Bundle Public Quality, Safety and Performance Committee 15 September 2022

0.0.0 10:00 - PRESENTATIONS

0.0.1 Velindre Cancer Service - Patient Story

Led by Ceri Stubbs, Acute Oncology Clinical Nurse Specialist

Patient story for QSP 15th September C Stubbs(v2).pptx

1.0.0 10:15 - STANDARD BUSINESS

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

1.1.0 Apologies

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

1.2.0 In Attendance

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

1.3.0 Declarations of Interest

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

1.4.0 10:30 - Review of Action Log

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

1.4.0 Public QSP Action Log.docx

1.5.0 Matters Arising

Led by Vicky Morris, Quality, Safety and Performance Committee Chair
CIVICA Electronic Feedback System Update
Anti-Racist Wales Action Plan (to be included on future workplan)
Receipt of briefing on oral SACT patient education (to be brought to November 2022 Committee)
Health Inspectorate Wales Report - DBS Issues and Recommendations (to be brought to November 2022 Committee)

1.5.0 CIVICA Update.pdf

2.0.0 CONSENT ITEMS

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

2.1.0 10:40 - ITEMS FOR APPROVAL

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

2.1.1 Draft Minutes from the meeting of the Public Quality Safety & Performance Committee held on the 14th July 2022

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

2.1.1 Public Quality Safety Performance Committee Minutes July (v4VM).docx

2.1.2 Trust Policies for Approval

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

2.1.2 WOD Policy Updates for Approval.pdf

2.2.0 ITEMS FOR ENDORSEMENT

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

2.2.1 Capital Scheme for Ventilation at Velindre Cancer Service

Led by Carl James, Director of Strategic Transformation, Planning and Digital

2.2.1 QSP VCC Ventilation project 15 sept 2022.docx

2.3.0 ITEMS FOR NOTING

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 14th July 2022

Led by Vicky Morris, Quality, Safety and Performance Committee Chair

2.3.1 Private QSP Summary Minutes 14.07.2022(MB).docx

2.3.2 Vaccination Programme Board Update

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.2 Vaccination Programme Board Update QSP 15.9.22.docx

2.3.3 Information Governance Assurance Report

Led by Matthew Bunce, Executive Director of Finance

2.3.3 20220913-QSP IG Assurance Report - Quarter 2 2022-23-FINAL Amended.docx

2.3.4 Velindre University NHS Trust Annual Net Zero Report

Led by Carl James, Director of Strategic Transformation, Planning and Digital

2.3.4 Net Zero Reporting.pdf

2.3.5 Freedom of Information Requests

***Deferred to November 2022 Committee*

2.3.6 Trust School of Oncology Update

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.6 School of Oncology Update.docx

2.3.7 Quality Safety & Performance Committee - Policy Compliance Report

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

2.3.7 Policy Compliance Report.pdf

3.0.0 10:45 - Velindre Quality & Safety Committee for NHS Wales Shared Services

Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Services Partnership

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

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

4.0.0 MAIN AGENDA

4.1.0 11:00 - 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
Finance Report
Workforce Report
Staff wellbeing – Overview and future plans

4.1.0 QSP Finance Workforce Key Risks Paper - Final.docx

4.1.0a VUNHST M4 Finance Report.pdf

4.1.0b Trust-wide WOD Performance Report - July 2022.pdf

4.1.0c QSP Wellbeing Update15.9.22.docx

4.2.0 Quality, Safety & Performance Reporting

Led by Cath O'Brien, Chief Operating Officer

4.2.0 VUNHST JULY PERFORMANCE COVER PAPER FOR SEPTEMBER QSP FINAL 6.9.22.docx

4.2.1 11:15 - Welsh Blood Service Performance Report

Led by Alan Prosser, Director of Welsh Blood Service
Summary of Serious Adverse Blood-Related Events
Welsh Blood Service Letter (COVID-19 Vaccination Programme)

4.2.1 Jul 2022 WBS PMF Report .pdf

4.2.1a QSP MHRA SABRE reports 2022 final.docx

4.2.1b Welsh Blood Service letter.pdf

4.2.2 11:25 - Velindre Cancer Service Quality Safety & Performance Divisional Report

Led by Rachel Hennessy, Interim Director of Velindre Cancer Service
• Radiotherapy / SACT Capacity and Demand update.

4.2.2 VCC QS Report sept 22 v4 007092022.docx

4.2.2a VCC Performance Report - July 2022 FINAL .docx

4.2.2b VCC DC plan QSP v6 09092022.docx

4.3.0 11:45 - Medical Education Governance Framework

Led by Jacinta Abraham, Executive Medical Director

4.3.0 Medical Education Governance Report 2020-2022.docx

4.4.0 11:55 - Medical Examiner's Service & Mortality Framework

Led by Jacinta Abraham, Executive Medical Director

4.4.0 MES Update August 2022.docx

4.5.0 12:05 - Health & Safety Annual Report

Led by Carl James, Director of Strategic Transformation, Planning & Digital

4.5.0 Health & Safety Annual Report.pdf

4.6.0 12:15 - Welsh Language Annual Report

Led by Sarah Morley, Director of Organisational Development & Workforce

4.6.0 Welsh Language Annual Performance Report 2021-2022.pdf

4.6.0a Adroddiad Monitro 2021 22 CYMRAEG.docx

4.7.0 12:25 - Putting Things Right Report - Quarter 1

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

4.7.0 QSP - Putting Things Right Report - Quarter 1 2022-23 - 2022-09.docx

4.8.0 12:35 - Trust Risk Report

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

4.8.0 QSP TRUST RISK PAPER - FINAL VERSION2 -amended 14.09.2022.pdf

5.0.0 INTEGRATED GOVERNANCE

5.1.0 12:45 - Analysis of triangulated meeting themes

Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members
Analysis of Quality, Safety & Performance Committee effectiveness
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 Escalation*
- *For Assurance*
- *For Advising*
- *For Information*

7.0.0 ANY OTHER BUSINESS

15 Step Challenge update

7.0.0 15 step challenge update QSP 15.9.22.docx

8.0.0 DATE AND TIME OF NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 10th November 2022 from 10:00-13:00h via Microsoft Teams

Patient Story

Quality, Safety & Performance Committee

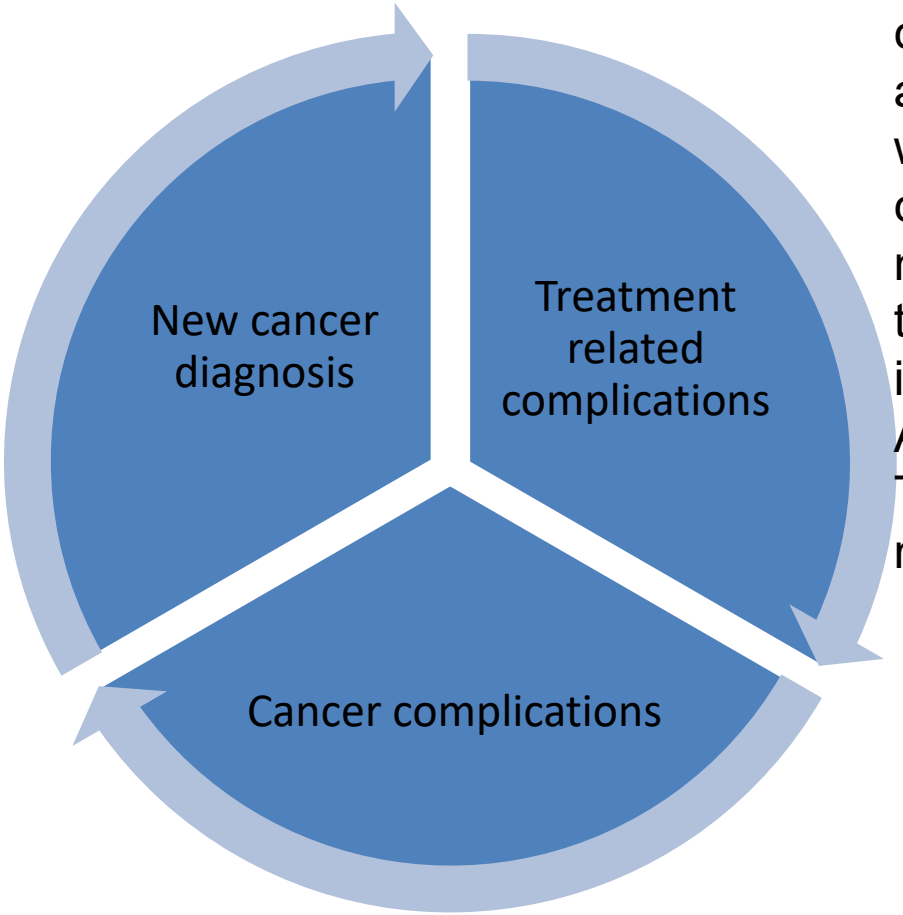
15th September 2022

Ceri Stubbs

Lead ANP AOS
Velindre Cancer Centre

3 Domains of Acute Oncology

Patients in whom a first diagnosis of cancer is made in the emergency setting.



Patients with known cancer who present as an emergency with acute complications of non-surgical treatment – including Systemic Anti-Cancer Therapy (SACT) or radiotherapy (RT)

Patients with known cancer who are acutely ill because of the disease itself.

The Patient

- 55 year old male Caucasian
- Lives with wife Emma and their border collie Dolly in a bungalow
- No children
- The couple have ageing frail parents has 2 siblings
- Manager of printing company
- Previously fit and well
- PMH - nil of note
- No regular medications and no known allergies
- Church of England
- Non smoker / no alcohol
- Enjoys outdoors – running, cycling, walking Dolly
- Enjoys theatre and reading Dan Brown and John Grisham

Timeline of events

November 21 newly presenting	December 21 MDT and RT	January 22 RT and confirmed diagnosis
• Collapsed at work cause unclear • Admitted to hospital scans / investigations etc • Brain metastases discovered (bleeding) • Newly presenting cancer of unknown primary (CUP) • Likely lung primary • Brain metastases resected • Wheelchair bound since surgery	• Discussed at Lung MDT ? Pathology of lung or melanoma primary • Seen by respiratory physician • Referred to oncology for Radiotherapy to brain • S/B oncology Whole Brain RT to start (WBRT) early Jan	• WBRT • Reviewed and symptoms managed well with neuro radiology team • Referred to dietician • Lung biopsy confirmed metastatic melanoma • Seen by Oncologist on 27th January • Aggressive disease with very limited prognosis and need to start treatment urgently

February 22
Immunotherapy treatment

- Treatment plan 27/01 for palliative Immunotherapy treatment (IO)
- Patient aware of aggressive nature of disease and urgency to treat
- Patient wants to give it “his best shot “
- Referral to pall care services
- Cycle 1 (IO) given on 2nd Feb - 6 days from OPD

February 22
Unwell after treatment

- Contacted treatment helpline (TH) c/o unwell pleuritic chest pain and coughing up blood
- 999 to local DGH
- Confirmed multiple pulmonary embolism – referral made to Cancer associated thrombosis (CAT) team
- Evidence of pneumonitis (inflammation)
- Admitted for 2 days
- Reviewed by AOS team at DGH and VCC team updated

February 22
Ongoing issues

- Further call to TH remains unwell very fatigued
- Reviewed on Assessment unit (AU)
- Covered with Antibiotics and commenced dose of IV steroids
- Inpatient admission avoided required daily reviews and steroids – which we were able to facilitate on AU and Ambulatory care units condition improved and steroids on reducing dose
- Later in month reported some visual disturbances via TH seen by optician – degenerative changes team aware

February / march 22

OPD reviews and treatment

- Seen in OPD clinic by oncologist things improving and patient much better
- Patient keen to continue with treatment
- CAT service MDT taken place
- Seen in CAT clinic 1/3 and advised on anticoagulation
- Ophthalmology follow up
- Pall care involved
- Continues on steroids but reducing dose

- Treatment
- Cycle 2 (IO) given on 22/2
- Cycle 3 (IO) given on 15/3

April 22

Unwell after treatment

- Contacted TH with diarrhoea and headaches end of march
- R/V on AU supportive medications commenced
- Medication advice
- Improved

- Cycle 4 (IO) given 05/4 – difficult decision – prognosis limited and scan does show some response to treatment

April 22

Further treatment toxicities

- Contacted TH with diarrhoea and generally unwell
- Reviewed on the AU
- Treated for urine tract infection with antibiotics
- Commenced IV steroids
- Admission avoided
- Daily follow up via AU condition improved

May 22
Ongoing issues

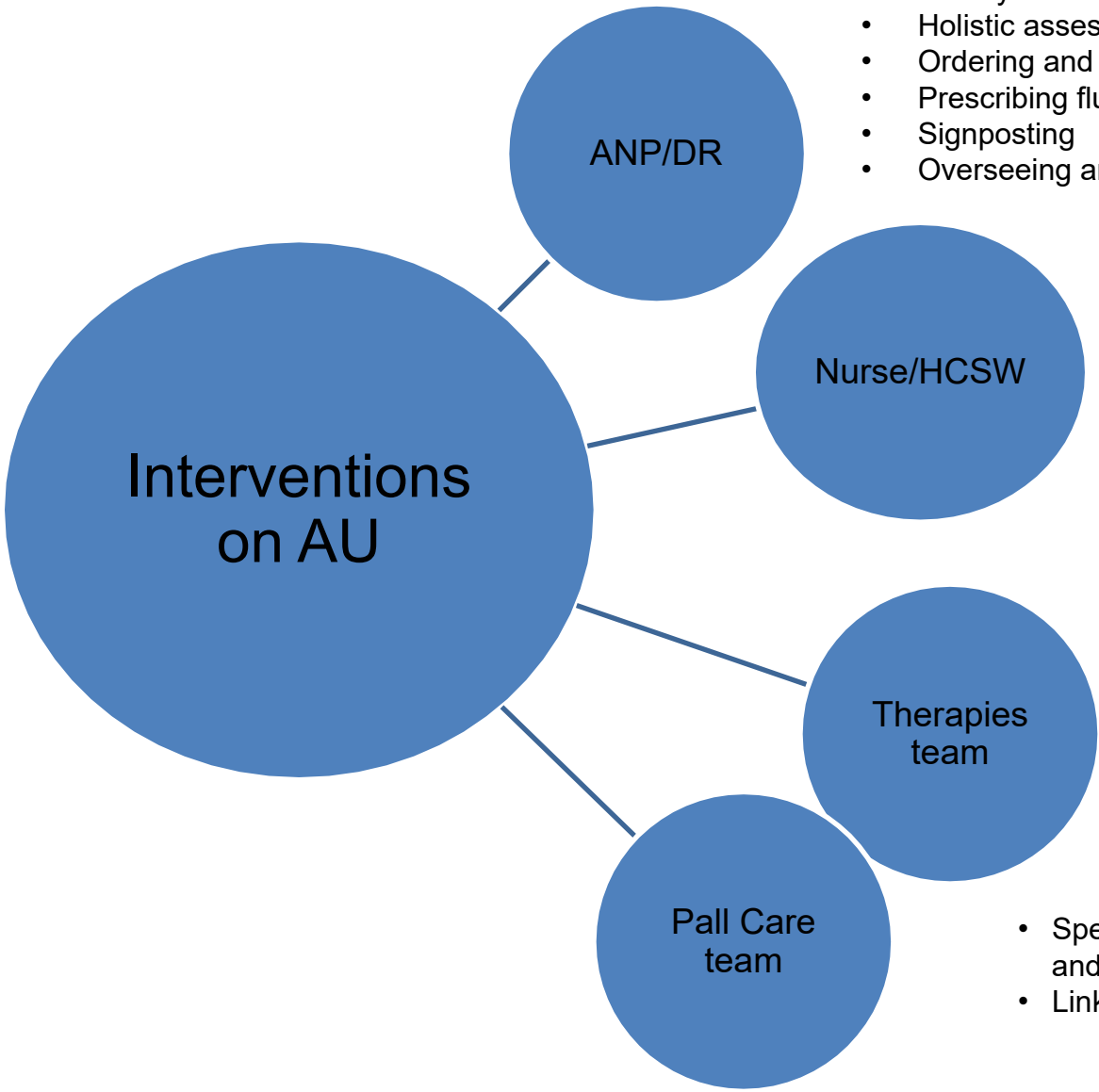
- Diarrhoea remains problematic
- Diarrhoea increases with reducing dose steroids regular reviews on AU with Consultant team resulting in referral to UHW gastroenterology team for a sigmoidoscopy - scope to assess if colitis (inflammation) present admitted to VCC for monitoring as no bed avail
- Complementary therapies
- Transferred to UHW for scope
- Scope shows inflammatory Bowel disease

June - July
More settled

- Treatment at DGH under gastro team - which settled symptoms completely
- Further Cycle of IO treatment on 12/7
- OPD reviews with consultant and team
- CAT clinic follow up continued on anticoagulation
- Reviewed by Community pall care team

August 22

- Further IO treatment on 9/08
- telephone call from team OPD with follow up
- Increased pain in both hips for past month
- Reviewed on the AU
- Pelvic and lumbar X rays no evidence of cancer - degenerative and osteoporotic changes detected
- MRI no evidence of spinal cancer or compression of spinal cord
- Seen by Pall care team
- Discussed at IO MDT – for long term bone protection with supportive medications
- Feeling better
- Celebrated his birthday with friends



- History and clinical exam
- Holistic assessment
- Ordering and interpreting results
- Prescribing fluids / medications
- Signposting
- Overseeing and coordinating care

- Cannulation, bloods,
- routine care
- safe administration of medications
- observations documentation / referrals etc

Fatigue management
Organising equipment /aids
Dietary supplements
Follow up community referral and care and repair
Neuro exam
Comp therapies where able – help with anxiety

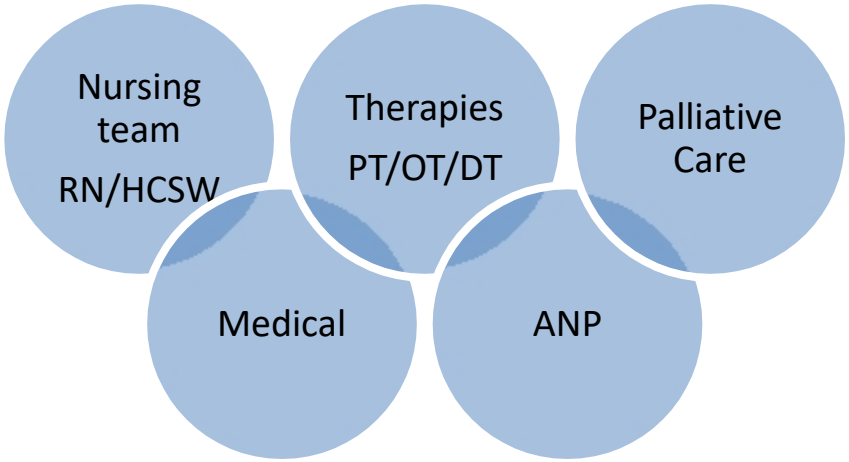
- Specialist advice with symptom management and medications
- Links / follow up with Community pall care team

Assessment Unit

Overview

- Opened September 2018
- Open Mon - Fri 8am – 8pm
- 6 assessment areas
- Single point of assessment
- SOP/ Referral pathways
- Assess to admit principle
- Admission avoidance
- Adjacent to ambulatory Care units

Staffing model



Assessment unit activity April 21- March 22

- Over 1600 patients seen - average 135/month
- > 75% patients same day discharge
- > 90% reviewed by senior clinician within 4 hours

Reason for referral to AU

- MSCC / RT
- SACT toxicity – N&V, Diarrhoea, temperature
- Generally unwell / fatigued
- SOB
- Pain
- Cancer associated thrombosis

Feedback from patient

Thank you for listening

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 24th March 2022 Committee					
2.1.2	A review of Trust policies adhered to by hosted organisations to be undertaken and documented within the overarching Trust Policy for Policies. ***Update*** **At the May Committee, the Chair requested a written cross-reference of relevant sections / agreements be included as a supporting appendix to the Trust Policy and Procedure for the Management of Trust-wide Policies and other Trust-wide written control documents to enable closure of the action.**	Lauren Fear	**Update 07/09/2022** - A supporting appendix has been completed and is included together with the approved overarching Trust Policy. This will be published and disseminated across the Trust.	01/08/2022	CLOSED
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.	10/11/2022	OPEN
2.1.1	Secretariat to amend May Committee minutes item 2.3.6 as per inaccuracy raised by DM and re-publish on website.	Secretariat	**Update 05/09/2022** - This action has been completed.	15/09/2022	CLOSED
2.3.11	Update to be provided to September Committee in relation to proposed resolutions for issues identified with implementation of CIVICA electronic feedback system and assurance of available resources to achieve this.	Nigel Downes/Anna Harries	**Update 07/09/2022** - This will be provided under Matters Arising at the September Committee.	15/09/2022	CLOSED
3.0.0	SH and GT to discuss outstanding issues (governance process in relation to manufacture of new products / classification of cytotoxic and immunotherapy medicines) with Colin Powell (Service Director) and summarise outcome at the September Committee.	Steve Ham/Gareth Tyrrell	**Update 05/08/2022** - Meeting scheduled for September 2022.	15/09/2022	OPEN
3.0.0	Include additional section of terms and definitions within Future Products Proposal Document to enable better understanding for the wider public.	Gareth Tyrrell	**Update 05/09/2022** - This is included in the September Committee papers.	15/09/2022	CLOSED

3.0.0	Summary of NWSSP compliance against relevant Health and Care Standards to be presented to September Committee.	Gareth Tyrrell	**Update 05/09/2022** - This is included in the September Committee papers.	15/09/2022	CLOSED
4.2.0	Steve Ham to issue letter from Minister approving the Trust's IMTP to all Independent Members and Executives.	Steve Ham	**Update 05/09/2022** - This action has been completed.	15/09/2022	CLOSED
4.3.0	SfM to update September Committee regarding actions taken to improve variance in PADR across divisions.	Sarah Morley	**Update 05/08/2022** - This is included in the Trust-wide Performance Report.	15/09/2022	CLOSED
4.3.1	PR to share information regarding 3 serious adverse blood related events as part of performance report at September Committee.	Peter Richardson	**Update 07/09/2022** - This will be provided as an additional item to the WBS performance report at the September Committee.	15/09/2022	CLOSED
4.3.1	AP to capture risks and mitigating actions in relation to management of performance under blue alert on WBS risk register.	Alan Prosser	**Update 06/09/2022** - A risk assessment has been completed and will be input into Datix as soon as possible.	15/09/2022	CLOSED
4.3.2	RH to bring detailed action plan addressing immediate workforce capacity issues within SACT and Radiotherapy to September Committee.	Rachel Hennessy	**Update 05/09/2022** - This is included in the September Committee papers.	15/09/2022	CLOSED
4.3.2	RH to confirm national guidelines in relation to pausing treatment pathway for patients suffering from COVID-19.	Rachel Hennessy	**Update 05/09/2022** - Treatment of COVID-19 patients continues on a clinical need basis (if no impact, treatment would be deferred for the short duration of COVID-19 infection). If clinically necessary	15/09/2022	CLOSED

			(palliative or symptom relief), treatment would continue.		
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** - The next quarterly PTR report will include comparison to other organisations.	10/11/2022	OPEN
4.5.0	ND to facilitate investigation into 25% of patients/donors not understanding their care and treatment, identifying themes, trends and learning.	Nigel Downes/Nicola Williams	**Update 16/08/2022** - Actions taken regarding 25% of patients/donors' understanding of their care/treatment to be included within future Patient & Donor Experience annual reporting.	May 2023	CLOSED
4.8.0	Health Inspectorate Wales Report detailing DBS issues and recommendations to be included as a main agenda item at the September Committee in addition to the Trust's current position in relation to the recommendations.	Nigel Downes/Tina Jenkins	**Update 07/09/2022** - This will be included under the Matters Arising section of the November committee following sight of this at the Safeguarding & Vulnerable Adults Management Group	10/11/2022	OPEN
4.11.0	ND to confirm whether Ligature and Ligature Point Risk Alert applies to the Trust.	Nigel Downes	**Update 08/09/2022** - This is not applicable to the Trust as we do not provide any form of mental health services.	15/09/2022	CLOSED
5.1.0	SfM to report on current position in relation to staff wellbeing at September Committee.	Sarah Morley	**Update 05/08/2022** - An overview of wellbeing support and plans going forward will be presented at the September Committee within the Finance/WOD paper.	15/09/2022	CLOSED
5.1.0	Consolidate and review agreed actions in terms of workforce, exploring whether further engagement is required and applying	Sarah Morley	**Update 05/08/2022** - The Integrated Workforce and Finance Paper for the September	15/09/2022	CLOSED

	timeframes for completion. To be brought to September Committee.		Committee contains actions and timeframes.		
5.1.0	ES/Secretariat to review QSP Cycle of Business, in particular July Committee due to high volume of annual reports.	Emma Stephens/Secretariat	**Update 05/09/2022 -** A meeting on 16th September 2022 identified further work which will be undertaken via individual meetings with Executive Leads.	15/09/2022	CLOSED

QUALITY, SAFETY & PERFORMANCE COMMITTEE

CIVICA Electronic Feedback System update report

DATE OF MEETING	15th September 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 of Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR NOTING

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on CIVICA implementation across the Trust as requested at the Committee held in July 2022.

2. BACKGROUND

At the July 2022 Committee the low number of patients / donors providing experience feedback through the CIVICA was escalated as an area of concern and a status update in respect of roll out and utilisation was requested for the following meeting.

In April 2021 the Trust procured the Patient / Donor Experience Software system

CIVICA. This system is now adopted as a Once for Wales system. Implementation commenced in April 2021 and was impeded by the pandemic and digital capacity. It was agreed from inception that the system would be implemented in two phases:

- Phase 1: across all areas of Velindre Cancer Service
- Phase 2: across all areas of WBS

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Update on CIVICA implementation since July 2022

Overall, there has been significant progress in relation to the implementation of CVICA across both divisions since the last Committee.

3.1.1 Velindre Cancer Service

CIVICA has now been fully implemented in all areas of Velindre Cancer Service. For the months of July and August there were 104 patients who provided feedback using the CIVICA system, 72 completed the 'Your Velindre Experience' (comprehensive experience questionnaire) and 32 using Friends & Family (short satisfaction questionnaire).

The last 3 months have focused on which approach best suits which area of the Cancer Service through shared learning. This has included exploring use of QR codes (your Velindre experience survey and Brachytherapy survey), and use of kiosk and ipads have provided application and links to the Friends and family surveys. Data is now being collated across all areas and a drive now to increase the response rates with internal signposting directed by each department.

3.1.2 Welsh Blood Service

All six collections teams within WBS are now live with the CIVICA system and the Apheresis team is going live in the second week of September 2022. Staff have been trained to access the app and support donors when needed. Each team have been provided with the QR code designed for that particular team and bespoke survey for their area, which has been a great success to those donors who are familiar with technology and some who aren't so familiar.

As of 7th September 2022, 768 Donors had provided feedback using the CIVICA System.

During each team training session staff were asked to relay the message that the survey has been implemented on the team and have found that due to this our donors are

forearmed prior to attending the Post Donation Care area (PDC) and so are automatically scanning the code to complete the survey whilst receiving their refreshments, others are offered the device to use.

The next areas to go live will be the Welsh Bone Marrow and Clinical services team.

Since implementation amendments have been made to some the questions, due to staff and donor feedback. It was identified by administrators of the system that the ease of changing questions proved extremely beneficial and deemed necessary as was the case in this scenario.

3.2 Outcomes to Date

3.2.1 Welsh Blood Service

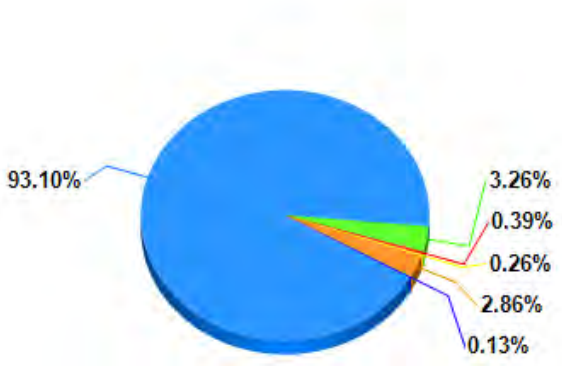
Results from: Bangor Team, East A, East B, East C, West Team, Wrexham Team

Start Date: 2022-08-22 00:00:00 **End Date:** 2022-09-06 23:59:59

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

Survey: Compliments and Concerns. West Team

Available Answers	Responses	Score (%)
5- Completely Satisfied	715	93.10%
4- Satisfied	25	3.26%
3- Neither Dissatisfied nor Satisfied	3	0.39%
2- Dissatisfied	2	0.26%
1- Completely Dissatisfied	22	2.86%
Other, Please Specify:	1	0.13%
Total	**768**	**100%**

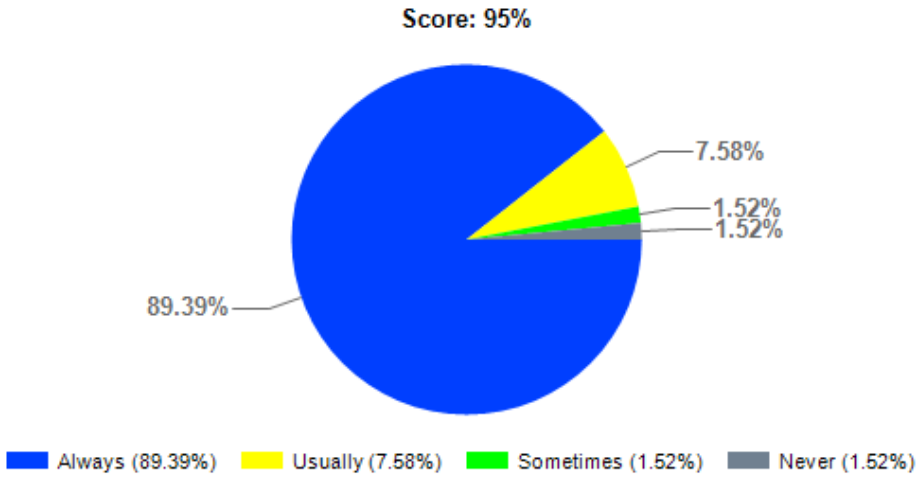


It was identified that the way questionnaire was worded was confusing donors and resulting in scoring completely dissatisfied rather than completely satisfied. The question has been changed to put the completely satisfied first. This change was made following discussions with donors.

3.2.2 Velindre Cancer Service

'Your Velindre Experience' (1st July – 31st August 2022)

Available Answers	Responses	Score (%)
10	53	80.30%
9	7	10.61%
8	4	6.06%
7	2	3.03%
6	0	0.00%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0	0	0.00%
Total	**66**	**100%**



Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

'Your Velindre Experience' Detailed breakdown

		2020	2021	2021	2021	2021	2021	2022	2022	2022	2022	2022	2022	2022	2022	2022	
Question:	Survey	Sept	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Benchmark
2. Did you feel that you were listened to?	Your Velindre Experience	100	97	93	98	95	96	94	95	98	96	100	94	96	94	83	85
3. Were you able to speak Welsh to staff if you needed to?	Your Velindre Experience	100	25	50	0	31	44	22	29	40	53	-	-	67	67	-	85
4. From the time you realised you needed to use the service, was the time you waited:	Your Velindre Experience	100	80	80	80	78	78	80	80	79	79	73	82	84	81	73	85
5. Did you feel well cared for?	Your Velindre Experience	100	98	93	99	97	98	97	97	98	97	100	100	100	97	88	85
6. If you asked for assistance did you get it when you needed it?	Your Velindre Experience	100	97	93	99	98	98	97	95	98	98	75	100	99	98	75	85
7. Did you feel you understood what was happening in your care?	Your Velindre Experience	-	96	89	90	92	94	95	92	91	94	75	92	99	93	88	85
8. Were things explained to you in a way that you could understand?	Your Velindre Experience	100	96	90	93	92	95	95	94	94	95	100	100	99	92	100	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your Velindre Experience	100	94	91	95	93	93	95	94	95	96	100	100	99	92	88	85
10. Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Your Velindre Experience	90	95	91	94	94	96	95	95	95	96	100	97	100	94	80	85
Overall:		99	94	89	93	91	93	93	92	93	93	90	95	97	92	85	92
Respondents:		1	69	57	71	108	58	63	83	101	72	1	6	38	32	2	

Friends and Family responses

Service Group	Location	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Velindre Cancer Centre	Ambulatory care	100.00%	0.00%	1	1	0	0	0	0	0
	Assessment unit	100.00%	0.00%	3	3	0	0	0	0	0
	First Floor-Ward	100.00%	0.00%	12	12	0	0	0	0	0
	Radiotherapy Department	100.00%	0.00%	7	7	0	0	0	0	0
	VCC Outpatients Department	100.00%	0.00%	9	9	0	0	0	0	0
	Total	100.00%	0.00%	32	32	0	0	0	0	0

3.3 Infrastructure

QR Code use: All departments have now been provided a QR codes for patients to scan with their devices, however this has proved challenging with connection to the internet on site. Staff have suggested providing the QR code on cards for patients to take out with them and complete at their convenience, unfortunately this does not facilitated patients use with own devices due to the poor internet connection for patients on site

Large screen fixed devices: Three large screens are now in place within the VCC: In Outpatients waiting room; Radiotherapy waiting room; and the entrance of CDU (this will be moved to Nuclear medicine) and handheld devices supplied to SACT. Further fixed devices are being rolled out.

Handheld devices: iPads with covers have been obtained and, as this is purely application based, this will allow survey completion without the need of connectivity via the cloud (Wi-Fi). These are in use in the following locations: Assessment Unit, Ambulatory Unit, First Floor Ward, Research & Development, Palliative Care, and SACT.

3.4 Staff Surveys

CIVICA has also been successfully used for training feedback for Information governance and will be used following Safeguarding training. In addition, the tool has been used for consultation on Trust wide Nursing and will also be used for the Nursing Strategy Consultation.

3.5 Velindre Leading the way:

The Trust is the first organisation in Wales to create a bespoke survey using the CIVICA system and the Trust is currently looking to expand this further into using the platform for additional staff surveys. A steering group has been running since June for staff use within School of oncology, Safeguarding, Information Governance and Radiation Protection (members added regularly).

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Effective Care
	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 **NOTE** the implementation developments since the last Committee.

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 14th July 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
Steve Ham	Chief Executive Officer	SHa
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
Nigel Downes	Interim Deputy Director of Nursing, Quality & Patient Experience (deputising for Nicola Williams)	ND
Carl Taylor	Chief Digital Officer	CT
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

0.0.0	PRESENTATIONS	Action Lead
0.0.1	**Welsh Blood Service (WBS)– Staff Story** Led by Alan Prosser, Director of Welsh Blood Service, supported by Stephen Pearce, Head of Manufacturing, Welsh Blood Service The Committee had received in advance a video outlining the critical role of staff in the performance of the manufacturing and distribution of blood and blood products within the Welsh Blood Service. The video outlined the importance of recruitment, development and retention of staff due to the unique skillset of the department and detailed examples of opportunities to facilitate this. The video focused on the journey of a staff member from initial recruitment to the position of a Medical Laboratory Assistant and progression to	

	Registered Biomedical Scientist, together with their anticipated continued further development to Specialist Biomedical Scientist and beyond. It was noted that the passion and commitment of staff was clear, and a result of the training and support provided by the Service. AP advised that a dedicated Education and Training Panel had been established for a number of years within the Service, assessing development of staff as they progress through the system. This extends wider than scientific services where appropriate, supporting retention and growing expertise across the breadth and depth of the Service. The story was considered a model example which could be applied to the organisation as a whole in terms of attraction, development and retention (growing our own workforce), as this is core to delivery of services. DM queried whether such opportunities were available to all staff throughout the Welsh Blood Service. AP advised that the Education and Training Panel meets on a bi-monthly basis, accepting applications Service-wide. Practical support is available for all staff undertaking development via a variety of routes. It was also noted that staff maintaining up to date knowledge via Continuing Professional Development (CPD) is vital due to the ever changing body of knowledge within the scientific field. CPD is critical to maintaining the quality of staff required for service delivery, in addition to being a registration requirement of Biomedical Scientists. NW suggested a review of education pathways (in conjunction with Workforce and Organisational Development) for specialist roles, conveying to staff that they will be supported in career progression and development. The Committee commended the Welsh Blood Service for their commitment to supporting the development of staff and acknowledged that this is a vital component in the effective retention of a niche skillset to maintain the quality of work undertaken by the Service.	
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science (*attending for item 4.1.0 only but above commenting on staff story*). • Cath O'Brien, Chief Operating Officer. • Hilary Jones, Independent Member. • Peter Richardson, Head of Quality Assurance and Regulatory Compliance (*attending for item 4.3.1 only*). • Emma Rees, Deputy Head of Internal Audit, NWSSP. • Stephen Allen, Chief Officer, South Glamorgan Community Health Council (CHC). • Huw Jones, Healthcare Inspectorate Wales. • Sarah Thomas, Healthcare Inspectorate Wales.	

1.2.0	**Additional Attendees:** • Katrina Febry, Audit Lead, Audit Wales. • Mair Evans, Principal Auditor (for Emma Rees) (NWSSP). • Gareth Tyrrell, Head of Technical Services (NWSSP) (*for item 3.0.0*). • Muhammad Yaseen, Head of Infection Prevention & Control (for items *4.6.0 and 4.7.0*). • Tina Jenkins, Senior Nurse Safeguarding & Public Protection (for items *4.8.0 & 4.9.0*). • Anna Harries, Senior Nurse Professional Standards & Digital (for items *2.3.11 & 4.10.0*).	
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 Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience and Jacinta Abraham, Executive Medical Director 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. Items not yet due for completion were not discussed and will remain open. The remaining Action Log was reviewed and the following amendments were agreed: ***(17.02.2022) - 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*** – LF advised that Professor Kelechi Nnoaham (Executive Director of Public Health at Cwm Taf University Health Board) had been invited to the next Board Development Session scheduled for October 2022 and that an update would follow at the November Committee. DM indicated despite public health expectations from the Trust, VUNHST Trust does not have a statutory duty for population health. Recent discussions have suggested that Professor Kelechi may attend Board Development on an annual basis to address any pertinent issues relating to the population served by the Trust. ***(24.03.2022) – Further work to be undertaken to transform how oral SACT education is provided to all patients via the Taskforce*** – As the target date had passed, it was agreed to close the action and a formal briefing to be issued to all members ahead of the September 2022 Committee in terms of approach and training methods. Receipt of this is to be noted in the Matters Arising section of the September 2022 agenda.	**LF** **COB**

	(2.1.2) – A review of Trust policies adhered to by hosted organisations to be undertaken and documented within the overarching Trust Policy for Policies. A written cross-reference of relevant sections / agreements be included as a supporting appendix to the Trust Policy and Procedure for the Management of Trust-wide Policies and other Trust-wide written control documents – A supporting appendix has been drafted for review by Executive Management Board on 1st August 2022. ***(4.2.0)*** - MB requested deletion of the words 'North Wales' from this closed action as they had been included erroneously. **Matters Arising** ***(4.5.0 – 12.5.22) - MB to provide an update on areas of deteriorating position within the IG Assurance Report at the July QS&P Committee*** – An initial review of work undertaken in relation to the self-assessment toolkit had identified that the Trust had underscored in a number of areas. Following a more detailed review of assessments, details of revised scores had been included in addition to a link to the Digital Health Care Wales website for those wishing to understand the process in more depth. Further work will be progressed over the next two years via a prioritised action plan. SH (as Independent Member for Information Governance) assured the Committee that regular meetings would be scheduled with MB and Head of Information Governance going forward to address the finer detail. ***4.16.0 (Trust Risk Report)*** LF reported that following Executive Management Board, the Trust Risk Report required a number of amendments, therefore missing the publication date for Quality, Safety & Performance Committee. Due to its significance, a short meeting with the relevant Independent Members will take place following the Committee to discuss the item prior to submission to Trust Board. LF noted that the Framework implementation had progressed positively and the policy had been endorsed by Executive Management Board, in addition to finalisation of the new Corporate-wide procedure and facilitation of level 2 training. VM suggested that all Committee attendees would receive the Trust Risk Report for review and comment. The Committee **NOTED** all updates as detailed above.	**LF** **Secretariat** **LF**
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 12th May 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair DM raised an issue of accuracy in relation to item 2.3.6 and gender identity. The report had stated that the Trust was unable to collect and record data on gender / gender identity. However, a number of tables within the report had used the term 'gender'. DM suggested that it would be more appropriate to label them 'male' and 'female'. The Secretariat will amend this section of the minutes before re-publishing on the Trust website. The Committee **APPROVED** the minutes subject to the required amendment. VM noted two appendices to the minutes. It was agreed that an update on outstanding actions in relation to the 'near miss' report (appendix 1) would be addressed via the next WBS performance report. The second appendix provided an update on the Trust's Operational Management Arrangements for Medical Gas Pipeline Systems to close action 2.3.8 from the May 2022 Committee.	**SfM** **Secretariat**
2.1.2	**Trust-wide Policies and Procedures for Approval** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience, Carl James, Director of Strategic Transformation, Planning & Digital and Matthew Bunce, Executive Director of Finance The following updated policies were discussed: • **QS03 - Handling Concerns Policy *(updated)*** – ND confirmed the addition of the Welsh language procedure and no other amendments. • **QS18 - Health, Safety & Welfare Policy** – CJ confirmed that the update had been made due to revised governance arrangements and updates on key legislation. • **IG01 – Records Management Policy, IG02 – Data Protection and Confidentiality Policy, IG08 – FOIA Policy, IG11 – Data Quality Policy –** MB confirmed that updates had been made due to general data protection regulations 2018 and a move from EU to UK GDPR, Freedom of Information Act 2000, Environmental Information Regulations 2004 and Records Management Code of Practice. • **IG05 – Software Policy, IG06 – Anti-virus Policy, IG13 – Confidentiality Breach Reporting Policy, IG14 – Information Asset Policy** – CJ confirmed that updates had been made following periodic review in relation to changes in GDPR, accentuation of global cyber risk and updates in relation to Executive leadership responsibilities. • It was also noted that the Policy and Procedure for the Management of Trust-Wide Written Control Documents had been updated to reflect this. The Committee was advised that all policies for APPROVAL had been ENDORSED previously by the Executive Management Board.	

	The Committee **APPROVED** all revised policies for publication on the Trust website and circulation to the policy distribution list.	
2.2.0	**ITEMS FOR ENDORSEMENT**	
2.2.1	**National Imaging Academy - Hosting Agreement** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The NHS Wales National Imaging Academy Hosting Agreement was received for ENDORSEMENT by the Committee for Trust Board APPROVAL. The following key points were discussed: LF advised that the Agreement formalises how the Imaging Academy is being hosted by Cwm Taf Morgannwg University Health Board and is now being signed by all organisations to reflect the current service provision. Kathy Ikin, Head of Radiation Services, has reviewed the Hosting Agreement and confirmed that it meets the service requirements. This has also been presented to the Directors of Corporate Governance Peer Group. The Commitee **ENDORSED** the NHS Wales National Imaging Academy Hosting Agreement for Trust Board APPROVAL.	
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 12th May 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 12th May 2022. No inaccuracies were raised.	
2.3.2	**Professional Nursing Update Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the Professional Nursing Update Report.	
2.3.3	**Datix Project Highlight Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** • The content of the Datix Project Highlight report and progress made against the Datix version 14 project plan for risks; • The progress and implementation made with the Once for Wales system; • The position regarding the legacy v12 Datix system archive plan and migration of risks.	
2.3.4	**Safe Care Together Review**	

	Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the work the Trust is embarking on a relationship with Improvement Cymru and the Institute for Healthcare Improvement (IHI).	
2.3.5	**Healthcare Inspectorate Wales 2022-2023 Operational Plan** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the Healthcare Inspectorate Wales 2022-2023 Operational Plan.	
2.3.6	**Highlight Report from the RD&I Sub Committee** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the key deliberations and highlights from the public meeting of the Research, Development and Innovation Sub-Committee held on the 7th April 2022.	
2.3.7	**Highlight Report from the Trust Estates Assurance Group** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee **NOTED** the content of the Trust Estates Assurance Group Highlight Report.	
2.3.8	**Quality Safety & Performance Committee - Policy Compliance Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff **The Committee:** • **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 24/06/2022, included at Appendices 1 to 8; • Received **ASSURANCE** that progress is being managed via the Executive Management Board.	
2.3.9	**Digital Service Operational Report** Led by David Mason-Hawes, Head of Digital Delivery The Committee **NOTED** the content of the Digital Services Operational Report.	
2.3.10	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Interim Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the content of the TCS Programme Scrutiny Sub	

	Committee Highlight Report and actions being taken.	
2.3.11	**CIVICA Electronic Feedback System Showcase Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience **SH requested this item be removed from consent to allow further discussion ** SH acknowledged that a number of issues (digital capacity / internet infrastructure) had impeded the full roll out of the electronic CIVICA system across all areas of the Trust over the past 12 months. The significance of the system was questioned and, owing to the current challenges faced by the Trust, whether there was sufficient digital and operational resource to achieve its implementation. ND advised that a bi-weekly Programme Board is progressing a number of the issues identified and VM requested that a follow up paper be included on the main agenda for the September 2022 Committee, can we track this please to ensure it gets on Sept agenda providing the current position, potential resolutions for issues identified and assurance that there are sufficient resources to progress these. Confirmation from Executives that technical and digital support will be made available to support this will also be essential. JA acknowledged that it has taken time for Consultants and Research, Development & Innovation to understand the CIVICA process and an uptake in response should be evidenced going forward. This will be evidenced at the September 2022 Committee. The Committee **NOTED** the position of CIVICA implementation and its importance for the Health and Social Care (Quality and Engagement) (Wales) Act (2021).	**ND/AH**
2.3.12	**Information Governance Assurance Update** Led by Matthew Bunce, Executive Finance Director The Committee **NOTED** that this item was discussed during the action log update.	
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, which set out the current levels of performance against Good Manufacturing Practice (GMP) Standards. In addition, the Committee received an update on the findings and CIVAS@IP5 risk status assigned by the Medicines and Healthcare products Regulatory Agency (MHRA) following its recent	

	inspection, and resulting action plan. The following was discussed: • *Governance Arrangements* – LF provided a brief overview of Director level governance arrangements within Shared Services. GT advised that internal Heads of Production and Heads of Quality Assurance assume legal responsibility within the organisation, including sign off of internal reports as recognition of regulatory compliance. This information and any items for escalation are taken to the IP5 Service Board (which includes Executive Directors for Finance, Procurement) on a monthly basis. Routine KPIs / information submitted are provided to Quality, Safety & Performance Committee in addition to items requiring Executive input for resolution. • *Process for the development and sign off of new products* **-** The Committee requested greater understanding of the governance process in relation to the manufacture of new products and sign off by Health Boards, in order to receive oversight and assurance that appropriate processes are being followed before new products arrive on stream. This will be discussed, and a clear process presented, at the September 2022 Committee. • *Cytotoxic Medications* – Due to facilities restrictions and risk of cross-contamination, the service does not offer cytotoxic medications (toxic to living cells) and there is currently no plan to do so. Following a request from DM, it was agreed that further clarity is required in relation to the categorisation / distinction of cytotoxic / immunotherapy medicines to allow the wider public a better understanding of products manufactured by the service. It was agreed that further discussion regarding a number of queries would take place between SHa, GT and Colin Powell (Service Director) and the outcome reported to the September 2022 Committee. SH suggested that it would be of benefit to include an additional section of terms and definitions in the Future Products Proposal document, as the paper may also be viewed by the wider public. VM advised that she had attended the Audit committee and discussed NWSSP compliance against the relevant Health and Care Standards. It was agreed a summary paper would be presented at the September 2022 Quality, Safety & Performance Committee. The Committee **NOTED**: • The current levels of service performance against the framework of standards set out in European Union (EU) GMP and which we are legally required to comply with as an MHRA “Specials” and Wholesale Dealer licence holder. 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 the agenda item.	**GT** **GT** **SHa/GT** **GT** **GT**

4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**Quality & Safety Framework (addressed following standard business)** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Trust Quality & Safety Framework 2022-2024 was received, and the following was discussed: • Following significant consultation, the Quality & Safety Framework has been developed in line with national requirements to ensure that foundations, infrastructure and ways of working are in place to allow the Trust to meet current requirements and work through current Quality priorities. • Due to the rapidly changing environment of the Quality agenda within NHS Wales and the current work in relation to organisational development and design, the Trust Quality & Safety Framework would undergo a further review, with agreement of Quality Improvement Goals during 2023. Additionally, statutory documents for the Duty of Quality and Duty of Candour will be consulted on from August 2022, and the Framework will require review once these are finalised. Additionally, findings from the scheduled foundation safety visits (July 2022) from the Institute of Healthcare Improvement (IHI) and Improvement Cymru will also feed into the review, enabling the Framework to remain live. • Next steps include the development of a Quality Management System, Divisional Quality Hubs and establishment of the Quality & Safety Operational Governance Group. This will provide triangulation of outcomes and analysis to the Executive Management Board and Quality, Safety & Performance Committee. VM queried whether the timing of Quarter 1 goals detailed in the report had been planned and were achievable within the timeframe. NW advised that work had already commenced, but that priorities for future years would be presented at the Quality, Safety & Performance Committee for approval *pre*-April 2023 and will also align to the IMTP planning. It was noted that the outputs of the Framework would form an essential element of the Committee. The Framework was commended and illustrates how the Trust can effectively provide services from a patient and donor perspective, with a view to achieving more cohesive planning across the Trust over the next planning cycle. Prioritising the implementation of the Framework and new ways of working within the organisation in addition to a number of changes currently being managed will require time and resource as this will impact all areas. DM queried the position regarding Brachytherapy breaches and Executive led improvements (item 4.3.0 from May 2022 Committee minutes).	

	Improvements are currently being facilitated via a Task & Finish group and external peer review with the Clatterbridge Cancer Centre, due for completion in May/June 2022. NW indicated that following initial delays, an on-site visit by Clatterbridge had now taken place and a report would be brought to the Committee once received. Initial feedback had been positive. NW also advised that the Brachytherapy Improvement Group will draft a clear work plan for delivery via the Senior Leadership Team within the Cancer Service. The Committee **ENDORSED**: • The 2022-2024 Quality & Safety Framework prior to submission to Trust Board for APPROVAL; • The plan to further refine this framework during 2023 to reflect the requirements outlined in the final Duty of Quality & Duty of Candour statutory guidance documents when published; • The 2022-2023 Quality Improvement Priorities and the Framework implementation plan.	
4.2.0	**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 Workforce and Organisational Development & Finance Performance Report was received, highlighting the key workforce and associated financial risks currently faced by the Trust and their impact on the ability to deliver core services. The following was discussed: • Risks associated with how the Trust is delivering services and current utilisation of the workforce remain in terms of the provision of adequate financial support / workforce for 'at risk' services. Work to secure additional funding to support posts already appointed to and potential migration of staff into vacancies within areas of concern is underway in both divisions to mitigate incurring premium agency costs where possible. • Absence levels continue to present challenges. A variety of wellbeing interventions have been introduced with the aim to reduce absence levels as stress / anxiety remain the leading causes. • A recruitment and retention project is currently under development to attract colleagues to hotspot areas within the organisation and support their development once appointed. • A holistic analysis of the organisation has been undertaken in relation to current vacancies, absence rates, substantive workforce and investment for additional capacity to support the COVID-19 backlog. Despite current sickness levels, operational workforce numbers remain at pre-COVID levels. However, a risk is posed to income flow should services not maintain pre-COVID-19 levels of activity, and a number of services are only recently returning to 2019-2020 activity levels. The main risks remain within Radiotherapy and Inpatients.	

