underway.

2.1.2 National Reportable Incidents closed during Quarter

There were **no** Nation Reportable Incidents closed during the quarter.

2.2 Early warning notifications (replaced 'No Surprises' in June 2021)

There were **no** Early Warning Notification submitted to Welsh Government.

2.3 IRMER Incidents reported to Healthcare Inspectorate Wales (HIW)

There were **4** IR(ME)R related incidents reported to Health Inspectorate Wales (HIW) during the quarter. Three were no or low harm but met the HIW reporting classifications. One related to the administration of Radiotherapy which was also reported as a National

Reportable Incident. The radiation services department continue to monitor its incident and reporting arrangements and have consistently reported IR(ME)R reportable incidents to HIW within the required timescales during the quarter. Three of these incidents are in relation to a known manufacturer fault with the radiotherapy system.

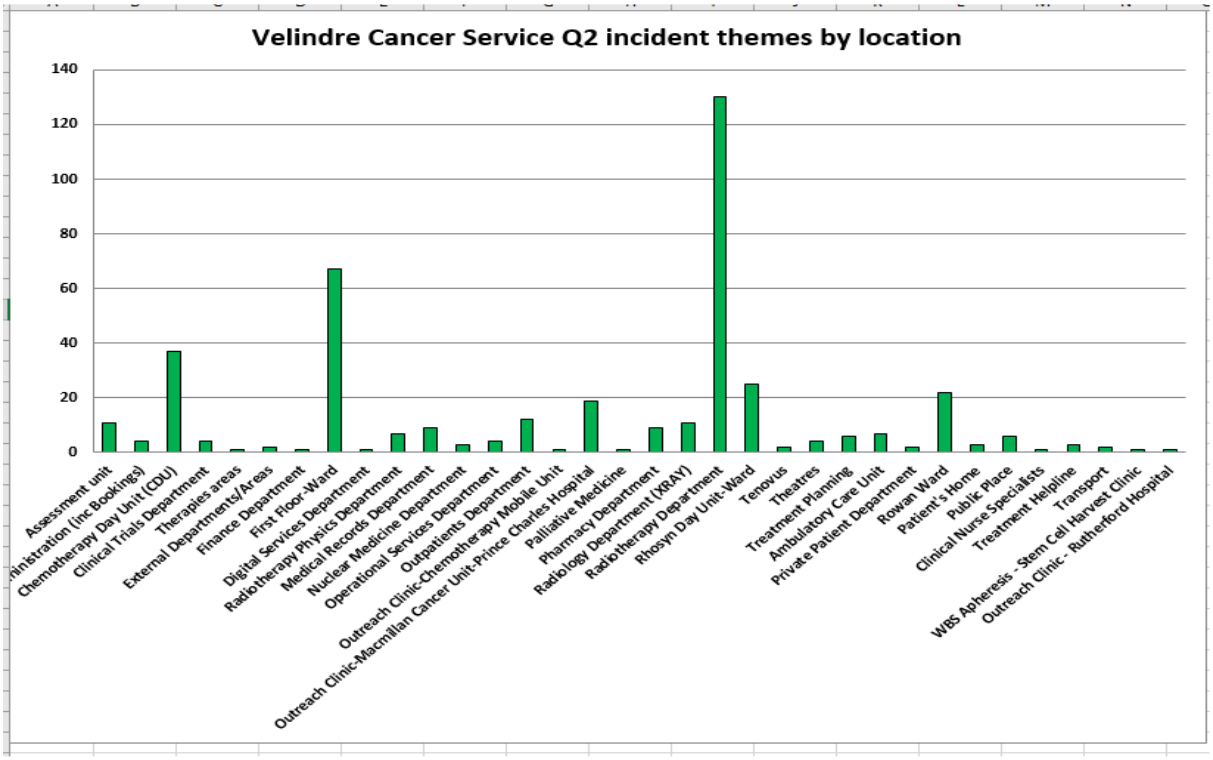
A full review of these incidents has been undertaken by an external expert from the UKHSA (UK Health Security Agency) the details of which were included in the Quarter 1 PTR report.

2.4 Additional Regulatory Incidents

There were **no** additional regulatory incidents reported during the quarter.

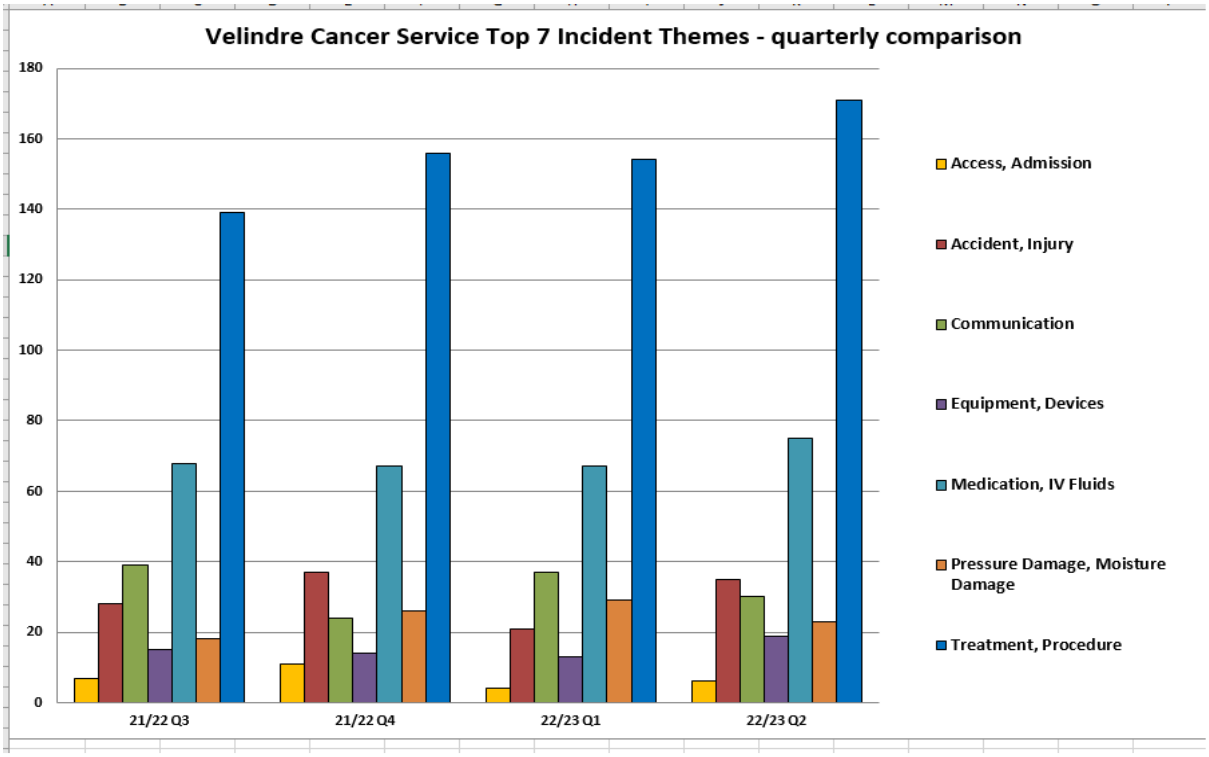
2.5 Velindre Cancer Service Incidents

445 incidents were recorded relating to Velindre Cancer Service. The graphs below display a snap shot of where the highest number of Velindre Cancer Centre incidents are taking place, along with comparative data themes over the last four quarters. Generally, the number of incidents being reported remains stable. The following bar chart displays the specific location at Velindre Cancer Centre where incidents are recorded:

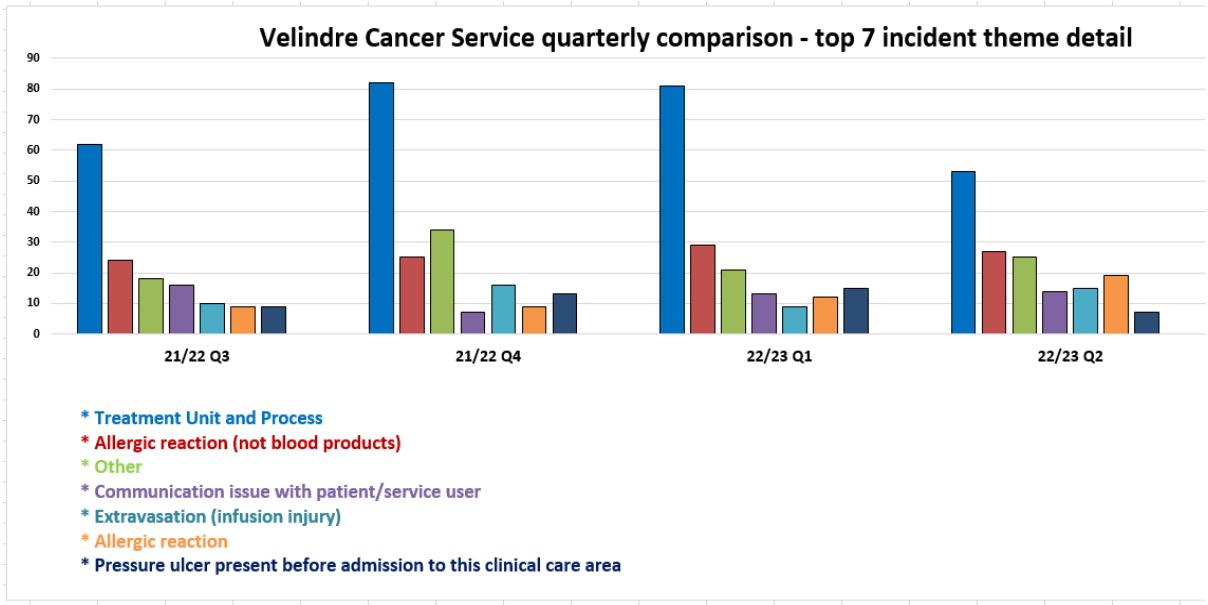


The Radiotherapy department remains the area where the highest number of incidents are reported. These incidents relate to equipment and procedural treatments that are carried out at Radiotherapy on a daily basis. Senior leaders at the Cancer Centre

recognise there is much work and improvement needed in this area and have appointed an interim radiotherapy service manager who within their role will focus on improvement areas. Datix training and investigation training has been organised for the Team with improvement plans, outcomes and anticipated deviations being reported back to the Quality, Safety and Performance Committee. Work continues within Radiotherapy to try and decrease the amount of incidents reported within the department.

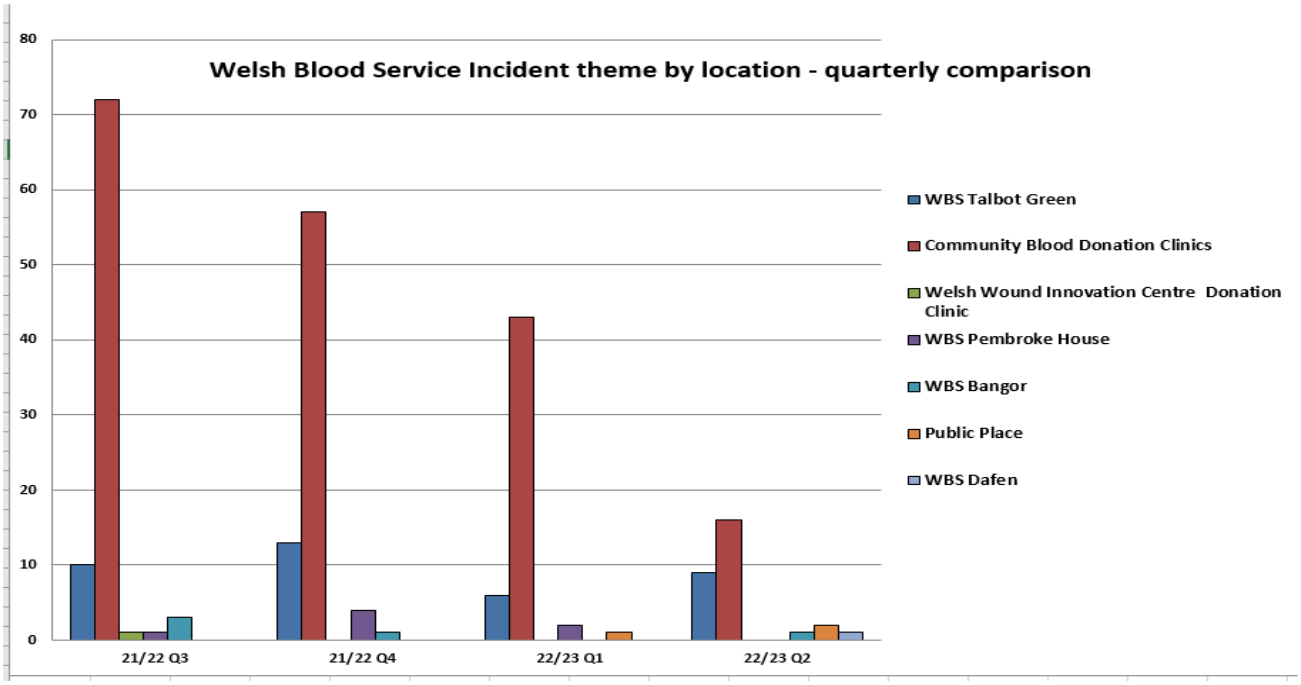


The highest number of reported incidents relate to procedures and treatments received at Velindre Cancer Service. The below graph displays a breakdown over the last 4 quarters and key themes of the highest numbers of incidents reported, evident that Radiotherapy have continued to record the most incidents during the quarter.

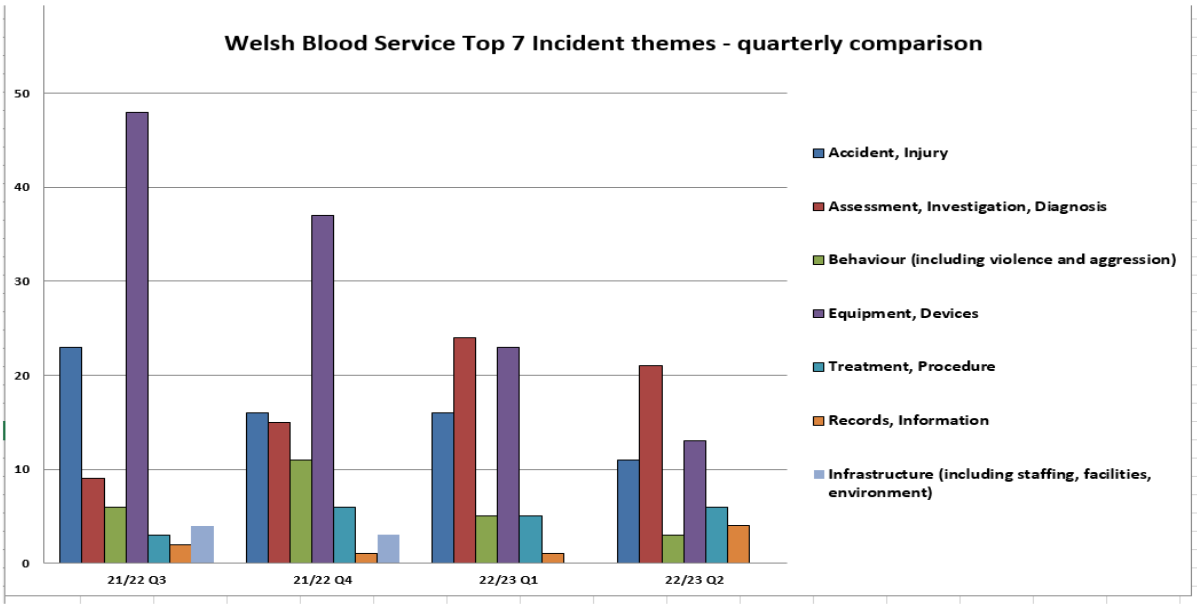


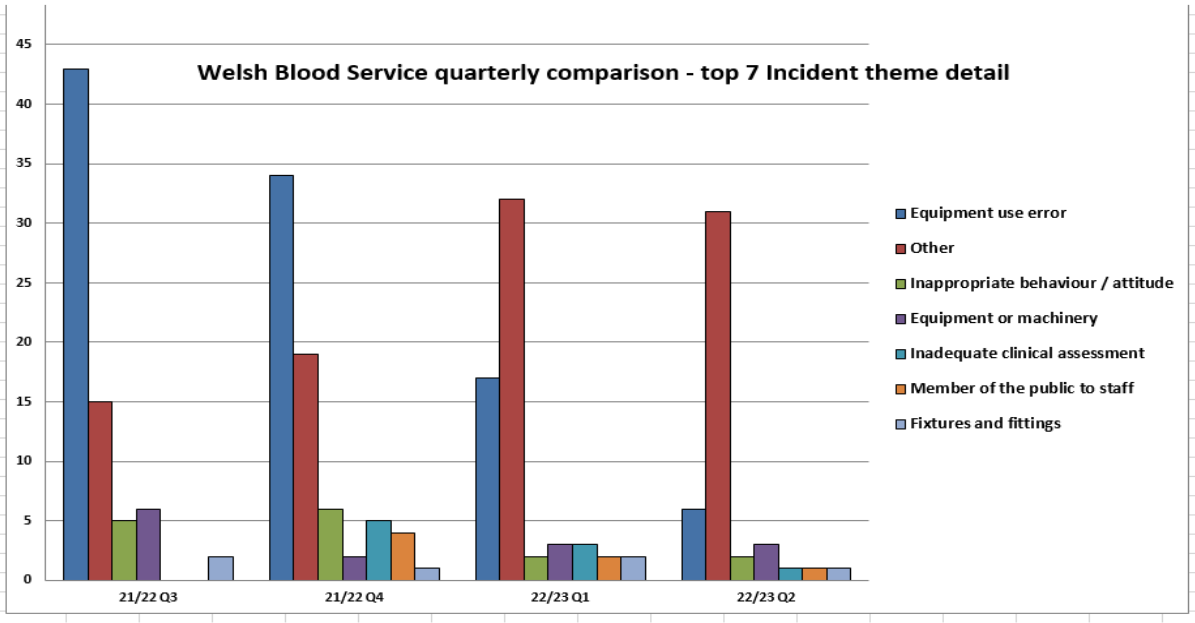
2.6 Welsh Blood Service

64 incidents were recorded relating to Welsh Blood Service during Quarter 2. The below bar chart shows that the number of incidents reported at the Welsh Blood Service have reduced steadily over the past four quarters. The reduction in incidents reported is due to a reduction in clip incidents, heat seal failures and weight shaker issues. The graph displays incident figures from the 1st October 2021 – 30th September 2022.



20 incidents were recorded for community base blood donation clinics, making up **31%** of Welsh Blood Service incidents being reported. Equipment and device related incidents also continue to be one of the highest number (**20%**) of incidents reported for the Welsh Blood Service. A breakdown of incident types are included below:



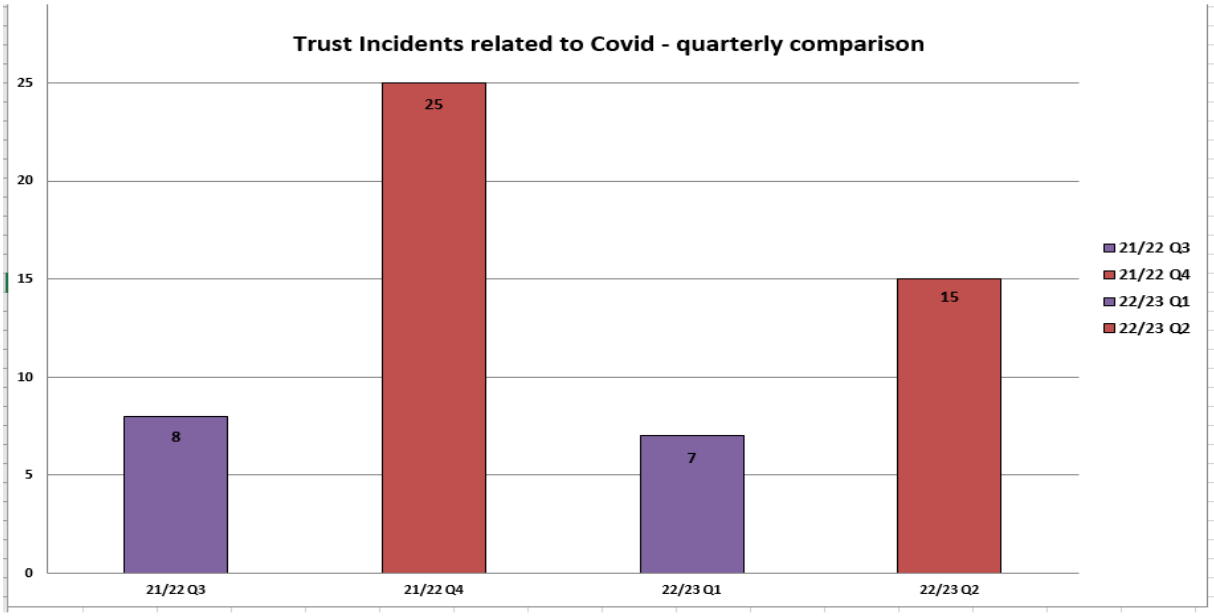


Medical Device incidents remain a consistent theme for Welsh Blood and relate to Centrifuge failures and other equipment failures. Senior leaders and team members are fully aware of the issues with Medical Devices and can specify that the incidents are linked to the collection of blood where an electronic process requires a blood bag to be clamped and then tilted back and forth. If the clamp on the bags does not clip on correctly it may result in an overweight bag. Clip incidents relate to a manual process carried out by staff members. As a result, staff member techniques are monitored and if the same staff member has 3 tolerance breaches within a month there is an intervention and review of that person's competency.

The Welsh Blood Service have a low tolerance for breaches and bleed 7000 units a month with a total of 20 as the maximum tolerance level. Clip incidents are within normal process variation and continue to be monitored to ensure no variance in activity.

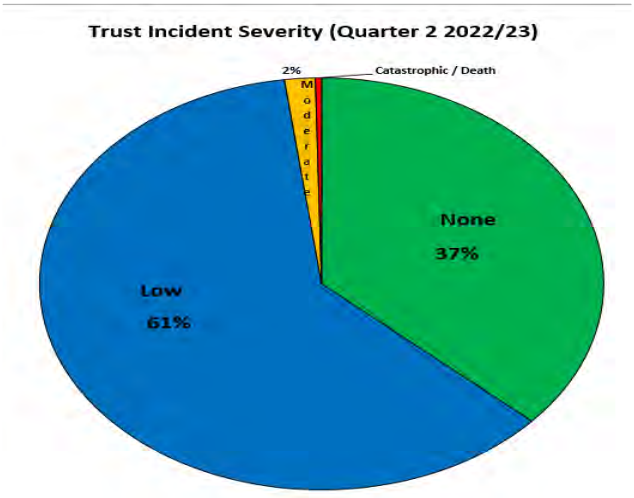
2.7 COVID related incidents

There were **15** incidents recorded that related to Covid during Quarter and the below bar chart displays an increase in Covid related incidents reported. Velindre Cancer Centre reported all 15 Covid related incidents, with 10 of the incidents relating to a Covid outbreak on the first floor ward during July 2022.



2.8 Incident severity

The majority of incidents reported caused low or no harm (**98%**). Moderate harm incidents made up just 2% of incidents raised and were linked to injuries received from fall and cut incidents. One incident case was recorded as a patient death following the patient attending a routine blood transfusion as a day case and became acutely unwell, deteriorating and sadly passing away at Velindre Cancer Centre several hours later with family present.

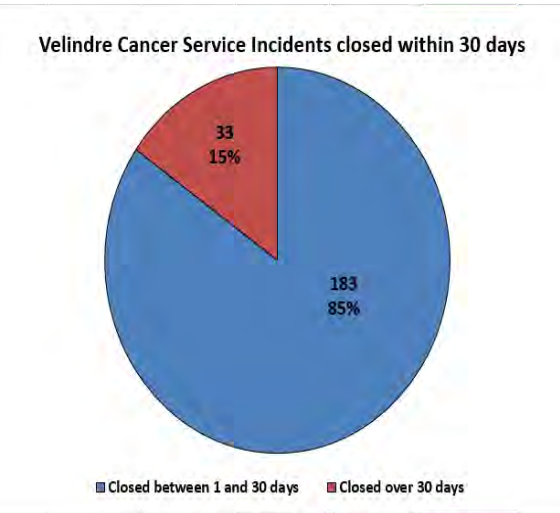


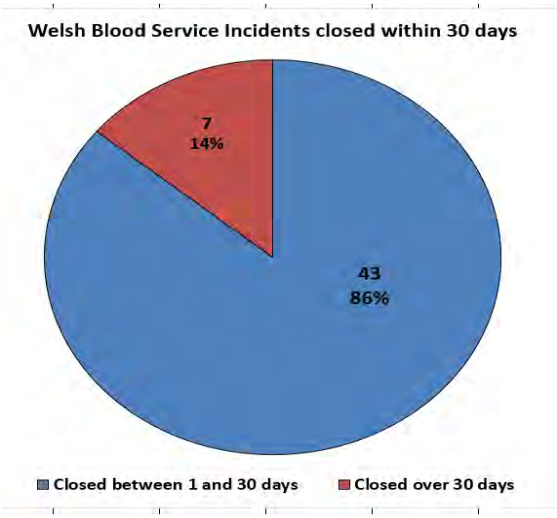
2.9 Closed incidents during the Quarter

2.9.1 Incidents closed within 30 days

80% of incidents should be investigated and closed on the Datix system within 30 days. **266** incidents were closed within the quarter. Of the closed incidents recorded, **216**, were closed for Velindre Cancer Service and **50** incidents were closed relating to the Welsh Blood Service.

The below pie charts further display the number of days it took to close the 266 incidents officially closed during quarter 2. The longest open incident recorded for Velindre Cancer Service was 55 days and the longest open incident recorded for Welsh Blood Service was 50 days.





The Velindre University NHS Trust has recognised that the closure rates for incidents that have been open for over 30 days within both Divisions need to improve, including the management of the timely investigation and closure of incidents that are raised within the Datix system. Incidents that have been open for over 30 days will become a standard agenda item for both divisional senior leadership team meetings following escalation of this theme through to senior management.

Many departments have already been contacted to review departmental incidents that have been open for over 30 day's and some action plans have already been produced to improve the closure status. Both Divisions on a monthly basis will now report incident closure rates to the directorate and senior leadership team meetings for review and, to monitor compliance and departmental closure rates.

3. LEARNING

A summary of the key learning identified from incidents reported and investigated by the Trust during the quarter is provided below:

Velindre Cancer Service
Following patient pressure ulcers being identified, when using medical devices, Nurses across Velindre Cancer Service have been reminded of the need to assess and review patient's skin under medical devices. These findings and any appropriate actions should be documented and evidenced within the patient's records. The medical device process and policy has been updated to include, that where medical devices are used, the skin and surrounding areas are assessed and reviewed for pressure ulcer problems on an as required basis, and at least once in every 24-hour period. This update has been circulated within the Velindre Cancer Service.

Following an increase in medicine related incidents on the First Floor ward, the medicines management nurse is going to attend the midday ward huddles regularly to support and discuss the incidents, and identify the themes.
Welsh Blood Service
The Operations Manager discussed an incident with the Clinical Governance team and advanced practitioner to establish a consistent approach when advising donors who attend donation sessions with children following a Donor being turned away from a session due to attending with her 7-Month-old baby.
Following a Donor being asked to wear a face mask post the height of the Covid pandemic, the Operations Manager has reminded staff, it is not a requirement for donors who attend sessions to donate blood to wear a face mask under the current guidelines.

4. CONCLUSION: CONCERNS AND INCIDENTS IN QUARTER 2.

The following overarching conclusions have been drawn for the Trust for Quarter 2:

- Senior Management have been asked to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, in an effort to successfully investigate and close any outstanding incidents.

- Escalation to the VCS Senior Leadership Team and Executive Management Board to support the further improvements identified in relation to the SACT treatment helpline, including:
    - progressing enhanced training
    - additional telephone triage training and;
    - full review of the helpline, how it functions and the staffing model.

- Directorate Quality and Safety leads are being asked to focus their efforts on learning, retraining and intervention where we have high numbers of incidents and concerns. This data is now routinely reviewed at both the Velindre Cancer Service and Welsh Blood Service Senior Leadership Team meetings.

- Focused efforts are underway to ensure the timely investigation and closure of Incidents. Improvements have been seen at the Welsh Blood Service however, overall this area has been identified and escalated to the senior leadership team for review and action to improve compliance with the national timeframes for the investigation of incidents. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards have been introduced in the monthly directorate meetings.

- There are many improvement plans in place across the Trust to address some of the

themes, these improvement plans are monitored through the Velindre Futures, and Senior Management Teams.

- Quality and Safety as a department has been engaged in work to support the upgrades to the OfW Datix system for the incident and risk modules.

- There is evidence that incidents, concerns and compliments are managed appropriately and compliant with the PTR regulations. Lessons learnt and actions are implemented and monitored by Directorate leads and their teams, we recognise there is always room to improve in this area.

- The after-action review database is a central learning database where learning from our complaints are visible and accessible to inform our quality indicators, clinical audits, internal and external audits. The learning database is shared at the Quality Safety Management Group meetings with departments being asked to provide an update on their learning.

- The Trust remains committed to learning from all concerns and incidents raised, and investigation training is currently underway for all key staff to strengthen our ability to objectively and comprehensively investigate and learn from all concerns and incidents.

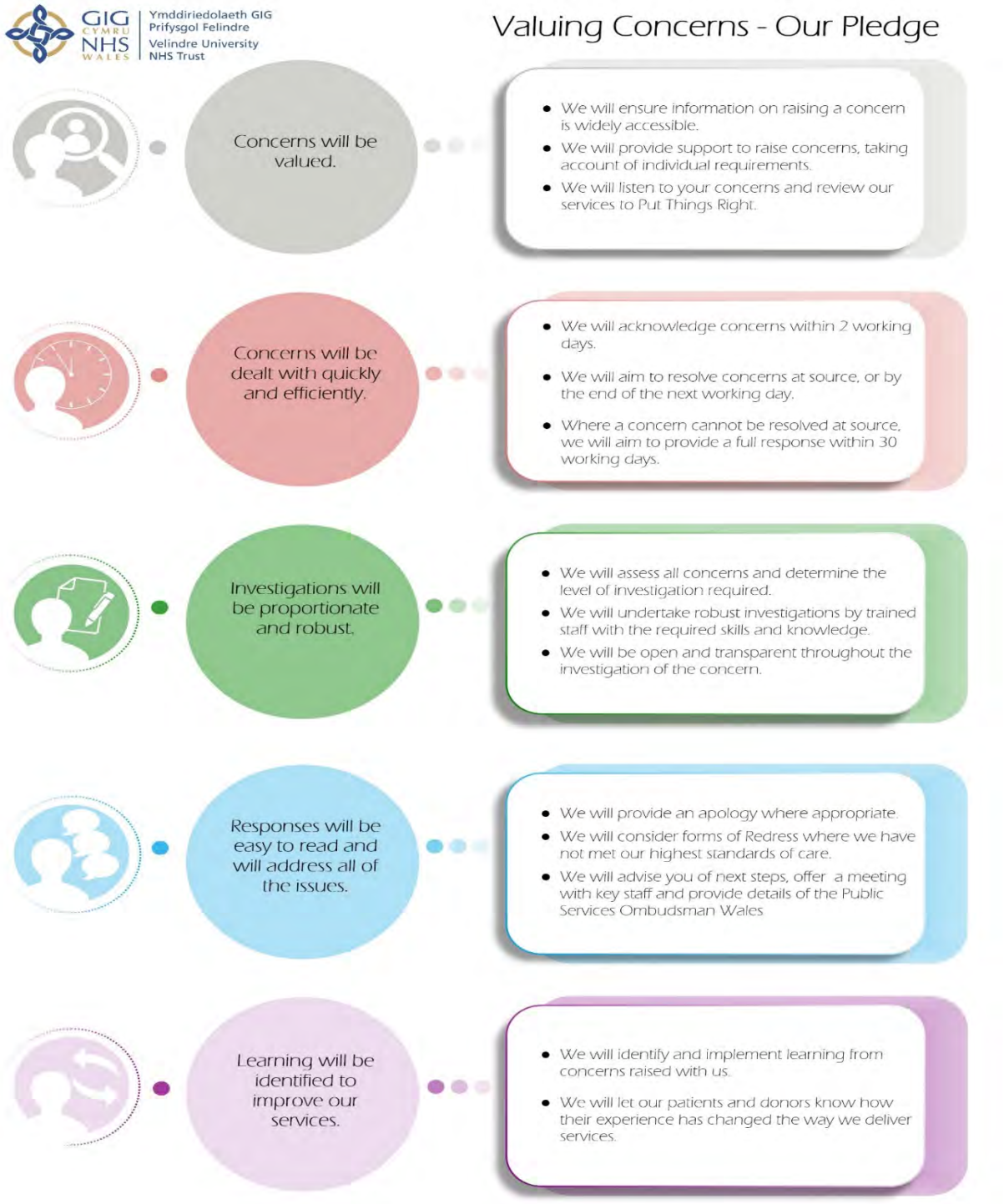
APPENDIX 1: Grading Framework

GRADING FRAMEWORK FOR DEALING WITH ALL CONCERNS

The All Wales grading framework is based on a risk matrix developed by the National Patient Safety Agency [2] and has been used to assess and manage risks and incidents. This approach has been built on to develop a framework for determining the level of investigation required in dealing with all types of concerns in order to promote a consistent approach across NHS Wales. The impact or harm experienced by the patient is always the overriding factor for grading concerns. The harm grading is dynamic in nature and must be considered throughout the investigation. Due consideration should also be given to the potential for litigation, regardless of the harm grading. However there may be situations where the grading of harm is low i.e. a grade 2, but there is indication there they will be pursuing a claim. **The examples listed are meant only to be a guide and not an exhaustive list.**

Grade	Harm	Examples of concerns	Consider potential for qualifying liability / Redress
1	None	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.	Highly unlikely
2	Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities; b) Increase in length of stay by 1 - 3 days; c) Patient fall - requiring treatment; d) Requiring time off work - 3 days; e) Concern involves a single failure to meet internal standards but with minor implications for patient safety; f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Unlikely
3	Moderate	a) Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; b) Additional interventions required or treatment / appointments needed to be cancelled; c) Readmission or return to surgery, e.g. general anaesthetic; d) Necessity for transfer to another centre for treatment / care; e) Increase in length of stay by 4 -15 days; f) RIDDOR Reportable Incident; g) Requiring time off work 4 -14 days; h) Concerns that outline more than one failure to meet internal standards; i) Moderate patient safety implications; j) Concerns that involve more than one organisation;	Possible in some cases
4	Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability; b) Additional interventions required or treatment needed to be cancelled; c) Unexpected readmission or unplanned return to surgery; d) Increase in length of stay by >15 days; e) Necessity for transfer to another centre for treatment / care; f) Requiring time of work >14 days; g) A concern, outlining non compliance with national standards with significant risk to patient safety; h) RIDDOR Reportable Incident;	Likely in many cases
5	Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects; b) Concern outlining gross failure to meet national standards; c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being; d) Clinical or process issues that have resulted in avoidable loss of life; e) RIDDOR Reportable Incident;	Very likely

Appendix 2: Concerns Pledges



QUALITY, SAFETY & PERFORMANCE COMMITTEE

Private Patient Service Improvement Group Highlight Report

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	LISA MILLER, HEAD OF OPERATIONAL SERVICES AND DELIVERY
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHPs and Health Sciences
EXECUTIVE SPONSOR APPROVED	NICOLA WILLIAMS, EXECUTIVE DIRECTOR OF NURSING, AHPS AND HEALTH SCIENCE

REPORT PURPOSE	FOR DISCUSSION AND APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Improvement Group	25/08/2022 /26/09/2022	Approved content
Executive Management Board	26/09/2022	Endorsed for Committee Approval

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board

VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is for the Quality, Safety & Performance Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meetings held during August and September 2022.
- **APPROVE** the amended Private Patient Improvement Plan
- **NOTE** the commissioning of external expert support for the areas identified in the improvement plan
- **APPROVE** the Private Patient Improvement Group Terms of Reference.
- **ENDORSE** the Executive Management Board preferred option regarding the future provision of Private Patient Services prior to consideration at Trust Board.

2. BACKGROUND

The Private Patient Improvement Group was established to enhance the governance and functioning of the Trusts Private Patient Service in response to the recommendations in the external review undertaken. The Improvement Group is not addressing financial matters identified by the external review. Two Private Patient Improvement group meetings have been held to date.

3. PRIVATE PATIENT IMPROVEMENT GROUP HIGHLIGHT REPORT

The following are additional highlights from the Private Patient Improvement Group meetings held during August and September meetings 2022:

ALERT / ESCALATE	• An NHS Private Patient Service Critical friend specialist support is essential to the success of the Group and to date has not been identified.