	No comments or questions were raised. The Committee **DISCUSSED** and **REVIEWED** 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 May 2022. The following was highlighted: • *Revenue* – A balanced position is forecast in line with expectations with a projected year-end position of breakeven. • *Capital* – It is anticipated that the Trust will remain within the capital funding 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. • *Risk* – Discussions are ongoing with the Trust's Commissioners in relation to the COVID-19 funding requirement for 2022-2023, as this poses a significant risk to the Trust should this not be met. The Trust had previously been protected by a block arrangement; however, this is now driven by long term activity. VM queried how the Waiting List Initiative and enhanced pay rates would be worked through and shared with the Committee (in the absence of outsourcing to the Rutherford Cancer Centre). MB noted that while enhanced pay rates are greater than the Trust's standard rates, the cost remains considerably less than the original £4m suggested for outsourcing. MB advised that the Committee would be sighted on the detail of this in a future report. SHa advised that DM had received a letter from the Minister approving the Trust's IMTP which would be circulated to all Independent Members and Executive Team. This will be followed by receipt of a conditions letter from Judith Paget (NHS Wales Chief Executive). SH queried whether funds previously transferred to the Charity would be due for return to the Trust. MB advised that during the two years of the pandemic, charges to the Charity were reduced due to a number of staff being redirected into the COVID response as opposed to involvement in charitable (funded) purposes. MB advised that a proposal had been drafted to potentially request recovery of funds should issues arise in relation to COVID capacity this year; however, this is not being explored as an option at this stage. The Committee **NOTED:** • The contents of the May 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve	**SHa**

	financial break-even and key risks in relation to income to cover COVID backlog additional capacity costs; • The Transforming Cancer Service Programme financial report for May 2022; • The Velindre Core Trust Welsh Government Monthly Monitoring Returns (MMR) for May 2022.	
4.3.0	**Quality, Safety & Performance Reporting** The Quality, Safety & Performance Update was received by the Committee and is discussed in further detail under items 4.3.1 and 4.3.2. **Workforce** It was noted that the workforce data contained in 4.3.0 had been incorrectly reported and the following Key Performance Indicators were noted: • Personal Appraisal Development Review (PADR) – 69.73% (Trust-wide). • Sickness Absence – 6.37% (year to May 2022). • Statutory & Mandatory Compliance – 86.09% (trust-wide). VM requested further information around actions taken within these areas due to the variance with PADR across the divisions. It was agreed the latest position would be included in the overarching September 2022 paper. The Committee **NOTED** the above figures and the content of the report.	**SfM**
4.3.1	**Welsh Blood Service Quality Safety & Performance Divisional Report** Led by Alan Prosser, Interim Director of Welsh Blood Service supported by Peter Richardson, Head of Quality Assurance and Regulatory Compliance The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of May 2022. The following areas were highlighted: • Clinical demand continues to be met; however the Service remains under blue alert status (a mutual support agreement with other UK blood services) for both O blood groups. The issue is UK-wide and work is currently underway to agree a collections recovery plan and to facilitate appropriate use and conservation of blood and blood products across Wales to avoid a potential national amber alert. • High sickness absence and a number of staff in training and introduction of Hepatitis B testing continue to present challenges in terms of team capacity. An improvement plan is currently under development to replenish supply ahead of the Autumn/Winter period. • Some improvement has been evidenced within Reference Serology, due to staff returning to work and a further stem cell and bone marrow	

	recruitment campaign will target 17-30 year olds and ethnic minorities from September 2022. • A review of Apheresis production is underway to enable analysis of platelet supply and demand in order to manage waste. • 3 Serious Adverse blood related Events (SAEs) were reported to the MHRA. No common root cause was identified. Proposed corrective actions have been accepted by the MHRA and an action plan is in place. VM requested that this information be shared at the September 2022 Committee as an addition to the performance report. • An MHRA inspection of the North Wales sites had identified one 'major' and three 'other' findings. Processes have since been amended and a proposed plan is awaiting sign off. The findings are not considered to pose a high risk. VM requested an overview of the position during the 15 step challenge scheduled for North Wales in August 2022. VM queried how performance is managed during blue alert. AP advised that there are particular challenges recruiting into the Service, compounded by 9 staff in training, Hepatitis B core testing, 23 collections staff on sickness absence and summer annual leave. However, the service has imported only the necessary amount of units and the focus is on a recovery plan and identifying gaps within predictions and demand. A robust system is in place, working closely with Health Board Colleagues. It was noted that mitigating actions would require accurate capture on the WBS risk register. The Committee commended the team and **NOTED** the content of the report.	**PR** **AP**
4.3.2	**Velindre Cancer Service Performance 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 May 2022. The following areas were highlighted: • Evidence of an increase in referrals over and above projected numbers due to an increase in activity within Health Boards (a national increase of 8% for Radiotherapy and 12% for Systemic Anti-Cancer Therapy (SACT) referrals is expected by year end). This is a UK wide prediction. • All three areas within Radiotherapy have seen improvement and plans are in place to facilitate phased increased LINAC capacity within the service by quarter 3 to accommodate ongoing increasing demand. This is also contingent on ensuring adequate workforce is in place. • A plan is in place to enable gradual improvement within SACT in the absence of support from the Rutherford Cancer Centre, via weekend clinics and additional outreach capacity at Prince Charles Hospital, to accommodate ongoing increasing demand. A successful recruitment campaign has seen a number of senior level staff shortlisted for appointment. • Challenges remain in relation to staff sickness absence within SACT, in	

	addition to a number of areas still operating within a COVID-19 environment. VM advised the Committee that a detailed action plan addressing workforce and capacity issues would be discussed at today's *private* Quality, Safety & Performance Committee. This will be followed by an update and sight of the action plan at the public September 2022 Committee. DM noted that in terms of Radiotherapy breaches, 17 patients did not begin treatment within the target timeframe of 28 days; 12 of these patients were treated by day 35. Although a number of breaches resulted from LINAC and workforce constraints, it was noted that there is no method of recording delays resulting from patients contracting COVID (therefore reporting as a breach), potentially resulting in over-inflated figures. DM suggested a national conversation around this. RH also suggested reviewing the general narrative of the report in relation to this, including information relating to when treatment commenced for the 5 remaining patients. RH advised that national guidelines indicate that the treatment pathway is no longer paused, however, this requires confirmation. JA indicated that interrupting the treatment pathway results in significant impact to the patient as there are no readily available slots to accommodate this. Work is currently underway within Radiotherapy exploring the management of pathways within each Site Specific Team when interruptions occur. The Committee **NOTED** the content of the report and the updates required for subsequent reports.	**RH** **RH**
4.4.0	**Putting Things Right 2021/22 Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Annual Putting Things Right Report, providing a summary of concerns, complaints and incidents received during the period 1st April 2021 and 31st March 2022, was discussed. The following was highlighted: • A 32% increase in concerns were managed as early resolution, evidencing quicker response to individuals raising concerns (150 of 190 concerns were managed as 'early resolution'). • Over the course of the year, 28 of 40 (70%) of Putting Things Right concerns were responded to within 30 working days due to staffing issues resulting from COVID-19. However, significant improvement had been made in quarters 3 and 4, which resulted in a return to 100% compliance by the end of the reporting period. • Only 2 concerns were re-opened during the year, due to dissatisfaction with the original response, which demonstrated a robust response process which is satisfactory in the main.	

	VM requested further understanding of the Trust's position as a benchmark to other organisations and that this be included within the next quarterly Putting Things Right report. The Committee also welcomed the inclusion of a snapshot of compliments received from patients, donors and carers. It was noted that the report should read '32% increase' rather than 'reduction', which will be amended prior to presenting at Trust Board. The Committee **ENDORSED** the 2021-2022 Velindre University NHS Trust Putting Things Right Annual Report prior to being submitted to the Trust Board for approval, pending the minor amendment to early resolution item on the cover paper and within the report.	**ND**
4.5.0	**Patient & Donor Experience Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Annual Patient & Donor Experience Report reflected the period 1st April 2021 to 31st March 2022 and the following was highlighted: • 70% of patients at Velindre Cancer Service had scored their experience as excellent (9 out of 10). • 91% of patients stated that they always felt cared for. • 90% of patients said that they always felt listened to. • 75% of patients always understood what was happening regarding their care and treatment. An analysis of themes and trends is currently being explored to enable improvements in this area and will be presented at a future Quality Safety & Performance Committee. • 10,438 (80.4%) of donors at Welsh Blood Service rated their care as 6 out of 6. • The total number of appointments booked from calls stood at 17,553 (13,751 of which were inbound calls). • An inspection of First Floor Ward at the Cancer Service during the 12th and 13th of July 2022 had received positive feedback in the main (one patient had described the Cancer Centre as 'a hospital like no other'). A comprehensive report of findings will be included at a future Quality, Safety & Performance Committee once finalised and received. DM suggested closer monitoring of complaints in relation to communication, in particular due to 25% of patients reporting that they did not always have an understanding of their care and treatment. ND advised that a deep dive was presented at the March 2022 Committee in relation to communication related complaints and this remains on the agenda. DM requested an update at the September 2022 Committee demonstrating investigation of the remaining 25% patients' understanding of their treatment, identifying possible themes, trends and learning. The Committee **DISCUSSED** and **ENDORSED** the 2021-2022 Trust Patient and Donor Experience Annual Report prior to submission to the Trust Board	**ND**

	for approval and publication on the Trust's website following Welsh language translation.	
4.6.0	**Highlight Report from the Infection Prevention and Control Management Group** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Infection Prevention & Control Management Group Highlight Report provided the Committee with details of the key issues considered at its meeting held on 19th May 2022. The following was highlighted: • The delayed action relating to the provision of adequate staff changing facilities has now progressed through the Senior Leadership Team at the Cancer Service, and a reduction in social distancing meterage and review of lockers will enable use of the space by more staff. • Staffing challenges at the Cancer Service, in particular affecting the delivery of cleaning and catering, have been exacerbated through delays in the Trac online appointment process. The Service has appointed a number of temporary agency staff to temporarily to assist with this issue. The Committee **DISCUSSED** and **NOTED** the Infection Prevention & Control highlight report, from the meeting held on the 19th May 2022 and actions being taken to address the areas where compliance / standards are not at the required level.	
4.7.0	**Infection Prevention & Control Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Annual Infection Prevention & Control Report was received, providing an outline of progress, activities and achievements for the period 1st April 2021 to 31st March 2022. The following key items were highlighted: • There have been no cases of inpatient Healthcare Acquired Bacteraemia. • There have been no cases of catheter associated Urinary Tract Infections. • There has been a 50% decrease in Healthcare Associated Clostridioides Difficile infection. • The issue of variable hand hygiene compliance has been addressed and appropriate action taken in a timely manner. MY advised that actions taken will be referenced in future reporting with the addition of a precise compliance percentage. This is of particular importance given guidance imposed by the pandemic. DM also noted that the Trust would shortly achieve its tenth year with no incidents of MRSA infection. This was commended as a great achievement given the vulnerability of our patients.	

	The Committee **ENDORSED** the 2021/2022 Trust Infection Prevention & Control Annual Report prior to submission to the Trust Board for approval and publishing following translation on the Trust's website, pending the addition of further information as discussed above.	
4.8.0	**Highlight Report from the Safeguarding & Vulnerable Adults Management Group** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience Two Highlight Reports were received from the Safeguarding & Vulnerable Adults Management Group, providing details of key issues considered at its meetings on 8th March and 13th June 2022. The following was discussed: • A Trust Disclosure and Barring Service (DBS) policy is currently under development with an anticipated completion date at end of September 2022; however, whilst awaiting the completion of this policy, robust procedures are in place to ensure any issues are addressed / escalated in a timely manner in the meantime. SfM advised that the only remaining outstanding DBS check was no longer necessary as the individual had left the Trust. • The DBS internal audit report had indicated reasonable assurance for most elements and substantial assurance in relation to current staff checks. • Three outstanding actions from the Safeguarding 2021-2022 work plan were not completed within the year, which was due to significant pressures posed by COVID-19, and it was agreed to progress these via the 2022-2023 work plan. • Delays to finalisation of the Safeguarding Training Needs Analysis have been resolved and, following the significant amount of work already undertaken, further data cleansing will be carried out. VM noted that the Health Inspectorate Report detailing the DBS issues and recommendations had not been sighted by the Committee to confirm the Trust position in relation to the recommendations. It was therefore agreed to include the report, recommendations and current position as a main agenda item at the September 2022 Committee. The Committee **NOTED** the key deliberations that took place at the Safeguarding and Vulnerable Adult Management Group meetings held on 8th March and 13th June 2022 and the actions taken to address the areas identified for alert.	**ND/TJ**
4.9.0	**Safeguarding Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Safeguarding 2021-2022 Annual Report reflecting the period 1st April 2021 to 31st March 2022 was received and the following was highlighted:	

	• The establishment of a Supporting Vulnerable Groups Forum which is developing a work plan to ensure the Trust is implementing adjustments for patients/donors requiring additional support. • The Trust is making progress in preparing for the Liberty Protection Safeguards. • The Trust has also developed resources to support compliance with legislative responsibilities such as the Mental Capacity Act. The Committee **ENDORSED** the Safeguarding and Vulnerable Adults 2021/2022 Annual Report prior to submission to the Trust Board for approval and publishing on the Trust's website, pending one minor spelling amendment.	
4.10.0	**Trust-wide Nurse Staffing Levels (2016) Act Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Nurse Staffing Levels (Wales) Act Annual Report provided the Committee with assurance in relation to the provision of safe staffing levels and that no incidents had occurred on the First Floor Ward of the Velindre Cancer Service as a result of Nurse Staffing levels. The following was highlighted: • On March 25th 2021, the Trust Board approved that the First Floor Ward at the Cancer Service would be recognised as a medical ward in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and full reporting requirements of the act in relation to the ward came into effect from 1st April 2021. • Full implementation of the electronic nurse rostering (*ALLOCATE*) within six nursing units (including First Floor Ward) at the Cancer Service. • Continued commitment to the COVID-19 response phase, ensuring sufficient staffing levels to meet the needs of patients in addition to reconfiguration of services to allow for the undertaking of additional COVID-19 related tasks such as the vaccination programme. The Committee **REVIEWED** the 2021/22 position in respect of the Nurse Staffing Levels Act (Wales) and **ENDORSED** the report prior to submission to Trust Board.	
4.11.0	**Highlight Report from the Patient Safety Alerts Group** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Highlight Report from the Trust Safety Alerts Management Group was received, providing key outputs for the period 1st January to 31st May 2022. The following was highlighted: • Following review, it was confirmed that the ligature and ligature point risk alert only applies to organisations providing mental health services and	

	is therefore not applicable to the Trust. Notwithstanding, a robust multi-disciplinary risk reduction plan has been developed, to include the following: o Completion of ligament audit tools for the First Floor Ward and the identification of an observation / treatment area for potentially mentally vulnerable patients. o A psychology team to assess and identify patients at risk of self-harm or suicide. o Training in the cutting of ligatures. o Development of patient information leaflets. Actions undertaken will be comprehensively referenced within future reporting. Confirmation of whether this safety alert applies to the Trust will also follow. The Committee **NOTED** the report and **CONSIDERED** the actions being taken to achieve compliance in relation to the two overdue safety alerts.	**ND**
4.120	**Health & Care Standards Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Health and Care Standards Annual Report provided the outcome of the 2021-2022 Health and Care Standards Assessment process, and details of the plans to further revise the assessment process for the Trust for 2022-2023. The following was highlighted: • The overarching Trust score is 4 out of 5. • The 2022-2023 assessment process will follow a different approach to reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. • Following a request by VM, It was agreed that future reports will reference NHS Wales Shared Services as a managed service and their assessment of relevant Health and Care Standards. The Committee: • **APPROVED** the overarching 2021/22 Health & Care Standards status as a level 4; • **APPROVED** the end of year 2021/22 Health and Care Standards assessment and Improvement Plan status; • **NOTED** the Divisional Assurance Highlight Reports; • **APPROVED** the working draft 2022/23 Health and Care Standards Improvement Plan.	
4.13.0	**Medical Workforce Update** *(deferred from May 2022 Committee)* Led by Jacinta Abraham, Executive Medical Director The 2021-2022 Annual Medical Workforce Revalidation Progress Report was received the following was highlighted:	

	• The report demonstrated that the Trust is compliant with the Medical Profession (Responsible Officers) Regulations 2010 and it was advised that systems and processes are in place to support and inform the appraisal and revalidation for medical staff. • Of the 78 'prescribed connections' for the Trust, 88.5% of appraisals (69) have been completed during the last year and work is underway to maintain this level. • 27 of the 29 domains outlined in the update are currently reporting as green in terms of assurance. Two recent areas proposed by Health Education & Improvement Wales (HEIW) require further development and are awaiting formal HEIW guidance ((1) considering public and patient views regarding revalidation processes (2) encouraging lay involvement in quality assurance processes to provide independent scrutiny and challenge). The Committee **NOTED** the position and feedback report.	
4.14.0	**Trust Clinical Audit Plan** *(deferred from May 2022 Committee)* Led by Jacinta Abraham, Executive Medical Director The Trust Clinical Audit Plan was received, representing an overview of the Trust-wide Clinical Audit Strategic approach and programme of work for 2022-2023. The following was highlighted: • A wide-ranging programme of work with a systematic process for the prioritisation and delivery of clinical audit across the Trust has been developed (in conjunction with Site Specific Teams (SSTs)) in line with the organisational strategic direction and is reflective of the services provided. • It is anticipated that the programme will be strengthened over the coming year through the Trust's Quality & Safety Framework, establishment of Quality Hubs across the Trust and developments within Clinical Strategy. The Committee **APPROVED** the Trust Clinical Audit Plan.	
4.15.0	**Local Partnership Forum Annual Report** *(deferred from May 2022 Committee)* Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Local Partnership Forum Annual Report for the period 1st April 2021 to 31st March 2022 was received, reflecting the activity undertaken by the Forum during this period. The following was highlighted: • The forum has provided the opportunity to improve partnership arrangements with Trade Union Partners, enabled the Trust to inform Trade Union Representatives on a number of issues and encourage participation of Representatives in agenda discussions.	

	• The Trust has committed to progressing the Partnership Working Action Plan, resulting from a number of workshops delivered via the Involvement and Participation Association during October 2021. There were no questions raised. The Committee **NOTED** the content of the 2021-2022 Local Partnership Forum Annual Report.	
4.16.0	**Trust Risk Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff This item had been deferred to the September 2022 Committee and was addressed in matters arising.	
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 SH acknowledged the significant amount of activity taking place within the Trust and that prioritising appropriate direction / acquisition of resources (either via internal redeployment or recruitment) is challenging. SH thanked staff for the achievements and improvements to date across a number of areas of the Trust. DM noted that a number of papers on today's agenda had reinforced the extent of workforce issues across the Trust. Although the Board has previously been sighted on these issues, the Quality, Safety & Performance Committee agreed to escalate concerns to the Board via the Highlight Report. SH (as Champion for staff wellbeing) had met with SfM to discuss the wellbeing of current staff as the issue extends further than staff availability. It was agreed to explore whether further support could be provided and report the current position at the September 2022 Committee. CJ noted that ensuring the best use of current workforce, capability and skills is essential (in addition to recruitment and funding) due to a change in requirements going forward. A holistic understanding of the wider NHS Wales and UK issue will enable a robust plan to deliver on a number of issues. SHa suggested consolidating and reviewing agreed actions, exploring whether any further engagement is required and applying timeframes for completion. This is to be presented at the September 2022 Committee.	**Secretariat** **SH/SfM** **SfM**

	Analysis of Quality, Safety & Performance Committee effectiveness Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members VM noted that today's agenda had been the most significant to date and although it was accepted that all papers had been allocated sufficient time for discussion, it was felt that further discussion around items relating to Information Governance would be beneficial. ES advised that the cycle of business will shortly be reviewed, in particular the July 2022 Committee due to the high volume of Annual Reports. As deferral of papers occasionally occurs for reasons beyond one's control, it was agreed to note reasons for deferral of papers within the narrative of the cover paper as a rule going forward.	**ES/ Secretariat**
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**	
6.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **15th September 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 & PERFORMANCE COMMITTEE

WORKFORCE AND OD POLICY UPDATES

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	AMANDA JENKINS, HEAD OF WORKFORCE
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	01/08/2022	ENDORSED FOR APPROVAL

ACRONYMS	
EMB	Executive Management Board
QSP	Quality, Safety and Performance

1. SITUATION / BACKGROUND

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

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

2.1.1 Equality and Diversity Version 4

- Minor amendments to sentence structure and language
- Amendment to format in line with Policy for The Management of Policies and Other Written Control Documents

2.1.3 Working Time Regulations Policy Version 3

- Glossary of Terms to explain legal definition within the Working Time Regulations, 1998
- Change of links from Wikipedia to legislation.gov.uk website
- Change section on Mobile Workers due to additional legislation, The Road Transport Working Time Regulations, 2005, that defines Working Time for all workers who are required to drive a vehicle for transport of passengers or goods on the road, not just drivers of vehicles over 3.5 tones.
- Removal of section on different terms for 'Bank Workers' as Working Time Regulations apply to causal workers as well as employees.
- New 'Opting Out' agreement form
- Amendment to format in line with Policy for The Management of Policies and Other Written Control Documents

2.2 The following are new or amended All Wales Polices to be approved by QSP for adoption by the Trust:

2.2.1 NHS Wales Special Leave Policy December 2020

- Amendments made in national partnership and document control is managed by NHS Employers.

2.2.2 NHS Wales Pay Progression Policy Updated May 2022 (for go live in October 2022)

- New Policy developed in national partnership and document control is managed by NHS Employers.

2.2.3 Procedure for NHS Staff to Raise Concerns (Whistleblowing) May 2021

- Amendments made at national levels and version control is managed by NHS Employers. Although titled a procedure this document replaces both the policy and procedure for Whistleblowing within NHS Wales.

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	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Each policy has been individually assessed to ensure compliance with EQIA's
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

4. RECOMMENDATION

It is asked that QSP approve the changes and additional policies for implementation within the Trust.

Ref: WF05

EQUALITY AND DIVERSITY POLICY

Executive Sponsor & Function	Director of Workforce and OD
Document Author:	Equality, Diversity and Inclusion OD Manager
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	January 2019
Equality Impact Assessment Outcome:	No impact identified
Review Date:	September 2025
Version:	4

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1. PURPOSE

This policy aims to ensure equality and fairness throughout Velindre University NHS Trust and to comply with the provisions of the Equality Act 2010, the Public Sector Equality Duty, National Terms and Conditions of Service for all NHS Employees, and good practice guidance. The policy specifically relates to workforce issues.

2. POLICY STATEMENT

Velindre University NHS Trust aims to eliminate unlawful discrimination, harassment and victimisation, and other conduct that is prohibited by the Act; advance equality of opportunity between people who share a relevant protected characteristic and those who do not; foster good relations between people who share a protected characteristic and those who do not under the Public Sector Equality Duty.

'Protected characteristics include:

- Age
- Gender reassignment
- Sex
- Disability
- Pregnancy and maternity
- Sexual orientation
- Race – including ethnic or national origin, colour, or nationality
- Religion or belief – including lack of belief

The Duty applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination. People who share a protected characteristic are sometimes referred to as 'protected groups'. An overview of the Equality Act 2010 is detailed in Appendix 1.

All employees of the Trust should be able to achieve their full potential and be treated with dignity and respect.

3. PRINCIPLES

Velindre University NHS Trust will seek to employ a workforce that is representative of all sections of society within the communities for which it provides its services.

Every employee will feel respected and able to be their authentic self and give their best to their roles.

Employees will be supported and encouraged to develop their full potential and the talents and resources of the workforce will be fully utilised to maximise the efficiency of the organisation.

Individual differences will be recognised and valued and no form of intimidation, bullying, or harassment will be tolerated.

Employees will be supported where they feel they are being unfairly treated and encouraged to report any incidents of hate crimes against them or people around them.

All of the Velindre University NHS Trust employment policies and practices and service developments will be equality impact assessed to avoid discrimination and to ensure mitigation where protected groups could be adversely affected.

4. SCOPE

This policy shall apply to all employees including volunteers (including those working within our hosted organisations) and potential employees of the Velindre University NHS Trust.

5. LEGISLATION AND NHS REQUIREMENTS

This policy complies fully with the following legislative and NHS requirements;

- Equality Act 2010 and Public Sector Equality Duty;
- National Terms and Conditions of Service (Agenda for Change) Equality and Diversity Statement;
- Human Rights Act 1998.

6. PROCEDURE

The principles of this policy will underpin all policies and practices of Velindre University NHS Trust. Equality in the workplace is good management practice and makes sound business sense. It can also contribute to prudent healthcare.

Velindre University NHS Trust will seek to achieve its objectives of achieving equality and fairness through its Strategic Equality Plan which can be found on the Velindre University NHS Trust website. The Strategic Equality Plan is fully supported by The Board and has been agreed upon with local and where applicable full-time trade union representatives.

To ensure that the Strategic Equality Plan is appropriate and current, every effort will be made to improve the collection of staff equality data.

Progress towards achievement of the Strategic Equality Plan and information contained in the Workforce Profile will be discussed by the Local Partnership Forum, Senior Workforce Team, and reported to the Corporate Quality and Safety Committee, Executive Management, and Trust Boards.

Where any shortfall or cause for concern is identified, further analysis will be undertaken and appropriate action plans agreed upon and monitored. This may include positive action.

Equality in pay and grading will also be considered as part of the gender pay element of the Public Sector Equality Duty and action plans developed where there is cause for concern, looking at intersectionality and pay. Gender Equality cannot be viewed in isolation, people's lives and identities are shaped by many factors. So within this Gender Pay report, it is only right that we look at the Trust workforce in all of its intersectionality. This means that we recognise how power structures based on factors such as sex/gender, race, sexuality, disability, age, and faith interact with each other and may create inequalities, discrimination, and barriers.

Velindre University NHS Trust will regularly review its employment practices and procedures to ensure fairness and compliance with the law and good practice on an ongoing basis. All new and existing policies will be impact assessed using the Trust's Equality Impact Assessment tool to ensure that they comply with legislation and good practice and to ensure that this can enable greater mainstreaming of equality so that it is considered at every opportunity. This will also apply to service change and developments.

The Trust's Recruitment processes aim to ensure all potential and actual applicants will have equality of opportunity in applying for our posts and following their appointment. The Trust will seek to employ a workforce that is representative of all sections of society within the communities from which it is drawn. It will also aim to promote gender equality as well as equality for all protected groups e.g. through appropriately designed posts that take full account of flexibility, use of appropriate language throughout the recruitment process, and positive practices aimed at avoiding direct or indirect discrimination. This is relevant to every stage of the process, from the initial identification of the post and its approval to the appointment. In some cases, positive action may be taken following appointment e.g. through the provision of mentoring or coaching opportunities to unsuccessful candidates particularly if they belong to under-represented groups.

Equality principles will also apply to other aspects of employment such as the practice of 'retire and return' so that the individual's request can be considered against the needs of the service but also of any other issues within the department, including under-representation of particular groups and the need to consider opportunities for existing employees too.

Full account shall be taken of the Welsh Language Standards, the Trust's Bilingual Skills Strategy, and the promotion of the Welsh Language.

A range of policies has been developed to support the promotion of equality and diversity. These will be updated to reflect legislative and other changes. Specific policies will also be developed in due course to address particular strands of the Equality Act 2010.

Employee engagement will be promoted throughout the organisation through the encouragement of the development of groups based on membership of particular protected groups and/or a broader group composed of members of a range of groups and/or the development of equality champions depending on the interest and availability of our employees.

Specific arrangements may need to be made to accommodate particular groups in terms of facilities, catering, adaptations to the workplace, etc.

Where an individual feels they have been treated unfairly from an equality perspective, they should raise the issue with their manager in the first instance. Where the issue relates to their treatment by another person, the situation may be addressed by the Trust's Dignity at Work procedure or the Grievance Policy if it relates to their inappropriate treatment by their manager. If the individual feels stressed by their situation, recourse should be made to the Management of Stress Policy.

If the issue relates to their application for employment, they may wish to raise their concern with the appointing officer and, where the matter is not resolved, via the complaints process. Whatever the circumstance, the Trust will endeavour to deal with the issue promptly and fairly.

Equality and Diversity training is now part of the Trust's core skills training requirements. As such employees will be required to undertake the 'Treat Me Fairly' e-learning package and/or classroom Equality Training sessions on a 3-yearly basis. This may be supplemented by further more detailed or specific training by request or to support specific initiatives as determined by the Trust. Wherever possible equality will be mainstreamed into other training delivered within the Trust by internal and external providers.

Every effort will be made to keep employees informed of news, initiatives, and developments about equality and diversity to also engage with staff by encouraging them to ask questions and discuss relevant issues. Further engagement will be undertaken through the NHS Wales Annual Staff Survey and the introduction of employee engagement and support groups. Examples of quality communication methods can be found in Appendix 2

7. TRAINING

Training will be delivered to managers via e-learning, formal training programmes, and on an informal basis to discuss specific equality issues e.g. equality impact assessment. Managers will be expected to raise awareness with their employees. Management development and organisational development programmes will also include equality elements wherever possible.

8. REVIEW, MONITOR, AND AUDIT ARRANGEMENTS

The policy will be monitored on an annual basis as described above and reviewed on a three-yearly basis.

9. MANAGERIAL RESPONSIBILITIES

Responsibilities at all levels of the organisation are detailed in Appendix 3.

10. NON-CONFORMANCE

Breaches of this equality policy will be regarded as misconduct and could lead to disciplinary proceedings.

11. EQUALITY IMPACT ASSESSMENT

This policy has been impact assessed and has not been found to be discriminatory in accordance with the Equality Act 2010 and the Human Rights Act.

12. APPENDIX 1: PROTECTED CHARACTERISTICS AND THE PROVISIONS OF THE EQUALITY ACT 2010

The Equality Act 2010 (the Act) brought together and replaced the previous anti-discrimination laws with a single Act. It simplified and strengthened the law, removed inconsistencies, and made it easier for people to understand and comply with it. The majority of the Act came into force on 1 October 2010.
The Act includes a **public sector equality duty** (the 'general duty'), replacing the separate duties on race, disability, and gender equality. This came into force on 5 April 2011.

The general duty covers the following protected characteristics:

- Age
- Gender reassignment
- Sex
- Race – including ethnic or national origin, colour, or nationality
- Disability
- Pregnancy and maternity
- Sexual orientation
- Religion or belief – including lack of belief

It applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination.

The general duty aims to ensure that public authorities and those carrying out a public function consider how they can positively contribute to a fairer society through advancing equality and good relations in their day-to-day activities. It is an integral and important part of the mechanisms for ensuring the fulfillment of the aims of the Equality Act 2010. The duty ensures that equality considerations are built into the design of policies and the delivery of services and that they are kept under review. This will achieve better outcomes for all.

In exercising their functions, public bodies are required to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation, and other conduct that is prohibited by the Act.
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

This guidance refers to these three elements as the three 'aims' of the general duty and so when we discuss the general duty we mean all three aims.

The Act explains that having due regard for advancing equality of opportunity in the second aim involves:

- removing or minimising disadvantages experienced by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

The Act describes fostering good relations in the third aim as tackling prejudice and promoting understanding between people who share a protected characteristic and those who do not. Meeting the duty may involve treating some people more favourably than others, as long as this does not contravene other provisions within the Act.

13. APPENDIX 2: EQUALITY COMMUNICATION

PLEASE NOTE THIS APPLIES TO SERVICE USERS AS WELL AS EMPLOYEES

Given the size of the Equality agenda, particularly in relation to the Public Sector Equality Duty and the All Wales Standards for Communication and Information for People with Sensory Loss, it is important to develop a two-way Communications Strategy. The key aims of the Communication Strategy will be to:

- Effectively convey and communicate key Equality, Diversity, and Human Rights activity and messages to all employees, the Trust, the public including difficult to reach groups, public sector, and third sector partners and any other key stakeholders

- Explore and deploy a series of appropriate communications mechanisms to enable the Forum to receive feedback and receive communication from all of the above parties e.g. in relation to service and policy development, this will be particularly beneficial in the equality impact assessment process.

- To support the training agenda by providing information, resources, toolkits, etc which can be easily accessed as appropriate.

Recommended Approaches

A multi-pronged Communication Strategy will be deployed in order to achieve the above aims. Several potential communication avenues are listed below;

- Newsletter Trust Talk (online and/or paper-based), Chief Executive's blog, news carousel on the Trust's Intranet Site. Wherever possible the timing of these will be linked to significant dates on the 'Equality calendar';

- Equality and Accessible Healthcare (AHS) sensory loss website pages, both internal and external, which both share information and resources and provide our employees and the public with the ability to feedback and communicate with the Equality Manager;

- Formal communication and engagement events;

- Development of networks e.g. employees who share 'protected characteristics', also link to existing groups e.g. Stakeholder reference groups, groups established by Third Sector organisations;

- Media - social media, press releases;

- Marketing events e.g. for the Treat Me Fairly package;

- Questionnaires e.g. at local events;
- Suggestion boxes;
- Link to existing Trust communications process e.g. the Concerns Team, Patient Experience; Partnership work;
- Inclusion of Equality information in internal training delivery;
- Exploration of new creative methods of communicating Equality information on an ongoing basis.

It will also be appropriate to ensure that the Trust's communication strategy is underpinned by equality considerations and regular communication will take place with the Communications Team to facilitate this. The need to provide information and ensure communication in accessible formats will be fundamental to this.

APPENDIX 3: RESPONSIBILITIES

It is important for all employees of Velindre University NHS Trust to be aware of the equality duty so that it is considered in their work where relevant.

- Board members – in how they set strategic direction, review performance and ensure good governance of the organisation with particular emphasis on ensuring equality impact assessment is undertaken in all policy and service development;

- Senior managers – in how they oversee the design, delivery, quality, and effectiveness of the organisation's functions and in how they recruit and manage their employees;

- Equality Manager – in how they raise awareness and build capacity about the general and specific duties within the organisation and how they support employees to deliver on their responsibilities within their roles and the workplace;

- Workforce & OD Officers – in how they build equality considerations into the development and application of employment policies and procedures and every element of the business partnership process;

- Communications Officers – in how they ensure information is available and accessible to all employees, service users, and the community taking account of their protected characteristics;

- Workforce Information Officers – in how they support the organisation in gathering information on equality characteristics and in providing regular workforce information reports to enable the monitoring of the effect of Trust policies and practices on people from protected groups;

- Frontline Employees – in how they meet the needs of people from protected groups;

- Trade union representatives – in contributing to the equality agenda and supporting their members, particularly where they have concerns about equality.

Ref: WF44

WORKING TIME REGULATIONS

Executive Sponsor & Function	Director of Workforce and OD
Document Author:	Head of Workforce
Approved by:	Trust Board
Approval Date:	TBC
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1. GLOSSARY OF TERMS

The Regulations	The Working Time Regulations, 1998
Adult Worker	A person working aged 18 years and older
Young worker	A person working aged 16 – 18 years old
Night Worker	Is a person who works at least 3 hours of the working time at night time (between the hours of 23:00 and 06:00)
Agreement to Exclude the Maximum	The written agreement between the employer and a person working to be excluded from the provisions set out in The Regulations.
Mobile Worker	A person whose work activities or duties require the operation of a motor vehicle to provide a service to passengers or the transport of goods by road

2. INTRODUCTION AND AIM

The Working Time Regulations, 1998 (The Regulations) is a legal requirement in UK law, that puts the European Working Time Directive into practice. This came into force in the UK on 1st October 1998. The Regulations place controls on working hours and are regarded as an integral element of managing health and safety at work and promoting health and wellbeing.

The Regulations introduced new limits on weekly working time, rest entitlements, annual leave and made special provisions for working hours and health assessments, in relation to night workers. They also implemented the provisions set out in the Young Workers Directive, which relates to the working time of a young worker.

Velindre University NHS Trust is committed to protecting the health and safety of all staff and the Trust recognises that control on working hours is an integral element of managing health and safety at work and will therefore comply with the principles The Regulations, as far as the needs of the service permit.

The Trust will endeavour to ensure that working hours arrangements introduced as a consequence of this policy do not discriminate against employees. Employees will therefore not suffer any detriment, should they exercise any of their entitlements as contained in the Regulations.

3. OBJECTIVES

This document will explain individual roles and responsibilities to enact The Regulations and summarise some of the key requirements of The Regulations. It is important to note that this document should be read alongside the full legislation **https://www.legislation.gov.uk/uksi/1998/1833/contents/made**

4. SCOPE

The procedure applies to all Trust employees and workers (including hosted organisations).

5. ROLES AND RESPONSIBILITIES

Managers are expected to ensure that all Trust employees and workers are working within the parameters of The Regulations.

Managers are required to ensure that The Regulations are applied and that appropriate monitoring arrangements are implemented within their departments, to monitor the hours that their employee's work, rest periods etc.

Managers should therefore not develop shifts or working patterns, which encourage or involve excessive working hours.

All employees are expected to act responsibly and comply with The Regulations.

All employees are required to notify the Trust if they undertake secondary employment, in accordance with the terms and conditions of their contract of employment.

6. SUMMARY OF THE WORKING TIME REGULATIONS AND LEGISLATIVE REQUIREMENTS

The main principles and requirements of The Regulations which affect the Trust and its employees and workers are:

6.1 WORKING TIME

Working Time as set out in the regulations is;

- Any period which a worker is at the disposal of the employer to carry out activities or duties
- Any period which a worker if receiving relevant training
- Any additional periods which can be treated as working time within The Regulations

Working Time is not considered;

- Any period of travel between their home and workplace;
- Any time resting at the end of the working day, when required to stay overnight
- Attending an event and not carrying out work related activities or duties
- Time spent on-call, when away from the workplace and not carrying out work related activities or duties
- Rest and break periods

6.2 WORKING WEEK

A typical full-time working week will follow a notional working week of 37.5 hours. The maximum working week is an average of 48 hours worked per week, including overtime, calculated over a 17 week reference period. The average of 48 hours per week, should also take into account any time worked by the employee or worker in additional posts or for another employer.

6.2.1 JUNIOR DOCTORS

It should be noted that a junior doctor's average working week should not exceed 48 hours. Their reference period will be calculated over a 26 week period.

6.2.2 YOUNG WORKERS

Employee's ages 16 – 18 years old cannot enter into an Agreement to Exclude the Maximum, as such they are not permitted to work in excess of 8 hours a day or 40 hours per week.

6.3 ON-CALL STAFF

Employees and workers who are required to work on-call, will be regarded as working from the time they are required to undertake any work related activity. Where an employee is on-call but is otherwise free to use the time as their own, this time will not be counted as working time, but will be used to calculate the on-call payment.

6.4 AGREEMENT TO EXCLUDE THE MINIMUM

Adult workers may choose to work more than the 48 hours average weekly limit, on a voluntary basis, if this is agreed with their manager. Should an employee choose to agree to work more than 48 hours per week, they will be required to sign a Working Time Regulations Opt Out Agreement Form. In so doing they will be confirming that they wish to be excluded from the maximum 48 hour week provision.

An Agreement to Exclude the Minimum may either relate to a specified period or apply indefinitely. Employees can rescind this agreement at any time, by giving at least seven calendar days' notice, in writing.

The employee's manager is required to review with the employee, on an annual basis, whether or not it is appropriate for the employee to continue to work in excess of the 48 hour week. This may be reviewed on a more regular basis, if the arrangement appears to be affecting the employee's work performance or / and their health and wellbeing. It may, in such circumstances, be appropriate for the manager to seek advice from the Workforce and OD Department.

Where an employee chooses to work in excess of the 48 hour limit, consideration must be given by the Trust, as to whether the employee's working hours foster and support safe working practice.

A risk assessment should be carried out to establish whether or not working in excess of the limit impacts on safe working arrangements. The Trust reserves the right to suspend or refuse to approve an Agreement to Exclude the Maximum, if there is a belief, held by the manager that the hours worked by the employee could result in harm to patients, donors, service uses or colleagues. The reasons for suspending or refusing an Agreement to Exclude the Maximum will be explained to the employee, in writing by their manager.

6.5 REST AND BREAK PERIODS

An adult worker is entitled to the following rest periods and breaks:

- An uninterrupted weekly rest period of 24 hours for each 7 days worked for the Trust
- 11 consecutive hours daily rest in every 24 hour period worked (alternatively, compensatory rest can be given).

- A minimum of 20 minutes uninterrupted break if working 6 hours or more in a work day.

Young workers are entitled to the following rest period and breaks:

- An uninterrupted weekly rest period of 48 hours for each 7 days worked for the Trust
- 12 consecutive hours daily rest in every 24 hour period worked
- A minimum of 30 minutes uninterrupted break if working 4.25 hours or more in a work day

In line The Regulations, a weekly rest period must not include any part of the 11 consecutive hours daily rest period, unless this is justified by objective or technical reasons or reasons concerning the organisation of work.

Should any employee believe that the hours they are required to work are excessive and/or disruptive to adequate rest, they should bring the matter to the attention of their manager, as soon as practicably possible. In such circumstances, the manager must take account of the employee's concerns and the employee must not be compelled to continue working excessive hours, irrespective of whether or not the employee has previously signed an opt out agreement.

Reasonable adjustments to rest requirement will be made for employees as a result of any disability, as provided for in the Equality Act (2010).

6.6 COMPENSATORY REST

Compensatory rest will be given to employees that have a rest period interrupted, e.g. staff on-call. This time will be reallocated in accordance with local on-call agreements.

Where it is not possible for an employee to achieve 11 hours rest between shifts, compensatory rest should be given at another time. In practice there may be less than 11 hours rest between shifts one day and much longer than 11 hours on another day. Therefore, on average, the 11 hours requirement should be met.

The 11 hours consecutive rest can be varied as long as compensatory rest is given, for example, where it is impractical to change shift patterns or the continuity of care is required. Departmental arrangements should be agreed to ensure that a period of equivalent compensatory rest is provided.

The Trust will require staff to be flexible at times of unforeseen circumstances, e.g. major incident or unforeseeable changes in activity. Under these circumstances where rest breaks may not be practicable, compensatory rest can be given at a later time.

Managers are required to keep and maintain records of allocated compensatory rest, as evidence of their compliance with The Regulations.

6.7 NIGHT WORKERS

It is a requirement of the Trust that all new employees and workers undergo pre-employment occupational health screening. When an individual is appointed to a post that will require them to work night hours, the appointing manager must ensure that the Occupational Health Department is informed that the appointee will be required to work nights and seek advice on whether or not they are fit to undertake night work.

All night workers will be offered a free and confidential annual health assessment by the Occupational Health Department, to ensure their continued suitability to undertake night work. Occupational Health will keep records of these assessments.

If an employee and worker that works nights develops an illness or medical condition that may impact on their ability to continue to perform night work, the manager is responsible for arranging a health assessment appointment with the Occupational Health Department to determine whether they are fit to continue undertaking their contractual night work. Should this assessment determine that the employee or worker is not fit to undertake night work on a temporary or permanent basis, alternative daytime employment will be sought, wherever possible, via the Trust's Redeployment Procedure.

6.8 MOBILE WORKERS

The Road Transport Working Time Regulations, 2005 covers employees and workers who are required to drive a vehicle for transport of passengers or goods on the road.

Under The Road Transport Working Time Regulations, 2005 working time must not exceed:

- an average of 48 hours per week over a 17 week reference period
- 60 hours in any single week, including overtime
- 10 hours in any 24 hour period, if working at night

Mobile workers must not work more than 6 hours without a break.

- Mobile workers, working time over 6 hours but is less than 9 hours are entitled to a break lasting at least a 30 minutes;
- Mobile workers, working time over 9 hours they are entitled to a break lasting at least 45 minutes;
- Each break can be made up of separate periods, but each period of break must be at least 15 minutes

Mobile workers are not permitted to opt out of the average weekly working limit set out in The Road Transport Working Time Regulations.

6.9 SECONDARY EMPLOYMENT

All employees are required to notify their manager if currently have or wish to undertake secondary employment (this includes any self-employed work).

The Trust has a duty of care to protect the health and safety of our patients, donors, service users and employees. Therefore employees that have secondary employment must ensure they have adequate rest periods and that their combined working hours are not excessive, to the extent that they could endanger their own health, safety and wellbeing and that of the Trust's patients, donors, service users and colleagues.

Employees are therefore required to inform their manager any secondary employment, using the Declaration of Secondary Employment Form. Should their secondary employment results in them working more than a combined average of 48 hours, over a 17 week reference period (or a 26 week reference period for junior doctors).

Where an employee has informed their manager that they undertake secondary employment, the manager will review the secondary employment declaration annually with the employee. This may be reviewed on a more regular basis, if the arrangement appears to be affecting the employee's work performance or / and their health and well being. It may, in such circumstances, be appropriate for the manager to seek advice from the Trust's Occupational Health Department.

6.10 ANNUAL LEAVE

The Working Time Regulations provides employee and workers with a minimum annual leave entitlement, which includes bank holidays.

Employees will receive contractual annual leave and bank holiday entitlements, which are in excess of The Regulation requirements, in line with their respective Terms and Conditions of Employment. More details can be found in Annual Leave and Bank Holiday Policy.

Bank Workers will receive statutory annual leave and bank holiday entitlements.

7. MONITORING AND REVIEWING THE POLICY

All Trust managers are responsible for implementing and monitoring compliance with The Regulations, in their areas of responsibility. Managers should ensure there is appropriate evidence of compliance to The Regulations on the employee or workers employment record. These records must be able to demonstrate the limits are being adhered to in respect of the:

- maximum working week;
- rest breaks;
- daily rest:
- weekly rest;
- night work

Where there is an entitlement to compensatory rest, this must be evidenced on the employee or workers employment record.

Opt Out Agreements and Declaration of Secondary Employment records must also be added to the employment record for the employee or worker.

All Working Time records, must be kept for a minimum of two years, from the date on which they were made, to ensure compliance with the regulatory requirement.

This document will be reviewed and updated when necessary to reflect any subsequent legislation or legal advice.

8. GETTING HELP

Further information and advice on The Regulations is available from the Trusts Workforce and OD Department.

Should an employee have a concern relating to The Regulations or the application of The Regulations, it will be dealt with in accordance with the Trust's Respect and Resolution Policy.

WORKING TIME REGULATIONS – OPT OUT AGREEMENT

The Agreement complies with the Working Time Regulations Statutory Instrument 1998/1833 Regulations (5) 1.

The Agreement provides for you a voluntary offer to enter into an agreement with Velindre University NHS Trust to opt out of the 48 hour limit in respect of total weekly average hours required in your case over an average 17 week period (excluding Junior Doctors in training as their average weekly working time is calculated using a 26 week reference period).

Your minimum weekly hours of work will continue to be specified in your contract of employment with the Trust.

Your signature is require for The Agreement to be accepted.

Name			
Job title on appointment			
Payroll Number			
Division / Organisation		Department	
Start Date in Post			

The Agreement

Please tick to confirm each of the following:

I agree that the 48 hour average weekly limit specified in the Working Time Regulations 1998 Regulation 4 (1) shall not apply in my case/	☐
I understand that this agreement will apply from and will continue indefinitely, or until such a time that I provide notice to withdraw The Agreement. I am aware that I am under no obligation to sign this agreement and that it is illegal for me to be subjected to any detriment if I decline to sign.	☐
Despite agreeing to opt out of the limit of 48 hours over an average 17 week period, (or 26 week period for Junior Doctors in training) I confirm that both the Trust and I have agreed to ensure extra hours worked do not impair my efficiency or expose colleagues, the public or property to risk.	☐
I confirm that I agree that both the Trust and I will keep accurate records of my working hours in accordance with the regulation requirements.	☐
I agree to give, in writing, a minimum of 7 days' notice to bring this agreement to an end. Less notice will be considered under exceptional circumstances.	☐
I understand I have a legal obligation to inform the Trust if I currently work for, or subsequently plan to work for a second employer (or undertake self-employment).	☐
I understand that if I work for a second employer (or undertake self-employment) and wish to continue working over a total of 48 hours per week, I must sign a waiver for my second employer as well as for the Trust.	☐

This sections must include signatures:

Full Name	

Signature (Employee)	
Manger Name	
Manger Job Title	
Signature (Manager)	

Completed agreements must kept on the employment record for at least 2 years

One copy to be retained by the employee or worker for their record.

An annual review of The Agreement is to be undertaken by the manager and the employee or worker that should also be recorded on the employment record.

All Wales

Velindre University NHS Trust

Special Leave Policy

GIG CYMRU NHS WALES

Sections

01

Special Leave Policy

02

Appendix A: Application for Special Leave

01

Special Leave Policy

Approved by: Welsh Partnership Forum

Issue Date: December 2020

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01 Special Leave Policy

1. Policy Statement

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued

dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

2. Introduction

This policy sets out the approach of the **Velindre University NHS Trust** to special leave and the procedure for dealing with applications for special leave.

This policy is intended to ensure that the **Velindre University NHS Trust** complies with section 57A of the Employment Rights Act 1996, as amended by the Employment Relations Act 1999, and the Civil Partnership Act 2004. This legislation provides a right for employees to request a reasonable amount of time off work to deal with unexpected or sudden emergencies and to make any necessary long-term arrangements; section 50 of the Employment Rights Act 1996, ensures that employees are allowed reasonable time off work to perform certain public duties.

In line with the Equality Act 2010, the **Velindre University NHS Trust** is committed to implementing the policy in a way which promotes the fair and equal treatment of all employees and eliminates discrimination on the grounds of race, disability, gender, gender reassignment, marriage and civil partnership, age, sexual orientation, religion or belief, language and human rights. It is the responsibility of managers and employees to ensure that they implement this policy/procedure in a manner that recognises and respects the diversity of the workforce and the different needs of all employees.

Velindre University NHS Trust recognises the right of all employees subject to this policy to be treated fairly and with dignity and respect.

Velindre University NHS Trust also recognises it has a legal duty to make any reasonable adjustments to the workplace, or to the way work is done, to ensure that a disabled employee is not substantially disadvantaged.

Velindre University NHS Trust attaches considerable importance to assisting employees in balancing the responsibilities of their work with their domestic and family responsibilities. It is recognised that in the majority of instances these commitments can be planned and are therefore outside of the remit of this policy.

Velindre University NHS Trust supports its employees, at times of urgent and unforeseen need, by consideration of the provision of additional leave according to circumstance.

The situations that this policy is intended to deal with are:

- Emergency carers and dependant leave
- Unexpected crisis leave
- Bereavement leave

Leave granted under this policy is not intended for long term or foreseeable domestic and family situations, which may be provided for in other ways, e.g. annual leave, unpaid leave, reduced working hours etc.
The policy will also consider the awarding of reasonable time off to staff to enable them to undertake civil and public duties requiring them to be away from the

workplace in the following circumstances:

- Time off for public duties
- Jury service
- Reserve and cadet forces
- Attending job interviews

(This list is not exhaustive)

Special Leave is not an entitlement; however, requests for special leave will be considered sympathetically in the light of individual circumstances and may be granted at the discretion of the line manager. It is important for employees to consider the needs of the **Velindre University NHS Trust** and to make every effort to make alternative arrangements wherever possible.

3. Scope of Policy

This policy applies equally to all employees and aims to give clear guidelines to employees and managers when dealing with requests for paid and/ or unpaid special leave.

There is no minimum service requirement to make a request for special leave.

This policy recognises that there are 2 types of special leave; unforeseen/ unplanned need for personal reasons; and time off to perform public duties. Section 7 of the policy looks at the differential between the two distinct types of leave in detail.

4. Principles

Managers should interpret the policy in a flexible and caring way. Managers will wherever possible and appropriate seek to grant requests for special leave, within the scope of the policy, bearing in mind workplace demands in the case of planned leave (see section 7.2). An underlying principle of the approach of the policy is that managers should "know their employees" and be familiar with any issues that the employee may have and be aware of needs of their employees. The manager in "knowing their employee", has the ability to apply discretion in the application of the policy.

Treating all employees in a trusting and respectful manner, at such times, is good management practice, which can bring positive long-term benefits to the employment relationship, between the manager and the employee.

Employees will need to openly discuss with their manager the reasons and circumstances that have led to their special leave request. There should be an acknowledgment by the employee that special leave may only be granted by the agreement of their manager, in consultation with their Workforce & OD department, if appropriate.

This policy includes the provision for staff to be granted a period of paid or unpaid leave, dependent upon the circumstances. It is also important to stress that it is not necessary for employees to use up their annual leave entitlement before they can apply for special leave.

All special leave must be applied for and granted consistently throughout the **Velindre University NHS Trust**

5. Responsibilities under the policy

5.1 Line Managers

Line managers are responsible for:

- ensuring that employees are aware of the policy;
- all requests for paid and unpaid special leave are made on the relevant application form (appendix A);

• decisions about special leave requests are made on the basis of the employee's individual circumstances and are consistent with the policy;
• considering flexible working, in consultation with the employee, if there is pattern emerging of utilising leave, sickness and special leave to cover short-term issues
• monitor the usage of special leave and where refused identify what alternatives have been offered;
• retaining relevant documentation within the employee's personal file;
• ensuring notification of any period of paid or unpaid special leave to payroll, including completion of the Electronic Staff Record (ESR) on Self Service where available;
• maintaining regular contact where appropriate with individual staff members;
• offering/signposting counselling as appropriate.

5.2 Employees

Employees are responsible for:

• ensuring they are familiar with this policy;
• ensuring they have relevant and appropriate arrangements, including contingency arrangements to allow them to fulfil their contractual obligations;
• ensuring that they tell their employer as soon as possible the reason for their absence and how long they expect to be absent;
• ensuring all requests for paid and unpaid special leave are made using the relevant special leave application form (appendix A), having been discussed with their line manager.

6. Types of Leave

6.1 Definition of paid leave

The pay that an individual would normally have expected to receive for the shift(s) had they been in work.

6.2 Unpaid leave

Leave taken when an employee's time off from work is not covered by existing benefits such as sick leave, annual leave and is not remunerated.

6.3 Time off in lieu

Time that an employee who has worked additional hours (unpaid not overtime) over and above their contacted hours may take off from work with the agreement of their employer.

6.4 Annual leave

Annual leave is paid time off from work granted by employers to employees to be used for whatever reason the employee wishes (see NHS Terms and Conditions of Service – Section 13 and Terms and Conditions of Service – Specialty Doctor (Wales), Terms and Conditions – Associate Specialist (Wales) and National Health Service Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) Terms and Conditions of Service as amended).

6.5 Flexitime leave

Leave to be taken from time built up as part of a formal or informal flexitime arrangement.

6.6 Parental leave

Leave for eligible employees for the purpose of caring for their child (see NHS Terms and Conditions of Service Section 33 and Terms and Conditions of Service – Specialty Doctor (Wales), Terms and Conditions – Associate Specialist (Wales)

Conditions - Associate Specialist (Wales) and National Health Service Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) Terms and Conditions of Service as amended).

7. Different types of Special Leave

7.1 Unplanned/Times of unforeseen need

7.1.1 Emergency carers and dependant leave

An employee has a right to take a reasonable amount of time off work when it is necessary to:

(a)provide assistance when a dependant falls ill, gives birth, is injured or assaulted;
(b)make longer-term care arrangements for a dependant who is ill or injured;
(c)take action required in consequence of the death of a dependant;
(d)deal with the unexpected disruption, termination or breakdown of arrangements for the care of a dependant (such as a child-minder falling ill); and/or
(e)deal with an unexpected incident involving their child while a school or another educational establishment is responsible for them.

A **dependant** is:

(a)the employee's spouse, civil partner, parent or child;
(b)a person who lives in the same household as the employee, but who is not their tenant, lodger, boarder or employee; or
(c)anyone else who reasonably relies on the employee to provide assistance, make arrangements or take action of the kind referred to above
(see NHS Terms and Conditions of Service Section 33).

A **carer** is:
someone who provides unpaid help and support to a relative, friend or neighbour who could not manage on their own, due to chronic or life limiting illness, disability, frailty, physical impairment, mental ill health or substance misuse.

It should be noted that this does not include any situations, which are pre-planned or where the employee has prior knowledge of the arrangements. In these instances, special leave will not apply, and the expectations will be for the employee to make alternative arrangements such as requesting annual leave.

Usually no more than 3 days may be granted per episode, or no more than 6 days paid leave pro rata in any rolling 12-month period, as other types of leave may be taken to extend the period of absence. As an alternative or in addition to the above, "home working" may be an option in some circumstances.

7.1.2 Unexpected crisis leave

There may be times when employees may need to deal with situations not mentioned in the policy but are nevertheless considered important enough to affect the ability of the employee to attend work and which may be resolved by limited time off. An example of such a situation may be the need to deal with urgent unexpected house repairs or following a burglary or flood. Usually no more than 1 day will be granted to deal with the initial crisis. This type of leave is not meant for example to await delivery of a household item or awaiting a pre-arranged engineer to call as these would not be regarded as emergencies.

7.1.3 Bereavement

An employee will be allowed to take a reasonable amount of time off, for

bereavement, as follows:-

- For bereavement purposes, individual, social, cultural, religious and geographical circumstances should be considered when granting special leave. Depending on these circumstances managers are able to grant either:
  - Special leave for the period up to and including the day after the funeral (if there are specific religious and/or cultural requirements for example in some religions/cultures individuals may be buried within 24 hours, discretion should be used when considering the amount of time required);
  - Special leave for the day of the funeral and/or the day of/after bereavement;
  - Annual leave, flexi-leave or unpaid leave for the day of the funeral.

It is recognised that grieving can go on for much longer than the initial bereavement and therefore the use of the managing attendance at work policy, annual leave, flexible working and unpaid leave should be considered.

- Death of a child, in respect of which the employee is the child's parent or for which an employee has had primary caring responsibility. Section 23 of the NHS Terms and Conditions of Service Handbook provides for two weeks paid leave. In line with the bullet point above, a significant period of time off in excess of two weeks may be required and appropriate conversations will need to be held on an ongoing basis between the employee and manager in a sensitive manner about the amount of ongoing special leave required and flexibility and support for the employee on their return to work. Section 23 also provides further detail regarding the wider provisions of support for employees in such difficult circumstances.

- The provisions equivalent to those contained in section 23 will apply to medical and dental staff.

7.1.4 Staff Experiencing Domestic Abuse

The effect of domestic abuse is wide ranging. Members of staff may need time off work to access legal or financial advice, to arrange child care or alternative accommodation and to seek medical advice. Managers should be flexible when supporting a member of staff who is experiencing domestic abuse and treat each instance sensitively and individually. Members of staff should not be expected to provide proof of their circumstances. Generally, up to 3 days may be granted for each required leave period with up to 10 days paid leave pro rata in any rolling 12-month period. Other types of leave may be taken to extend the period of absence

7.1.5 Medical Appointment

Reasonable time off for medical and dental appointments is covered in the All Wales Managing Attendance at Work Policy.

7.2 Planned Time Off

7.2.1 Time off for public duties

Individuals have the right to reasonable paid time off work to carry out certain public duties and services. These rights will vary depending on the type of work, and what the duty or service is. When contemplating undertaking such roles, staff should discuss this with their line manager and together they should consider the likely impact this will have on their work attendance and the needs of the service.

Individuals are allowed reasonable time off work for public duties (up to 18 days pro rata) if they are one of the following:

- a magistrate, sometimes known as a justice of the peace

• an elected local councillor
• a member of a police authority
• a member of any statutory tribunal (e.g. an Employment Tribunal, Fitness to practice hearings)
• a member of the managing or governing body of an educational establishment
• a member of the General Teaching Council for Wales
• a member of the Natural Resources Wales
• a member of the prison independent monitoring boards
• a member of any other applicable organisation referred to in section 50(2) of the Employment Rights Act 1996

Individuals requesting time off for public duties need to discuss these arrangements with their line manager in a timely manner, confirming the nature of the duties and the amount of time to be taken.

Any individual who has been allowed paid time off for public duties must refrain from then claiming or accepting any fee or allowance for undertaking that public duty. For the avoidance of doubt, in this context, 'fee or allowance' is not intended to cover any subsistence payment or re-imbursement of expenses incurred in the performance of the public duties.

7.2.2 Job Interviews

Requests for leave to attend job interviews within the NHS or Welsh Government's Health and Social Care Department will not be unreasonably refused. However, NHS organisations may insist that annual leave is taken to attend interviews outside of the NHS rather than special leave granted.

7.2.3 Jury Service/Court Witnesses

Individuals will initially continue to be paid by the NHS organisation for an initial period of jury service or court attendance as a witness that they are required to undertake. The individual should discuss with their line manager whether or not they will continue to be paid as normal during the entire period of jury service or court attendance as a witness, and consequently, whether they will need to make a loss of earnings claim to the Court or elsewhere.

Individuals should provide documentary evidence of the request for jury service/ court attendance as a witness and discuss with their line manager in a timely manner.

Employees must be aware that if the court advises that they are not required for court service on any given day or if the court finishes early the employee must contact work and agree working arrangements for the period.

Alternative arrangements to cover this e.g. home working / annual leave may be agreed through discussion with their line manager.

7.2.4 Reserve and Cadet Forces

Refer to Reserve Forces – Training and Mobilisation Policy.

7.2.5 Fertility Treatments

It is recognised that infertility can cause considerable distress and **Velindre University NHS Trust** is supportive of employees who may decide to undertake fertility treatment. **Velindre University NHS Trust** will provide limited paid leave for this purpose, where the request is supported by documentary evidence, from the employee's GP or consultant/specialist.

As fertility treatment can be a lengthy process, managers should discuss with the employee concerned, the likely duration of their treatment, together with the number of occasions and where possible dates, when they are likely to need time off work, to attend hospital for

their fertility treatment appointments.

It should be noted that following implantation, in law the employee will be considered to be pregnant and as such should be treated as pregnant and the normal pregnancy provisions applied.

Velindre University NHS Trust

will provide an employee who is to receive fertility treatment, with normally up to three days paid leave and a period of agreed unpaid special leave, in any rolling 12-month period. Each case should be treated on its own merits and alternative arrangements may also be considered, e.g. annual leave.

Where an employee experiences side effects or ill health as a result of their fertility treatment, which renders them unfit for work, such absences must be reported, certified and recorded in accordance with the sickness absence policy.

Velindre University NHS Trust

will provide an employee who is the partner of someone receiving fertility treatment with support and reasonable time off.

7.2.6 Wales for Africa

Requests for leave to attend initiatives as part of the "Wales for Africa" programme will be given fair consideration where not covered in local policies.

8. Appeals

An individual who considers the **Velindre University NHS Trust** has failed to comply with the provisions described previously in this policy should refer to the appeal process within the **Velindre University NHS Trust** Grievance Policy and Procedure.

9. Training and awareness

All staff will be made aware of this policy upon commencement of employment with the NHS Organisation. Copies can also be viewed on the NHS Organisation's Intranet or obtained via the Workforce and OD department and/or line manager.

10. Equality

Velindre University NHS Trust recognises and values the diversity of its workforce. Our aim is to provide a safe environment where all employees are treated fairly and equally and with dignity and respect.

Velindre University NHS Trust recognises that the promotion of equality and human rights is central to its work both as a provider of healthcare and as an employer. This policy has been impact assessed to ensure that it promotes equality and human rights.

11. Personal Data

Whenever **Velindre University NHS Trust** processes personal data about employees in connection with this policy, we will process it in accordance with our Data Protection Policy. We will only process employee personal data if we have a lawful basis for doing so. We will notify you of the purpose or purposes for which we use it.

12. Freedom of Information Act 2000

All NHS Organisations' records and documents, apart from certain limited exemptions, can be subject to disclosure under the Freedom of Information Act

2000. Records and documents exempt from disclosure would, under most circumstances, include those relating to identifiable individuals arising in a personnel or staff development context. Details of the application of the Freedom of Information Act within the NHS organisation may be found in the [redacted] publications scheme.

13. Records Management

All documents generated under this policy are official records of the [redacted] and will be managed and stored and utilised in accordance with the [redacted] Records Management Policy.

14. Monitoring

An accurate record of all special leave requests should be maintained on the Electronic Staff Record (ESR), to enable the organisation to consider whether there any issues that may be contributing to unintended discrimination. This information must be capable of being disaggregated by each of the protected characteristics and routinely collected, analysed and reported on to ensure that the process is fair and equitable for all individuals and groups, and to demonstrate that the [redacted] is meeting its employment equality monitoring duties.

15. Review

This policy will be reviewed in two years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

Signed on behalf of the Staff Side:

Signed:
Name:
Title:
Date:

Signed on behalf of the Management Side:

Signed:
Name:
Title:
Date:

02

Appendix A: Application for Special Leave

2 Appendix A: Application for Special Leave

Please note that if your organisation is using ESR self-service then special leave should be recorded through this mechanism

Velindre University NHS Trust

Application for special leave

Personal Details

Full name:

Employee number:

Position:

Organisation (Department):

Work base:

Contact telephone number:

Circumstances of leave

Emergency carers & dependant leave – Section 7.1.1 of policy (please give details)

Unexpected crisis leave – Section 7.1.2 of policy (please give details)

Bereavement – Section 7.1.3 of policy (please give details)

Time off for public duties – Section 7.2.1 of policy (please give details)

Job Interviews – Section 7.2.2 of policy (please give details)

Jury service/Attendance at court as a witness – Section 7.2.3 of policy (please give details)

Fertility Treatments – Section 7.2.5 of policy (please give details)

Wales for Africa – Section 7.2.6 of policy (please give details)

Other reason (please specify)

Number of days requested

Total number of days requested:

From (date):

To (date):

Signed:

Date:

To be completed by Line Manager

Special leave granted (this episode):

Is the special leave paid or unpaid?:

Number of days granted:

Number of days granted (in last 12-month period)

From (date):

To (date):

If not granted, please give reason:

Signed:

Date:

Name:

Position:

Copy to be placed on employee's personal file. This form can be completed retrospectively as long as permission for the special leave has been granted verbally.

Pay Progression Policy

GIG CYMRU NHS WALES

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Pay Progression Policy

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The Pay Progression Process

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Appendix 2: Principles and Best Practice to be integrated in to Local Appraisal

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Appendix 3: EQUALITY IMPACT ASSESSMENT

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Pay Progression Policy

Approved by: Welsh Partnership Forum

Issue Date: January 2020

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01 NHS Wales Pay Progression Policy

1. The Core Principles of NHS Wales:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimisation of any patient, service user or member of employees.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support employees working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by employees in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

2. Policy Aims, Summary and The Appraisal Process

Policy Aims

- **2.1** This policy applies to all members of staff on NHS Terms and Conditions of Service and has been developed in line with Annex 23 of the NHS Terms and Conditions Handbook and must be used in conjunction with local PADR and KSF policies and with the PADR/ Appraisal principles.

- **2.2** This policy sets out the reasons for pay progression and the procedure to be followed to deal with the pay step process. It clarifies the performance ratings to be used and includes a description of each rating. The policy also covers issues arising relating to pay step progression and deferment and the process for handling any disagreement and it aims to ensure consistency of approach and application.

- **2.3** The aim of the pay progression approach is to improve performance and productivity as well as support the implementation of change by helping staff to understand more clearly what is expected of them in terms of behaviours and new ways of working. The aim is to provide a framework that seeks to get value for money by linking pay progression with performance rather than time served in a role.

- **2.4** The Pay Progression Policy needs to work closely with the Appraisal Process and therefore sets out some best practice principles for appraisal that all organisations should embed in their local processes.

These principles are:

- We will agree and understand what's expected of us in terms of what we should be doing and how we should be doing it
- We will all receive constructive and timely feedback on how we have done
- We will all ensure that we actively seek to develop and improve what we are doing for the benefit of patients

- **2.5** The Pay Progression Policy together with local Appraisal Policies will encourage and reward all staff to give their best contribution whatever their job is and to ensure that when pay steps are awarded they are a reward for performance not because of time in employment.

- **2.6** The Chief Executive of NHS Wales will ensure that the policy is implemented fairly.

- **2.7** This policy will be subject to a full review in April 2021 when a full year of data on pay progression will be available. This review will include an impact assessment of the number of first and final written disciplinary warnings against the protected characteristics outlined in the Equality Act.

3. Pay Progression summary

- **3.1** To help us give the best possible care and services, whatever our role, it is important that we understand what is expected of us, how our contribution helps the organisation achieve its aims and that we are rewarded for doing the right things well and not because of another year in post. Therefore, pay steps will only be given after we've achieved what's expected of us in 3 areas:

Doing the right things, Doing them the right way, Doing things better.

- **3.2** The reason for introducing pay progression linked to performance is to help improve your performance and productivity and that of the organisation. It will better support the implementation of change by helping you and your manager agree what is expected of you in terms of your behaviours and new ways of working. It is important to understand that this has been introduced to increase value for money and to promote fairness by linking pay progression with performance rather than basing incremental progression simply on time served in the role.

- **3.3** Alongside this rationale, Annex 23 of the NHS Terms and Conditions of Service sets out five specific pay progression standards which set out requirements which need to be demonstrated before you are able to progress to your next pay step point on your pay step date.

  These standards are:

  i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
  ii. There is no formal capability process in place.
  iii. There is no formal disciplinary sanction live on your record (this policy expands on the specific application of this provision in paragraph 5.4.4).
  iv. Statutory and/or mandatory training has been completed.
  v. For line managers only – appraisals have been competed for all your staff as required.

- **3.4** Your pay step submissions will only take place after two, three or five years depending on your pay band. Your appraisals will continue to take place annually.

- **3.5** All pay bands will have either one or two step points with specified minimum periods before you become eligible to progress. Your pay step point is set in relation to your start date in that pay band. It is expected that if you meet the required standards at your pay step date you will progress to your next pay step point.

- **3.6** Each year, you and your manager will review how well you have met your objectives, whether you have met the pay progression standards and agree whether your performance is satisfactory or unsatisfactory. In the year when a pay step is due your performance will need to be satisfactory for you to progress to the next pay step point.

If it is unsatisfactory then you will not receive your pay step and you will work with your manager to agree a plan to help you meet the requirements in order that you receive your pay step once the relevant requirements are shown to have been met.

Importantly, there will be checks in place to make sure that if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the next pay step.

- **3.7** Pay progression works in parallel with appraisal however they remain as two separate processes. The flow diagram overleaf shows how the two work together.

4. The Appraisal Process

- **4.1** This Pay Progression Policy does not replace or change Appraisal policies but does set out three principles that will be embedded into local appraisal processes. They are:

  - *We will agree and understand what's expected of us in terms of what we should be doing and how we should be doing it*
  - *We will all receive constructive and timely feedback on how we have done*
  - *We will all ensure that we actively seek to develop and improve what we are doing for the benefit of patients*

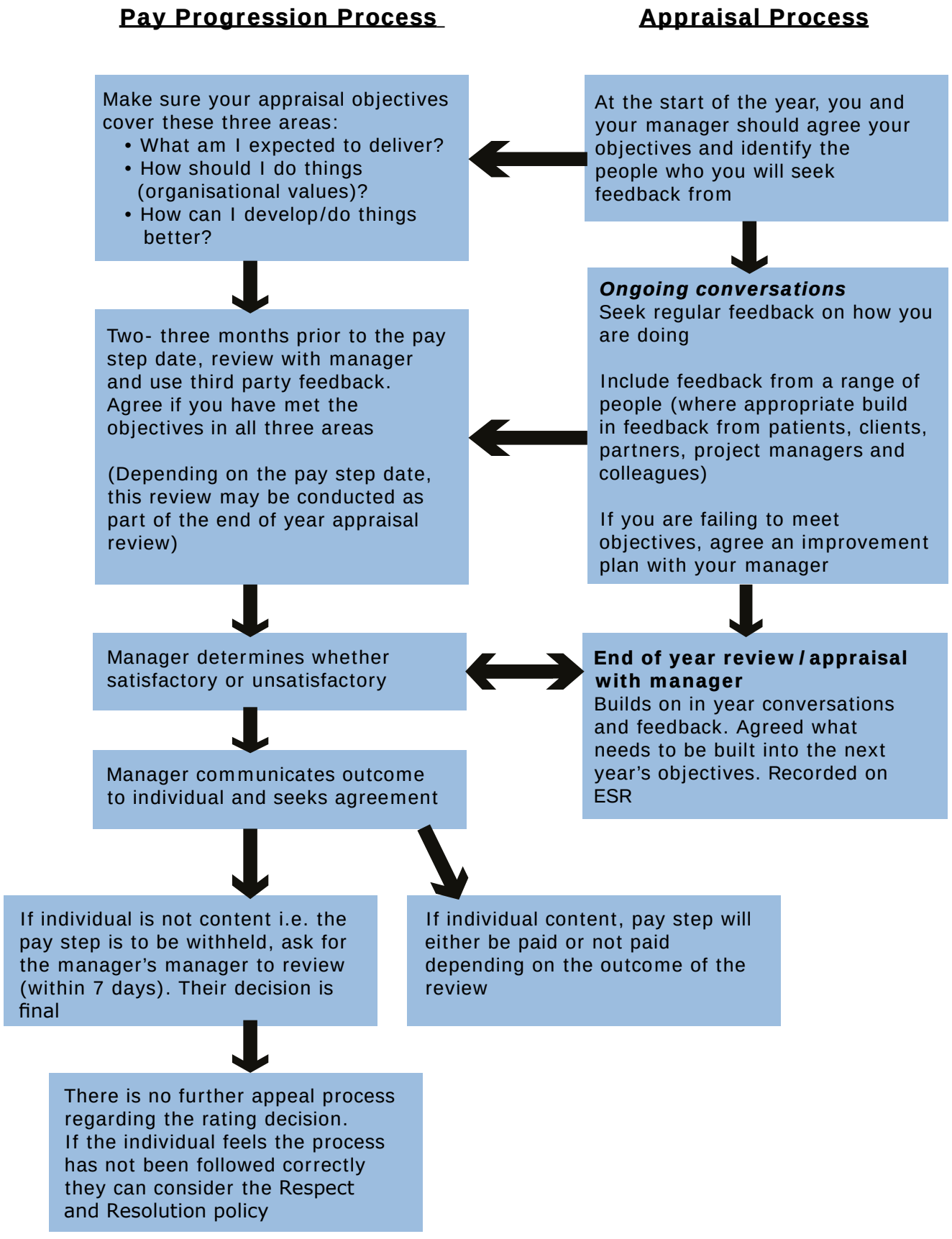
- **4.2** The details of best practice appraisal techniques which will support performance linked pay progression are included in appendix 2 and should be embedded in your local appraisal processes.

- **4.3** Your appraisals should continue to take place on an annual basis at the very least, regardless of whether it is a year which includes a pay step date, or you are at the top of the scale.

02

The Pay Progression Process

2 The Pay Progression Process



5. Who does what and when?

5.1 Agreeing Objectives

As part of the annual appraisal process, you and your manager will agree a set of objectives which cover:

- what you need to do i.e. the things you need to deliver;
- how you need to do things, i.e. your behaviours, and the way you demonstrate the values;
- ways in which you can seek to develop and improve what you are doing.

You should play an active role in setting the objectives and checking that you understand what your manager expects of you as the extent to which you meet these objectives will determine whether or not you receive your pay step when it is due.

5.2 Feedback

Both you and your manager should actively seek feedback and information from different people (e.g. patients, colleagues, partners), any relevant results/data, project/improvement work you have been involved in.
This feedback will help you and your manager prepare for your pay progression review and support the rating you are given.

5.3 Pay Step Review

You should have a review 8-12 weeks before your pay step is due which will be arranged by your manager. Both you and your manager should prepare in advance. At the meeting you should discuss examples of how you have met your objectives, where appropriate using feedback from other people. Depending on your pay step date, this meeting may also be your end of year appraisal/PADR review. It is good practice to have regular conversations and feedback through out the year so there should be no surprises.

If you have been struggling to meet your objectives, this should have been discussed earlier in the year and an improvement plan agreed.

5.4 Agreeing the rating

- **5.4.1** At the end of your pay step review, your manager will tell you your rating i.e. whether you are satisfactory or unsatisfactory and their reasons for the decision. If you both agree the rating, your manager will inform the W&OD department and payroll and undertake the necessary steps in relation to ESR. If the rating is satisfactory your pay step uplift will be paid, if the rating is unsatisfactory you will not receive the pay step.

Satisfactory

Has successfully met core objectives and demonstrated satisfactory progress in achieving other objectives and met the national pay progression principles set out overleaf

Unsatisfactory

Has been unsuccessful in meeting core objectives and/or has not demonstrated satisfactory progress in achieving other objectives and/or has not met the national pay progression principles set out overleaf

Individual organisations will need to determine what will constitute a satisfactory or unsatisfactory performance on a departmental, team or individual basis. It will depend on the type and nature of the role but should be based on clear, reasonable, agreed objectives.

Managers should agree a core set of achievable objectives on which pay progression is assessed but also include furthermore ambitious objectives as part of a wider performance review process. It must, however, be made clear what level of performance would amount to satisfactory and therefore what would be an unsatisfactory level of performance.

- **5.4.2** In addition to achieving objectives the following national pay progression standards will also need to be demonstrated:

  i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
  ii. There is no formal capability process in place.
  iii. There is no formal disciplinary sanction live on the staff member's record (the specific application of this provision is set out in paragraph 5.4.4).
  iv. Statutory and/or mandatory training has been completed.
  v. For line managers only – appraisals have been competed for all their staff as required.

- **5.4.3** It is expected that you will achieve the required standards at the point of your pay step date. It is also expected that you and your line manager should have had regular discussions about any problems in reaching the required standards before the pay step date. This will allow time for issues to be raised and possible solutions found to enable the pay step point to be opened on time.

- **5.4.4** Your manager must use the pay step review meeting to discuss the standards. If any of the standards have not been met, there should be a review of the previous discussions about these to consider any mitigating factors and to record the decision.

With regard to live disciplinary sanctions, if you are in receipt of a first written warning, your progression won't be delayed because of the warning. Your manager will however, consider the reasons and circumstances giving rise to the sanction, as well as your performance and behaviour since the sanction was applied. This will form part of the information which your manager will use in determining a pay progression rating. If following due consideration your manager determines that you should receive a satisfactory rating, then you will progress to the next pay step. If you receive an unsatisfactory rating your pay step will be delayed. The decision will be clearly recorded, noting the rationale for withholding the pay step. A final warning will always result in a pay step delay.

- **5.4.5** Importantly, if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the pay step.

- **5.4.6** Pay step points will be closed on the payroll system. Once the pay step review has been successfully completed your manager must take the necessary action to open the pay step point.

- **5.4.7** Managers must ensure that the pay step submission process is completed in a timely fashion to ensure that pay step points can be implemented in time for the staff member's pay step date. This must take account of local payroll timescales and ESR requirements.

- **5.4.8** Although you must have successfully completed your last appraisal to move to your next pay step point, the date the appraisal takes place does not have to be linked to your pay step date. If your last appraisal outcome was not satisfactory but remedial actions have been successfully completed by the time of the pay step date you will be able to progress without delay if you meet the other standards.

5.5 Decisions to delay a pay step

- **5.5.1** In situations where standards have not been met and there are no mitigating factors sufficient to justify this, your pay step will be delayed. Your line manager will discuss and agree a plan with you for any remedial action needed to ensure that the required standards for pay progression are met, including a timescale, and how any training and support needs will be met. In such circumstances you must take all necessary steps to meet the requirements as soon as possible and your line manager must provide you with the necessary support.

- **5.5.2** A further pay step review meeting should be arranged at an agreed date to review progress and, where satisfactory, initiate the opening of the pay step. The effective date for progressing to the next pay step should be the earliest date that the relevant requirements are shown to have been met. The pay step date for future years will remain unchanged.

- **5.5.3** Where a pay step is delayed due to a live disciplinary sanction, or a formal capability process, your line manager should initiate a pay step review meeting before the expiry of the sanction or capability plan. This should be used to confirm that all other requirements have been met and to ensure that you progress to the next pay step, effective the day after the sanction expires. Any future pay step dates will remain unchanged.

5.6 Integrating outcomes into next year's appraisal

- **5.6.1** The pay step review should be part of your ongoing performance management discussions with your manager and will provide a useful source of feedback to take into account in the end of year appraisal review and future objective setting.

If you are rated satisfactory then you and your manager can discuss whether you require further development opportunities etc. If you are rated unsatisfactory you and your manager should agree a plan to help you improve and get your performance back on track.
These objectives should be included and reviewed in your next appraisal.

- **5.6.2** If your manager identifies that you have been unable to meet your objectives through no fault of your own, then you and your manager will need to work together to reset your objectives or remove the barriers to their achievement

5.7 Dealing with disagreement

Very occasionally, you and your manager may disagree on how well you have met your objectives and therefore on the rating you are given. Wherever possible, you should try to resolve issues with your manager. If your manager rates you unsatisfactory and you feel that you have demonstrated satisfactory progress in achieving your objectives and you have met the national pay progression principles, and you can't resolve the reason for an unsatisfactory rating directly with your manager, then you can ask your manager's manager to review the decision.

This process will take place within the provisions of the Respect and Resolution Policy and should be undertaken within 14 calendar days of notification to your manager that you wish to.

The notification requirements for requesting a formal resolution within the Respect and Resolution policy should be used, setting out the grounds upon which you consider the rating should be reviewed. Your manager's manager will want to understand both you and your manager's points of view. She/he will then make a decision on the rating and will communicate their reasons to both you and your manager.

If you are unhappy with the process, have other concerns not linked directly to the result of your appraisal, or believe that you have been discriminated against in any way, then please raise a formal request for resolution in line with the Respect and Resolution policy. Your manager will then inform the W&OD department and payroll, and update ESR. If it is agreed that you should receive your pay step it will be backdated to the original pay step date.

5.8 Band 8c/d and 9 Roles

We recognise that rewarding good performance with pay steps is a significant and positive change. We also recognise that senior leaders are in the main already expected to be setting and reviewing objectives in this way. They are also more likely to be used to asking for and receiving feedback from a number of people. Additionally, we know it's important for leaders to model the behaviours we want from others.

Therefore, for Band 8c, 8d and 9 roles, there are the following differences:

In the year after you have reached the top of bands 8c, 8d or 9, 5 per cent or 10 per cent of basic salary will become re-earnable. Where a satisfactory performance is agreed, your salary will be retained at the top of the band.

If your performance is deemed to be unsatisfactory, your salary may be reduced by 5 per cent or 10 per cent * from the pay step date. You will be able to restore your salary to the top of the band at the end of the following year by meeting the required standards.
You have the right to contest a decision to reduce your pay using the Dealing with Disagreement process outlined above.

*the NHS Staff Council Executive has advised that there are plans to develop some criteria in relation to the application of the re-earnable 5% and 10% of salary and this section of the policy will include the appropriate details once these have been determined.

03

Appendix 1: Legal issues

3 Appendix 1: Legal issues

Absence from Work When a Pay Step Is Due

If you are absent from work for reasons such as sickness or parental leave when a pay step is due, the principle of equal and fair treatment should be followed so that no detriment is suffered as a result.

In the case of planned long-term paid absence such as maternity, adoption and shared parental leave your pay step review can be conducted early if this is reasonable and practical, allowing the pay step to be applied on your pay step date in your absence.

If you are on long-term paid absence such as maternity, adoption and shared parental leave and a pay step review cannot be conducted prior to the pay step date, the pay step point should be automatically applied in your absence provided that there are no disciplinary sanctions or formal capability processes in place.

If there is a live disciplinary sanction in place at the point you go on leave, the pay step point should be applied in your absence if appropriate, effective from the day after the sanction expires.

If there was an active formal capability process underway at the point you go on leave, the pay step point can be delayed. The improvement process should be resumed immediately upon your return. On satisfactory completion, the period of absence should be set aside, and the pay step point backdated to an agreed date as if you had completed the improvement process without being absent.

Suspension from work on full pay is a neutral act. In order to ensure this is the case, your employer should ensure that your pay step point is applied from your pay step review date where you are suspended on that date, provided your performance was deemed satisfactory and you have met the national pay progression standards.

These standards are:

i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
ii. There is no formal capability process in place.
iii. There is no formal disciplinary sanction live on your record (this policy expands on the specific application of this provision in paragraph 5.4.4.
iv. Statutory and/or mandatory training has been completed.
v. For line managers only – appraisals have been competed for all your staff as required.

If it is unsatisfactory then you will not receive your pay step and you will work with your manager to agree a plan to help you meet the requirements in order that you receive your pay step once the relevant requirements are shown to have been met.

Importantly, there will be checks in place to make sure that if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the next pay step.

Sabbaticals/career breaks are by definition your choice, therefore if you choose to take a sabbatical/career break at any stage during your career your pay progression will be 'frozen' at the incremental point you have achieved at your last working day.

You, therefore, will return to work at the same incremental point you left on.

An assessment will need to be undertaken within a few weeks of returning to identify your training and development needs.

Equality Monitoring

will monitor the application of the policy against the protected characteristics in line with the Equality Act 2010. This may be done a sample basis. A report will then be provided to the Board or appropriate sub committee on an annual basis.

Other Extenuating Circumstances

recognises that there may be other extenuating circumstances that have not already been covered in this section. In cases where it is believed there are extenuating circumstances for not achieving the progression criteria, advice should be sought from your line manager and a relevant member of the W&OD department.

04

Appendix 2: Principles and Best Practice to be integrated in to Local Appraisal processes

4 Appendix 2: Principles and Best Practice to be integrated in to Local Appraisal processes

To help us give the best possible care and services, whatever our role, it is important that we understand what is expected of us and how our personal contribution helps our teams and the organisation achieve its aims.

Appraisal discussions should be ongoing and:

- Provide feedback on how we have done - feedback should be honest, constructive and timely and where possible we should seek feedback from a range of people we work with (e.g. colleagues, stakeholders, patients, project managers)

- Ensure each of us agree and understand what's expected of us and how we should be doing things i.e. what we need to deliver and the behaviours and ways of working that are expected of us

- Ensure that we develop ourselves to do things better and/or move to another role and have a plan of what learning we are going to do

Managers involved in reviewing, assessing, agreeing objectives and supporting personal development plans, must ensure that they are competent and confident to do this role. Learning and development teams can help support managers where this is needed.

Agreeing Objectives

It is vital that we know what is expected of us. Importantly, we should agree our specific objectives so that we own them. Objective setting should always be a two-way conversation.

For objectives to be meaningful, they must be SMART: specific, measurable, realistic, time-based and achievable; they must particularly be "within our circle of control". You should not agree objectives on things you can do nothing about. Good objectives are ones where the outcomes are as a result of what we do and how we behave, i.e. they are things we can control.

Agreeing Development Needs

As part of the review or setting of objectives, it is likely that you will have identified things and/or ways you can do better. These are likely to need us to spend time developing ourselves and you should agree the best way to do this with your manager. Often a formal training course may not be the only or the best solution and you should think about the time you need to spend on your development, not just the budget you may need.

Keeping Records

Keeping accurate records is important and any records that you and your manager keep should be within the General Data Protection Regulations 2018 requirements. Managers must ensure that all details of appraisal meetings are recorded on ESR.

05

Appendix 3: EQUALITY IMPACT ASSESSMENT

1. General

Title of document	Pay Progression Policy (non-medical staff)
Purpose of document	To set out the procedure to be followed for linking pay progression to performance, to describe the process for handling annual incremental reviews, addressing issues arising relating to incremental progression and deferment and to ensure consistency of approach and application. The document shows how pay progression and appraisal processes align and reiterated the need for all staff to have a clear understanding of their expected role and function and have the opportunity to receive feedback about their performance in order that they may develop to their maximum potential.
Intended scope	All non-medical and dental staff employed by NHS Wales.

2. Consultation

Which groups / associations / bodies or individuals were consulted in the formulation of this document?	NHS Wales Partnership Forum (including all unions recognised by NHS Wales); Strategic Pay Taskforce Implementation Group; NHS organisations; Line Managers.
What was the impact of any feedback on the document?	Amendments were made and a commitment given to a full review in April 2021 when a full year of data will be available. See paragraph 2.7.
Who was involved in the approval of the final document?	NHS Wales Partnership Forum & Strategic Pay Taskforce Implementation Group.
Any other comments to record?	

3. Equality Impact Assessment

Does the document unfairly affect certain staff or groups of staff? If so, please state how this is justified.	No.
What measures are proposed to address any inequity?	None
Can the document be made available in alternative format or in translation?	Yes, on request to Workforce & OD Directors.

4. Compliance Assessment

Does the document comply with relevant employment legislation? Please specify.	Yes.

5. Document assessed by:

Name	Pay Progression Partnership Review Group
Post Title / Position	
Date	June 2019

Designed by the NWSSP Communications Team

Velindre University NHS Trust

Procedure for NHS Staff to Raise Concerns

Introduction

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

The safety and wellbeing of patients and service users are seen as the responsibility of everyone involved in the provision of health and social care services. Velindre University NHS Trust Board and senior management are committed to providing an environment which facilitates open dialogue and communication so as to ensure that any concerns which staff may have are raised as soon as possible.

This procedure refers in the main to ‘raising concerns’ rather than ‘whistleblowing’ because the latter has come to denote a sudden, drastic or last resort act which can hold negative connotations.

Velindre University NHS Trust is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage. This procedure should also be used by staff to raise any concerns with regard to practices within the supply chains through which Velindre University NHS Trust sources its goods and services (in line with the Supporting Ethical Employment in Supply Chains Code of Practice Commitments). Staff should also recognise that elements of wrongdoing that involve aspects of Fraud, Bribery or Corruption, have a separate reporting process, which should be presented to your Local Counter Fraud team for investigation.

It is, however, acknowledged that such processes take time to develop and embed into the organisation and until such time as such a culture exists comprehensively across Velindre University NHS Trust that a clear process needs to be in place to guide individuals who wish to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. This procedure sets out Velindre University NHS Trust's commitment to support individuals who raise concerns as well as setting out the processes for individuals to raise such concerns and to provide assurance on how such concerns will be listened to, investigated and acted upon as necessary.

'Whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation raises concerns to people who have the power and presumed willingness to take corrective action. The types of situation where this will be appropriate are outlined in Appendix 1. "Protected disclosure" is the legal term for whistleblowing and is referenced in the context of describing the protection that is afforded to the person raising the concern in the interest of the public (see appendix 2).

The development of this procedure is an ongoing process and is a part of the wider work across NHS Wales to ensure that an open culture exists to provide the highest standards of care and experience across all services. This procedure does not form part of an employee's contract of employment and may need to be amended from time to time.

1. A Commitment to Support Those Who Raise Concerns

1.1 Velindre University NHS Trust actively encourages feedback and has a transparent and open approach to listening to and responding to all concerns.

1.2 Velindre University NHS Trust aims to ensure that individuals:

- Are fully supported to report concerns and safety issues;
- Are treated fairly, with empathy and consideration when raising concerns; and
- Have their concerns listened to and addressed when they have been involved in an incident or have raised a concern.

1.3 Velindre University NHS Trust aims to develop and maintain a culture across all parts of the organisation that provides an environment where people feel able to raise concerns and are treated with respect and dignity when raising concerns.

1.4 Safety is at the heart of all care and must be underpinned by a culture which is open and transparent. This leads to increased reporting, learning and sharing of incidents and development of best practice. Velindre University NHS Trust recognises that this is the responsibility of everyone involved in the provision of health and social care services. Velindre University NHS Trust is committed to working towards ensuring that all individuals are treated in a service which is open to feedback and encourages as well as supports its staff to raise concerns.

1.5 Velindre University NHS Trust will ensure that individuals always feel free to raise concerns through local processes and are supported to do so directly with Velindre University NHS Trust, their professional regulatory body, professional association, regulator or union.

1.6 Velindre University NHS Trust facilitate an individual to raise an issue or concern in Welsh and they should be advised of this at the outset. Any subsequent proceedings should be conducted in Welsh or a simultaneous translation service provided.

1.7 Velindre University NHS Trust is committed to: -

- Working in partnership with other organisations to develop a positive culture by promoting openness, transparency and fairness;
- Fostering a culture of openness which supports and encourages staff to raise concerns;
- Sharing expertise to create effective ways of breaking down barriers to reporting incidents and concerns early on;
- Exchanging information, where it is appropriate and lawful to do so, in the interests of patient and public safety; and
- Signposting individuals to support and guidance to ensure that they are fully aware of and understand their protected rights under the Public Interest Disclosure Act 1998.

1.8 A definition of whistleblowing is included at appendix 1.

1.9 Velindre University NHS Trust will monitor the use of this procedure and report to the Board or a sub committee, as appropriate.

2. About this Procedure

2.1 The aims of this procedure are:
(a) To encourage staff to discuss concerns and safety issues as soon as possible, in the knowledge that their concerns will be taken seriously and acted upon as appropriate,
(b) To encourage staff to report more serious concerns and suspected wrongdoing as soon as possible, in the knowledge that their concerns will be taken seriously and investigated as appropriate, and where requested that their confidentiality will be respected.
(b) To provide staff with guidance as to how to raise those concerns.
(c) To assure staff that they should be able to raise genuine concerns without fear of reprisals, even if they turn out to be mistaken.

2.2 This procedure applies to all employees, officers, consultants, contractors, students, volunteers, interns, casual workers and agency workers.

3. Raising a Concern

3.1 All healthcare settings and workplaces should encourage ongoing open dialogue and feedback on matters relating to provision of care/service delivery through supervision, team or departmental meetings, staff forums. These ongoing mechanisms are the place where Velindre University NHS Trust will actively seek suggestions for improvement and regularly review the safe and effective delivery of services and ways of working.

3.2 All managers will ensure that there is a shared responsibility to focus positively on the quality of service/care, continuous improvement and/or problem solving.

3.3 If concerns are held by an individual or individuals Velindre University NHS Trust will ensure that such concerns are addressed and responded to with the outcome being verbally communicated, as a minimum, to the individual or individuals raising the concern. An individual may raise a concern in Welsh and they should be advised of this at the beginning of any proceedings. Any subsequent proceedings should be conducted in Welsh or a simultaneous translation service provided.

3.4 More Serious Concerns

Confidentiality

As noted in section 1.3 of this procedure “Velindre University NHS Trust aims to develop and maintain a culture across all parts of the organisation that provides for an environment where people feel able to raise concerns”. It is therefore hoped that all staff will feel able to voice concerns openly under this procedure. However, if an individual wants to raise a concern confidentially this will be respected. It is sometimes difficult however, to investigate a concern without knowing the individual’s identity. In such circumstances if it is considered absolutely necessary to share the identity of the person raising the concern this will be discussed with them prior to any disclosure being made, and their permission sought.

Stage 1 – Internal (Informal)

If an individual has a concern about any issue involving malpractice/wrongdoing they are encouraged to raise it first either verbally or in writing with their line manager or the manager responsible for that area of work, unless it relates to fraud or corruption (see paragraph overleaf relating to this issue). They may also wish to involve their Trade Union/Staff Representative. Medical staff should report the issue to their Lead clinician.

It is important to remember that raising a concern is different from raising a personal complaint or grievance and in such circumstances the All Wales Respect and Resolution Policy may be appropriate (see appendix 1). If the concern is around the abuse of children or adults with vulnerabilities then the Wales Safeguarding Procedures should be followed and initiated immediately.

and/or

To ensure effective operation of the Procedure for Raising Concerns, Velindre University NHS Trust must provide an alternative route for issues to be raised where going through the line manager is not appropriate e.g.

- *the member of staff feels there is an immediate issue of significant risk to safety which would not be addressed by line management*
- *the concern raised relates to the conduct or practice of one or more individuals in the line management accountability structures who would normally consider the concern*
- *the member of staff has strong experiential evidence that the line manager(s) would not address the concern*
- *the member of staff feels that similar concerns raised in the past had been ignored*
- *the member of staff feels that the raising of concern would place him/her at risk of harassment or victimisation from colleagues or managers*

Accordingly, Velindre University NHS Trust should set up their own arrangements, e.g.

- *Workforce & OD (HR) staff*
- *Governance staff*
- *Professional heads*
- *"Raising concerns" champion (this should be a nominated member of the Board)*
- *Telephone hotline*
- *Safe Haven*

The individual will be entitled to a verbal response, as a minimum, and where appropriate detail needs to be conveyed a written response to their concern may be appropriate, provided that they have not wished to remain anonymous. The responsibility for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised as described in the previous paragraph.

Any concerns regarding potential fraud or corruption should be raised initially with the Local Counter Fraud Specialist (LCFS) via CounterFraudEnquiries.cav@wales.nhs.uk. Alternatively, reports can be made via the Fraud and Corruption Reporting Line or within the NHSCFA website https://cfa.nhs.uk/. Full contact details are available via the Counter Fraud pages of the Health Board / Trust intranet site.

These concerns will then be managed in line with Velindre University NHS Trust's Counter Fraud Policy.

Stage 2 – Internal (Formal)

If, having followed the approach outlined in stage 1, the individual's concerns remain, or they feel that the matter is so serious that they cannot discuss it with any of the above then they can move on to use the more formal steps as follows.

The individual should make their concerns known to an appropriate senior manager in writing. The WB1 forms in appendix 3 are included to help an individual formulate concerns but they do not need to be used if an individual chooses to use a different approach.

They may also wish to involve their Trade Union/Staff Representative.

When a concern is raised it is helpful to know how the individual considers the matter might be best resolved.

The senior manager will meet with the individual raising the concern within seven working days. The outcome of the meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Once an individual has told someone of their concern, whether verbally or in writing, Velindre University NHS Trust will consider the information to assess what action should be taken. This may involve an informal review or a more formal investigation.

The individual will be told who is handling the matter, how they can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom they have reported their concern will appoint an Investigating Officer. If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible (usually within 28 days) in light of the matters to be investigated. At their request, the individual will be written to summarising their concern, and setting out how it will be handled along with a timeframe.

Velindre University NHS Trust will aim to keep the individual informed of the progress of the investigation and its likely timescale. However, sometimes the need for confidentiality may prevent specific details of the investigation or any disciplinary action from being disclosed. All information about the investigation should be treated as confidential.

If the matter falls more appropriately within the remit of other W&OD policies, the employees should be advised that they should pursue the matter through the relevant policy and that the Procedure for NHS Staff to Raise Concerns will not be followed (see appendix 1).

Velindre Univeristy NHS Trust does not expect any individual reporting a matter under this procedure to have absolute proof of any misconduct or malpractice that they report, but they will need to be able to show reasons for their concerns, so any evidence that they have such as letters, memos, diary entries etc. will be useful. These will need to be redacted if they contain any patient identifiable information.

If the alleged disclosure is deemed to be serious enough, then Velindre University NHS Trust may follow the process laid down in the Disciplinary policy and procedure, where the issues raised could relate to individual misconduct, when considering the most appropriate line of action.

The aim of this procedure is to provide an effective process for serious concerns to be raised. If it is concluded that an individual has deliberately made false allegations maliciously or for personal gain, then *NHS Organisation* will instigate an investigation into the matter in accordance with the Disciplinary policy and procedure.

Subject to any legal constraints, *Velindre University NHS Trust* will inform the individual(s) who raised the concern, of an outline of any actions taken. However, it may not always be possible to divulge the precise action, e.g., where this would infringe a duty of confidentiality of *Velindre University NHS Trust* towards another party.

Stage 3 – Executive Director

If an individual is either dissatisfied with a decision to only undertake an informal review or is dissatisfied with the outcome of stage 2 through the mechanisms outlined previously, they should raise their concerns in writing with the Chief Executive, and/or an appropriate Executive Director. If the concern relates to the Chief Executive or Executive Director, concerns should be raised with the Chair. Exceptionally, an individual should be able to go directly to this stage if the concerns are so serious as to warrant it ***or*** the previous stages have failed to address their concerns.

The Chief Executive or Chair (or a nominated representative not previously involved) will meet the individual within 28 working days. Again, the outcome of this meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Stage 4 - Serious or Continued Concerns and Regulatory/Wider Disclosure

The aim of this procedure is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing/inappropriate practices in the workplace. In most cases individuals should not find it necessary to alert external parties.

However, the law recognises that in some circumstances it may be appropriate to report concerns to an external body. It will very rarely if ever be appropriate to alert the media. It is strongly encouraged that an individual seeks advice before reporting a concern to external parties. The independent charity, Protect operates a confidential helpline to support individuals in determining the appropriate course of action. They also have a list of prescribed regulators for reporting certain types of concern. Protect details are included later in this procedure.

All staff have an individual responsibility to safeguard people from harm or suspected harm, by making known their concerns about abuse. Children and adults with vulnerabilities can be subjected to abuse by those who work with them in any setting; all allegations of abuse must therefore be taken seriously and treated in accordance with the Wales Safeguarding Procedures. These procedures may dictate that any investigation should be handled by a partner organisation such as Social Services or the Policy which would take precedence over internal procedures, therefore advice from a safeguarding professional should be sought at the earliest opportunity.

If an individual has followed the above procedure to deal with the matter and still has concerns or if they feel that the matter is so serious that they cannot discuss it in any of the ways outlined previously, then in exceptional circumstances they may wish to contact: -

The National Fraud and Corruption reporting Line on 0800 028 40 60, or alternatively via the online reporting facility at https://cfa.nhs.uk/reportfraud (if your concern is about aspects of Fraud, Bribery or Corruption.

Velindre University NHS Trust hopes that this procedure will provide individuals with the reassurances required to raise any matters of concern internally or exceptionally with the organisations referred to above. However, there may be circumstances where individuals are required under their professional regulations to report matters to external bodies such as the appropriate regulatory bodies, including: -

- General Medical Council (www.gmc-uk.org)
- Nursing and Midwifery Council (https://www.nmc.org.uk/)
- Health and Care Professions Council (www.hpc-uk.org)

- General Pharmaceutical Council (www.pharmacyregulation.org)

Velindre University NHS Trust would rather the matter is raised with the appropriate regulatory body than not at all. Other regulatory bodies may include;

- Health and Safety Executive
- Health Inspectorate Wales
- Wales Audit Office
- Police

(This list is not exhaustive).

If an individual needs further advice they can contact the charity Protect on 020 3117 2520 or by email at whistle@protect-advice.org.uk. Protect can advise individuals how to go about raising a matter of concern in the appropriate wayhttps://protect-advice.org.uk/. Alternatively, the Department of Health also provide a free, independent confidential advice service for NHS and Social Care employees and employers in England and Wales known as Speak Up. They can be contacted on 08000 724 725 or via their website at https://speakup.direct/.

Appendix 1

What is whistleblowing?

Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g., patients, colleagues or the public).

This may include:

- Systematic failings that result in patient safety being endangered, e.g., poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff;
- Poor quality care;
- Acts of violence, discrimination or bullying towards patients or staff;
- Malpractice in the treatment of, or ill treatment or neglect of, a patient or client;
- Disregard of agreed care plans or treatment regimes;
- Inappropriate care of, or behaviour towards, a child /vulnerable adult;
- Welfare of subjects in clinical trials;
- Staff being mistreated by patients;
- Inappropriate relationships between patients and staff;
- Illness that may affect a member of the workforce's ability to practise in a safe manner;
- Substance and alcohol misuse affecting ability to work;
- Negligence;
- Where a criminal offence has been committed / is being committed / or is likely to be committed (or you suspect this to be the case);
- Where fraud or theft is suspected;
- Disregard of legislation, particularly in relation to Health and Safety at Work;
- A breach of financial procedures;
- Undue favour over a contractual matter or to a job applicant has been shown;
- Information on any of the above has been / is being / or is likely to be concealed.

This procedure should not be used for complaints relating to your own personal circumstances, such as the way you have been treated at work. In these cases, the Respect and Resolution Policy should be used. Link here.

Appendix 2

Protection of those making disclosures

It is understandable that individuals raising concerns are sometimes worried about possible repercussions. *Velindre University NHS Trust* aims to encourage openness and will support staff who raise genuine concerns under this procedure, even if they turn out to be mistaken. In addition, there are statutory provisions for individuals who make what are termed “protected disclosures”.

In law individuals must not suffer any detrimental treatment as a result of raising a concern. Detrimental treatment includes dismissal, disciplinary action, threats or other unfavourable treatment connected with raising a concern. If an individual believes that they have suffered any such treatment, they should inform a member of the Workforce and Organisational Development department, immediately. If the matter is not remedied, they should raise it formally using the All Wales Respect and Resolution Policy.

Those who raise concerns must not be threatened or retaliated against in any way. If an individual is involved in such conduct, they may be subject to disciplinary action. [In some cases, the individual raising a concern could have a right to sue for compensation in an employment tribunal.]

Velindre University NHS Trust aims to protect and support staff to raise legitimate concerns internally within the organisation where they honestly and reasonably believe that malpractice/wrongdoing has occurred or will be likely to occur. Staff who make what is referred to as a “protected disclosure”, i.e., a disclosure concerning an alleged criminal offence or other wrongdoing, have the legal right not to be dismissed, selected for redundancy or subjected to any other detriment (demotion, forfeiture of opportunities for promotion or training, etc.) for having done so and the protections are set out in law in the Public Interest Disclosure Act 1998.

If an individual is raising a matter of serious or continued concern the same protection applies as for internal disclosure. This is intended to promote accountability in public life and there is no requirement that such concerns should first be raised with Velindre University NHS Trust although it is preferred that the Velindre University NHS Trust should be given an opportunity to resolve the matter first.

If an individual is raising a matter with a regulatory body defined within the Public Interest Disclosure Act 1998 they will be protected where they honestly and reasonably believe that the malpractice/wrongdoing has occurred or is likely to occur and in addition they honestly and reasonably believe that the information and any allegation contained in it are substantially true. The Public Interest Disclosure (Prescribed Persons) Order 2014 amends the list of prescribed persons

and came into force on 1 October 2014 and applies to disclosures made on or after this date. The new list of prescribed persons in respect of matters relating to healthcare services is set out below: -

Relevant matters	Prescribed person
Matters relating to the registration and fitness to practice of a member of a profession regulated by the relevant council and any other activities in relation to which the relevant council has functions.	The Nursing and Midwifery Council, Health and Care Professions Council, General Medical Council, General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council.

For healthcare services in Wales (specifically):

Relevant matters	Prescribed person
Matters relating to the registration of social care workers under the Care Standards Act 2000.	Care Council for Wales
Matters relating to: • The provision of Part II services as defined in section 8 of the Care Standards Act 2000 and the Children Act 1989. • The inspection and performance assessment of Welsh local authority social services as defined in section 148 of the Health and Social Care (Community Health and Standards) Act 2003. • The review of, and investigation into, the provision of health care by and for Welsh NHS bodies as defined under the Health and Social Care (Community Health and Standards) Act 2003. • The regulation of registered social landlords in accordance with Part 1 of the Housing Act 1996 (as amended by the Housing (Wales) Measure 2011.	Welsh ministers

If an individual is making a wider disclosure (for example to the police, or an Assembly Member (AM) (other than the Welsh Ministers) there are rigorous conditions for such wider qualifying disclosures to be protected:

Belief. The individual must reasonably believe that the information disclosed, and any allegation contained in it, are substantially true.
Not for gain. The individual must not make the disclosure for the purposes of personal gain (but rewards offered under statute, for example by HMRC, are ignored).
The individual must:

- have **previously disclosed** substantially the same information to their employer or to a prescribed person; or
- reasonably believe, at the time of the disclosure, that they will be subjected to a **detriment** by their employer if they make disclosure to the employer or a prescribed person; or
- reasonably believe (where there is no prescribed person) that material evidence will be **concealed or destroyed** if disclosure is made to the employer.