ADVISE	• Project Support rather than a dedicated Project Manager had been identified. Given the level of work required it was assessed that a dedicated Project Manager was necessary. A Project Manager was subsequently identified following the meeting. • Long term plan for administrative support pending appointment into vacant posts but currently this is being provided in an ad hoc way. • The original Improvement Plan developed from the external review recommendations that had been approved by the Audit Committee has been reviewed and redrafted to reflect realistic deliverable actions and timescales. During the meetings the improvement plan was updated and finalized. All changes are shown in red font for transparency. The plan was approved by the Improvement Group and is attached in ***Appendix 1*** for **ENDORSEMENT**. • The Group has identified that in order to deliver a number of the required outputs by the end of March 2023 external specialist support is required. This is currently being procured by the Executive Director of Finance. • The following critical action was agreed to be completed by the next meeting: o Benchmarking KPIs and private patient service specifications with other national private patient cancer services o Review of Private Patient Policy o Identification of Critical Friend / s for the Group – to date no response has been received from the hospital of choice (Moorfields).
ASSURE	• Monthly meetings established with terms of reference approved that clearly articulates the task and finish nature of the group, the required attendee and their roles/responsibilities (attached in ***Appendix 2***). • The aged debt profile and risk have been reduced significantly which is reflected in regular reporting to the Audit Committee. • Good progress has been made on the operational actions which includes a review and update of Standard Operating Procedures, a review of pre-authorisation and invoicing processes. • Clear demarcation required between the Improvement and Delivery Groups.

INFORM	There were no matters to Inform
Appendices	***1. Private Patient Improvement Plan*** ***2. Private Patient Improvement Group Terms of Reference***

4. OPTIONS FOR FUTURE VELINDRE UNIVERSITY NHS TRUST PRIVATE PATIENT SERVICE

It is important that the Trust has a clear vision and ambition for its private patient service and that this is described in all specification documents as it will ensure that all Improvement Group outputs are robust and support delivery of the agreed vision and ambition. The options are detailed below:

VELINDRE UNIVERSITY NHS TRUST PRIVATE PATIENT SERVICE OPTIONS

Number	Options	Benefits	Risks	Recommendation
1.	Cease Private Patient Service at Velindre – i.e. no longer treat private patients at Velindre	• Irradicates current PP Governance & financial risks • Releases capacity (small numbers) for NHS activity (if capacity not removed from department as no longer funded from PP)	• Due to the committed contribution (profit) from PP income into NHS service at VCC it would create £1.1m financial deficit, without removing £1.1m of NHS costs • Consultants may seek employment with other centers where private practice is supported • Consultants that wish to continue to provide private work may switch their private practice to a private provider which could lead to them reduce NHS sessions in order to travel to other locations. • Increasing numbers of consultants providing private practice off the VCC site would adversely impact the on call medical cover • Negatively impact on the ability to recruit Consultants as PP gives opportunity to	**Not considered a viable option given impact of risks compared to benefits**

			develop skills & knowledge in new drug therapies or RT treatments not yet approved in NHS • Workforce & contractual implications	
2.	Stabilise & enhance governance of current VCC Managed Private Patient Service (VCC Managed) – do same better	• Ensures Trust meeting its financial and governance responsibilities • Maintains VCC as an attractive employer for consultants	• Potential for future deterioration in PPR Governance & financial standards	**Preferred option – essential as a minimum**
3.	Expand & Extend Private patient service to optimise (VCC Managed) - do more of same & do more	• As per Option 2 • Additional income opportunities • Equity of PP provision across all core services provided • VCC uniquely provide treatments that are not available in other private providers. Therefore, there is a potential to increase income due to the specialization.	• Add additional pressure on service – could not be expanded until service stabilised and governance is robust • Investment in expansion may not increase patient activity and income / contribution	**Would be an option once stabilisation and enhanced governance in place**
4.	Outsource – procure private partner to stabilise	• As per Options 2 & 3	• Potential reduced income and contribution (profit) for Trust depending	**Not a favoured option given loss of control and**

	and expand / extend service	• No requirement for Trust management time and operational staff in PP and reduced level scrutiny • Experts in management of private patient services • Commercial & Marketing expertise • Would expand services, grow income base and contribution (profit)	on commercial arrangement for Trust share of contribution (profit) • Loss of control – potential reputational impact • Contractual oversight still required by Trust • Possible staff contractual issues	**possible reduction in contribution (profit)**

The Executive Management Board endorsed option 2 immediately with a view to evaluating the service position and exploring commencement of option 3 in April 2023.

5. REPORTING COMMITTEES

It had previously been approved by the Board that the Private Patient Improvement Plan actions would be allocated and reported to three Board Committees for oversight and assurance. This would create duplication of work and prevent oversight of the 'whole improvement'. It is therefore proposed that the financial improvements will be reported to the Audit Committee by the Executive Director of Finance and the improvement plan as a whole and delivery via the Improvement Group will be reported to the Quality, Safety & Performance Committee by the Executive Director Nursing, AHP & Health Science.

6. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Organisational learning identified through external report - significantly enhanced governance of the Private Patient service required
RELATED HEALTHCARE STANDARD	Safe Care
	All other Standards are also relevant
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There are adverse legal implications if there is insufficient governance in relation to Private Patient service
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Significant financial implications in respect of current service provision as identified in external report

7. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the highlights from the Private Patient Improvement Group meetings held during August and September 2022.
- **APPROVE** the amended Private Patient Improvement Plan and **AGREE** to oversee its implementation

- **NOTE** the commissioning of external expert support for the areas identified in the improvement plan
- **APPROVE** the Private Patient Improvement Group Terms of Reference.
- **ENDORSE** the Executive Management Board preferred option regarding the future provision of Private Patient Services prior to consideration at Trust Board.

Private Patient Improvement Group

Name of Group/ Committee/ Board:	**Private Patient Improvement Group**
Overview/Summary of Role:	Responsible for developing a robust private patient service specification for VCC that includes a delivery plan, management structure and governance infrastructure. This will incorporate the delivery of the Velindre University NHS Trust Private Patient Service Improvement Plan, developed following the TPW Consultancy Report. The core outputs will be: • Deliver all agreed improvement actions within 12 months • Development of an approved VCC Private Patient service specification • Development of an approved Private Patients delivery model including: o Private Patient Service staffing model (incl. training, competency, experience) o Private Patient modus operation o Clinical delivery plan o Clinical Staff renumeration model o Funding strategy / plan • Development of a robust Private Patient governance infrastructure. • Development and agree service key performance indicators (KPI's) including experience and outcome measures and ensure mechanisms for regular electronic data capture, review, monitoring and reporting.
Remit:	In order to achieve the required outputs the group will undertake the following – all areas will be informed by feedback from our patients, and exploring through the literature and 'peer review' methodologies 'what good looks like': <u>Strategic Direction</u> • Develop Trust Strategy for the Private Patient Service which will include a marketing and communication plan <u>Workforce</u> • Staffing – roles / responsibilities; training, competency framework • Service ownership <u>Finance</u> • Identification and understanding of income model, how current funding is currently allocated etc.
Reports to:	VCC Senior Leadership Team Executive Management Board – Quarterly or more frequently by exception
Informs:	Private Patient Service Management Group
Sub Groups/Committees:	As required to deliver agreed objectives / outcomes
Chair / SRO:	Nicola Williams, Executive Director Nursing, Allied Health Professionals and Health Science
Vice Chair / Vice SRO:	TBC

Secretarial Support:	Leah Smith	
Project Manager:		
Membership	Dr Eve Gallop-Evans, Clinical Director	Ensure clinical standards for private patients are incorporated Represent Consultant Clinical Oncologists
	Lisa Miller, Head of Operational Services and Delivery	Strategic delivery lead for private patients VCC SLT Representative Ensuring robust functioning of the improvement group Ensuring effective and timely operationalisation of all outcomes / outputs through the Private Patient Delivery Group
	David Osbourne, Finance Business Partner	Finance lead Identification of all Improvement Group funding requirements – sources of funding Ensure all finance requirements and governance are met Develop the funding strategy / plan
	Ann Marie Stockdale, Head of Outpatients, Medical Records and Private Patients	Operational delivery lead for private patients Ensuring robust functioning of the improvement group Ensuring effective and timely operationalisation of all outcomes / outputs through the Private Patient Team
	Sam Johnston, Directorate Support Manager, Medicine	Provision of service delivery and project delivery support
	Carolyn Gent, Lead, Clinical Nurse Specialists	To represent VCC Nursing Team To ensure clinical standards for private patients are incorporated
	Martyn Rees-Milton, Pharmacy	To represent pharmacy Ensure all pharmaceutical clinical standards are met
	Donna Dibble, Workforce & OD	To ensure that all WOD requirements are fully met Development of clinical staff renumeration model Development of induction, training & education plan
	???? Digital / Informatics	To identify relevant digital and informatics solutions to ensure the delivery of a robust Private Patent service at VCC. Lead implementation of required solution/s including electronic quality and quantitative data capture and analysis

	Critical Friend (to be agreed)	To ensure there is external scrutiny and specialty private patient expertise throughout the tenure of the programme

All members are required to:

- Prioritise attendance
- Ensure a nominated deputy if off work and unable to attend. The nominated deputy must be fully briefed and be able to fully decision make on behalf of the substantive attendee.
- Actively participate to discussions
- Ensure the Group achieves its agreed aims and delivery outcomes
- Agree on on the project priorities and clearly defining the intended aim and benefits
- Take on agreed pieces of work and deliver on these within agreed timescales
- Identifying and owning project risks, including carrying out mitigating actions

Co-option	Other attendees will be invited to attend in order to address areas of work e.g. radiotherapy, performance teams etc. To be agreed in advance with the meeting chair.
Quorum:	Attendance is required from each of the following services for a meeting to go ahead: • Chair or a Vice Chair • Consultant Clinical Oncologist • Senior Leadership Team (SLT) representative or Head of Service • A senior representative from the SACT and Medicines Directorate • A senior representative from the Finance Department • A senior representative from the Medicine Directorate (management side) • A senior representative Nursing
Meeting Frequency:	At least monthly Improvement Group will meet for no more than 12 months – following this revised Governance arrangements through to SLT oversight will be in place.
Documentation required:	• Project / work plan • Improvement Plan • Private Patient Risk Register • Private Patient Issue Log • Private patient KPI's and performance management framework
Meeting governance:	Members will need to submit all agenda items and papers to secretarial support 5 days in advance of meeting Agenda and papers will be circulated at least 3 working days to all attendees in advance of meetings Verbal updates and reports will not be accepted (unless significant unplanned events) – minimum of 1 page SBAR style reports required for all agenda items Action logs and draft high level meeting notes will be submitted 1 week following each meeting
Outputs from meeting:	• High level meeting notes • Action Log • Highlight Report to SLT & EMB (include issues, risk, action logs and work plan update) • Private Patient service specification • Private patient delivery plan • Private patient governance structure

Contact:	**Date TOR Last Reviewed**	**Next Review Date**
Lisa Miller	July 2022	January 2023

Improvement Plan - Private Patient Service

Date Updated: 17.08.2022

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Original Action Target Date	Improvement Plan revised Target Date
STRATEGIC BUSINESS MANAGEMENT							
PP1	NOT STARTED	28.01.22	A Velindre Trust Private Patient Service Specification to be developed and approved	Inaugral Private Patient Improvement group held in July.2022. Project Manager yet to be appointed.	Lisa Miller	30/06/2022	31/03/2023
PP16	NOT STARTED	28.01.22	A Private Patient marketing / commercial plan including digital to be developed and implemented	Procurement process complete. External provider appointed. Business intelligence being collated.	David Osborne/Matthew Bunce / External Provider	31/07/2022	31/03/2023
PP19	NOT STARTED	28.01.22	A Velindre Trust Private Patient pack, brochure, and stationery to be developed, implemented and sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Procurement process complete. External provider appointed. Business intelligence being collated.	Lisa Miller/ External provider	30/09/2022	31/03/2023
PP17	NOT STARTED	28.01.22	Contracts between Velindre Trust and Insurance Companies to be reviewed and renegotiated, removing any level of unreasonable pressure exerted and a rebalance of the relationship .	Procurement process complete. External provider appointed. Business intelligence being collated.	David Osborne/Matthew Bunce / External Provider	30/09/2022	31/03/2023
PP18	NOT STARTED	28.01.22	New process to be developed and approved to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.	Procurement process complete. External provider appointed. Business intelligence being collated.	David Osborne/Matthew Bunce / External provider	31/05/2022	31/03/2023
PP20	NOT STARTED	28.01.22	Professional fee arrangements to be reviewed and further developed to provide consistency across disciplines. Fees to be set at commercial levels.	Procurement process complete. External provider appointed. Business intelligence being collated.	David Osborne/Matthew Bunce /External provider	31/07/2022	31/03/2023
CLINICAL GOVERNANCE							
PP7	IN PROGRESS	28.01.22	An evaluation and review of all Velindre Trust clinical professionals undertaking private practice at Velindre Cancer Centre, including privilege rights, and appropriate indemnity insurance.	Discussions underway with regard to process requriements. All Consultants who undertake private practice at Velindre Cancer Centre have provided/provide evidence that indemnity insurance has been procuedured and is in place. The is held on a central repository by the Private Patient Manager. Clinic professionals (excluding Consultants) are covered by the Welsh Risk Pool. This has been confirmed. David Osborne to provide further detail.	Eve Gallop-Evans/Nicola Hughes	30/04/2022	30/09/2022
			A private patient multi professional workforce delivery infrastructure (incl renumeration) to be established - to include details of skills and compitencies required		Lisa Miller / WOD / David Osbourne		
			A Velindre Trust Private Patient Medical Advisory Committee to be established.		Dr Jacinta Abraham		
COMMERCIAL							
PP21	IN PROGRESS	28.01.22	A Velindre Trust Private Patient tariff to be developed and approved for self-paying and insured private patients.	This work has commenced but requires further work when specialist support available. Procurement process complete. External provider appointed. Business intelligence being collated. Standard Operating Procedure developed and implemented for Self Paying patients who pay for treatment prior to delivery.	David Osbourne / External provider	31/07/2022	31/03/2022
PP22	NOT STARTED	28.01.22	A new Velindre Trust Private Patient charge capture process and procedure to be developed and approved. Billing methodology to be implemented, reflective of the new tariff structue.	Procurement process complete. External provider appointed. Business intelligence being collated.	David Osbourne / External provider	31/07/2022	31/03/2022
PP25	IN PROGRESS	28.01.22	Process for the production of Velindre Trust Private Patient Service cost estimates to be developed with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Standard Operating Procedure developed and implemented for Self Paying patients who pay for treatment prior to delivery. Cost estimates provided for those that self pay. Work progressing for private patients and insurance companies.	David Osbourne / External provider	31/07/2022	31/03/2023
PP27	IN PROGRESS	28.01.22	Progress an increase in private income through exploiting opportunities to expand the clinical scope of the private patient service.	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy.	Clinical Lead	31/07/2022	31/03/2023
OPERATIONAL							
PP10	OPEN	28.01.22	Velindre Trust Private Patient Pathway Review to be completed to ensure equity of service provision (MDT, CNS, psychology etc)	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action.	Eve Gallop-Evans	30/06/2022	31/12/2022
PP14	NOT STARTED	28.01.22	Review of the Velindre Trust Private Patient Service management structure and reporting arrangements to be undertaken.		Lisa Miller / External Provider	30/04/2022	31/03/2023
PP15	NOT STARTED	28.01.22	Review of the Velindre Trust Private Patient Service management arrangements by creating a Senior Private Patient Manager role reporting to the Chief Operating Officer.		Lisa Miler / External Provider	30/04/2022	31/03/2023
PP24	IN PROGRESS	28.01.22	Velindre Trust Private Patient Service Terms of Business statement to be developed and shared with private patients prior to any care being provided.	Signed agreement of undertaking to pay in place. Content currently under review.	Louise Blackmore	31/07/2022	
PP29	IN PROGRESS	28.01.22	Velindre Trust Private Patient Service billing practices to be reviewed and revised where necessary to ensure there is a reduced risk of the insurers 6-month treatment date billing cut off being breached	Review of billing has been completed by the Private Patient Manager. A review of the information reports that support the billing process has been completed and discussions have commenced in relation to potential improvements to reduce the level of time taken to complete the billing process itself. There are two staff members due to take up post on the 4th July 2022 which will take the team back to full establishment. Recognising there will be a period of training, it is anticipated that the risk of the cut off date being breached will be further reduced. Executive Director of Finance has agreed that Healthcode can now be used for insurer billing, Velindre Cancer Centre membership being progressed.	Louise Blackmore	30/03/2022	31/07/2022
PP35	IN PROGRESS	28.01.22	The Velindre Private Patient Team to to undergo a training programme against Private Patient Service Standard Operating Procedures.	Private Patient Team at full establishment from August 2022. Standard Operating Procedures have been reviewed and developed. Staff training against this procedures undereway. PADRs completed and development requirements incorporated in to each plan.	Ann Marie Stockdale	30/09/2022	
PP36	IN PROGRESS	28.01.22	Implement new procedures which clearly differentiate overseas and private patients within the patient health record and other systems.	A review of WPAS is complete and confirmation has been received that overseas and private patients can be recorded separately supporting clear differentiation when reporting. This differentiations is already in place for finance reports (debt reports). This data will structed within WPAS.	Ann Marie Stockdale	30/05/2022	30/11/2022
PP37	IN PROGRESS	28.01.22	Procure or develop a Velindre Trust Private Patient Management System that will enable production of regular management information including a private patient activity report.	The CANISC Patient Administration System is the primarily solution for this information. Therefore an additional system is not required. Three standard reports have been established:- Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Patient outpatient KPI report (activity and phlebo) established and submitted to the Velindre Cancer Centre Management Group. Requirementsprovide a single report that captures all activity at a patient level (which can be filtered, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team.	Wayne Jenkins	30/05/2022	31/03/2023
PP43	NOT STARTED	28.01.22	Velindre Trust to undertake a commercial review of the Sciensus contract and consider the creation/establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24.	Paul Wilkins	31/07/2022	31/03/2023

QUALITY SAFETY AND PERFORMANCE COMMITTEE

ESTATES ANNUAL REPORT 2021/22

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jonathan Fear Capital and Operations Manager
PRESENTED BY	Jason Hoskins, Assistant Director of Capital Planning, Estates and Environmental Development
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	26/10/2022	Noted

ACRONYMS	
VCC	Velindre Cancer Centre
WBNS	Welsh Blood Service
WG	Welsh Government
FSM	Fire Safety Manager
FRA	Fire Risk Assessment
VR	Virtual Reality

nVCC	New Velindre Cancer Centre
SRU	Satellite Radiotherapy Unit
PV	Photo Voltaic cell

1. SITUATION/BACKGROUND

As part of the corporate assurance process, the Trust Board receives an annual report which details management of The Trust Estate. This paper has been prepared to provide the Trust Board with an overview of Estates, performance and delivery during the financial year 2021/22.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Throughout 2021/22 The Trust Quality, Safety & Performance Committee received Highlight Reports from the Trust Estates Assurance Meeting informing of the condition of the estates with specific focus on Estates compliance and Fire Safety.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	WHTM HASAW Various ACOPs
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety & Performance Committee are requested to **NOTE** the annual report.

AN OVERVIEW OF THE ESTATE: PERFORMANCE AND DELIVERY IN 2021/2022

1.0 Introduction

The Welsh Government's aim is to improve the health and well-being of the population through available resources. This includes ensuring that land and property is used effectively to support strategic plans for health and social services and to support the clinical needs of the local population.

This report seeks to provide a high level overview of the changes and progress made to ensure a safe environment for staff, patients, donors and volunteers during a challenging year. This report only provides a brief summary of the activity completed by the Estates Management Team during the financial year of 2021/22 and covers elements of the department's integral role in the Trusts response to COVID-19.

The report consists of two distinct sections which encompass;

- Estates Compliance Report including Capital Works
- Trust Fire Safety Report

Formerly the Estates Report has embedded the Fire safety aspects into the main body, however due to the importance and breadth of Fire Safety the decision has been made to incorporate a complete section to provide a level of detail required.

2.0 Estates Report

The Estates Department sits within the Strategic Transformation, Planning and Digital Directorate The function consists of the following -

- Assistant Director of Estates, Environment and Capital Development
- Capital Development Manager (Secondment)
- Estates Manager (currently vacant)
- Trust Fire Safety Manager
- Trust Environmental Development Officer
- Trust Health and Safety Manager
- Trust Statutory Compliance Officer (Temporary)
- Estates Manager
- Maintenance Technicians (x4)
- Maintenance Assistant
- Estates Administration Manager
- Estates Administration Assistant (Bank)

The Estates Management Team has been through a period of change over within their personnel –

Having appointed an Assistant Director and Health and Safety Manager in 2020/21, further funding has been approved through the course of 2021/22 to strengthen the Team to meet the needs of the Trust. The departure of the Estates and Capital Development Officer has allowed a slight restructure which will provide an optimised arrangement. Posts are progressing through the recruitment process, and include key positions;

- Senior Estates Officer
- Estates Officer x 2
- Maintenance Technician x 3
- Fire Safety Operative
- Quality, Health and Safety, Fire and Environmental Support Operative
- Administrational Assistant
- Maintenance Assistant

Previously the Welsh Blood Service had a designated teams/support delivering the estate functionality of the service needs which fell outside the direct line management responsibility of the Assistant Director of Estates, Environmental and Capital Development. The Estates Manager and wider team is now responsible for both divisions, VCC and WBS which provides the Trust with a consolidated and consistent service.

The Trusts Hosted Bodies, NWSSP and HTW, are outside of the direct line management of the Assistant Director of Estates, Environment and Capital Development as hosted bodies. Notwithstanding this, the Estates Department

provide technical support when required to these areas and ensure the on-going Statutory Compliance within the facilities of the Hosted bodies and Divisions.

2.1 Policy and Procedures (Trust Wide)

The following policies were within review period :-

- The Asbestos Policy (currently being reviewed)
- Business Continuity Management Policy
- Control of Contractors
- Environmental Policy (currently being reviewed)
- Fire Safety Policy
- Fire Prevention Arson Prevention Protocol
- Medical Gas Piped systems Policy
- Protocol for Dealing with Suspect Packages and Bomb Threats (currently being reviewed)
- Security Policy
- Waste Management Policy (currently being reviewed)
- Water Safety Policy (currently being reviewed)
- Health and Safety Policy
- High Voltage Contractor as AP
- Operational Policy for High Voltage
- Low Voltage Electrical
- Ventilation

2.2 Estates Compliance

2.2.1 Velindre Cancer Centre WHTM Compliance

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2.2.2 Decontamination (HTM 01-01)

To assess the requirements of the in house provision of decontamination within the clinical trials department, a gap analysis was undertaken. Following the analysis, it was determined further decontamination works must be undertaken by an out sourced model type Service Level Agreement (SLA).

2.2.3 Medical Gas Pipeline Services (HTM 02-01) (Reasonable Assurance)

There has been a significant improvement and assurance on the standard of compliance for medical gases. All recommendations outlined in the audit report were implemented, to strengthen resilience further, provision of a Secondary Manifold installation onsite at VCC.

2.2.4 Ventilation Systems (HTM 03-01) (Reasonable Assurance)

Following the first annual Authorising Engineer (Ventilation) in January 2017, there has been a marked improvement in the governance and operational procedures at Velindre Cancer Centre. The most recent audit (undertaken in 2021) has issued the Trust Reasonable Assurance with a recommendation that all 15 AHU plants are to be validated by NWSSP. To date a number of the critical plant have scheduled verifications undertaken with a keen rectification plan in place to address recommendations. AP and CP staff trained and appointed Trust wide.

2.2.5 Water (HTM 04-01) (Reasonable Assurance)

There have been further improvements related to water safety across VCC and WBS. Water safety plans implemented across both divisions and demonstrate improved level of compliance. A new AE has been appointed by NWSSP and audits will be undertaken 2022 across both divisions.

2.2.6 Fire (WHTM 05-01) Limited Assurance

The Trust has received Welsh Government funding to improve fire compliance over the past 2 years. A number recommendations have been addressed and will continue in the 2022-23 financial year. The Trust has continued to employ fire safety technician to undertake fire maintenance activities throughout the Trust and support the estates team.

2.2.7 Electrical Low Voltage (WHTM 06-02) (Reasonable Assurance)

Velindre Cancer Centre has not had an audit undertaken since January 2018 where a list of recommendations were developed. A number of the recommendations such as AP appointments and operational policies have been actioned and closed. VUNHST also has a keen attendance in the electrical safety group and meets every quarter. VUNHST has been supply electrical cover by external contractors trained as Competent Person (CP) role for the past year due to recruitment challenges. The site audit is scheduled for September 2022.

2.2.8 High Voltage (HV) (HTM 06-03) (Reasonable Assurance)

An audit undertaken in 2021 at Velindre Cancer Centre. Following the audit, a series of recommendations all of which were implemented.
External contractor now provide AP roles to the Trust and HV operational procedure manual completed. A training scheduled has been developed which Electrical Safety Group will roll out in 2022 for HV officer awareness as per one of the recommendations.

2.2.9 Welsh Blood Service

Welsh Blood Service has continued to benefit from an in-house maintenance service for all WBS buildings. Further recruitment in 2022 will strengthen and improve the maintenance service provided to WBS by VUNHST Estates team. There is recognition that VCC & WBS are subject to different approaches to maintenance, with WBS currently sitting outside of WHTM guidelines.

Through the course of 2022/23 maintenance will be aligned in both divisions for consistency of reporting and operating procedures, this will include alignment with EFpims reporting.

WBS benefits from two technicians based onsite covering the WBS buildings Bangor, Wrexham, Talbot Green and Dafen. The Estates Team also provide an out of hours on call service consisting of a team of managers and technicians.

Since insourcing of Estates Services, a full compliance audit was conducted on all WBS buildings. This included undertaking a full asset recording exercise and the Estates team is currently in the process of integrating the asset information into a new CAFM system that is SFG20 WHTM aligned. This will ensure that all asset maintenance is recorded and reported effectively.

Further AP and CP appointments have been made in WBS to cover the various systems which is an added benefit of provision of a central Estates Function.

2.3 Estates Training (Trust wide)

The following specialised training has taken place for the required individuals in the divisions and hosted bodies -

- Asbestos Awareness
- Legionella Responsible Person Role

Training

Authorised Persons (AP) training has taken place for the following disciplines:

- High Voltage
- Low Voltage
- Responsible persons Water safety
- Ventilation
- Medical Gases

A number of assessments and appointments have been made for the listed disciplines.
Competent Persons (CP) training has taken place for the following disciplines:

- Ventilation
- Medical gases
- Water safety
- Low Voltage

Training Estates Staff

- Working at Height
- Asbestos Awareness
- Confined Spaces
- Legionella Awareness
- Lift Release (Otis)

2.4 Leases and Land Acquisition

The Department develops, maintains and accesses the Trust's Property Management Portfolio database (e-PIMS – Electronic Property Information Mapping Service) for all Trust premises including key date and actions in accordance with the operational management requirements of the Trust.

With the assistance of NWSSP, the Trust ensures that the necessary leases and agreements for properties across the Trust are completed and approved by a Trust Board Member.

The current list of properties hosted or owned by the Trust (Appendix A) has been updated and the areas highlighted in yellow are the properties updated in 2021/2022.

2.5 Estates Statutory Compliance (Trust Wide)

VCC overall annual compliance	PPM – 95.24%	Reactive – 87.86%
WBS overall annual compliance	PPM – 95.26%	Reactive – 95.82%

The Estates team has had a challenging year which has seen a number of staff exit the organisation resulting in appointment of temporary posts to support the team while seeking to recruit.

A full asset survey has been conducted for both divisions. This will form the basis of a newly populated CAFM system that will support automation of task order allocation and close down, and functional reporting which will make for accurate reporting.

A staffing strategy has been derived and business case approved with recruitment taking place 2022/23. The staffing strategy is focussed on the transition to the nVCC MIM model and WBS buildings. The positions will allow for a full complement of authorised and competent person within the Estates Team which in turn will positively influence compliance, and management of the Estate.

2.6 Capital Programme

There were a number of Capital Schemes delivered throughout the course of 2021/22 to benefit the Trust, below is a list of the higher profile works,

- Theatre Decontamination room upgrades has been completed to address audit recommendations and improve operational and clinical processes and flow.
- Building Management System upgrades and a site energy optimisation was completed in 2021/22 with EFAB funding provided by Welsh Government.
- HQ Nantgarw LED lighting upgrades completed and BMS site optimisation EFAB Funding via Welsh Government
- Window replacements scheme Rhosyn Day Unit

- Pharmacy dispensary refurbishment to improve temperature control and ventilation requirements. Design alterations made to improve processes and social distancing requirements.
- Fluoroscopy machine installation Xray and room refurbishment.
- Asbestos abatements undertaken onsite to maintain progress and reduce the number of ACM's.
- Roofing works – a number of roofs at VCC have undergone patch repairs and general maintenance.
- Water Heater replacement WBS – 1 hot water heater failed in WBS HQ resulting in both water heaters to be replaced.
- Ventilation verification recommendations addressed under the Estates Discretionary Capital Allocation.
- SFG20 subscription completed to revise all asset maintenance requirements throughout the Trust.
- Distribution Board upgrades undertaken to improve electrical compliance onsite at VCC.
- Estates stores – workshop development completed to improve stores and estates facilities at VCC.
- Oxygen secondary manifold installation completed to improve medical gas resilience and compliance.
- Fire door upgrades – a number of fire door recommendations completed VCC.
- OPD Flooring replacement scheme completed to improve IPAC and environmental conditions in VCC.
- 19 Park Road – Health and Wellbeing facility refurbishment completed to provide facilities for staff.
- Site schematics for Hot and Cold water services address audit recommendations and improve records of systems onsite.

2.7 Summary

There have been numerous challenges presented to the department through the course of 2021/23, including the continued disruption caused by the pandemic compounded by turnover of staff.

That said the team has continued to deliver an acceptable level of service both from an estates and project programme perspective. Strategies developed and approved through the course of the year will provide the foundations to deliver an improved service in the coming years. Key areas of focus are the approved staffing business case, and the asset collection and automation of works allocation which will be realised through the course of 2022/23.

Further focus will be provided to creation and implementation of an Estates Strategy which will underpin the development and management of the future estate.

3.0. FIRE SAFETY ANNUAL REPORT – 2021/22

3.1 INTRODUCTION

This report provides a summary of activity relating to fire safety between April 2021 and March 2022 and information is based on data captured from *Key Performance Indicators* and the Trust Performance Management Framework.

3.2 SUMMARY OF ACTIVITY

3.2.1 Policies, Protocols and Procedures

The Trust fire safety policy [PP01] was reviewed and updated in September 2021 and the review took into consideration the findings of relevant assessments, audits and inspections

3.2.2 Fire Safety Management

Over the 2021/22 financial year, a number of the non-conformities identified in previous assessments, audits and inspections have been addressed and WG have granted the Trust sufficient funds to continue remedial works around improvement to compartmentation (including fire doors), fire dampers and emergency/escape lighting on both the VCC and WBS HQ sites up to the end of the current (2022/23) financial year.

The Trust Fire Safety Manager has undertaken a comprehensive gap analysis exercise and a fire risk/safety Improvement and Development plan [appended to this report] has been drafted and communicated across the Trust. This exercise has not only identified areas where the Trust is not meeting its Statutory and Mandatory duties [areas of improvement] but also considers areas of opportunity where best practice can be applied to allow the Trust to exceed those duties and aim to be an example of excellence [areas of development]. Implementation of this plan will support both VCC and WBS to continue to deliver safe and resilient services in safe, resilient spaces operated by safe, resilient and knowledgeable staff.

Moving forward, the plan also provides the foundation for demonstrating advancement in fire safety and will evolve following the findings of future risk assessments, audits and inspections.
Both VCC and WBS now have established internal forums where fire safety is discussed and action against remedial issues are raised and agreed with the Trust FSM being an active member of both groups. These forums provide assurance to the Trust Health, Safety and Fire Management Group which provides upward assurance to the relevant Trust Boards and Committees.

3.2.3 Assessments, Audits and Inspections

Fire risk assessments across the Trust are reviewed and updated following completion and submission of the annual NWSSP-SES fire audit in May/June and this strategy was adopted in 2021/22 with the development of bespoke risk assessments to reflect changes made due to the pandemic. Generally, FRAs were reviewed within 1 month of passing their formal review date or following significant changes to buildings or occupancy; however, due to restrictions, some

reviews exceeded their review by a couple of months but were reviewed as soon as possible and up to the end of March 2022, all fire risk assessments were up to date.

The 2021/22 audit was completed and submitted on 30th May 2022 and the issues identified have be added to the fire risk/safety Improvement and Development plan with relevant parties providing assurance through the existing meeting/reporting structure detailed above.

a) Neither NWSSP-SES nor NWSSP Internal Audit have undertaken any audits during the 2021/22 financial year and no sites have received visits from the local Fire and Rescue Service during the same period.

3.2.4 Fire Safety Training

Figure 1 - Fire Safety [L1] compliance: 2021/22 financial year

Figure 2 - Fire Safety [L2] compliance: 2021/22 financial year

As with other statutory and mandatory training subjects, compliance for fire safety training has proved difficult to achieve and maintain. The Trust FSM in cooperation with the Trust Education and Development team has continued to consider how the delivery of training can be adapted in order to make it more accessible and easier for staff with the support of their manager.

Where possible, individual departments have been contacted and have worked with the FSM on establishing local arrangements for the delivery of fire training at a time and location to suit the learner rather than the trainer. The general feedback supported by improved compliance has

demonstrated the benefit. This approach has been sustained with the continuation of more traditional classroom sessions where possible.
The Trust FSM has drafted a revised training plan which provides a clearer, more sustainable approach to fire safety training, and which also explores the wider use of technology to deliver some of the more basic fire information. The plan considers more innovative training solutions to allow the learner to take more ownership of their learning and supports the wider blended training strategy.

3.2.5 Incidents

Over the 2021/22 financial year, there were no fire incidents recorded but there were 2 unnecessary fire alarm activations at the Cancer Centre; both occurred within 1 week (20th to 24th September), but causes were not linked:

- 21/09/22 – Automatic fire detector activated by steam from unattended kettle in Stores; on investigation, the kettle was found to be faulty [ill-fitting lid] which failed to cut-out once boiled and filled the room with steam. The kettle and others were removed from the department and staff instructed to use flasks [filled from existing kitchens] for hot water.
- 24/09/22 – Automatic fire detector activated by excessive use of aerosol air-freshener in small space.
- In both cases, the incidents were investigated quickly, and the Cancer Centre was able to stand fire service response down with follow-up calls to them to confirm the causes.

3.2.6 Other Activity

3.2.6.1 Ongoing development of VR training

One ongoing provision of support which was reported last year is the FSM's continued involvement in the development of virtual reality training for Nursing; however, whilst the project is not managed by Estates, the FSM is providing advice and support on the training content and development of the virtual learning space. Although the project stalled at the beginning of the pandemic, it has been picked again and the Trust has worked with external bodies such as the academic community and have also taken the opportunity to employ an apprentice post with 6 months funding through the *Kickstart* scheme who will provide internal support to drive this project forward with target completion date of *Q4 2022/23 [March 2023]*.

3.2.6.2 nVCC / SRU

The Trust FSM has been involved in the dialogue process with both bidders regarding the delivery of the new Cancer Centre and has advised on how the schemes have met or not met the various criteria; especially the need for proposed designs to meet Trust ambition whilst not losing sight of the fire safety challenges and opportunities.

The FSM has also been involved in the development of Satellite Radiotherapy Unit at Neville Hall and similar conversations have taken place.

Both schemes have presented challenges and opportunities from a fire safety perspective (such as sustainable design and construction and the move towards the use and support of electric vehicles and sustainable energy including use of PV and battery storage) which, as the Trust move forward have provided a good foundation for future sustainable development which will continue to be resilient and safe.

3.3 SUMMARY OF FIRE SAFETY MANAGEMENT IMPROVEMENT AND DEVELOPMENT PLAN

As noted above, the Trust FSM undertook a gap analysis exercise to assess the current position of fire safety against statutory and mandatory requirement as well as current best practice [reports are appended to this document].

The process identified the following areas for *improvement* [the things we MUST do] and areas for *development* [the things we ASPIRE to do to enhance fire safety]:

Key Areas for *Improvement*:

- Need for protocols to support the Trust fire safety policy and inform development of divisional and departmental procedures;
- Communication of fire risks to divisions and departments and need for divisions and departments to include them on relevant risk registers;
- Re-establishment of regime for emergency evacuation drills / exercises;
- Improvements to compartmentation [including fire doors and fire dampers] at VCC and WBS Headquarters including development of a *Permit to Work* system;
- Training for staff expected to operate evacuation aids, especially evacuation chairs.

Key Areas for *development*:

- Review fire risk assessment process including update of fire safety Improvement & Development plans – these also need to be updated following any audits/inspections by external bodies such as NWSSP-SES and/or fire & rescue service;
- Review of existing emergency evacuation procedures to make sure they align with wider emergency preparedness requirements;
- Improve communication with fire & rescue service;
- Review/update of site fire safety information [including drawings] which align with fire service needs such as *Initial Attendance Plans* and Salvage plans – this would also support business continuity & emergency planning requirements;
- Ensure workplace inspections are undertaken and returned to support fire risk assessments and audits;
- Review and consider how fire safety training can be delivered including development of technology-based platforms to support staff accessing training at a place and time to suit them.
-

Division-specific action plans are in place which are monitored, updated and reported [including the Trust PMF reporting structure] via the relevant divisional and Trust groups.

As noted, the action plans are also live documents which are updated as necessary following any fire risk assessment, audit, inspection and lessons learnt following incidents and near-misses.

Summary

Over the 2021/22 financial year, a number of improvements have been made with respect to fire safety and these continue to be built upon in the current [2022/23] financial year.

One significant improvement is the move back towards strong communication and collaboration between the divisions and the corporate function which, in turn supports the further improvement of fire safety and the aspiration of not just doing the minimum but trying to do the most to provide the services expected from the Trust in environments which demonstrate the Trust's commitment to their patients/donors, visitors etc. and delivered by staff who understand their role and responsibilities for fire safety and are enabled to carry those roles and responsibilities out.

Another key development has been the opportunity to undertake the gap analysis which provides a strong starting point for the recovery and evolution of fire safety across the organisation and also identifies where fire safety compliance has the potential to support other key activities across the Trust such as business continuity & emergency preparedness.

Additionally, the ongoing development of the new Cancer Centre provides an ideal opportunity to ensure that the Trust continues to deliver cancer care and other services in a safe, resilient environment fit for the future.

However, it is important that the Trust and its staff do not become complacent and allow standards to slip; especially if there is a resurgence in the pandemic.

APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	VUNHST Fire Safety Gap Analysis [VCC], October 2021
	VUNHST Fire Safety Gap Analysis [WBS], October 2021

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

AUDIT WALES REVIEW OF QUALITY GOVERNANCE ARRANGEMENTS – MANAGEMENT RESPONSE

DATE OF MEETING	10.11.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff & Nicola Williams, Executive Director Nursing, AHPs and Health Science

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26.10.2022	NOTED

1. SITUATION/ BACKGROUND

This paper is presented to the Quality, Safety and Performance Committee to **NOTE** the **MANAGEMENT RESPONSE** to Audit Wales' Review of Quality Governance Arrangements (refer to ***Appendix 1***), which concluded in June 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The purpose of the audit was to examine whether the organisation's governance arrangements support the delivery of high quality, safe and effective services. The review focused on both the operational and corporate approaches to Quality Governance, Organisational Cultures and Behaviours, Strategy, Structures and Processes, Information Flows and Reporting.

Overall the report found that significant progress has been made to improve the Trust Quality Governance arrangements. The recommendations arising from the audit and management response is summarised in ***Appendix 1.***

The report summarises the work carried out between June 2021 and May 2022. To assess arrangements from 'Floor to Board', Audit Wales examined the arrangements in both the Velindre Cancer Service and Welsh Blood Service.

The audit consisted of a number of phases, which included observations of a number of the Trust key quality and safety group forums, documentary evidence based on three sets of forms Corporate Governance; Welsh Blood Service; and Velindre Cancer Service, staff survey and interviews with key personnel aligned with the scope of the audit.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	ALL
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Related to Quality legislation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety and Performance Committee are asked to **NOTE** the **MANAGEMENT RESPONSE** to Audit Wales' Review of Quality Governance Arrangements.

Management response

Report title: Review of Quality Governance Arrangements – Velindre University NHS Trust

Completion date: June 2022

Document reference: 3034A2022

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
R1	At the time of writing, the Trust had recently developed 10 new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.	No	Yes	Trust will ensure 2023/24 and future years quality Goals are specific (SMART) and timebound.	March 2023	Executive Director Nursing, AHP & Health Science
R2	To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) Provide appropriate consideration of each of the controls and sources of assurance, and b) Scrutinise progress to address gaps in controls and assurances.	No	Yes	a) Agreement of Committee mapping to TAF risks complete and endorsed by Strategic Development Committee in October for implementation through next governance cycles, starting from November. *Cross-reference to Governance, Assurance & Risk Programme of Work under BOFT - Project TAF 4.0* b) Further scrutiny and evidence of this, in line with the comments made in the report, will be actioned as part of the next governance cycle review of the TAF.	a) January 2023 b) January 2023	Lauren Fear, Director Corporate Governance & Chief of Staff

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
R3	Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) Determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action). b) If risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report. c) Executive risk owners should lead discussions on risks within their areas of responsibility.	No	Yes	a) Quality of data and consistency of reporting is a focus of the current risk work *Cross-reference to Governance, Assurance & Risk Programme of Work under BOFT - Project Risk 4.0 & Risk 5.0* *b) To be included in new Cover Paper Template and Risk Register report Cross-reference to Governance, Assurance & Risk Programme of Work under BOFT - Project GOV 2.0* *c) Implement from next governance cycle*	a) March 2023 b) January 2023 c) January 2023	Lauren Fear, Director Corporate Governance & Chief of Staff
R4	Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and: a) Undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse. b) Undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.	No	Yes	a) Trust wide conversations are underway regarding the way staff feel about working in the organisation. The outputs of this work will give a picture of the culture of the organisation and enable the next iteration of the Trust Values. Part of this engagement work will also be extended to address particular feedback on dealing with Bullying, Harassment or abuse.	a) January 2023	Sarah Morley, Executive Director of OD & Workforce

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
				b) The work described at a) will also address the issue of dealing with concerns raised in the workplace.	b) January 2023	
R5	Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide. a) Ensure that the group structures and meeting remits avoid unnecessary duplication of coverage. b) Ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines. c) Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.	No	Yes	Integrated Quality & Safety Group being established (19th October 2022). This Group will take responsibility for reviewing Trust wide Quality & Safety related meeting structures, including required representation. Output to be approved by EMB & QSP. It is noted however that this will require ongoing review as Trust and Integrated Quality & Safety Group matures	March 2023	Nicola Williams, Executive Director Nursing, AHP & Health Science & Lauren fear, Director Emma Stephens, Head of Corporate Governance
R6	Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.	No	Yes	Reporting cover periods to be made explicit as part of Committee agenda setting and work plan	From January 2023 QSP meeting	Nicola Williams, Executive Director Nursing, AHP & Health Science & Lauren fear, Director Emma Stephens, Head of Corporate Governance

Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Velindre University NHS Trust

Audit year: 2020

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Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and service user safety first more than anything else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of 'quality governance' arrangements is to help organisations and their staff monitor and where necessary, improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users. Statutory guidance in relation to the Duty of Quality and the Duty of Candour are yet to be consulted upon but expected in autumn 2022. The date for enactment of both duties is yet to be determined but anticipated to be part way through 2023-24.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality whilst responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approaches to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Velindre University

NHS Trust (the Trust) carried out between June 2021 and May 2022[1]. To test arrangements from 'floor to board', we examined the arrangements in both the Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

Key messages

6 Overall, we found **that significant progress has been made to improve the Trust's quality governance arrangements.**

7 The Trust has approved a new Quality and Safety Framework. It sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. The Trust has set out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and strategic priorities.

8 The Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and experiences and to share these. Some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment. Work to understand views expressed in the NHS Staff Survey is in motion.

9 The new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational quality and safety governance structures and flows of assurance to support quality governance. There are appropriate identified resources for quality governance and plans to address gaps in resources.

10 The agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.

Recommendations

11 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**. **Appendix 1** will be completed once the report and management response have been considered by the Audit Committee.

[1] At varying points in the review, we paused our work, to allow the Trust to respond to the pandemic.

Exhibit 1: recommendations

Recommendations
Quality priorities R1 At the time of writing, the Trust had recently developed ten new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.
Board Assurance Framework R2 To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) provide appropriate consideration of each of the controls and sources of assurance, and b) scrutinise progress to address gaps in controls and assurances.
Risk information for scrutiny R3 Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action); b) if risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report; and c) executive risk owners should lead discussions on risks within their areas of responsibility.

Recommendations

Action to address staff survey results

R4 Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and:

a) undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse; and

b) undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.

Quality and safety flows of assurance

R5 Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide:

a) ensure that the group structures and meeting remits avoid unnecessary duplication of coverage;

b) ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines; and

c) ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.

Quality and safety information

R6 Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods..

Detailed report

Organisational strategy for quality and service user safety

12 Our work considered the extent to which there are clearly defined priorities for quality and service user safety and effective mitigation of the risks to achieving them.

13 We found that **the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities. There are ambitious quality priorities with appropriate arrangements to monitor delivery, however, they do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and risks to achieving strategic priorities.**

Quality and safety framework

14 We found that **progress to review and finalise the Trust's Quality and Safety Framework was adversely impacted by the pandemic. However, the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities**.

15 The Trust has long recognised that the Quality and Safety Framework (the Q&S Framework) needed a significant overhaul. In 2019, work commenced to develop a new Q&S Framework, with the intention to complete the work in 2020. However, work did not proceed as planned due to significant adverse operational pressures resulting from the pandemic.

16 Early in 2021, the Trust consulted with executives, senior leaders, and health care standard leads, and a Trust-wide staff consultation took place in June 2021. An early draft was issued at this time to stimulate further comment.

17 Work to progress the Q&S Framework was adversely impacted by a further peak of COVID-19. The Trust intended to take the Q&S Framework to the January 2022 meeting, However, a committee paper indicated that it would be postponed to the March meeting due to pressures caused by the pandemic. However, there was no challenge when it was excluded from the March meeting agendas. Similarly, the Board Assurance Framework shared at the May 2022 committee meeting stated that the Q&S Framework would be tabled at that same meeting, but there was no challenge when it was excluded from the agenda.

18 In 2022, several changes were made to the draft Q&S Framework, as a result of the consultation undertaken in 2021. In July 2022, following endorsement from the Quality, Safety and Performance Committee, the Board approved the Q&S Framework and supporting Implementation Plan.

19 Completing the Q&S Framework was an important and necessary priority for the Trust. The new Q&S Framework sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies

roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. There is clear alignment between the Q&S Framework and the new Trust Strategy and supporting enabling strategies.

20 The supporting Implementation Plan sets out the actions needed to ensure arrangements set out in the Q&S Framework are fully operationalised. For each action there is an identified lead and delivery timescale. The Trust recognises that fully implementing the Q&S Framework will take time. However, the Trust told us that work undertaken over the previous three years has laid the foundations, both organisationally and culturally. The Trust has set an ambitious, but achievable timescale for the actions in the Implementation Plan to be embedded and fully operational.

21 Progress against the Implementation Plan will be monitored quarterly by the Executive Management Board and twice a year by the Quality, Safety and Performance Committee.

22 The Trust has committed to reviewing the Q&S Framework in 2023 once the duties set out in the Health and Social Care (Quality and Engagement) (Wales) Act (see **paragraph 2)** are enacted.

Quality and service user safety priorities

23 We found that the **Trust sets out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved**.

24 The Trust included 12 quality priorities in the 2019-2022 Integrated Medium Term Plan (IMTP). Since then, the 2020-2021 quarterly plans and the 2021-2022 Annual Plan included high level quality priorities focused on quality arrangements during the pandemic[2]. However, no reports have been received by the Quality, Safety and Performance Committee to indicate how the Trust did in delivering against these quality priorities.

25 Within the 2022-25 IMTP, the Trust set out a programme of work to progress clinical quality and safety arrangements and ensure delivery of Health and Social Care (Quality and Engagement) (Wales) Act 2020. The IMTP sets out 11 key priorities supported by specific actions with timescales for delivery. The priorities are focused on setting up the arrangements and infrastructure through which the Trust will meet its quality and safety responsibilities, and include;

- implementing the Q&S Framework;
- developing Quality Hubs (VCC, WBS and Trust);

[2] Including optimising infection prevention and control measures; strengthening service user engagement and the capture of service user experiences; and implementing digital initiatives to ensure continued patient engagement throughout the pandemic.

- establishing a Quality and Safety team fit to deliver new legislation;
- implementing Duty of Quality and Candour requirements;
- planning for and implementing new Quality Standards;
- ensuring there are clear service delivery to Board quality metrics;
- implementing a Trust Quality Management system;
- ensuring robust mechanisms for capturing service user experiences, with learning and improvement mechanisms;
- ensuring robust clinical leadership, and establishing a Clinical and Strategy Board; and
- optimising working at top of license and optimising advanced practice working.

26 It is our understanding that the Quality, Safety and Performance Committee will monitor delivery of these priorities as part of its quarterly review of monitoring delivery of priorities set out in the IMTP.

27 In conjunction with the new Q&S Framework, the Trust developed ten new Quality Improvement Goals for 2022-23. These are in addition to the 11 priorities set out in the 2022-25 IMTP (see **paragraph 25**). The focus of the ten new Quality Improvement Goals is service redesign to meet increasing predicted demand and to deliver further service improvements. Going forward, the Trust should ensure that the Quality Improvement Goals are SMART. They should indicate what specific actions will be taken, by when, and what the intended outcome is, and thereby allow assessment of whether they have been fully achieved. The Trust should also reflect on including more service user reported outcome measures/experience measures as well as pure quality indicators (**Recommendation 1**).

28 The Trust told us it intends to consult with staff to develop annual Quality Improvement Goals by 31 January each year for inclusion in the IMTP. Each Quality Improvement Goal will have a defined outcome and delivery plan and will be managed by an identified operational lead and executive director sponsor. Delivery will be monitored through relevant quality teams, and by exception through to Executive Management Board and quarterly to the Quality, Safety and Performance Committee.

Risk management

29 We found that the **Trust has made good progress to improve risk management arrangements. However, the Board and its committees need to ensure they scrutinise progress to address gaps in controls and assurances of strategic risks. There are opportunities to improve scrutiny of risks appearing in risk registers both operationally and by the Board's committees**.

30 In 2020, the Trust produced a Board Assurance Framework which identifies ten principal risks to achieving strategic priorities. During 2021 and 2022, work progressed to populate each principal risk with key controls and sources of assurance and identify any gaps. Each risk is assigned to a responsible executive lead, and an appropriate Board committee for monitoring purposes.

31 Whilst the Board Assurance Framework was developing and maturing, it has been considered by the Board, the Strategic Development Committee and the Audit Committee to ensure the direction of travel is right, more so than considering the controls and assurance in place or yet to be developed. However, to achieve the next level of maturity, Board committees will begin to review their assigned strategic risks more methodically, receive and monitor progress against associated action plans and ensure that Board committee cycles of business provide appropriate consideration of each of the controls and sources of assurance.

32 The Board Assurance Framework contains a strategic risk specific to quality and safety[3]. At the time of writing, the Quality, Safety and Performance Committee had not received the Board Assurance Framework or any paper specifically on the quality and safety strategic risk. As set out in **paragraph 31,** we expect to see the Quality, Safety and Performance Committee's cycle of business to be updated to include the Board Assurance Framework for regular review and ensure regular consideration of the sources of assurance (**Recommendations 2a and 2b**).

33 The Trust has a limited dedicated corporate risk management team. Previously, it consisted of a 0.2 WTE working to the Director of Corporate Governance. The Trust are trialling a new Risk and Compliance and Assurance Officer role to increase capacity in the team. VCC and WBS both have risk management leads, and there is a risk management lead for the Transforming Cancer Services

[3] The strategic risk is 'the Trust does not currently have cohesive and fully integrated Quality and Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback (patient/donor feedback/outcomes/complaints/claims, incidents) and the ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor/patient harm. This could result in the Trust not meeting its national and legislative responsibilities (The Health and Social Care (Quality and Engagement) (Wales) Act, 2020) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

programme[4] team. The risk management leads in VCC and WBS are not dedicated risk management resources, and they both have wider portfolios of work.

34 In September 2020, the Board approved the Trust's new risk management framework, risk appetite statement and associated risk management procedures and user guides. In our 2021 Structured Assessment, we reported that the Trust had made good progress to develop new risk management arrangements.

35 The Trust undertook a significant review of all open risks on operational risk registers during 2021. The review was necessary to ensure risk information was current and complete prior to the migration of all risks to a new version of Datix[5] and to ensure information was recorded consistently with the new requirements in the new risk management framework. The review of open risks took longer than anticipated and at the time of our fieldwork there remained some work to complete, including:

- migrating WBS risks to the new version of Datix;
- updating procedures within the Risk Management Framework as a result of refinement following implementation;
- delivering training to operational and corporate staff; and
- ensuring consistency and clarity in the way that both existing controls and planned additional controls are recorded.

36 Since our fieldwork, rollout of risk management training has largely been completed and each of the other areas of outstanding work have been finished.

37 The divisional risk leads meet weekly with the Director of Corporate Governance to manage any risk management issues and ensure that risk scoring is appropriate and consistent across the Trust.

38 We observed the scrutiny of divisional risk registers at a number of VCC Quality and Safety Group meetings and WBS Regulatory Assurance and Governance Group meetings between June 2021 and February 2022. Whilst there was reasonably good scrutiny of the risks on registers (particularly at the WBS meetings), the ability to scrutinise was hampered by the way risk information was presented. Our observations took place during the time the risk registers were being reviewed and updated, this led to omissions in the data provided. For example, in the February 2022 VCC Quality and Safety Committee meetings, only the current risk score was provided (but not the initial or target scores) and the mitigating control information was unclear (and in some cases omitted) meaning it

[4] Transforming Cancer Services is a programme of work to keep pace with the increasing demand and complexity of cancer care and to deliver more care closer to home. The programme comprises several projects. These include the construction of a new cancer centre, the development of a new radiotherapy satellite centre, procurement of clinical and digital equipment, delivery of more outreach services, and clinical service transformation.

[5] Datix is a web-based incident reporting and risk management system used by healthcare organisations.

was impossible to determine whether there was any progress to reduce risk scores, or what further action was required. The Trust should ensure that risk reports provided for monitoring and scrutiny at all levels include the necessary detail to enable good scrutiny and challenge. There should be agreement on the level of detail provided on risks, but this should include opening, current and target risk scores, and ensure sufficient clarity on existing controls and mitigating action (**Recommendation 3a**).

39 The respective divisional senior management teams review and scrutinise divisional risks. The Trust Executive Management Board reviews risk registers at its monthly meetings. Any risks meeting the risk score of 12 or more are added to the Corporate Risk Register. The Corporate Risk Register is reported to the Board's committees (the Audit Committee, the Quality, Safety and Performance Committee, and the Strategic Development Committee). Risks scored 16 and over are scrutinised by the Board.

40 Our observations of the Quality, Performance and Safety Committee found that when the Corporate Risk Register is tabled, there appears to be little discussion or scrutiny on the risks within the register assigned to the Committee. We believe there are a number of reasons for this:

- currently, the narrative on controls is unclear in the risk registers. It is difficult to differentiate between controls already in place, and those which are intended to be put in place and by when. Therefore, it is impossible to see if any intended mitigating action has been implemented on time, and whether it has had the intended impact (such as a reduction in the risk score) (**Recommendation 3a**).
- for many risks, there are separate agenda items which provided detailed information, and thus the discussion had already occurred. When discussing the Corporate Risk Register, it would be beneficial for the Trust to draw attention to any risks that have previously been discussed within a different agenda item (**Recommendation 3b**).
- discussions have focused on the progress to update and the risk registers, rather than the risks themselves. Whilst the executive risk owners are present, they do not lead discussion on risks within their areas of responsibility (**Recommendation 3c**).

41 Going forward, discussions in Board and committee meetings need to scrutinise the appropriateness of existing controls, ensuring that intended actions to increase and improve controls are timely and having the desired impact.

Organisational culture

42 NHS organisations need to focus on continually improving the quality of their care whilst using finite resources to achieve better outcomes and experiences for service users. Our work considered the extent to which the Trust is promoting a quality and service-user, safety-focused culture. We considered: compliance with

statutory and mandatory training, participation in quality improvement processes integral with wider governance structures, listening and acting upon feedback from staff and service users, and learning lessons.

43 We found that **the Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and to share these. However, some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment.**

Quality improvement

44 We found that **reporting of clinical audit has improved, although opportunities remain to demonstrate how learning from clinical audit is embedded. Good progress has been made to implement the requirements of the Medical Examiner Service**.

Quality cycle

45 The Trust plans to develop an organisation-wide quality management (assurance) system. It is intended that the system will align with the Board Assurance Framework and incorporate the management of risk, internal and external assurance mechanisms, mechanisms for regulatory and legislative monitoring, and quality, safety, outcome and experience oversight.

Clinical Audit

46 Clinical audit is an important way of providing assurance about the quality and safety of services. Each year, VCC participates in relevant clinical audits within the national programme of clinical audits and reviews; while WBS is subject to routine external audits to ensure compliance with regulatory requirements. The Trust also agrees a programme of local clinical audit in both divisions to provide assurance about the quality and safety of services and compliance with expected standards of care.

47 The Trust told us they have no corporate central resources for Clinical Audit. However, the Executive Medical Director is responsible for clinical audit and ensuring that the Trust makes adequate provision to support clinicians and managers undertaking clinical audits. Both VCC and WBS division have designated clinical leads for clinical audit.

48 In VCC, local clinical audit plans are determined and prioritised by the cancer site teams. Local clinical audit plans are linked to national standards set by the National Institute for Health and Care Excellence, findings arising from the review of significant incidents and complaints and to assess the introduction of new technologies. VCC has a dedicated clinical audit team led by the Clinical Audit Manager.

49 VCC and WBS report progress against the clinical and other audits within their respective quarterly divisional reports, which are received by the Quality, Safety and Performance Committee.

50 The Trust introduced its first Trust-wide Clinical Audit Plan in 2020 (previous plans covered just VCC). The Quality, Safety and Performance Committee approved the 2022-23 Clinical Audit Plan in July 2022.The development of the Q&S Framework should strengthen alignment between clinical audit and the quality and safety agenda across the Trust and ensure there is alignment between the co-ordination, oversight, and triangulation of outcomes.

51 The first Trust-wide Clinical Audit Report in 2020-21 was received by the Quality, Safety and Performance Committee in July 2021[6]. In previous years our Structured Assessment reviews have found that the Trust's clinical audit reports have not adequately and clearly identified key actions for improvement, making it difficult to track progress against implementing identified actions. Our view is that whilst the Clinical Audit Report 2020-21 highlights areas for improvement, the report does not set out what action will be taken, or by when. We remain of the opinion that there needs to be a more robust reporting of findings, learning and resulting actions to allow demonstration of how learning has been shared and implemented[7].

Mortality and morbidity reviews

52 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality, to reflect, learn, and improve patient care. The Medical Examiner Service was rolled out across Wales, and became a statutory independent review mechanism for patient deaths from April 2022.

53 VCC already had a specific process to review mortality and morbidity. All inpatient deaths are reviewed by a consultant nurse and input provided by consultants and the ward team that provided treatment. Any issues raised were escalated to the VCC Significant Clinical Incident Forum which has multi-disciplinary membership to conduct reviews and disseminate learning across the Trust.

54 To support the introduction of the new requirements of the Medical Examiner Service, VCC identified a consultant lead for the Significant Clinical Incident Forum and Mortality reviews. In October 2021, VCC commenced a pilot to ensure that requirements for reporting patient deaths to the Medical Examiner Service were complied with. VCC established a Mortality Project Group to lead this work. Training has been provided to appropriate staff. Since the pilot, the Mortality Project Group has been developing a standard operating procedure for the process.

[6] In previous years the Clinical Audit Report contained VCC audits only.

[7] The Clinical Audit Report 2021-22 had not been tabled at a Quality, Safety and Performance Committee by the time of reporting.

55 VCC reported to the March 2022 Quality, Safety and Performance Committee that it is meeting the requirements of the Medical Examiner Service. VCC will present a Medical Examiners Service and Mortality Framework Report to the Quality, Safety and Performance Committee twice a year.

Values and behaviour

56 We found that the **Trust has a well-established Values and Behaviour Framework which encourages an open and learning culture. Compliance with statutory and mandatory training is good but has been impacted by the pandemic**.

57 The Trust's Values and Behaviours Framework was launched in 2018 and supports a quality and service-user focused culture with emphasis on continuous improvement, openness, transparency and learning when things go wrong. When launched, the Trust took steps to publicise the values and behaviours. There have been no recent refresher initiatives. However, we were told that the Trust's Independent Members have requested a refresh for staff and there are plans in place to refresh organisational awareness of the Values and Behaviours Framework to ensure that values are at the forefront of everything that staff do. The Trust's Values and Behaviours are integral to Personal Appraisal and Development Reviews (PADRs), and form part of interview assessments and induction training.

58 Our work revealed a positive picture in relation to the culture of reporting errors, near misses, incidents and raising concerns. Of the staff who completed our survey[8], 53 out of 61 staff agreed or strongly agreed that the Trust encourages staff to report errors, near misses or incidents. Two-thirds of staff (39 out of 61 staff) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Most staff (48 out of 61 staff) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

59 In the NHS Wales Staff Survey undertaken in November 2020, a proportion of Trust staff indicated they had experienced bullying, harassment, or abuse by another colleague, member of the public or line manager over the previous year (15%, 8%, 6% respectively). Disappointingly, fewer than half (42%) agreed or strongly agreed that the organisation takes effective action (**Recommendation 4a**). The Trust reviewed the NHS Staff Survey Findings results and key messages at their Board in February 2021. It was agreed that the results would be discussed within teams and that a Trust-wide action plan would be developed. Pressures

[8] We invited operational staff working across the VCC and WBS to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. The estimated response rate is 2.9%. Although the findings are unlikely to be representative of the views of all staff across VCC and WBS, we have used them to illustrate particular issues.

arising from the pandemic led to delays, but at the time of writing, the Trust were planning to restart the work.

60 Undertaking annual PADRs is important for identifying training needs. The Welsh Government target for PADR compliance is 85%, WBS were reported to be just below this target at 78.4% and VCC lower at 66.0% (March 2022)[9]. Compliance with undertaking annual PADRs was impacted by the pandemic, and at the time of writing, action to improve compliance included targeting hotspot areas.

61 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. The Trust is required to report compliance to the Welsh Government each month, and the target for compliance is 85%. Figures reported at the May 2022 Quality, Safety and Performance Committee show in March 2022, WBS achieved 92.3% compliance and VCC 84.8%. The pandemic has inevitably impacted the ability for staff to attend training. Therefore, it is not surprising that less than half (26 out of 61) of staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training. Whilst performance in both divisions is near to or above the target, the Education and Development Team continue to work closely with VCC to improve compliance and a training plan is being developed.

Listening and learning from feedback

62 We found that the **Trust demonstrates a strong commitment to learn from service user and staff experiences. There are good arrangements to collect service user feedback, and these have been enhanced by an electronic system to collect real time feedback and a new patient engagement strategy for cancer services. There is a culture of staff feeling able to raise concerns, however, some staff are concerned that the Trust will not act in response to concerns**.

Service user experience

63 Both divisions have designated leads for patient/donor experience with protected time to carry out this role. The Trust have worked with a range of patients, staff and wider stakeholders to develop a Patient Engagement Strategy for cancer services, which was approved by the Board in May 2022. The Patient Engagement Strategy covers a wide range of interactions with patients, including future planning, service design, service delivery and individual care. It sets out a series of goals and underlying principles for VCC to ensure patient engagement is integral to how VCC works.

[9] As reported in the May 2022 Quality, Safety and Performance Committee.

64 The Patient Engagement Strategy sets out plans to create a Patient Engagement Hub in VCC which will be a focal point for patients, staff and stakeholders to contact VCC and to co-ordinate engagement activities.

65 VCC currently has a range of mechanisms to collect patient feedback, including the All-Wales Patient Questionnaire, social media, the Patient Leadership Group and specific surveys developed for Clinical Audits. Whilst some patient experience activities ceased during the height of the pandemic, they recommenced in 2021. The pandemic led to a greater emphasis for digital capture of patient feedback, including social media. VCC are now using a digital platform, Civica, to collect patience experience, which allows the collection of real time data to enable immediate identification of issues and a quicker response.

66 VCC has a well-established Patient Liaison Group. Designated patient 'leaders' from this group are active in helping staff understand things from a patient or carer's perspective. The Trust has adopted a 'You said, we did' approach to demonstrating learning and responding to patient feedback.

67 Learning from patient experience is discussed in the VCC Quality and Safety Management Group and the Trust's Putting Things Right Panel.

68 WBS invites all donors to give feedback via paper, online or SMS surveys. Compliment and concerns cards are available in all donation clinics and social media channels offer further opportunities to provide feedback. Feedback is reviewed each month and key learning is discussed at the WBS Regulatory Assurance and Governance Group meeting. WBS is also using Civica to capture donor experience.

69 The Quality, Safety and Performance Committee receives a range of service user experience, including summaries of each division's survey results. The Trust also produces an annual patient and donor experience report. Service user feedback continues to be very positive.

70 Despite the range of mechanisms to collect data, only half (29 out of 61) of Trust staff responding to our survey agreed or strongly agreed that they receive regular updates on service user feedback for their work area,

71 The Trust produces an annual Putting Things Right Report, and quarterly updates are presented to the Quality, Safety and Performance Committee. The most recent update, Quarter 4 2021-22, was presented to the Quality, Safety and Performance Committee in May 2022. Most concerns were rated as low level, and similarly nearly all incidents were graded as no harm/low harm. Across the Trust, the main themes of concerns were associated with communication, attitudes, and behaviours. The more highly graded concerns related to communication about clinical care, such as perceived miscommunication regarding treatment plans. Lower graded complaints relating to attitude centring on scheduling of appointments. Reports include a summary of the learning captured from reviews of concerns and incidents, and examples of actions taken in response.

72 The Welsh Government target for timely response to complaints is 75% within the 30-day target. The Trust reported in the May 2022 Quality, Safety and

Performance Committee that the Trust's performance for quarter 4 2021-22 was 100% compliance, exceeding the Welsh Government target.

Service user stories

73 Quality, Safety and Performance Committee meetings commence with either a patient or a donor story, which usefully sets the tone for the remainder of the meeting. Service user stories allow a deep dive into events that have not gone so well as well as positive experiences. Stories lead to discussion and challenge to ensure that lessons have been identified and shared. Podcasts are produced and staff are encouraged to consider the stories.

74 Patient Safety WalkRounds provide Board members with an understanding of the experiences of staff, patients and donors and help to make data more meaningful. In 2022, the Trust restarted their programme of 15 step challenge following the cessation during the height of the pandemic. The 15 step challenge visits help to reassure senior staff and independent members that services are welcoming, caring, well organised and safe. They also provide an opportunity for staff to raise concerns and ask questions. The recommendations and actions from visits are taken to a subsequent Quality, Performance and Safety Committee for discussion and a follow-up visit scheduled to ensure recommendations are addressed.

Listening to staff feedback and concerns

75 The Trust is committed to listening and learning from staff experiences and concerns. Quality, Safety and Performance Committee meetings hear staff stories.

76 Staff can report their concerns through the Work in Confidence virtual platform. Comments are reviewed and investigated by staff from the Workforce and Organisational Development team. The Workforce Report for February 2022, presented to the May 2022 Quality, Safety and Performance Committee noted that as a result of low usage of the Work in Confidence Service, they were unable to provide information without it being potentially identifiable.

77 Our interviewees were confident that they and other staff members would feel comfortable raising concerns directly via their manager or more senior managers. However, our survey found that only half (30 out of 61) staff members agreed or strongly agreed that the Trust acts on concerns raised by staff. A similar theme was identified in the NHS Staff Survey 2020. The Trust should set out in their NHS Staff Survey action plan how it intends to explore the reasons why some staff may not feel the Trust adequately acts on concerns (**Recommendation 4b**).

78 VCC staff have daily handover meetings where staff are encouraged to raise any concerns and use the opportunity to share learning. WBS donor collection teams hold a daily de-brief after each donation session where they can raise any concerns. Executive and senior clinicians within the Trust and both divisions are operationally visible, to help them understand the staff experience and be more accessible to staff.

79 Just under half (27 out of 61) of staff agreed or strongly agreed that communication between senior management and staff is effective. This may be a result of the opportunities to meet being more limited during the pandemic. We note that during the pandemic, the Trust stepped up opportunities to communicate with staff via social media, digital and video conferencing. However, the Trust should consider how it may re-stimulate staff engagement.

80 Whilst not universal views, our fieldwork identified that some divisional staff feel remote from the Trust executive team, and consequently distant from strategic decision making. The Trust told us of plans to re-establish the Clinical Advisory Group on a permanent basis (in summer 2022) and to develop a Clinical and Scientific Strategy Board. These fora will provide clinicians from both divisions with the opportunity to inform decision making.

Governance structures and processes

81 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

82 We found that the **new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational governance structures and flows of assurance to support quality governance.**

Resources and expertise for quality governance

83 We found that **there are appropriate identified resources for quality governance, and the Trust, in operationalising its new Quality Hubs has plans to address gaps in resources**.

VCC quality governance resources

84 The Director of Velindre Cancer Services holds ultimate responsibility for quality and safety in VCC. Whilst the VCC senior management team has collective responsibility for quality and safety, the VCC Head of Nursing Quality, Patient Experience and Integrated Services is the identified lead. The VCC Clinical Director is responsible for providing leadership for the VCC medical directorate. There are appropriate leads for services such as mortality reviews, quality and safety, radiology quality and safety, complaints, and patient experience.

85 VCC told us they receive support from the corporate quality and safety team and the corporate governance team as required.

86 At the time of our fieldwork, VCC told us that they felt they needed additional quality and safety resources to fully implement new requirements arising from the new Q&S Framework, the Medical Examiner Service requirements and to implement the Duty of Candour, and to improve reporting between VCC and the Trust.

87 As set out in the Q&S Framework, the Trust intends to create a VCC Quality Hub, led by a nominated divisional lead. The intention is for the VCC Quality Hub to support the VCC Senior Management Team in executing quality, safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation and effective functioning of Divisional Quality and Safety Group. There are plans to develop and operationalise the VCC Quality Hub during the remainder of 2022, including identifying and filling resource needs.

WBS quality governance resources

88 The Director of the Welsh Blood Service holds ultimate responsibility for quality assurance and safety in the division. Whilst the senior management team has collective responsibility for quality assurance and safety, the Head of Quality Assurance and Regulatory Compliance leads the strategic development, delivery and management of the quality systems throughout the division. The WBS Head of Nursing is responsible for clinical governance, managing concerns and donor engagement. There are designated leads for, infection prevention and control, clinical audit, quality improvement, risk management, Datix, health and safety and data analytics. Some leads do not have protected time to fulfil their role, including the leads for clinical audit and infection, prevention and control.

89 At the time of our fieldwork, WBS told us that resources to support quality assurance and safety were inadequate with a number of vacant posts. Staff told us that there was a pending (overdue) review of WBS quality staff requirements, which was necessary, because staffing needs had changed over time.

90 The Q&S Framework sets out that there will be a WBS Quality Hub with the same purpose as the VCC Quality Hub (see **paragraph 87**). There are plans to develop and operationalise the WBS Quality Hub during the remainder of 2022, including identifying and filling resource needs..

Trust leadership for quality governance

91 There is collective responsibility for quality and safety amongst the Executive Management Board, senior managers and leads within the divisions to ensure the quality and safety of services. However, it is the Director of Nursing, Allied Health Professionals and Health Science (Director of Nursing) who is the executive lead for quality and safety across the Trust.

92 The Director of Nursing has delegated responsibility for ensuring the necessary infrastructure is in place to deliver quality and safe services and is the professional lead for Putting Things Right, Infection Prevention and Control, decontamination, safeguarding, managing incidents and service user experience. The Director of Nursing chairs the Trust's Infection Prevention and Control Group and the Safeguarding and Vulnerable Adults Group and also co-chairs the Clinical Strategy Group with the Trust's Executive Medical Director.

93 The Director of Nursing is supported by the Deputy Director of Nursing, Quality and Patient/Donor Experience, however, at the time of our fieldwork, there were a number of unfilled vacancies within the corporate quality and safety support team. In 2020, the Trust identified the need to strengthen the central quality and safety function. A review of the corporate quality resources was delayed due to the pandemic. More recently, a more integrated structure has been identified to pull together all elements of quality and safety regardless of executive portfolio, with additional funding identified to create new roles within a Corporate Quality Hub. The Trust began a process to populate posts after our fieldwork was completed.