Reasonableness. In all the circumstances of the case, it must be reasonable for them to make the disclosure.

Protect or a Trade Union will be able to advise on the circumstances in which an individual should use this procedure and where they may be able to contact an outside body without losing the protection afforded under the Public Interest Disclosure Act 1998.

Appendix 3 - *Velindre University NHS Trust*

Form WB1 – Recording a concern raised under the procedure

Concern raised by (name):				
Designation				
Ward / Department				
Confidentiality requested:	yes		No	
Nature of concern raised:	Delivery of care/services to patients			
	Value for money			
	Health and safety			
	Unlawful conduct			
	Fraud, theft or corruption			
	The cover-up of any of the above			
Details of concern raised: (Continue overleaf is necessary)				

Evidence to support the concern (if available): (Continue overleaf if necessary)		
Any suggestions from employees as to a resolution?		
How will the matter be handled?	Informal review	
	Internal investigation	
Concern reported to:		
Contact name:		
Designation:		
Telephone no:		
Signed:		
Date:		
N.B. Once completed, this form should be retained on a case file		

Appendix 4 - *Velindre University NHS Trust*

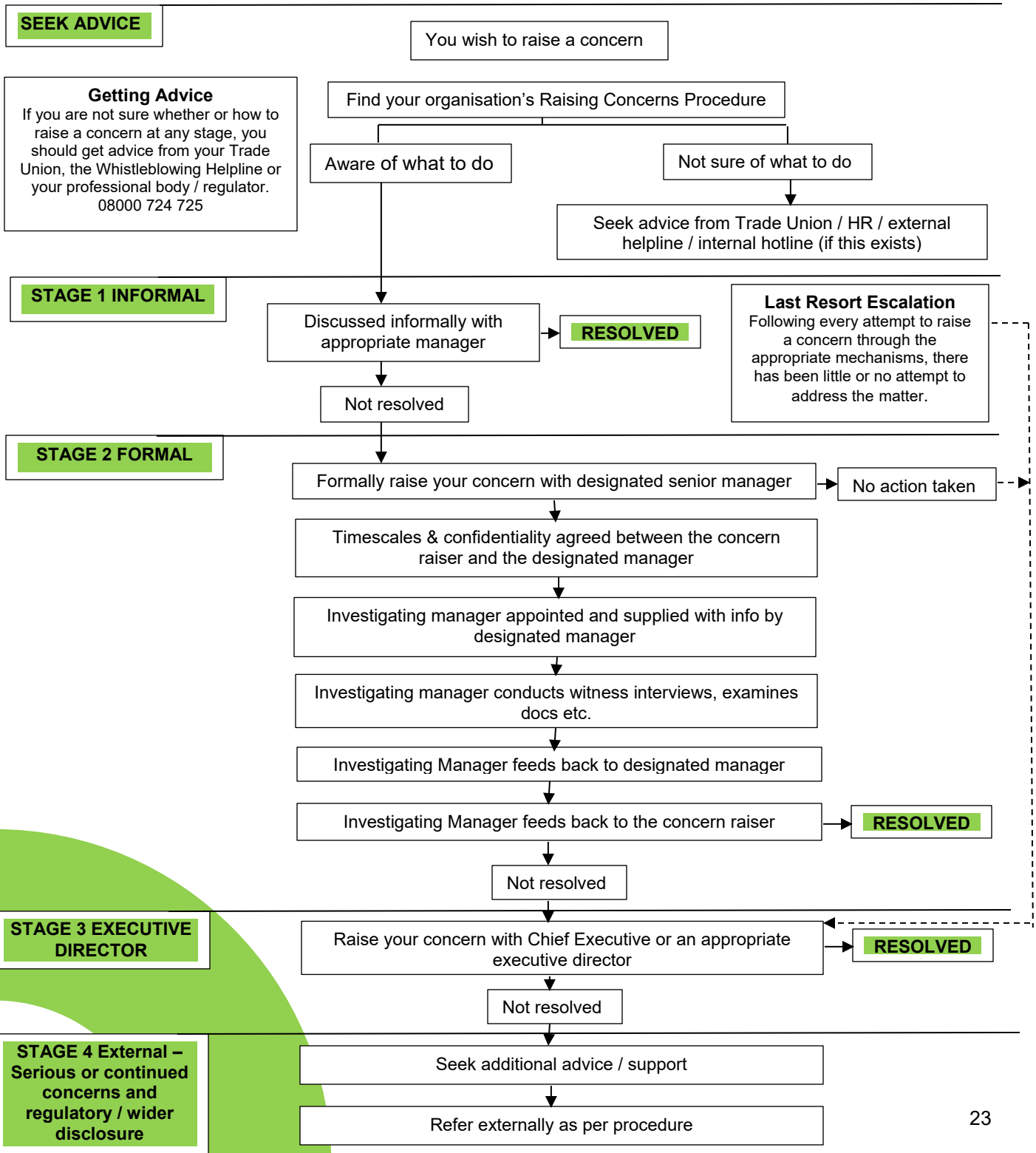
Form WB2 Concerns Raised Under the Procedure: Summary of findings and outcome of investigation

Concern raised by (name):	
Designation:	
Informal review undertaken by:	
Investigation undertaken by:	
Summary of findings of review / investigation: (continue overleaf if necessary)	
Outcome: Action taken: (continue overleaf if necessary)	

No action taken for the following reasons:	
Further action (if appropriate): (e.g., report the matter to Welsh Government / Regulator)	
Name:	
Signed:	
Designation:	
Date:	
N.B. Once completed, this form should be retained on a case file.	

Appendix 5 – Flowchart of Raising Concerns Process

This flowchart sets out the stages in raising a concern and shows the management levels for internal disclosure. In a small organisation, there may not be more than one or two levels of management to whom you can escalate your concerns. In these cases, you should consider escalating your concern to the regulator or other prescribed person at an earlier stage than is shown on the flowchart.



QUALITY, SAFETY AND PERFORMANCE COMMITTEE

CAPITAL SCHEME FOR VENTILATION AT VELINDRE CANCER CENTRE

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING (NOTE:

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	6th September 2021	ENDORSED
Quality, Safety and Performance Committee	16th September 2021	ENDORSED
Trust Board	30th September 2021	APPROVED WITH CONDITIONS (SEE 1.1)
Ventilation Group	6th September 2022	ENDORSED
Executive Management Board	1st September 2022	ENDORSED

ACRONYMS	
N/A	Not Applicable
BJC	Business Justification Case
VCC	Velindre Cancer Centre
EMB	Executive Management Board
nVCC	New Velindre Cancer Centre
IP&C	Infection Prevention and Control

1. SITUATION / BACKGROUND

1.1 A Business Justification Case (BJC) was presented to the Velindre University NHS Trust Board in September 2021. The BJC requested approval to submit a Business Justification Case to the Welsh Government for £2.2m of capital investment to support the implementation of compliant mechanical ventilation systems within the inpatient and outpatient areas at the Velindre Cancer Centre. The Board approved the BJC subject to the following two conditions being met:-

- A solution which had minimal impact on capacity loss on the inpatient wards. The solution would need to include the required availability of single cubicles to support the care of COVID patients to support IP&C requirements.
- Certainty regarding forecast prevalence of Covid in the community its impact its ability to treat patients in accordance with the national quality requirements.

1.2 Work was progressed in accordance with these conditions and a revised plan was developed to minimise the loss of capacity on the inpatient wards (with approximately 2 cubicles likely to be impacted as a minimum). However, the variability of Covid-19 together over the past two years together with the need to retain the maximum capacity (and cubicles) to treat patients as quickly as possible, in the context of the ongoing Covid-19 pandemic, has resulted in the second condition still not being able to be met.

1.3 During this period the Trust has deployed an interim ventilation solution at VCC through which reduces the temperature and supports effective infection prevention control. This solution has received positive feedback from staff and patients and supports controlled environmental conditions through the summer months by the

provision of clean filtered cooled air which is compliant with IP&C standards. During this period the IP& C data does not point to any increased levels of infection.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Executive Management Board received a paper on 1st September 2022 which revisited the position given the time between the Board decision in principle and the current position. The Executive Management Board considered the following information:

- Still no likely start date for the implementation of the Ventilation Scheme at VCC due to:
    - o the continuing impact of COVID on service delivery i.e. backlog and increased waiting times.
    - o the increasing demand for services. The SACT demand also impacts the potential decant options during the period of construction i.e. proposed decant areas will be required for the delivery of SACT treatments.
    - o continued uncertainty surrounding future waves of COVID as we move out of the summer months into the winter season. This is likely to be see an increase in Covid prevalence together with seasonal flu.
- The proposed project programme for the delivery of the permanent ventilation scheme is 48 weeks. This will cause major disruption to the delivery of services at VCC during this period.
- The effectiveness of the interim ventilation solution which has improved patient and staff comfort through the provision of filtered temperature controlled air into the space.
- The continued progress of the nVCC with an expected opening date of 2025.

2.2 Given this position, the Executive Management Board concluded that the scheme would not proceed as there is still no likely start date given the continuing prevalence of Covid and the priority to treat patients as quickly as possible; the stable nature of the interim solution; the likely significant impact of the scheme compared the reduced likely benefits given the move to the nVCC in 2025 i.e. the completion of the planned ventilation scheme is not likely to be completed until 2024 given approvals, procurement and delivery of the scheme).

2.3 The Executive Management Board also committed to enhancing the current interim ventilation solution at VCC, ensuring that is meets required IPC standards by seeking to purchase the equipment permanently (currently leased) through any

capital slippage in 2022/2023 or allocation of Trust discretionary capital in 203/2024.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The proposed investment be a betterment on the current position providing an element of compliance with HTM 03 (Healthcare Technical Memorandum)
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 • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	2022/23 Slippage Welsh Government Funding Discretionary Capital 2023/24

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **ENDORSE** the paper for consideration by the Trust Board.

Summary Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 14th July 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
Prof. Donna Mead OBE	Velindre University NHS Trust Chair	DM
Steve Ham	Chief Executive Officer	SHa
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Rachel Hennessy	Interim Director of Velindre Cancer Service	RH
Jacinta Abraham	Executive Medical Director	JA
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Alan Prosser	Director, Welsh Blood Service	AP
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:** • Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science • Cath O'Brien, Chief Operating Officer • Hilary Jones, Independent Member	
1.2.0	**In Attendance:**	
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 Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience 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 12th May 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes of the meeting held on the 12th May 2022 as an accurate reflection of proceedings.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Transforming Cancer Services Programme Private Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Independent Member and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the contents of the Private and Extraordinary Private TCS Scrutiny Sub-Committee highlight reports and actions being taken.	
2.2.2	**Patient Nosocomial Transmission Review Update** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the contents of the Nosocomial Transmission Review Update and the work being undertaken to fulfil the Trust's responsibilities in relation to nosocomial transmissions.	
2.2.3	**Highlight Report from the Private RD&I Sub Committee** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the key deliberations and highlights from the private meeting of the RD&I Sub-Committee held on 7th April 2022.	
3.0.0	**MAIN AGENDA**	
3.1.0	**Offsite Records Storage Incident *(Datix Ref: 4411)***	

	Led by Matthew Bunce, Executive Finance Director The Committee received an update on the current position with regards to the offsite records storage flooding incident which occurred during February 2022. The following was highlighted: • All affected organisations have provided contract termination letters to the current storage provider. • A number of options are currently under consideration by the Trust to progress the transfer of records to a new storage provider. • A communications plan and FAQs are currently under development to support consistent response to potential queries. The Committee **DISCUSSED** and **NOTED** the update report relating to the Offsite Records Storage Incident which took place on February 20th 2022.	
3.2.0	**Claims / Redress 2021/22 Annual Report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Committee received the Claims / Redress 2021/22 Annual Report, to provide the Trust with assurance of arrangements in place for effective claims management and developments made during the reporting period to improve services and implement learning. Learning continues to be a priority for the Trust and regular briefings reinforce learning across the organisation and provide assurance of actions being undertaken to improve the overall safety of patients, donors and service users. The Committee **ENDORSED** the Trust Claims / Redress 2021/2022 Annual Report prior to submission to the private Trust Board for **APPROVAL**.	
4.0.0	**Analysis of meeting outputs** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
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**	
6.0.0	**ANY OTHER BUSINESS**	

	Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee received a presentation by RH, outlining the Trust's current position in relation to increasing demand within SACT (Systemic Anti-Cancer Therapy) and Radiotherapy, in addition to predicted activity requirements, immediate plans, options available and mitigating action underway. This included details of the regular proactive engagement with Health Board Colleagues to enable the continued delivery of these services and supporting communication plan. The Committee **DISCUSSED** and **NOTED** the update relating to the issues and concerns raised. The Committee agreed an update would be provided at the September public meeting of the Quality, Safety & Performance Committee in relation to the workforce constraints and delivery of the action plan, allowing for sufficient discussion of key issues, risks and deliverables. **Additional** ND reported that a COVID-19 outbreak had developed on First Floor Ward at Velindre Cancer Service during the weekend of 9th / 10th of July 2022 and provided a brief overview of the current position It was also reported that Healthcare Inspectorate Wales (HIW) informed the Trust on July 11th 2022 that an inspection of the First Floor Ward would be undertaken on the 12th and 13th July 2022. HIW were advised of the current position on the First Floor Ward and determined that the audit would go ahead. Full PPE was employed. Feedback was very positive in the main, with no immediate actions or concerns and only minor areas for improvement identified. A follow-up action plan will ensue in due course. The Trust's management of the current COVID-19 outbreak was also commended and it would be of benefit for the Trust to share this publicly.	**SHa**
7.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on **15th September 2022 from 13:15 – 13:45 via Microsoft Teams.**	
CLOSE		

Quality, Safety & Performance Committee

VELINDRE UNIVERSITY NHS TRUST VACCINATION PROGRAMME BOARD UPDATE

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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**
Trust Vaccination Programme Board	19/08/2022	Items for discussion agreed
Executive Management Board	01/09/2022	NOTED

ACRONYMS	
JCVI	Joint Committee on Vaccination and Immunisation
DHCW	Digital Health & Care Wales
WIS	Welsh Immunisation System
WBS	Welsh Blood Service
VCC	Velindre Cancer Centre

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the Trust's Autumn 2022 COVID-19 Booster and Influenza vaccination plans as discussed and agreed at the Trust's Vaccination Programme Board held on the 19th August 2022.

The Quality, Safety & Performance Committee is asked to **NOTE** the revised Autumn 2022 Vaccination plans.

2. BACKGROUND

The purpose of the Trust-wide Vaccination Programme Board is to assume responsibility for planning and safely delivering the Public Health Wales Vaccination Programmes for the Trust, to include vaccines for Influenza and the COVID-19 virus in line with Joint Committee on Vaccination and Immunisation (JCVI) guidelines, frontline categories and age groups on an ongoing basis as dictated.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Autumn 2022 programme

Following agreement at a National level that responsibility for the staff Autumn COVID-19 booster was to remain within Velindre University NHS Trust, advice received from the Delivery Unit and Digital Health & Care Wales (DHCW) indicates that the Trust is now unable to administer COVID-19 booster vaccinations to its staff. This is due to failure by DHCW to maintain / upgrade the Velindre instance of the Welsh Immunisation System (WIS) since May 2021. Staff will now receive their COVID-19 Autumn boosters by their respective Health Board as a result. Some staff have already been invited to attend a mass vaccination centre for their COVID booster.

The intention to provide an Influenza vaccination to all staff remains and the following revised plan has been agreed for each division as follows:

VCC

- Clinics will run on the 26th, 27th and 28th of September in the Bobath (Wellbeing) Centre between 9am and 3pm, manned by 3 vaccinators.
- If required, 'mop-up' sessions will run on the 5th, 6th and 7th October. Any further mop-up requirements will be covered on an ad hoc basis.
- Clinics over both weeks will cover Monday to Friday to enable capture of all part-time staff.

WBS

- Clinics will run on the 26th and 27th September 2022 at the Wound Centre for WBS staff, HQ staff and South Collection Teams. 3 chairs are to be used during the day, increasing to 5 chairs to capture Collections Teams on their return to WBS HQ.
- An evening clinic will run at Swansea.com Stadium on the 29th September 2022 for the West Collection Team.
- A clinic will run at the Stock Holding Unit (Wrexham) on 4th October for North Collection Teams and SHU staff. The time of clinic is still to be confirmed.
- 'Mop up' appointments will be arranged on an ad-hoc basis.

- Recording of 'Flu vaccinations will be achieved via hard copy consent forms in the current absence of WIS. This information may be uploaded to WIS at a later date if required.

3.2 Management / validation of staff data and communications

3.2.1 Management/validation of staff data

There is a requirement for VUNHST to review the data for its staff that is recorded within the Health Board instances of WIS, to ensure staff are correctly invited for their booster in accordance with the JCVI priority groups. Ensuring the correct assignment of priority status to each staff member will be undertaken via Line Managers in the first instance. Following confirmation of a defined list of frontline staff, the data will be compared with current data within WIS. The following options are available for data validation:

- Trust admin to create a list of all WIS registered Trust staff requiring updating and send to DHCW for bulk upload. This is currently the most efficient and preferred option.
- Trust admin to create a list of all WIS registered Trust staff requiring updating and send to respective Health Boards to ensure staff are invited for appointments.
- Trust admin to create a list of all WIS registered staff requiring update and manually update locally. This would be onerous and likely infeasible.

It is intended to proceed with the first approach and contact will be made with DHCW once the list has been refined.

3.2.2 Communications

Communication regarding the plans for both COVID-19 booster vaccinations and Influenza vaccinations were posted on the Trust intranet and included in both divisional newsletters following the Vaccination Programme Board meeting.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	No
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	Yes (Include further detail below)

	Any COVID-19 vaccination costs for the financial year will be funded centrally.

4 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** 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 WIS system and the Trust's revised Autumn 2022 Influenza Vaccination plans.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
2022 / 2023 QUARTER 2 (1st July 2022 to 31st July 2022) INFORMATION GOVERNANCE ASSURANCE REPORT

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Ian Bevan, Head of Information Governance Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

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	1st September 2022	**ENDORSED** for **NOTING** and **ASSURANCE** by the Committee

ACRONYMS			
IG	Information Governance	NWSSP	NHS Wales Share Service Partnership
VCC	Velindre Cancer Centre	ICO	Information Commissioners Office
WBS	Welsh Blood Service	NIIAS	National Intelligent Integrated Audit Solution

DHCW	Digital Health and Care Wales	SAR	Subject Access Requests
HoIG	Head of Information Governance	DPIAs	Data Protection Impact Assessments
GDPR	General Data Protection Regulation	VUNHST	Velindre University NHS Trust
AHRA	Access to Health Record Act 1990	IGMAG	Information Governance Management Advisory Group
SIRO	Senior Information Responsible Officer	DPO	Data Protection Officer
FOIA	Freedom of Information Act	EIR	Environmental Information Regulation
NCSC	National Cyber Security Council	VCC QSMG	VCC Quality Safety Management Group
IM	Independent Member	WCCIS	Welsh Community Care Information System
SMSC	Senior Medical Staff Committee	OOH	Out Of Hours

1. SITUATION

The purpose of this report is to provide **ASSURANCE** about the way VUNHST manages its information in respect of patients, donors, service users and staff, highlighting compliance with IG legislation and standards, actions to improve management of IG risks and reporting IG incidents and actions from lessons learned.

The report outlines key activities in the following areas, (1) Data Protection, (2) Physical Security Securing Records (3) Information Security for the reporting period of 1st June 2022 to 31st July 2022.

The Committee is asked to **NOTE** the report for **ASSURANCE**.

2. BACKGROUND

All NHS Bodies in Wales must ensure that they have in place organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the DPA (2018) GDPR, FOIA (2000) and EIR (2004).

VUNHST is committed to ensuring the provision of an effective IG Framework. This ensures that the Trust meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the quarter 2 report for the period 1st June 2022 to 31st July 2022:

- The three IG Framework areas being focused on are: (1) Data Protection (2) Physical Security (3) Information Security. Work in these areas will lead to improvements in IG systems & processes.
- SARs, DPIAs and Data Security incidents & investigations activity and actions to provide assurance around compliance with legislation and standards and improvements in these core areas of IG.

The detailed report presented to EMB is available for further information.

(1) Data Protection

Provides assurance that the Trust is processing personal data in line with data protection legislation. The following areas of work and key actions focussing on data protection are highlighted:

- Impact of the resignation of the Medico-Legal clerk in VCC on the Cancer Centre's ability to comply with data protection legislation in relation to Subject Access Requests

  Action: temporary cover being provided by Health Records Manager and recruitment to vacancy being progressed supported by HoIG

- Procurement of the Integrated Radiotherapy Solution

  Action: HoIG reviewed and amended IG sections of contract and a DPIA produced, with regular review by contracts manager supported by the HoIG to ensure IG risks are mitigating activity are recorded

- Digital Health and Care Record (DHCR) activity that requires an IG overview and involvement.

  Action: This is a priority for the HoIG given potential IG risks. Support has focussed on ensuring robust processes for handling of data transfer, recording of patient vulnerability within the record and ongoing support to the DHCR Board and working group to ensure IG risk is identified and mitigated during implementation and on-boarding

- A WBS project for a proof-of-concept trial of the methodology to remove extracellular harmful agents from stored red cell units. The project required the further assessment of:

- Risk in relation to the transfer of pseudonymized data from WBS to commercial systems where data centres were located outside the UK
- The commercial company's technical and organisational measures to protect the integrity of the data being processed
- Material transfer and other types of legal agreements to ensure that they complied with data protection legislation and ICO contracts guidance.

Action: HoIG support to RD&I team and WBS to finalising the agreement between the Trust and commercial company

(2) Physical Security

Work undertaken to ensure the Trust is protecting information assets physically as well as electronically. In this reporting period, attention has focused on addressing the objective in the IG Toolkit; to review CCTV equipment, DPIA's and associated contracts so that they comply with data protection legislation, the Human Rights Act 1998 and the Surveillance Camera Code of Practice (Updated November 2021).

Action: service manager's shared contracts and drafted DPIAs for HoIG review, risk assessment and approval. Ongoing review of DPIAs during contract.

(3) Information Security

Work undertaken to ensure the Trust:

- is processing requests for information from members of the public in accordance with Data Protection legislation
- is investigating and processing IG incidents in accordance with Data Protection legislation
- learns from incidents and puts in place measures to reduce the likelihood of re-occurrence of incidents.

Action: Follow up awareness and training sessions are based on the incidents that are occurring across the Trust. Should there be further action required, this recommendation is communicated by the HoIG to the Line Manager for further consideration.

SARs, DPIAs and Data Security incidents & investigations

Data Protection Subject Access Requests (SARs)

There have been no breaches against SAR response timescales

clinical information	**Quarter 1: 1st Apr – 30th Jun**	**Quarter 2:1st Jul – 31st Jul**
Requests for access to health records	63	10
No. Breaches against one calendar month response timeframe	0	0
% Breaches against one calendar month response timeframe	0%	0%

non-clinical information	**Quarter 1: 1st Apr – 30th Jun**	**Quarter 2:1st Jul – 31st Jul**
Requests to provide information held on an individual	3[1]	0
No. Breaches against one calendar month response timeframe	0	0
% Breaches against one calendar month response timeframe	0%	0%

[1] Two of the information requests were made by Police as part of enquiries.

DPIAs

- 44 DPIA's were commenced since Oct 21, 42 of which are Trust DPIA's, 2 are NHS Wales national DPIA's
- 5 Trust DPIA's and no NHS Wales DPIA's have been approved during quarter 1 2022-23
- 5 Trust DPIA's and no NHS Wales DPIA's have been approved during quarter 2 2022-23 (July only)

Action:

- Work ongoing to identify all existing Trust digital or paper systems where a DPIA has not been completed. A risk-based approach is being taken to prioritising assessments to be undertaken in 2022/23
- DPIA's and Data Processing Agreements are not all currently aligned with service Contracts (NHS and non-NHS). Work ongoing with service leads to ensure alignment.

Data security incidents & investigations.

There have been three digital incidents of note since the last report:

- Cyber Incident – A food supplier to NHS bodies across the UK has experienced a cyber-attack at the end of June 2022. The Trust was not a customer of the affected company therefore it

was quickly **assessed as no risk to the Trust**. However, it has been an important reminder of the need to ensure that supply chain is afforded the same consideration in relation to cyber security as other core areas within a Trust.

- Human Resource (HR) Network Drive access – Inappropriate access to the HR Drive had been given to individuals not employed by the Trust. The Digital Services team removed access immediately and locked the folder with access to authorised personnel only. Investigation found that in the 30 days prior to discovery no access had been made by unauthorised persons. 30 days was the furthest the team could go back. The **likelihood of a data breach has been assessed as low.**

- Specific Cyber Attack – Advanced Limited – 5th August 2022 - Incidents in August are not in the scope of this report, but it has been included as it was an exceptional UK wide Cyber-attack on an NHS service supplier that provides technical digital services to GP OOH and the 111 Service across all 4 UK Nations' NHS Bodies. Since the data and systems do not specifically affect the Trust, at this point in time it is **assessed that risk of harm to Trust data and systems is low.**

Incidents & Investigations for the period 1st April 2022 to 30th June 2022 (Quarter 1)

	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Velindre Cancer Centre	15	0	15	1	14	1	15	6	9	15
WBS	2	0	2	0	2	0	2	1	1	2
NWSSP	6	9	15	0	9	6	15	0	15	15
Total Trust	**23**	**9**	**32**	**1**	**25**	**7**	**32**	**7**	**25**	**32**

Incidents & Investigations for the period 1st July 2022 to 31st July 2022 (Quarter 2)

	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Velindre Cancer Services	6	0	6	0	6	0	6	1	5	6
WBS	2	0	2	0	2	0	2	0	2	2

	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
NWSSP	7	0	7	0	7	0	7	1	6	7
Total Trust	**15**	**0**	**15**	**0**	**15**	**0**	**15**	**2**	**13**	**15**

- The top three themes in incidents continue to be confidentiality breaches; failure to secure records (lost) and records misfiled, disclosed in error (sent/delivered to wrong recipient, divulged in error).
- Two incidents during the reporting period were outside the normal themes; a failure to follow policy in processing confidential waste and the loss of a laptop from an unsecured vehicle. There was no risk of data breach in relation to the stolen laptop as it was switched off with additional technical security measures in place to prevent any unauthorised access to the device..
- Most incidents could be avoided with improved compliance with IG policies. IG awareness & training of staff continues to be a priority, as human error is the common factor. The target attainment for the Trust overall is 85%, the current value of attainment is 82.59%.
- **100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff**
- VCC has 7 incidents under investigation for quarters 1 and 2 (July only). 6 present low risk which is expected to present no harm. The 7th incident relates to the Offsite Storage Incident, which remains ongoing, but which has been assessed by the VCC Clinical Director as low risk of harm.
- WBS has 1 incident under investigation for quarter 1 which is low risk and expected to present no harm.
- NWSSP has undertaken Root Cause Analysis (RCA) on their reported incidents, all of which highlight human error as the common cause.
- The backlog of incidents under investigation is decreasing as the IG resources deployed on the Offsite Storage Incident has reduced.
- Quarterly IG assurance meetings between Stephen Harries (IM Champion for IG), Matthew Bunce (SIRO) and Carl Taylor (Chief Digital Officer) provide additional assurance to the committee.

Action:

- Individual(s) who have caused incident are required to re-take ESR IG awareness training
- Enhanced IG training delivered by HoIG to teams and/or individuals using a risk-based assessment i.e., no. of incidents from each team balanced against impact

- If an incident is assessed as potentially having a serious impact on the patient/donor or the family of a patient/donor a Root Cause Analysis investigation is undertaken in addition to the investigation template within DATIX

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The loss or disclosure of personal information should be an important consideration for all staff on a day-to-day basis as it can seriously damage the Trust's reputation and undermine patients, donors and/or service user's trust.
RELATED HEALTHCARE STANDARD	Effective Care
	Standard 3.4 Information Governance and Communications Technology
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, all personally identifiable data may lead to a breach of security and the noncompliance with Data Protection Legislation. Where there is an impact on the rights and freedoms to the Data Subject, this may be reportable to the ICO within 72 hours of the discovery of the breach. unauthorised access to systems may also lead to further legal ramifications (Computer Misuse Act 1990)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Information Commissioners Office has the power to impose financial penalties (fine of up to 20 million euros (approx. £17.5m) and issue enforcement action.

5. RECOMMENDATION

The Committee is asked to **NOTE** the 2022/2023 Quarter 2 (1st July 2022 to 31st July 2022) Information Governance Report for **ASSURANCE**.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NET ZERO REPORTING

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rhiannon Freshney, Trust Environmental Development Officer
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 NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
ISO14001:2015 MANAGEMENT GROUP	31/08/2022	ENDORSED
JOINT ESTATES MANAGEMENT GROUP	01/09/2022	ENDORSED
EXECUTIVE MANAGEMENT BOARD	Circulated out of Board – 01/09/2022	NOTED

ACRONYMS

1. SITUATION/BACKGROUND

1.1 In 2017, the Welsh Government set the ambition of achieving a carbon neutral public sector by 2030. In March 2019, the Welsh Government published '*Prosperity for All: A Low Carbon Wales'* that includes Policy 20: Support the public sector to baseline, monitor and report progress towards carbon neutrality.

1.2 The Net Zero Reporting spreadsheet/returns has been developed to estimate baseline emissions; support the identification of priority sources of carbon; and to monitor progress towards meeting the collective ambition of a carbon neutral public sector by 2030.

1.3 The Trust is committed to demonstrating leadership in sustainability and has comprehensive plans to deliver significant improvements, including a Decarbonisation Action Plan, with the help of its staff, key partners and other stakeholders.

1.4 The Net Zero Reporting spreadsheet, coupled with The Decarbonisation Action Plan creates an opportunity for targeted improvements across the Trust achieving ambitions set out within the Sustainability Strategy and contributes to the Trust Well-being Objective, "*deliver bold solutions to the environmental challenges posed by our activities".*

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Information has been collated by with professional and site leads in all associated areas to complete the Net Zero Reporting spreadsheet: summary (Appendix 1).

2.2 Further to scrutiny at ISO14001:2015 Management Group and Joint Estates Management Group, the Estates Manager has reviewed the data collected. Furthermore, NWSSP – SES and VUNHST have undertaken a peer review of each organisation's dataset.

2.3 A meeting was held with NWSSP-SES on 6th September to finalise the review and discuss lessons learnt from the data collection exercise and how to improve data collection and validation in future reports.

2.4 The Net Zero Reporting was submitted to Welsh Government on 9th September 2022 in line with the set deadline. It is acknowledged by all partners (the Trust and Welsh Government) that continued work will be required to improve the collection of data and provision of information relating to the Net Zero agenda.

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)
	N/A
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with Environment (Wales) Act 2016
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	N/A

4. RECOMMENDATION

4.1 The Committee is asked to **NOTE:**

- 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.
- Further work is required within the Trust to finalise the programme of works to support the achievement of Net Zero within NHS Wales.

Appendix 1

NET ZERO REPORTING: SUMMARY

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Summary of results

This section provides a summary of the reported emissions for Velindre University NHS Trust

You do not need to input any information into this sheet.

Buildings, fleet & other assets

Categories	Units of $kgCO_2e$						
	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Buildings	908,858	1,081,889	559,832	2,550,579	*2,615,343*	*2,485,814*	-
Streetlighting	-	-	-	-	-	-	-
Fleet and equipment	202,054	-	46,953	249,006	*261,457*	*236,556*	-
Agriculture	-	-	-	-	-	-	-
Buildings, fleet & other assets	**1,110,912**	**1,081,889**	**606,785**	**2,799,586**	***2,876,801***	***2,722,370***	-

Business travel, commuting & homeworking

Categories	Units of $kgCO_2e$						
	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Business travel	-	-	251,027	251,027	*282,405*	*219,649*	-
Commuting	-	-	-	-	-	-	-
Homeworking	-	-	-	-	-	-	-
Business travel, commuting & homeworking	-	-	**251,027**	**251,027**	***282,405***	***219,649***	-

Waste

Categories	Units of $kgCO_2e$						
	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Organisational waste	-	-	121,385	121,385	*127,455*	*115,316*	-
Municipal waste	-	-	-	-	-	-	-
Project waste	-	-	-	-	-	-	-
Waste	-	-	**121,385**	**121,385**	***127,455***	***115,316***	-

Land based emissions

Categories	Units of $kgCO_2e$	
	Emissions	Removals
Total land based emissions	145	-

Renewables

Categories	Units of kWh	
	Total generated	Total exported
	Scope 1	Scope 2
Onsite renewables - heat	-	-
Onsite renewables - electricity	-	-
Onsite renewables - CHP	-	-
Purchased renewables - heat	-	
Purchased renewables - electricity	5,095,319	
Renewables	**5,095,319**	-

The table below on the left summaries your organisation's supply chain emissions, calculated with a Tier 1 methodology. The table on the right briefly summarises any emissions that your organisation has calculated using a Tier 2 methodology (any emissions reported in the Tier 2 table should also be included in the total spend for that category in the Tier 1 table). Any emissions calculated by Tier 2 methods will be reconciled when compiling the data.

Supply chain - Tier 1

Categories	Units of $kgCO_2e$			
	Direct	Indirect	Indirect	Outside of scopes
	Scope 1	Scope 2	Scope 3	
Agriculture, forestry and fishing			-	
Mining and quarrying			-	
Manufacturing			116,696	
Electricity, gas, steam and air conditioning supply			-	
Water supply; sewerage, waste management and remediation activities			112,139	
Construction			109,821	
Wholesale and retail trade; repair of motor vehicles and motorcycles			76,081	
Transportation and storage			2,366	
Accommodation and food service activities			-	
Information and communication			27,474	
Financial and insurance activities			635	
Real estate activities			493	
Professional, scientific and technical activities			99,990	
Administrative and support service activities			9,983	
Public administration and defence; compulsory social security			14	
Education			6,510	
Human health and social work activities			1	
Arts, entertainment and recreation			14,186	
Other service activities			-	
Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use				
Supply chain - Tier 1			**576,389**	

Supply chain - Tier 2 (optional)

Categories	Units of $kgCO_2e$
	Indirect
	Scope 3
Total emissions	-

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VELINDRE SCHOOL OF ONCOLOGY UPDATE

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

PREPARED BY	Hannah Russon, School of Oncology Project Lead
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP & 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	01/08/22	Approved proposals

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the work to establish the Velindre University NHS Trust School of Oncology.

The Quality, Safety & Performance Committee is asked to **NOTE** the developments to date and the plans approved by the Executive Management Board on the 1st August 2022.

2. BACKGROUND

Velindre University NHS Trust has an ambition to be an exemplar nationally and internationally in relation to non-surgical cancer services. Alongside the development of the new Velindre Cancer Centre and the development of regional hubs via the Velindre @ model, Velindre Cancer Services is in a unique position to lead in improving cancer outcomes and patients' experience of their care. This is not only through the delivery of high quality clinical services, but through leading on multi-professional cancer education to develop highly skilled Oncology leaders.

There are a number of Cancer Centres that provide a School of Oncology such as the Royal Marsden and this is one of the ambitions for the Trust. In order to achieve this ambition, a Clinical Project Lead has been funded to undertake benchmarking, scope out opportunities, the definitive vision and undertake some proof of concept modules. This work also fully aligns with the Centre for Collaborative Learning. The Project Lead commenced on the 1st December 2021, but due to pressure on the service brought by Omicron the Project Lead had been redeployed for some of this time to support clinical services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Summary of work to date

Since the 1st December 2021 the following has been undertaken:

- ***Benchmarking*** with Oncology schools / academies, including exploration of their business models and existing / future resources.

  The Christie NHS Trust and the Royal Marsden NHS Trust have well established Schools of Oncology which deliver a combination of formalised pre-registration and post graduate educational programmes in conjunction with local universities. In

addition, they also deliver clinical skills and SACT delivery training along with the hosting of educational events and conferences.

Within Velindre we undertake some of the above but at present, Wales does not have a School of Oncology or any form of formalised multi-professional oncology educational pathways or an Oncology Educational Centre. Velindre University NHS Trust is well placed to lead on the development of this nationally.

- ***Multi-professional stakeholder meetings:*** within the Trust and externally including the scoping of existing education resources within departments.

- ***Proof of Concept 2-day Course:*** On the 26th and 27th April 2022, a 2 day 'Foundations in Acute Oncology' course was delivered virtually to a peak audience of 91 delegates consisting of a range of health professionals and undergraduate nursing students from across the UK and some international delegates. The event was advertised internally via internal communication channels and externally via Eventbrite and various networks and groups such as UKONS and AONS. The event on this occasion was free of charge and was based on a previous 2-day course that used to run bi-annually from the cancer centre but had been paused since the COVID pandemic. It was re-launched as a virtual event due to resource, COVID restrictions and the requirement to reach a wider audience. 182 delegates signed up for the event as the event was also advertised that individuals could access recordings at a later time in order to fit in with their clinical commitments. Feedback was received from 18 participants that was very positive (detail is available on request). The feedback, however, did identify the need to ensure sufficient organisational resources in respect of the management and organisation of events.

  Potential financial impact: As it was the inaugural event for the School of Oncology, there was no charge for this event. Based on prices charged by other Oncology education institutions (£120 for the 2-day event), there was the maximum potential for this event to raise £10,920. It is recognised that an event fee may have reduced student numbers. This figure is conjecture but shows the potential that a course like this could generate.

3.2 School of Oncology Vision Opportunities

The Trust school of Oncology Vision is being refined. However, early thoughts are that Velindre University NHS Trust would have the first Wales School of Oncology that could offer accredited educational opportunities across Wales aligned with the non-surgical cancer related clinical skill and education priorities of NHS Wales. The School could also offer such opportunities beyond Wales. In line with benchmarking findings, when established, the School would be 'self-funding' and income-generating for the Trust. It is envisaged that a Velindre School of Oncology would:

- Deliver accredited and non-accredited courses and study days / sessions at a variety of levels. The well established schools of Oncology at the Christie and Royal Marsden offer a variety of educational opportunities for multi-professional staff. These include:
  - Undergraduate and postgraduate degree modules in cancer care in conjunction with local universities e.g. BSc / MSc in Cancer Care;
  - Short courses and study days e.g. symptom management in Head and Neck cancer, management of Oncological Emergencies;
  - Clinical skills training e.g. SACT theory and administration, PICC / CVC care;
  - Events and Conferences.
- Provide the specialist clinical education and skills development for Velindre Cancer Services' own clinical staff, NHS Wales and wider.
- Tailor through forecasting and planning skills a training and education programme that meets the local, regional and national cancer requirements e.g. Acute Oncology, Palliative Care, Communication, virtual consultation modules supporting the delivery of the Transforming Cancer Services agenda.
- A tiered 'charging' framework will be established for all training / education provided to non-Velindre Cancer service staff.
- Further enhance the reputation and recognition of Velindre as a high quality specialist cancer centre supporting the organisation as an attractive employer, helping to attract a high calibre of specialist staff and supporting the attraction of multi-professional research.
- In person, virtual and hybrid events / sessions will be offered.
- Raise Velindre's profile at a national level regarding oncology and cancer education, and developing an 'All Wales' reach.

3.3 Next Steps

- ***A long term School of Oncology Business Case*** development has commenced. This will include the proposed vision, scope and phased priorities.

- ***Additional temporary delivery resources*** – It has become evident that the existing supporting resource will be insufficient to run the School of Oncology through its development phase (1WTE band 8a). This was evident during the proof of concept study day where the Project Lead had to undertake all roles and functions, including bookings, organisation, hosting and managing the digital virtual link. This, as well as being against 'top of licence' resulted in technical problems that could not be resolved on the day. There is insufficient space at the cancer centre to deliver face to face events, particularly for those events that have the potential to be delivered to delegates outside of the organisation. Digital support to deliver virtual events is lacking; a single facilitator dealt with a recent two-day course and despite the positive evaluation of the content and delivery, there were technical/digital issues the facilitator could not deal with due to the lack of digital skills on platforms such as Microsoft Teams.

  In order to address this the Executive Management Board approved recruitment into a band 2 administrative apprentice and a band 4 Events Co-ordinator until April 2024 utilising a 'spend to save' financial strategy. The financial forecasting to facilitate this has been completed. The longer term resources will be factored into the full Business Case.

- ***University Accreditation*** – University accreditation is critical for the credibility and viability of the School of Oncology. There are a number of possible options. Discussions will commence with a number of Welsh Universities during September 2022. The costs of accreditation is as yet unknown. These will need to be factored into course costing and the short and long term financial planning.

- ***Run a further Velindre Oncology event in Autumn 2022***:

  In order to assess more thoroughly the potential for income generation, there is a need to run some further Oncology events starting in the Autumn 2022. The following is proposed:

  - As clinical sessions are being provided by Velindre Cancer Service staff there will be no charge for cancer service staff but a charge for other participants.
  - These events will again be held virtually given the uncertain COVID-19 landscape.

- ***Phasing of the work*** - There is the potential for a Velindre School of Oncology to deliver all that is listed in 3.2 but this requires phasing.

  Initial assessment based on internal scoping exercises and conversations with key education leads has highlighted the inequity of resources amongst different departments / professional groups and professional silos in respect of training and education. There is no clear multi-professional clinical training and education infrastructure. This results in inefficiency, duplication and inequity across the whole clinical training and education spectrum as well as lost opportunities for optimisation of enhancing multi-professional team working and professional respect and equity. There is also very limited administration and digital support available to educational leads resulting in clinicians delivering clinical skills or education programmes undertaking the related organisation and administrative duties themselves, often in their own time.

  The following phasing is proposed:

  - Phase 1A – Oncology educational events for Nursing, AHPs and medical staff (online events for the foreseeable future). Topics could include: Acute Oncology, SACT & Immunotherapy overview, Communication, Management of Radiotherapy side effects, Genomics – commencing as further pilots in autumn 2022 with 'course fees' for external attendees.
  - Phase 1B – Undertake an Oncology clinical training, education, skills training and competency needs assessment to identify possible further Oncology educational events that are clinically required. Agree accreditation process and map points against said courses and arrange along with hosting of regional / national conferences e.g. Lung cancer care, Acute Oncology – external course / events fees applied.
  - Phase 2 - Delivery of short courses e.g. – communication – Sage & Thyme model, 2 day course in the management of Acute Oncology, Breast Cancer, MSCC etc. – external course / events fees applied.
  - Phase 3 – Clinical skills training e.g. SACT – external course / events fees applied.
  - Phase 4 (long term plan) – BSc / MSc pathway degree modules e.g. BSc / MSc in Cancer Care – external course / events fees applied.

    Phase 1 is already underway with foundations in acute Oncology delivered in April to a wider reaching audience. This was achieved by advertising through various societies, networks such as UKONS.

- ***Continue to work with TCS and key stakeholders*** - to ensure the School of Oncology has a presence within local and national agendas and to help shape the collaborative centre for learning in the new cancer centre by building those foundations now.

- ***Agree a name*** - as 'Velindre School of Oncology' is a working title, a name needs to be agreed and finalised on order to start branding the events appropriately.

- ***Establish a faculty structure*** - when moving into the later phases.
  - Explore the development of new hybrid roles as we enter MSc/BSc module development such as practitioner/clinical teacher role for the delivery of a SACT module.
  - CIVICA staff survey has been undertaken to gain staff thoughts, views and perspective of the School of Oncology and what it should be delivering in order to best serve their educational and professional development needs.
  - The delivery of Sage and Thyme intermediate communication training to both internal and external delegates.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Having Velindre School of oncology will ensure more robust clinical education & training therefore improving patient safety
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Covers all areas of the Health & Care standards
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)
	As outlined in section 3 of the report

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** 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 licenses being purchased; and,
- Progression of all plans detailed within the paper and to continue with the School of Oncology proof of concept.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST
POLICY MANAGEMENT REVIEW AND COMPLIANCE
STATUS: AUGUST 2022

DATE OF MEETING	15/09/2022

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	01/09/2022	DISCUSSED & NOTED PROGRESS

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSPC	Quality, Safety and Performance Committee

1. SITUATION

1.1 The purpose of this report is to provide the Quality, Safety and Performance Committee with assurance on the progress that has been made on the fourth tranche of work undertaken on the policy management and review programme in the July to August 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. **DISCUSS AND REVIEW** the findings of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b. **NOTE** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at **26/08/2022,** included at ***Appendices 1 to 8***.

c. 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 and 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 *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

2.7 *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

2.8 *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 basis 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 is a continuation of ongoing engagement and monitoring of progress. This report summarises the fourth tranche of work undertaken during July and August 2022 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 August is summarised under paragraph 3.1.1.
ii. Next steps are outlined of the ongoing work being undertaken (See tables 4, 5, 6, 7, 8 and 9).
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 collation of data and information based on the review of the policies for the above, a comprehensive preliminary compliance report was compiled to highlight key information and was reported in March 2022, with progress and updates provided in May and July 2022.

There has been ongoing validation and analysis through collaborative engagement with all of the relevant policy leads to confirm status, risk profile and any ongoing actions required or underway. A summary of the outcome of this exercise is included at ***Appendices 1 to 8***.

3.1.1 Collaborative Engagement Exercise

As indicated earlier, following an assessment of the policies currently held on record, continuous collaborative engagement was 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:

- Whether the versions of the policies held on file are correct.
- Clarification on existing policies review dates.
- A risk assessment of policies passed their review date.
- Ongoing actions underway or actions required.

A summary is provided below of information gathered from the engagement exercise during the fourth tranche of this work:

- ***Quality and Safety***

A total of 11 Quality and Safety Policies were included as part of the review, one of which is an All Wales policy (refer to Table 12):

  - 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 2022, two additional policies had passed their review dates one of which is the All Wales policy, Consent to Examination and Treatment.
  - With the latest review in August 2022 five policies **(45%)** are in date and six **(55%)** are outside their review date, one of which is an All Wales policy. Five policies are undergoing the review and approval process.

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 – August 2022			Next Steps
	March – April	May – June	July - August	
Medical Gas Cylinders Policy	Review and update of the policy	Consultation	Further amendments following consultation	Q4 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	• Finalise Consultation • Q4 Submission to EMB & Approving Body
International Health Partnership Related Activity Policy	Established that policy requires complete rewrite	Review and update	Consultation Process to resume Q3	Q4 Submission EMB and Approving Body following consultation
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	Q4 Submission EMB and Approving Body following consultation.
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	Q3 Amendments to be made based on review

- ***Health and Safety***

The policy compliance status of all Health and Safety Policies remains at **100%** as reported in July 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 (refer to Table 12):

  - In March 2022 four policies were outside their review date.
  - In June 2022 16 of the 17 policies were in date **(94%)**.
  - During July 2022 and August 2022 a total of six policies had passed their review dates. Therefore, as at the end of August 2022 nine policies (**53%)** are in date and 8 **(47%)** policies are outside their review date, two of which are All Wales Policies (refer to Table 12).

An update is provided in Table 5 below of progress made to update IPC policies outside their review. This excludes All Wales policies as their review falls outside the remit of the Trust. Further detail is provided in ***Appendix 3***.

Table 5: Infection, Prevention and Control Policy Progress Update

Policy Title	Progress March – August 2022			Next Steps
	March – April	May – June	July - August	
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.	A decision will be taken as to whether the policy will be superseded by the Cleaning Manual.
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 Consultation process to resume in September 2022
Hand Hygiene Policy	Not applicable Policy in date	Not applicable Policy in date	Engagement with Policy Leads on the status of the policy	Review currently underway following which to be included on the agenda for discussion at the IPC Management meeting due to take place in September 2022
Guidelines on Single Use Medical Devices	Not applicable Policy in date	Not applicable Policy in date	Policy assigned to the Medics Team	Policy Lead to be assigned Review process to resume during September 2022

Policy Title	Progress March – August 2022			Next Steps
	March – April	May – June	July - August	
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	Review currently underway following which to be included on the agenda for discussion at the IPC Management meeting due to take place in September 2022
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.	Policy to be updated for submission to EMB at its October 2022 meeting.

- ***Information Governance***

A total of seven Information Governance policies were included as part of the review:

  - 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.
  - In August 2022, six of the seven policies **(86%)** are in date with one policy undergoing review.

Table 6 provides detail on the progress made between March to August 2022 and next steps for approval of the Freedom of Information (FOI) Standard Operating Procedure. More detail is available in ***Appendix 7***.

Table 6: Information Governance Policy Progress Update

Policy Title	Progress March - August 2022			Next Steps
	March – April	May – June	July – August	
FOI Standard Operating Procedure	Upon review there was a rewrite of the procedure	Further review and updates to align with Legislation	Consultation	Consultation and further updates concluded in readiness for submission to EMB and QSPC
Data Protection & Confidentiality Policy	Review and update of the policy	Consultation resumed	Approved by Quality, Safety and Performance Committee and noted at Trust Board	Review concluded Next review due July 2025

Policy Title	Progress March - August 2022			Next Steps
	March – April	May – June	July – August	
FOI Policy	Review and update of the policy	Consultation resumed	Approved by Quality, Safety and Performance Committee and noted at Trust Board	Review concluded Next review due July 2025
Records Management Policy	Review and update of the policy	Consultation resumed	Approved by Quality, Safety and Performance Committee and noted at Trust Board	Review concluded Next review due July 2025
Confidentiality Breach Reporting Policy	Review and update of the policy	Consultation resumed	Approved by Quality, Safety and Performance Committee and noted at Trust Board	Review concluded Next review due July 2025

- ***Digital Services***

A total of six policies were included in the review in Tranche one, two of which are All Wales policies (refer to Table 12):

- In March 2022, it was identified that five **(83%)** of the six Digital Services policies were outside their review dates. One of the five policies is an All Wales policy with four policies subject to review and approval.
- In July 2022, the four policies under review were approved by QSPC.

A summary of progress and the latest position is detailed in Table 7 below. Refer to ***Appendix 4*** for more detail.

Table 7: Digital Services Policy Progress Update

Policy Title	Progress March - August 2022			Next Steps
	March – April	May – June	July-August	
Anti-Virus Policy	• All policies were subject to rigorous review and updates • Further review to reflect latest updated Digital guidance was incorporated	Consultation was undertaken internally as well as collaborative exchange with external partners	All four policies approved by Quality, Safety and Performance Committee and noted at Trust Board	Reviews concluded Next review due July 2025
Data Quality Policy				
Software Policy				
Information Asset Policy				

- ***Corporate Communications***

One Corporate Communications policy, the Social Media Policy was included in the review process which is outside its review date. It was clarified in July 2022 that this is an All Wales Policy with Health Education and Improvement Wales (HEIW) assigned as the Policy Lead for review and approval of the policy. Refer to ***Appendix 5*** for more detail.

- ***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 nine policies have been included in a rigorous review process. Due to the changes in Welsh Government guidelines around COVID and the impact on the Estates function, the review of EPP policies has been complex. Engagement and discussions both within and outside the Trust have been undertaken to support the review of these policies to ensure compliance.
  - In August 2022, the consultation process for three of the six policies will be concluded in readiness for submission to the Quality, Safety and Performance Committee at its meeting in September 2022.

Table 8 below summarises the progress made between March and August 2022, and next steps. Refer to ***Appendix 6*** for more information.

Table 8: Estates, Planning & Performance Policy Progress Update

Policy Title	Progress March to August 2022			Next Steps
	March – April	May – June	July – August	
Safety and Protocol Prevention of Fire and Arson	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation resumed	Q4 Submission to Approving Body
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	Q4 Consultation and submission to Approving Body
Protocol for dealing with suspect packages and bomb threats	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation resumed	Q4 Submission to Approving Body
Environmental Policy	Policy Lead assigned –	Policy review and updates resumed	Consultation resumed	Q4 Submission to Approving Body
Control of Contractors	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Consultation concluded	Submission to EMB 01.09.2022 in readiness for submission to Approving Body

Policy Title	Progress March to August 2022			Next Steps
	March – April	May – June	July – August	
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	Q4 Submission to Approving Body
Waste Management Policy	Policy Lead to be assigned	Policy Lead to be assigned	Policy reviews and updates resumed	Consultation concluded
Water Safety Policy	Policy Lead assigned – Estates Manager	Policy review and updates resumed	Consultation concluded	Submission to EMB 01.09.2022 in readiness for submission to Approving Body
Asbestos Policy	Content and relevance of the policy reviewed	Policy Lead to be assigned	Consultation concluded	Submission to EMB 01.09.2022 in readiness for submission to Approving Body

- ***Workforce and Organisational Development (WOD)***

In the second tranche of the policy review work, **54** policies were identified as WOD policies and included in the review exercise.

The work carried out in tranche three confirmed seven policies are to be archived and 47 policies under review. This review work has continued during July and August 2022.

  - Of the 47 policies, 12 **(26%)** are in date and 24 **(49%)** are outside their review date. Eleven policies outside their review dates are All Wales policies, and the responsibility for review of these policies falls outside the remit of the Trust.

Table 9 below summarises the progress made between May and August 2022 with the updating of policies and next steps. Refer to ***Appendices 8a, 8b & 8c*** for more detail.