94 The Q&S Framework sets out that the Corporate Quality Hub will be a virtual hub of all quality and safety activity covering the span across a number of executive/director responsibilities and not just those managed through the Corporate Quality Team. The Corporate Quality Hub is planned to interface significantly with national work programmes and bodies, as well as professionally support the two divisional quality hubs. The three Quality Hubs are intended to be accountable for co-ordination, oversight and triangulation rather than delivery of the quality and safety agenda for respective services as this lies with responsible managers.

95 The Director of Nursing works closely with the Trust's Medical Director. The Medical Director is responsible for the quality of medical care, clinical audit and effectiveness and mortality reviews. The Medical Director is supported by five Assistant Medical Directors, each with a lead Trust-wide role (including clinical audit, education and training, and quality and safety). At the time of our fieldwork, there was very little support capacity for the Medical Director and the Assistant Medical Directors. However, since our fieldwork, the Trust has created a senior support role to help support these Trust-wide functions.

96 The Director of Corporate Governance has responsibility for governance, risk, assurance, legal and compliance frameworks and also communications and engagement and Freedom of Information.

Governance structures to support quality governance

97 We found that **the Trust in developing a new Quality and Safety Framework and operationalising in Quality Hubs has articulated the operational governance structures and flows of assurance to support quality governance**.

VCC quality and safety meetings

98 VCC's main forum for discussing quality and safety is the VCC Quality and Safety Management Group (VCC Q&SMG). It meets each month, and is chaired by VCC's Head of Nursing, Quality, Safety and Integrated Care. Meetings cover a range of critical quality and safety information and arrangements. Coverage includes new policies and guidelines, the divisional risk register, incident management and

compliance with health care standards, patient experience, infection, prevention and control, clinical audit, digital, outpatients, radiotherapy and therapies. The VCC Q&SMG reports to the VCC Senior Management Team and the reports are also tabled at Quality, Safety and Performance Committee meetings.

99 We observed the VCC Q&SMG on three occasions in 2021 and early in 2022. We found that meetings were well-structured and well-chaired, and coverage was appropriate. We did observe that on numerous occasions, agenda items were presented, which stimulated very little discussion or questions. VCC Q&SMG attendees told us that some members suggested there was significant duplication of information considered in other fora (**Recommendation 8a**). In addition, historically the VCC Q&SMG has had no or little medical representative attendees, which has limited the ability for multidisciplinary discussions (**Recommendation 8b**). We also noted that some papers would have benefited from the inclusion of a cover paper, providing a summary of the main issues being presented.

100 Whilst we anticipate that once the VCC Quality Hub is fully operationalised, work will be undertaken to address our **Recommendations 8a and b**. However, until the Trust's quality hubs are fully operational, we are unable to make an assessment, and thus our recommendations remain in place.

101 Whilst undertaking our fieldwork we were aware of a number of groups in VCC that cover quality and safety matters, for instance, the Medical Gases Committee, the Medicines Management Group, the Safety Alerts Group, the Controlled Drugs Group, the Radiation Protection Group and the VCC Infection, Prevention and Control Group. We were unable to ascertain where the reporting of quality and safety information and assurance rising from these groups fed. However, the new Q&S Framework sets out the topics which the VCC Q&SMG will consider in its meetings.

WBS quality and safety meetings

102 WBS's main forum for discussing quality and safety is the WBS Regulatory Assurance and Governance Group (WBS RAGG). Meetings are monthly and chaired by WBS's Head of Quality Assurance and Regulatory Compliance. Meetings cover a range of key quality management arrangements.

103 The agenda for the WSB RAGG contains good coverage of quality and safety issues via monthly update reports. There is a good balance of looking at performance issues triangulated with patient and donor feedback.

104 The structure of fora covering quality and safety matters in WBS is straightforward. There are two main groups that report to the WBS RAGG, the Donor Clinical Governance Group and the Patient Clinical Governance Group.

105 Our observations of the WBS RAGG found the meeting to be well structured, and well chaired. We observed good debates and constructive challenges on agenda items. The WBS RAGG reports to the WBS Senior Management Team, and the reports are also tabled at Quality, Safety and Performance Committee meetings.

Trust-wide quality and safety meetings

106 There are a small number of Trust-wide meetings which cover quality and safety, such as the Infection, Prevention and Control Group and the Safeguarding and Vulnerable Adults Groups. Significant work had been undertaken during the 12 months prior to our fieldwork to strengthen and enhance the workplans of the Trust-wide groups.

107 During our fieldwork, we asked the Trust to provide us with a diagram setting out the groups/fora at a Trust level and within both divisions that consider any quality and safety matters, and associated flows of assurance. At the time of our fieldwork, the Trust was unable to provide us with a comprehensive diagram. Whilst there is more clarity in the new Q&S Framework, we are still of the view it would be beneficial to set out all, rather than just some, of the meetings that consider quality and safety matters across the Trust (**Recommendation 8c**).

108 The new Corporate Quality Hub and Divisional Quality Hub leads will formally meet at bi-monthly (from October 2022) as a newly created Quality and Safety Governance Group (Q&S Governance Group). The purpose of the Q&S Governance Group will be to ensure effective triangulated assurance and/or exceptions reporting to the Executive Management Board and the Quality and Safety Performance Committee.

Trust Quality, Safety and Performance Committee

109 The Trust's Quality, Safety and Performance Committee is responsible for providing assurance and advice to the Board in respect of quality and safety. The Quality, Safety and Performance Committee meets on a bi-monthly basis. During the pandemic the Committee increased the frequency of meetings as and when deemed appropriate. We observed the Committee on several occasions and found that there was good challenge and scrutiny from independent members.

Arrangements for monitoring and reporting

110 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

111 We found that **the agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.**

Coverage of quality and patient safety matters

112 We found that the **agendas of Quality, Safety and Performance Committee meetings are becoming more manageable, with less duplication of coverage,**

and cover papers are now focusing on key matters. However, some information is not timely.

113 The remit of the Quality, Performance and Safety Committee is vast. In our Structured Assessment 2021, we found that the amount of detail provided to the committee on many items was too great, and that further work was needed to agree the amount and level of detail needed to provide necessary assurance to the committee. We said consideration was needed on how to best summarise and synthesise information to help provide focus on key matters. During 2022, we have seen improvements, meetings are generally running to time, there is less duplication of coverage within committee papers, and papers and verbal presentations are providing better focus on key matters.

114 We understand that once operationalised, the Q&S Governance Group will play a critical role in ensuring effective triangulated assurance and/or exception reporting to the Quality, Safety and Performance Committee, and thus ensure that the detail of committee papers is pitched correctly.

115 Every four months, VCC and WBS separately produce divisional Quality and Safety Performance Reports providing a summary of performance information against key quality and safety metrics. The reports are structured around the six domains of quality and safety (Safe Care, Effective Care, Efficient Care, Patient Centred Care, Timely Care and Equitable Care). The reports are comprehensive covering incidents, complaints, risks, claims, clinical audit plan updates, service user experience, external/interview audit findings and training compliance. VCC and WBS present their reports alternatively at Quality, Safety and Performance Committee meetings. Each report provides the most recent month of validated data available. For instance, the May 2022 Committee meeting received the VCC Quality and Safety Performance Report which included February 2022 data. Whilst the report provides useful information on many areas of quality and safety, scrutiny is not completely effective if the data and information presented are not as up to date as possible (**Recommendation 6**).

116 A highlight report of the discussion from the most recent Quality, Safety and Performance Committee is presented by the Chair to the Board meeting. The Committee has a cycle of business which sets out what it intends to cover across the year in its meetings.

Performance information for scrutiny and assurance

117 We found that the **Trust produces lots of information for scrutiny and assurance, but data analytics support is limited. The introduction of quality dashboards would improve the timeliness of data and thus strengthen oversight and monitoring**.

118 The Chief Operating Officer presents a cover paper of the Trust-wide Performance Management Framework to each Quality, Safety and Performance Committee meeting. The cover paper draws attention to key performance metrics across VCC,

WBS, and Workforce. Where performance is off track, the cover paper summarises actions to address performance. There are separate performance reports for VCC, WBS and Workforce.

119 The performance reports provided to the May 2022 Quality, Safety and Performance Committee, contained data from March 2022 (VCC and WBS) and February 2022 (Workforce). Therefore, the data is not as timely as it could be (**Recommendation 6**).

120 The Trust has long intended to make significant improvements to the Performance Management Framework report. Progress has been delayed due to the pandemic. However, following an initial tranche of work, a summary dashboard is now included, and improvements made to explanations of performance and intended actions. Further work is planned in 2022, to fully revise the report and use business intelligence reporting. Plans also include developing more outcome-based measures, adding benchmarking comparisons, and aligning performance reporting to strategic priorities. During 2022, the Trust intends to develop specific performance scorecards for the Board, the Quality, Safety and Performance Committee, Executive Management Board and the divisional senior management teams. The proposed approach is a hierarchy of performance measurements appropriate to the remit and scrutiny requirements at each level and the Board will take assurance from the detailed review and challenge undertaken by each level below..

121 The Trust does not currently have a dedicated data analytics team which means, operationally, there is limited data analytics support available to help divisions manage their data. However, the Trust is seeking funding to increase its data analytics functions. The Trust does not have a live dashboard of key performance data.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response This table will be completed once the report and detailed management response have been considered by the relevant committee(s).

Recommendation	Management response	Completion date	Responsible officer

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	35	18	5	3	0	0	61
2. I am satisfied with the quality of care I give to patients	28	25	8	0	0	0	61
3. There are enough staff within my work area/department to support the delivery of safe and effective care	7	20	7	21	6	0	61
4. My working environment supports safe and effective care	18	24	10	6	3	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
5. I receive regular updates on patient feedback for my work area/department	12	17	11	14	4	3	61
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	21	23	9	1	0	7	61
7. My organisation acts on concerns raised by staff	10	20	19	8	3	1	61
8. My organisation encourages staff to report errors, near misses or incidents	30	23	5	0	2	0	60
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	21	18	15	2	1	4	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61
11. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
12. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
13. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61
Managing patient and staff concerns							
14. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
15. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
16. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
17. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HEALTHCARE INSPECTORATE WALES (HIW) REPORT – FIRST FLOOR WARD, NUCLEAR MEDICINE VCS

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

PREPARED BY	RACHEL HENNESSY, ACTING DIRECTOR OF CANCER SERVICES
PRESENTED BY	RACHEL HENNESSY, ACTING DIRECTOR OF CANCER SERVICES
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer Nicola Williams, Executive Director Nursing, AHP & Health Science

REPORT PURPOSE	For ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCS Senior Leadership Team	06.10.2022	NOTED
Executive Management Board	24.10.2022	NOTED

ACRONYMS	
HIW	Healthcare Inspectorate Wales

1. SITUATION

The purpose of this paper is to provide the Quality Safety and Performance Committee with the Healthcare Inspectorate Wales inspection visits that took place at Velindre Cancer Service, Nuclear Medicine on 14th and 15th June 2022 and the First Floor Ward, 12th and 13th July 2022.

Their findings and the Trust's response, including detailed Improvement Plans to address the issues highlighted in the inspector's report are provided.

The Quality, Safety & Performance Committee are asked to note the findings of the two HIW Inspections, the agreed improvement plans and implementation progress to date.

2. BACKGROUND

Healthcare Inspectorate Wales completed an inspection of Nuclear Medicine on the14th and 15th June 2022 (Report is attached in ***Appendix 1*** and improvement plan in ***Appendix 2***) and the inpatient ward in Velindre Cancer Service on the 12th and 13th July 2022 (Report is attached in ***Appendix 3*** and improvement plan in ***Appendix 4***). The inspection report details all findings relating to the provision of high quality, safe and reliable care that is centered on individual patients.

For noting, in relation to the inpatient ward inspection, the Trust received a 24-hour notice period owing to the nature of the ward with the intention of allowing sufficient time for the COVID-19 safe arrangements to be put in place for the inspection. At the time of the inspection, the inpatient ward was experiencing an outbreak of COVID-19.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Overall, the findings for both visits were positive, with no immediate concerns noted in the reports.

However, there were some recommendations for service improvements, which are detailed in the report. The VCC respective senior teams have each reviewed the recommendations from the inspection reports and developed an Improvement Action Plan to address the areas highlighted for improvement by the inspection team. The full reports and action plans are attached.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Effective Care
	Safe care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality Safety and Performance Committee is asked to **NOTE** the HIW Reports, Improvement Plans and implementation of agreed actions to date.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

HIW Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Nuclear Medicine Department, Velindre Cancer Centre, Velindre University NHS Trust

Inspection date: 14 and 15 June 2022

Publication date: 21 September 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Nuclear Medicine Department, Velindre Cancer Centre, Velindre University NHS Trust on 14 and 15 June 2022.

Our team for the inspection comprised of two HIW Senior Inspectors and a Senior Clinical Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. As part of this inspection, an additional Senior Clinical Officer was also present to observe, as part of the peer review programme within MEG. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

There was very positive feedback provided by patients about their experiences when attending the department.

We saw that arrangements were in place to promote privacy and dignity of patients and found that staff treated patients in a kind, respectful and professional manner.

Information provided indicated that there were adequate arrangements in place to meet the communication needs of patients attending the department. The setting could improve these arrangements further by providing patients with the 'active offer'.

This is what we recommend the service can improve

- To provide more information on the 'active offer'
- The process in place to inform patients of the results of the patient experience feedback collected.

This is what the service did well:

- Well maintained environment with good signage
- Very positive patient experience comments
- A number of communication tools were available to help people with difficulties in communication.

Safe and Effective Care

Overall summary:

There was good compliance overall with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). We found arrangements were in place to provide patients visiting the Nuclear Medicine Department with safe and effective care.

Information provided indicated that appropriate arrangements had been implemented by the service to allow for effective infection prevention and control within the department.

We identified some areas for improvement including the need to improve the robustness of electronic referrals, the Medical Physics Expert (MPE) support in the short and medium term and the risk assessment of the general area.

This is what we recommend the service can improve

- Operating at levels of MPE support that are consistent with national guidance
- Formalising the clinical audit programme
- Having a study of the risk associated with the therapies to consider accidental and unintended exposures.

This is what the service did well:

- All staff understood their roles under IR(ME)R
- Local DRLs were established at or below national DRLs
- Isostock system, with clear records and double checking of dose entries to minimise risk and audit easily.

Quality of Management and Leadership

Overall summary:

There was a management structure with clear lines of reporting in place. There were effective governance arrangements in place to support ongoing regulatory compliance. We found visible and supportive leadership being provided within the department.

Staff demonstrated they had the correct knowledge and skills to undertake their respective roles within the department.

Some issues were identified that needed to be addressed by the employer.

This is what we recommend the service can improve

- Need to strengthen accountability by introducing document control onto employer's procedures (Eps) and other documents and protocols

- The competency records to be built into the document quality system to ensure a consistency in their format.

This is what the service did well:

- HIW Self-Assessment Questionnaire completed in a timely manner
- Good compliance with staff mandatory training and appraisals
- Good management evidenced.

3. What we found

Quality of Patient Experience

Patient Feedback

HIW issued both online and paper surveys to obtain patient views on the Nuclear Medicine Department (the department) at Velindre Cancer Centre. In total, we received 27 responses. Patient comments included the following:

> *"Staff at this hospital are fabulous, caring and friendly, and very reassuring to nervous patients."*
>
> *"All staff made my treatment and care feel amazing. Nothing was too hard for them. Thank you."*
>
> *"All staff I have encountered during … visits have been courteous, supportive and reassuring. I could not ask for any better treatment - I'm very grateful."*

Most responses to the questions asked indicated a positive patient experience by users of this service. Most comments were complimentary about staff and the overall service. Patients were asked in the questionnaire to rate their overall experience of the service; they all rated the service as 'very good'.

Staff Feedback

HIW issued an online survey to obtain staff views on the department at Velindre Cancer Centre. As we only received three responses, we have only been able to comment generally on the staff responses. The comments given should therefore be considered in light of the number of staff who responded.

Staying Healthy

Health Protection and Improvement

We found limited health promotion material was displayed within the department. However, a range of patient information leaflets were available and provided to patients prior to their appointments. Macmillan leaflets were also available in a designated area within the hospital. There was relevant information displayed on posters in the department.

Dignified care

Communicating effectively

Staff we spoke with confirmed that there was a hearing loop system available. They told us that additional arrangements could be made, where required, if patients had any other communication requirements. Staff confirmed access to translation services to assist, should a patient attend the unit and be unable to communicate in English and they were able to book a translator for the patient's appointment.

We saw good provision of bilingual information posters. However, there was no information displayed to inform patients that they could speak to staff in Welsh, also known as the 'active offer'. We were told, whilst there were no Welsh speaking staff at the department, there were Welsh speaking staff working in the hospital.

Only one of the 25 patients who answered indicated that Welsh was their preferred language. They said they were actively offered the opportunity to speak Welsh throughout their patient journey and indicated healthcare information was available in Welsh.

All patients who answered the question agreed staff treated them with dignity and respect and measures were taken to protect their privacy. They all agreed they were able to speak to staff about their procedure or treatment without being overheard by other patients and staff listened to them and answered their questions. We also viewed interactions between staff and patients that were respectful and professional with efforts made to protect patients' privacy and dignity.

All bar one patient agreed they were involved as much as they wanted to be in any decisions about their procedure or treatment.

Staff we spoke with told us that the patient information manager would provide aids for patients with impairments such as, language line, amplifiers and a hearing loop. The equipment was available on a stand that would be moved to the department. All documentation given to the patient was bilingual and staff tried to answer the phone in Welsh.

Patient information

Posters were clearly displayed requesting individuals who were, or may be, pregnant or breastfeeding to inform a member of staff. There was information displayed in the department's main waiting area and in the nuclear medicine waiting area, detailing the benefits and risks of the various types of medical exposures to ionising radiation carried out. Patients were also advised to avoid close contact with children and individuals who were pregnant. We saw nuclear medicine specific information posters displayed within the waiting area. There was

also evidence of sufficient bilingual signage to allow the patient to find the department and there were a number of bilingual posters on display.

All patients who answered the question agreed they were given enough information to understand the risks and benefits of the procedure or treatment. They all agreed they had been given information on how to care for themselves following their procedure or treatment. All bar one patient agreed they had been given written information on who to contact for advice about any 'after-effects' from their procedure or treatment.

Timely care

Timely Access

We identified that patients were seen promptly when attending the department. Suitable arrangements were described for informing patients of delays.

All patients who answered agreed it was easy to get an appointment and that they were able to find the department easily. Whilst 22 of the 27 respondents agreed they were told, at the department, how long they would likely have to wait, only three waited between 15 and 30 minutes and one waited for more than 30 minutes. Staff we spoke with also confirmed that if there were delays, they would inform the patients.

Individual care

People's rights

We were told that there was an equality and diversity policy within the organisation as well as mandatory training on this area. In addition to meeting communication requirements of patients, there were wide doors to the department and level access as well as a bed hoist available for patients.

All patients said they felt they could access the right healthcare at the right time.

Listening and learning from feedback

We saw evidence of the process in place for patients to provide feedback or raise concerns. We were also provided with copies of the feedback obtained through the external provider. We were told that there was a monthly report on feedback for the whole hospital and the relevant sections were extracted for the department. However, we did not see any information on learning from feedback being displayed for patients to see. More detailed information regarding how to make a complaint could also be displayed.

Compliments and concerns would be recorded on Datix. Concerns would be passed onto the line manager and attempts made to deal with the matter in house in the first instance.

Delivery of Safe and Effective Care

Compliance with Ionising Radiation (Medical Exposure) Regulations

Prior to our inspection, HIW required senior staff within the department to complete and submit a self-assessment questionnaire (SAF). This was to provide HIW with detailed information about the department and the employer's key policies and procedures in respect of IR(ME)R 2017. This document was used to inform the inspection approach.

The SAF was returned to HIW within the agreed timescale and was comprehensive. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly.

Duties of the employer

Patient identification

Staff we spoke with were able to describe the employer's procedure to correctly identify individuals. This included how to correctly identify individuals who may not be able to identify themselves. All patients agreed they were asked to confirm their personal details. However, we noted that Appendix 1 - Patient Identification procedure (of the Nuclear Medicine IR(ME)R document) was not as clear as it should be as it did not specify the questions to ask the patient.

Individuals of childbearing potential (pregnancy enquiries)

Staff were able to describe the procedure for making enquiries of individuals of childbearing potential to ensure they were not pregnant or breastfeeding. This included the procedure where individuals may not be able to respond to this enquiry. The relevant appendix also covered pregnancy and breastfeeding questions.

The SAF stated that two members of staff were always present at the time of the administration of the radiopharmaceuticals. Where more than one operator was involved in the exposure, the patient ID checks, radiopharmaceutical details, pregnancy and breastfeeding status were checked by both operators.

The SAF provided evidence that there were regular monthly audits of referrals to ensure pregnancy and breastfeeding checks and justification/authorisation was carried out.

Non-medical imaging exposures

The documentation provided stated that as non-medical imaging was not carried out at the centre, there was not an employer's procedure for this. However, a procedure is still required, stating that this is the case.

Referral guidelines

The process of how the employer ensures referral guidelines were established and made available to all referrers was described. The induction training for new referrers was also explained and that referral guidelines were included in the training package relating to request forms used within the department.

Currently referrals were made on up to five different coloured forms depending on the type of referral. The reasons for this system were also explained. If the referral was completed on the wrong form, then it would be returned. We were also told that the requirement for electronic referrals was being developed.

Staff were able to describe the referral criteria used. There was a list of entitled referrers listed in IR(ME)R documents and a printed copy was displayed in the office.

Duties of practitioner, operator and referrer

The SAF explained how practitioners, operators and referrers were entitled to carry out their duties which was included in an employer's procedure. We were told that referrers completed the induction and practitioners were entitled by the medical director and the Head of Nuclear Medicine entitled the operators. They all received a letter giving their entitlement.

The employer's procedure used in this section included more than one entitlement matrix and the entries against the named personnel were ticked to demonstrate tasks that staff were entitled to do. As these were not dated it was not clear when this entitlement happened or when this would be reviewed.

The example of a completed entitlement letter provided with the SAF showed that the scope of practice was clear for the practitioner role but it was not clear how this reflected operator or referrer tasks. Delegation of authority to entitle operators was also included in this example and allowed this individual to entitle operators to administer radiopharmaceuticals.

Regarding practitioner support there were many individuals providing low whole time equivalent support as well as remote practitioner support for therapies. The department needs to consider future requirements for these services to improve the service resilience. This is particularly the case with remote practitioner support. Best practice is for the practitioner to be based on site, especially for therapies.

Justification of Individual Medical Exposures

There was a set of supplementary employer's procedures for the department, which included the justification of individual exposures. The SAF stated that justification was recorded in the appropriate place on the form and included the date and signature of the practitioner. Where operators authorised exposures according to guidelines, this process was described. An electronic signature was accepted from a remote practitioner, providing the referral form was sent from that practitioner's email account.

We discussed justification of exposures to carers and comforters with senior staff, including considering pregnancy status and levels of patient care required as part of the justification decision. There was a specific nuclear medicine employer's procedure in place in relation to dose constraints and guidance for nuclear medicine exposures of carers and comforters. Currently only the practitioner licence holders were entitled to act as practitioners for this process. We were told that individual risk assessments were carried out if the dose was expected to go above the recorded limit and the three instances where this was carried out, were described.

Staff we spoke with described the process to consider when justifying exposures. They also knew where the authorisation of exposures was recorded. They were also able to describe the guidance in relation to carers and comforters.

Optimisation

The SAF included good examples of responses to the questions asked. These included:

- How exposures to individuals in whom pregnancy cannot be excluded or were breastfeeding were optimised
- How the operator selected protocols for individual examinations to ensure optimisation of the exposure
- How the MPE was involved in optimisation for all nuclear medicine practice and a good range of examples were given
- The procedure for providing written instructions and information to each patient or patient's representative.

We were also told by senior staff that written information, as described above, was given to patients with their appointment letters describing the procedure, this information was provided bi-lingually. This also gave the patient information on the benefits and risks of the procedure and described any restrictions after the test. Staff would advise patients to avoid prolonged and close contact with children and pregnant people for the remainder of the day and to drink plenty of fluids to aid the excretion of the radiopharmaceutical.

Staff also described the process to ensure that the administered activities and x-ray exposures given were as low as reasonably practicable, with particular attention being paid to certain patient groups.

Diagnostic reference levels (DRLs)

We were told that local DRLs were available and were lower than national DRLs. These had been optimised in collaboration with other centres in South-East Wales. Clinicians had not requested any change to these DRLs as there had not been concerns with image quality.

Staff we spoke with were aware of the DRLs set and their understanding of these was clear and consistent with procedures as well as how to apply them. The table of DRLs for radiopharmaceuticals was displayed by the equipment. Isostock software would also alert staff during the measurement, if the activity to be administered was not within 10% of what had been requested. Staff were able to describe the isostock computer software system used to account for the acquisition, use and disposal of radioactively labelled compounds and that the measurements were double checked.

Paediatrics

We received a comprehensive response in the SAF provided on paediatric optimised protocols. The patient's weight would be provided to Cardiff and Vale Radiopharmacy and they adjusted the activity for administration, based upon that weight. Whilst paediatric patients were not routinely imaged at Velindre, slower bed speed resulting in longer scanning time would be employed, if a paediatric bone scan was required.

Clinical evaluation

There was both an appendix to the Nuclear Medicine IR(ME)R document and an employer's procedure on clinical evaluation. The SAF described how clinical evaluation was undertaken and evidenced for each type of exposure. We were able to check two records to show that there had been a clinical evaluation performed by an appropriately entitled member of staff.

Equipment: general duties of the employer

The employer had an inventory (list) of the equipment used within the department. The inventory contained the information required under IR(ME)R 2017. We reviewed the employer's procedure in place in relation to the quality assurance (QA) programme. We also viewed the quality assurance programme in place, as well as employer's procedures and written protocols, these were in date.

The SAF gave a detailed schedule of the quality assurance programme in place for all relevant equipment. An appendix and an employer's procedure for the quality assurance programme was also provided.

There was also a comprehensive response on how the QA programme ensured accurate verification of the administered activity. Similarly, the response was comprehensive on the measures in place to improve inadequate or defective equipment and any corrective actions that may be taken.

Safe Care

Managing risk and promoting health and safety

The department was easy to find from the main entrance. There were no obvious hazards identified within the public areas and the corridors were clear of obstructions. However, the layout and location of the department could present challenges should spillages occur**.** The department was located along a main thoroughfare and arranged either side of this corridor**.** There was level access and there were facilities for people with mobility difficulties. We were told that the environmental constrictions identified, were well recognised by the Trust and were being addressed in the new hospital build.

All staff were positive in their replies to the care they gave to patients. All staff agreed that the care of patients and service users was the organisation's top priority, that they acted on any concerns raised and staff would recommend their organisation as a place to work.

Staff described the process to ensure that adequate information was provided to individuals or representatives relating to the benefits and risks associated with the radiation dose from exposures.

Infection prevention and control (IPC) and Decontamination

All areas seen appeared to be clean and well maintained. We discussed the arrangements with staff regarding spillages or contamination. Staff confirmed that if the corridor outside the department was contaminated, it would be monitored to prevent exposure to staff and patients. The use of the dedicated toilet in the department was limited to Nuclear Medicine patients for contamination control.

There were sharps bins lined with orange bags and used for swabs that covered the injection site. Whilst there were no lids on the bins, staff confirmed that swabs were dry and did not need to be in a lidded bin. We spoke to the infection control nurse who confirmed these arrangements were in keeping with the Trust policy.

Handwashing and drying facilities were viewed around the department. Personal protective equipment (PPE) was available for staff to use and all staff were observed to be wearing masks. Chairs within the waiting area were seen to be socially distanced and information was displayed for patients and staff regarding COVID-19 precautions.

Staff we spoke with confirmed that all equipment was cleaned after each patient and that staff wore PPE such as masks, aprons, gloves and visors. We were also

told of the weekly report sheet to infection control to confirm that staff had been checked wearing PPE and that all surfaces were cleaned twice a day. We were also told that appointments were arranged to minimise footfall and patients were told to wait in their car or in the main waiting area, until called into the department.

All 27 patients said the setting was 'very clean' and that COVID-19 infection control measures were being followed, where appropriate.

We checked a sample of three staff records and noted that they had all completed the relevant training up to the required level.

Safeguarding children and safeguarding adults at risk

Staff and senior staff we spoke with stated that safeguarding training was completed up to level two. Staff were aware of the procedures in place and the actions that needed to be taken in the event of there being a safeguarding concern.

We checked a sample of three staff records and noted that they had all completed safeguarding training up to the required level.

Effective care

Quality improvement, research and innovation

Clinical audit

There was not a defined nuclear medicine specific clinical audit programme. Whilst there was evidence provided that some audits were taking place, these were not formalised. We were told that there was a Trust clinical audit programme which focuses on local tumour site specific and National Cancer audits. This was modified to focus on COVID-19 specific local and national audits in 2020 and 2021. The nuclear medicine department need to develop a formal clinical audit plan which is reflected in the Trust Clinical Audit programme.

Expert advice

The SAF showed that the MPEs and Radiation Protection Advisors (RPAs) played a full role in the department. This involvement included developing procedures for diagnostic, non-imaging and therapies as well as advice on radiation protection related to patients, carers, comforters and family members. The MPEs also reported into the radiation protection (incorporating medical exposure) committee. The report would include departmental optimisation work in the future.

Staff we spoke with were aware of who the MPEs were in the department and how to access them in a timely manner.

We were told of the honorary contract and service level agreements (SLA) with Cardiff and Vale University Health Board in place for clinical scientist support. The department had not reviewed the SLA for some time and support under the SLA was not defined. We were told that the Trust has given notice to end the SLAs and to have staff employed by the Trust in the future.

We were told that the number of principal clinical scientists had reduced by 1.7 whole time equivalents. We were told that several meetings had been held between the Chief Operation Officer of the Trust, lead clinicians and the Head of Physics of Swansea Bay University Health Board to ensure good candidates were interviewed to fill the vacancies.

In addition, the discussion also included the supply of support in this area in the short term. This highlighted that the department would be operating at levels of MPE support below national guidance. Although there were arrangements to recruit in the interim, the department should complete a gap analysis until someone is recruited and there is a need to think about future level of support for new therapies and across the region. We were told there had been an agreement corporately not to extend services until MPE resource was secured.

Medical Research

The department participated in research involving medical exposures. There was an appendix and an employer's procedure for this. The governance arrangements in place for research trials involving ionising radiation exposures were well described in the terms of reference provided.

Record keeping

We checked a sample of five current patient referral documents and four retrospective documents. A range of different coloured paper forms were used, and these could potentially be rationalised.

For the current forms, there was a process noted for the referrals where electronic justification and authorisation was sought and recorded. The robustness of this process should be considered and comparison made with other local departments. This was because the practitioner would be sent scanned copies of the referral and the email text included 2 identifiers (name and ID number) instead of 3 required by a verbal procedure. Whilst there was no record of authorisation seen on one (out of five) referral, this referral could have been authorised under the delegated authorisation guidelines (DAG). The authorising operator did not sign the referral form.

For the retrospective referrals we noted a carers and comforters consent form signed for a 17-year-old patient. There was evidence seen of dose recording on the form for the carer and comforter.

Quality of Management and Leadership

Governance, Leadership and Accountability

A management structure with clear lines of accountability and reporting was noted. Whilst we found that governance arrangements were in place to support the effective operation of the department, there had been some recent staffing changes.

Staff we spoke with confirmed that they felt supported by their line manager. Staff also told us that they felt that the managers were very visible and approachable should they have any issues or queries they wished to discuss.

The limited number of staff who completed the questionnaire were mainly positive in their replies about the organisation. They were also mainly positive regarding the statements about their immediate manager and senior managers.

Duties of the employer

Entitlement

The SAF explained how the employer had delegated the task of carrying out IR(ME)R duties to others. This included a note that an amendment is required to Appendix 6 for entitlement of Medical Referrers and Medical Practitioners as the document listed the Clinical Director when it should be the Medical Director.

There were two relevant procedures for this area both the Nuclear Medicine IR(ME)R document; Appendix 2 – Referrer, Practitioners and Operators and the employer's procedure on duty holders and entitlement. The employer's procedure included the entitlement flow chart from the ionising radiation policy. There was an amount of duplication in this procedure and some inconsistencies. There were no dates listed in the operator matrices, which meant that dates for review and update could not be identified. This also meant that the appendix had to be changed frequently with changes in medical staff. We were told that future changes would be managed through the operational steering group. Training records were maintained for individual members of staff.

Staff we spoke with were made aware of their duties and entitlement through IR(ME)R documentation and entitlement letters. Staff were told of changes to written procedures both verbally and by email.

Procedures and protocols

We reviewed the employer's procedures provided as evidence to support the SAF and found that document control was inconsistent. Some improvements could be made in the consistency of the document control. Examples included:

- Employer's procedure part d (EP d), did not specify the document review timescale, review dates were being added to procedures as they were reviewed

- There are no details on who was involved in establishing or reviewing procedures or how they were agreed by the employer

- Different document formats for all supplied protocols

- Administration of radiopharmaceuticals to patient version two. This document did not appear to be part of the QA system (no footer with author/review date for example).

We were also told of the arrangements in place to strengthen the accountability structure and to ensure that the employer (the Chief Executive) was informed of radiation protection compliance and assurance and was aware of their responsibilities. These included setting up an operational group and strategic group to discuss trust wide radiation protection issues as well as reviewing the ionisation radiation policy. These groups reported to the radiation protection committee and eventually via the Quality, Safety and Performance Committee to the Trust's board.

Significant accidental or unintended exposures

The SAF gave a description of how the referrer, practitioner and the individual (or their representative) would be informed (or not) of a clinically significant unintended or accidental exposure (CSAUE) and provided with the outcome of the investigation into the event. The employer's procedure should be updated to match the regulation requirement that if a CSAUE occurs, they should always inform the patient (or their representative).

Additionally, there was not a document in place for studying the risk of accidental or unintended exposures for nuclear medicine therapies. The study of risk should be separate to the radiation risk assessments required under the Ionising Radiations Regulations 2017 (IRR).

Only one member of staff in the survey stated that they observed an accidental or unintended exposure in the last month and they said that they reported it. All staff we spoke with knew how to raise a concern about unsafe clinical practice and felt secure in raising these concerns. They would also be confident that the organisation would address their concerns.

Workforce

Staff we spoke with said that the staff numbers and skill mix were appropriate with appointments booked based on the number of staff on duty. However, there was not any administrative support and technologists arranged the appointments, manned the reception and imaged patients.

Senior staff stated that there was a need to employ one further technologist, otherwise the level was right currently because appointments were booked based on who was working, with staff available to cover for sickness or absence.

Senior staff also stated that they were trying to encourage new members of staff into the department from the next qualified student graduates from Swansea University. The department were also looking to have student placements from the university.

All staff agreed that their training, learning and development had helped them in their role.

We checked the records held and noted that all appraisals were up to date. Training compliance was almost 95 percent. There was an electronic system in place to monitor training and appraisal compliance.

Staff we spoke with were also aware of the wellbeing support offered by the department and the Trust.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: **Nuclear Medicine Department, Velindre Cancer Centre**

Date of inspection: **14 and 15 June 2022**

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurances were identified on this inspection				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Nuclear Medicine Department, Velindre Cancer Centre

Date of inspection: 14 and 15 June 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The Trust is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'.	3.2 Communicating effectively	The Nuclear Medicine service will place posters at key positions in the department promoting the 'active offer'. They will inform patients that if they wish to converse in Welsh to ask a member of staff.	Trust Welsh Language Manager / Head of Nuclear Medicine	30th September 2022
		A list of Welsh speaking staff within VCC will be held in the department and work contact details so can be contacted if no Welsh speaking staff available in Dept to support department meeting patients Welsh Language	Trust Welsh Language Manager / Head of Nuclear Medicine	30th November 2022

		needs for the duration of their procedure.		
		All Welsh Speakers to have the required Logo displayed on their uniform.	Trust Welsh Language Manager (Trust wide)	30th November 2022
		A Trust wide audit of 'Active Offer' to be undertaken across all patient / donor facing clinical areas and local action taken to ensure any 'Active Offer' deficits are addressed	Trust Welsh Language Manager	31st March 2023
The Trust must ensure that the results of any feedback or satisfaction questionnaires are made know to patients.	6.3 Listening and Learning from feedback	A fixed CIVICA patient experience feedback terminal will be put in place in nuclear medicine.	Head of Nuclear Medicine / Head of Nursing Professional Standards & Digital	30th November 2022

		Nuclear medicine to be fully set up on the CIVICA patient feedback system – QR code and web links to be made available and provided to patients as they leave the department (pending the fixed terminal being available.	Head of Nuclear Medicine / Head of Nursing Professional Standards & Digital	30th September 2022
		The department will implement a 'You Said, we did' feedback board in the department to visually display patient feedback and subsequent actions by the department - will be updated monthly.	Head of Nuclear Medicine	30th September 2022
The employer must ensure that various appendices are updated as follows: • Appendix 1 - Patient Identification procedure (of the Nuclear Medicine IR(ME)R document) to specify the questions to ask the patient to	IR(ME)R Reg 6 Schedule 2 1 (a)	The patient identification procedure in the Nuclear Medicine IR(ME)R document will updated to specify the exact line of questioning to ask patients to ensure they are appropriately identified using three patient	Head of Nuclear Medicine	30th November 2022

ensure the correct patient is identified		specific indicators being their full name, date of birth and address.		
• Appendix 6 for entitlement of Medical Referrers and Medical Practitioners is amended to read the Medical Director	IR(ME)R Reg 6 Schedule 2 1 (b) and IR(ME)R Reg 10 (3)	The entitlement structure is being reviewed as part of the scheduled review of the Velindre University NHS Trust Ionising Radiation Policy. The policy once approved will dictate the entitlement chain for Medical Referrers and Practitioners. This chain will be imbedded in the Nuclear Medicine IR(ME)R procedures and updated accordingly referring to the Medical / Clinical Director as appropriate.	Head of Nuclear Medicine	30th November 2022
The employer must ensure that there is an employer's procedure written for non-medical imaging.	IR(ME)R Reg 6 Schedule 2 1 (m)	A procedure for non-medical imaging will be produced and included in the Nuclear Medicine IR(ME)R documentation. The procedure will state that no non-medical imaging is undertaken within the Nuclear Medicine Department.	Head of Nuclear Medicine	30th November 2022

The employer must ensure that the entitlement matrix is updated to include dates, as opposed to ticks, so that management are aware of when the documents need to be reviewed. The documentation must also be in a consistent format as part of the document quality system.	IR(ME)R Reg 6 Schedule 2 1 (b)	The entitlement matrix will be reviewed to include the date on which entitlement was granted and in addition the specified period of review of individual entitlements.	Head of Nuclear Medicine	30th November 2022
		This and other documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.	Director of Operations / Head of Nuclear Medicine	28th February 2023

The Trust must risk assess the location of the department in view of the risks posed should spillages occur outside the department on a main hospital thoroughfare.	Standard 2.1 Managing Risk and Promoting Health and Safety	A review of the existing radiation risk assessment under IRR17 is currently underway. This is to be completed and to include risks and mitigations regarding spillages outside of the department.	Head of Nuclear Medicine / Velindre University NHS Trust Radiation Protection Advisers	30th November 2022
		A review of the plans for the new Cancer Centre to be undertaken to ensure the Nuclear Medicine Department is not within a thoroughfare and is segregated from unnecessary footfall.	Head of Nuclear Medicine / Director of TCS	30th November 2022
The employer must ensure that there is a defined programme in place for clinical audit.	IR(ME)R Reg 7	A Nuclear Medicine Specific Clinical Audit programme will be introduced and integrated into the Trust existing Clinical audit and feedback programmes.	Clinical Director for Radiology / Head of Nuclear Medicine	30th November 2022
The employer must ensure that all documented SLAs are in date, regularly reviewed and define the	Standard 7.1 Workforce	The SLA with Cardiff and Vale for the provision of Physics support is no longer operational as from the 14th July 2022.	Head of Radiation Services	Complete

support to be given as part of the SLA.				
The employer must ensure that the system used for referrals made by electronic methods such as emails, uses the same controls as paper referrals.	IR(ME)R Reg 10 (5)	All electronic confirmations of justification and authorisation now include the same three patient specific identifiers as would be used for verbal confirmation of identity.	Head of Nuclear Medicine	Complete.
The employer must ensure that a consistent system of document control is introduced into employer's procedures. This must include the document review timescale, review dates, who is involved in establishing or reviewing procedures and how they are agreed by the employer	IR(ME)R Reg 6 (5) (b)	Documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.	Director of Operations / Head of Nuclear Medicine	28th February 2023
		New and revised documents will be subject to governance oversight by the Radiation Protection and Medical Exposures Operational Group.	Director of Operations / Head of Nuclear Medicine	With immediate effect

The employer must ensure that the employer's procedure which covers clinically significant unintended or accidental exposure is updated to match the regulatory requirement that if this occurs, they should always inform the patient (or representative).	IR(ME)R Reg 8 (1)	The clinically significant unintended or accidental exposure in the Nuclear Medicine IR(ME)R document will updated to match the regulatory requirements.	Head of Nuclear Medicine	30th September 2022
The employer must ensure that a document is written on the study of the risk of accidental or unintended exposures for nuclear medicine therapies.	IR(ME)R Reg 8 (2)	A document will be prepared covering the study of the risk of accidental or unintended exposures for nuclear medicine therapies and incorporated into the document management system.	Head of Nuclear Medicine	30th November 2022
The Trust must ensure that appropriate staff are employed to carry out functions appropriate to their role. This includes administrative support to complete administrative functions.	Standard 7.1 Workforce	One administrative assistant has been recruited and is currently undertaking training in Nuclear Medicine to provide secretarial support to the service.	Head of Radiation Services	Complete
The employer must ensure there is sufficient MPE support available to meet minimum national guidelines.	IR(ME)R Reg 14 (1)	A gap analysis will be conducted on the provision of Nuclear Medicine MPE support to the	Head of Radiation Services	30th November 2022

Furthermore, the employer should complete a gap analysis to establish the number and qualifications of MPE required to cover all the therapies in place and those intended to be introduced.		service. No new diagnostic or therapeutic procedures will be initiated until MPE capacity is improved. In discussions with Welsh Government and local Directors of Therapies and Health Care Science, the department is actively engaged in recruiting new Clinical Scientist and MPE resource and building a regional advisory service to improve resilience. As part of the regional delivery of MPE services additional scientific resource has been recruited including two Band 7 Clinical Scientists and an 8B Clinical Scientist.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Kathy Ikin**

Job role: **Head of Radiation Services**

Date: **02/09/2022**

HIW Improvement plan

Nuclear Medicine Department, Velindre Hospital

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale	Status	Close out date	Notes
The Trust is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'.	3.2 Communicating effectively	The Nuclear Medicine service will place posters at key positions in the department promoting the 'active offer'. They will inform patients that if they wish to converse in Welsh to ask a member of staff.	Trust Welsh Language Manager / Head of Nuclear Medicine	30th September 2022	Complete	30/09/2022	Active offer poster is now in place in Nuclear Medicine waiting area.
		A list of Welsh speaking staff within VCC will be held in the department and work contact details so can be contacted if no Welsh speaking staff available in Dept to support department meeting patients Welsh Language needs for the duration of their procedure.	Trust Welsh Language Manager / Head of Nuclear Medicine	30th November 2022			
		All Welsh Speakers to have the required Logo displayed on their uniform.	Trust Welsh Language Manager (Trust wide)	30th November 2022			
		A Trust wide audit of 'Active Offer' to be undertaken across all patient / donor facing clinical areas and local action taken to ensure any 'Active Offer' deficits are addressed	Trust Welsh Language Manager	31st March 2023			
The Trust must ensure that the results of any feedback or satisfaction questionnaires are made know to patients.	6.3 Listening and Learning from feedback	A fixed CIVICA patient experience feedback terminal will be put in place in nuclear medicine.	Head of Nuclear Medicine / Head of Nursing Professional Standards & Digital	30th November 2022	Complete	26/10/2022	Fixed terminal installed.
		Nuclear medicine to be fully set up on the CIVICA patient feedback system – QR code and web links to be made available and provided to patients as they leave the department (pending the fixed terminal being available.	Head of Nuclear Medicine / Head of Nursing Professional Standards & Digital	30th September 2022	Complete	26/10/2022	Reports are being issued.
		The department will implement a 'You Said, we did' feedback board in the department to visually display patient feedback and subsequent actions by the department - will be updated monthly.	Head of Nuclear Medicine	30th September 2022	In progress		Board has been ordered and due to be installed on the 27th October.
The employer must ensure that various appendices are updated as follows: - Appendix 1 - Patient Identification procedure (of the Nuclear Medicine IR(ME)R document) to specify the questions to ask the patient to ensure the correct patient is identified	IR(ME)R Reg 6 Schedule 2 1 (a)	The patient identification procedure in the Nuclear Medicine IR(ME)R document will updated to specify the exact line of questioning to ask patients to ensure they are appropriately identified using three patient specific indicators being their full name, date of birth and address.	Head of Nuclear Medicine	30th November 2022			
The employer must ensure that various appendices are updated as follows: - Appendix 6 for entitlement of Medical Referrers and Medical Practitioners is amended to read the Medical Director	IR(ME)R Reg 6 Schedule 2 1 (b) and IR(ME)R Reg 10 (3)	The entitlement structure is being reviewed as part of the scheduled review of the Velindre University NHS Trust Ionising Radiation Policy. The policy once approved will dictate the entitlement chain for Medical Referrers and Practitioners. This chain will be imbedded in the Nuclear Medicine IR(ME)R procedures and updated accordingly referring to the Medical / Clinical Director as appropriate.	Head of Nuclear Medicine	30th November 2022			
The employer must ensure that there is an employer's procedure written for non-medical imaging.	IR(ME)R Reg 6 Schedule 2 1 (m)	A procedure for non-medical imaging will be produced and included in the Nuclear Medicine IR(ME)R documentation. The procedure will state that no non-medical imaging is undertaken within the Nuclear Medicine Department.	Head of Nuclear Medicine	30th November 2022			
The employer must ensure that the entitlement matrix is updated to include dates, as opposed to ticks, so that management are aware of when the documents need to be reviewed. The documentation must also be in a consistent format as part of	IR(ME)R Reg 6 Schedule 2 1 (b)	The entitlement matrix will be reviewed to include the date on which entitlement was granted and in addition the specified period of review of individual entitlements.	Head of Nuclear Medicine	30th November 2022			
		This and other documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.	Director of Operations / Head of Nuclear Medicine	28th February 2023			
The health board must risk assess the location of the department in view of the risks	Standard 2.1 Managing Risk and Promoting	A review of the existing radiation risk assessment under IRR17 is currently underway. This is to be completed and to include risks and mitigations regarding spillages outside of the department.	Head of Nuclear Medicine / Velindre University NHS Trust Radiation Protection Advisers	30th November 2022			

posed should spillages occur outside the department on a main hospital thoroughfare.	Risk and Promoting Health and Safety	A review of the plans for the new Cancer Centre to be undertaken to ensure the Nuclear Medicine Department is not within a thoroughfare and is segregated from unnecessary footfall.	Head of Nuclear Medicine / Director of TCS	30th November 2022			
The employer must ensure that there is a defined programme in place for clinical audit.	IR(ME)R Reg 7	A Nuclear Medicine Specific Clinical Audit programme will be introduced and integrated into the Trust existing Clinical audit and feedback programmes.	Clinical Director for Radiology / Head of Nuclear Medicine	30th November 2022			
The employer must ensure that all documented SLAs are in date, regularly reviewed and define the support to be given as part of the SLA.	Standard 7.1 Workforce	The SLA with Cardiff and Vale for the provision of Physics support is no longer operational as from the 14th July 2022.	Head of Radiation Services	Complete	Complete	01/09/2022	Completed prior to Inspection report
The employer must ensure that the system used for referrals made by electronic methods such as emails, uses the same controls as paper referrals.	IR(ME)R Reg 10 (5)	All electronic confirmations of justification and authorisation now include the same three patient specific identifiers as would be used for verbal confirmation of identity.	Head of Nuclear Medicine	Complete.	Complete	01/09/2022	Completed prior to Inspection report
The employer must ensure that a consistent system of document control is introduced into employer's procedures. This must include the document review timescale, review dates, who is involved in establishing or reviewing procedures and how they are agreed by the	IR(ME)R Reg 6 (5) (b)	Documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.	Director of Operations / Head of Nuclear Medicine	28th February 2023			
		New and revised documents will be subject to governance oversight by the Radiation Protection and Medical Exposures Operational Group.	Director of Operations / Head of Nuclear Medicine	With immediate effect	Complete	01/09/2022	All Amended docments are subject to oversight by the operation group.
The employer must ensure that the employer's procedure which covers clinically significant unintended or accidental exposure is updated to match the regulatory requirement that if this occurs, they should always inform the patient (or representative).	IR(ME)R Reg 8 (1)	The clinically significant unintended or accidental exposure in the Nuclear Medicine IR(ME)R document will updated to match the regulatory requirements.	Head of Nuclear Medicine	30th September 2022	Complete	23/08/2022	The IR(ME)R17 Nuclear Medicine departmental procedure now requires that the patient is informed of any SAUE and CSAUE incident.
The employer must ensure that a document is written on the study of the risk of accidental or unintended exposures for nuclear medicine therapies.	IR(ME)R Reg 8 (2)	A document will be prepared covering the study of the risk of accidental or unintended exposures for nuclear medicine therapies and incorporated into the document management system.	Head of Nuclear Medicine	30th November 2022			
The Trust must ensure that appropriate staff are employed to carry out functions appropriate to their role. This includes administrative support to complete administrative functions.	Standard 7.1 Workforce	One administrative assistant has been recruited and is currently undertaking training in Nuclear Medicine to provide secretarial support to the service.	Head of Radiation Services	Complete	Complete	01/07/2022	A Administrator is now employed in Nuclear Medicine to provide administrative support.
The employer must ensure there is sufficient MPE support available to meet minimum national guidelines. Furthermore, the employer should complete a gap analysis to establish the number and qualifications of MPE required to cover all the therapies in place and those intended to be introduced.	IR(ME)R Reg 14 (1)	A gap analysis will be conducted on the provision of Nuclear Medicine MPE support to the service. No new diagnostic or therapeutic procedures will be initiated until MPE capacity is improved. In discussions with Welsh Government and local Directors of Therapies and Health Care Science, the department is actively engaged in recruiting new Clinical Scientist and MPE resource and building a regional advisory service to improve resilience. As part of the regional delivery of MPE services additional scientific resource has been recruited including two Band 7 Clinical Scientists and an 8B Clinical Scientist.	Head of Radiation Services	30th November 2022			

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

HIW Hospital Inspection Report (Unannounced)

First Floor Ward, Velindre Cancer Centre, Velindre University NHS Trust

Inspection date: 12 and 13 July 2022

Publication date: 12 October 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an inspection of the inpatient ward at Velindre Cancer Centre on 12 and 13 July 2022. The Trust was provided with a 24 hour notice period owing to the nature of the ward with the intention of ensuring our teams have time to communicate with staff to allow time for COVID safe arrangements to be put in place for the inspection.

The following hospital ward was reviewed during this inspection:

- First Floor Ward - 30 beds providing a breadth of inpatient oncology care and treatment

Our team, for the inspection comprised of 2 HIW Inspectors, 2 clinical peer reviewers and 1 patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, we found that patients were provided with a positive experience. We observed kind and respectful interactions between staff and patients, and there were effective processes in place to capture, respond to and learn from patient feedback.

This is what we recommend the service can improve:

- Strengthen the dementia provision on the ward

This is what the service did well:

- Kind and respectful staff interactions
- Effective patient feedback processes

Safe and Effective Care

Overall summary:
Overall, we found that the ward and wider Trust was committed to maintaining patient safety, which was evident through its audit and governance processes. Some of the improvements that we identified, such as falls prevention, had already been recognised by the Trust and we saw evidence that work is underway in these areas.

This is what we recommend the service can improve:

- Continued focus on falls prevention
- Aspects of nutrition and hydration
- Aspects of medicines management
- Individualised care planning and aspects of record keeping

This is what the service did well:

- Aspects of infection prevention and control (IPC)
- Aspects of blood management
- Aspects of audit activity

Quality of Management and Leadership

Overall summary:
We found good management and leadership on the ward with staff commenting positively on the support that they receive from the ward manager.

This is what we recommend the service can improve:

- Aspects of staff feedback could be reflected upon

This is what the service did well:

- Positive ward management and leadership was identified

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used HIW questionnaires to obtain views and feedback from patients. A total of 3 were completed, as patient contact was limited during this inspection due to the COVID-19 status of the ward. Patient comments included the following:

"Patient feels ward is very friendly. Good choice of food"
"Nice and peaceful for recovery. Patients encouraged to go outside"
"A hospital like no other"

We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

Staying Healthy

Health Protection and Improvement
There was a range of information leaflets available in the patient information centre located near to the ward for patients and relatives to read and take away. These leaflets were informative, treatment specific and provided patients with an overview of their procedure.

There were a number of posters and reminders related to COVID-19 safety. This included reminders to wear masks and the promotion of good hand hygiene.

Dignified care

Dignified care
We observed kind and respectful interactions between all staff and patients at all times. Patients who completed a HIW questionnaire told us that they had been treated with dignity and respect by the staff at the hospital and that they felt listened to.

The ward environment overall provided patients with an appropriate level of privacy and dignity. Patients benefited from a number of individual cubicles or had access to curtains if they were located in a bay.

All but one staff member who completed a HIW questionnaire agreed that patient privacy and dignity is maintained on the ward.

Communicating effectively

We observed staff talking to patients in a respectful, professional and appropriate tone at all times during the inspection. This extended to clinical and non-clinical staff.

We found that bilingual (Welsh and English) signage was displayed throughout the ward and wider hospital. We were told that whilst there was a limited number of Welsh speaking staff on the ward, staff who could speak Welsh wore a 'Cymraeg' logo on their uniform to encourage use of the language. One patient indicated that they were a first language Welsh speaker but told us that they were only 'sometimes' offered the opportunity to speak Welsh and that no Welsh language information was offered to them. Senior management informed us that there were plans in place to improve the Active Offer[1] and we saw evidence in support of this.

We noted that a digital interpreter service was available on the ward and that patient information provided by the charity Macmillan was available to be requested in other languages or in braille for the visually impaired.

Patient information

There was a range of information leaflets available in the patient information centre located near to the ward for patients and relatives to read and take away. These leaflets were informative, treatment specific and provided patients with an overview of their procedure. There were also a number of posters and reminders related to COVID-19 safety.

We noted that patient status at a glance boards were in use on the ward which contained an appropriate level of information related to each patient. These boards were kept in secure areas of the ward in order to protect patient confidentiality.

Timely care

Timely Access

Overall, we found evidence that patients were provided with timely care during their time on the ward. Patient needs were promptly assessed upon admission and we observed staff assisting patients in a timely manner when requested.

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[1] An 'Active Offer' simply means providing a service in Welsh without someone having to ask for it.

There was clear evidence of transfer of care and discharge planning, which was documented in the patient records that we reviewed. This included assessment by other professionals within multidisciplinary team to facilitate a safe and effective discharge.

Individual care

People's rights

We found that the multidisciplinary team enabled patients' individual needs and rights to be considered as part of the approach to their care. Access to clinical counselling, spiritual and third sector services work closely with the ward to support patients.

There were no patients under Deprivation of Liberty Safeguards (DoLS) at the time of the inspection. However, the ward manager was aware of the procedure and was able to describe the process that would be followed. We found compliance with DoLS training to be at a high level amongst ward staff.

We reviewed dementia initiatives and awareness on the ward and found that schemes such as the Butterfly scheme were no longer in use. We also found that dementia training was not mandatory for ward staff at the time of the inspection, although we were informed that new dementia related training will soon become mandatory for staff.

The Trust must ensure that there is close focus on the dementia provision given the noted increase in DoLS patients and falls associated with confusion.

Visiting was restricted at the time of the inspection, but visitors would ordinarily be permitted at reasonable hours. Wi-fi was available on the ward to enable patients to use their phones and tablets as required. We were informed that patients who were at end of life would be allowed to receive visitors and a family room was available on the ward.

Listening and learning from feedback

We found that patients were provided the opportunity to provide feedback on their care, treatment and overall experience. Posters with QR codes were displayed throughout the ward and staff told us that they encouraged patients to provide feedback. We found that the system was effective in providing leadership and ward management with detailed results, enabling learning to be shared clearly and widely.

We found that Putting Things Right information was available on the ward and throughout the wider hospital.

We reviewed a sample of three complaints outcomes and found that these had followed an appropriate review and follow-up process. Where identified, actions had been implemented by the ward manager in a timely manner, which included communication to the wider ward team.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We found that measures were in place to manage risk and to promote the health and safety of patients, staff and visitors. The ward was accessible for those with a disability or mobility difficulties, and we observed the ward to be locked at all times to prevent unauthorised access.

The internal ward environment was visibly clean and reasonably well organised, although some staff told us that space was limited in some parts of the ward. We noted that access to the cleaner's room was wedged fully open during the inspection. **The Trust must ensure** that this door remains locked when not in use to prevent access to hazardous substances.

We reviewed the emergency resuscitation trolley and found that staff checks had been completed on a consistent basis. All items observed were complete and in-date.

Preventing pressure and tissue damage
In all ten patient records that we reviewed, we found that patients had been assessed for pressure ulcer risk upon admission and there was evidence of an appropriate skin assessment, which were completed to a good standard. However, we noted that, whilst the nursing assessments were comprehensive, individualised care plans were not reflected within the patient notes.

We noted that there was evidence of on-going monitoring of pressure areas and evidence of repositioning patients in all but one record. Access to a tissue viability specialist was available if required.

We found robust arrangements for the reporting and monitoring of pressure and tissue damage. This included review at a Scrutiny Panel, which included a breadth of staff at various levels of seniority and the production of a monthly report to aid effective learning at a ward level.

Falls prevention
In all ten patient records that we reviewed, we found that patients had been assessed for risk of falls. However, where we identified patients who were a falls risk, we did not find an up-to-date and individualised care plan for two out of the three at risk patients. We did however find evidence that post falls observation

charts were completed and multidisciplinary team input was provided in a full and timely manner in one record where a fall had occurred.

We noted that falls on the ward had persistently been given a red or amber rating in the Trust's performance indicators at a corporate level. This is due to the rightful low tolerance that the Trust places on fall incidents. It was to note that the Trust had completed a recent comprehensive audit of falls and that plans were in place to review the falls procedure and to implement a patient supervision policy. The ward manager also explained how learning is fed back to ward staff and provided examples of changes that had been made in response.

The Trust must maintain a close focus on falls prevention on the ward and monitor the timely implementation and effectiveness of the above measures. The Trust may also wish to consider implementing intentional (safe) rounding on the ward as an additional proactive measure to aid the delivery of safe and effective care.

Infection prevention and control (IPC)

Overall, we found the ward environment to be visibly clean in all areas. The environment appeared to be well maintained, which helps to promote effective cleaning. Cleaning schedules were available and were completed on a consistent basis.

All shared equipment was clean, with stickers indicating this, and equipment was covered where appropriate. Disposable curtains had recently been replaced and sharps boxes were in use and secure.

The ward had a small number of COVID-19 cases affecting patients on the ward at the time of the inspection. We found that patients were isolated as far as possible and we observed staff wearing, changing and disposing of appropriate personal protective equipment (PPE). We also observed good hand hygiene measures being adhered to by staff on the ward.

We spoke with IPC staff who described suitable arrangements for the response to and monitoring of any outbreaks on the ward. This included convening outbreak meetings, increased audit activity, microbiologist input and a post incident review to capture any learning. An example of learning included the need to re-introduce rapid COVID-19 testing on the ward.

In the patient records that we reviewed, we found that there was a general infection risk assessment, which did not include an assessment of COVID-19. Only two records that we reviewed contained a specific COVID-19 risk assessment. The Trust must ensure that COVID-19 risk assessments continue to be completed and evidenced within patient records.

It was positive to note that there were notably low infection rates in a number of areas, including catheter related infections. Aseptic Non Touch Technique (ANTT) compliance on the ward was also maintained to a high standard and we were informed that the Trust is preparing to apply for gold accreditation to reflect the positive practice.

Nutrition and hydration

We found that patients were provided with meals in a timely manner and staff were available to assist if required. Patients had access to water, which we observed to be within arms reach.

Nutritional needs were clearly recorded on Patient Status at a Glance Boards and we observed specific needs (e.g. coeliac) was marked on the patient cubicle door as an additional reminder for staff.

Staff informed us that there were positive links with dieticians who formed part of the multidisciplinary team and we found that there were generally timely specialist referrals when required.

In two records, we found that patients had been regularly weighed, had a mouth care and nutritional assessment completed, and nursing notes and paper care plans were completed to a good standard. However, we found that improvements could be made to the overall record keeping and care planning associated with nutrition and hydration for the following reasons:

- Patient 1: patient notes included a standard assessment and were not individualised to the needs of the patient
- Patient 2: the patient was admitted with nausea and unintentional weight loss, but there was a lack of care plan and referral recorded
- Patient 3: the patient experienced significant weight loss during their admission and there was a lack of care plan or dietician referral recorded.

Medicines management

We found that medication was consistently signed and dated when prescribed and administered and all medication was legible. However, we found that patient names / ID's were not consistently recorded on all pages in the majority of the records that we reviewed.

The ward has access to a pharmacy cover and there were appropriate arrangements in place for accessing medicines out of hours. We found that intravenous fluids were prescribed and recorded appropriately, and the administration of all medication was

recorded in a consistent and contemporaneous manner. However, we noted that oxygen was only prescribed in one out of the ten records that we reviewed.

We noted that patients do not administer their own medication, although we were informed that this was under review at a corporate level. We observed that patient lockers were secured when not in use.

We found that the medication rooms were secured from the outside, although we noted that individual medication fridges were not locked. We saw evidence of fridge temperature checks being completed on a consistent basis and controlled drugs checks were being completed at the appropriate intervals.

We were unable to observe a medication round during the course of this inspection.

Safeguarding children and safeguarding adults at risk

We found evidence in all patient records that questions related to safeguarding and mental capacity were discussed with patients and were appropriately recorded.

There was clear Trust policies and procedures in place for staff to follow in the event of a safeguarding concern and there was a safeguarding lead within the service for professional advice.

We reviewed staff training records in relation to safeguarding and found high level of completion amongst staff groups on the ward. There were no open safeguarding cases or concerns on the ward at the time of the inspection.

Blood management

The service manages and stores its own blood products. We found that there were staff trained to check, monitor and order the blood products, and that there was a suitable process in place to monitor the safe and appropriate use of blood products.

We noted that staff had received training for blood transfusions and that there were appropriate checks in place to ensure that patient identification and blood component checks are established at all stages of the transfusion process.

Medical devices, equipment and diagnostic systems

We found that the ward had the right equipment and medical devices to meet the needs of patients. There were appropriate processes in place for the checking of equipment on the ward, but we noted that two of the ECG machines on the ward required an annual maintenance service.

The Trust must ensure that medical devices and equipment is reviewed within the appropriate timeframes.

Effective care

Safe and clinically effective care

There was evidence of sound multidisciplinary team working between the nursing and medical teams on the ward.

We found evidence that patients with suspected sepsis are identified and treated within the appropriate timeframes using relevant national screening tools. Monthly audits demonstrated generally good levels of compliance in identifying and treatment of sepsis cases. We were informed that sepsis training is provided in-house, however, we found limited evidence of completion (e.g. logs of attendance, dates or schedule of delivery).

We found evidence that pain relief was managed appropriately. There was evidence that pain was being measured, actioned and evaluated at regular intervals using an appropriate national assessment chart. All patients had an up-to-date pain score recorded and suitable pain relief was administered when necessary. Whilst assessments were completed to a good standard, we recommend that individualised care plans are used, particularly given the patient group being cared for.

We were assured that the discussions related to DNACPR[2] was undertaken appropriately and sensitively. We saw evidence the DNACPR forms were completed to a high standard and that discussions had been held with individual patients and their relatives where it was appropriate to do so.

We were informed that recently implemented treatment escalation plans were also in use on the ward to help guide future clinical interventions. However, we found no evidence in four patient records we reviewed of a treatment escalation plan or, if required, discussions related to DNACPR. One of these records involved a palliative care patient who was admitted very unwell. We recommend that the Trust ensures that where these discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate audit trail.

Quality improvement, research and innovation

There was evidence of a breadth of clinical audit activity which was mapped against performance indicators. We saw evidence that audit activity was closely monitored at a local and corporate level, and that clear learning outcomes were identified and disseminated to ward staff.

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[2] Do not attempt cardiopulmonary resuscitation

Information governance and communications technology

We found that patient records and identifiable patient data was kept securely to ensure that confidentiality was maintained. There was a combination of electronic and paper records in use at the service, with paper records stored in locked offices to prevent unauthorised access.

We found that the majority of staff on the ward had completed information governance training.

Record keeping

The Trust had recently implemented the Welsh Nursing Care Record (WNCR) system, which we found to be a beneficial addition to the ward. The electronic nursing assessments that we reviewed were overall thorough and robust, however, it was unclear in a number of patient records what care plans were implemented following relevant assessments. The absence of these care plans and notes made it difficult for us to accurately provide an informed view on the care and treatment provided to those patients. Some records were also missing relevant charts, such as medication and NEWS[3].

We also noted that access to records, particularly the electronic system, is only accessible to certain staff groups. Aspects of patients records are also split across systems, including CANISC[4] and a paper file, which can give rise to a potential lack of multidisciplinary team approach to unified care.

Overall, the patient document that was available was completed to a satisfactory standard. We saw positive examples, including a 'What matters to me'[5] form completed to a high standard, containing person-centred detail and written in the patient's own words. A treatment escalation plan and DNACPR form that we reviewed was also completed to a high standard, with the involvement of the patient and their relatives.

The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated within patient notes. The Trust should consider how its patient record systems align to ensure that there

[3] National Early Warning Score (NEWS)

[4] Cancer patient record management system

[5] This aims to encourage and support more meaningful conversations between people who provide health care and the people, families and carers who receive care.

is a unified and streamlined approach to the access and review of patient notes by all staff groups

Quality of Management and Leadership

Governance, Leadership and Accountability

We found good management and leadership on the ward with staff commenting positively on the support that they receive from the ward manager. However, a number of staff commented that communication and decision making involving senior management could be strengthened.

We found that there were clear governance processes in place to ensure that the Trust placed a strong focus on quality and safety, and we saw evidence that there was a generally effective flow of information from board to ward.

Workforce

We found kind and respectful staff and we observed positive interactions between staff and staff and patients.

We found that there were sufficient numbers and skill mix of staffing during the inspection. We noted that staff absences due to sickness had caused some difficulties in recent months, but we noted that the ward occupancy was reduced to help ensure that patient needs continue to be met. Senior staff told us that the requirement for inpatient care had reduced significantly during the pandemic due to a reconfiguration of outpatient care and treatment.

During the inspection, we distributed HIW questionnaires to staff to seek their views on the service. We received 14 completed questionnaires. Some of the highlights include:

All but one staff member who expressed a view recommend their organisation as a good place to work and would be happy with the standard of care provided by their organisation for themselves, their friends or their family.

All but one staff member agreed that their training, learning and development helped them to do their job more effectively and all staff told us that they had completed an appraisal within the last 12 months. We asked staff whether there was any other training they would find useful, they told us:

'Venepuncture and cannulation'
'Airways'

Only half of staff agreed that they have enough time to give patients the care they need, with half of staff disagreeing that there are enough staff for them to do their job properly. Staff comments included:

'Assess staffing for each shift for the ward need'
'Use agency to help with staff shortages'

Despite this, all staff indicated that they were satisfied with the quality of care they give to patients and all agreed patients and their relatives are involved in decisions about their care. All but one staff member agreed that patient privacy and dignity is maintained at all times.

All staff who expressed an opinion agreed that their manager can be relied upon to help with a difficult task and all but two agreed that their line manager asks for their opinion before making decisions that affect their work.

However, the majority disagreed that communication between senior management is effective and disagreed that senior management try to involve staff in important decisions. Despite this, all agreed that senior managers are committed to patient care.

All staff who expressed an opinion agreed their organisation encourages them to report errors, near misses or incidents and that they know how to do this. All but one agreed their organisation takes action to ensure that they do not happen again. Despite this, the majority of staff disagreed that they are given feedback about changes made in response.

The majority of staff agreed that there are appropriate IPC procedures in place. However, only half of staff who expressed an opinion agreed that their organisation has implemented the necessary environmental changes in response to COVID-19. One comment included:

'Separate area for COVID patients'

The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required..