Table 9: Workforce and Organisational Development Policy Progress Update

Policy Title	Progress May to August 2022		Next steps
	May – June	July – August	
Study Leave Policy, Procedure & Guidelines	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Complete rewrite required	Q3 Consultation Q4 Submission to Approving Body
Voluntary Early Release Scheme	Policy added to WOD tracker	Resumed review and rewrite of policy	Policy rewrite and consultation Q4 Submission to Approving Body

Policy Title	Progress May to August 2022		Next steps
	May – June	July – August	
Maternity, Paternity, Adoption and Parental Leave Policy	Policy Review Completed	Consultation	Submission to Approving Body.
Working Time Directive Policy	Policy Review Completed	Submitted to EMB 01.08.2022	Submission to Approving Body.
NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Discussions with NHS Wales as to whether policy is still relevant	Policy review	Decision to be taken on relevance of policy
Recruitment of Locum Doctor Policy	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Policy review and rewrite	Q3 Policy rewrite completed and consultation process resumed
Annual Leave and Bank Holiday Policy	• Review underway • Discussion on protocol for Medical and Dental Terms and Conditions	Policy review and rewrite	Q3 Policy rewrite completed and consultation process resumed
Disciplinary Policy		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
PADR Policy	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body
Sabbatical Leave Policy for Consultant Medical Staff	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body
Mental Health, Wellbeing & Stress Management Policy	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body

Policy Title	Progress May to August 2022		Next steps
	May – June	July – August	
Policy for Employing Ex-Offenders and people with a criminal record	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body
Close Personal Relationships in the Work Place	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body
Adverse Weather Policy	Policy review underway	Review and updates progressing	Q3 Consultation Q4 Submission to Approving Body
Homeworking Policy	Policy referred to 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	Submission to Approving Body in September
Redundancy and Security of Employment Policy	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Policy Rewrite resumed	Q3 Rewrite and consultation completed Q4 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	Submission to Approving Body in September 2022
Policy on Reimbursement of Removal and Associated Expenses	Policy lead assigned	Review and update of policy resumed	Q3 Consultation Q4 Submission to Approving Body
Supporting Transgender Policy	Policy lead Assigned	Review and update of policy resumed	Q3 Consultation Q4 Submission to Approving Body
Equality & Diversity Policy	Review and updates completed	Review and update of policy resumed	Q3 Consultation Q4 Submission to Approving Body

Policy Title	Progress May to August 2022		Next steps
	May – June	July – August	
Dealing with Anonymous Communication Policy	Engagement and discussion between WOD and Corporate Communications	Discussion being held on remit of policy	Decision to be taken on remit of policy
Supporting Staff who are Carers	Policy Lead to be assigned	Review and updates resumed	Q3 Consultation Q4 Submission to Approving Body
Capability Policy and Procedure	Velindre feedback submitted to NHS Confederation May 2022		Awaiting confirmation on whether this will be an All Wales policy

3.1.2 Policy Audit Compliance Status

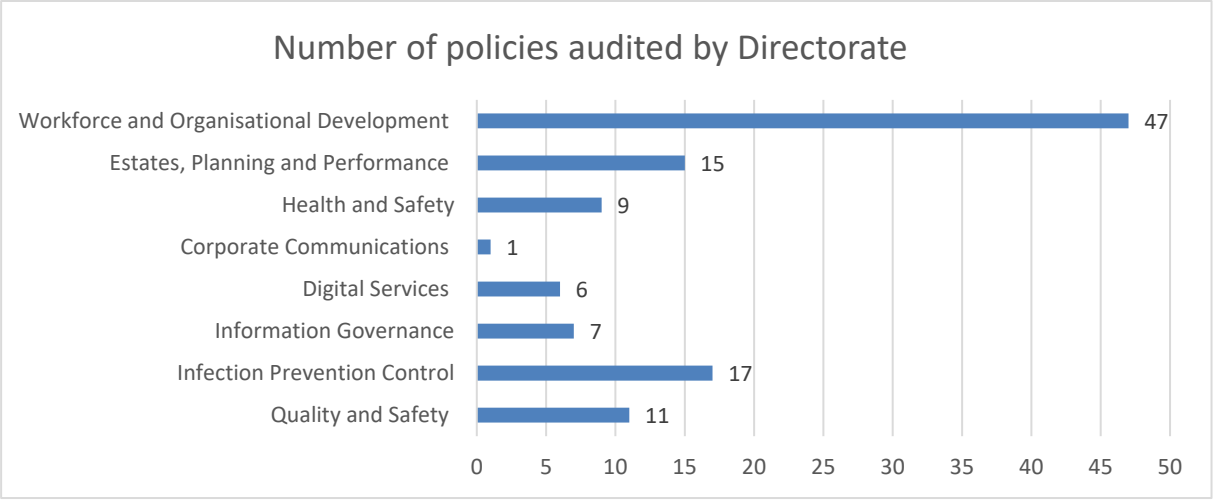
The findings of the Policy Audit Compliance Status for each of the directorates outlined above is reported below against the following categories:

- 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 24/08/2022, 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 24/08/2022, 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 10 below provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee

Table 10: Overall Policy Status

Policy Status	Number of Policies
Policy in date	**52**
Policy review date passed – action underway/required	**45**
All Wales Policy review date passed – awaiting national review	**16**
Policies Archived	**10**

3.1.3 Archived Policies

It was reported in July 2022 to QSPC that ten policies have been archived which has not changed as at the end of August 2022. Table 11 below provides information on the rationale for archiving these policies. The number of

Table 11: 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

Directorate/ Department	Policy Title	Rationale
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

Table 12 below provides an overview of the 123 policies audited per Directorate.

Table 12: 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	24	11	7

4. Policies Passed their Review Dates

Table 13 below provides a summary of the number of policies passed their review dates excluding All Wales Policies.

Table 13: Policies passed their review dates

	Jan 2010 to Dec 2016	Jan 2017 to Dec 2018	Jan 2019 to May 2022	June 2022 to August 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	
Health and Safety	0	0	0	0
Workforce & OD	5	1	18	0

Note: Of the six policies with review dates between 2010 and 2016, all policies are currently under review in readiness for submission to the Approving Body in Q2 and Q3. 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 14 below provides an overall breakdown of policies audited that have passed their review dates by Directorate.

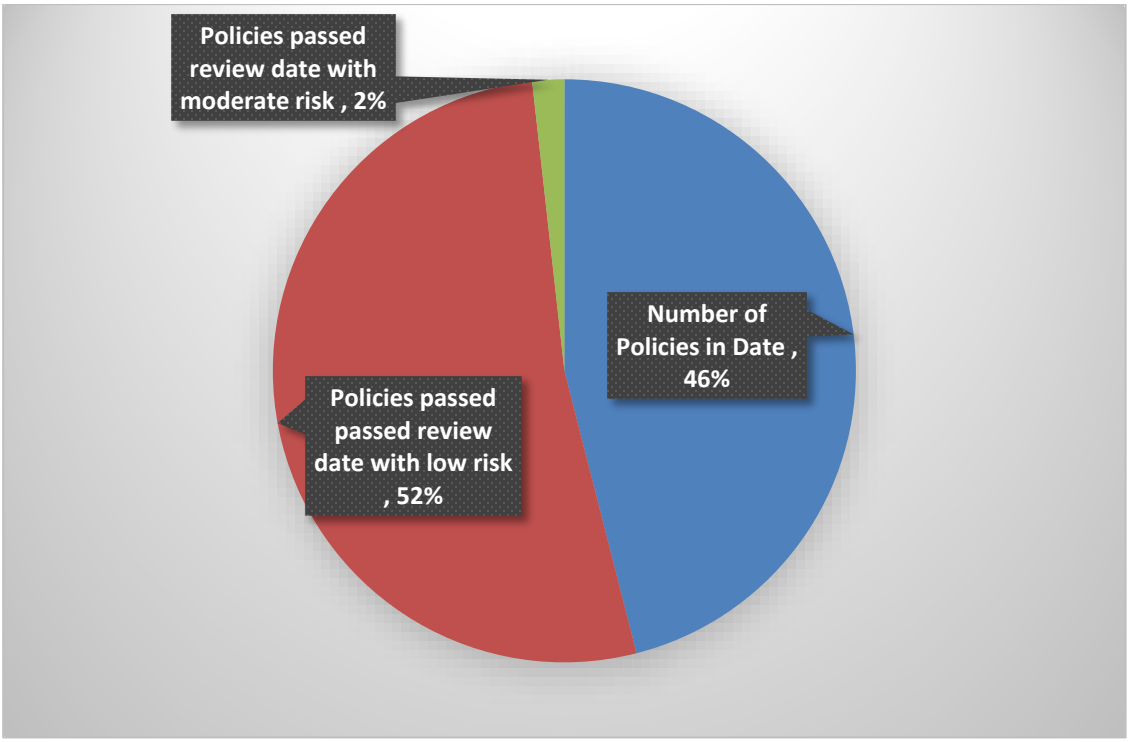
Table 14: Policy Risk Assessment

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
Workforce and Organisational Development	12	35	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 24/08/2022 that fall within the remit of the Quality, Safety and Performance Committee.

Figure 2: Overall Compliance



6. NEXT STEPS

In addition to the continuous review and monitoring of those policies that fall within the remit of the Quality, Safety and Performance Committee, the ongoing audit review will continue to focus on those policies that fall within the remainder of the Trust Board Committees until end of September 2022.

Following which, all Trust wide policies will have been subject to a comprehensive rigorous review.

7. 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.

8. RECOMMENDATIONS

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

a. **DISCUSS AND REVIEW** the findings of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b. **NOTE** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at **26/08/2022,** included at ***Appendices 1 to 8***.

c. 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)	Is the Policy on the Internet (Yes / No)	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	N/A	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
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	Yes		Policy in date	Policy in date with no risk assessment required
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	Yes	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	Yes	Approved: EMB & QSP Trust Board: 26.07	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	No		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	No		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 07	Medical Gas Cylinders Policy	Executive Medical Director	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Dec-21	Yes	Q4 Submission to EMB and 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	No	•Finalise Consultation •Q4 Submission to EMB & 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	Yes	Q4 Submission EMB and Approving Body following consultation	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	Yes	Policy went out of date end June 2022 and is undergoing review to align with All Wales Patient Safety Solutions Guidance Policy	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	Yes	Q3 Review and consultation Q4 Submission to 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	All Wales	Aseptic Non Touch Techniques (ANTT)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22		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		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	Approved by QSP on 24.03.2022	Policy in date	Policy in date with no risk assessment required
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		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	Approved Approved by QSPC 12 May	Policy in date	Policy in date with no risk assessment required
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		Policy in date	Policy in date with no risk assessment required
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		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	Approved by QSP on 24.03.2022	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	Review and Consultation process to resume in September 2022	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	Review and Consultation process to resume in September 2023	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	Review and Consultation process to resume in September 2024	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	Review and Consultation process to resume in September 2025	Policy review date passed – action underway/required	Policy review date passed with low 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	Review and Consultation process to resume in September 2026	Policy review date passed – action underway/required	Policy review date passed with low 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	Q2 Review & consultation Q3 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate 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 - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jun-18	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
DIGITAL	All Wales	Internet Use Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jul-25	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	Jul-25	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	Jul-25	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	Jul-25	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	Jul-25	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 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 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 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 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 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 01a	Safety and Protocol Prevention of Fire and Arson	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Feb-21	Q3 Consultation & 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	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 03	Environmental Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Mar-21	Q3 Consultation & 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	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 06	Business Continuity Policy	Chief Operating Officer	Quality, Safety & Performance Committee	Apr-21	Q3 Consultation & 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	Q3 Consultation & 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	Q2 Consultation Q3 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	Q2 Consultation Q3 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 04	Asbestos Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Dec-20	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk

APPENDIX 7: INFORMATION GOVERNANCE

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
Information Governance	IG 08a	FOI Standard Operating Procedure	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Apr-22		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Information Governance	IG 13	Confidentiality Breach Reporting Policy	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	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 08	Freedom of Information Act Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Jul-25		Policy in date	Policy in date with no risk assessment required
Imformation Governance	All Wales	Information Governance 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	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 01	Records Management Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required

APPENDIX 8a: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Dress Code and Uniform Policy	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Pay Progression Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/09/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/04/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Protocol on Collective Consultation of Proposed Radiance	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/09/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Special Leave Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2022	N/A	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)	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Dates missing on front page	Currently updating & formatting policy Q3 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	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Employment Break Scheme	Executive Director of OD and Workforce	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 21	Professional Registration Policy	Executive Director of OD and Workforce	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	All Wales Velindre adopted	Reserve Forces Training and Mobilisation Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2024		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Respect and Resolution Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2024		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Secondment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/07/2024		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 55	Smoke Free Policy	Executive Director of OD and Workforce	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	GC 03	Standards of Behaviour Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2022		Policy in date	Policy in date with no risk assessment required
Workforce & OD	GC 03	Standards of Behaviour Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2022		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 54	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Executive Director of OD and Workforce	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 16	Welsh Language Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2022		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 13	Adverse Weather Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 35	Annual Leave and Bank Holiday Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	Q2: Review & updates Q3: Consultation Q4: 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Q2 Submitted to EMB Q3 Submitted to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Capability Policy and Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 21	Close Personal Relationships in the Work Place	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/02/2021	Under Review Q3 Submission to 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	Director of Corporate Governance and Chief of Staff	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 02	Disciplinary Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	31/03/2020	Review on hold NHS Employers to focus on implementation of Respect & Resolution policy	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	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	WF 05	Equality & Diversity Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/09/2021	Review completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 45	Homeworking Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q2 Review & updates Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2016	Review completed Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 47	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2016	WOD confirming with NHS Wales whether policy still in place or should be archived	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 30	PADR Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2020	Review completed Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review and updates completed Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Under Review Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2017	Q3 Review and updates Q4 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)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q2 Submitted to EMB Q3 Submitted 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q3 Review and updates Q4 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 38/ WF12	Study Leave Policy, Procedure & Guidelines	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2013	Q3 Review and updates Q4 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/12/2021	Q2 Review & updates Q3 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	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	missing	Voluntary Early Release Scheme	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2015	Q2 Review and updates completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 44	Working Time Directive Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2016	Q2 Submitted to EMB Q3 Submitted to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

QUALITY, SAFETY & PERFORMANCE COMMITTEE

(CIVAS@IP5)

DATE OF MEETING	15/09/2022

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
- 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
- 92% Documentation Review dates met
- Environmental failure rates for critical area and operators 1.8% and 3.5 % respectively (target of <5%)
- Zero service complaints
- 96% Production yield (target >95%)
- 100% compliance with CD checks

2.3 Current service developments are linked to current service pressures across NHS Wales and focus on patient safety, alleviating service capacity pressures and support of the national COVID-19 booster Programme:

- WDA of SpikeVax Moderna Vaccine using new fridge and freezer facilities based at Imperial Park Building 5, Newport.
- Dose banded Nivolumab and Atezolizumab Infusions
- Standardised Potassium Chloride syringe (50mmol in 50mL)
- Patient safety pilot with CAV UHB providing Emergency Intubation injections. This has potential for all Wales expansion
- Rituximab dose banded infusions provided in ready to use format
- Calcium Folinate infusions provided in ready to use format – pending improved stability

2.4 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 Medicines Unit. MS52641

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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.**

		will allow early identification of issues that require risk assessment and Corrective and Preventative actions.		**Target date exceeded due to delay in roll out of national programme putting our installation and validation further behind. This will be outlined to the inspectorate in our compliance report due at end of September 2022.**
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	SOP PQS14 – Recall Process will be updated to provide clarification that once collected by courier (external or internal) then the	**March 2022**	**Owner AD** **Q-Pulse Ref: REG 69** **Completed**

	Centre) of the recall of batch 1001220008 (Morphine).	product is required to be reported to the DMRC where a recall or quality issue is identified. 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	**March 2022**	**Owner AD** **Q-Pulse Ref: REG79** **Completed**

		actions required for differing levels of Recall.		
3.3	The technical agreement with Health Courier services did not state how quickly the site should be notified of a temperature excursion of product during shipment to ensure that appropriate actions could be taken.	As part of annual SLA review with Health Courier Service, the QA team will discuss 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.	**May 2022**	**Owner GT/AD** **COMPLETED**
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

WORKFORCE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	15th September 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 into 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 funding is no longer available.

The full year pay budget is £71.967m based on 1,582 WTE.

As at July 2022, the current staff in post is 1,444 WTE. The number of vacancies is 138 WTE, which represents 9.6% 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 in response to Covid which were funded directly by Welsh Government in 2021-22, which in 2022-23 for VCC have to be funded by the marginal income received from commissioners through the LTAs for activity above baseline, which is leading to a financial risk as currently activity in some service areas is below baseline. Also it has been necessary to proceed with forward recruitment on service developments prior to Business Case approval and funding agreed due to recruitment lead times. 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 157
- Work is taking place with divisions to work through the remaining contracts to decide if they should change to permanent – this will be completed by the end of September 2022

The Trust has reported a cumulative year-to-date spend of £24.048m on pay against a budget of £24.083m resulting in an underspend position of £0.035m as at July 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, the Trust are taking forward a number of projects, focused on hotspot areas, to address the need to change the workforce model. The agreed workforce planning principles are focused on a set of key considerations (Appendix A)

The projects, linked to the principles, are summarised below:

WP Principles	Hotspots	Transformation Work ongoing	Outputs	Timelines
Agile Transformative	• Diagnostic Radiation Services • Nuclear Medicine	Radiation Services Treatment Model	IRS implementation will provide extended working hours with increased service capacity Recruitment plan in place to support additional capability and staffing	22-23
MDT focus Co-Produced Whole system		Radiation Services Diagnostic Model	Joint regional work addressing succession planning and talent management with joint training contracts with Cardiff and the Vale in place to support cross cover and provide service resilience. Locally in Velindre current implementation of apprenticeship schemes is providing immediate succession planning and talent management provision	22-23
Intelligence led ED&I focus	Effective provision of intelligent information	Bi-Service Model Review	Streamline data to support whole trust information picture	22-23

WP Principles	Hotspots	Transformation Work ongoing	Outputs	Timelines
Welsh language considerations		Use of Workforce Repository and Planning tool	Workforce modelling tool to be utilized to provide a baseline of what the future workforce could look like	
Agile Transformative MDT working Whole system Support H&W of staff	SACT /Medical Oncology/Culture change- ways of working	Redesign of pre-SACT Medical Model	MDT models of work	22-23
MDT working Agile	Collections	Collections Service model	Top of license working Workforce around the service	2022

- 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, however these options may be considered unsustainable given the high level of vacancies and sickness levels.
- The W&OD and Finance team will work with departments to manage any associated workforce risk regarding staff recruited permanently due to Covid or other reasons where recurrent funding is no longer available. This will be through re-deployment into vacancies primarily with redundancy as an option if required
- 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 strategy. Initial analysis is presently being validated by respective Directorates, prior to wider Divisional aggregation.

- The Workforce Repository and Planning Tool will be utilised in all the hotspot areas above. The tool is a recognised strategic workforce-planning tool for health and social care used in NHS England. It is a web-based application that enables the collection, analysis and modelling of workforce information from providers across the whole health and social care economy. It is a flexible tool which, at its core, established the relationship between workforce capacity and service activity
- There are two primary functions of the tool: 1) The Workforce Repository and 2) Scenario modelling. It is anticipated by the end of September/early October models will be available to discuss.

2.2 Wellbeing

2.2.1 Key Workforce and Associated Financial Risks

Key workforce risk: The COVID pandemic has resulted 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 July Workforce Monthly Performance Report Pages 7-8 Sickness Narrative for further details.

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 premium 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 WOD and Finance Risks related to Wellbeing

The Staff Wellbeing paper presented to QSP highlights the actions taken to mitigate the risk.

3. Attraction and Retention

3.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: The Trust is currently carrying 138 WTE vacancies as at the end of July 2022. An Attraction and Retention plan has been developed with targeted specific intentions 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 July 2022 on measures to bridge the vacancy gap include:

- Agency spend £512k (£128k directly related to Covid)
- Overtime spend £156k

The 2022/23 full year forecast outturn for Agency spend is £1,478k (£379k Covid related) compared to £1,906k 2021/22, which is a £428k (22%) 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 WOD 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.

The main outputs are as follows:

Marketing:

- Working closely with the Assistant Director of Communications for the Trust to develop a Corporate Video promoting working in the Trust. This is being filmed and delivered by the same company procured to film the corporate strategy videos and the development of nVCC promotional videos.
- The brief ‘This is Velindre’ will showcase some of the lesser-known roles within the Trust and some of the more common roles, along with the benefits available to staff that will be of specific interest to perspective candidates

Process:

- The group has developed a paper for EMB on streamlining the scrutiny process and utilising technologies we already have in place to ensure financial and legal requirements are met. This has been developed from benchmarking our process with that of our other NHS Wales Partners.
- 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.

Retention:

- This group will assess the current turnover and retention strategies of the Trust and consider next steps for retention.
- A review of the current Job Description template is underway – changes expected to take place in the Autumn across Wales that will reduce the need for long and complex Job Descriptions.
- National Recruitment Modernisation Board have begun implementing faster processes for on-boarding new employees and for when employees move within the NHS.
- 1st 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
Attraction and Retention		Vacancy Rate Vacancy turnover rate

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 Principle

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 31ST JULY 2022 (M4)

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Financial Planning & Reporting Manager / 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	01/09/2022	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 July 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	0.000	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.856	3.989	24.535
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.5%	95.5%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid) 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 July 22 is an underspend of **£0.007m**, 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, for which the Trust is expecting to receive WG funding to cover during the first 6 months of the year, with strategic plans being 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 therefore it is important that those schemes that have not yet gone live are reviewed at divisional level with a view to either turn green or find replacement schemes.

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs are fully reimbursed by WG, all planned additional income is received and the savings targets achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust (inc. NWSSP) is currently 95.59% against a target of 95%, with the performance against the Core Trust (exc. NWSSP) being 95.54%

Measures have recently been put in place to target key areas which have been causing 'bottlenecks' in the PSPP process which has been reflected recent performance figures.

2.4 Covid Expenditure

Covid-19 Funding 2022/23			
	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.336		0.336
PPE	0.225		0.225
Cleaning	0.418		0.418
Other Covid Response	0.249		0.249
Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261

	1.228	**3.906**	**5.134**

The overall gross funding requirement related to Covid has reduced further and currently stands at £5.134m, with £1.228m being recognised although not confirmed for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £5.134m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, 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 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 several savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully achieved. Those schemes with risk of delivery are being reviewed at divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

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.

Other Exceptional National Cost Pressures

The Trust is anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£2.235m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during August, which indicates another significant rise from the £1.669m included in the prior month forecast.

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.

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, however following a request to support costs associated with the bunker refurbishment and purchase of equipment in relation to IRS an impact assessment on the previously approved discretionary capital allocation for 2022/23 has been completed with the expectation that circa £750k could, if required be released this financial year.

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 July 2022 is an underspend of £0.007m 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 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.

4.2 the TCS Programme financial report for July 2022 attached as **Appendix 1**.

4.3 In line with WG expected reported guidance the Velindre Core Trust monthly monitoring return (MMR) for July attached as **Appendix 2.**

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JULY 2022/23

QUALITY SAFETY & PERFORMANCE COMMITTEE
15/09/2022

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

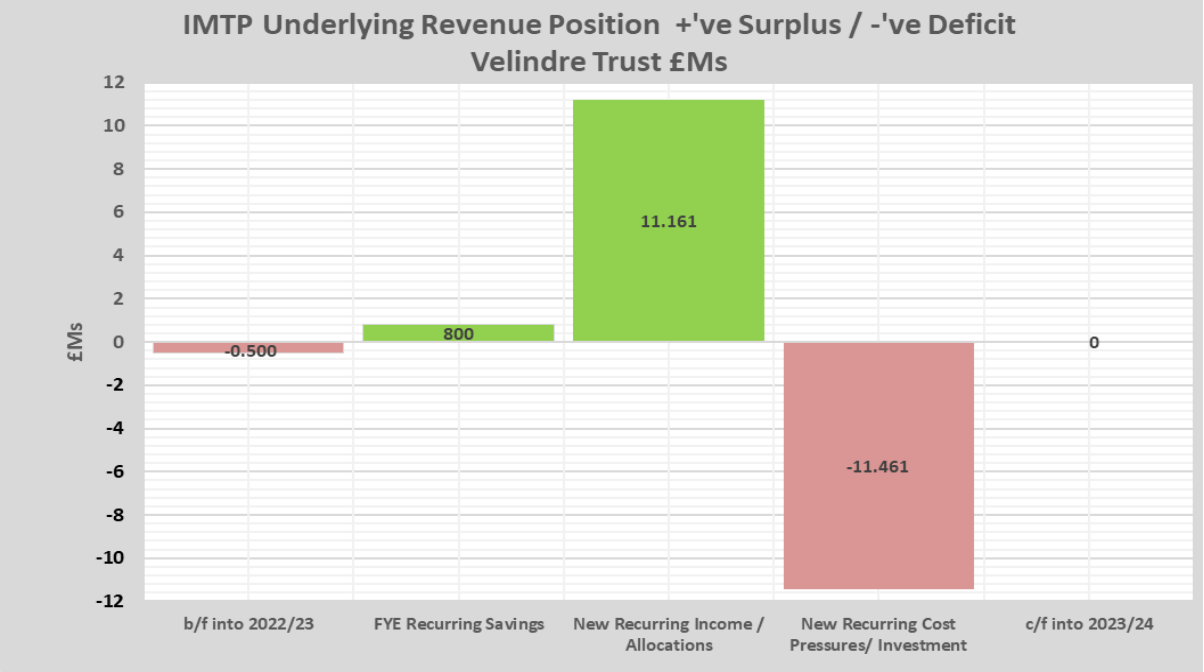
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- 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 £000	Year to date £000	Year End Forecast £000
Revenue	Variance	0	7	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	856	3,989	24,535
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.5%	95.5%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a nil movement for July '22, with a cumulative position of £0.007m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at July 2022 is **£24.535m**. This represents all Wales Capital funding of **£23.081m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to July'22 of £3.989 and is forecasting to remain within its CEL of £24.535m.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£M June 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	-1.900	22.002
Total CEL	**25.856**	**-1.321**	**24.535**

Slippage on the TCS Programme has led to £1.900m Capital funding being pushed back to 2023/24 financial year, reducing the WG Capital allocation to £22.002m this financial year.

PSPP

During July '22 the Trust (core) achieved a compliance level of **96.51%** (June 22: 95.97%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.54%** as at the end of month 4, and a Trust position (including hosted) of **95.59%** compared to the target of 95%.

PSPP has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness being experienced in the Trust over the past year. The finance team has been working with NWSSP colleagues with a view to help improve performance, which has included a full review the approval hierarchy which has been reflected in recent performance figures.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23.

Revenue Position

Cumulative				Forecast		
£0.007m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(56.615)	(56.302)	(0.314)	(179.584)	(179.277)	(0.307)
Pay	24.083	24.048	0.035	71.967	72.053	(0.086)
Non Pay	32.532	32.247	0.285	107.617	107.225	0.392
Total	**(0.000)**	**(0.007)**	**0.007**	**0.000**	**0.000**	**(0.000)**

The overall position against the profiled revenue budget to the end of July 2022 is an underspend of **£0.007m**, with a Pay and Non 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 are fully reimbursed by both WG and the Trust commissioners, that all 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 July and 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 July 2022 is 138WTE, VCC (71WTE), WBS (35WTE), Corporate (6WTE), R&D (18WTE), TCS (2WTE) and HTW (6WTE).

The pay award is based on the pay circular that was shared on the 27th July (corrected version 4th August). Early indications based on an approximate calculation is that the cost to the Trust during 2022-23 will be circa £3.4m, and the Trust is working on the assumption that this will be fully funded by WG.

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding is currently expected to be secured from WG through the recognition of exceptional national cost pressures but remains a risk.

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 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

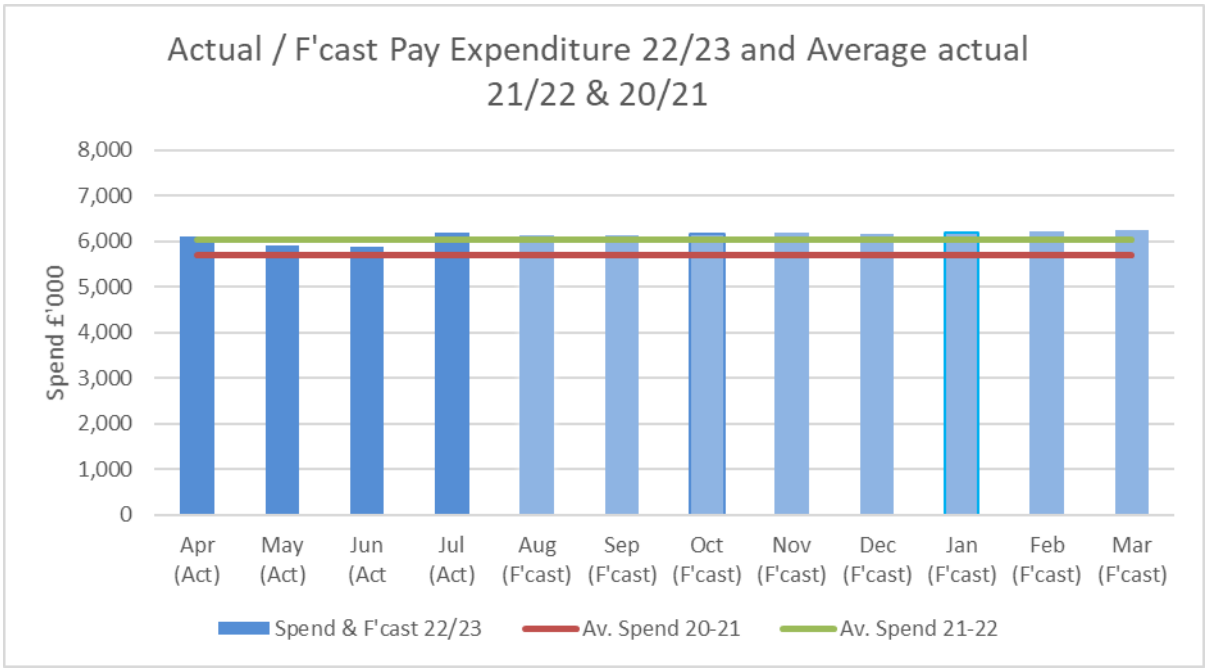
The expected increase in energy prices circa (£2.235m) June (£1.669m), has been recognised as an exceptional national cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23, although this is yet to be confirmed.

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 for 2022/23.

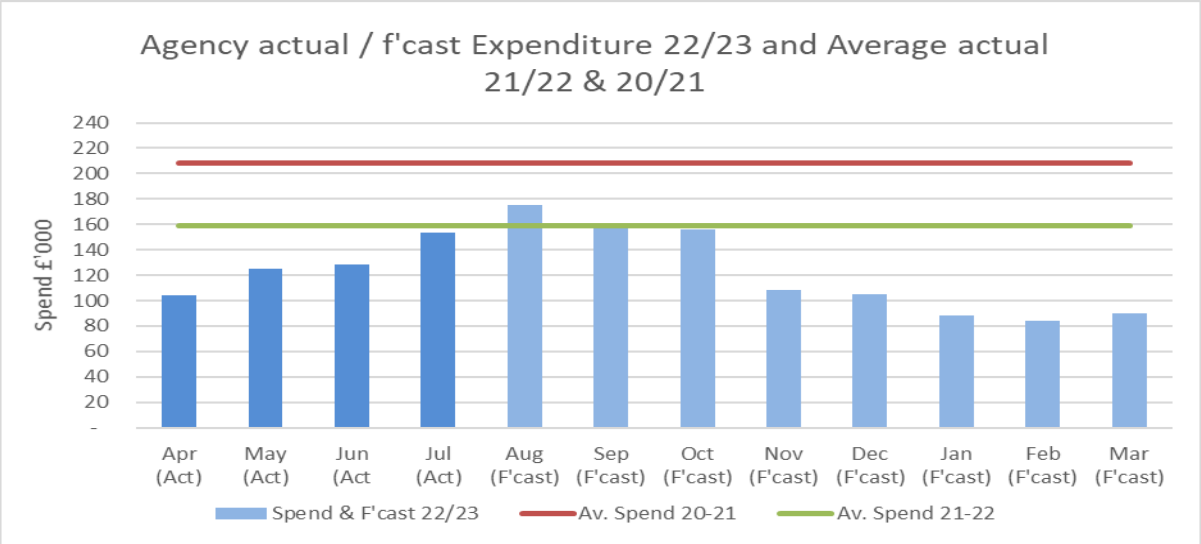
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

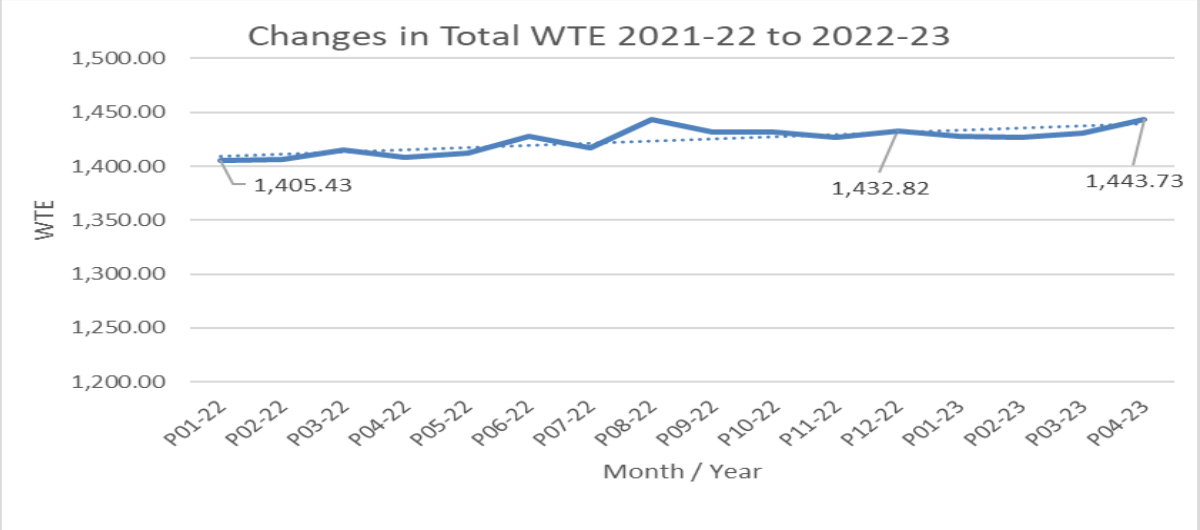
4.2 Pay Spend Trends (Run Rate)

The effect of pay award for 2022/23 is still being calculated by the divisions and is therefore not included within the pay spend. it is hopeful that agency costs will decrease during 2022/23 largely from the reduction of agency staff that has been used over the past year in response to Covid and through the recruitment into filling vacancies.



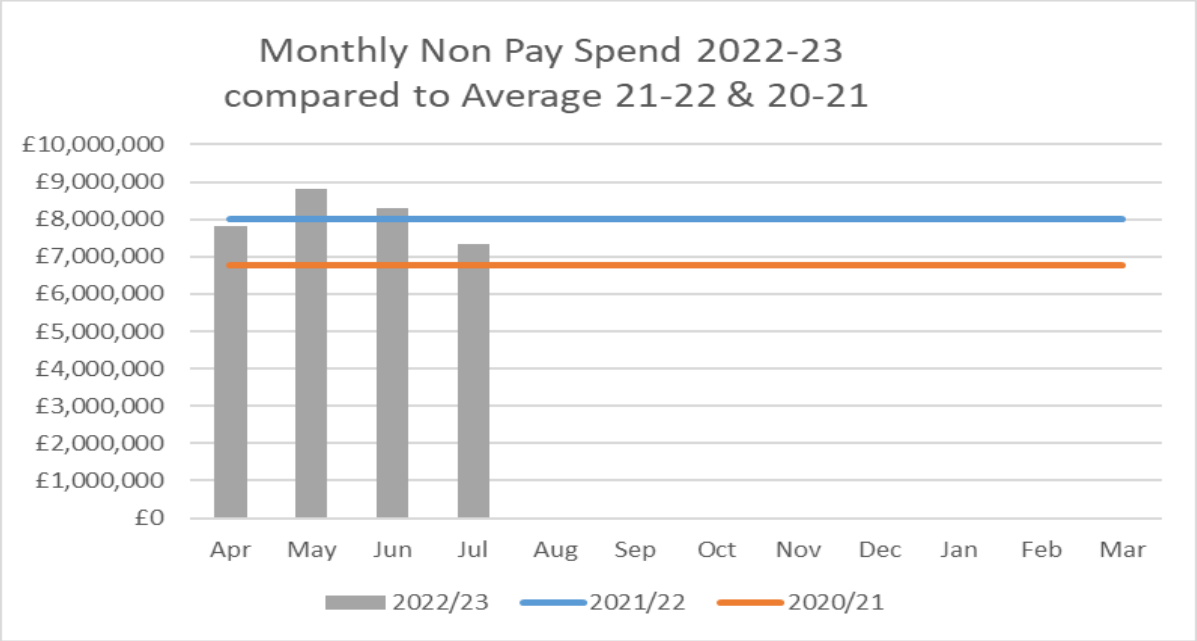
The spend on agency for July'22 was £0.154m (June £0.129m), which gives a cumulative year to date spend of **£0.512m** and a current forecast outturn spend of circa **£1.478m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of July is £0.128m and forecast spend is circa £0.379m (£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 £8.06m which is currently in line with 21/22.



4.4 Covid-19

Covid-19 Funding 2022/23			
	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.336		0.336
PPE	0.225		0.225
Cleaning	0.418		0.418
Other Covid Response	0.249		0.249
Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261
	1.228	**3.906**	**5.134**

The latest forecast funding requirement as at 31st July in relation to Covid for 2022-23 has been further revised down to £5.134m (June £5.680m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £5.134m total Covid requirement £1.228m (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.

The latest forecast spend and funding requirement from WG has reduced by a further £0.100m from £1.328m reported in June to £1.228m. which is due to further de-escalation of security on the WBS sites for storage of vaccines, and the utilisation of stored PPE stock.

WG funding has been assumed for programme related Covid costs of £0.561m (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 to date invoiced for QTR 1 costs relation to Mass Vaccination and PPE.

Covid-19 Revenue Spend/ Funding		
	YTD Actual £m	Forecast Spend 2022/23 £m
Mass Covid Vaccination	0.114	0.336
PPE	0.065	0.225
Cleaning Standards	0.110	0.418
WG Other Covid Response	0.095	0.249
Covid Recovery	1.234	3.906
Total Covid Spend /Funding Requirement 2022/23	**1.618**	**5.134**
WG Funding		1.228
Commissioner Funding		3.906
Balance of Funding Requirement	**0.000**	**5.134**

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 (£4.150m) previously required for outsourcing has now been removed, with the residual balance previously reported of £0.500m which related to patients already in the system being managed through the release of a provision made at the end of 2021-22 for the expected outsourcing costs. In response the Trust is looking to establish additional outreach Capacity at Prince Charles Hospital for SACT with forecast additional cost above that already invested in Covid capacity of circa £0.320m and is currently developing plans for Radiotherapy capacity internally looking to weekend working which will require waiting list initiatives (WLI)and enhanced pay rates. The cost of this additional capacity is 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%).

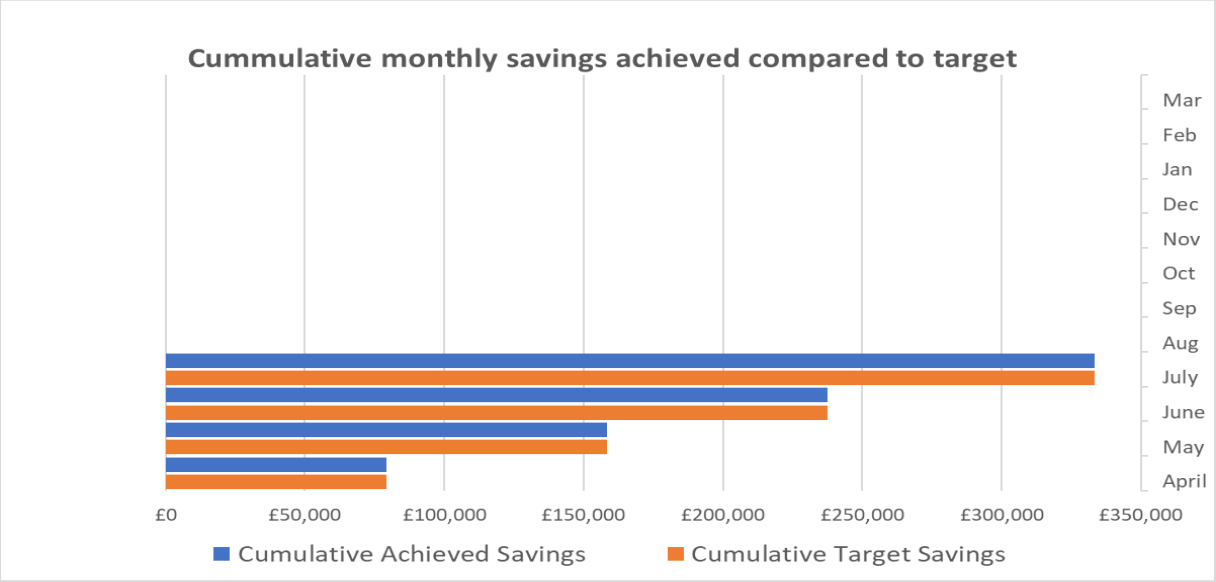
Currently two of the schemes relating to service redesign and supportive structures are still RAG rated amber which are those that continue to be impacted by Covid during 2022-23

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. Due to the pandemic the savings scheme start date has been pushed back further to September, with work ongoing but proving to be difficult under the current workforce situation, particularly with the high number of vacancies and the high level of sickness currently being experienced throughout the core Trust.

It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved alternative schemes are implemented to ensure that the Savings target is met for 2022-23.

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**	**133**	**133**	**0**	**700**	**0**
			100%		**100%**	
WBS TOTAL SAVINGS	**500**	**167**	**167**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**33**	**33**	**0**	**100**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**333**	**333**	**0**	**1,300**	**0**
			100%		**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	33	33	0	100	0
Laboratory & Collection Model (WBS)	Green	50	17	17	0	50	0
Laboratory & Collection Model (WBS)	Green	50	17	17	0	50	0
Stock Management (WBS)	Green	100	33	33	0	100	0
Stock Management (WBS)	Green	150	50	50	0	150	0
Procurement - Supply Chain (WBS)	Amber	50	17	17	0	50	0
Service Redesign (VCC)	Amber	100	0	0	0	100	0
Supportive Stuctures (VCC)	Amber	100	0	0	0	100	0
Procurement - Supply Chain (VCC)	Amber	50	17	17	0	50	0
Total Saving Schemes		**750**	183	183	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	17	17	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Geen	50	17	17	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Amber	150	17	17	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	33	33	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	67	67	0	200	0
Total Income Generation		**550**	150	150	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**333**	**333**	**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	1.190
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.080)
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	1.404
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
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 all Covid related expenditure will be 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 £0.100m, Likelihood - Medium*

The Trust as part of the IMTP identified £1,300k 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, or to find replacement schemes as the year progresses.

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 TBC, Likelihood - High*

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 £3,906k (June £3,852k). 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 outsourcing NHS Wales 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 £1.228m, 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 £100k from £1,328k reported in June to £1,228k. The costs for Mass Vaccination and PPE have further reduced which is due to de-escalation of security on the WBS sites for storage of vaccines, and the utilisation of stored PPE stock.

Other Exceptional National Cost Pressures – *Risk £2.219m - Medium*

The Trust is still anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£2.235m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during August, which indicates another significant rise from the £1.669m included in the prior month forecast .

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 £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M4 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
nVCC - project costs	2,089	1,140	0	949	2,539	(450)
nVCC - Enabling Works	19,913	2,194		17,719	19,463	450
Canisc Cancer Project	579	259	0	320	579	0
Fire Safety	500	117	0	383	500	0
			0			
Total All Wales Capital Programme	23,081	3,710	0	19,371	23,081	0
Discretionary Capital	1,454	279	117	1,058	1,454	0
Total	24,535	3,989	117	20,429	24,535	0

The approved 2022/23 Capital Expenditure Limit (CEL) as at July 2022 was £24.535m. This includes All Wales Capital funding of £23.081m, and discretionary funding of £1.454m. The approved CEL has been reduced by £1.900m to reflect the latest forecast requirement on the nVCC Enabling works project for 2022/23. Following agreement with WG the £1.900m will be re-provided to the programme during 2023/24.

In addition, WG colleagues have been notified of an additional request to move £0.450m from the nVCC enabling works to support the additional costs associated with the nVCC project fees and advisory activities.

In January 2022 WG informed the Trust that the discretionary allocation with 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.

In addition, following a request to support costs associated with the bunker refurbishment and purchase of equipment in relation to IRS an impact assessment on the previously approved discretionary capital allocation for 2022/23 has been completed with the expectation that circa £750k could, if required be released this financial year.

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.

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 July 2022 on the All-Wales Capital Programme schemes was £3.710m, this is broken down between spend on the nVCC enabling works £2.194m, nVCC project costs of £1.140m, Canisc Cancer Project £0.259m, and fire safety £0.117m.

Spend to date on Discretionary Capital is currently £0.279m with a further £0.117m leaving a remaining balance of £1.058m as at the 31st July.

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*	OBC & PBC approved by WG, FBC under development	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 Jul-22	Movement from 1st April Jul-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	148.317	5.18	139.375
Intangible assets	8.667	7.803	(0.864)	5.869
Trade and other receivables	1,092.008	1,337.143	245.14	1,337.143
Other financial assets	0.000	0.000	0.00	0.000
Non-Current Assets sub total	1,243.811	1.493	0.25	1.482
Current Assets				
Inventories	65.207	55.913	(9.294)	55.913
Trade and other receivables	540.227	234.828	(305.399)	273.614
Other financial assets	0.000	0.000	0.00	0.000
Cash and cash equivalents	30.404	46.410	16.01	18.500
Non-current assets classified as held for sale	0.000	0.000	0.00	0.000
Current Assets sub total	635.838	337.151	(298.687)	348.027
TOTAL ASSETS	1,879.649	1,830.414	(49.235)	1,830.414
Current Liabilities				
Trade and other payables	(277.601)	(224.035)	53.57	(224.035)
Borrowings	0.00	0.00	0.00	0.00
Other financial liabilities	0.00	0.00	0.00	0.00
Provisions	(341.123)	(342.125)	(1.002)	(342.125)
Current Liabilities sub total	(618.724)	(566.160)	52.56	(566.160)
NET ASSETS LESS CURRENT LIABILITIES	1,260.93	1,264.25	3.33	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	165.319	5.94	165.319
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	15.474	0.01	15.474
Other reserve	0.000	0.000	0.00	0.000
Total Taxpayers' Equity	159.383	165.319	5.936	165.319

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.

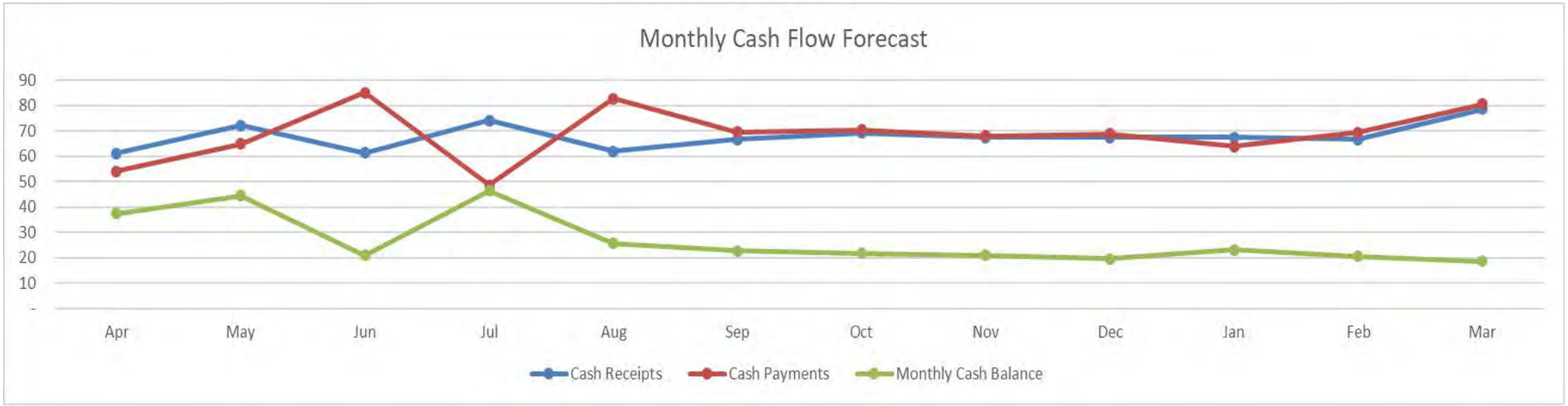
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains 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 this 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 is 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	36.250	39.077	41.352	40.038	39.900	39.850	39.536	35.218	462
2	WG Income	20.937	24.551	17.010	24.552	22.450	24.145	24.620	24.155	24.188	24.158	24.037	24.182	279
3	Short Term Loans													0
4	PDC				5.928								15.307	21
5	Interest Receivable													0
6	Sale of Assets													0
7	Other	7.106	7.289	4.321	6.094	3.223	3.448	3.223	3.190	3.271	3.520	3.183	3.947	52
8	TOTAL RECEIPTS	**61**	**72**	**61**	**74**	**62**	**67**	**69**	**67**	**67**	**68**	**67**	**79**	**814**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	30.000	30.029	30.080	30.097	30.095	30.148	30.112	30.593	351
10	Non pay items	30.543	33.079	54.139	17.703	50.423	37.050	38.650	36.325	35.488	32.340	37.496	38.622	442
11	Short Term Loan Repayment												7.000	7
12	PDC Repayment													0
14	Capital Payment	1.926	2.567	1.420	1.215	2.280	2.453	1.587	1.660	3.289	1.383	1.849	4.409	26
15	Other items													0
16	TOTAL PAYMENTS	**54**	**65**	**85**	**49**	**83**	**70**	**70**	**68**	**69**	**64**	**69**	**81**	**826**
17	Net cash inflow/outflow	7	7	(24)	25	(21)	(3)	(1)	(1)	(2)	4	(3)	(2)	
18	Balance b/f	30	37	45	21	46	26	23	22	21	19	23	20	
19	Balance c/f	37	45	21	46	26	23	22	21	19	23	20	18	



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	(11.350)	(11.350)	(0.000)	(36.398)	(36.398)	0.000
RD&I	(0.325)	(0.325)	(0.000)	0.365	0.365	0.000
WBS	(6.414)	(6.414)	0.000	(19.882)	(19.882)	0.000
Sub-Total Divisions	**(18.088)**	**(18.088)**	**(0.000)**	**(55.915)**	**(55.915)**	**0.000**
Corporate Services Directorates	**(3.367)**	**(3.361)**	**(0.006)**	**(10.117)**	**(10.117)**	**0.000**
Delegated Budget Position	**(21.455)**	**(21.449)**	**(0.006)**	**(66.032)**	**(66.032)**	**0.000**
TCS	(0.184)	(0.184)	0.000	(0.551)	(0.551)	0.000
Health Technology Wales	(0.009)	(0.009)	(0.000)	(0.028)	(0.028)	0.000
Trust Income / Reserves	21.648	21.648	0.000	66.611	66.611	0.000
Trust Position	0.000	0.007	(0.007)	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	**22.690**	**22.744**	**0.054**	**74.456**	**74.456**	**0.000**
Expenditure						
Staff	**14.327**	**14.298**	**0.029**	**43.408**	**43.408**	**0.000**
Non Staff	**19.712**	**19.795**	**(0.083)**	**67.447**	**67.447**	**0.000**
Sub Total	**34.040**	**34.093**	**(0.053)**	**110.855**	**110.855**	**0.000**
Total	**(11.350)**	**(11.350)**	(0.000)	**(36.398)**	**(36.398)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of July 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 3 represents an overachievement of **£0.054m**. 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 and a one off drug rebate. This is offsetting the divisional income savings target and the loss of income from the now permanent closure of gift shop, which was initially closed due to Covid, and will now be transformed to make additional clinical space at the Cancer Centre.

VCC have reported a year to date underspend of **£0.029m** 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 (£0.357m to end of June) although £0.100m is 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 covered by Jnr Dr's with expectation that the transition to nursing starts to take place from august.