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified			

Appendix B - Immediate improvement plan

Service:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues were identified				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Appendix C - Improvement plan

Service: **First Floor Ward, Velindre Cancer Centre**

Date of inspection: **13-13 July 2022**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The Trust must ensure that there is a close focus on the dementia provision on the ward. This may include implementing a patient identification system on the ward and a review of the current non-mandatory approach to training	Standard 4.1			
The Trust must ensure that the cleaning room on the ward is locked when not in use.	2.1			
The Trust must continue to carefully monitor falls incidents on the ward to ensure that the	2.3			

anticipated improvements are realised in a timely and effective manner. The Trust may wish to consider implementing intentional (safe) rounding as an additional proactive measure.				
The Trust must ensure that COVID-19 risk assessments continue to be completed and evidenced within patient records.	2.4			
The Trust must ensure that, following completion of risk assessments, patients are followed up at the required intervals and that these checks are evidenced within patient notes. This includes evidencing a plan of care or referrals to specialist services (e.g. dieticians) where required.	3.5			
The Trust must ensure that:	2.6			

• Patient names / IDs are recorded on all pages • Oxygen is prescribed • Medication fridges are locked when not in use				
The Trust must ensure that medical devices / equipment on the ward are serviced at the required intervals.	2.9			
The Trust must ensure that sepsis training is delivered on a consistent basis and that evidence of attendance is maintained.	7.1			
The Trust must ensure that where DNACPR discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate audit trail.	3.5			
The Trust must consider how care plans are completed and reviewed	3.5			

to ensure that individualised patient care can be captured and demonstrated within patient notes				
The Trust should consider how its patient record systems align (or otherwise) to ensure that there is a unified and streamlined approach to the access and review of patient notes by all staff groups	3.5			
Given the improvements identified above, the Trust should increase its record keeping audit activity.	3.6			
The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required.	7.1			

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role:

Date:

HIW Improvement Plan

Velindre Cancer Centre, First Floor Ward

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale	Status	Close out date	Notes
The Trust must ensure that there is a close focus on the dementia provision on the ward. This may include implementing a patient identification system on the ward and a review of the current non-mandatory approach to training	Standard 4.1	The Enhanced Supervision Policy to be fully implemented. The policy will identify the requirements of patients with confusion or cognitive impairment e.g. closer supervision, open visiting.	Matthew Walters, Operational Senior Nurse Rhian Hathaway, First Floor Ward Manager	30th September 2022	In progress		Final draft is currently being finalised and will then go through approval via ICOG and SLT
		Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.	Rhian Hathaway, First Floor Ward Manager	From 3 months post implementation – January 2023.			
		First Floor ward to implement “This is me” booklet for patients with dementia and cognitive impairment	Matthew Walters, Operational Senior Nurse Rhian Hathaway, First Floor Ward Manager	30th November 2022	In progress		"This is me booklet's" are being reviewed to assess most suitable for FF Ward and our patients.
		The implementation of “This is Me” booklet will be audited quarterly for the first year to assess effectiveness.	Rhian Hathaway, First Floor Ward Manager	3 months post implementation – February 2023.	In progress		
		A dementia awareness/ update session to be provided to all staff within a ward meeting	Rhian Hathaway, First Floor Ward Manager	30th November 2022	In progress		Dementia awareness update being negotiated with Tina Jenkins
		All staff to receive formal dementia training via the arrangement with Cardiff and Vale Heath Board	Rhian Hathaway, First Floor Ward Manager	31st March 2023			
		Ward to develop as part of patient status at a glance board, above beds & handover process a visual mechanism for all patients with cognitive impairment that’s a visual reminder to all personnel.	Rhian Hathaway, First Floor Ward Manager	30th November 2022			
The Trust must ensure that the cleaning room on the ward is locked when not in use.	2.1	The operational services team to ensure the cleaning room remains locked at all times unless personnel are in the room	Susan Shepherd-Murphy, Operational Services Manager	Completed	Complete		
The Trust must continue to carefully monitor falls	2.3	Trust monthly falls scrutiny panels to continue	Viv Cooper Head of Nursing VCC	Completed	Complete		

		All actions from the recent corporate nursing falls audit to be fully implemented	Matthew Walters, Operational Senior Nurse	30th November 2022			
		The ward Manager and Operational Senior to formally consider implementing intentional rounding.	Matthew Walters, Operational Senior Nurse Rhian Hathaway, First Floor Ward Manager	Oct-22	In progress		Implementation of intentional/safe rounding is currently being assessed
		Enhanced Supervision Policy to be fully implemented which identifies the level of supervision a patient requires dependent on risk of falls, confusion, risk of patient becoming lost/ wandering.	Matthew Walters, Operational Senior Nurse, Sarah Owen, Quality & Safety Manager	Oct-22			
		Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.	Rhian Hathaway, Ward Manager	3 months post implementation – January 2023.			
		The ward manager to implement the “Big 4” as a communication tool. Each day 4 important messages are relayed to staff at the midday safety huddle, including learning and improvements identified from scrutiny panels. The same big 4 themes are repeated for a week at each huddle to ensure maximum number of staff are informed.	Rhian Hathaway, First Floor Ward Manager	Completed	Complete		
The Trust must ensure that COVID-19 risk assessments continue to be completed and evidenced within patient records.	2.4	All patients have a covid PCR test on admission. Informal risk assessments currently being done on all admissions (history of cough, temperature, close contact?) Clerking proforma to be updated to include a formal	Ceri Stubbs, Acute Oncology Lead Nurse	Oct-22	Complete		
The Trust must ensure that, following completion of risk assessments, patients are followed up at the required intervals and that these checks are evidenced within patient notes. This includes evidencing a plan of care or referrals to specialist	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle. The ward manager, senior operational nurse, ward clinical educator, and digital CNS are meeting to formulate and roll out an improvement plan for documentation.	Rhian Hathaway, Ward Manager, Matthew Walters, Operational Senior Nurse	Dec-22	In progress		

of referrals to specialist services (e.g. dieticians) where required.		Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.	Matthew Walters, Operational Senior Nurse, Rhian Hathaway, Ward Manager	Dec-22	Complete		
The Trust must ensure that: •Patient names / IDs are recorded on all pages •Oxygen is prescribed •Medication fridges are locked when not in use	2.6	All staff (doctors, nurses, AHP's) reminded to include patient ID on all pages. Included in Big 4, emailed to all doctors, emailed to all AHP, put on nurses Whatsapp work group. This information to be included in future documentation audits.	Rhian Hathaway, First Floor Ward Manager, Matthew Walters, Operational Senior Nurse	30th September 2022	Complete		
		All staff (nurses and doctors) reminded that oxygen must be prescribed – included in Big 4, emailed to all doctors, put on nurses Whatsapp work group, Audit to be taken quarterly and fed back to ward and medical gases group	Rhian Hathaway, First Floor Ward Manager, Matthew Walters, Operational Senior Nurse	30th September 2022	Complete		
		All staff (nurses and pharmacy) reminded of safe storage of medication. Emailed to all pharmacy staff, included in Big 4, put on nurses Whatsapp work group, and emailed to Medicines Safety Group chair. Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to ward Medicines Safety Group.	Bethan Tranter - Chief Pharmacist, Kate Baker - Head of Therapies, Dr Eve Gallop-Evans, Clinical Director	30th September 2022	Complete		
The Trust must ensure that medical devices / equipment on the ward are serviced at the required intervals.	2.9	Ward manager and medical physics to undertake a spot check of all medical devices on the ward to identify devices/ equipment that need immediate servicing	Rhian Hathaway - First Floow Ward Manager, Jignesh Raiyani - Medical Physicist	Oct-22			
		Ward manager and medical physics to ensure a robust system in place for regularly checking the service date for medical devices/ equipment	Rhian Hathaway - First Floow Ward Manager, Jignesh Raiyani - Medical Physicist	Oct-22			
		Trust to consider implementing a Medical Devices electronic tracking system that recalls devices requiring service	Jignesh Raiyani, Medical Physicist	30th March 2023			

The Trust must ensure that sepsis training is delivered on a consistent basis and that evidence of attendance is maintained.	7.1	Sepsis training is delivered to all registered nursing staff as a core part of the Acute Oncology Study day.	Rhian Hathaway Ward Manager Ceri Stubbs Acute Oncology Lead Nurse	Oct-22	Complete		
		Training compliance to be reviewed and be further rolled out as part of the implementation of NEWS Cymru. Training Plan will be developed to be delivered over 6 months	Rhian Hathaway Ward Manager Ceri Stubbs Acute Oncology Lead Nurse	Mar-22			
The Trust must ensure that where DNACPR discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate audit trail.	3.5	The clinical director discusses regularly with all doctors about documenting decision making around DNACPR and escalation in the medical notes at morning handover. To discuss at SMSC (Senior Medical Staff Committee) on 7th September 2022. Speedy Cascade to be circulated with immediate effect. Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to clinical team. Ward daily midday safety huddle to include question regarding treatment escalation plan to ensure in place for all patients.	Dr Eve Gallop-Evans Dr Eve Gallop-Evans Rhian Hathaway, Ward Manager Matthew Walters, Operational Senior Nurse	Completed	Complete		
The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated within patient notes	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle. The ward manager, senior operational nurse, ward clinical educator, and digital CNS to formulate and roll out an improvement plan for documentation.	Rhian Hathaway, Ward Manager Matthew Walters, Operational Senior Nurse	Dec-22			
		Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.	Rhian Hathaway, Ward Manager Matthew Walters, Operational Senior Nurse	From September 2022	Complete		

The Trust should consider how its patient record systems align (or otherwise) to ensure that there is a unified and streamlined approach to the access and review of patient notes by all staff groups	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. The Velindre Cancer Centre (VCC) is implementing WPAS in November 2022 and full use of WCP as the clinical record as part of its Canisc replacement, this will improve the current situation where there are multiple sources of documentation in relation to a patients care at VCC.	Matthew Walters Senior Operational Nurse (lead for the FF ward WPAS implementation)	30th December 2022	In progress		
Given the improvements identified above, the Trust should increase its record keeping audit activity.	3.6	Following improvements being made to documentation overall, regular audits will be undertaken quarterly to monitor risk assessments, care plans, referrals, and patient identification.	Rhian Hathaway - Ward Manager, Matthew Walters - Operational Senior Nurse	Dec-22	Complete		
The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required.	7.1	The team have reflected on the staff feedback, there are in place multiple ways of receiving staff feedback, in relation to the specific feedback in this report the senior nurses will include themes from the feedback in the ward and team meetings agendas and in the daily Big 4 communications.	Rhian Hathaway Ward Manager Matthew Walters, Operational Senior Nurse	Oct-22	Complete		
		Explore the use of Civica for regular staff feedback, pulse surveys, implement and monitor feedback from themes.	Rhian Hathaway Ward Manager Matthew Walters, Operational Senior Nurse	Oct-22			

QUALITY SAFETY AND PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE TRUST SAFETY ALERTS MANAGEMENT GROUP

DATE OF MEETING	10th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jade Coleman, Quality, Safety and Assurance Manager
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patent Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	

ACRONYMS	
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
PSN	Patient Safety Notice
PSA	Patient Safety Alert
MDA	Medical Device Alert

1. PURPOSE

This report provides the Quality, Safety and Performance Committee with the key highlights / outputs from the Trust's Safety Alerts Management Group for the period of the 1st June 2022 – 30th September 2022 and updated details in relation to the alert which the Trust deem itself non-compliant.

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **NOTE** the report and the actions being taken by Velindre Cancer Service to achieve compliance in relation to the ***Safe Storage of Medicines*** Alert***.***

2. BACKGROUND

Velindre University NHS Trust regularly receives various types of Safety Alerts which include:

- Patient Safety Notices (advising the Trust on changes to practices/procedures to prevent possible harm to patients)
- Dangerous Incident notifications (which can relate to Estates concerns such as high voltage hazards)
- Medicine updates (such as shortages of particular drugs)
- Medical device notifications
- Covid related updates and notifications

The Trust must be able to demonstrate that it has responded appropriately to the requirements of each applicable Safety Alert in order to reduce the risk of harm occurring to patients, staff and service users. The role of the Trust Safety Alerts Management Group is to provide and ensure an effective management system for the distribution, assessment and monitoring of all Safety Alerts received from Welsh Government.

The Trust Quality & Safety Team undertake an immediate review, dissemination and escalation of any Safety Alerts that the Trust receives. This ensures that prompt action is taken to assess applicability and levels of compliance and areas of action required. In addition, the Trust is a member of the All Wales Patient Safety Reference Group so that it is fully involved in discussions of any 'Alerts of concern', the sharing of best practice and ongoing national network support.

Each safety alert received by the Trust is distributed across the organisation via the Datix reporting safety alert system.

3. ASSESSMENT

3.1 Highlights from the Safety Alert Group for the period of 1st June 2022 – 30th September 2022

ALERT / ESCALATE	**Current Open Safety Alert Position** • ***The Safe Storage of Medicines: Cupboards PSN055: Original deadline (30th September 2021)*** Most actions in the alert have been addressed and Trust are compliant with the majority of requirements. There are 4 areas however that require capital funding to further improve compliance. These are currently being prioritized for capital expenditure and risk based value for money reviews being undertaken due to pending new hospital build: o Implementation of Digitrac in additional areas. (On value for money approval) o Air conditioning (On value for money approval) o Changing of lighting to improve Lux. o Appropriate locks It is anticipated that by December 2022 compliance will be further enhanced pending risk-based value for money pending new hospital build decisions being made.
ADVISE	**Compliance status update** • ***Emergency Steroid Therapy Treatment Card PSN057*: (*Original deadline: 31st January 2022)*** Trust declared compliance with the ***Emergency Steroid Therapy Treatment Card*** patient safety notice on the 30th September 2022 following a lengthy commitment by multi-disciplinary teams within the Velindre Cancer Service to address the actions set out in the alert.
ASSURE	**42 *new Safety Alerts*** were received by the Trust during the period of the 1st June 2022 to the 30th September 2022 which is consistent in comparison to previous months. A breakdown of the number and type of alerts received are detailed below: • ***Two Patient Safety Alerts*** were received during the period and related to: o ***Nasogastric pH testing of aspirate.*** The Delivery Unit were advised on the 31st August 2022 that the Trust are compliant with the alert and utilise the

Avanos asphirate PH indicator strips set out in the Patient Safety Alert, which are the most accurate strips and are CE marked.

- ***The safe use of ultrasound gel to reduce infection risk.*** The Delivery Unit were advised on the 9th August 2022 that the Trust acknowledge the updated guidance on the safe use of ultrasound gel and have adjusted ordering and practice in line with the updated alert.

- ***Medication Alerts - 32*** medicine / drug related alerts were received. Each alert was reviewed by Trust Pharmacy safety alert leads to establish whether the alert was applicable to the Trust. Each drug was stock checked to determine whether the Velindre Cancer Centre were in receipt of that particular drug and also to confirm any last issued dates. ***9 of the 32 alerts were assessed as being applicable to the Trust***. Pharmacy leads confirmed that Velindre Cancer Centre drug stock was checked against any identified shortages highlighted within the safety alerts ensuring that the Cancer Centre were not impacted and that alternative drug supply was available if needed.

- ***Covid-19 Alerts:*** **4** Covid-19 related alerts were received and circulated via the Datix system. The 4 alerts were reviewed and deemed ***not applicable*** to Velindre University NHS Trust as any patient requiring specific Covid-19 related treatment is cared for under their Health Board and the Trust are not directly involved in the vaccination of severely immunocompromised patients.

- **Medical Device Alerts: 2** Medical Device alerts were received and reviewed by the Trust Medical Physics lead at Velindre Cancer Centre and Health & Safety Environmental Officer, Quality Assurance at Welsh Blood Service both confirming that the type of equipment identified in the alerts are not used at any Trust site.

- **1** alert was received and shared via the Datix system for review and information relating to the treatment for patients hospitalised with the monkey pox viral infection.

	• **1** alert was received and shared via the Datix system for information only and related to the extreme hot weather the UK faced during the month of July 2022.
INFORM	There were no items for information.
Appendices	**NA**

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **NOTE** the report and the actions being taken by Velindre Cancer Service to achieve compliance with the ***Safe Storage of Medicines*** alert***.***

QUALITY, SAFETY & PERFORMANCE COMMITTEE

TRUST QUALITY & SAFETY FRAMEWORK & QUALITY PRIORITIES UPDATE

DATE OF MEETING	10th November 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP & Health Science
REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	Discussed and Noted

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the implementation of the Trust's Quality & Safety Framework and Quality Priorities.

2. BACKGROUND

The Trust Board approved the Quality & Safety Framework in July 2022. An implementation plan was developed. In addition, 2022 / 2023 Quality Improvement Goals were approved.

3. IMPLEMENTATION STATUS

3.1 Quality & Safety Framework Implementation Status

The implementation status of the Quality & Safety Framework is attached in ***Appendix 1***.

3.2 2022/2023 Quality Improvement Goals

The position in relation to each Quality Improvement Goal is detailed in ***Appendix 2***.

3.3 Quality & Safety Framework Evaluation

The Quality Framework implementation approach will be evaluated by Internal Audit during 2022/23 Quarters 3 & 4 and through an externally commissioned peer review in 2023. The 2022/23 Internal Review will guide any refinements to the implementation plan and approach.

The 2023 Peer Review will be used as part of the Framework implementation assurance mechanisms as well as be used to inform the review of the framework that will need to be completed by 2024.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care Applicable to all Health & Care standards
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be adverse legal implications in the event of Trust not meeting its quality & safety responsibilities
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be resource requirements to meet this framework responsibilities within divisions and corporately. Resources agreed re restructuring of Corporate Quality & Safety Team. Resource requirements within VCC require quantifying.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the status in relation to the implementation of the Quality & Safety Framework and the 2022/23 Quality Improvement Goals prior to submission to the Quality, Safety & Performance Committee.

Appendix 1

Quality and Safety Implementation Plan

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	December 2023 required status	Status October 2022
Dedicated implementation support available to support establishment of Quality Hubs and work with services and teams to determine what good looks like and required measures	Recruitment of agreed / resourced one year framework implementation lead	Executive Director Nursing, AHP &Health Science	Recruitment completed by 30th August 2022 Revised date Dec 2022	75% of clinical teams agreed 'what good looks like', agreed metrics to assess status	Third attempt to recruit post underway
Staff across the Trust aware of the framework and what this means for them and their teams	Quality Framework in action animated video to be produced aimed at teams and departments	Executive Director Nursing, AHP &Health Science	30th September 2022 Revised date Dec 22	Fully completed	Shared Services agreed to support development – work on video not yet commenced
	Quality Framework roadshows to be held within clinical areas and pre- arranged team meetings	Executive Director Nursing, AHPs & Health Science	Completed by 30th September 2022 Revised date Dec 22	Fully completed	A number of roadshows held – some delayed due to operational demands

Quality, Safety, outcome and experience measures routinely monitored and used to inform decision making, prioritisation and improvements	Service level to Board quality, outcome & experience measures identified and captured across all services as part of routine monitoring arrangements	Divisional Quality Leads, Head of Quality & Safety& Quality & Safety implementation manager	December 2023	100% of clinical teams agreed 'what good looks like', agreed metrics to assess status	
	Quality & Safety Governance Group to be established	Deputy Director Nursing, AHPs & Health Science, Head of Quality & Safety	30th September 2022	Fully embedded in how organisation functions	Integrated Quality & Safety Group established – inaugural meeting held 19/10/2022
Corporate & Divisional Quality Hubs fully operationalised, undertaking triangulated analysis and supporting the creation of the required quality & safety culture	Quality Hub Lead role specification to be developed	Deputy Director of Nursing, Quality & Patient Experience	31st July 2022	Fully completed	Included as part of Health of Quality, Safety & Assurance Job Description
	Quality Hub Leads to be identified / appointed	Divisional Directors & Director of Nursing, AHPs & Health Science	30th August 2022 Revised date Dec 22	Fully completed	Plans to establish Division Hubs underway
	Corporate & Divisional Quality Hubs to be fully operational	Divisional Directors & Deputy Director of Nursing, Quality & Patient Experience	30th September 2022 Revised date Dec 22	Quality Hubs fully embedded in how organisation functions	Plans to establish Division Hubs underway Delay with corporate Hub establishment due to protracted OCP
Quality and Quality Improvement is embedded at the centre of all decisions made across the Trust	Trust Quality Management System to be designed and implemented with support from Improvement Cymru	Director of Nursing, AHPs & Health Science, Medical Director & Director of	30th September 2023	Fully completed	Discussions commenced with Improvement Cymru

		Corporate Governance			
	The Trust will undertake a review of its quality improvement infrastructure and mechanisms supported by Improvement Cymru	Director of Nursing, AHPs & Health Science, Medical Director & COO	March 2023	Fully completed	Discussions commenced with Improvement Cymru
	2022/23 Quality Improvement Goals met	Executive Directors	March 2023	Fully completed	
	2023/2024 Trust Quality Improvement Goals agreed	Executive Directors	31st March 2023	Priorities on Trajectory for delivery	
Trust safety Monitoring Framework developed and in place	IHI Foundation safety & improvement assessment to be undertaken and any further improvement actions quantified	Director of Nursing, AHPs & Health Science, Medical Director & COO	30th July 2022 Revised date Dec 22	Fully completed	
	Trust Safety Advisors to undertake staff safety survey and repeat annually	Trust Safety Advisers	Initial by 30th September 2022 Revised date Dec 22	Two staff surveys completed and analysed to assess culture changes	
	Trust Safety Monitoring Framework to be established and implemented across both divisions	Trust Safety Advisers	30th March 2023	Fully operational	

	Harm to be defined across all services both potential and actual and harm reduction goals determined	Trust Safety Advisers	July 2023	Defined across all clinical services	
	A programme of SLT and Board Safety Walkabouts to be implemented	Trust Safety Advisers	December 2022	Fully established as part of how Trust & Divisions operate	
	A Trust wide Quality & Safety portal to be developed for sharing of good practice and Welsh Government	Deputy Director Nursing, Quality & Patient Experience & Chief Digital Officer	March 2023	Fully completed	
	Senior Trust Officers & Members all trained in strategic safety & improvement	Director of Corporate Governance	December 2022	Members received training	100% members Divisional
Well-developed Quality & Safety assurance mechanisms in place	Trust Board level Assurance infrastructure and reporting requirements to be clearly defined	Director of Corporate Governance	31st October 2022 Revised date Dec 22	Fully Completed	Meeting review commenced & Operacy review of VCC Q&S reporting completed
	Trust assurance and frameworks aligned with 6 domains of Quality	Director of Corporate Governance & Director of Strategic Transformation, Planning & Digital	31st December 2022	Fully Completed	

	Trust meeting Structure to be reviewed to ensure transparency of reporting and removal of any duplication post implementation of the Quality & Safety Governance Group	Executive Directors, Divisional Directors	March 2023 Revised date Dec 22	Fully completed	Meeting review commenced & Operacy review of VCC Q&S reporting completed
Clinical Leaders setting Trust clinical quality priorities for future IMTPs	Clinical & Scientific Strategic Board Established	Medical Director, Directorof Nursing, AHPs & Health Science	30th September 2022	Fully completed	Required resources mapped – to date these have not been made available therefore Board not yet established
	Trust wide Clinical & Scientific Strategy developed	Medical Director, Directorsof Nursing, AHPs & Health Science	March 2023 Revised date December 2023	Fully completed	Required resources mapped – to date these have not been made available therefore work on strategy not commenced
Robust and clearly defined clinical effectiveness arrangements across whole organisation	A formal review of Clinical effectiveness and clinical audit infrastructure to be undertaken	Head of Quality & Safety	June 2023	Fully Completed	

Values based healthcare principles embedded across organisation	The Trust has identified a number of values based healthcare priorities for 2022/24 – these will be implemented through a project management approach.	Medical Director	December 2023	Top five VBHC priorities delivered	

RAG	***Meaning***
	Delivered
	On track to be delivered by required timescale
	Delivery delayed – will be completed by December 2023
	Delivery significantly delayed – at risk of non delivery

Review: October 2022

Further Review dates: January 2023 & July 2023

Appendix 2:

Velindre University NHS Trust 2022/2023 QUALITY IMPROVEMENT GOALS

status October 2022

Goal Number	***Improvement Goal***	***Position October 2022***	***RAG***
1	Revised brachytherapy service delivery specification that meets predicted demand, is resilient and benchmarks favorably in terms of outcomes and experience with other brachytherapy providers across the UK	External Peer Review completed. Improvement plan to address the 134 recommendations under development.	
2	SACT service redesigned to meet predicted demands ensuring all SACT delivered within clinical required timescales and benchmarks favourably with other international SACT services	Considerable re-design work underway – SACT service on track to meet predicted	
3	Radiotherapy service redesigned to meet predicted demands ensuring Radiotherapy is delivered within clinical required timescales and benchmarks favorably with other international Radiotherapy services	A revised demand and capacity structure has been established to ensure overall demand and the variation experienced is understood and its implications in different tumour sites and all options for increasing capacity are being explored	
4	VCC Telephone helpline review to ensure patient needs are being met, national standards delivered and the previous improvement plan fully implemented (unless superseded)	SACT and Medicines Management Directorate leading on this work, project proposal shared at first team meeting. National review continues via the Network VCC fully engaged and leading on aspects.	
5	Implement SaBTO recommendations for detection of Occult Hepatitis B Infection in donors to further reduce risk of Hepatitis B transmission through blood transfusion	SaBTO recommendations for detection of Hepatitis B Infection fully implemented in WBS including donor follow up. Formal WG & Trust governance infrastructure in place to agree lookback pathway for recipients of blood products. Lookback process being agreed.	

6	Blood collection delivery post pandemic redesign (including staffing model redesign) ensuring service can meet demand predicted demand for blood & blood products	Clinic venue portfolio: • WBS has begun the reintroduction of venue types that had been stood down due to pandemic venue availability and IPC constraints. These include educational establishments, companies, the 6 chair mobile donation clinics and returning to some smaller communities not served during the pandemic. • Identification of a fixed site in South Wales has stalled due to the unsuitability of the potential venue suggested by NWSSP Estates. Alternatives sites are being explored. • The Head of Resource, Planning & Logistics post, vacant due the secondment of the substantive post holder, has been refilled on a new interim basis to provide leadership of the post pandemic clinic venue portfolio work. Whole blood collection staffing model: • Implementation of the 2019 Terms and Conditions Organisational Change (OCP) consultation outcomes began in October. • Preparations are underway for phase 2 of OCP to, consult on the collections team model work has commenced on the development of new job descriptions and benchmarking against other UK blood services to share best practice in staffing models.	
7	Velindre Cancer Centre mee ting the national consent standards 100% of times.	Consent Working Group led by Q&S manager, agreement to implement all Wales consent form, consent audit included in agreed audit plan.	

8	Ensuring the Cancer Service is able to respond appropriately & timely to the deteriorating patient (adult & child)	Review of management of the deteriorating patient (adult and child) being commissioned currently with critical care lead for ABHB who is pulling together a peer review team	
9	Fully functioning Quality Governance Group that provides triangulated quality, safety, outcome, experience and governance assurance & exceptions to Executive Management Board and Quality, Safety & Performance Committee.	Integrated Quality & Safety Group planning meeting held September 2022 & inaugural meeting held 19th October 2022. Formal reporting into Quality, Safety & Performance Committee to commence in January 2023.	
10	Fully established and functioning Corporate and Divisional QualityHubs	Divisional Hubs under development Corporate Hub development delayed due to protracted OCP.	

RAG	***Meaning***
	Delivered
	On track to be delivered by March 2023
	Delivery by March 2023 at risk
	Delivery significantly delayed

Quality Safety and Performance Committee

SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	10th November 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-Applicable
PREPARED BY	Tina Jenkins Senior Nurse Head of Safeguarding & Vulnerable Groups
PRESENTED BY	Nigel Downes Deputy Director of Nursing, Quality and Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
REPORT PURPOSE	DISCUSS/REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Safeguarding and Vulnerable Adults Group	9th September 2022	Areas for inclusion agreed
Executive Management Board	3rd of October 2022	**NOTED** and **APPROVED** the GAP Analysis against the HIW report 2019 into Abertawe Bro

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Trust's Safeguarding and Vulnerable Adults Management Group at its meeting held on the 9th of September 2022 and to provide the full Trust GAP Analysis against the Healthcare Inspectorate Wales (HIW) January 2019 report into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. The Quality, Safety & Performance Committee is asked to:

- **NOTE** the training compliance status and actions being taken to address the training data accuracy.
- **APPROVE** the GAP Analysis against the HIW report 2019 into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.

2. SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP HIGHLIGHT REPORT

The Safeguarding & Public Protection Management Group met on the 9th of September 2022 and agreed the following areas for highlighting:

ALERT / ESCALATE	• **Safeguarding & Vulnerable Adult Mandatory & Statutory Training Compliance:** The group could not receive assurance regarding the accuracy of the training compliance data provided. Significant work had been undertaken following the previous group to cleanse the Safeguarding and Vulnerable Adult training data aligning to the outcomes of the Training Needs Analysis. Final data validation is being undertaken by Workforce and Organisational Development Colleagues.

2

ADVISE	• ***HIW Report GAP analysis***: A paper was provided to the Group for endorsement providing an update on the 24 recommendations included in the Healthcare Inspectorate Wales (HIW) January 2019 report into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. (2019). A number of recommendations were identified as being non applicable for the Trust.
ASSURE	• **Divisional reporting templates:** The Group approved an enhanced divisional safeguarding report template. These templates will also be used for reporting through to Divisional Senior Management Team. • ***Health & Care Standard 2.7 Quarter 2 Position:*** Divisional assessments and Trust priorities were reviewed and discussed. The Trust as a whole and both Divisions continue to score a level 4 (unchanged from previous quarter). All identified improvements have been incorporated into the work plan of the Safeguarding and Vulnerable Adults Management Group. • The Group received an assurance paper in respect of the ***lessons learnt detailed in the report arising from the David Fuller case*** in England (related to mortuary governance). In November 2021 the Trust Welsh Government requested assurance on the Cold Room Security, specifically Procedures for Body Storage. The group was presented with an improvement plan that has been actioned in terms of cold room process and the group were satisfied with the steps taken at VCC to improve security. The Group was assured that all required actions to learn from these events had been taken.

3

	• **Safeguarding and Vulnerable Groups, work Programme and audit plan 2022-23** was received and is progressing with no anticipated delays.
INFORM	• ***Safeguarding Maturity Matrix 2022-2023:*** The Safeguarding Maturity Matrix is a self-assessment that aims to provide assurance, share practice and drive improvements. ABUHB and Velindre University NHS trust were approved as the pilot sites for a revised Safeguarding Maturity Matrix (SMM) self-assessment tool. The intention of the new tool is unchanged, the tool has been strengthened in respect of changing the indicators for assessment to reflect adult and child safeguarding, also changing the scoring system by introducing a RAG rating. The Group reviewed the completed tool, made some suggestions for enhancing submission further and agreed to transfer all required improvements in the work plan of the group. The submitted Safeguarding Maturity 2022/23 Matrix is attached in ***Appendix 2***).
APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	Appendix 1: GAP Analysis against the HIW report into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. (2019) Appendix 2: Safeguarding Maturity Matrix Pilot final submission.

3. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the training compliance status and actions being taken to address the training data accuracy.
- **APPROVE** the GAP Analysis against the HIW report 2019 into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.

4

Review of transferable learning from the HIW Special Review of ABMUHB's handling of the employment and allegations made against Mr. W

HIW Recommendation		Related H&C Standard	VUNHST Current Position (August 2022)	Additional Action Required	Deadline	Owner
1	The HB must ensure the redeployment policy is consistently followed	7.1 Workforce	A revised procedure for redeployment was endorsed by EMB on 01/08/2022. This will go to September's QSP for approval. The redeployment of staff procedure and the required documents to implement the procedure have been updated. These include new 'notes' sections that: provide clear advice to employees; and manager's ensuring the process is followed correctly.	SOP for the application of the procedure within Workforce team – COMPLETED	September 2022	Head of Workforce
2	The HB needs to consider how occupational health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned	7.1 Workforce	Occupational Health reports are sent directly to the referring manager for consideration. WOD are copied into the email and a 121 meeting is arranged between the manager and WOD to implement any recommendations of the report.	None	NA	Workforce and OD Team
3	The HB must ensure the suspension	7.1 Workforce	Regular manager training on people management (including	None	NA	Workforce and OD Team

	and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation		application of polices) is delivered by the WOD Department. Induction for all staff includes overview of policies and procedures including. Suspension of an employee, on grounds of an investigation, must be discussed with a Senior member of the Workforce Team. Managers must complete the suspension checklist and follow the disciplinary suspension flow process, clearly explain the reasons for the suspension to the employee. All employee suspensions due to disciplinary investigation are reported to QSP in line with the NHS Wales policy.			
4	The HB must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion	7.1 Workforce	The WOD Team regularly train staff internally on conducting a disciplinary investigation. There are currently 35 trained investigators in the Trust. Due to the Trust being smaller than many of our NHS Wales	A business case is in development for recruiting a bank Investigating Officer for instances when we cannot use internally trained IOs.	October 2022	Head of Workforce

			counterparts, there is occasionally a need for external investigators, to ensure timely and appropriately fair investigations are undertaken. The Workforce team monitor ER investigation process and timescales. The average time for ER cases from open to close, including those that progress to hearing, was 65 days in 21-22.			
5	The HB must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings.	7.1 Workforce 6.3 Listening & learning from feedback	The WOD Team ensure IO's are suitable qualified and trained and the service provides relevant clinical input to support the investigation. Review of cases 21-22 found across the Trust the investigations delays were due to the clinical / professional advice however this is inconsistent depending on the division.	WBS to date have provided adequate input from clinical / professional advisors to support investigations. Joint WOD / SLT plan required for VCC to make this more effective.	September 2022	Director of Velindre Cancer Centre Head of Workforce
6	WG through its work with safeguarding boards, needs to ensure that national safeguarding processes enable	2.7 Safeguarding children & safeguarding adults at risk	The Trust is represented at Cardiff and Regional Safeguarding Board (RSB) and the subgroup has representation from the Head of safeguarding and Vulnerable Groups and is	None		Head of Safeguarding and Vulnerable Groups

	consistency of reporting to facilitate benchmarking, and information sharing across Wales.		fully engaged in the work of the RSB.			
7	The HB should ensure there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents	2.7 Safeguarding children & safeguarding adults at risk	The Trust has identified named individual to provide strategic and operational leadership support and advice in relation to safeguarding and public protection. The Executive Director of Nursing and Service Improvement (supported by the Assistant Director of Nursing and Service Improvement) has delegated executive responsibility for the safeguarding and public protection portfolio.	None		
8	Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.	7.1 Workforce	NHS Wales review group in progress – needs an update on where this is and deadlines	To work with the NHS Wales group regarding a position.	National timescales	Head of Workforce
9	The HB must ensure all staff, where required by their role, receive a DBS check	7.1 Workforce	A task and finish group to review the current DBS potion in the Trust was set up by the Trust.	An audit of the Trust DBS procedures and processes has been undertaken to assess the Trust response to this	Completed	Head of Workforce

	following: • As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check • The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role • The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff • The responsibility for conducting DBS checks for redeployed staff & volunteers is clarified within HB policies.		The recommendations for action from this point have been addressed as part of a DBS Review Project.	recommendation and substantial reassurance was given by the auditors.		

10	The health board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training.	2.7 Safeguarding children & safeguarding adults at risk 7.1 Workforce	As a minimum, all staff and volunteers are required to undertake awareness level training. All staff with direct patient or donor contact are required to undertaken level 2 safeguarding children and level 2 safeguarding adults training. Compliance is monitored by the Education and Training Department and reported to the WOD Committee; it is recognised that further work is necessary for the organisation to be assured about compliance with required update timelines. Safeguarding training is offered in a classroom or staff are encouraged to access e-learning training materials. The Trust is in line with the NHS safeguarding training framework. Safeguarding newsletters have been	To improve training compliance across the divisions.	March 2023	All

			distributed to ensure staff are aware of training requirements dependant on role.			
11	The health board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases. This should include whether learning from Unit A has been shared with other units.	2.7 Safeguarding children & safeguarding adults at risk	Newsletters and safeguarding updates are circulated through comms. The safeguarding nurse is available for group or team sessions if learning is required in specific teams.	None		
12	The health board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance.	2.7 Safeguarding children & safeguarding adults at risk 7.1 Workforce	Safeguarding supervision is available for staff as required and following any safeguarding concerns. The Trust has agreed to the All Wales Safeguarding Best Practice Supervision Guidance 2017. The Head of Safeguarding works closely with both division leads for safeguarding and quarterly activity reports are developed and shared with the safeguarding and vulnerable adult's management group.	Work ongoing to consider methods of supervision across the Trust. Safeguarding supervision will be considered within this work and consideration for opportunities for safeguarding supervision.	March 2023	Head of Safeguarding and Vulnerable Groups.
13	The health board must review its processes to ensure all relevant	2.7 Safeguarding children &	Any allegations of Abuse that occurred within the in the Trust would be referred to Cardiff	None		

	safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person.	safeguarding adults at risk	Multiagency Safeguarding Hub. The Head of Safeguarding and Vulnerable Groups works closely with the local authority to make relevant enquiries. The Trust has evidence of compliance with the Wales Safeguarding Procedures. Level 3 safeguarding training is being delivered in the Trust. This explains the safeguarding process after a report is made and the responsibilities of practitioners to engage. In strategy discussions, meetings and conferences.			
14	The health board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed.	2.7 Safeguarding children & safeguarding adults at risk	Any allegations of Abuse that occurred within the the Trust would be referred to Cardiff Multiagency Safeguarding Hub. The Head of Safeguarding and Vulnerable Groups works closely with the local authority to make relevant enquiries and obtain feedback for staff following reports. Level 3 safeguarding training also explains the use of the protocol for the resolution of professional differences and encourage staff to challenge safeguarding	None		

			decisions if appropriate using scenario-based examples.			
15	The health board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units.	6.3 Listening & learning from feedback	A Supporting Vulnerable Groups Forum has been established to provide a forum and focus on the development of resources and guidance to support staff in addressing the needs of patients and family members who may have a cognitive impairment: engaging with health board specialist colleagues to support the group. The Trust have agreed developed resources to support and record best interest decision making and an advocacy referral pathway has been agreed to ensure signposting to statuary advocacy services. The Trust's safeguarding intranet pages have been redesigned to enable easier access to information and guidance including a specific tab on advocacy.	None		
16	The health board must ensure there is effective and timely communication with	6.3 Listening & learning from feedback	During safeguarding supervision staff are encouraged to ensure that, where appropriate, adults and children at risk are included	None		

	individuals and families (where appropriate) affected by incidents throughout the safeguarding process.		and updated on all safeguarding reports and associated actions.			
17	The health board must ensure staff understand that anyone raising a safeguarding allegation should be treated seriously in all cases.	2.7 Safeguarding children & safeguarding adults at risk	The Trust's safeguarding intranet pages have been redesigned to enable easier access to information and guidance. A safeguarding and public protection guidance booklet has been developed to provide staff with quick reference flowcharts and pathways to support and enable decision making and signposting. The Head of Safeguarding and Vulnerable Groups, is copied into all Safeguarding Datix reported incidents. Any allegations of Sexual or Physical abuse by a member of Trust staff would also require to be reported as a notifable incident in line with putting things right. The quality and safety team work closely with the senior nurse to ensure that any safeguarding incidents are also reported as a duty to report in line with SSWA (2014).	None		

			Safeguarding pocket guide resources have been developed and purchased for WBS collection teams who may not have easy access to the intranet site to support the recognition of safeguarding concerns and reinforce the duty to report.			
18	The health board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the health board should consider how it enables staff to feed in to improvements to practice.	7.1 Workforce 6.3 Listening & learning from feedback	Recommendation 18 and 21. The Trust has revised its professional abuse policy, in line with section 5 of the Wales Safeguarding Procedures. The policy gives clear direction of how professional allegations should be managed in line with the disciplinary process. This meeting would be a separate meeting to an adult at risk strategy meeting and would always be discussed with the local authority and attended by a senior member of the workforce team. There is an expectation following the meeting that the staff member would receive information and support that was appropriate to share and be kept informed.	Section 5 training is being incorporated into Workforce training for mangers.	October 2022	Head of Workforce.