Non-Staff Expenditure at Month 3 was **£(0.083)m** overspent. The overspend largely relates to the maintenance and repairs of the Linacs, transport SLA overspend, and unexpected prior year invoices being received from Virgin Media. 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	**8.659**	**8.304**	**(0.354)**	**22.967**	**22.423**	**(0.544)**
Expenditure						
Staff	**5.414**	**5.476**	**(0.062)**	**15.414**	**15.601**	**(0.187)**
Non Staff	**9.659**	**9.242**	**0.417**	**27.435**	**26.704**	**0.732**
Sub Total	**15.073**	**14.718**	**0.354**	**42.849**	**42.305**	**0.545**
Total	**(6.414)**	**(6.414)**	0.000	**(19.882)**	**(19.882)**	**0.000**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of July 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.354)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Plasma sales recovery is still being impacted and expected to continue in the short term, with the pan to award a new contract in September, however volume of product to sell is extremely low linked to stock pressures. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. Covid funding will be utilised during the first 6 months to offset reduce activity impacted by the pandemic, with the division developing a strategy to increase the panel to help mitigate the risk during the latter part of the year.

Staff reported a year-to-date overspend of **£(0.062)m** to July. 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 Plasma Fractionation where no WHSSC funding has been secured.

Work is 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 **£0.417m** is largely due to reduced costs from suppressed activity (currently running at 80%), underspend on Collections Services, Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.257**	**0.357**	**0.100**	**0.757**	**0.995**	**0.238**
Expenditure						
Staff	**2.859**	**2.873**	**(0.014)**	**8.565**	**8.463**	**0.102**
Non Staff	**0.764**	**0.845**	**(0.081)**	**2.310**	**2.649**	**(0.339)**
Sub Total	**3.623**	**3.718**	**(0.095)**	**10.875**	**11.112**	**(0.237)**
Total	**(3.367)**	**(3.361)**	0.006	**(10.117)**	**(10.117)**	**0.000**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of July 2022 was an underspend of **£0.006m**. 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 is being reflected in the overachievement on income within the Corporate Division.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £100k divisional savings target of.

Non pay overspend is **£(0.081)m** as at month 4 largely relates to the divisional savings target £(0.052)m 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 pressure include the increased running costs for the Hospital Estate with work ongoing to understand the total pressure 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	**0.522**	**0.518**	**(0.004)**	**3.102**	**3.102**	**0.000**
Expenditure						
Staff	**0.813**	**0.798**	**0.015**	**2.573**	**2.573**	**0.000**
Non Staff	**0.033**	**0.044**	**(0.011)**	**0.164**	**0.164**	**0.000**
Sub Total	**0.847**	**0.842**	**0.004**	**2.737**	**2.737**	**0.000**
Total	**(0.325)**	**(0.325)**	(0.000)	**0.365**	**0.365**	**0.000**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of June 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Reduced income expectations is offsetting staff vacancies.

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	**0.184**	**0.184**	**0.000**	**0.551**	**0.551**	**0.000**
Non Staff	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Sub Total	**0.184**	**0.184**	**0.000**	**0.551**	**0.551**	**0.000**
Total	**(0.184)**	**(0.184)**	0.000	**(0.551)**	**(0.551)**	**0.000**

TCS Key Issues

The reported financial position for the TCS Programme at the end of July 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 £0.053m.

The TCS report assumes budget for the above Trust reserves allocation which is pending formal approval

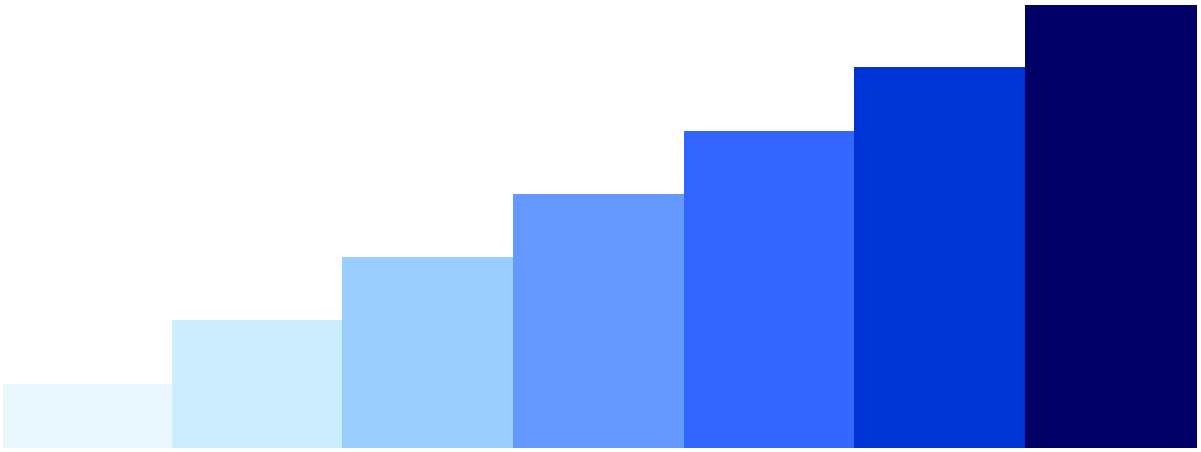
HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.416**	**0.338**	**(0.078)**	**1.664**	**1.664**	**0.000**
Expenditure						
Staff	**0.364**	**0.299**	**0.065**	**1.456**	**1.456**	**0.000**
Non Staff	**0.059**	**0.046**	**0.013**	**0.235**	**0.235**	**0.000**
Sub Total	**0.423**	**0.344**	**0.079**	**1.692**	**1.692**	**0.000**
Total	**(0.007)**	**(0.007)**	(0.000)	**(0.028)**	**(0.028)**	**0.000**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of June 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 Finance Report



TCS PROGRAMME

FINANCE REPORT 2022/23

Period Ending 31st July 2022

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 04 and current forecast.

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

1.3 Please note that this report is still in development and will be fully updated for August 2022.

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022/23 as at 31st July 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	£3.433m	£22.436m	£22.434m	£0.002m
Revenue	£0.200m	£0.684m	£0.684m	£0m
Total	**£3.633m**	**£23.120m**	**£23.118m**	**£0.002m**

2.2 The Programme is currently forecasting an overall underspend of £0.002m for capital and revenue expenditure for the financial year 2022/23.

2.3 There are currently two key risks for the Programme: an Enabling Works underspend due to delays; and increased New Velindre Cancer Centre (nVCC) advisory fees. Plans to mitigate these risks are in place or being developed by the relevant Project Teams.

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, 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 To date, £22.436m capital and £0.684m revenue funding has been provided to the Trust to support the TCS Programme in 2022/23, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1 WG has issued a Capital Expenditure Limit (CEL) of £19.913m 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 has been utilised in, therefore no CEL has been issued for this Project. The capital funding requirement of £0.434m will be provided from the Trust's discretionary capital allocation.

4.3 The capital position as at 31st July 2022 is outlined below, with a forecast outturn of £22.434m for 2022/23 against an overall budget of £22.436m.

Capital Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£2.195m	£19.913m	£19.462m	£0.451m
nVCC Project	£1.140m	£2.089m	£2.538m	-£0.449m
IRS Project	£0.098m	£0.434m	£0.434m	£0m
Total	**£3.433m**	**£22.436m**	**£22.434m**	**£0.002m**

4.4 The forecast overspend of £0.449m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.451m. This reflects the support provided by the nVCC project to the Enabling Works Project in 2021/22.

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 The revenue position as at 31st July 2022 is outlined below, with a forecast outturn of £0.694m for 2022/23 against a budget of £0.684m.

Revenue Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
PMO	£0.072m	£0.300m	£0.300m	£0m

nVCC Project	£0.031m	£0.073m	£0.073m	£0m
SDT Project	£0.097m	£0.311m	£0.311m	£0m
Total	**£0.200m**	**£0.684m**	**£0.684m**	**£0m**

6. CASH FLOW

6.1 This update is currently being develop and will be provided in the next financial report.

7. PROJECT FINANCE UPDATES

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

Programme Management Office (PMO)

7.2 In November 2021, the Trust EMB approve phased funding of £0.250m for the Strategic Transformation Programme from 2021/22 to 2023/24. £0.060m has been provided to the TCS Programme in 2022/23 as part of 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 There is no capital funding requirement for the PMO in 2022/23.

7.4 The revenue position for the PMO as at 31st July 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
Pay	£0.070m	£0.283m	£0.283m	£0m
Non Pay	£0.002m	£0.017m	£0.017m	£0m
Total	**£0.072m**	**£0.300m**	**£0.300m**	**£0m**

7.5 There are currently no financial risks relating to the PMO.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC, along with a total capital funding of £28.089m. £19.913m of this funding has been allocated in the financial year 2022/23.

7.7 The Enabling Works financial position for 31st July 2022 is shown below, with a further breakdown provided in Appendix 3. The forecast position reflects an underspend of £0.451m, which will be used to support the nVCC Project as agreed by WG. This reflects the support that was provided by the nVCC Project in 2021/22.

Enabling Works Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
Pay	£0.071m	£0.220m	£0.217m	£0.002m
Non Pay	£2.123m	£19.693m	£19.245m	£0.448m
Total	**£2.195m**	**£19.913m**	**£19.462m**	**£0.451m**

7.8 There is a financial risk related to a significant underspend as a result of the delay in key project activities. The Project will make an assessment for the virement of funding into 2023/24 as per agreement with WG.

New Velindre Cancer Centre (nVCC) Project

Capital

7.9 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.

7.10 The capital financial position for the nVCC Project for 31st July 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.449m, which will be supported from the Enabling Works Project as agreed by WG. This reflects the support that was provided to the Enabling Works Project in 2021/22.

nVCC Capital Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
Pay	£0.433m	£1.413m	£1.412m	£0.001m
Non Pay	£0.707m	£0.676m	£1.126m	-£0.449m
Total	**£1.140m**	**£2.089m**	**£2.538m**	**-£0.449m**

7.11 There is a financial risk relating to advisory fees to conclude the tender evaluation stage, and Successful Participant to Financial Close stage. The Project will track the progress of these fees and develop a mitigation plan if required.

Revenue

7.12 No revenue funding has been provided for this project by WG, therefore the Trust has ring-fenced £0.030m for nVCC Project Delivery, and a further £0.043m for the Judicial Review Matter. This is an increase from the overall revenue funding of £0.044m reported in May 2022 due to the increased fees for the Judicial Review Matter. Formal delegation for both budgets is pending.

7.13 The revenue financial position for the nVCC Project for 31st July 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	£0.010m	£0.030m	£0.030m	£0m
Judicial Review	£0.021m	£0.043m	£0.043m	£0m
Total	**£0.031m**	**£0.073m**	**£0.083m**	**£0m**

7.14 The Trust has been informed that the application for Judicial Review of the nVCC OBC has been refused, resulting in the closure of this matter. The forecast spend for this matter therefore remains at £0.043m for 2022/23.

7.15 The revenue financial risk previously reported for this Project has now been mitigated by the closure of the Judicial Review matter.

Integrated Radiotherapy Solution Procurement (IRS) Project

7.16 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 is assumed to be provided by the Trust from its discretionary capital allocation.

7.17 There is no revenue funding requirement for the Project in 2022/23.

7.18 The capital position for the IRS Project for 31st July 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	£0.057m	£0.072m	£0.072m	£0m
Non Pay	£0.041m	£0.362m	£0.362m	£0m
Total	**£0.098m**	**£0.434m**	**£0.434m**	**£0m**

7.19 There are currently no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation (SDT) Project

7.20 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.

7.21 There is no capital funding requirement for the Project in 2022/23.

7.22 The SDT Project revenue position as at 31st July 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022/23 Full Year		
		Budget	Forecast	Variance
Pay	£0.097m	£0.288m	£0.288m	£0m
Non Pay	£0m	£0.023m	£0.023m	£0m
Total	**£0.097m**	**£0.311m**	**£0.311m**	**£0m**

7.23 There are currently no financial risks relating to the SDT Project.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently two three key financial risks for the TCS Programme:

- An underspend by the Enabling Works Project as a result of the delay in key project activities; and
- Increased advisory fees required to conclude the nVCC tender evaluation stage, and Successful Participant to Financial Close stage.

These risks have mitigation plans in place or being developed by the relevant Project Teams.

The previously reported revenue financial risk of increased legal fees for the Judicial Review matter has been mitigated by the closure of this matter.

9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being develop and will be provided in the next financial report.

APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 31st July 2022

CAPITAL	Year to Date			Financial Year		
	Budget Jul-22	Spend Jul-22	Variance Jul-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	69,592	71,095	-1,503	208,776	212,686	-3,910
Project 1b - Enabling Works FBC	73,248	71,377	1,871	219,744	217,334	2,410
Project 2a - New Velindre Cancer Centre OBC	375,221	362,374	12,847	1,203,913	1,199,190	4,723
Project 3a - Radiotherapy Procurement Solution	56,302	57,048	-745	72,101	72,101	0
Capital Pay Total	**574,363**	**561,894**	**12,470**	**1,704,534**	**1,701,312**	**3,223**
NON-PAY						
nVCC Project Delivery	32,890	33,745	-855	84,000	84,000	0
Project 1b - Enabling Works FBC	2,271,769	2,123,381	148,388	19,693,260	19,244,930	448,330
Project 2a - New Velindre Cancer Centre OBC	513,111	672,984	-159,873	592,311	1,041,784	-449,473
Project 3a - Radiotherapy Procurement Solution	95,500	40,598	54,902	361,899	361,899	0
Capital Non-Pay Total	**2,913,270**	**2,870,708**	**42,562**	**20,731,470**	**20,732,612**	**-1,142**
CAPITAL TOTAL	**3,487,633**	**3,432,601**	**55,032**	**22,436,004**	**22,433,923**	**2,080**

REVENUE	Year to Date			Financial Year		
	Budget Jul-22	Spend Jul-22	Variance Jul-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	69,213	69,967	-754	282,993	282,993	0
Project 6 - Service Change Team	96,130	97,137	-1,007	288,390	288,390	0
Revenue Pay total	**165,343**	**167,104**	**-1,761**	**571,383**	**571,383**	**0**
NON-PAY						
nVCC Project Delivery	10,366	10,492	-127	30,000	30,000	0
nVCC Judicial Review	43,417	20,927	22,490	43,417	43,417	0
Programme Management Office	2,000	1,626	374	17,007	17,007	0
Project 6 - Service Change Team	5,675	89	5,586	22,610	22,610	0
Revenue Non-Pay Total	**61,457**	**33,134**	**28,323**	**113,034**	**113,034**	**0**
REVENUE TOTAL	**226,800**	**200,238**	**26,562**	**684,417**	**684,417**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.300m**
Commissioner's funding (April 2022)		£0.240m
Year 1 of Trust revenue funding for Strategic Transformation (April 2022)		£0.060m
Enabling Works OBC	**£19.913m**	**£0m**
2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£19.913m	£0m
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 the Judicial Review matter (May 2022)		£0.014m
Additional Trust revenue funding for the 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 No funding requested or provided for this project to date	**£0m**	**£0m**
SACT and Outreach No funding requested or provided for this project to date	**£0m**	**£0m**
Service Delivery, Transformation and Transition Commissioner's funding (April 2022) Trust Funding (April 2022)	**£0m**	**£0.311m** £0.180m £0.131m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£22.436m**	**£0.684m**

Appendix 3: Enabling Works Project Budget and Spend 2022/23 as at 31st July 2022

Description		Year to Date Budget £	Year to Date Spend £	Year to Date Variance £	Financial Year Annual £	Financial Year Annual £	Financial Year Annual £
PAY							
Project 1b - Enabling Works FBC		73,248	71,377	1,871	219,744	217,334	2,410
Pay Capital Total		**73,248**	**71,377**	**1,871**	**219,744**	**217,334**	**2,410**
NON-PAY - PROJECTS							
EF01	Construction Costs	0	28,800	-28,800	0	28,800	-28,800
EF02	Utility Costs	0	0	0	1,850,895	1,850,895	0
EF03	Supply Chain Fees	190,719	193,794	-3,075	596,047	720,826	-124,779
EF04	Non Works Costs	21,451	22,123	-672	553,200	553,872	-672
EF05	ASDA Works	225,600	224,018	1,582	5,928,137	5,907,430	20,707
EF06	Walters D&B	1,495,180	1,499,665	-4,485	8,735,418	8,739,903	-4,485
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	234,000	234,000	0
EFQR	Quantified Risk	338,820	0	338,820	1,351,828	625,141	726,687
EFQS	QRA - SCP	0	0	0	454,080	454,080	0
EFRS	Enabling Works FBC Reserves	0	154,983	-154,983	-10,345	129,983	-140,327
Enabling Works Project Capital Total		**2,271,769**	**2,123,381**	**148,388**	**19,693,260**	**19,244,930**	**448,330**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**2,345,017**	**2,194,758**	**150,259**	**19,913,004**	**19,462,264**	**450,740**

APPENDIX 4: nVCC Project Budget and Spend 2022/23 as at 31st July 2022

Description	Year to Date			Financial Year		
	Budget Jul-22	Spend Jul-22	Variance Jul-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	69,592	71,095	-1,503	208,776	212,686	-3,910
Project 2a - New Velindre Cancer Centre OBC	375,221	362,374	12,847	1,203,913	1,199,190	4,723
Pay Capital Total	**444,813**	**433,469**	**11,344**	**1,412,689**	**1,411,876**	**813**
NON-PAY						
nVCC Project Delivery	**32,890**	**33,745**	**-855**	**84,000**	**84,000**	**0**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	513,111	590,851	-77,740	592,311	1,009,651	-417,340
VC10 Legal Advice	0	1,537	-1,537	0	1,537	-1,537
VC11 S73 Planning	0	99,036	-99,036	0	99,036	-99,036
VCRS nVCC Reserves	0	-18,440	18,440	0	-68,440	68,440
nVCC Project Capital Total	**513,111**	**672,984**	**-159,873**	**592,311**	**1,041,784**	**-449,473**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**990,814**	**1,140,197**	**-149,383**	**2,089,000**	**2,537,660**	**-448,660**

Velindre Trust

Period : **Jul 22**

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	7	0

Velindre Trust **Period : Jul 22**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 14 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-500	0	-500	-500	1	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-167	-500
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-23,256	-1,100	-22,156	-22,156	2	-1,678	-1,681	-1,681	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-4,462	-6,758	-23,256
3	Planned Expenditure For Covid-19 (Negative Value)	-2,104	-1,407	-697	-697	3	-168	-168	-168	-168	-171	-201	-171	-171	-171	-171	-171	-202	-673	-2,104
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	6,345	600	5,745	5,745	4	300	300	300	300	300	300	300	300	300	300	300	3,043	1,201	6,345
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	2,104	1,407	697	697	5	166	169	169	169	172	201	172	172	172	172	172	202	672	2,104
6	Planned Provider Income (Positive Value)	16,111	0	16,111	16,111	6	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	5,370	16,111
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	7												0	0	0
8	Planned (Finalised) Savings Plan	750	150	600	600	8	46	46	46	68	68	68	68	68	68	68	68	68	206	750
9	Planned (Finalised) Net Income Generation	550	350	200	200	9	33	33	33	50	50	50	50	50	50	50	50	50	150	550
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	10													0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0			11													0	0
12		0	0			12													0	0
13	Planning Assumptions still to be finalised at Month 1	0	0			13													0	0
14	**Opening IMTP / Annual Operating Plan**	**0**	**0**	**0**	**0**	14	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0			16													0	0
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0			17													0	0
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	0	19	0	0	0	-22	-22	-22	11	11	11	11	11	11	-22	0
20	Additional In Year Identified Savings - Forecast	0	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Variance to Planned RRL & Other Income	-4,150	-4,150			21			-365	-421	-421	-421	-421	-421	-421	-421	-421	-421	-786	-4,150
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	-876	-876			22	0	-85	-138	-65	-71	-63	-71	-71	-71	-71	-71	-101	-288	-876
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	1,635	1,635			23							273	273	273	273	273	273	0	1,635
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	875	875			24	2	84	138	65	70	63	70	70	70	70	70	101	289	875
25	In Year Accountancy Gains (Positive Value)	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	1	1			26	-1	2	4	23	16	22	-11	-11	-11	-11	-11	-10	28	1
27	Reduction in outsourcing spend (RCC)	4,150	4,150			27			365	421	421	421	421	421	421	421	421	421	786	4,150
28	In year increase in Energy Forecast (£2,235 - £600 IMTP Plan) (based on latest NWSSP Schedule)	-1,635	-1,635			28							-273	-273	-273	-273	-273	-273	0	-1,635
29		0	0			29													0	0
30		0	0			30													0	0
31		0	0			31													0	0
32		0	0			32													0	0
33		0	0			33													0	0
34		0	0			34													0	0
35		0	0			35													0	0
36	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**0**	**0**	**0**	36	**1**	**2**	**3**	**1**	**-7**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**7**	**0**
37	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**				37	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Velindre Trust

Period : Jul 22

Table A1 - Underlying Position

This table needs completing monthly from Month: 1

This Table is currently showing 0 errors

	Section A - By Spend Area	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Pay - Administrative, Clerical & Board Members				0		0
2	Pay - Medical & Dental	(47)		47	0		0
3	Pay - Nursing & Midwifery Registered	(50)		50	0		0
4	Pay - Prof Scientific & Technical	(195)		195	0		0
5	Pay - Additional Clinical Services				0		0
6	Pay - Allied Health Professionals				0		0
7	Pay - Healthcare Scientists				0		0
8	Pay - Estates & Ancillary				0		0
9	Pay - Students				0		0
10	Non Pay - Supplies and services - clinical				0		0
11	Non Pay - Supplies and services - general	(208)		208	0		0
12	Non Pay - Consultancy Services				0		0
13	Non Pay - Establishment				0		0
14	Non Pay - Transport				0		0
15	Non Pay - Premises				0		0
16	Non Pay - External Contractors				0		0
17	Health Care Provided by other Orgs – Welsh LHBs				0		0
18	Health Care Provided by other Orgs – Welsh Trusts				0		0
19	Health Care Provided by other Orgs – WHSSC				0		0
20	Health Care Provided by other Orgs – English				0		0
21	Health Care Provided by other Orgs – Private / Other				0		0
22	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

	Section B - By Directorate	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Primary Care				0		0
2	Mental Health				0		0
3	Continuing HealthCare				0		0
4	Commissioned Services				0		0
5	Scheduled Care				0		0
6	Unscheduled Care				0		0
7	Children & Women's				0		0
8	Community Services				0		0
9	Specialised Services	(292)		292	0		0
10	Executive / Corporate Areas				0		0
11	Support Services (inc. Estates & Facilities)	(208)		208	0		0
12	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

Velindre Trust

Period : **Jul 22**

This Table is currently showing 0 errors

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END	
		£'000	Likelihood
	Opportunities to achieve IMTP/AOP (positive values)		
1	**Red Pipeline schemes (inc AG & IG)**		
2	**Potential Cost Reduction**		
3	**Total Opportunities to achieve IMTP/AOP**	**0**	
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker	(100)	Medium
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	Full covid funding requirement not flowing from commissioners	TBC	High
13	Management of Operational Costs Pressures	(250)	Low
14	WG Covid funding requirement	(1,228)	Medium
15	Operational Exceptional Cost Pressures	(2,902)	Medium
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26	**Total Risks**	**(4,480)**	
	Further Opportunities (positive values)		
27	Emergency Reserve	500	Low
28	Covid cost reduction (mitgation from opening plan requirement)	TBC	Medium
29	Additional in Year vacancy factor	250	Medium
30			
31			
32			
33			
34	**Total Further Opportunities**	**750**	
35	**Current Reported Forecast Outturn**	**0**	
36	**IMTP / AOP Outturn Scenario**	**0**	
37	**Worst Case Outturn Scenario**	**(3,730)**	
38	**Best Case Outturn Scenario**	**750**	

Velindre Trust

YTD Months to be completed from Month: 1
Forecast Months to be completed from Month: 1

Table B - Monthly Positions **Period : Jul 22**

#REF!
#REF!

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Revenue Resource Limit	Actual/F'cast													0	0
2	Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast													0	0
3	Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast	7,827	8,495	8,345	7,982	9,056	9,056	9,076	9,076	9,076	9,076	9,076	9,081	32,648	105,220
4	WHSSC Income	Actual/F'cast	4,696	4,456	4,209	3,888	4,722	4,711	4,731	4,731	4,731	4,731	4,731	4,943	17,248	55,276
5	Welsh Government Income (Non RRL)	Actual/F'cast	606	698	479	679	670	853	909	909	909	909	909	1,127	2,462	9,659
6	Other Income	Actual/F'cast	785	1,052	1,062	943	790	790	790	790	790	790	790	832	3,843	10,202
7	**Income Total**		**13,914**	**14,700**	**14,094**	**13,492**	**15,237**	**15,410**	**15,506**	**15,506**	**15,506**	**15,506**	**15,506**	**15,982**	**56,201**	**180,358**
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast													0	0
9	Primary Care - Drugs & Appliances	Actual/F'cast													0	0
10	Provided Services - Pay	Actual/F'cast	6,099	5,896	5,865	6,186	6,140	6,141	6,166	6,178	6,170	6,187	6,206	6,234	24,047	73,469
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	2,657	3,525	4,351	3,233	3,305	3,469	3,541	3,528	3,536	3,456	3,437	3,385	13,766	41,422
12	Secondary Care - Drugs	Actual/F'cast	4,265	4,570	3,381	4,036	5,246	5,246	5,246	5,246	5,246	5,246	5,246	5,246	16,252	58,220
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
15	Continuing Care and Funded Nursing Care	Actual/F'cast													0	0
16	Other Private & Voluntary Sector	Actual/F'cast	346	156	0	(502)	0	0	0	0	0	0	0	0	0	0
17	Joint Financing and Other	Actual/F'cast													0	0
18	Losses, Special Payments and Irrecoverable Debts	Actual/F'cast													0	0
19	Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/F'cast			(76)	(25)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(101)	(181)
21	Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
22	DEL Depreciation\Accelerated Depreciation\Impairments	Actual/F'cast	530	534	552	546	546	546	546	546	546	610	610	610	2,162	6,723
23	AME Donated Depreciation\Impairments	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	17	68	204
24	Uncommitted Reserves & Contingencies	Actual/F'cast												500	0	500
25	Profit\Loss Disposal of Assets	Actual/F'cast													0	0
26	**Cost - Total**	Actual/F'cast	**13,913**	**14,698**	**14,091**	**13,491**	**15,245**	**15,410**	**15,506**	**15,506**	**15,506**	**15,506**	**15,506**	**15,982**	**56,194**	**180,358**
27	**Net surplus/ (deficit)**	Actual/F'cast	**1**	**2**	**4**	**0**	**(7)**	**(0)**	**0**	**0**	**0**	**(0)**	**0**	**0**	**7**	**(0)**

	B. Cost Total by Directorate		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
28	Primary Care	Actual/F'cast													0	0
29	Mental Health	Actual/F'cast													0	0
30	Continuing HealthCare	Actual/F'cast													0	0
31	Commissioned Services	Actual/F'cast													0	0
32	Scheduled Care	Actual/F'cast													0	0
33	Unscheduled Care	Actual/F'cast													0	0
34	Children & Women's	Actual/F'cast													0	0
35	Community Services	Actual/F'cast													0	0
36	Specialised Services	Actual/F'cast	12,157	12,886	12,269	11,639	13,377	13,527	13,538	13,538	13,538	13,475	13,475	13,451	48,951	156,871
37	Executive / Corporate Areas	Actual/F'cast	813	832	759	798	809	809	809	809	809	809	809	809	3,202	9,674
38	Support Services (inc. Estates & Facilities)	Actual/F'cast	397	429	494	491	495	510	595	595	595	595	595	595	1,811	6,386
39	Reserves	Actual/F'cast	0											500	0	500
40	**Cost - Total (Excluding DEL & AME Non-Cash Charges)**	Actual/F'cast	**13,367**	**14,148**	**13,521**	**12,928**	**14,681**	**14,846**	**14,942**	**14,942**	**14,942**	**14,879**	**14,879**	**15,355**	**53,964**	**173,430**

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000	
28 . Actual YTD surplus/ (deficit)	7	
29. Actual YTD surplus/ (deficit) last month	7	
30. Current month actual surplus/ (deficit)	0	
		Trend
31. Average monthly surplus/ (deficit) YTD	2	▼
32. YTD /remaining months	1	

Full-year surplus/ (deficit) scenarios	£'000
33. Extrapolated Scenario	9
34. Year to Date Trend Scenario	21

D. DEL/AME Depreciation & Impairments

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	DEL															
41	Baseline Provider Depreciation	Actual/F'cast	433	433	341	341	341	341	341	341	341	389	389	389	1,547	4,416
42	Strategic Depreciation	Actual/F'cast	84	84	195	195	195	195	195	195	195	211	211	211	560	2,169
43	Accelerated Depreciation	Actual/F'cast													0	0
44	Impairments	Actual/F'cast													0	0
45	IFRS 16 Leases	Actual/F'cast	12	17	16	10	10	10	10	10	10	10	10	10	56	138
46	**Total**		**530**	**534**	**552**	**546**	**546**	**546**	**546**	**546**	**546**	**610**	**610**	**610**	**2,162**	**6,723**
	AME															
47	Donated Asset Depreciation	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	17	68	204
48	Impairments (including Reversals)	Actual/F'cast													0	0
49	IFRS 16 Leases (Peppercorn)	Actual/F'cast													0	0
50	**Total**		**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**68**	**204**

E. Accountancy Gains

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
51	Accountancy Gains	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**

F. Committed Reserves & Contingencies

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	List of all Committed Reserves & Contingencies inc above in Section A. Please specify Row number in description.															
52		Forecast Only													0	0
53		Forecast Only													0	0
54		Forecast Only													0	0
55		Forecast Only													0	0
56		Forecast Only													0	0
57		Forecast Only													0	0
58		Forecast Only													0	0
59		Forecast Only													0	0
60		Forecast Only													0	0
61		Forecast Only													0	0
62		Forecast Only													0	0
63		Forecast Only													0	0
64		Forecast Only													0	0
65		Forecast Only													0	0
66		Forecast Only													0	0
67		Forecast Only													0	0
68		Forecast Only													0	0
69		Forecast Only													0	0
70		Forecast Only													0	0
71		Forecast Only													0	0
72		Forecast Only													0	0
73		Forecast Only													0	0
74		Forecast Only													0	0
75		Forecast Only													0	0
76		Forecast Only													0	0
77		Forecast Only													0	0
78		Forecast Only													0	0
79		Forecast Only													0	0
80	**Total**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
		Phasing	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Velindre Trust

Period : Jul 22

YTD Months to be completed from Month: 1

This Table is currently showing 0 errors

Forecast Months to be completed from Month: 1

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	1,793	1,727	1,708	1,832	1,830	1,801	1,825	1,838	1,830	1,836	1,856	1,884	**7,059**	**21,759**
2	Medical & Dental	1,114	1,049	1,066	1,140	1,090	1,080	1,080	1,080	1,080	1,080	1,080	1,080	**4,369**	**13,019**
3	Nursing & Midwifery Registered	875	833	832	869	880	890	890	890	890	900	900	900	**3,408**	**10,548**
4	Prof Scientific & Technical	214	216	211	220	228	235	235	235	235	235	235	235	**861**	**2,734**
5	Additional Clinical Services	580	580	555	561	560	560	560	560	560	560	560	560	**2,275**	**6,755**
6	Allied Health Professionals	601	600	595	633	628	625	625	625	625	625	625	625	**2,429**	**7,432**
7	Healthcare Scientists	722	706	724	748	740	740	740	740	740	740	740	740	**2,900**	**8,820**
8	Estates & Ancillary	189	178	167	176	176	202	202	202	202	202	202	202	**711**	**2,301**
9	Students	11	8	8	8	8	8	8	8	8	8	8	8	**35**	**101**
10	**TOTAL PAY EXPENDITURE**	**6,099**	**5,896**	**5,866**	**6,187**	**6,140**	**6,141**	**6,166**	**6,178**	**6,170**	**6,187**	**6,206**	**6,234**	**24,047**	**73,469**

Analysis of Pay Expenditure

11	**LHB Provided Services - Pay**	6,099	5,896	5,865	6,186	6,140	6,141	6,166	6,178	6,170	6,187	6,206	6,234	**24,047**	**73,469**
12	**Other Services (incl. Primary Care) - Pay**													**0**	**0**
13	**Total - Pay**	**6,099**	**5,896**	**5,865**	**6,186**	**6,140**	**6,141**	**6,166**	**6,178**	**6,170**	**6,187**	**6,206**	**6,234**	**24,047**	**73,469**
		0	0	0	0	0	0	0	0	0	0	0	0		

B - Agency / Locum (premium) Expenditure
- Analysed by Type of Staff

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	23	26	36	43	38	33	41	26	16	8	3	3	**129**	**294**
2	Medical & Dental	5	3	5	3	5	5	5	5	5	5	5	5	**16**	**53**
3	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
4	Prof Scientific & Technical	2	3	2	2	2	2	2	2	2	0	0	0	**9**	**18**
5	Additional Clinical Services	5	0	10	0	0	0	0	0	0	0	0	0	**15**	**15**
6	Allied Health Professionals	39	48	50	73	93	89	81	48	48	48	48	48	**210**	**713**
7	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
8	Estates & Ancillary	30	44	27	32	38	31	28	28	35	28	28	35	**133**	**385**
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
10	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**129**	**154**	**175**	**159**	**156**	**108**	**105**	**88**	**84**	**90**	**512**	**1,478**
11	**Agency/Locum (premium) % of pay**	**1.7%**	**2.1%**	**2.2%**	**2.5%**	**2.9%**	**2.6%**	**2.5%**	**1.7%**	**1.7%**	**1.4%**	**1.3%**	**1.4%**	**2.1%**	**2.0%**

C - Agency / Locum (premium) Expenditure
- Analysed by Reason for Using Agency/Locum (premium)

REF	REASON	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Vacancy	25	33	39	50	43	38	42	27	17	8	3	3	**147**	**328**
2	Maternity/Paternity/Adoption Leave													**0**	**0**
3	Special Leave (Paid) – inc. compassionate leave, interview													**0**	**0**
4	Special Leave (Unpaid)													**0**	**0**
5	Study Leave/Examinations													**0**	**0**
6	Additional Activity (Winter Pressures/Site Pressures)	49	51	64	72	95	91	86	53	53	53	53	53	**236**	**771**
7	Annual Leave													**0**	**0**
8	Sickness													**0**	**0**
9	Restricted Duties													**0**	**0**
10	Jury Service													**0**	**0**
11	WLI													**0**	**0**
12	Exclusion (Suspension)													**0**	**0**
13	COVID-19	29	41	26	32	38	31	28	28	35	28	28	35	**128**	**379**
14	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**129**	**154**	**175**	**159**	**156**	**108**	**105**	**88**	**84**	**90**	**512**	**1,478**
		0	0	0	0	0	0	0	0	0	0	0	0		

Velindre Trust

Period : Jul 22

#REF!

Table B3 - COVID-19 Analysis

A - Additional Expenditure

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	*Enter as positive values*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	**Testing (Additional costs due to C19) enter as positive values - actual/forecast**														
2	**Provider Pay (Establishment, Temp & Agency)**														
3	Administrative, Clerical & Board Members													0	0
4	Medical & Dental													0	0
5	Nursing & Midwifery Registered													0	0
6	Prof Scientific & Technical													0	0
7	Additional Clinical Services													0	0
8	Allied Health Professionals													0	0
9	Healthcare Scientists													0	0
10	Estates & Ancillary													0	0
11	Students													0	0
12	**Sub total Testing Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Primary Care Contractor (excluding drugs)													0	0
14	Primary Care - Drugs													0	0
15	Secondary Care - Drugs													0	0
16	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													0	0
17	Healthcare Services Provided by Other NHS Bodies													0	0
18	Non Healthcare Services Provided by Other NHS Bodies													0	0
19	Continuing Care and Funded Nursing Care													0	0
20	Other Private & Voluntary Sector													0	0
21	Joint Financing and Other (includes Local Authority)													0	0
22	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
23														0	0
24														0	0
25														0	0
26	**Sub total Testing Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
27	**TOTAL TESTING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	**PLANNED TESTING EXPENDITURE (In Opening Plan)**													0	0
29	**MOVEMENT FROM OPENING PLANNED TESTING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
A2	***Tracing (Additional costs due to C19) enter as positive values - actual/forecast***														
30	**Provider Pay (Establishment, Temp & Agency)**														
31	Administrative, Clerical & Board Members													0	0
32	Medical & Dental													0	0
33	Nursing & Midwifery Registered													0	0
34	Prof Scientific & Technical													0	0
35	Additional Clinical Services													0	0
36	Allied Health Professionals													0	0
37	Healthcare Scientists													0	0
38	Estates & Ancillary													0	0
39	Students													0	0
40	**Sub total Tracing Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
41	Primary Care Contractor (excluding drugs)													0	0
42	Primary Care - Drugs													0	0
43	Secondary Care - Drugs													0	0
44	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													0	0
45	Healthcare Services Provided by Other NHS Bodies													0	0
46	Non Healthcare Services Provided by Other NHS Bodies													0	0
47	Continuing Care and Funded Nursing Care													0	0
48	Other Private & Voluntary Sector													0	0
49	Joint Financing and Other (includes Local Authority)													0	0
50	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
51														0	0
52														0	0
53														0	0
54	**Sub total Tracing Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55	**TOTAL TRACING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
56	**PLANNED TRACING EXPENDITURE (In Opening Plan)**													0	0
57	**MOVEMENT FROM OPENING PLANNED TRACING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0

A3	***Mass COVID-19 Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***															
58	**Provider Pay (Establishment, Temp & Agency)**															
59	Administrative, Clerical & Board Members					3	6	3	3	3	3	3	3	**0**	**27**	
60	Medical & Dental													**0**	**0**	
61	Nursing & Midwifery Registered						20							**0**	**20**	
62	Prof Scientific & Technical													**0**	**0**	
63	Additional Clinical Services						12							**0**	**12**	
64	Allied Health Professionals	7	11	29	7	10	10	10	10	10	10	10	10	**55**	**131**	
65	Healthcare Scientists													**0**	**0**	
66	Estates & Ancillary						2							**0**	**2**	
67	Students													**0**	**0**	
68	**Sub total Mass COVID-19 Vaccination Provider Pay**	**7**	**11**	**29**	**7**	**13**	**50**	**13**	**13**	**13**	**13**	**13**	**13**	**55**	**192**	
69	Primary Care Contractor (excluding drugs)													**0**	**0**	
70	Primary Care - Drugs													**0**	**0**	
71	Secondary Care - Drugs													**0**	**0**	
72	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	15	19	15	11	11	11	11	11	11	11	11	11	**59**	**144**	
73	Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
74	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
75	Continuing Care and Funded Nursing Care													**0**	**0**	
76	Other Private & Voluntary Sector													**0**	**0**	
77	Joint Financing and Other (includes Local Authority)													**0**	**0**	
78	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**	
79														**0**	**0**	
80														**0**	**0**	
81														**0**	**0**	
82	**Sub total Mass COVID-19 Vaccination Non Pay**	**15**	**19**	**15**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**59**	**144**	
83	**TOTAL MASS COVID-19 VACC EXPENDITURE**	**22**	**30**	**45**	**18**	**23**	**60**	**23**	**23**	**23**	**23**	**23**	**23**	**114**	**336**	
84	**PLANNED MASS COVID-19 VACC EXPENDITURE (In Opening Plan)**	24	24	24	24	27	57	27	27	27	27	27	57	**97**	**375**	
85	**MOVEMENT FROM OPENING PLANNED MASS COVID-19 VACC EXPENDITURE**	**2**	**(5)**	**(20)**	**6**	**4**	**(3)**	**4**	**4**	**4**	**4**	**4**	**34**	**(17)**	**39**	
A4	***Extended Flu Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***															
86	**Provider Pay (Establishment, Temp & Agency)**															
87	Administrative, Clerical & Board Members													**0**	**0**	
88	Medical & Dental													**0**	**0**	
89	Nursing & Midwifery Registered													**0**	**0**	
90	Prof Scientific & Technical													**0**	**0**	
91	Additional Clinical Services													**0**	**0**	
92	Allied Health Professionals													**0**	**0**	
93	Healthcare Scientists													**0**	**0**	
94	Estates & Ancillary													**0**	**0**	
95	Students													**0**	**0**	
96	**Sub total Extended Flu Vaccination Provider Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
97	Primary Care Contractor (excluding drugs)													**0**	**0**	
98	Primary Care - Drugs													**0**	**0**	
99	Secondary Care - Drugs													**0**	**0**	
100	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													**0**	**0**	
101	Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
102	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
103	Continuing Care and Funded Nursing Care													**0**	**0**	
104	Other Private & Voluntary Sector													**0**	**0**	
105	Joint Financing and Other (includes Local Authority)													**0**	**0**	
106	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**	
107														**0**	**0**	
108														**0**	**0**	
109														**0**	**0**	
110	**Sub total Extended Flu Vaccination Non Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
111	**TOTAL EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
112	**PLANNED EXTENDED FLU VACC EXPENDITURE (In Opening Plan)**													**0**	**0**	
113	**MOVEMENT FROM OPENING PLANNED EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

A5	Cleaning Standards (Additional costs due to C19) enter as positive values - actual/forecast															
114	**Provider Pay (Establishment, Temp & Agency)**															
115	Administrative, Clerical & Board Members														0	0
116	Medical & Dental														0	0
117	Nursing & Midwifery Registered														0	0
118	Prof Scientific & Technical														0	0
119	Additional Clinical Services														0	0
120	Allied Health Professionals														0	0
121	Healthcare Scientists														0	0
122	Estates & Ancillary	46	19	0	35	35	35	35	35	35	35	35	35		100	380
123	Students														0	0
124	**Sub total Cleaning Standards Provider Pay**	**46**	**19**	**0**	**35**	**35**	**35**	**35**	**35**	**35**	**35**	**35**	**35**		**100**	**380**
125	Primary Care Contractor (excluding drugs)														0	0
126	Primary Care - Drugs														0	0
127	Secondary Care - Drugs														0	0
128	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	5	1	3	1	4	4	4	4	4	4	4	4		10	38
129	Healthcare Services Provided by Other NHS Bodies														0	0
130	Non Healthcare Services Provided by Other NHS Bodies														0	0
131	Continuing Care and Funded Nursing Care														0	0
132	Other Private & Voluntary Sector														0	0
133	Joint Financing and Other (includes Local Authority)														0	0
134	Other (only use with WG agreement & state SoCNE/I line ref)														0	0
135															0	0
136															0	0
137															0	0
138	**Sub total Cleaning Standards Non Pay**	**5**	**1**	**3**	**1**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**		**10**	**38**
139	**TOTAL CLEANING STANDARDS EXPENDITURE**	**51**	**20**	**3**	**36**	**39**	**39**	**39**	**39**	**39**	**39**	**39**	**39**		**110**	**418**
140	**PLANNED CLEANING STANDARDS EXPENDITURE (In Opening Plan)**	51	51	51	51	51	51	51	51	51	51	51	51		**202**	**607**
141	**MOVEMENT FROM OPENING PLANNED CLEANING STANDARDS EXPENDITURE**	**(0)**	**31**	**47**	**14**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**13**		**92**	**189**

A6	**PPE, Long Covid & Other (Additional costs due to C19)** ***enter as positive value - actual/forecast***														
142	**Provider Pay (Establishment, Temp & Agency)**														
143	Administrative, Clerical & Board Members													**0**	**0**
144	Medical & Dental	21	12	24	25	19	19	19	19	19	19	19	19	**82**	**232**
145	Nursing & Midwifery Registered													**0**	**0**
146	Prof Scientific & Technical													**0**	**0**
147	Additional Clinical Services													**0**	**0**
148	Allied Health Professionals													**0**	**0**
149	Healthcare Scientists													**0**	**0**
150	Estates & Ancillary	25	(20)											**5**	**5**
151	Students													**0**	**0**
152	Movement of Annual Leave Accrual													**0**	**0**
153	Other (only use with WG Agreement & state SoCNE/I line ref)													**0**	**0**
154														**0**	**0**
155														**0**	**0**
156	**Sub total Other C-19 Provider Pay**	**46**	**(8)**	**24**	**25**	**19**	**19**	**19**	**19**	**19**	**19**	**19**	**19**	**87**	**237**
157	Primary Care Contractor (excluding drugs)													**0**	**0**
158	Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income													**0**	**0**
159	Primary Care - Drugs													**0**	**0**
160	Secondary Care - Drugs													**0**	**0**
161	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see separate line**	20	24	(37)	1	1	1	1	1	1	1	1	1	**8**	**12**
162	Provider - Non Pay - PPE	28	18	(4)	24	20	20	20	20	20	20	20	20	**65**	**225**
163	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
164	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
165	Continuing Care and Funded Nursing Care													**0**	**0**
166	Other Private & Voluntary Sector													**0**	**0**
167	Joint Financing and Other (includes Local Authority)													**0**	**0**
168	Other (only use with WG Agreement & state SoCNE/I line ref)													**0**	**0**
169														**0**	**0**
170														**0**	**0**
171														**0**	**0**
172														**0**	**0**
173														**0**	**0**
174														**0**	**0**
175														**0**	**0**
176	**Sub total Other C-19 Non Pay**	**48**	**42**	**(41)**	**24**	**21**	**21**	**21**	**21**	**21**	**21**	**21**	**21**	**73**	**237**
177	**TOTAL OTHER C-19 EXPENDITURE**	**94**	**35**	**(17)**	**49**	**39**	**39**	**39**	**39**	**39**	**39**	**39**	**39**	**160**	**474**
178	**PLANNED OTHER C-19 EXPENDITURE (In Opening Plan)**	94	94	94	94	94	94	94	94	94	94	94	94	**374**	**1,122**
179	**MOVEMENT FROM OPENING PLANNED OTHER C-19 EXPENDITURE**	**0**	**59**	**111**	**44**	**54**	**54**	**54**	**54**	**54**	**54**	**54**	**54**	**214**	**648**
180	**TOTAL ADDITIONAL EXPENDITURE DUE TO COVID**	**166**	**84**	**31**	**103**	**101**	**138**	**101**	**101**	**101**	**101**	**101**	**101**	**384**	**1,228**
181	**PLANNED ADDITIONAL EXPENDITURE DUE TO COVID (In Opening Plan)**	**168**	**168**	**168**	**168**	**171**	**201**	**171**	**171**	**171**	**171**	**171**	**202**	**673**	**2,104**
182	**MOVEMENT FROM OPENING PLANNED ADDITIONAL COVID EXPENDITURE**	**2**	**84**	**138**	**65**	**70**	**63**	**70**	**70**	**70**	**70**	**70**	**101**	**289**	**875**

B - Additional Welsh Government Funding for C19

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total YTD**	**Forecast year-end position**
	Enter as Positive values	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
183	**PLANNED WG FUNDING FOR COVID-19**	166	169	169	169	172	201	172	172	172	172	172	202	**672**	**2,104**
184	**MOVEMENTS FROM OPENING PLANNED WG FUNDING FOR COVID-19**	**0**	**(85)**	**(138)**	**(65)**	**(71)**	**(63)**	**(71)**	**(71)**	**(71)**	**(71)**	**(71)**	**(101)**	**(288)**	**(876)**
185	**TOTAL ACTUAL / FORECAST WG FUNDING FOR COVID-19**	166	84	31	103	101	138	101	101	101	101	101	101	**384**	**1,228**
186	**ACTUAL / FORECAST NET IMPACT ON OVERALL FINANCIAL POSITION DUE TO COVID-19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Velindre Trust

Period : Jul 22

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Non Pay	Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	133	400		400	0			
11		Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	133	400	33.33%	400	0	150	250	250
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
13	Pay	Budget/Plan	13	13	13	35	35	35	35	35	35	35	35	35	72	350		150	200			
14		Actual/F'cast	13	13	13	13	13	13	46	46	46	46	46	46	50	350	14.29%	150	200	0	350	350
15		Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	*(30.77%)*	0	0			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	46	46	46	68	68	68	68	68	68	68	68	68	206	750		550	200			
20		Actual/F'cast	46	46	46	46	46	46	79	79	79	79	79	79	183	750	24.44%	550	200	150	600	600
21		Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	*(10.81%)*	0	0			
22	Variance in month		0.00%	0.00%	0.00%	(32.65%)	(32.65%)	(32.65%)	16.33%	16.33%	16.33%	16.33%	16.33%	16.33%	(10.81%)							
23	In month achievement against FY forecast		6.11%	6.11%	6.11%	6.11%	6.11%	6.11%	10.56%	10.56%	10.56%	10.56%	10.56%	10.56%								

Velindre Trust **Period : Jul 22**

Table C1- Savings Schemes Pay Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	72	350		150	200			
2		Actual/F'cast		13	13	13	13	13	13	46	46	46	46	46	46	50	350	14.29%	150	200	0	350	350
3		Variance		0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	*(30.77%)*	0	0			
4	Variable Pay	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	72	350		150	200			
20		Actual/F'cast		13	13	13	13	13	13	46	46	46	46	46	46	50	350	14.29%	150	200	0	350	350
21		Variance		0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	*(30.77%)*	0	0			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

Velindre Trust

Jul 22

This Table is currently showing 2 errors

Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	46	46	46	68	68	68	68	68	68	68	68	68	206	750	150	600	0	600
	Month 1 - Actual/Forecast	46	46	46	46	46	46	79	79	79	79	79	79	183	750	150	600	0	600
	Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	46	46	46	68	68	68	68	68	68	68	68	68	206	750	150	600	0	600
	Total Actual/Forecast	46	46	46	46	46	46	79	79	79	79	79	79	183	750	150	600	0	600
	Total Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	0	0	0	0
Net Income Generation	Month 1 - Plan	33	33	33	50	50	50	50	50	50	50	50	50	150	550	350	200	0	200
	Month 1 - Actual/Forecast	33	33	33	50	50	50	50	50	50	50	50	50	150	550	350	200	0	200
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	33	33	33	50	50	50	50	50	50	50	50	50	150	550	350	200	0	200
	Total Actual/Forecast	33	33	33	50	50	50	50	50	50	50	50	50	150	550	350	200	0	200
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	79	79	79	118	118	118	118	118	118	118	118	118	356	1,300	500	800	0	800
	Month 1 - Actual/Forecast	79	79	79	96	96	96	129	129	129	129	129	129	333	1,300	500	800	0	800
	Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	79	79	79	118	118	118	118	118	118	118	118	118	356	1,300	500	800	0	800
	Total Actual/Forecast	79	79	79	96	96	96	129	129	129	129	129	129	333	1,300	500	800	0	800
	Total Variance	0	0	0	(22)	(22)	(22)	11	11	11	11	11	11	(22)	0	0	0	0	0

Velindre Trust

Period : **Jul 22**

This Table is currently showing 0 errors

Table E1 - Invoiced Income Streams - TRUSTS ONLY

Ref		Swansea Bay ULHB	Aneurin Bevan ULHB	Betsi Cadwaladr ULHB	Cardiff & Vale ULHB	Cwm Taf Morgannwg ULHB	Hywel Dda ULHB	Powys LHB	Public Health Wales NHS Trust	Welsh Ambulance NHS Trust	Velindre NHS Trust	NWSSP	DHCW	HEIW	WG	EASC	WHSSC	Other (please specify)	Total	WG Contact, date item first entered into table and whether any invoice has been raised.
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1	**Agreed full year income**	4,654	33,946	1,430	33,086	23,942	3,481	1,745	1,721	13	0	0	0	1,201	5,241		55,276	10,202	**175,939**	
	Details of Anticipated Income																			
2	DEL Non Cash Depreciation - Baseline Surplus / Shortfall														(1,792)				**(1,792)**	Gary Young M1
3	DEL Non Cash Depreciation - Strategic														2,169				**2,169**	Gary Young M1
4	DEL Non Cash Depreciation - Accelerated																		**0**	
5	DEL Non Cash Depreciation - Impairment																		**0**	
6	DEL Non Cash Depreciation - IFRS 16 Leases														138				**138**	Jackie Salmon M1
7	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)																		**0**	
8	AME Non Cash Depreciation - Donated Assets														204				**204**	Gary Young M1
9	AME Non Cash Depreciation - Impairment																		**0**	
10	AME Non Cash Depreciation - Impairment Reversals																		**0**	
11	Total COVID-19 (see below analysis)														1,228				**1,228**	See below analysis
12	Removal of IFRS-16 Leases (Revenue)														(140)				**(140)**	Jackie Salmon M1
13	Energy (Price Increase)														2,235				**2,235**	Steve Elliot M1
14	Employers NI Increase (1.25%)														550				**550**	Steve Elliot M1
15	Real Living Wage														0				**0**	Steve Elliot M1
16	WRP														(282)				**(282)**	Andrea Hughes M1
17	Band 1 & 2 Increase														19				**19**	Andrea Hughes M2
18	Anticpated Real Living Wage Increase														89				**89**	Andrea Hughes M3
19																			**0**	
20																			**0**	
21																			**0**	
22																			**0**	
23																			**0**	
24																			**0**	
25																			**0**	
26																			**0**	
27																			**0**	
28																			**0**	
29																			**0**	
30																			**0**	
31																			**0**	
32																			**0**	
33																			**0**	
34																			**0**	
35																			**0**	
36																			**0**	
37	**Total Income**	**4,654**	**33,946**	**1,430**	**33,086**	**23,942**	**3,481**	**1,745**	**1,721**	**13**	**0**	**0**	**0**	**1,201**	**9,659**	**0**	**55,276**	**10,202**	**180,357**	

	ANALYSIS OF WG FUNDING DUE FOR COVID-19 INCLUDED ABOVE	Allocated £'000	Anticipated £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
38	Testing (inc Community Testing)			0	
39	Tracing			0	
40	Mass COVID-19 Vaccination		336	336	Richard Dudley M1 Qtr 1 raised
41	PPE		225	225	Richard Dudley M1 Qtr 1 raised
42	Extended Flu			0	
43	Cleaning Standards		418	418	Richard Dudley M1 Not Raised
44	Long Covid			0	
45	A2. Increased bed capacity specifically related to COVID-19			0	Richard Dudley M1 Not Raised
46	A3. Other Capacity & facilities costs (exclude contract cleaning)			0	Richard Dudley M2 Not Raised
47	B1. Prescribing charges directly related to COVID symptoms			0	
48	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance		237	237	Richard Dudley M2 Not Raised
49	D1. Discharge Support			0	
50	D4. Support for National Programmes through Shared Service			0	
51	D5. Other Services that support the ongoing COVID response		12	12	Richard Dudley M3 Not Raised
52	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income			0	
53				0	
54				0	
55				0	
56				0	
57				0	
58				0	
59				0	
60				0	
61				0	
62				0	
63				0	
64				0	
65				0	
66				0	
67				0	
68	Total Funding	0	1,228	1,228	

Velindre Trust

Table M - Debtors Schedule

		Period:	**Jul 22**
11 weeks before end of Jul 22 =	15 May 2022		
17 weeks before end of Jul 22 =	03 April 2022		

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
Aneurin Bevan ULHB	1112682	27 April 2022	10,000.00	10,000.00	Yes, valid entry for period	10,000.00		24 August 2022	Chased in line with policy
Aneurin Bevan ULHB	1112671	28 April 2022	1,337.97	1,337.97	Yes, valid entry for period	1,337.97		25 August 2022	Chased in line with policy
Betsi Cadwaladr ULHB	1112797	09 May 2022	4,398.00	4,398.00	Yes, valid entry for period	4,398.00		05 September 2022	Chased in line with policy
Cardiff & Vale ULHB	1112678	27 April 2022	6,786.00	6,786.00	Yes, valid entry for period	6,786.00		24 August 2022	Chased in line with policy
Cardiff & Vale ULHB	1112680	27 April 2022	23,025.34	23,025.34	Yes, valid entry for period	23,025.34		24 August 2022	Chased in line with policy
Cardiff & Vale ULHB	1112674	28 April 2022	25.18	25.18	Yes, valid entry for period	25.18		25 August 2022	Chased in line with policy
Cwm Taf Morgannwg ULHB	1112660	28 April 2022	2,603.81	2,603.81	Yes, valid entry for period	2,603.81		25 August 2022	Chased in line with policy
Cwm Taf Morgannwg ULHB	1112782	09 May 2022	38620.00	7,860.00	Yes, valid entry for period	7,860.00		05 September 2022	Chased in line with policy
Welsh Government	1112651	28 April 2022	6039.00	6,039.00	Yes, valid entry for period	6,039.00		25 August 2022	Chased in line with policy
			92,835.30	**62,075.30**		**62,075.30**	**0.00**		

Invoices paid since the end of the month		
Total outstanding as per MR submission date	**62,075.30**	**0.00**

Workforce Monthly Report

July 2022

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, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Jul-22	Jun-22	
PADR	69.29	69.81	85%
Sickness	6.51	6.42	3.54%
S&M Compliance	85.27	86.20	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	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
Corporate	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74
Research, Development & Innovation	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14
Transforming Cancer Services	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22
Velindre Cancer Centre	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30
Welsh Blood Service	79.78	78.27	77.93	77.52	82.19	83.06	83.73	81..75	78.44	78.16	79.26	77.53	76.90
Velindre Organisations	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45
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)	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
Corporate	69.26	70.45	71.36	74.54	72.32	74.40	72.17	73.64	74.51	73.48	74.31	74.41	73.06
Research, Development & Innovation	86.00	85.80	86.25	84.89	84.58	85.83	84.26	80.42	80.21	80.23	79.56	82.95	81.09
Transforming Cancer Services	76.84	85.26	82.50	82.86	83.33	81.43	77.86	77.39	77.39	78.64	80.91	76.96	75.65
Velindre Cancer Centre	82.70	83.16	82.89	83.11	84.91	84.93	84.73	84.18	84.88	85.17	85.46	85.22	84.68
Welsh Blood Service	93.38	92.66	92.21	92.54	93.36	93.56	93.78	92.02	92.30	92.19	92.44	93.17	91.72
Velindre Organisations	84.97	85.24	84.95	85.10	86.06	86.40	85.97	85.26	85.77	85.76	85.08	86.20	85.27

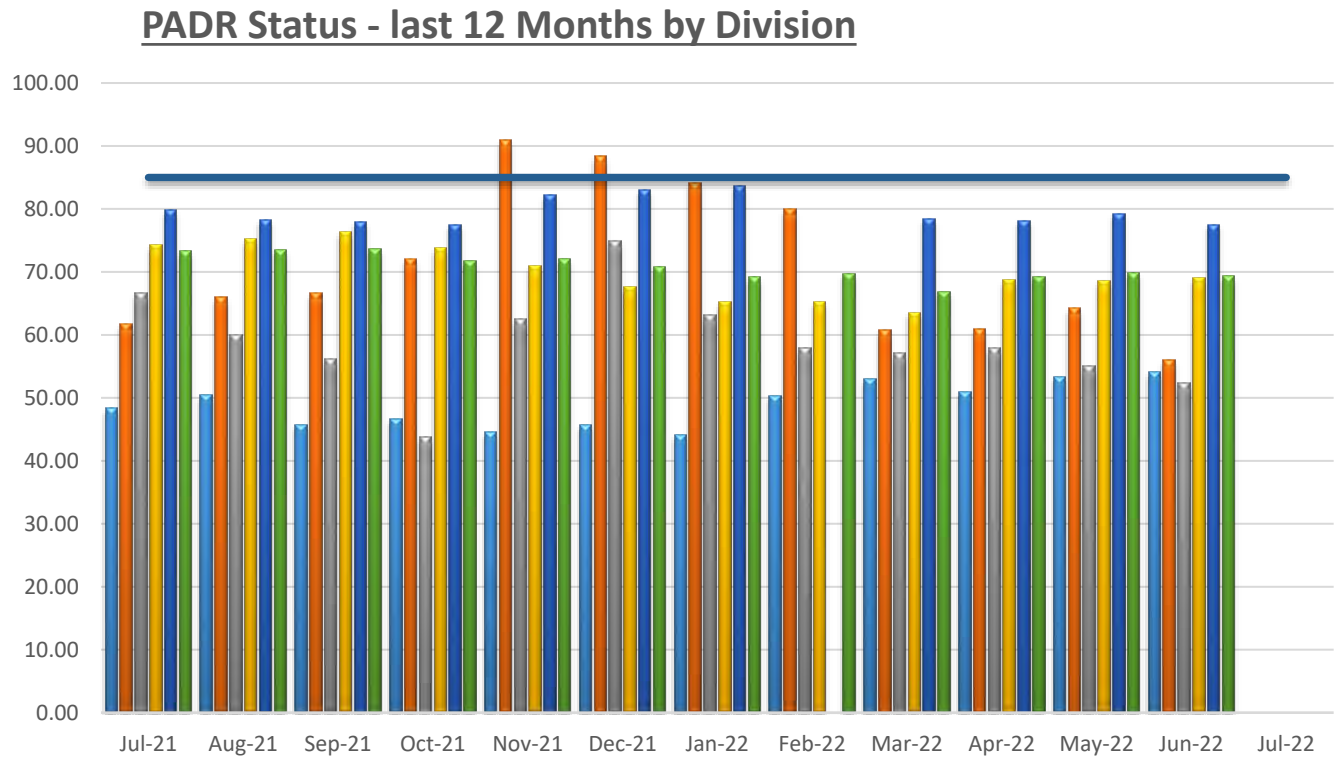
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Corporate	4.64	4.49	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.22
Research, Development & Innovation	3.34	3.55	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.24	6.86	7.30	7.30
Transforming Cancer Services	0.32	0.33	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18
Velindre Cancer Centre	5.47	5.47	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.30	6.40
Welsh Blood Service	4.82	5.11	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41
Velindre Organisations	5.05	5.13	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.51
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	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
Corporate	0.99	1.16	1.34	1.46	1.57	1.64	1.71	1.73	1.69	1.66	1.63	1.57	1.54
Research, Development & Innovation	0.45	0.43	0.43	0.43	0.53	0.66	0.87	1.08	1.33	1.59	1.68	1.96	2.21
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01
Velindre Cancer Centre	0.87	0.88	0.85	0.86	0.84	0.73	0.82	0.89	1.07	1.17	1.17	1.23	1.32
Welsh Blood Service	0.29	0.29	0.36	0.39	0.38	0.36	0.38	0.42	0.60	0.79	0.85	0.93	1.13
Velindre Organisations	0.67	0.69	0.72	0.75	0.74	0.70	0.77	0.83	0.98	1.10	1.12	1.18	1.30

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	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
Corporate	0.06	0.05	0.03	0.09	0.09	0.09	0.09	0.10	0.10	0.12	0.13	0.15	0.13
Research, Development & Innovation	0.60	0.74	0.92	1.08	1.25	1.37	1.57	1.62	1.69	1.89	1.89	1.81	1.74
Transforming Cancer Services	0.53	0.56	0.55	0.54	0.41	0.25	0.08	0.07	0.07	0.07	0.07	0.06	0.05
Velindre Cancer Centre	0.43	0.46	0.48	0.53	0.57	0.61	0.66	0.67	0.73	0.79	0.79	0.80	0.79
Welsh Blood Service	0.57	0.58	0.59	0.59	0.58	0.56	0.53	0.51	0.49	0.50	0.48	0.47	0.43
Velindre Organisations	0.45	0.47	0.49	0.53	0.55	0.56	0.58	0.59	0.61	0.65	0.65	0.65	0.63

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	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
Corporate	0.11	0.03	0.01	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.05	0.07	0.08
Research, Development & Innovation	0.21	0.13	0.13	0.15	0.10	0.15	0.20	0.20	0.21	0.30	0.30	0.30	0.31
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	0.90	0.70	0.69	0.71	0.64	0.65	0.70	0.69	0.75	0.83	0.85	0.88	0.90
Welsh Blood Service	0.68	0.62	0.67	0.67	0.68	0.65	0.63	0.61	0.59	0.63	0.69	0.69	0.68
Velindre Organisations	0.72	0.58	0.59	0.60	0.56	0.56	0.58	0.57	0.60	0.65	0.68	0.70	0.71

PADR – The Figures



	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
Corporate	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	
Research, Development & Innovation	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	
Transforming Cancer Services	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	
Velindre Cancer Centre	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	
Welsh Blood Service	79.78	78.27	77.93	77.52	82.19	83.06	83.73	0.00	78.44	78.16	79.26	77.53	
Velindre Organisations	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	June Figure	Hotspot Areas	%	Comment
PADR Compliance (85%)	**70.45%** ↑	69.29%	**Welsh Blood Service (76.90%)**		
			Directors	25.00	No change from last month
			Quality Assurance	55.81	Decrease on last month of 64.29%
			General Section	62.96	Increase on last month 74.07%
			Velindre Cancer Centre (71.30%)		
			Cancer Services Management Officer	26.92	Decrease on previous month 30.77%
			Medical Staffing	60.94	Increase from previous 54.84%
			Outpatients	50.00	Decrease from previous month 61.11%
			Psychology	40.00	New hotspot
			Corporate Areas (58.37%)		
			Finance – Management Accounting	28	Decrease from previous month 33.46%
			Fundraising	0.00	Same as previous month PADR conversations all complete and ESR team have supported management to being the inputting of these conversations into ESR.
			Corporate Management Section	40	Decrease on previous month 42.86%
			Clinical Governance Section	14.29	New Hotspot

Action/reasons/initiatives:

<u>Velindre University NHS Trust</u>

Senior Business Partners continue to support the leadership teams in improving PADR targets across the Trust however the growth is slow given the complex operational priorities ongoing currently. WOD Department are in the process of developing an effective people management training framework that will be available to all managers and which will include the importance of PADR's and how to undertake a successful PADR.

The NHS Wales Pay Progression Policy will come into effect in October 2022, Comms will be send to all staff in September 2022 and a targeted training approach based on those impacted soonest will take place by the ESR tea,

Welsh Blood Service

PADR compliance continues to steadily grow month on month in WBS, although still reporting below target, managers are working around operational pressures to progress these conversations.

VCC

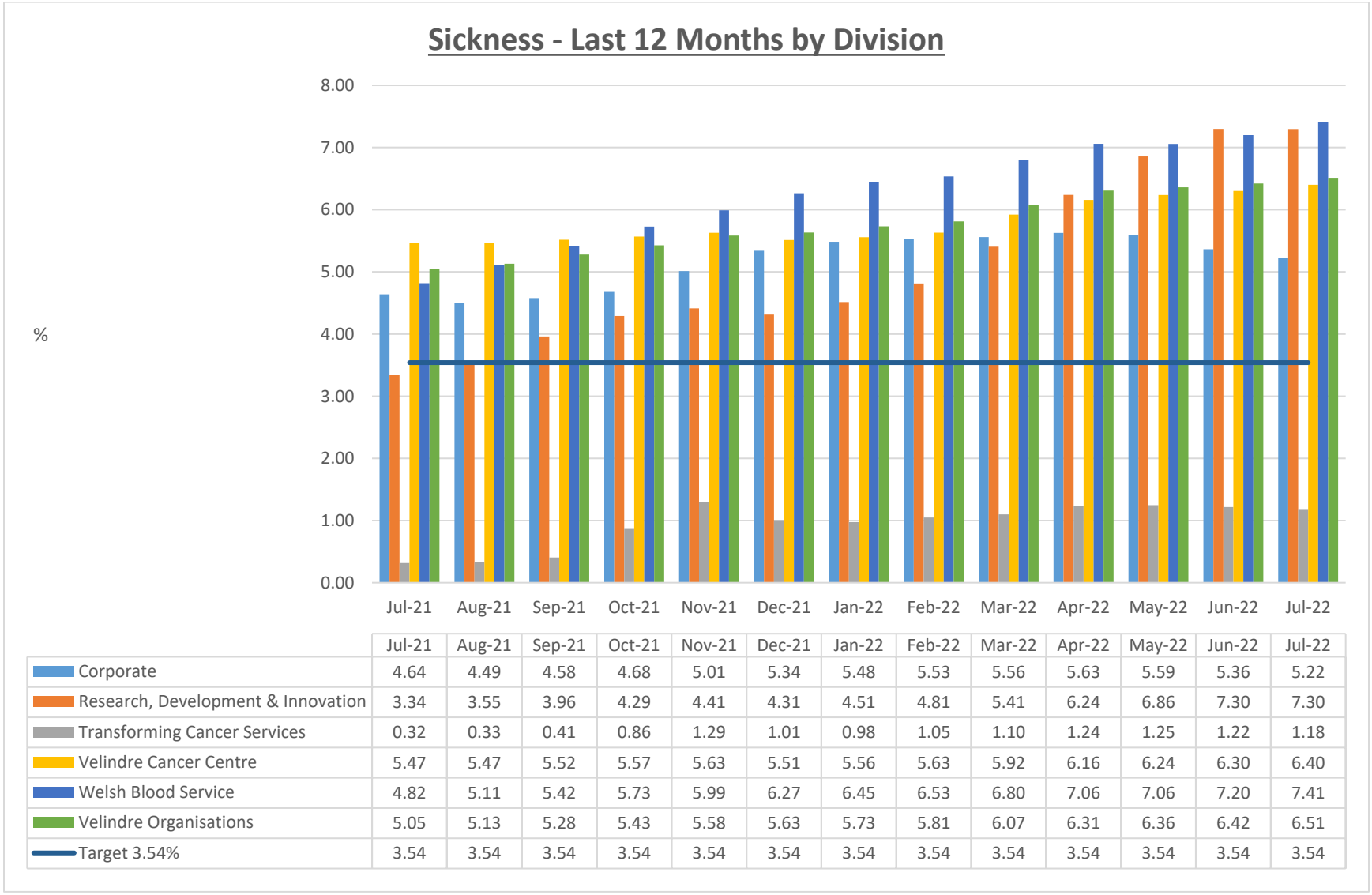
Workforce People and Relationship Team continue to highlight PADR compliance in regular meetings with managers.

PADR compliance is discussed monthly at SLT performance meetings, and compliance has improved slightly this month in comparison to June 2022.

Corporate Areas (including RD&T, HTW & TCS)

An increase of 4.19% compliance in one month following targeted interventions from the People and Relationship Team in June to support managers in improving compliance. This support will continue through August and September.

Sickness Data – The Figures



	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
Corporate	4.64	4.49	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.22
Research, Development & Innovation	3.34	3.55	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.24	6.86	7.30	7.30
Transforming Cancer Services	0.32	0.33	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18
Velindre Cancer Centre	5.47	5.47	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.30	6.40
Welsh Blood Service	4.82	5.11	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41
Velindre Organisations	5.05	5.13	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.51
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

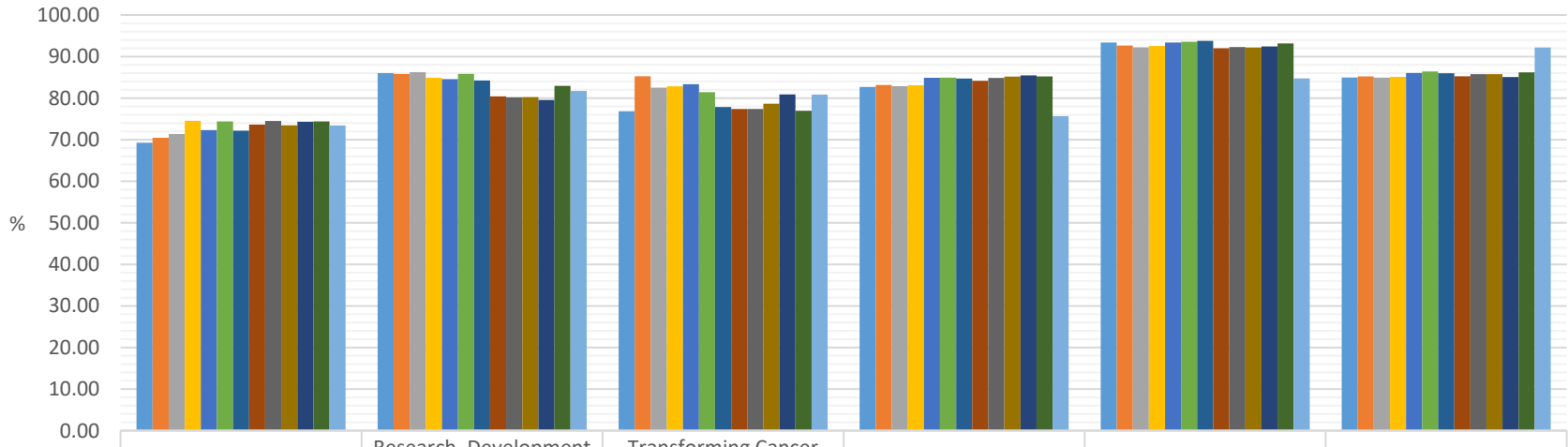
<table>
<tr><th>Performance Indicator</th><th>RAG/ Change from previous month</th><th>June Figure</th><th>Hotspot</th><th>%</th><th>Comment</th></tr>
<tr><td rowspan="11">Sickness absence (3.42%)</td><td rowspan="11">6.51%
↑</td><td rowspan="11">6.34%</td><td colspan="3">Welsh Blood Service (7.41%)</td></tr>
<tr><td>Collections Section</td><td>13.00</td><td>Increase on last month 9.86%</td></tr>
<tr><td>Laboratory Section</td><td>8.02</td><td>Increase on last month 7.62%</td></tr>
<tr><td>Quality Assurance</td><td>4.76</td><td>Improvements continue to decline month on month. Remove as hotspot</td></tr>
<tr><td colspan="3">Velindre Cancer Centre (6.40%)</td></tr>
<tr><td colspan="3">Significant number of departments are showing as a concern and significantly over the target for absence this month. Only 6 areas in VCC are showing sickness of less than 6% areas over 6% are:

• Clinical Audit – 8.63%
• Information Services – 11.23%
• Nuclear Medicine – 24.89%
• Nursing – 7.89%
• Operational Services – 6.07%
• Outpatients – 11.99%
• Pharmacy – 8.71%
• Psychology – 6.14%
• Radiotherapy – 9.06%
• Therapies – 7.86%

This change of in month absence in all figures is not representative in the rolling absence yet but it needs to be noted that this will grow significantly given the developing absence rates month on month in almost all areas.</td></tr>
<tr><td colspan="3">Corporate Areas (4.57%)</td></tr>
<tr><td>Clinical Governance</td><td>14.8</td><td>Same as previous month</td></tr>
<tr><td>Estates</td><td>0.00</td><td>Decrease on previous month 14.29%. Consider removing form hotspot due to significant improvement in absence figures.</td></tr>
</table>

			RD&I CTU Research (late phase0	11.06	Decrease on previous month 11.89%

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95
Oct-21	74.54	84.89	82.86	83.11	92.54	85.10
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06
Dec-21	74.40	85.83	81.43	84.93	93.56	86.40
Jan-22	72.17	84.26	77.86	84.73	93.78	85.97
Feb-22	73.64	80.42	77.39	84.18	92.02	85.26
Mar-22	74.51	80.21	77.39	84.88	92.30	85.77
Apr-22	73.48	80.23	78.64	85.17	92.19	85.76
May-22	74.31	79.56	80.91	85.46	92.44	85.08
Jun-22	74.41	82.95	76.96	85.22	93.17	86.20
Jul-22	73.42	81.74	80.87	75.65	84.75	92.18

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	June Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**92.18%** ↑	86.20%	**Welsh Blood Service (84.75%)**		
			Directors	72.50	New Hotspot
			Velindre Cancer Centre (75.65%)		
			Cancer Services Management Officer	78.21	New Hotspot
			Medical Staffing	52.46	Decrease on previous month 52.99%
			Palliative/Chronic Pain	64.50	Decrease on previous month 65.71%
			Corporate Areas (78.68%)		
			Fundraising	55.0	Decrease on previous month 56.25%
			Corporate Management Section	51.18	Decrease on previous month 52.5%
			TCS Programme Management Office	50.00	Same as previous month

Action/ initiatives:

Velindre University NHS Trust

Statutory and Mandatory compliance has reported over target for 10 months within the last year for the Trust. Face to face training has now fully resumed and the digital VAR training project continues. The Education and Training Team have also been through a procurement exercise to bring in a temporary trainer for inanimate load training while the in-house recruitment is ongoing.

WBS

WBS is reporting below target for the first time in over 12 months, Interventions will be undertaken with SMT to understand this change and support on brining compliance back to target.

VCC

This month has seen a significant decline in statutory and mandatory figured from 85.22% in June to 75.65% in July. Intervention will be undertaken with SLT to understand this huge dip in figures.

Corporate Areas (including RD&T, HTW & TCS)

Slight improvement made on June's performance but work is still required to improve compliance.

Job Planning

Work is currently ongoing with the Medical Directorate to ensure compliance with Job Plans and significant work has been undertaken to represent the data without those employees on long-term sickness, maternity leave or appointed within the last 12 months.

No data available for July 2022 at time for publishing report.

Work In Confidence (WIC)

No new concerns have been raised via the Work in Confidence platform in relation to behaviour of colleagues.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Staff Wellbeing

DATE OF MEETING	15 September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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	1.9.22	Noted

ACRONYMS	
EMB	Executive Management Board

1. SITUATION/BACKGROUND

1.1 Wellbeing and Engagement is one of the six themes in the Trust People Strategy, as agreed in May 2022. A programme of work has been developed over the past few years to support staff wellbeing and since 2021 this has been driven and coordinated through the Healthy and Engaged Steering Group.

1.2 The last update to EMB on Wellbeing was in May 2022 in the presentation of the Trust's response to the Audit Wales survey 'Taking Care of the Carers'.

1.3 The current position in relation to staff wellbeing is outlined in this report.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Healthy and Engaged Steering group, having been set up in 2021, is now running effectively. It has agreed Terms of Reference, an Annual Workplan and confirmed membership representing a range of areas and professions in the Trust. It has an annual timetable of meetings and is submitting a Highlight Report to EMB once a Quarter. A wide range of activities are underway with the aims of supporting staff wellbeing:

1. A new Wellbeing Hub has opened at the Velindre Cancer Centre which provides a welcoming environment for staff to relax. This will be the home of the Staff Psychologist and will become a centre for providing psychological or complementary therapies. A week-long Festival of Wellbeing took place there in May to mark its opening. Whilst this is a resource for all Trust staff, it is recognised that we have to offer wellbeing resources across our Trust footprint to support staff in all geographical areas.

2. Psychological support for staff is well established. We have a network of trained Mental Health First Aiders who provide in-the-moment support and signposting to staff experiencing distress. Access to counselling through Workplace Options and Canopi is advertised and used by staff. In Quarter 1, 67 people contacted Workplace Options, 60 of whom entered counselling. NWSSP made up the majority of the cases, with 40, followed by Velindre Cancer Centre with 12, Corporate with 7 and Welsh Blood Service with 4. The final 4 were from DHCW. In addition, 39 people accessed web-based services. This followed a similar pattern to Quarter 4 2021-22, when 50 people contacted them and 32 accessed web-based services.

3. Underpinning skills and knowledge to support physical and psychological wellbeing of staff has been built into the Trust's training agenda for 2022-23. This includes a module on the Inspire management development programme on inclusion and bias, an Equality, Diversity and Inclusion Board development programme and also promoting the all-staff e-learning package 'Treat Me Fairly'. Manager briefings on Menopause and mental wellbeing are also planned for this year.

4. Menopause Cafes have taken place in the VCC Wellbeing Hub and at Welsh Blood Service Headquarters and were well attended by staff. Links have been made with HEIW and other NHS organisations to share good practice and developed shared educational events on the Menopause.

5. Steps have been made to enable staff to talk about things which matter to them, including raising concerns where they exist. The Work in Confidence platform was recommissioned from April 2022 and provides a means of raising a concern anonymously. One contact was made through this route in Quarter 1. The Trust has contributed to the development of the All Wales approach to Freedom to Speak Up, a piece of work commissioned by the Welsh Partnership Forum. This will provide a toolkit for staff and managers to raise and respond to sensitive or confidential matters in a way that protects people involved. A key medium for staff voice is the NHS Staff Survey. This was expected to be issued in November 2022 but it is now expected in the Spring 2023.

6. In light of the rise in the cost of living, there has been a focus on Financial Wellbeing with information from Money Helper and Salary Finance being made clearly available to staff. This has been supplemented by Wellbeing Drop-In sessions on MS Teams for staff to hear about the resources available and to ask any questions. NHS Pensions have also run a set of webinars for staff.

2.2 At a strategic level, the Building our Future Together programme includes a section on reviewing and refreshing the Trust Values as part of developing a positive culture in the organisation. This aims to enhance staff wellbeing through providing a healthy environment supported by Compassionate Leadership. This will be progressed through staff engagement sessions and surveys during the rest of 2022.

2.3 During August 2022 the Trust Audit Services undertook a Staff Wellbeing Advisory Review. This was not intended to provide an assurance rating but instead to offer recommendations for improvement. The focus of the review was to consider how to develop robust measures of the effectiveness of wellbeing interventions and also to offer suggestions for improving our wellbeing framework. The feedback from the review is being taken forward at the next Healthy and Engaged Steering Group.

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

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 and Performance Committee is asked to **NOTE** the report.

QUALITY, SAFETY &PERFORMANCE COMMITTEE

JULY 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wayne Jenkins, Head of Planning and Performance 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	10.8.22	Reviewed and Noted
VCC SLT	17.8.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	17.8.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	19.8.22	Reviewed and Noted
EMB RUN	1.9.22	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 July 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:

We continue to experience service challenges in providing capacity to meet the overall demand for services and also to meet targets for treatment due to the variation in referral patterns for patients with different tumour sites due to the specific needs of these patients. For example, the LINAC for radiotherapy are configured for certain treatment sites.

With referrals expected to continue to increase as Health boards target their waiting lists, regular operational meetings are taking place with the three Health Boards we work with and these will enable us to gain a clearer picture of what the demand and referral numbers will be going forward, building on the work done previously to create data on the system wide referral pathways and patient numbers. These meetings are enabling us to have more detailed discussions with health board colleagues to understand the team by team changes in their services that impact on the demand profile for patients coming to Velindre.

Alongside better intelligence on demand to support planning, we have a comprehensive programme of work underway to expand capacity and to maximise the use of the capacity that we have by ensuring that we are as efficient as we can be.

Below we outline the details of the factors influencing performance in July 22, however we have also provided a fuller summary of the activity underway to increase capacity and efficiency in a separate paper which will be presented at September's QSP meeting (see appendix 4)

Demand and Capacity

Alongside better intelligence on demand to support planning, we have a comprehensive programme of work underway to expand capacity and to maximise the use of the capacity that we have by ensuring that we are as efficient as we can be.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity task forces in Radiotherapy and SACT. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying

options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

In SACT, a redistribution of patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics have been established from August to expand capacity using overtime and drawing on as many staff as possible with the appropriate skills. This is an interim arrangement pending the next stage plan of increasing SACT delivery at Prince Charles Hospital by 100% and the ultimate plan of reopening capacity in ABUHB. Discussions are also taking place in relation to an interim option for services within ABUHB whilst the new satellite centre is in progress.
In Radiotherapy, a gradual increase in LINAC capacity by 8% is underway, through extending working days and a gradual increase in utilisation of LINAC capacity from 73.5 planned hours in June to 79.5 planned hours in October. 75 hrs has been delivered in July in line with plans. Risks remain however to provide specific Brachytherapy capacity and Medical Physics capacity and there are significant risks and challenges associated with the age of the equipment and potential breakdown.

Radiotherapy Waiting Times

Overall referrals to radiotherapy for July (387) were marginally lower than those received in June (388).

With the exception of urology, referrals across all tumour sites has seen an increase in the monthly average number of referrals for that site when compared to 2020/21 and 2021/22.

We have already seen higher than anticipated and 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 capacity in the initial parts of their treatment pathway.

Patient receiving radical radiotherapy within 28 day

Of the 197 patients referred for radical radiotherapy, 55 did not begin treatment within the 28 day target leading to a performance of 72%. The target is 98%. We have looked at the breach data at an individual patient level to determine why they occurred. There are various reasons; lack of planning and deep x-ray capacity and process issues relating to

re-scans and re-plans. However the prime issue in July was the capacity for treating Breast Cancer patients. There were 38 breast cancer patients in the 55 breaches. All of these were treated within 7 days of the target. All these patients would have been clinically prioritised by the clinical teams.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity review. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

SACT Waiting Times

July's performance improved to 58%. Of the 389 patients referred for non-emergency SACT treatment, 134 patients did not start their treatment within 21 days. The longest wait for a patient was 59 days.

This is the first month since December 2021 where performance has improved from the previous month, arresting a 7 month decline. Breach numbers have also reduced to 134 in July from 147 in June and 158 in May.

All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Escalation and capacity needs are continually reviewed and change frequently throughout the day at an operational level within the clinic.

Additional booking clerks have been appointed to fill vacancies and interviews for additional nursing vacancies were held in July with an expectation that they will boost the workforce team by October.

Internal mutual aid is being provided from nursing within other departments to support maintaining activity.

A taskforce has been established to identify short to medium term options to address shortfall in capacity and this is being reviewed weekly by the SLT and Executive team. A redistribution of appropriate patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics have been established from August to expand capacity using overtime and drawing on as many staff as possible with the appropriate skills. This is an interim arrangement pending the next stage plan of increasing SACT delivery at Prince Charles Hospital and the ultimate plan of reopening capacity in ABUHB. Discussions are also taking place in relation to an interim option for services within ABUHB whilst the new satellite centre is in progress.

Outpatients

Data collection relating to the 30 minute target, was paused in December 2021, due to operational pressures and staff absence as manual collection of individual patient attendances is required. This has now been reinstated in this month's report, but is still limited in sample size. We are reviewing a number of new outpatient KPIs as part of the new PMF development that will enable a wider view of the service delivery in this area.

Other areas

Falls

During July 2022, 2 falls were reported on first floor ward, involving 2 patients who mobilised independently and did not use the call bells available. The falls scrutiny panel deemed the both falls as unavoidable. The patients were unharmed.

Pressure Ulcers

There were no pressure ulcers reported in July 2022.

Healthcare Acquired Infections

There was 1 reported case of E.coli bacteraemia in July 2022.

The root cause analysis and review by MDT identified it as bowel source probable malignant translocation.

SEPSIS bundle NEWS score

14 patients initially met the criteria for administration of the sepsis treatment bundle in July 2022. All 14 patients received all elements of the bundle within 1 hour.
6 patients received a diagnosis of sepsis and all of them had received all elements of the bundle within 1 hour.

Delayed Transfers of Care (DTOC's)

There was no Delayed Transfer of Care was reported in July 2022.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

Performance for July remains encouraging overall despite experiencing high sickness levels in collection teams and the current pressures on demand and capacity within the blood supply chain.

2.2.1 Supply Chain Performance

Whilst Covid and general sickness continues to be challenging, during July the service continued to meet demand.

Stock dropped below the 3 day benchmark on 6 occasions for the O- and O+ due to pressures on the blood supply chain. As a result, a total of 97 units of red cells were provided as part of our mutual aid support.

Blue Alerts continued due to ongoing low stock levels for the O+ blood group, and were also extended to O- and A+ blood groups for periods in the month.

Daily emergency planning meetings have been convened to consider the current challenges in meeting demand and to address stock recovery.

In addition, the UK supply remains fragile and a weekly UK Forum has been established to consider current challenges, mutual aid and shared learning across nations.

2.2.2 Whole Blood Collection Productivity

The collection productivity rate dropped slightly from last month, however efficiency varies between teams (0.79% for Bangor to 1.21% for East B). This is due, in part, to low Registered Nurse (RN) absence throughout the month causing overstaffing of RNs to small clinics and high absence of Clinic Collections Assistants (CCA) causing a reduction in clinic capacity. The misalignment of RN and CCA workforce continues to result in over resourcing of RNs in West, Wrexham and Bangor, reducing efficiency of clinics operating in these areas. In addition, the inability to offset donor non-attendance (DNAs) with 'ad-hoc walk ins' also continues to hinder a return to target efficiency.

Data analysis is being undertaken on Donor Non Attendance trends to identify if the resulting gap can be mitigated by over booking of appointments or 'controlled walk ins' at carefully selected clinics. The 6 chair mobile units are scheduled to return to service from September following post COVID modifications and a review of individual venue capacity continues with a view to reintroducing 10 chair clinics across south and west Wales where possible. A revised training schedule is also in development to accelerate timescales for new staff to become fully trained/operational.

2.2.3 Recruitment of new bone marrow volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June but is still below target.

The action plan to promote recruitment at universities, colleges and sixth forms on the return of students in September continues, along with profiling on social media and improving content and visibility on the WBS website. WBMDR staff are promoting bone marrow donor recruitment at national events. Alongside this, the team have issued a tender to work with an external company to develop a donor recruitment campaign and the production of promotional material. The expectation remains that increases in bone marrow donors will be evident once the campaign launches.

2.2.4 Reference Serology

In July, Reference Serology turn around performance reached its target of 80% for the first time this year.

This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. However, it is hoped that continued implementation of the findings of the recent 'Out of Hours Referrals' audit and the solutions outlined in the recent paper regarding service pressures will support maintaining target on an ongoing basis.

2.2.5 Time Expired Platelets

Platelet expiry did not reach target in July. This was due to an unpredicted drop in demand to 167 per week (against planned production of 215 per week). This month's demand was lower again than May (216 units per week) and June (173 units per week). As the impact of production on supply is delayed by 2.5 days, any excess supply cannot be reduced as the excess is usually nearing expiry, and there is not a strong correlation between weekly issues to inform demand.

Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates. A platelet group has recently been established to look at improvements in wastage, apheresis clinic collection times and additional areas for improvement. The work will include international benchmarking and liaising with other blood services to see if any improvements in platelet planning can be made.

2.2.6 Quality

Incidents reported to Regulator/Licensing

There was 1 Serious Adverse Event (SAE) reported to regulators during July: A Critical core temperature alarm limit was breached for a plasma freezer. The investigation determined that affected plasma was safe for transfusion. A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward.

Incidents closed within 30 days

99% of Quality Incident Records were closed within 30 days (for the three month rolling period to July) against a target of 90%. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1. The overdue Datix incident is now closed, but exceeded the 31-day closure requirement. This was a no harm event investigation which was awaiting closure from the incident owner.

Number of Concerns Received

4 concerns (0.05%) were reported within this period and were closed as early resolutions.

Donor Satisfaction

At 96.0% donor satisfaction continued to perform strongly at a national level despite the COVID restrictions in place.

3. WORKFORCE

3.1 PADR

Trust Wide 70.45%, increase on previous month (Target 85%)
WBS 76.90%, compliance rates declined compared to last month.
VCC 71.30%, increased compared to last month

Sickness Absence

Trust wide 6.81%, sickness increased on last month. (Target 3.54%)
WBS 8.49%, sickness rates increased compared to last month
VCC 6.83%, sickness increased compared to last month.

3.2 Statutory & Mandatory Compliance

Trust Wide 85.46%, above target (Target 85%)
WBS 92.18%, well above target but decrease on previous month
VCC 84.75%, slight dip since last month taking below target.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY	Yes (Please see detail below)

IMPLICATIONS/IMPACT	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 May PMF Report
2. WBS May PMF Report
3. Workforce Monthly PMF Report

Welsh Blood Service Monthly Report
July 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- Whilst COVID related sickness continues to be challenging, during July, all clinical demand was met. Total stock dropped below 3 days on 6 occasions (Group O) and as a result, the service received 97 units of mutual aid. Blue Alerts continued for the O+ blood group, which were also extended to O- and A+ blood groups for periods in the month. Daily emergency planning meetings have been convened by the WBS Director to consider the current challenges in meeting demand and to address stock recovery and a weekly UK Forum meeting has been established to consider current challenges, mutual aid and shared learning across nations.

- In July, Reference Serology turn around performance reached its target of 80% for the first time this year. This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. However, it is hoped that continued implementation of the findings of the recent 'Out of Hours Referrals' audit and the solutions outlined in the recent paper regarding service pressures will support maintaining target on an ongoing basis. All time critical tests are being completed on time

-The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June but is still below target. There were no university, college or sixth form sessions due to the end of the academic year and coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has resulted in only a modest increase in bone marrow volunteers. The WBMDR five year strategy, currently in development, will reappraise the approach to recrutiment and propose actions to expand the bone marrow donor panel.

- No stem cells were collected in July due to the one request being cancelled by the transplant centre, however, 8 requests for stem cell products were received for collection in August and September. Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. The service has also seen a higher cancellation rate (30%) compared to that pre pandemic (15%). The WBMDR five year strategy, currently in development, will reappraise the existing collection model and its ambition.

- Platelet expiry did not reach target in July. The normal challenges were exacerbated by an unpredicted reduction in demand. Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates. A platelet group has recently been established to look at improvements in wastage, apheresis clinic collection times and additional areas for improvement. The work will include international benchmarking and liaising with other blood services to see if any improvements in platelet planning can be made.

- Collection efficiency target was not met in July at 1.13 against a target of 1.25. This is due to transition from Covid model to the future model.

- 99% of Quality Incident Records were closed within 30 days (for the three month rolling period to July) against a target of 90%. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1, with performance for QPulse at 100% and 95% for Datix.

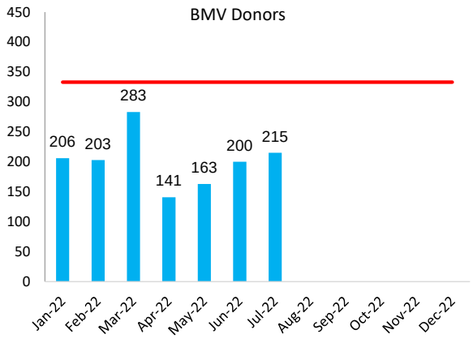
- There was 1 Serious Adverse Event (SAE) reported to regulators during July: failure to respond to a critical temperature alarm for a plasma freezer. The investigation determined that affected plasma was safe for transfusion. A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward.

- In July 2022, 8,094 donors were registered at donation clinics. 4 concerns (0.05%) were reported within this period and were closed as early resolutions. 541 new donors completed a donation in July, 7.59% of the total donations received in the month. At 96.0% donor satisfaction continued to be above target for July with 1,201 respondents to the donor survey.

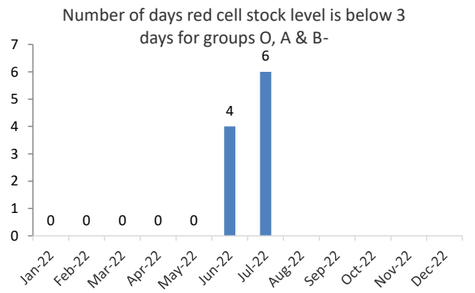
Reference Table

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

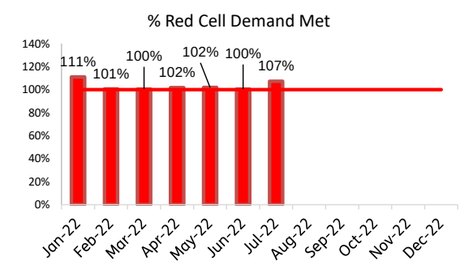
Monthly Reporting



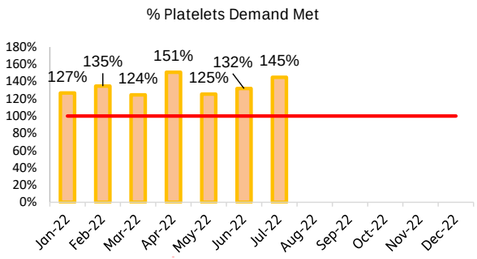
Annual Target: 4000 (ave 333 per month)	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June, but is still below target. There were no university, college or sixth form sessions due to the end of the academic year. Coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has resulted in only a modest increase in bone marrow volunteers in July.	The WBMDR five year strategy, currently in development, will reappraise the approach to recrutiment and propose actions to expand the bone marrow donor panel. The action plan to promote recruitment at universities, colleges and sixth forms on the return of students in September continues, along with profiling on social media and improving content and visibility on the WBS website. WBMDR staff are promoting bone marrow donor recruitment at national events. Alongside this the team have issued a tender to work with an external company to develop a donor recruitment campaign and the production of promotional material. The expectation remains that increases in bone marrow donors will be evident once the campaign launches.	Quarter 3



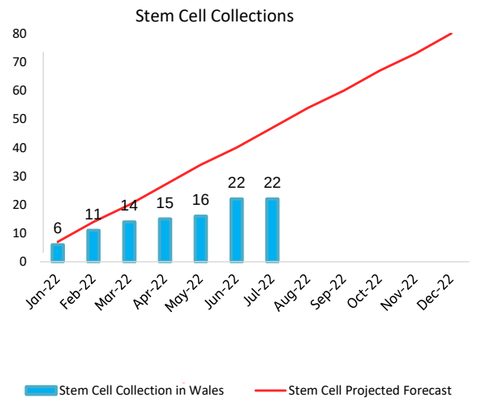
Monthly Target: 0	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All clinical demand was met, however, during July total stock dropped below 3 days on 6 occasions (Group O). As a result, in July, the service received 97 units of mutual aid. Blue Alerts continued in July due to continued low stock levels for the O+ blood group, which was also extended to Blue Alerts on the O- and A + blood groups for periods in the month.	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 at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages. Daily emergency planning meetings have been convened by the WBS Director to consider the current challenges in meeting demand and to address stock recovery. It should be noted that all UK services are experiencing similar issues and a weekly UK Forum has been established to consider current challenges, mutual aid and shared learning across nations.	Reviewed daily to support responses to changes in demand



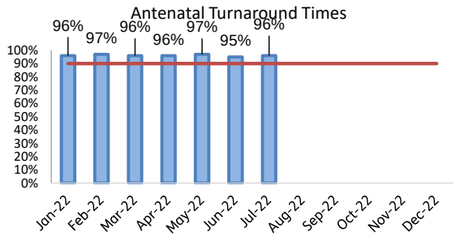
Monthly Target: 100%	**SMT Lead: Jayne Davey/ Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All hospital demand for red cells was met. Demand in July (full weeks) averaged at 1480 units per week which was a reduction from June.	The 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. Daily emergency planning meetings have been convened by the WBS Director to consider the current challenges in meeting demand and to address stock recovery. It should be noted that all UK services are experiencing similar issues and a weekly UK Forum has been established to consider current challenges, mutual aid and shared learning across nations.	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 July, platelet demand was 167 units per week on average - this is an unpredicted reduction from May (216) and June (173) issuing. 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. A platelet group has recently been established to look at improvements in wastage, aphesis clinic collection times and additonal areas for improvement. The work will include international bencharking and liaising with other blood services to see if any improvements in platelet planning can be made.	Reviewed daily

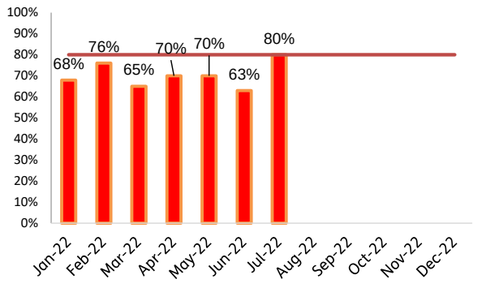


Annual Target: 80 (ave 7 per month)	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No stem cells were collected in July due to the one request being cancelled by the transplant centre. The pandemic has impacted on unrelated donor stem cell transplants globally, which has reduced the number of stem cell collection requests. In addition, the Service continues to experience a cancellation rate of around 30% compared to 15% pre COVID pandemic 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. Eight requests for stem cell products were received in July, due for collection in August and September.	The WBMDR five year strategy, currently in development, will reappraise the existing collection model and its ambition. The move to Velindre Cancer Centre (VCC) has enabled WBS to offer more options and additional capacity for collections going forward.	Action plan monitored monthly



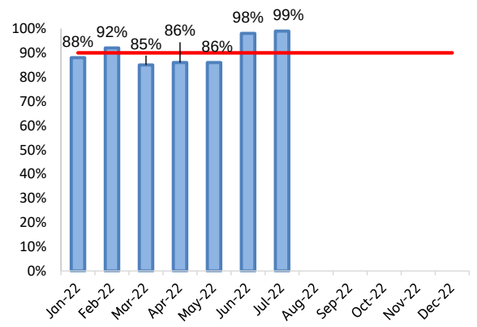
Monthly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96%, the turnaround time for routine Antenatal tests in July remains above the target of 90%.	Efficient and embedded testing systems are in place. Continued monitoring and active management remains in place, maintaining high performance against current target.	Business as Usual, reviewed daily

Reference Serology



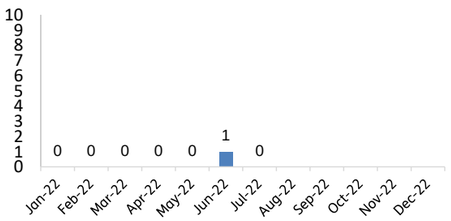
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turnaround performance reached target at 80% for July for the first time this year. This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. The number of samples referred for July (269) continues to be to be high compared to the average of hospital patient referrals at 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. The findings of the recent 'Out of Hours Referrals' audit are being implemented. In addition, the solutions outlined in the recent paper regarding service pressures are also being implemented with a view to improving the performance in the short, medium and long term. It is hoped that continued implementation of these actions will support maintaining the target on an ongoing basis. 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
(rolling 3 months)

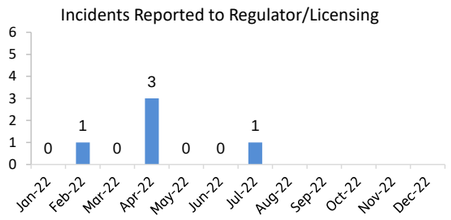


Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 99% the performance has met target (90%) for the three-month rolling period to July. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1 (0 QPulse and 1 Datix). Performance for incidents reported via QPulse is at 100% and 95% for Datix. The overdue Datix incident is now closed, but exceeded the 31-day closure requirement. On investigation this was a no harm event which was awaiting closure. All QPulse incidents have been risk assessed, investigated and closed. QPulse does not permit closure of the report until all CAPA are completed.	New reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The process will be revised to address the findings of the recent MHRA inspection, i.e. to update the WBS incident management process and ensure that all low and moderate risk incidents have root cause assigned. The QA team continue to send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines with progress of actions to address these incidents closely monitored.	Continue with close monitoring and early recognition of potential timeline breaches.

Critical Findings

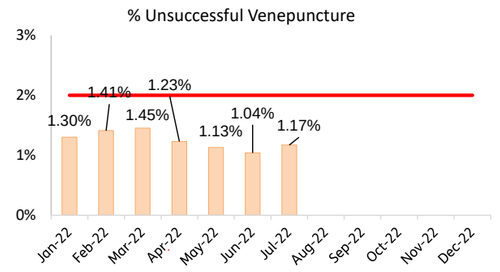


Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no external audits undertaken during July.	A formal response to the findings from the MHRA regulatory inspection undertaken in June was submitted and has been reviewed by MHRA . The inspectors have requested further information for three of the proposed actions; these are being addressed following discussion with the Head of QA&RC.	Completion of all action plans for external audits is monitored via the monthly RAGG meeting.