			All employee's undergoing any form of investigation or with allegations raised against them for formal hearing are provided with a welfare officer, options of independent counselling through the EAP and occupational health support to ensure wellbeing support is provided.			
19	The health board is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing.	Governance, leadership & accountability	N/A			
20	The health board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance.	Governance, leadership & accountability	The Trust has a clear reporting structure regarding safeguarding concerns and information. A highlight report is provided following each safeguarding meeting with any risks highlighted for escalation.	None		

21	The health board must ensure there are effective arrangements and information systems in place to triangulate: • Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes. • Information from claims, concerns and incidents to highlight areas of concern.	Governance, leadership & accountability 2.7 Safeguarding children & adults at risk 3.4 Information governance & communications technology	As Recommendation 18 The all-Wales disciplinary process is clear in the governance route of all suspensions and the standard operating procedure within WOD follows this. Trust safeguarding procedures have been updated to reflect section 5 of the Wales Safeguarding Procedures.	None		
22	The heath board must ensure there are clear and effective pathways for sharing learning from safeguarding and incidents throughout the health board.	Governance, leadership & accountability 2.7 Safeguarding children & adults at risk	The Head of Safeguarding and Vulnerable Groups attends national safeguarding meetings and communication is circulated across the Trust.	None		
23	Welsh Government should consider how a more robust mechanism for sharing safeguarding learning	2.7 Safeguarding children & adults at risk	The Trust is represented at National and Regional groups. Work is still ongoing with the Single Unified Review Process.	None		

	can be developed across Wales.					
24	The health board must progress a formal commissioning arrangement, across the three health board areas, regarding the provision, planning and performance monitoring of learning disability services provided.	Governance, leadership & accountability	N/A			

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

MEDICINES MANAGEMENT GROUP HIGHLIGHT REPORT
January – June 2022

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Usman Malik, Principal Pharmacist Clinical Services Bethan Tranter, Chief Pharmacist
PRESENTED BY	Usman Malik, Principal Pharmacist Clinical Services Bethan Tranter, Chief Pharmacist
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VCC	Velindre Cancer Centre
MMG	Medicines Management Group
SST	Site Specific Team
SACT	Systemic Anti-Cancer Therapy
KPI	Key Performance Indicators
NICE	National Institute for Health and Care Excellence
IPFR	Individual Patient Funding Request
SABR	Stereotactic Ablative Radiotherapy
SSTF	Start Smart Then Focus
ARK	Antimicrobial Review tool Kit

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 Medicines Management Group.

Key highlights from the meeting are reported in Section 2.

The Quality, Safety and Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	MMG works alongside Site Specific Teams (SSTs) and individual clinicians to update clinical guidelines related to their area of practice. The number of clinical guidelines has significantly increased over the past 2-3 years which is a reflection of the introduction of new indications and novel therapies. It is now in excess of 100, so the mechanism for updating them is continuously being reviewed. A 3 yearly cycle of updating these guidelines has been devised which may occur sooner in response to a change in practice. There are 35 clinical guidelines that needed to be updated during this 6-month period and 17 (49%) were completed in the time period and uploaded onto the intranet site . A further 11 have since now been updated and reviewed awaiting uploading. MMG has a clear process for prioritisation of clinical guidelines where there have been changes in practice or new treatment options identified. For the remaining guidelines that still require updating, MMG undertakes an initial review to ensure they remain clinically appropriate. Given the volume and intensity of this work, dedicated capacity from pharmacy and clinical staff is being identified to ensure we can continue to meet our requirements for maintaining up to date clinical guidelines. It is expected that the Pharmacy Capacity Review, which is currently being undertaken, will support the realization / operationalisation of the pharmacists intended job plans. This will enable development of SST specialist pharmacists who, with dedicated time within their working weeks, can lead on guideline development and upkeep across the spectrum of medicine management topics in partnership with medical colleagues.
ADVISE	Between Jan – June 2022, 22 IPFR requests have been reviewed by the VCC IPFR Advisory Group. Of these, 20 requests have been approved by either VCC or the patient health board. 2 requests were declined by the patient's HB as considered treatments not routinely funded.

ASSURE	MMG has regular updates from several other groups within the cancer centre. These are highlighted below: **Medicines at Home Service (M@H)** The M@H service provide Key Performance Indicators (KPI) along with a regular update of financial savings to MMG. To date, there have been no areas of concern identified. **Anti-Microbial Team (AMT)** Assurances of good Antimicrobial Stewardship (AMS) involves a monthly audit against the national 'Start Smart Then Focus' (SSTF) measures. The national measures, which form part of the Welsh Government Improvement Goals for 2021/22, are made up of 4 individual KPI's which all hospitals in Wales have to audit against. Currently VCC are performing above the national average against these SSTF measures. VCC was the first NHS organisation to fully implement the Antimicrobial Tool Kit (ARK) chart in all clinical areas and have undertaken a qualitative assessment of its impact into VCC. The overall results of this assessment were excellent, and no areas of concern have been recognised. Additional medicines management practices that MMG have oversight include the following: • Review, approve and continue to have governance oversight of all unlicensed and 'off-label' medications. From January – June 2022, there have been 10 medication requests which have all been approved by MMG as clinically appropriate. • As a review of Patient Safety Notices, work is ongoing with Patient Safety Notice 055 relating to Safe Storage of Medications. An action has been developed which is monitored via MMG. • Monitoring and if required, managing the impact of medication shortages / medication discontinuation. Also, oversight of national drug recall alerts and drug shortages, whether they impact on VCC and undertake appropriate action as needed. Between Jan – June 2022, there have been 27 drug recall alerts and 21 drug shortage alerts, all of which have been managed by pharmacy to ensure ongoing patient care. • Continual monitoring of the drug expenditure including the general drugs budget, the high-cost drugs budget and the NICE drugs budget. All drug expenditures are within budget. • Ownership and responsibility of the 'Medicines Management Health and Care standards (Standard 2.6, Safe Care Medicines Management), to ensure that VCC is compliant against the standards set. VCC is currently shown to be compliant across all 4 standards.

INFORM	Moving towards a 6 monthly Assurance report from March 2023, which will bring all the elements of Medicines Management Service together including medical gases and the controlled drugs management assurance. This report will provide more detail on the performance against each area or responsibility for the MMG.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Medicines Management Group.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST
POLICY MANAGEMENT REVIEW AND COMPLIANCE
STATUS: OCTOBER 2022

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	Lenisha Wright, Business Support Officer Kay Barrow, Corporate Governance Manager Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	For **ASSURANCE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	26.10.2022	DISCUSSED & NOTED PROGRESS

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSPC	Quality, Safety and Performance Committee
IPCMG	Infection Prevention and Control Management Group

1. SITUATION

1.1 The purpose of this report is to provide the Quality, Safety and Performance Committee (QSPC) with assurance on the progress that has been made on the fifth tranche of work undertaken on the policy management and review programme in the September to October 2022 Governance reporting cycle. This programme of work forms part of the step change in the governance and management arrangements for all Velindre University NHS Trust (VUNHST) Trust wide Policies, launched in March 2022.

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

a. **NOTE** the Quality, Safety and Performance Committee Policies Extract Compliance Report as at **20/10/2022,** included at ***Appendices 1 to 8***.

b. Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

2. BACKGROUND

2.1 A comprehensive review was launched in March 2022 of the existing arrangements in place for the management and reporting of Trust wide Policies. The purpose of which was to identify any areas for improvement to strengthen the operation of the governance framework, increase control to enable effective assurance arrangements and build firm foundations for a step change in the management and reporting of all Trust wide Policies.

2.2 The scope of the audit applies to all Trust wide policies. As such, any locally managed controlled documentation, for example Standard Operating Procedures that only apply to one of the core Divisions i.e. the Welsh Blood Service or Velindre Cancer Centre of the Trust, are excluded from the scope of this work.

2.3 A total of **157** Trust wide policies were included in the assessment as part of the audit underway. As such, due to the scale and rigor required to complete a comprehensive and robust audit, a phased approach has been undertaken.

2.4 The **first and second tranche** of the review, reported through the March to May 2022 Governance reporting cycle included:

i. Approval of the revised Trust Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents, following a Pan-Wales benchmarking review of the 'Policy on Policy Management' from other Health Boards and Trusts.

ii. Root and branch audit of the status of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee.

iii. Creation of a new Document Control Register to accurately record the status and risk profile of all Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee, to underpin future reporting and enhanced governance arrangements.

iv. Assessment of the existing document control management systems in operation across the Trust to consider options available for the electronic management of all Trust wide Policies going forward, and action required to facilitate this.

2.5 The **third tranche** of the review reported in the July 2022 Governance reporting cycle focussed on monitoring progress.

2.6 The **fourth tranche** of work undertaken during July and August 2022 was a continuation of ongoing engagement and monitoring of progress.

2.7 *Policy Status:* In the assessing and the recording of the Policy Status, Table 1 below has been used to capture the various aspects of the policies status, including whether policies were in date or if review dates had passed. For those policies where review dates had passed, actions currently underway and other actions required were also captured which will form part of the ongoing monitoring by the Corporate Governance Team for scrutiny and assurance.

Table 1: Policy Status Key

POLICY STATUS KEY:
Policy in date
Policy review date passed – action underway/required
All Wales Policy review date passed – awaiting national review
Policies Archived

2.8 *Policy Risk Assessment:* Each policy passed its review date a Policy Risk Assessment has been undertaken to assess any risks associated with policies with review dates that have passed, and the associated actions required to address this. Table 2 below captures the outcome of this assessment.

Table 2: Policy Risk Assessment Key

POLICY RISK ASSESSMENT KEY:
Policy in date with no risk assessment required
Policy review date passed with low risk
Policy review date passed with moderate risk
Policy review date passed with high risk

2.9 *Document Control Register:* A Document Control Register was compiled during tranche one and has been updated through to tranche four to explain the outcome of the audit for effective monitoring and reporting purposes. This is included at ***Appendices 1 to 8***. Ongoing updates and progress will continue to be captured and recorded in the Document Control Register and reported against with each reporting cycle until compliance status is 100% at which time the frequency of reporting will reduce to quarterly updates.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Policy Compliance Status

A risk-based phased approach has been adopted for the Policy Compliance Audit.

The **first tranche** of work concentrated on an overall review of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee and was reported in March 2022.

The **second tranche** of work assessed the status of policies passed their review dates and engagement with policy leads. Whilst the first tranche audit excluded Workforce and OD Policies due to the volume held, these policies were included as part of the second tranche of this work. The outcome of the second tranche audit was reported in May 2022.

The **third tranche** of work focussed primarily on monitoring the progress made on the policy review status, consultation and submission of policies to their Approving Body and was reported in July 2022.

The **fourth tranche** of work undertaken during July and August 2022 was a continuation of ongoing engagement and monitoring of progress.

This report summarises the **fifth tranche** of work undertaken during September and October 2022 (up to 20th October 2022) and highlights the following:

i. Progress for policies identified for review, updates and approval by the Quality, Safety and Performance Committee (QSPC) tracked from March through to October is summarised under paragraph 3.1.1.
ii. Next steps are outlined of the ongoing work being undertaken (See tables 4, 5, 6, 7 and 8).
iii. An update of the Policy Audit Compliance Status is included in paragraph 3.1.2.
iv. Ongoing monitoring focuses on the status of policies under review, a breakdown of some of the detail is included in paragraphs 4 and 6 of this report.

There is an ongoing review and follow up of the latest policies held on record in order to collate a report including information on document control, review dates, policy status and risk assessments for the following directorates/departments:

- Quality and Safety
- Infection, Prevention and Control
- Health and Safety
- Estates, Planning and Performance
- Information Governance
- Digital Services

- Corporate Communications
- Workforce and Organisational Development

Following the initial collation of data a compliance report was compiled in March 2022 followed by progress and update reports in May, July and September 2022. This report provides progress and update of the compliance work undertaken during October and November 2022.A summary of the outcome of this exercise is included at ***Appendices 1 to 8***.

3.1.1 Collaborative Engagement Exercise

As indicated above, following an assessment of the policies currently held on record, regular collaborative engagement has been undertaken with each of the respective policy leads. Table 3 details the Policy Leads for each Directorate:

Table 3: Directorate Policy Leads

Directorates	Policy Lead(s)
Quality and Safety	Quality & Safety Manager, Claims Manager, Chief Pharmacist, Quality & Safety Facilitator, Senior Nurse Safeguarding & Public Protection, Head of Radiation Protection Services, Interim Deputy Director of Nursing, Quality & Patient Experience
Health and Safety	Health and Safety Manager
Infection, Prevention & Control	Head of Infection Prevention and Control
Information Governance	Head of Information Governance
Digital Services	Head of Digital
Corporate Communications	Head of Information Governance
Estates, Planning & Performance	Assistant Director of Estates Fire Safety Manager
Workforce and Organisational Development	Executive Director of Organisational Development and Workforce, Head of Workforce, Equality and Diversity Manager

The purpose of the ongoing engagement exercise is to confirm and validate the following:

- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

A summary is provided below of information gathered from the engagement exercise undertaken in the **fifth tranche** of this work undertaken during September and October 2022:

- ***Quality and Safety***

A total of 11 Quality and Safety Policies were included as part of the review process, one of which is an All Wales policy. In summary:

- In March 2022 six policies were outside their review dates.
- In June two of the six policies were updated and approved, with four policies under review.
- In July, two additional policies had passed their review dates, one of which is an All Wales policy.
- With the latest review in October, five policies **(45%)** are in date and six **(55%)** outside their review date, one of which is an All Wales policy. All five policies are undergoing the process of review and consultation in readiness for submission to the approving body.

Table 4 provides an update on the status of policies under review as well as next steps. Refer to ***Appendix 1*** for more detail.

Table 4: Quality and Safety Policy Progress Update

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-Aug	Sept-Oct	
Medical Gas Cylinders Policy	Review and update of the policy	Consultation	Further amendments following consultation	Review and consultation	April 2023 Submission to EMB and Approving Body
Ionising Radiation Safety Policy	Review and update of the policy	Submitted to Radiation Committee for discussion and input	Consultation which is expected continue through to September 2022	Approved by Radiation Protection Committee	Dec 2022 Submission to SLT April 2023 Submission to EMB and Approving Body
International Health Partnership Related Activity Policy	Established that policy requires complete rewrite	Review and update	Consultation Process to resume Q3	Ongoing consultation, review and updates	April 2023 Submission to EMB and Approving Body
Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Review and update of the policy	Submission to Professional Nursing Forum	Consultation Process to resume Q3	Approved by EMB	Nov 2022 Submission to Approving Body

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-Aug	Sept-Oct	
Safety Alert Procedure	Not applicable Policy in date	Not applicable Policy in date	Policy went out of date end June 2022 and is undergoing review to align with All Wales Patient Safety Solutions Guidance Policy	Ongoing review and updates	Dec 2022 Consultation April 2023 Submission to EMB and Approving Body
Compensation Claims Policy & Procedure				Policy went out of date Sept 2022	Review, updates and alignment with legislation underway April 2023 Submission to EMB and Approving Body

- ***Health and Safety***

The policy compliance status of all Health and Safety Policies remains at **100%** as reported in September 2022. Refer to ***Appendix 2*** for more detail.

- ***Infection, Prevention and Control (IPC)***

A total of 17 IPC policies have been included in the review, two of which are All Wales policies

- In March 2022 four policies were outside their review date.
- In June 2022 16 of the 17 policies were in date (94%).
- During July-August 2022 six policies had passed their review dates.
- With the latest review in October 2022, six policies **(35%)** are in date and 11 **(65%)** outside their review date, two of which are All Wales policies.

Table 5 provides an update of progress made to update IPC policies outside their review dates and next steps. Further detail is provided in ***Appendix 3***.

Table 5: Infection, Prevention and Control Policy Progress Update

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-August	Sept-Oct	
Management and Control of the Environment **(Cleaning)**	Upon review, it was decided that this remains a Quality and Safety Policy but falls within the remit Operations.	The policy has been reviewed and aligned a number of times to reflect changing COVID measures.	The Policy is currently being reviewed against the All Wales Cleaning Manual.	Policy archived & superseded by Decontaminatio n policy with accompanied Cleaning manual.	Decontamination policy reviewed to ensure all aspects of cleaning included. Cleaning manual - approval by IPC and EMB.

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-August	Sept-Oct	
Sharps Safety Policy & Addendum	Not applicable Policy in date	Not applicable Policy in date	Engagement with Policy Leads on the status of the policy	Review and updates	Dec 2022 resume ratification with IPCMG, Health and Safety, & Fire Safety April 2023 Submission to Approving Body
Hand Hygiene Policy	Not applicable Policy in date	Not applicable Policy in date	Engagement with Policy Leads on the status of the policy	Approved by IPCMG 28.09	Nov 2022 Submission to Approving Body
Guidelines on Single Use Medical Devices	Not applicable Policy in date	Not applicable Policy in date	Policy went out of date in July 2022	Review and update	Decision taken to archive guidelines and incorporate relevant aspects into the Medical Devices policy
Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	Not applicable Policy in date	Not applicable Policy in date	Engagement with Policy Leads on the status of the policy	Approved by IPCMG Sept 2022	Nov 2022 Submission to Approving Body
Framework Policy for Infection Prevention and Control	Not applicable Policy in date	Not applicable Policy in date	Policy review and updates and received at the IPC Management meeting held in July 2022.	Approved by IPCMG Sept 2022	Nov 2022 Submission to Approving Body
Infection Prevention and Control within Building Development, Change and Adaptation Policy	Not applicable Policy in date	Not applicable Policy in date	Not applicable Policy in date	Policy went out of date in Sept 2022	To be replaced by National All Wales document. IPCMG proposed current policy remain in place until All Wales renewed policy

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-Aug	Sept-Oct	
Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids	Not applicable Policy in date	Not applicable Policy in date	Not applicable Policy in date	Policy went out of date in Sept 2022	Discussion and decision about reallocation of policy to Health and Safety Decision will be shared in future reporting
Policy for the Prevention and Control of Transmissible Spongiform	Not applicable Policy in date	Not applicable Policy in date	Not applicable Policy in date	Policy went out of date in Sept 2022	Under revision April 2023 Submission to Approving Body

- ***Information Governance***

A total of seven Information Governance policies were included as part of the review process.

- In March 2022, it was identified that five Information Governance policies were outside their review dates.
- In July 2022, four of the five policies outside their review dates were approved by the QSPC.
- With the latest review in October 2022, six of the seven policies **(86%)** are in date, with the FOI procedure undergoing consultation in readiness for submission to the approving body.

Table 6 provides detail on the progress made March to October 2022 and next steps for approval of the Freedom of Information (FOI) Standard Operating Procedure (see ***Appendix 7)***.

Table 6: Information Governance Policy Progress Update

Policy Title	Progress March - August 2022				Next Steps
	March–April	May-June	July-August	Sept-Oct	
FOI Standard Operating Procedure	Upon review there was a rewrite of the procedure	Further review and updates to align with Legislation	Undergoing consultation	Consultation and further amendments	Submission to EMB - March 2023

- ***Digital Services***

A total of six policies were included in the review during Tranche one, two of which are All Wales policies (refer to Table 12). Refer to ***Appendix 4*** for more detail.

- During March-August 2022, policies outside their review dates were updated and approved by the approving body.
- With the latest review in October 2022, all policies are in date except for the Email Use Policy which falls within the remit All Wales remit.

- ***Corporate Communications***

One Corporate Communications policy was included in the review process, the Social Media Policy, which is an all Wales policy. The policy has been assigned to Health Education and Improvement Wales (HEIW) and is undergoing review. Refer to ***Appendix 5.*** Updates will be provided in future reporting.

- ***Estates, Planning & Performance (EPP)***

A total of 15 Estates, Planning and Performance policies were included in the review process:

- In March 2022, nine of the 15 policies **(60%)** were outside their review dates. All policies outside their review dates have been put through a rigorous review and consultation process.
- During May 2022, the Environmental Policy was approved
- During August-September 2022, the consultation process was concluded for the following policies:
  - Asbestos
  - Control of Contractors
  - Water Safety
- With the latest review in October 2022, 7 **(47%)** policies are in date and eight **(53%)** outside their review date. It was confirmed that the three policies mentioned above will be submitted to the approving body at its meeting in November. The remaining five policies are undergoing review and consultation in readiness for approval by April 2023.

Table 7 below summarises the progress made between March and August 2022, and next steps. Refer to ***Appendix 6*** for more information.

Table 7: Estates, Planning & Performance Policy Progress Update

Policy Title	Progress March to August 2022				Next Steps
	March–April	May-June	July-August	Sept-Oct	
Safety and Protocol Prevention of Fire and Arson	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation resumed	Review & consultation	Submission to approving body April 2023
Security Policy	Engagement and discussion on remit of the policy	Decision to be taken as to whether the policy falls within Operations or Estates	Review and updates finalised	Review & consultation	Submission to approving body April 2023
Protocol for dealing with suspect packages and bomb threats	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation resumed	Review & consultation	Submission to approving body April 2023

Policy Title	Progress March – October 2022				Next Steps
	March–April	May-June	July-Aug	Sept-Oct	
Control of Contractors	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation concluded	Consultation and further updates	Submission to EMB 26.10.2022 & QSPC 10.11.2022
Business Continuity Policy	Engagement and discussion on remit of the policy	Decision to be taken as to whether the policy sits within Operations or Estates	Consultation resumed	Review & consultation	Submission to approving body April 2023
Waste Management Policy	Policy Lead to be assigned	Policy Lead to be assigned	Policy reviews and updates resumed	Review & consultation	Submission to approving body April 2023
Water Safety Policy	Policy Lead assigned – Estates Manager	Policy review and updates resumed	Consultation	Consultation and further updates	Submission to EMB 26.10.2022 & QSPC 10.11.2022
Asbestos Policy	Content and relevance of the policy reviewed	Policy Lead to be assigned	Consultation	Consultation and further updates	Submission to EMB 26.10.2022 & QSPC 10.11.2022

- ***Workforce and Organisational Development (WOD)***

54 policies were included in the review process for Workforce and Organisational Development (WOD). Eight Policies have been archived therefore 46 policies have been included in the review.

- During September 2022 the following policies were approved by QSPC:
  - Equality & Diversity
  - Pay Progression (All Wales Policy)
  - Procedure for NHS Staff to Raise Concerns -Whistleblowing (All Wales Policy)
  - Special Leave Policy (All Wales)
  - Working Time Regulations
- With the review in October 2022, of the 46 policies, 9 are All Wales policies which fall outside the remit of the Trust. 17 policies **(45%)** are in date and 21 policies **(55%)** outside their review date.

Table 8 below summarises the progress made between May to October 2022 and next steps. Refer to ***Appendices 8a, 8b & 8c*** for more detail.

Table 8: Workforce and Organisational Development Policy Progress Update

Policy Title	Progress May to August 2022			Next steps
	May-June	July-August	Sept-Oct	
Study Leave Policy, Procedure & Guidelines	• Policy reviewed –established that significant rewrite is required • Policy lead assigned	Complete rewrite required	Review and rewrite ongoing	March 2023 Submission to Approving Body
Voluntary Early Release Scheme	Policy added to WOD tracker	Resumed review and rewrite of policy	Review and rewrite ongoing	March 2023 Submission to Approving Body
Maternity, Paternity, Adoption and Parental Leave Policy	Policy Review Completed	Consultation	Finalise consultation	Jan 2023 Submission to Approving Body
Recruitment of Locum Doctor Policy	• Policy reviewed –established that significant rewrite is required • Policy lead assigned	Policy review and rewrite	Review completed	Dec 2022 Consultation March 2022 submission to Approving Body
Annual Leave and Bank Holiday Policy	• Review underway • Discussion on protocol for Medical and Dental Terms and Conditions	Policy review and rewrite	Ongoing review	Dec 2022 Consultation Jan 2023 submission to Approving Body
Disciplinary Policy	Awaiting Welsh Government input	The review of this policy is on hold due to focus of NHS Employers on implementation of Respect and Resolution Policy as recommended by Welsh Government.	Review on hold	Jan 2023 – progress on the implementation of the Respect & Resolution Policy to be provided as well as status of Disciplinary policy
PADR Policy	Policy review underway	Review and updates progressing	Ongoing review & updates	Dec 2022 Consultation March 2023 Submission to Approving Body

Policy Title	Progress May to August 2022			Next steps
	May-June	July-August	Sept-Oct	
Sabbatical Leave Policy for Consultant Medical Staff	Policy review underway	Review and updates progressing	Consultation	Jan 2023 Submission to Approving Body
Mental Health, Wellbeing & Stress Management Policy	Policy review underway	Review and updates progressing	Review and updates ongoing in readiness for consultation	March 2023 Submission to Approving Body
Policy for Employing Ex-Offenders and people with a criminal record	Policy review underway	Review and updates progressing	Finalisation of review	Dec 2022 Consultation resumed March 2023 submission to approving body
Close Personal Relationships in the Work Place	Policy review underway	Review and updates progressing	Finalisation of review	Dec 2022 Consultation March 2023 Submission to Approving Body
Adverse Weather Policy	Policy review underway	Review and updates progressing	Review and consultation concluded Dec 2022	March 2023 submission to Approving Body
Homeworking Policy	Policy referred to Agile Working Programme Board	Feedback awaited from Agile Working Programme Board	Feedback awaited from Agile Working Programme Board	Feedback awaited from Agile Working Programme Board
Redeployment Policy (Ex OCP Redeployments)	• Review and updates completed • Decision taken to change from policy to procedure	Submitted to EMB 01.08.2022	Further updates following EMB	Jan 2023 Submission to Approving Body
Redundancy and Security of Employment Policy	• Policy reviewed –established that significant rewrite is required • Policy lead assigned	Policy Rewrite resumed	Review and consultation concluded Dec 2022	March 2023 submission to Approving Body
Applying for Incremental Credit for Staff starting or re-joining the NHS	Completed. Change from Policy to Procedure	Submitted to EMB 01.08.2022	Further amendments undertaken	January 2023 submission to Approving Body

Policy Title	Progress May to August 2022			Next steps
	May-June	July-August	Sept-Oct	
Policy on Reimbursement of Removal and Associated Expenses	Policy lead assigned	Review and update of policy resumed	Review and consultation concluded Dec 2022	March 2023 submission to Approving Body
Supporting Transgender Policy	Policy lead Assigned	Review and update of policy resumed	Ongoing review & updates	March 2023 submission to Approving Body
Dealing with Anonymous Communication Policy	Engagement and discussion between WOD and Corporate Communications	Discussion being held on remit of policy	Policy on WOD Register	March 2023 submission to Approving Body
Supporting Staff who are Carers	Policy Lead to be assigned	Review and updates resumed	Ongoing review and updates	March 2023 submission to Approving Body
Capability Policy and Procedure	Velindre feedback submitted to NHS Confederation May 2022	Awaiting feedback	Awaiting feedback	Awaiting confirmation on whether this will be an All Wales policy

3.1.2 Policy Audit Compliance Status

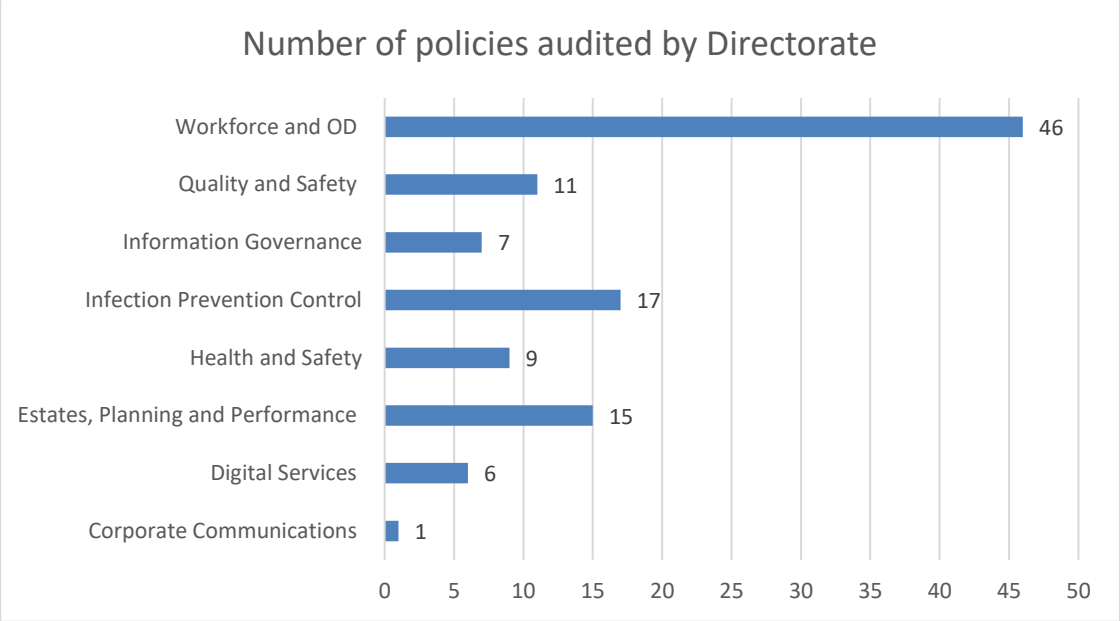
The findings of the Policy Audit Compliance Status for each of the directorates outlined above is reported below against the following categories:

- Policies reviewed by directorate
- An overview of the status of the policies
- Rationale for policies archived
- Policies passed review dates
- Policy risk assessment

- ***Number of Policies under review***

As at 20th October 2022, a total of 123 Trust wide Policies that fall within the remit of this Committee have been included in the review for ongoing monitoring and updates. This includes 10 policies that have been archived. A breakdown of the number of policies reviewed across each of the directorates is shown in Figure 1 below.

Figure 1: Number of Policies audited by Directorate



- ***Policy Status***

As at 20/10/2022, of the policies under review, **52 (42%)** are in date and **45 (37%)** have passed their review date. Sixteen policies **(13%)** are classified All Wales policies, and **10 (8%)**have been archived.

Table 9 below provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee.

Table 9: Overall Policy Status

Policy Status	Number of Policies
Policy in date	**52**
Policy review date passed – action underway/required	**42**
All Wales Policy review date passed – awaiting national review	**18**
Policies Archived	**11**

3.1.3 Archived Policies

It was reported in July 2022 to QSPC that ten policies have been archived. During the October review, an additional policy for was archived, therefore a total of 11 policies to date have been archived. Table 10 below provides information on the rationale for archived policies.

Table 10: Rationale for Archived Policies

Directorate/ Department	Policy Title	Rationale
Infection, Prevention and Control	Standard Infection Control and Transmission Based Precautions	Superseded by National IPC manual
Infection, Prevention and Control	Outbreak Management Policy	Superseded by National IPC manual
Infection, Prevention and Control	Policy for the Management of Prevention and Control of Legionellosis	Superseded by Water Safety Policy (under Estates)
Workforce & OD	Framework for the Development of Consultant Practitioner Posts	This is a framework not a Policy
Workforce & OD	Time off and Facilities for Trade Union Representatives	This is a framework agreed by NHS employers not a policy
Workforce & OD	Procedure for Delivering Interpreter Services	This is a procedure not a Policy
Workforce & OD	Recruitment & Retention Payment Protocol	This is a managers guide not a Policy
Workforce & OD	Grievance Policy	Superseded by Respect and Resolution Policy
Workforce & OD	Childcare Voucher Policy	Policy no longer relevant due to Legislation change
Workforce & OD	Shared Parental Leave Policy	Superseded by new Maternity and Parental Leave Policy
Workforce & OD	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Confirmed by NHS Wales that this is no longer a policy

Table 11 below provides an overview of the 123 policies audited per Directorate.

Table 11: Overall Policy Status by Directorate

Policy Directorate/ Department	Policy in date	Policy review date passed – action underway/ required	All Wales Policy review date passed – awaiting national review	Policies Archived
Health and Safety	9	0	0	0
Quality and Safety	5	5	1	0
Information Governance	6	1	0	0
Digital Services	5	0	1	0
Corporate Communications	0	0	1	0
Infection, Prevention & Control	9	6	2	3
Estates, Planning and Performance	6	9	0	0
Workforce and OD	12	21	13	8

4. Policies Passed their Review Dates

Table 12 below provides a summary of the number of policies passed their review dates excluding All Wales Policies.

Table 12: Policies passed their review dates

	Jan 2010 to Dec 2016	Jan 2017 to Dec 2018	Jan 2019 to May 2022	June 2022 to Sept 2022
Infection Prevention and Control	1	0	0	5
Quality & Safety	0	1	3	1
Information Governance	0	0	1	0
Corporate Communications	0	0	0	0
Digital Services	0	0	0	0
Estates	0	0	9	0
Health and Safety	0	0	0	0
Workforce & OD	4	1	16	0

Note: Policies with review dates between 2010 and 2016 have reduced from 6 to five with all five policies under review. It should also be noted that the above figures exclude All Wales policies that have passed their review dates and therefore fall outside of the Trust policy review programme.

5. Policy Risk Assessment

The policy audit included an exercise to establish any risks associated with policies that have passed their review date, including All Wales policies. Table 13 below provides an overall breakdown of policies audited that have passed their review dates by Directorate.

Table 13: Policy Risk Assessment

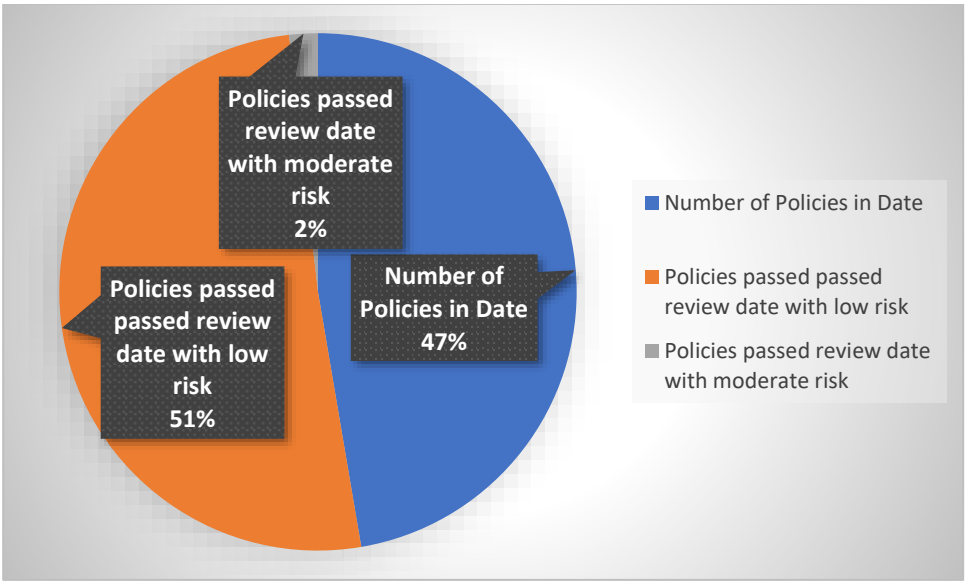
Policy Directorate	Policy in date with no risk assessment required	Policy review date passed with low risk	Policy review date passed with moderate risk	Policy review date passed with high risk
Health and Safety	9	0	0	0
Quality and Safety	5	6	0	0
Information Governance	6	1	0	0
Corporate Communications	0	1	0	0
Digital Services	5	1	0	0
Infection, Prevention and Control	9	7	1	0
Estates, Planning and Performance	6	8	1	0

Policy Directorate	Policy in date with no risk assessment required	Policy review date passed with low risk	Policy review date passed with moderate risk	Policy review date passed with high risk
Workforce and Organisational Development	13	33	0	0

5.1.1 Overall Policy Compliance Status

Figure 2 below represents the overall compliance status of the audit work on policies as at 20/10/2022 that fall within the remit of the Quality, Safety and Performance Committee.

Figure 2: Overall Compliance



6. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related 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.

7. RECOMMENDATIONS

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

a. **NOTE** the Quality, Safety and Performance Committee Policies Extract Compliance Report as at **20/10/2022,** included at ***Appendices 1 to 8***.

b. Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

APPENDIX 1: QUALITY AND SAFETY POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Quality & Safety	All Wales	Consent to Examination or Treatment - All Wales	Executive Medical Director	EMB - Endorsing for adoption QSP - Approval for adoption Trust Board - Noting	Jul-22	Sept 2022 Review/Consultation April 2023 Approving Body	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Quality & Safety	QS 03	Handling Concerns Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Apr-23	Approved: EMB & QSP Trust Board: 26.07	Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 01	Incident Reporting and Investigation Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Apr-23	Approved: EMB & QSP Trust Board: 26.07	Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 08	Policy for the management of Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-23		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 12	Safeguarding & Public Protection Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-23		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 04a&b	Compensation Claims Policy & Compensation Claims Procedure	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Sep-22	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 31	International Health Partnership related Activity Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Dec-19	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 19	Ionising Radiation Safety Policy	Executive Medical Director	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Nov-21	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 07	Medical Gas Cylinders Policy	Executive Medical Director	EMB - Endorsing QSP - Approval Trust Board - Policy Update	N/A	April 2023 Approving body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 25	Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-18	Oct 2022 EMB Nov 2022 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 02	Safety Alert Procedure	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Jul-22	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 2: HEALTH AND SAFETY POLICY REGISTER

Directorate/ Department	Policy Reference	Version	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Policy status	Policy Risk assessment
Health and Safety	QS 09	Version 6	Latex Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 14	Version 7	Safer Manual Handling Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 15	Version 7	Management of Violence & Agression Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 18	Version 7	Health Safety & Welfare Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Jul-25	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 24	Version 4	Medical Devices & Equipment Management Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Jan-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 26	Version 5	Safe Use of Display Screen Equipment & Appendices	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	May-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 30	Version 7	Lone Working Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 33	Version 4	Control of Substances Hazardous to Health (COSHH)	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23	Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 36	Version 1	Workplace Equipment Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Sep-22	Policy in date	Policy in date with no risk assessment required

APPENDIX 3: INFECTION, PREVENTION AND CONTROL POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Infection, Prevention and Control	IPC 03	Aseptic Non Touch Techniques (ANTT)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Infection, Prevention and Control	All Wales	Scottish Manual for IPC	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Missing	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Infection, Prevention and Control	IPC 15	Control and Management of Multi Drug Resistant Bacteria	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jun-24		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 04	Decontamination Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 07	Meticillin Resistant Staphylococcus Aureus (MRSA)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 11	Specimen Collection, Handling and Transport Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Dec-22		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 18	Tuberculosis Management	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Dec-24		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 01	Viral Gastro Enteritis (including Norovirus) Policy & Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 00	Framework Policy for Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 12	Guidelines on Single Use Medical Devices	Executive Medical Director	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 10	Hand Hygiene Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 21	Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 19	Infection Prevention and Control within Building Development, Change and Adaptation Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
~~Infection, Prevention and Control~~	IPC 22	Management and Control of the Environment **(Cleaning)**	Chief Operations Officer	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-10	Dec 2022 Consultation April Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Infection, Prevention and Control	IPC 06	Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Infection, Prevention and Control	IPC 13	Policy for the Prevention and Control of Transmissible Spongiform	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Infection, Prevention and Control	IPC 09	Sharps Safety Policy & Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 4: DIGITAL SERVICES POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Policy status	Policy Risk assessment
DIGITAL	All Wales	Email Use Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	Jun-18	Policy review date passed – action underway/required	Policy review date passed with moderate risk
DIGITAL	All Wales	Internet Use Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 05	Software Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 06	Anti Virus Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 11	Data Quality Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 14	Information Asset Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval for Adoption Trust Board - Policy update	31 July 2025	Policy in date	Policy in date with no risk assessment required

APPENDIX 5: CORPORATE COMMUNICATIONS

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Corporate Communications	All Wales	Social Media Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk

APPENDIX 6: ESTATES, PLANNING AND PERFORMANCE POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Estates, Planning & Performance	PP 13	Electrical Low Voltage Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 01	Fire Safety Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 10	Medical Gas Piped Systems Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 12	Operational Policy for High Voltage Electricity Supply Systems	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 11	Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 14	Ventilation Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 03	Environmental Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	May-25		Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 04	Asbestos Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Dec-20	Nov 2022 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Estates, Planning & Performance	PP 06	Business Continuity Policy	Chief Operating Officer	Quality, Safety & Performance Committee	Apr-21	Dec 2022 Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 05	Control of Contractors	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-21	Nov 2022 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 07	Protocol for dealing with suspect packages and bomb threats	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Jul-21	April 2023 EMB only	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 01a	Safety and Protocol Prevention of Fire and Arson	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Feb-21	April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 02	Security Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-21	April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 08	Waste Management Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Mar-21	April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 09	Water Safety Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-20	Nov 2022 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 7: INFORMATION GOVERNANCE

Directorate/ Department	Policy Reference	Policy Title	Policy Lead(s)	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Imformation Governance	All Wales	Information Governance Policy	All Wales Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23		Policy in date	Policy in date with no risk assessment required
Imformation Governance	All Wales	Information Security Policy	All Wales Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 08	Freedom of Information Act Policy	Head of Information Governance	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 01	Records Management Policy	Head of Information Governance	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 02	Data Protection & Confidentiality Policy	Head of Information Governance	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 13	Confidentiality Breach Reporting Policy	Head of Information Governance	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 08a	FOI Standard Operating Procedure	Head of Information Governance	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Apr-22	Submission to EMB - March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 8a: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Directorate/ Department	Policy Reference	Policy Title	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Capability Policy and Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Dress Code and Uniform Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/02/2018	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Exit Policy & Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2016	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Flexible Working Policy and Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Managing Attendance at Work Policy	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/10/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Menopause Guidance	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/12/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Organisational Change Redeployment Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Protocol on Collective Consultation of Proposed Radiance	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/09/2017	To EMB only (protocol)	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Upholding Professional Standards in Wales (Medical Staff Only)	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2018	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	WF 18	Alcohol, Drugs & Sustance Misuse Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2022		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 10	Employer Pension Contritubtions Alternative Payment Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Dates missing on front page	Currently updating & formatting policy Dec 2022 Submission to Approving Body	Policy in date	Policy in date with no risk assessment required

APPENDIX 8b: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Directorate/ Department	Policy Reference	Policy Title	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Exit Policy & Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2016	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Flexible Working Policy and Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Managing Attendance at Work Policy	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/10/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Menopause Guidance	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/12/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Organisational Change Redeployment Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Employment Break Scheme	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	02/01/2023		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 05	Equality & Diversity Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	31/09/2025		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Pay Progression Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	31/09/2025		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	31/09/2025		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 45	Homeworking Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2016	Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 43	Mental Health, Wellbeing & Stress Management Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 30	PADR Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2020	Review completed Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 50/ WF19	Policy for Employing Ex Offenders and people with a criminal record	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 17	Policy on Reimbursement of Removal and Associated Expenses	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Sept 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 8c: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Directorate/ Department	Policy Reference	Policy Title	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	WF 56	Smoke Free Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2022		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 54	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/07/2023		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 44	Working Time Regulations	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	31/09/2025		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 35	Annual Leave and Bank Holiday Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	June 2022 Review & updates Dec 2022Consultation April 2023: Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 34	Applying for Incremental Credit for Staff starting or rejoining the NHS	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Sept 2022 Review & updates Dec 2022 Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 48	Dealing with Anonymous Communication Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2021	Sept 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 45	Homeworking Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2016	Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 43	Mental Health, Wellbeing & Stress Management Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 30	PADR Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2020	Review completed Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 28	Recruitment of Locum Doctor Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2017	Dec 2022 Review and updates April 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 52	Redeployment Policy (Exc OCP Redeployments)	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 53	Redundancy and Security of Employment Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Dec 2022 Review and updates April 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 31	Sabbatical Leave Policy for Consultant Medical Staff	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Sep 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 40	Supporting Staff who are Carers	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/12/2021	Sept 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 46	Supporting Transgender Policy	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2021	Sept 2022 Review & updates Dec 2022 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Highlight report from the Chair of the Trust Estates Assurance Meeting

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development
PRESENTED BY	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NWIS	NHS Wales Informatics Service
CSTF	Core Skills Training Framework
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
HSE	Health and Safety Executive
RIDDOR	Reporting of Diseases and Dangerous Occurrences Regulations
nVCC	New Velindre Cancer Centre

1. PURPOSE

1.1 This paper had been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Trust Estates Assurance Meeting.

1.2 The Trust Estates Assurance meeting provides an overview of divisional meetings for Health and Safety, Fire Safety, Environment and Statutory Compliance and as such, this report now provides an overview of the Trust position.

1.3 Key highlights from the meeting are reported in section 2.

1.4 The Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Health and Safety** Mandatory Training levels are below acceptable levels across the board. Action has been taken to address the situation. Focus continues on this area with positive steps and responses received. Education & Development are working very closely with the H&S Team to ensure all managers are aware of available training. There remains an issue with staff being booked onto courses but the situation is improving. Education & Development have appointed a new trainer to support the Trust. Time will be prioritised to deliver inanimate load training. A Nurse Educator will complete the train the Trainer Patient Handling training in September enabling Patient Handling training to be carried out on the VCC site. Training dates have been finalised for October/November Asbestos PI claim has been received from a former employee. The Trust has issued a response to the RFI but as yet has received no further correspondence. Training statistics are reported as part of the performance management framework and have clear KPI's which are captured on a monthly basis. Figures are discussed monthly with various operational groups to support improving areas of concern with issues being discussed at quarterly H&S Board **Fire Safety** Mandatory Training levels are below acceptable levels across the board. Action has been taken to address the situation. A review of current fire safety training strategy underway in conjunction with Trust Education & Development Team; and a paper submitted to The Trust Education Steering group on 22/06/2022 and to the members of the Trust Health, Safety and Fire Management Group for ratification. The plan was endorsed by the Group

	Flexible approach taken to training to support departmental requirements. Training statistics are reported as part of the performance management framework and have clear KPI's which are captured on a monthly basis. Figures are discussed monthly with various operational groups to support improving areas of concern with issues being discussed at quarterly H&S Board **Environmental / Sustainability** Utility costs remain at an inflated level but are being closely monitored and reported working with NWSSP and Health Board colleagues to review costs. This is an ongoing concern although the Director of Finance is aware and is updated regularly. This topic is currently an agenda item for the All Wales Financial Managers Forum. **Estates and Statutory Compliance** The Trust has received a limited assurance result on a recent LV Audit conducted by Specialist Estates Services. This is largely due to the instability of the workforce while recruitment is taking place. An action plan is being drafted and necessary steps will be taken to bring the assurance level to an acceptable level. This will include actions being assigned an owner and delivery date with progress managed through the Estates Team and reported at the monthly meeting.
ADVISE	**Health and Safety** WBS are currently transferring risks from Datix v12 to Datix 14 New Trust Risk Assessment Policy circulated to senior management for comment. A series of seminars surrounding Management of Risk has been delivered by the Trust to staff. PMF reporting finalised for review. Ongoing reporting cycle has been finalised in support of provision of monthly updates. **Fire Safety** A review of Emergency Evacuation strategy(s) across Trust is underway supported by the Fire Safety Manager. PMF Reporting finalised for review. It is felt that PMF will support improvement of training figures and present a transparent view of where issues are. **Environmental / Sustainability** The Trust Sustainability Strategy was signed off by EMB PMF Reporting finalised for review and the process imbedded into the reporting cycle for ongoing updates.

	SUSTAINABILITY STRATEGY DEVELOPMENT PLAN Following approval of The Sustainability Strategy a development plan is being developed to prioritise actions for development over the next five years. The plan will highlight key capital investments and provide a cost benefit analysis. The prioritised plan will correlate with the Sustainability Themes and will consolidate the various action plans (for example, the Decarbonisation Action Plan and the Trust Travel Plan) into a final report of initial priority actions. A dashboard is underdevelopment, with a series of workshops undertaken. Following completion of the workshop/s, a consolidated list which will inform dashboard with progress and forecasting potential. Work is progressing to introduce the Velindre Veg Stand. This will support address of individual food waste, utilising food packaging and contributing to circular economy, and will be launched during November. Sustainable Autumn Jamboree - Following on from the success of the summer festival an Autumn festival is planned starting late October. **Estates and Statutory Compliance** Staffing still remains a major focus for the department and will do for the foreseeable future while recruitment is ongoing. Key appointments have been made and the team is expected to be at full strength by the end of January 2023 which will have a positive impact on the management and delivery of Estates Services. The team are starting to focus on the new structure and enhancing the process for management of compliance and reporting which will be complemented by the new CAFM System. The Water Safety Policy has been reviewed and is pending upload onto the Trust Intranet following approvals from EMB and QSP All actions arising from the recent Ventilation Verifications are listed in an action plan, works currently being costed. Funding available through the annual Estates Discretionary Capex. Electrical Safety Actions are in the process of being addressed action plan in place for monitoring and close out purposes.
ASSURE	**Health and Safety** HSG65 Audit scheduled for 10th November with RD&I. Hot surfaces audit completed action plan is being developed to prioritise and address identified actions. New training needs analysis to be issued to staff to improve accuracy of who required health safety and fire compliance training. Quite a few anomalies appear to be on ESR at present. This is likely to result in additional training needs being

identified since a number of staff appear to be missing competencies from their TNA.

On-line Electrical Safety Training developed by Swansea Bay Health Board now available on ESR. Education & Development have made the competency available to Velindre staff. Initial roll out identified as Estates staff, Operational Services and WBS Collections staff.

CDM training completed for Estates staff.

Fire Safety

Fire risk assessment are up to date and a new cycle of review will begin following the completion and submission of the annual fire audit [2021-22] in May 2022.

All fire safety risks are in the process of being uploaded onto Datix.

All actions are being monitored through the relevant divisional forums with upward reporting to the Trust Health, Safety and Fire Management Group. There are outstanding actions although these are not deemed to be high risk.

Welsh Government funded Fire Safety Projects are on Programme. All are overseen and will be signed off by the Trust Fire Safety Manager.

Environmental / Sustainability

Sustainability Strategy Launch will be followed by implementation over the next quarter.

Decarbonisation Plan implementation is planned over the next quarter

Travel Plan Launch & Implementation over the next quarter

Internet / Intranet – updated in line with the Travel Plan & Strategy

ISO14001:2015 contract awarded. BMTrada were successful for a second term. Surveillance audit planned for the end of October 2022

In August – September 2022, the nVCC Project and Trust Sustainability Team collaborated on the development of a 'Sustainable Summer Jamboree', hosted in a giant tipi on site at the Velindre Cancer Centre Staff Well-being Hub. This was part of the wider Hefyd programme of works and acted as a 'soft launch' to the public. The feedback from this was incredible, and a number of recommendations were made.

The Autumn Jamboree will be held from 31st October to 4th November (half term), in the Velindre Tipi at Noddfa. Update on recommendations from Sustainable Summer Jamboree Report:

- More permanent base for Ray of Light (all-weather and all-season friendly!) – the shipping container in the Noddfa garden has been identified for this,

and work is ongoing bring it up to scratch. A 'launch' party will be held on 2nd December.

- Increasing green social prescribing – aiming to run accredited green woodworking skills workshops this autumn to build benches, picnic tables and a roundhouse for the new Velindre Cancer Centre. To be based out of the tipi, over November – December 2022; roundhouse to be temporarily constructed at Noddfa and moved to nVCC site at a suitable point in/after nVCC construction.
- Capturing memories, stories and feelings of VCC to take to nVCC – have launched call to artists for the Moving House Art Project (Appendix B).
- A permanent 'non-hospital' space and programme for patient families to 'drop in' for arts and crafts – intention is to develop an ambitious proposal for charitable funds for the resources required to support this on a long-term basis. Will link in with therapies, volunteers and Velindre Crafters also.

Art and craft activities to improve staff wellbeing – in staff-friendly time – grant funding has been granted to undertake research into Arts in Health. We are compiling a proposal to use this to undertake a series of 'micro' 2-minute craft activities accessible to staff. The intention will be to analyse the impact on staff well-being – a joint piece of research between an Arts in Health Masters student and a psychology (or similar) student.

Decarbonisation Audit - Scope of works determined with NWSSP Audit and Assurance team. A Meeting was held with Internal Audit 20.10.2022 to review documentation. It has been noted the audit scope has changed – all LHBs / Trusts audited are encountering similar themes, therefore, the decision has been made the audit will be an overarching national thematic analysis. It is anticipated that the report will be received in November.

Environmental Compliance currently at 80.66%

Estates and Statutory Compliance

Funding has been approved to appoint key positions within the estates Team to support focus on a compliance and to aid transition and management of nVCC. Roles identified have been approved through the scrutiny and job matching process and have been appointed. It is thought that all new positions will be in post by the end of January 2023.

The appointment of the Estates Officers roles has proven to be beneficial to the overall compliance situation

VCC Compliance is at 94%

Park Road Compliance is at 92%

WBS Compliance is 93%

HQ 64%

	Dafn Compliance 56% Pembroke House Compliance 75% Continued focus on compliance and training A four-year Programme of works is being compiled and costed (rough order costs) to support financial planning and the transition to nVCC. The focus will be IP&C, H&S and statutory compliance, with elements of value add. This will be complete by November 2022. Three schemes have been put forward for assessment by the Capital Management Group following a request for deliverable schemes from Welsh Government. • VCC FF Ward Ventilation • Trust Wide Utility metering (support management of costs due to the economic environment) • WBS Liquid Nitrogen Cylinder All water sampling through August and September has returned no positive samples, which is hugely positive and demonstrates the focus in this area. The Capital Programme remains on track although there have been minor issues encountered and a small number of variations to schemes. All of which have been captured and reported to the Capital management Group.
INFORM	**Health and Safety** **Focus for the next period** • Roll out of the HSG65 Audit to VCC and some Departments in Corporate Division. Audit of the Estates Department against existing procedures and HSG65. • Implementation of Hybrid Working principles – health and safety support • Development of a Trust wide Health and Safety Induction • Roll out of paperwork to support the Control of Contactors Policy and CDM. • Trust wide risk assessments – Stress and Hybrid working • Risk assessment training – development • Health and Safety Management training – adaption of an on-line package being developed by CTBMHB • Development of Health and Safety Trust Pages • 'Reset' of Trust Health and Safety Manager's post • Joint visits to Donation sessions and increased contact at WBS. • Visits to WBS collection teams. • WBS Health Safety and Fire meeting to be arranged • Arrangements for Water Safety training to be rolled out to staff. **Fire Safety** Continuation with Fire Safety Improvement & Development plan(s) across Trust.

	Environmental / Sustainability **Priorities for the coming period include:** • Sustainability Strategy Launch and implementation • Decarbonisation Plan implementation • Recruitment for Placement Student • Internet / Intranet – updated in line with the Travel Plan & Strategy • ISO14001:2015 Surveillance Audit • Decarbonisation Internal Audit • Autumn Jamboree • Ray of Light Launch **Estates and Statutory Compliance** The Trust Have met with Synbiotix to view the new format for the CAFM System which has been populated with the Trust information. The System will be rolled out over the coming two months, which will be a major step forward in management of Estates Services. Handheld units will be trialled to automate works allocating and reporting. The team are currently supporting a number of schemes: • nVCC • IRS • RSU
APPENDICES	**NOT APPLICABLE**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	10.11.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	**26.10.2022**	**Discussed and Noted**

Acronyms

VCC	Velindre Cancer Centre	SLT	Senior Leadership Team
WBS	Welsh Blood Service	SMT	Senior Management Team
TCS	Transforming Cancer Services	EMB	Executive Management Board

1. BACKGROUND

The purpose of this report is to:

Share the current extract of risk registers to allow the Quality, Safety and Performance Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.

- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.
- Update on approach to risk appetite review for autumn 2022.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

2.1 Key points for the Trust Board:

- There remains substantial work required from Velindre Cancer Service to clarify the SMART action plans in Datix for their risks rated 15 and above.
- Note the discussion on risk appetite in the Trust Board development session on 8th November.

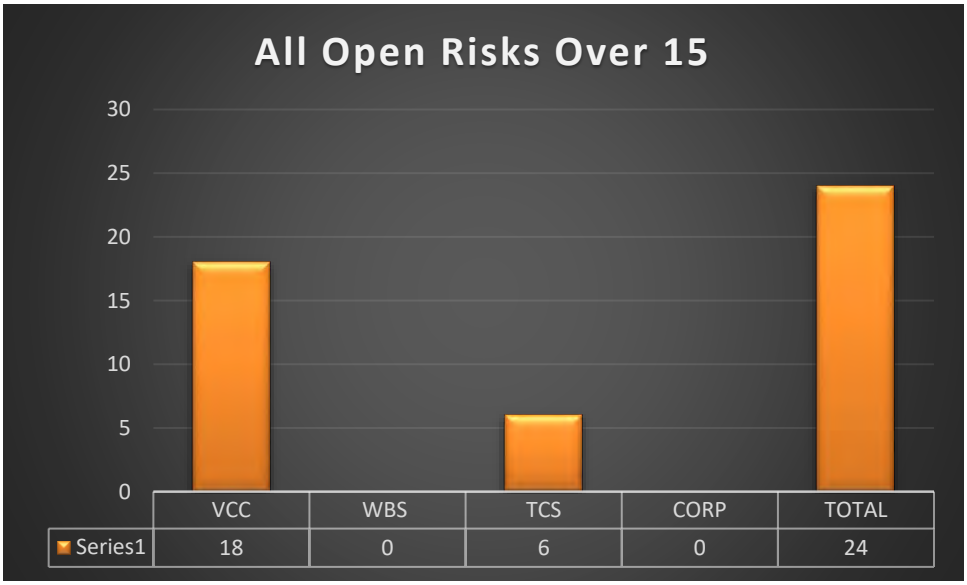
2.2 Trust Risk Register

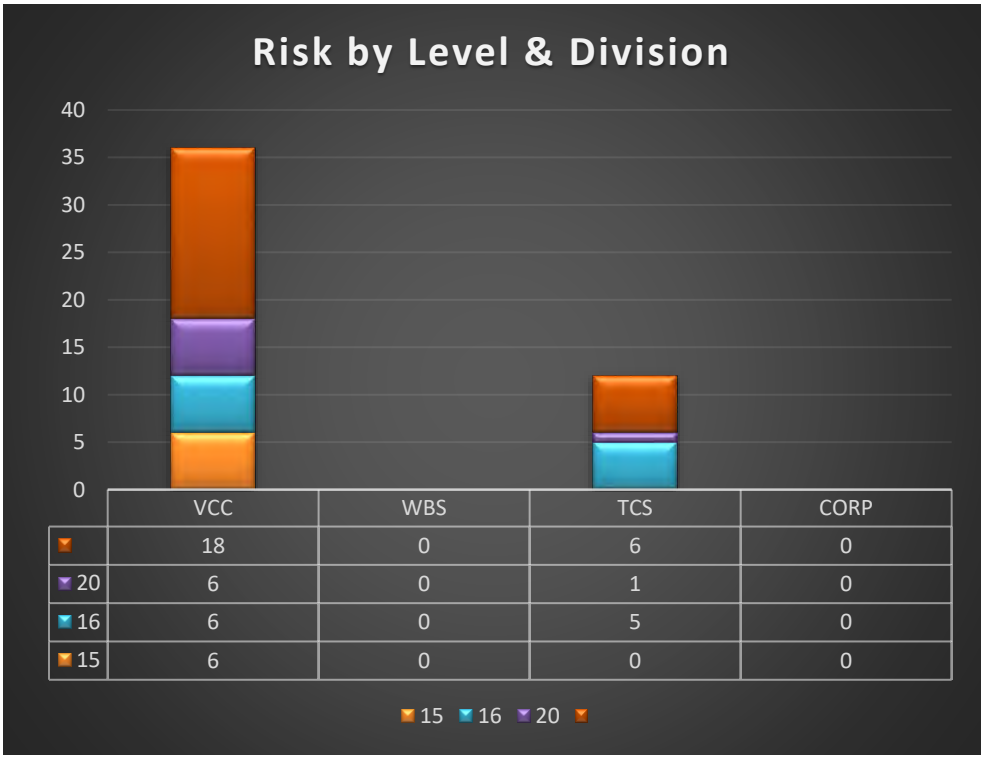
2.2.1 Total Risks

There are a total of 16 risks with a current risk level over 15 recorded on Datix 14.

2.2.2 Risks by Level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and division is also included.





2.2.3 Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

Of the risks recorded there are ten risks for Velindre Cancer Service, six risks for Transforming Cancer Services and no risks over 15 for the Welsh Blood Service and the Corporate functions.

Risks level 20

The table below provides a breakdown of level 20 risks.

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date
2701	Digital Health & Care record DHCR098(R) - There is a risk that not all the required triggers are accessible in the current SACT PDF treatment summary as a result of only two triggers being made available in WCP to select from (These triggers are when treatment is authorised and when treatment is given to a patient). This may lead to the PDF document not being kept up to date and becoming out of sync with the Chemocare system which has 9 additional triggers. These triggers are currently the same triggers that send SACT Treatment Summaries into Canisc, no additional triggers can be implemented to the live HL7 feed that is currently feeding Canisc.	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Phillip Allen	Cath O'Brien	The current design of the SACT PDF Treatment Summary will only be updated in WCP by two triggers from Chemocare. These triggers are when treatment is authorised and when treatment is given to a patient. These triggers are currently the same triggers that send SACT Treatment Summaries into Canisc, no additional triggers can be implemented to the live HL7 feed that is currently feeding Canisc. The additional triggers are:- CARE - Message sent when a Programme is created or modified UNAUTH - Message sent when treatment is Unauthorised DISP - Message sent when Drugs Prepared time is set in the Chemolist FINISH - Message sent when Treatment Finished time is set in the Chemolist ALLO - Message sent when a Drug or Treatment containing a Drug id Allocated DEFER - Message sent when Treatment is deferred or moved DEL - Message sent when Drug or Treatment containing a drug is deleted MODIFY - Message sent when a drug is modified SUBS - Message sent when a drug is Substituted	1. VCC Propose a disclaimer be added to the document stating the latest information is held within the VCC Chemocare system. 2. Phase II development to include the additional triggers start as soon as WPAS is implemented and the existing SACT Treatment Summary interface into Canisc is decommissioned.	20	17.10.2022
2735	Q-Pulse end of life	Compliance	Accepted	Velindre Cancer Centre	Rebecca Windle	Cath O'Brien	There is a risk of Physics working instructions and quality documentation being unavailable to staff after April 2023 due to the current version of Q-Pulse going end of life. A new system is required before the end of 2022 to ensure migration of documentation can be resourced alongside other projects.	1.looking to extend current contracts as an interim measure. Plans to particpate in Trust wide procurement process being led by WBS. Service specification being developed.	20	24.10.2022

2630	Digital Health & Care Record DHCR062(R) - There is a risk that as a result of suspensions and other reasons causing patients to still be 'live' in Canisc at the end of the 12-week dual running period, which may lead to the need to manually migrate IRMER forms that are nearly complete or fully complete, which would take a significant amount of time and may impact staff from physics, radiotherapy and consultant groups. This may impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Phillip Allen	Cath O'Brien	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirements, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	1. An impact assessment and project plan is being written, requiring further review. 2. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period.	20	30.12.2022

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date
2710	Price Hold - There is a risk that if the project is delayed beyond the anticipated financial close date (w/c 20th March 2023) that the cost of the project will increase due to the financial model being increased in line with changes to RPI.	Financial Sustainability	Accepted	Transforming Cancer Services	David Powell	Carl James	There is a risk that if the project is delayed beyond the anticipated financial close date (w/c 20th March 2023) that the cost of the project will increase due to the financial model being increased in line with changes to RPI.	1. Maintain the contingency within the current budget. Ongoing 2. Confirm with funders a new price hold. To be undertaken, 3 months before financial close. Seek additional funder if required. Not started 3. If an increase occurs due to delay there is an option to proceed to a new funding competition. Action not required at present. 4. Monitor project workstreams and related projects and manage risk that may impact on March 2023 financial close. Ongoing	16	28.11.2022

2714	There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	Accepted	Transforming Cancer Services	Craig Salisbury	Carl James	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Ongoing	16	27.10.2022
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	Accepted	Velindre Cancer Centre	Eve Gallop-Evans	Jacinta Abraham	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	1. An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. 2. Task and finish group to be established with key staff members in attendance.	16	30.11.2022
2513	Brachytherapy capacity	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	There is a risk that patient treatment is delayed as a result of a lack of medical workforce holding a prostate brachytherapy practitioners licence	1. Clinical service is dependent on a single handed consultant. A second consultation is undergoing training to obtain his licence. In order to achieve his license there is a requirement to see a number of patients which is taking time due to limited number of patients requiring this treatment	16	30.11.2

Risks level 15

Summary of level 15 risks are detailed in the table below.

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date

2187	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing.	Safety	Accepted	Velindre Cancer Centre	Rebecca Windle	Cath O'Brien	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in patient treatment delay, Radiotherapy treatment errors, key projects not keeping to time e.g. commissioning of essential systems, suboptimal treatment, either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice, Inability to provide engineering cover during weekend quality control activities, MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice, Development of workflow processes to increase efficiency, Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN), vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C), MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	1. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. 2. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. 3. Development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment.	15	30.12.2022

2612	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced resulting in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	Workforce and OD	Accepted	Velindre Cancer Centre	Sam Johnstone	Cath O'Brien	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	1. Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. 2. AOS sessions have been put into consultant job plans going forward.	15	28.12.2022
2253	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	David Mason-Hawes	Cath O'Brien	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	1. Implement DHCR (WPAS / WCP), to replace 'core' CANISC functionality in VCC. DHCR go-live schedled	15	01.12.2022
2205	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Dewi Johns	Cath O'Brien	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling.IRMER-lite form in WPAS will go live in November 2023	Replacement for CANISC Go Live 11th Nov 22	15	01.12.2022

2407	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline 4. IRS contract to be signed imminently. Implementation plan in development to align with RSC, VCC and equipment	15	31.10.2022
2400	Risk that there is lack of project support	Workforce and OD	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC 3. Programme report completed and more additional recruitment undertaken	15	30.09.2022
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met	1. Review Programme and Project resources / gaps and make approporiate investments where required. 2. Introduce new ways of working - VF & Strategic Infrastructure Board 3. Programme stocktake review undertaken. Risk of lack of capacity for SACTin new hospital (project 5) considered managable.	15	01.12.2022

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required.There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day.""There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	Mitigations is we are managing rotas and leave tightly. Action is in expansion of service via the WHSSC business case which will aid sustainability. Current capacity development in Medical Physics will support the wider provision of Brachytherapy.	15	25.07.2022

3. Development of Risk Framework

- Three levels of training to be delivered:
    - All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input from which all staff in the organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the process with Shared Services and is anticipated to be life on the online learning portal by the end of November 2022.
    - Management level – covering the Policy and Corporate Management Level Procedure and second form on Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk. Level 2 training has been completed at the Welsh Blood Service and the Corporate division, and training for Velindre Cancer Service will be completed by early December, with some sessions already delivered via their away day and additional sessions. .
    - Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

- Oversight of the development of the risk framework is via the Audit Committee. This includes specific action tracking following Internal Audit's report on the Risk Framework at the end of 2021.

- The November Board Development Session agreed the following next steps:
    - Proposal of new levels to EMB Shape in December 2022 for

endorsement to Trust Board in January 2023 for approval

- Refreshed Framework document to Audit Committee for endorsement to Trust Board in January 2023.

Further steps discussed to embed included:

- Link to IMTP clear and transparent.
- Level 2 access cohort will also receive specific regular risk briefings – including on Risk Appetite refresh outcome.
- Embedded into new cover paper format in risk section to encourage active consideration.
- All challenging each other in strategic decision making to make the risk appetite strategic direction active and relevant.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	If risks aren't managed / mitigated it could have financial implications.

4. RECOMMENDATIONS

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	10/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	**26/09/2022**	**Discussed and Noted**
STRATEGIC DEVELOPMENT COMMITTEE	**13/10/2022**	**Discussed and Noted**

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the Quality, Safety & Performance (QSP) Committee with a report on the Principal Risks identified in the Trust Assurance Framework that fall within the remit of this Committee (***ref. Appendix1***), which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.

1.2 The report also provides a summary of the ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 **Update on key developments:**

2.1.1 Link to Risk Register, Performance Framework and Quality & Safety Framework

It was agreed through the July governance reporting cycle that the first step change in the triangulation and linking of the Trust Assurance Framework with the Trust's other key frameworks will be to develop the link between the Trust Risk Management Framework. A preliminary exercise has been undertaken to link the Trust Assurance Framework Strategic Risks to the agreed risk domains on Datix, the outcomes of which are recorded on the Trust Assurance Framework Dashboard in ***Appendix 1***.

In addition, following the development of the Trust Performance Management and Quality & Safety Management Frameworks, key metrics relating to the strategic risks will also be linked during quarter 3.

2.1.2 Reverse Stress Testing

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible,

risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

This work will be progressed with the Trust Board via a targeted workshop at a Trust Board Development Session on the 8th November 2022. The outcome of which will be reported in the subsequent governance reporting cycle.

2.1.3 **Link to Strategy Development**

In reviewing the risk profile, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then be progressed in the Board development session on the 8th November 2022 as outlined in **2.1.2** above.

2.1.4 **Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.**

Collaborative work continues with the Datix Team at Hywel Dda Health Board to support increased automation of the Trust Assurance Framework regarding the development of the Trust's Principal risks within Datix Version 14. We now have baseline reference information, which is under review and in the process of being cross referenced with the Principle Risk information for the Trust Assurance Framework for the Trust.

Discussions took place in the Audit Committee regarding Power Business Intelligence for reporting against the Trust Assurance Framework and the benefits this can deliver. It was recognised that currently the availability of such resource within the Trust is extremely limited, although liaison within the Trust is underway regarding Power Business Intelligence knowledge and resource. Options to explore availability of external resource and support across NHS Wales was discussed. It was agreed that colleagues in Audit

Wales will assist in exploring any opportunities that may be available for the Trust to access and tap into the Data Analytics Team within Audit Wales.

2.2 **Further developments discussed and agreed through September and October 2022:**

2.2.1 **Mapping Trust Assurance Framework to governance cycle**

In line with the Board development discussions with Internal Audit and Audit Wales it has been agreed that there should be a clearer link between the Trust Assurance Framework and the governance cycle. This work has commenced and will continue to be progressed during the next reporting period and includes:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.
- Ensure each Committee scrutinise progress to address gaps in controls and Assurances within its scope – from November Committees onwards.
- EMB to agree Committee oversight:

01	Demand and Capacity	QSPC
02	Partnership Working / Stakeholder Engagement	SDC
03	Workforce Planning	QSPC
04	Organisational Culture	SDC
05	Organisational Change / 'strategic execution risk'	SDC
06	Quality & Safety	QSPC
07	Digital Transformation – failure to embrace new technology	SDC
08	Trust Financial Investment Risk	QSPC
09	Future Direction of Travel	SDC
10	Governance	AC

2.2.2 **Link to Audit tracker**

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account. In the September meeting, Executive Management Board agreed to complete this for the next reporting period in November 2022.

2.3 **Trust Assurance Framework Dashboard**

2.3.1 The updated Trust Assurance Framework Dashboard Report for the Principal Risks that fall within the remit of the Quality, Safety & Performance Committee is included at ***Appendix 1.***

2.3.2 To also note that in the Strategic Development Committee and Audit Committee, the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

2.3.3 **Actions on specific strategic risks**

- **TAF 01: Demand and Capacity**
  - **Residual Risk Score –** 16. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

- **TAF 03: Workforce Planning**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review

- **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

- **TAF 06: Quality and Safety**

The description of the risk has been amended during this review, now detailed as:
'Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

- **At present Residual Risk Score –** 15. This remains unchanged since the previous review.
- **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE), unchanged since the last review.
- **Sources of Assurance –** Gaps in controls and assurance have been amended following review;
    - Following approval of the Quality and Safety Framework approved in July 2022, implementation commenced.
    - Quality and Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.

  An additional gap in assurance has been identified:
    - The current mapped meeting reporting structure does not cover floor to board at divisional level.

- **Action Plan for Gaps Identified –** Amendments have been made to the action plan to address the gaps identified and target dates reviewed, however two actions remain overdue.

- **TAF 08: Trust Financial Investment**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** The reviewed sources of assurance have resulted in some additions:
    1. Key objectives of investment framework and relationship to contract performance and value identified.
    2. Investment framework to be articulated and agreed by Divisions and Executive Team.
    3. Investment framework to be applied within IMTP process.
  - **Action Plan for Gaps Identified –** There has been extensive review of the action plan resulting in the addition of new actions being added, detail below the main actions can be seen in Appendix 1:
    1. Review of contracting model for impact of COVID related measures.
    2. Establish Trust Investment Prioritisation Framework

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Committee is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard for the Principal Risks that fall within the remit of the Quality, Safety & Performance Committee, included at ***Appendix 1.***

b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2.

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance

09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

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

KEY CONTROLS

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

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

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

DEFINITIONS

CONTROL EFFECTIVENESS

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

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA

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

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporally reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruption environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

LIKELIHOOD MATRIX

LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

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

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Sep-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Oct-22	RISK DOMAIN — Performance and Sustainability
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	5	20	4	4	16	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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	Blood stock planning and management function WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against national and international standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

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 arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
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 need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
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 if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap anaylysis is underway across Health Boards. The IBI lens will be used on this project	Dec-22
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Contact has been made with HBs and work has been done on data sets and will continue to be reviewed in regular VCS/HB meetings	Complete
A formal demand and capcity review meeting has been established at V	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	3	12	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Internal Audit Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	PA				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA				

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA				
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

TAF DASHBOARD

WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully relaise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

		RISK SCORE (See definitions tab)								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
EXECUTIVE LEAD	Nicola Willams	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

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	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
							EMB	IA			Professional bodies	Not Assessed
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE	Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
							PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

TAF DASHBOARD

QUALITY AND SAFETY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser Paul Wilkins	Corporate OCP completed and recruitment commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Oct-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022	COMPLETE
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23

TAF DASHBOARD

QUALITY AND SAFETY

1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Jan-22
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.									
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Nov-22	**Goal 2**			**RISK DOMAIN**		**Financial Sustainability**				
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	G+A9:U12OING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

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 Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	**Support the embedding of investment framework within Divisions**	**David Osborne**	**Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.**	**Dec-22**
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Dec-22
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Dec-22

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

1.2	**Review of contracting model for impact of COVID related measures**	**David Osborne**	**Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.**	**Dec-22**
	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Dec-22
1.3	**Establish Trust Investment Prioritisation Framework**	**Matthew Bunce**	**Initial proposals prepared, Executive discussions to shape and take forward**	**Dec-22**