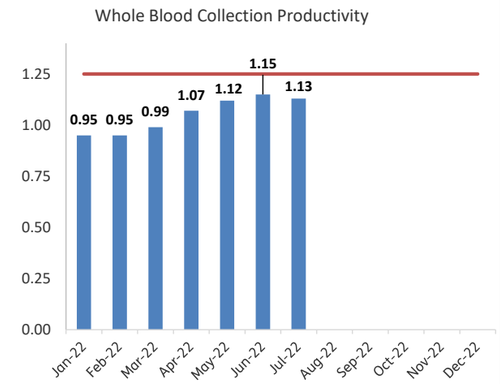


Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There was one Serious Adverse Event (SAE) reported to regulators during July. Failure to respond to a critical core temperature alarm for a plasma freezer. The investigation determined that affected plasma was safe for transfusion.	A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward.	Preventive actions due for completion 31/08/2022

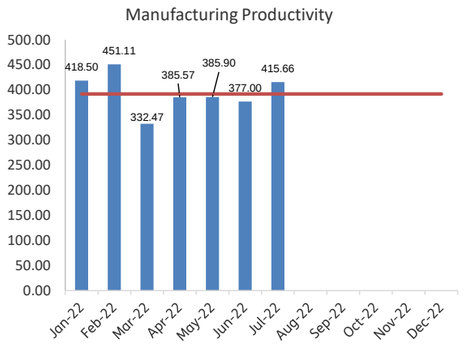
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The All Wales combined 'Part Bag' rate for whole blood teams remains within the required tolerance level (3%) at 2.09% during July. Analysis of the part bag rates shows no individual team breaches for July. 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).	Continue to monitor trend analysis - escalate to Collections if required.	Continued close monitoring and intervention where required



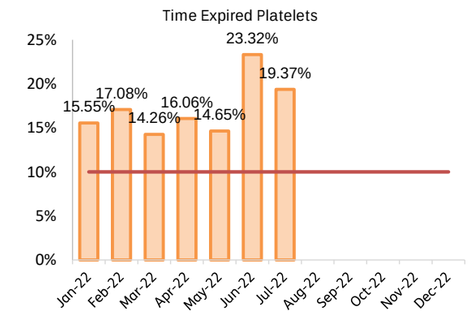
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The All Wales combined Failed Venepuncture (FVP) rate for all whole blood teams for July 2022 remains within the required tolerance (2%) at 1.17%. Analysis of the FVP rates shows no individual team breaches for July.	Continue to monitor trend analysis - escalate to Collections if required.	Continue with close monitoring and intervention where required



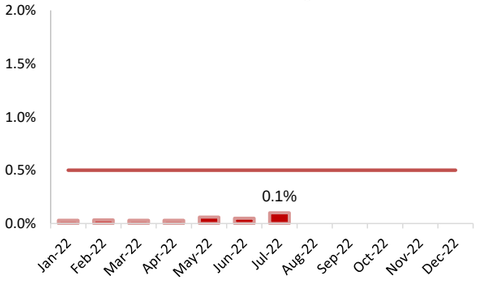
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Collection efficiency target was not met in July at 1.13 against a target of 1.25. This is due to transition from Covid model to the future model. The inability to offset donor non attendance (DNAs) with 'ad-hoc walk ins' also continues to hinder a return to target efficiency.	Data analysis is being undertaken on Donor Non Attendance trends to identify if the resulting gaps in donor attendance can be mitigated by over booking of appointments or 'controlled walk ins' at carefully selected clinics. Post COVID modifications to the 6 chair mobile donations units are now complete and the units scheduled to return to service from September 2022. Continue to review venue capacities with a view to reintroducing 10 chair clinics across south and west Wales, where possible. Progress a revised training schedule for new entrants to shorten timescale from Induction to fully operational.	Quarter 2



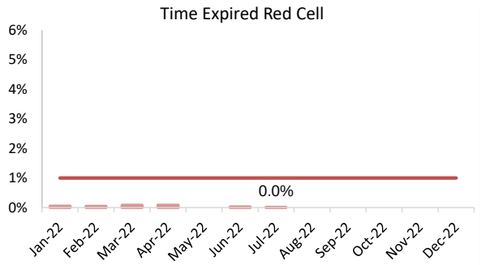
Monthly Target 392	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Actions(s) bring taken to improve performance**	**By When**
At 416 manufacturing efficiency for July is above target for the first time since February. This is reflective of increased collection activity particularly towards the end of July and emphasis on FFP and Cryoprecipitate production to support the provision of Hepatitis B core tested products to Welsh hospitals. There were no significant changes in staffing. 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.	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 2



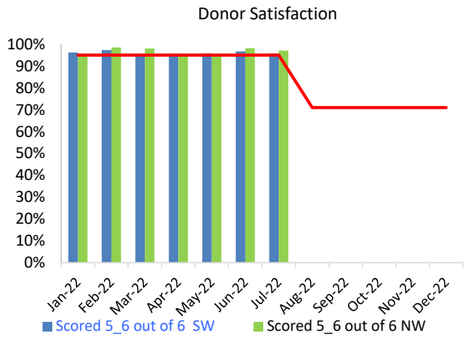
Monthly Target: Maximum 10%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Platelet expiry did not reach target in July. The normal challenges were exacerbated by an unpredicted drop in demand. For July, platelet demand was 167 units per week on average - this is a reduction from May (216) and June (173) issuing. NB: All demand continues to be met without the need to rely on any mutual aid support.	Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates. A platelet group has recently been established to look at improvements in wastage, aphesis clinic collection times and additonal areas for improvement. The work will include international bencharking and liaising with other blood services to see if any improvements in platelet planning can be made.	Quarter 3



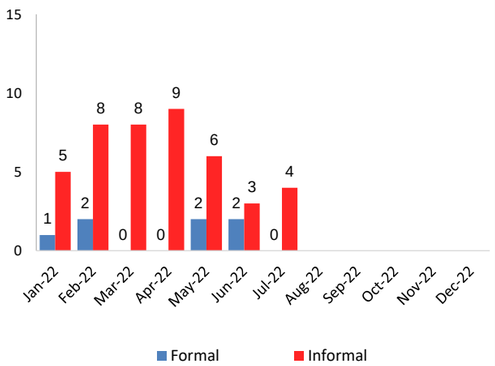
Monthly Target: Maximum 0.5%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were extremely low at <0.1% and remain within tolerance of below 0.5%. The losses were (units): M&D Heat sealer : 2 units M&D Operator - Automated Blood Press : 1 unit 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



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Red cell expiry was 0.01%. COVID challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage. This metric remains within the target and there are no concerns around expiry of red cells.	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

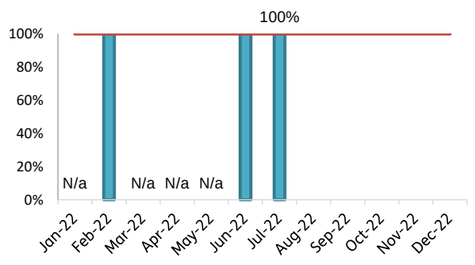


Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96.0% donor satisfaction continues to be above target for July. In total there were 1,201 respondents to the donor survey (some of which are non attributable), 222 from north Wales, and 962 from south Wales where location was able to be defined.	Findings are reported to the Senior Management Team (SMT) at the Collections meeting to address any actions for individual teams.	Business as usual, reviewed monthly



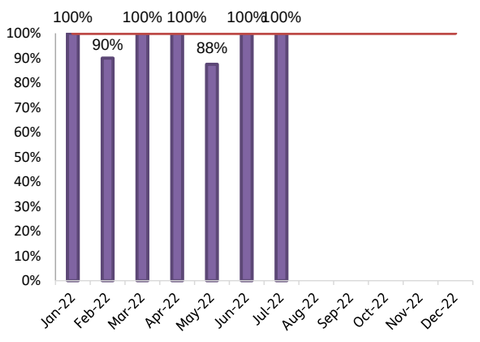
Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In July 2022, 8,094 donors were registered at donation clinics. Four concerns (0.05%) were reported within this period and were closed as early resolutions. The two concerns reported in June, being managed under 30-day timeline, were resolved in the month of July ahead of 30-day timeline, under the Putting Things Right regulations (PTR). 1. Complainant 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. 2. Donor unhappy he has active deferral on his record due to a technical glitch in the WBS computer system. 3. Donor unhappy to be turned away from session for being late for appointment. 4. Donor and his wife were unhappy they were turned away from the donation session due to their age.	Individual concerns have been addressed by Heads of Departments and / or Operational Managers. Where donors were unable to be reached, messages inviting the donor to return the calls were left. The two concerns received in June 2022, were closed in July 2022, ahead of the PTR 30-day timeline. All early resolution concerns have been closed to donor satisfaction within the required timescales. 1. 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. 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. 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. 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.	Business as usual, reviewed daily

% Responses to Concerns within 30 Working Days



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Two formal concerns were received in June, one due to be completed in July and the other in August, and were closed ahead of the 30 day timeline under 'Putting Things Right' (PTR) guidelines. * 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

% Concerns Acknowledged within 2 Working Days



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 July 2022 were managed within 2 working days as required by 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

QUALITY SAFETY AND PERFORMANCE COMMITTEE

Summary of Serious Adverse Blood-Related Events reported to Regulators

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	PETER RICHARDSON, HEAD OF QUALITY ASSURANCE AND REGULATORY COMPLIANCE, WBS
PRESENTED BY	Alan Prosser, Director WBS
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**
Welsh Blood Service Regulatory Assurance and Governance Group	25/08/2022	Noted

ACRONYMS	
WBS	Welsh Blood Service
MHRA	Medicines and Healthcare products Regulatory Agency
RAGG	Regulatory assurance and governance group
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with a summary of the investigations into three Serious Adverse Blood-Related Events (SABRE) reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).

2. BACKGROUND

The UK Blood Safety and Quality Regulations 2005 and the EU Blood Safety Directive require that serious adverse events and serious adverse reactions related to blood and blood components are reported to the MHRA. These adverse events include any that could affect the safety or quality of blood components, or that could lead to a loss of a significant quantity of blood components affecting the availability for clinical use. This is not intended as a regulatory sanction, but as a means of ensuring that blood establishments recognise the potential consequences of such events and providing oversight and feedback for the investigation.

From the date of the initial report to the MHRA, the reporting establishment has 30 days to complete a detailed root cause investigation and to report the outcomes and proposed corrective action to the regulator. These reports are reviewed and, if deemed insufficient, the Regulator may ask for more information or further investigations.

Any trends emerging from investigations are taken into account by the MHRA when planning future inspections.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Since the start of 2022/23 the Welsh Blood Service has made 4 reports to the MHRA under the SABRE scheme. All reports and follow-up investigations were completed and submitted within the MHRA timescales and have been accepted by the regulator.

SABRE Reference 99 and 100:

Two of the reports relate to the same incident where the risk of malaria infection was incorrectly assessed for a donor at the clinic meaning that the appropriate malaria screening test was not requested, and the failure to follow up previous donations from this individual to screen for malaria. In both cases there was a failure to follow the correct process by the staff involved, and this was aggravated by the way information was presented to users by the blood establishment computer system (BECS). The root cause was assessed by the investigation as 'Human Error'.

The immediate response was to review previous donation records from this donor and complete malaria screening, this confirmed that the donor was not carrying malaria. An update to the BECS has now been deployed to automate the malaria assessment process and improve the way in which data is presented to users. This significantly improves process reliability and removes the reliance on human interpretation of donor answers.

SABRE Reference 101

One report relates to a complex process for the reworking of neonatal red cell units into an adult unit. There are several laboratory tests required during the process, and the operator then has to interpret the results and decide on the correct blood component to be created and labelled. In this case the final unit was labelled as suitable for neonatal use even though it contained an additive not suitable in for neonates. The operator who labelled the unit was still training and was working under supervision, the root cause was assessed by the investigation as 'Human Error'.

Once the issue was recognised, the affected blood component was traced via the standard recall process, the receiving hospital confirmed that the unit had been administered to an adult patient. A full process review was completed resulting in a number of process steps being simplified or removed, and a greater focus on independent verification of critical decision points. These changes, in combination, have reduced the opportunities for human error.

SABRE Reference 102

The final report relates to incorrect action taken following a temperature alert in a freezer containing plasma and cryoprecipitate. An operator acknowledged a series of high temperature alarms whilst searching for a specific component in a freezer but did not recognise the difference between air probes which are an early warning, and a core probe requires product to be quarantined. The root cause was assessed by the investigation as 'Human Error'.

Following consultation with the Responsible Person and the Head of Quality Assurance, the temperature excursion was deemed to be within allowable limits and the products released from quarantine. A review of the written procedure indicated a need for more detailed guidance, especially for the on-call staff, when dealing with these types of situation, This guidance has now been issued and will reduce the reliance on individual judgement.

Regulator Feedback

The regulator has fed-back that the root cause in each case should be recorded as 'System Error' and not 'Human Error'. The implication being that the systems and processes under investigation are too reliant on individual decisions or interventions without additional verification steps or follow-up.

This feedback was reviewed by the Welsh Blood Service regulatory Assurance and Governance Group and has been incorporated into the Welsh Blood Service Quality Assurance review of all incident investigations before closure. Additional training in human factors is also being considered for process leads to support the ongoing review and refinement of safety-critical procedures.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The feedback from regulators indicates broad compliance to the SABRE reporting process.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe 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	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATIONS

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

Llywodraeth Cymru
Welsh Government

By E-mail to:

Alan Prosser, Director, Welsh Blood Service

24 August 2022

Dear Alan,

COVID Vaccination Programme: Welsh Blood Service continued support

Thank you for your and the Welsh Blood Service's (WBS's) continued support for Wales COVID-19 vaccination programme. WBS has made an invaluable contribution to the programme both by providing ultra-low temperature cold chain infrastructure and expertise since December 2020. This letter sets out a request for WBS to continue to provide support in the short term as we transition to a business-as-usual approach to COVID-19 vaccination in the medium term, and to remain ready and flexible to support a surge response should prevailing conditions necessitate it.

Subject to your agreement I would be grateful if WBS would:

1. Store and distribute the Moderna Spikevax® bivalent and Pfizer Comirnaty® 30mcg concentrate ("wildtype") vaccines as we have discussed with WBS colleagues previously, until the end of October after which time we envisage the responsibility for supply can be transferred either to UKHSA or the NHS Wales Shared Services Partnership's medicines unit.
2. Retain capacity and capability to store Pfizer Comirnaty® 30mcg concentrate (wildtype) vaccine at ultra-low temperate to support deployment to health board mass vaccination centres only in the event of a need to implement a surge plan.
3. Continue to store and distribute Pfizer Comirnaty® paediatric vaccine (in low volumes) until we receive later advice on timing of booster vaccination for children; and
4. Allow Sharon Hamer to continue providing expert advice to the vaccine policy team in Welsh Government, the NHS Delivery Unit, and health boards on deployment of autumn boosters at the equivalent of 0.6WTE until the end of September and 0.4WTE in October, before returning completely to WBS to take forward the important work on plasma fractionation in Wales. As now this time can be recharged to the vaccination programme at Agenda for Change band 8A.

Peter Richardson met with Andrew Evans recently to discuss the approach outlined above which I understand subject to your agreement is acceptable to Peter and Sharon.

I would like to thank Sharon and the wider team at WBS both in Talbot Green and Wrexham for the support and the dedicated service they have given the programme. Your organisation has played a pivotal role in the success of the vaccine programme in Wales.

Yours sincerely

Chris Jones

Deputy Director of Covid 19 Vaccination Policy

QUALITY SAFETY AND PERFORMANCE COMMITTEE
VELINDRE CANCER CENTRE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

PREPARED BY	Viv Cooper, Head Of Nursing, Quality, Safety And Patient Experience, Sarah Owen, Quality & Safety Manager and Tracey Langford, Quality & Safety Officer
PRESENTED BY	Rachel Hennessy, Acting Director, VCC
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR NOTINGFOR NOTINGFOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCC SLT	25/08/22	Approved (out of committee)
Executive Management Board	01/09/2022	Supported

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

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 Velindre Cancer Centre for the period 1st March 2022 to 30th June 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 VCC

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the VCC between March and June 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

3.1 The key messages within the report are::

- A COVID-19 outbreak was managed involving First Floor Ward – no breaches in infection prevention and control standards were identified during regular audits and observations of practice
- Considerable improvements identified through audits in relation to antimicrobial prescribing following implementation of 'ARK'.
- Experience feedback was provided from 171 patients:
    - 73.86% rated their overall experience as excellent
    - 92.75% of patients felt always listened to
    - 92.09% felt well cared for
    - 74.16% felt they understood what was happening in their care
    - 84.09% felt they were involved as much as they wanted to be in decision about their care.

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. The content of this report will be considerably developed in preparation for the next reporting cycle focussing on quality outcomes and metrics as well as themes, trends and areas of learning and improvement. In addition the following will be undertaken:

- Implementation of CIVICA across all departments within VCC ensuring real time capture of patient feedback, analysis of the results and publishing results on 'know how we are doing boards' across the Cancer Service

- Implementation of Waiting time Harm Review process
- Targeted work within radiotherapy and SACT to improve the number of incident investigations concluded within 30-working days.

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.There are no specific legal implications related to the activity outlined in this report.There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATIONS

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

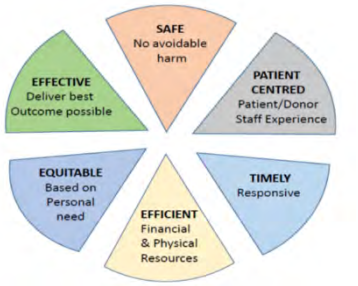
- Performance against the six domains of Quality
- Issues, corrective actions and monitoring arrangements in place
- Service developments within VCC

VELINDRE CANCER SERVICE - QUALITY, SAFETY & PERFORMANCE REPORT – JUNE 2022

1. INTRODUCTION

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

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



2. SAFETY

Incidents/near-misses/compliments/feedback are used as indicators of safe care and are captured using the Once for Wales DATIX software system. Assurance regarding the safety of the services provided at Velindre Cancer Centre is provided through various routes/reports and committees including the Divisional Performance Group, Divisional Quality & Safety Management Group (QSMG) and local Directorate meetings.

For the period of March to June 2022, there were 532 incidents reported. There were no severe or catastrophic incidents.

	No of incide	No ne	Low	Moder ate	Seve re	Catastro phic
March	151	98	47	8	0	0
April 2022	122	73	43	6	0	0
May 2022	129	73	48	8	0	0
June 2022	130	91	36	3	0	0

1.1 Moderate Indcidents

There were 25 incidents were categorised as moderate harm initially by the reporter. Following investigation, 1 incident was confirmed as being of moderate harm and related to a fall within the SACT department. The incident was reported as a National Reportable Incident and as a RIDDOR as the patient fell from a treatment chair. Following this incident all patients attending for SACT are educated about the importance of being aware of the footrest and not to use as a step.

The Quality and Safety Team have been feeding back to departments about the importance of reviewing the incident harm categorisation which has resulted in an improvement in the number of incidents that are closed with a complete incident harm categorisation review. In Q3 2021 13 moderate harm incidents were closed that had not had the incident harm categorisation reviewed compared to 0 for this reporting period, this is an example of a positive improvement in relation to quality and safety activity across the directorates.

1.2 Open Incidents

There are 399 incidents open over 30 days. This is an increase from the last VCC report which showed 293 incidents open over 30 days.

The two service areas with the largest number of incidents which remain open are Radiotherapy and SACT. Incidents within radiotherapy are challenged by the need for regulator assessment, of which there is a shortage and due to the complexity of the investigations are likely to require a significant time to undertake the work and therefore whilst under investigation are likely to take longer than 30 days.

While the pressures are acknowledged within the clinical departments of VCC, the issue of open incidents has been escalated to VCC SLT and a meeting has been arranged between VCC and WBS Quality and Safety Teams to share best practice on managing open incidents.

1.3 Fall scruinty panel

There were 16 falls on First Floor ward during reporting period (9 occurring during March). During this period there was a particularly complex patient caseload with high levels of acuity and a Covid outbreak.

All 16 cases were discussed at scrutiny panel and 2 of the patient falls were identified as avoidable due to enhanced supervision not being in place continuously (1 patient was covid positive and therefore cubicle door closed, and 1 patient was in the toilet

unsupervised.) In order to address this an Enhanced Supervision Policy has been developed and implemented during September 2022. This will provide a formal assessment of patient's requirement for enhanced supervision and clearly outline the level of supervision needed.

An independent review (of VCC) of the VCC falls process has undertaken by the Senior Nurse, Professional Standards & Digital. Overall processes were identified as satisfactory with a small number of recommendations only being made to further enhanced fall scrutiny and prevention arrangements.

1.4 Pressure Ulcer Scruitny Panel

During the reporting period two patients developed a pressure ulcer in VCC. Both cases were discussed at Pressure Ulcer Scrutiny Panel.

A patient developed a Grade 1 to right buttock which was found to be unavoidable as the patient was at the end of life and the family asked for the patient not to be moved during last day of life.

A patient developed a suspected deep tissue injury to both ears which was found to be avoidable as there was no evidence of regular skin checks underneath the nasal cannula oxygen tubing. The identified learning from this case is that the nursing staff must regularly check the skin underneath medical devices, and the Pressure Ulcer Policy has been updated to include information about skin checks where there is a device in place.

1.5 National Reportable Incidents

There was one National Reportable Incident during the reporting period which related to a patient fall in the SACT department. The fall resulted in a fractured hip which needed surgery to treat. The patient is recovering well. As a result of this fall the SACT department are now educating all patients on ensuring they don't use the footrest as a step and to move the footrest before standing. The incident has been closed and no further actions requested by the Delivery Unit.

1.6 Early Warning Notifications

There are no Early Warning Notifications for the time period.

1.7 IRMER Compliance/ Issues/ Incidents

During the reporting period, 162 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 162 incidents reported, 121 were classed as radiotherapy errors / radiation incidents. 65 of which are under investigation by the radiotherapy department and have been coded in line with Towards Safer (TSRT) and 56 have been referred to Radiotherapy Physics for investigation

100% of radiation incidents were classed as minor radiation incidents (Level 3), near misses (Level 4), or other non-conformances (Level 5) for the 4-month period 1/3/2022 to 30/6/2022 which benchmarks well with the National report of 98.1%, reported in the UK Health Security Agency Safer Radiotherapy e-Bulletin #7 May 2022

1.7 Mortality

Mortality Reviews continue to be undertaken on all VCC inpatient deaths in line with WG guidance and Medical Examiner Regulations. For the period March to June 2022 there are no trends or concerns identified.

1.8 Mortality & Morbidity (M&M) Pilot

As reported in the last VCC report a M&M pilot has been established within the colorectal SST in the first instance to look at any deaths within 30 days SACT/ 30-day palliative radiotherapy/ 90 days radical radiotherapy. The focus of the meeting is primarily educational and to improve patient care. They will be delivered in a supportive and confidential manner. A formal report will be compiled outlining lessons learned and recommendations to support a potential further roll our across other SST sites.

1.9 Significant Clinical Incident Forum (SCIF)

Two forums have been held in this reporting period looking at Perceived delay in transfer of care to DGH and Management of hyperglycemia in VCC. The outcomes from these are detailed below:

Case discussed	Learning and actions
Perceived delay in transfer of care to DGH	• Disseminate to junior doctors the importance of AOS referrals at time of transferring patients. Let AOS know if they will need Patient at Risk Team (PART) review (renamed critical care outreach) • VCC currently working with UHW AOS to improve pathways through front door for cancer patients. • Disseminate importance of being clear about escalation plans, and to be made in a timely manner. Escalation plans should be transferred with patient Disseminate the importance of 5pm handover to clarify the

	plan for patients overnightTo share the improvement work done with OPD in the consultants meeting trialing ANP “outreach service”/ NEW >9 = 2222, teaching with OPD) • Grand round teaching on NIV to be organised • Discuss case at 9am handover
Management of hyperglycemia in VCC	•Blood glucose test to be on undertaken on all patients with pancreatic cancer in OPD pre each cycle of SACT. •OPD reviewing how to identify diabetic patients to ensure they have a blood glucose level prior to each cycle of SACT •All patients to have a blood glucose level before the 1st cycle of SACT •HHS and DKA policies to be reviewed as per review date indication •To organise training and education in HHS and DKA management in oncology Diabetes in Cancer CNS funding approved, recruitment will begin asap. Speedy cascade attachment **

1.10 COVID 19

On 30th March 2022, an outbreak of COVID-19 was declared on First Floor Ward in Velindre Cancer Centre involving 10 patients (2 confirmed as Community acquired). This outbreak was declared and managed in line with the All-Wales Infection Control and Prevention Standards and reported to Welsh Government. No breaches in standards were identified. The Outbreak closedown meeting will be held in September 2022 and a closure report produced.

Patient nosocomial assessments continue.

1.11 Safeguarding

Safeguarding and public protection training needs analysis has been completed to ensure the accurate monitoring of compliance with required safeguarding training.

There was the following Safeguarding activity for the reporting period:

- One safeguarding Datix was raised following a wellbeing concern.
- Four urgent applications for Deprivation Liberty Safeguards (DoLs) were made for First Floor Ward
- The ward accessed appropriate support and supervision regarding mental capacity act compliance.

1.12 Medical Gas Group

VCC Medical Gas Group meets twice per year. The following are to be noted:

- A plan is in place for medical gas training to be rolled out within SACT day-case, outpatients and radiotherapy during 2022
- Operational Services continue to undertake monthly stock take and expiry checks on medical gas cylinders within clinical areas.

1.13 Regulatory Inspections/external/internal audit

Radioactive op and waste source management compliance (open and waste source permit EPR/HB3393NP)

Velindre Cancer Centre is permitted to hold and dispose of opensource radioactive materials subject to the conditions specified in the Velindre Cancer Centre permit.

Clinical scientists conducted an audit, with the findings reviewed by the Radioactive Waste advisor. The audit included a review of waste documentations, visiting key areas within the department to assess practical compliance, in addition to reviewing waste figures.

A review of actions from the previous NRW inspection 3rd October 2019 was carried out and all actions were found to be completed at the time of the review.

The following actions were identified:

- It is recommended additional radiation protection supervisors are trained and appointed ASAP
- Add the following activity to the permit variation application: 26: Teaching including further and higher education and training
- Spill kit container to be sealed, with the review date displayed.
- It is recommended that a programme for the review of environmental monitoring results by the RPS is developed
- It is recommended that staff record all personal monitoring undertaken.
- It is recommended to provide tolerances for monitor QA, if not already derived within the associated process.

1,14 Compliance rates against PHW ‘Start Smart the Focus (SSTF) Indicators

Concerns had been raised by the Trust Infection Prevention & Control Management Group regarding VCC compliance against targets set by PHW relating to antimicrobial prescribing. It was recommended that VCC implement the ‘ARK’ project (to improve the use of antimicrobials in secondary care by changing the mindset of prescribers from continuing antibiotics unless you can justify stopping to stopping unless you can justify continuing). After several months and training and promotion the ARK charts were implemented in March 2021.

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Start Smart then Focus measures were compared pre and post ARK implementation and compliance rates for the 72hour review of antibiotic increased from 66.7% to 93.5%. There have been similar increases in the compliance rates of 'documentation of stop/ review dates' and the other 2 measures have maintained a high compliance (compliant with guidelines, and documented indication for treatment). Overall the implementation of ARK has been shown to significantly improve antimicrobial prescribing standards.

1.14 Risk Register

The Divisional risk register is monitored through the monthly Senior Leadership Team. Risks have been updated and have been fed into the Risk Report for September Quality, Safety & Performance committee.

2 EFFECTIVENESS

2.1 Claims

During the reporting period there were eight active claims relating to VCC:

Personal Injury		**Clinical Negligence**	
Slips trip fall	1	Alleged missed diagnosis	2
Defective equipment	2	Alleged misreporting	1
		Treatment complications	2

Thematic Data for Active Cases VCC as of 30th June 2022

- 2 denials of liability issued
- 1 reimbursement from WRP sought
- 2 remain under investigation
- 1 damages payment made in full and final settlement of the claim, costs awaited
- 1 amber referral issued by the WRP, evidence sought during the reporting period
- 1 case settled (all financial aspects of the claim), Case Management Record (CMR) in progress for submission to WRP

There were no new or reopened claims and no claims closed. Notification was received of two potential claims: one relating to an alleged delayed diagnosis and; one relating to a previous employer alleged contact with asbestos.

2.2 Redress Cases

The Trust opened a new Redress case during the reporting period following a complaint investigation. It relates to insufficient consent in respect of late side effects of the anti-cancer treatment they received.

2.3 Clinical Audit Summary

A clinical audit programme for 2022/23 has been established. The programme is prominently made up of key indicators of practice, NICE guidelines, patient experience, local concerns and national audits. There are currently 140 audits on the programme for 2022/2023;

- 28 audits have been completed
- 108 audits are in progress,
- 43 audits of which are continuous monitoring projects,
- 3 audits are on hold
- 1 audit has been discontinued

2.4 National Audits

Nationally the audit department ensures participation in all audits within the Welsh national cancer audit portfolio as cited in the NHS Wales National Clinical Audit and Outcome Review Plan. This currently includes audits in lung (LUCADA), gastric and oesophageal cancers (NOGCA), the national prostate cancer audit (NPCA) and the national audit of breast cancer in older patients (NABCOP) has commenced. VCC also submitted data for audits from NCEPOD (National Confidential Enquiry into Patient Outcome and Death) and RCR (Royal College of Radiographers).

2.5 Electronic Clinical Audit System

VUNHST Innovation team has recently a purchased a license to support a web-based Audit Management and Tracking tool to streamline all of auditing requirements (AMaT). The license is for a 2-year period; funded by HTW. A number of LHB's have purchased AMaT recently and are in the process of implementation. Training has commenced on the system. It is anticipated that implementation of this system will transform the Trusts clinical audit systems and processes.

2.6 Feedback from Audits

2.6.1 Consent re-audit: The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. There have been

improvements in a number of areas but there is still work to been done in order to achieve the standards. There has been an increase in the use of CRUK and RCR forms within the cancer centre, however consent form 1 is still being used in nearly half (45%) of cases. The results will be feedback to the consent task and finish group and an action plan will be developed.

2.6.2 ER Her2 misreporting re-audit: A re-audit was undertaken following an incident where by a patient was treated as having oestrogen receptor negative breast cancer (ER) on the basis of a negative ER result instead of positive (+). In total the records of 1145 patients were reviewed, and no error in treatment were identified. There were a small number of documentation errors, however, this did not impact on treatment. There has been asignificant improvement in the availability of source data within the Welsh Clinical Portal, principally the histopathology results for patients diagnosed through the screening service at Breast Test Wales. Post pandemic, increasing numbers of patients are being diagnosed with breast cancer in the Private sector, then subsequently treated in the NHS. These results are not available in any accessible portal and this is a potential risk. Currently results must be scanned into Canisc,

2.6 Velindre Cancer Centre Excelling

The following has been recognized:

- ***Tessa Jowell Centre of Excellence accreditation:***

At a special ceremony last Friday (1 July) in London, the Cardiff Neuro-oncology Centre, which comprises of University Hospital of Wales, Velindre Cancer Centre and Cardiff University, became the first in Wales to be awarded Tessa Jowell Centre of Excellence status.

- ***CNO Award***

During International Nurses Day VCC had a visit from the Chief Nursing Officer (CNO) for Wales, Sue Tranka to present Rachel James, Advanced Nurse Practitioner with a CNO Excellence Award - one of only 3 presented on International Nurses Day across Wales - for the outstanding work she had been leading on to improve the care to patients in particular in relation to Acute Kidney Injury.

- ***FAKTON Trial***

A breast cancer clinical trial led by Professor Rob Jones found women who have a common genetic abnormality in their cancers could expect to survive almost twice as long after being given capivasertib than those given the standard treatment alone. Professor Rob Jones presented the findings at the prestigious ASCO conference in Chicago and the research was published in the Lancet Oncology Journal.

- ***Moondance Cancer Awards winners***

On 16 June, Velindre Cancer Centre scooped three awards at the prestigious Moondance Cancer Awards.

  - Innovation in Early Detection & Diagnosis – *The SYMPLIFY Study*
  - Innovation in Treatment – *Virtual Assessment Patient pathway*
  - Workforce – *Acute oncology ANP workforce resilience framework*

3 SERVICE-USER CENTRED

Patient feedback is now being gathered using the digital system CIVICA which is being rolled out across VCC. CIVICA has recently been implemented in the Outpatients department, Radiotherapy, Assessment Unit, Ambulatory Care Unit (including the Patient Support Unit) and First Floor ward to capture Patient Reported Experience Measures (PREMS).

The feedback highlights are:

During The period March to June 2022 171 responses were received:

- 73.86% rated their overall experience excellent
- 92.75% of patients felt always listened to
- 92.09% felt well cared for
- 74.16% felt they understood what was happening in their care
- 84.09% felt they were involved as much as they wanted to be in decision about their care

The managers of all departments are reviewing the detailed survey results with their teams so that improvement actions are taken to improve the experiences of their patients.

3.1 Compliments

Compliments received are added to the Datix system and shared with staff via feedback boards in the clinical areas. During March, April, May and June 2022, 42 compliments were captured on the OfW Datix system. Further work is also required to ensure that all compliments received by the Cancer Service are recorded on the Datix system as this is a significant under representation of those received.

3.2 Concerns

In the period March to May 2022, 39 concerns were received. 28 were managed as an early resolution (resolved within 48 hours); 9 as putting things right (formal) and 2 were re-opened putting things right concerns.

Early Resolutions	Lessons Learnt/ Improvements
• 10 related to patients wait to start SACT • Unhappy with treatment in radiotherapy • x Communication issue with team • IPFR application refused • Unhappy treatment has been transferred to Royal Gwent • Visiting rules on First Floor ward • Lack of food and drink available for OP • Lack of communication by team • Delay in ophthalmology	• SACT ER's have been escalated to SLT • Radiotherapy have discussed issues with patient and provided additional support • Plan put in place with individual to include family member in all communication with clinical team • Ensure all staff know the most current visiting guidelines • SACT booking rules amended to consider time patients who require hospital transport are booked in • Develop a pathway for ophthalmology reviews for patients due to start genomic

Putting Things Right	Lessons Learnt/ Improvements

• Suspected missing patient property on FF • Unhappy with care and lack of follow up • Concern about incorrect treatment due to cancer relapse • Lack of communication with family • Lack of communication about blood results x 2 • Patient not fully consented for long term side effects of	• Update admission documentation to include an itemised property list • Formal process being developed for communicating SACT deferrals with patient • To fully adopt the Royal College of Radiotherapy and CRUK consent forms to consent for radiotherapy and SACT • Feedback to junior doctors and ward staff about communicating with family

Lessons learned

A number of themes from incidents and claims have been identified as listed below. Directorates are asked to consider these areas when developing improvement plans and taking forward key programmes of work.

- Appointments
- Staff attitude/behaviours
- Clincial services/assessments
- Communication (including language)
- Infeciton control
- Monitoring and observations
- Access to services and resources
- Test and investigaitons
- Patient care

4. TIMELINESS

4.1 Same Day Emergency Care (SDEC)

The expansion of Ambulatory Care and the Immunotherapy Toxicity Service Projects (funded by Welsh Government SDEC fund) continue to progress well. Recruitment for both services is well advanced, including the Lead nurse for Immunotherapy Toxicity service and the MDT coordinator now in post. This facilitated the extended opening of the ACU / PSU to include Sunday opening from 3rd July 2022.

The following progress has been made

- Regular progress reports are submitted to Welsh Government
- Internet page has been set up for each service.
- Good news stories have also been published including a video outlining the projects' plans and benefits.

- An Acuity tool has been implemented in the Assessment Unit with data now available.
- The newly appointed Head & Neck ANP has now completed induction and undergoing final competency sign off
- IV Access Service is being expanded to five days a week and a recent bid to Scrutiny has the service is hoping to appoint an additional IV Access Nurse to support the increase in demand
- An Ambulatory Care Co-ordinator is also being recruited to support the general increase in ambulatory care, including the PICC and ambulatory care service

4.2 Appointment of a Diabetic CNS

VCC is planning to recruit a Diabetic CNS to work as part of the Diabetology service and Prehab2Rehab optimisation programme in Cardiff & Vale UHB to support oncology patients who either have pre-existing diabetes or develop diabetes as a result of cancer treatment. This post has been secured as a result of a successful bid submitted to the Welsh Government Outpatients Transformation Fund

This is a joint appointment between VUNHST and C&VUHB. It is envisaged that the post will be based in University Hospital of Wales in-reaching into VCC.

4.3 Resuscitation Services

Ongoing work to review and improve resuscitation services, including:

- Regular reviews of 2222 calls and TEPs – registrar nominated to support with this work.
- Standardisation of resuscitation trolleys and new checklist to be introduced
- Protocols for Major / Terminal Haemorrhage being reviewed
- Review of training requirements for staff in radiology and radiotherapy
- Review of resuscitation policies and guidelines completed, including EMRTS SOP.
- Review of the Resuscitation Services SLA recently completed with positive feedback received from staff and also the SLA provider.

4.4 CNS Navigators

- Additional Navigator posts recruited to ensure support across all Site Specific Teams.
- A ‘duty Navigator’ role / system is being implemented within the CNS team. The role will be fulfilled by the existing Navigators and will ensure that all calls to the CNS team are answered and dealt with appropriately. It will also reduce calls to

other areas, e.g. medical secretaries when the CNS is not available.

5 EQUITY

5.1 Regional AOS

Work with the Regional AOS team is underway to develop a service for Cancers of Unknown Primary (CUP). A CUP CNS has recently been appointed to support the development of this service. It is also planned to recruit a CUP / AOS Oncology Co-ordinator to support this work and the wider AOS programme.

Work is also being progressed to improve virtual AOS at lunchtime meetings and also offer AOS support to local health boards during the morning handover meetings.

5.2 Verbal Orders in Prince Charles Hospital-Macmillan Outreach Clinic

An SOP has been devised for a safe and consistent procedure on how to manage 'verbal orders' in the outreach clinic for the administration of medicines only in exceptional or emergency circumstances when there is no prescriber available, and the medication required is not covered by a patient group directive (PGD). This ensures equitable and safe care for patients receiving SACT in Outreach clinics compared with the service patients receive within the SACT department in VCC.

5.3 Assurance/ Learning

There is one learning brief for this reporting period which is related to a historic incident which identified the need to streamline communication between the SACT Treatment Helpline and other organisations.

Improvement work has been undertaken as part of the SACT Treatment Helpline Review. Phase 1 has been completed, which included a SACT clinical lead to oversee the Treatment Helpline. Appointment of a Duty Navigator to work alongside nurse specialist to support patients who contact the CNS service during working hours, to signpost patients to the right place to organise practical help and provide emotional support. Development of a call flow model for switchboard staff/staff training and reassessment to signpost patients to appropriate key professionals/ department.

Phase 2 is currently being managed by SACT and MM Directorate. The South Wales Cancer Network are undertaking an All Wales review of SACT Treatment Helplines which will feed in to this piece of work

6. EFFICIENCY

VCC Performance

Referrals are expected to continue to increase as Health boards target their waiting lists. Regular operational meetings taking place with the three Health Boards we work with and these will enable us to gain a clearer picture of what the demand and referral numbers will be going forward, building on the work done previously to create data on the system wide referral pathways and patient numbers.

All patients are prioritised in line with Clinical prioritisation matrix developed by the Wales cancer Network.

Radiotherapy

Robust capacity planning has identified the level of capacity needed for the next 12 months. It is anticipated there will be an 8% increase in radiotherapy referrals by year end

The original plan for service capacity for June was to access short term support with capacity at Rutherford Cancer Centre This is now no longer an option and those patients are now being accommodated at VCC. This has exacerbated capacity problems

There is planned increase in capacity September 2022 with the further implementation of the breast contingency (Elekta option) in readiness for the LA6 replacement wider programme which is due to commence October 2022

SACT

We have continued to see increased pressures on the capacity available to deliver SACT treatment as a result of increased referrals, sickness and vacancies. Detailed capacity planning has identified the requirement for a 12% increase parental SACT in year to meet demand. The demand for oral SACT has increased circa 30%.

The following actions have been taken:

- A taskforce has been established to identify short to medium term options to address shortfall in capacity
- Additional weekend clinics due to commence August. Utilisation of clinical trials unit to deliver SACT treatments
- Increased use of ambulatory care and outpatient treatment areas to deliver injectable or short regimens

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (July 2022)

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			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page xx)	Actual	96%	97%	96%	92%	78%	92%	92%	92%	87%	92%	83%	72%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page xx)	Actual	82%	82%	82%	74%	84%	90%	90%	81%	79%	81%	83%	83%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page xx)	Actual	100%	97%	100%	85%	89%	100%	93%	88%	84%	88%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page xx)	Actual	99%	98%	99%	99%	99%	94%	91%	71%	69%	61%	58%	66%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page xx)	Actual	100%	100%	100%	86%	100%	100%	100%	83%	100%	100%	86%	100%
		Target	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%	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%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

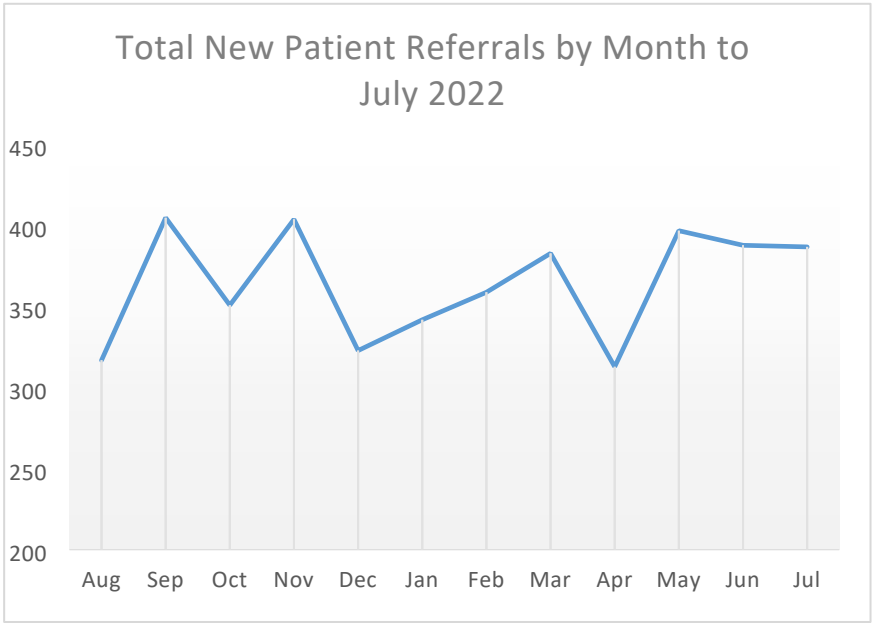
			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
	Did Not Attend (DNA) Rates	Actual	5%	5%	5%	5%	3%	3%	3%	3%	3%	3%	3%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page xx)	Actual (Dietetics)	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%
		Actual (Physiotherapy)	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%
		Actual (Speech and Language Therapy)	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%

			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%
		Actual (Speech and Language Therapy)	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page xx)	Actual	2	1	1	0	1	0	1	1	0	0	1	0
		Target	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
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page xx)	Actual (Total)	4	2	3	1	4	3	2	9	4	1	1	2
		Unavoidable	4	1	3	1	4	2	2	9	3	0	1	2
		Avoidable	0	1	0	0	0	1	0	0	1	1	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	1	0	4	0	0	1	4	1	1	0	0	0

			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
		Target	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
		Target	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 (page xx)	Actual	100%	75%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page xx)	Actual	0	0	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (E.Coli bacteremia)
		Target	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%
		Target	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

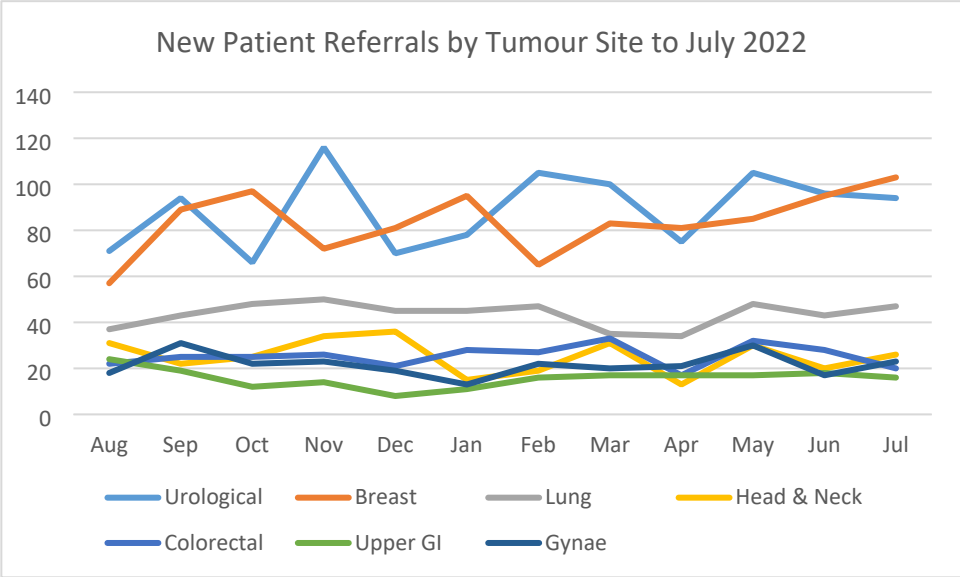


Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (July 2022)
315	364	387

The total number of referrals received in July 2022 (387) was marginally lower than those received in June 2022 (388). The number of referrals remains high compared to the average number received, during 2020-21 and 2021-22.

Radiotherapy – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patients (July 2022)
Breast	**88**	**60**	**84**	**29%**	103
Urology	**82**	**82**	**89**	**8%**	94
Lung	**47**	**38**	**44**	**14%**	47
Colorectal	**20**	**22**	**25**	**12%**	20
Head and Neck	**23**	**23**	**25**	**8%**	26
Gynaecological	**18**	**18**	**22**	**18%**	23
Upper Gastrointestinal	**16**	**13**	**16**	**19%**	16
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**	**82%**		**84%**

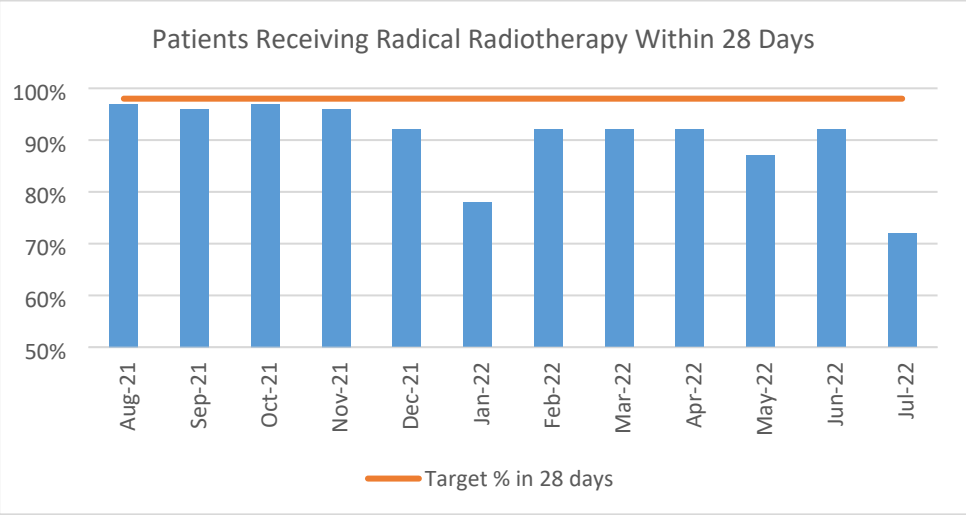
The graph and table show the number of patients scheduled to begin treatment in July by the tumour sites most commonly referred for radiotherapy treatment.

- Referrals overall have returned to pre-covid levels and across some tumour sites, (Breast, Urology, Colorectal) they now exceed Pre Covid levels.
- Breast referral increases are a significant service challenge.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by Site Specialist Teams (SST's) to meet short term surges and to respond to health board backlog clearance.

Patients Receiving Radical Radiotherapy Within 28-Days

Target: 98% | **SLT Lead: Radiotherapy Services Manager**

Trend



Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (July 2022)
Radical	177	183	197
	Patients Scheduled to Begin Treatment (July 2020)	Patients Scheduled to Begin Treatment (July 2021)	
	140	229	

Current Performance

197 patients were referred for treatment with radical intent. 55 did not begin treatment within 28-days (performance rate of 72%).

Breakdown of breach length of waits and Reasons:

Treatment Intent	< 35 days	< 40 days	< 45 days	< 50 days	> 50 days
Radical (28-day target)	37	4	5	3	6

38 as a result of Linac capacity (Breast) (all patients prioritised to minimise clinical significance)
2 booking process failure as a result of booking capacity,
7 orthovoltage (DXR) capacity,
3 rescan/ replan required,
4 were as a result of pre-treatment breast planning capacity,
1 due to the consultant requesting treatment to commence on a Monday.

We have maintained the position of over 90% of patients treated in July within 35 days (179 of 197).

Outsourcing of RT for Breast and prostate patients to RCC ceased - all RCC patients repatriated to VCC which has increased demand-maximising capacity options under revision.

Opportunities for improvement
Escalation process continues to monitor predicted breaches and prevents breaches where possible through weekly capacity meeting
Delays and cancellations monitored weekly and reported back to RMG and the pathway sub group

	Areas of risk: Breast capacity- loss of RCC outsourcing and increased Breast referral- has resulted in escalation process being implemented for breast referrals, all potential breaches are reviewed for clinical harm and prioritised accordingly. A revised demand and capacity structure has been established to ensure demand is fully understood and its implications in different tumour sites and all options for increasing capacity and maximising use of our capacity are explored and secured. One area of work us to focus on DNA's and patients who become too ill to attend. Capacity losses due to both these areas are not fully understood and discussions underway with clinical teams to review protocols in place and minimise lost capacity. **Short term actions:** • Gradual increase in LINAC capacity by 8% is planned from Mid-July onwards. Work being undertaken within the Directorate to extend working days and gradual increase utilisation of LINAC capacity from 73.5 planned hours in June to 79.5 planned hours in October. 75 hrs delivered in July. This is reliant on new staff commencing in post in October and identifying sufficient treatment planning capacity. Risks remain however to provide specific Brachytherapy capacity and Medical Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown. • Fleet configuration changes to support Breast patient treatment options in progress. • DXR capacity to be extended by 1.5 hrs per day subject to appointment of advanced practitioner.

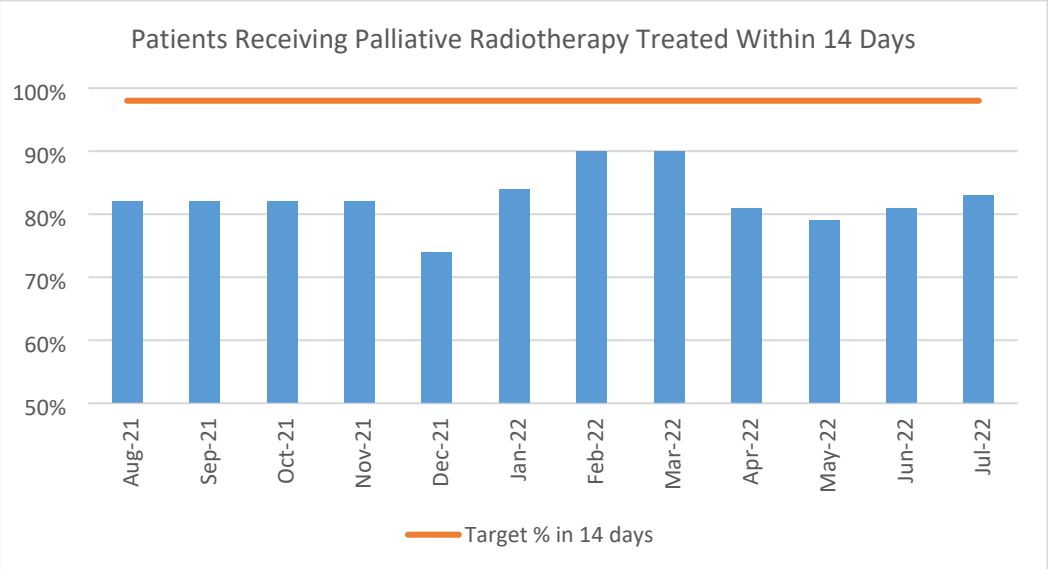
	• Treatment planning taskforce established to identify opportunities to release non-medical treatment planning. • Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.
	Medium Term Actions
	• We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy. • Recruitment and appointments in progress for additional front-line resources. However, this will not create capacity increases until Q3/4 of 2022 due to lead in time.

Patients Receiving Palliative Radiotherapy Within 14-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin palliative radiotherapy treatment in June 2022 (88) was above the monthly average observed in 2021-22 (71) and was higher than the number scheduled to begin treatment in May (84).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (July 2022)
Palliative	99	87	102
	Patients Scheduled to Begin Treatment (July 2020)	Patients Scheduled to Begin Treatment (July 2021)	
	116	105	

Current Performance

102 patients were referred for treatment with palliative intent. 17 did not begin treatment within 14-days (performance rate of 83%). Of these 17 patients:

Breakdown of breach length of wait and reason:

Treatment Intent	15- 20 days	21-25 days	26- 31 days
Palliative (14-day target)	9	4	4

Palliative breach data- 17 breaches on validation-
13 as a result of requiring a complex 3D plan all were treated within the locally agreed timeframe which is in compliance with the Wales time to radiotherapy metrics (COSC).
1 was as a result of capacity on orthovoltage,
1 was as a result of consultant requested treatment start dates due to complexity of plan,
1 was as a result of a rescan, and
1 was as a result of change of intent

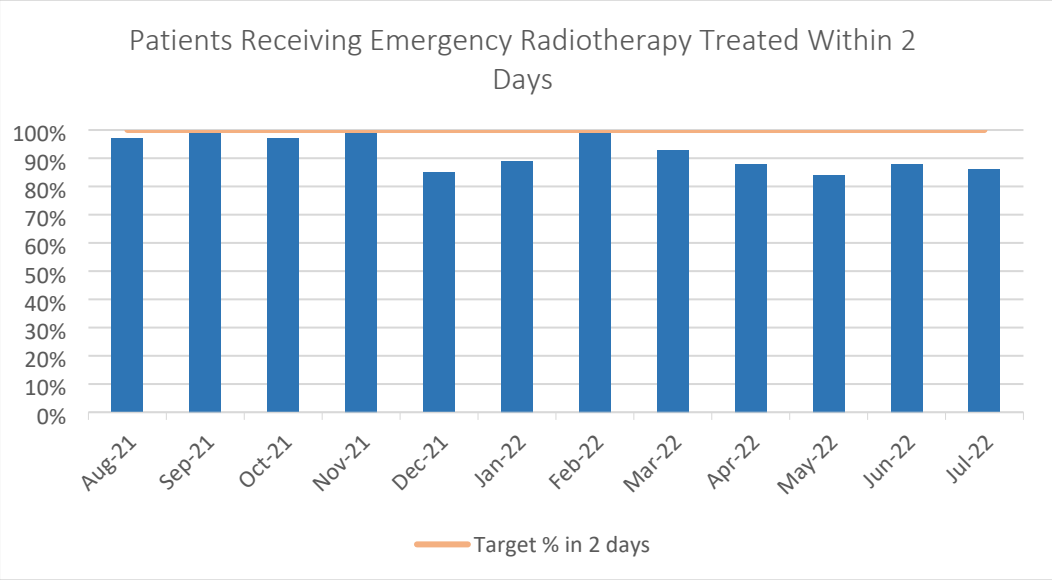
As a result of breaches primarily reflecting issues in areas of patient pathway not necessarily Linac capacity, a taskforce has been established to target the areas where there are process variation. This taskforce commenced in August 2022.

Medium Term Actions

Refer to 28 day medium term actions.

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 June 2022 (25) was fewer than the number scheduled to begin treatment in the previous month (17).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (July 2022)
Emergency	29	24	21
	Patients Scheduled to Begin Treatment (July 2020)	Patients Scheduled to Begin Treatment (July 2021)	
	28	32	

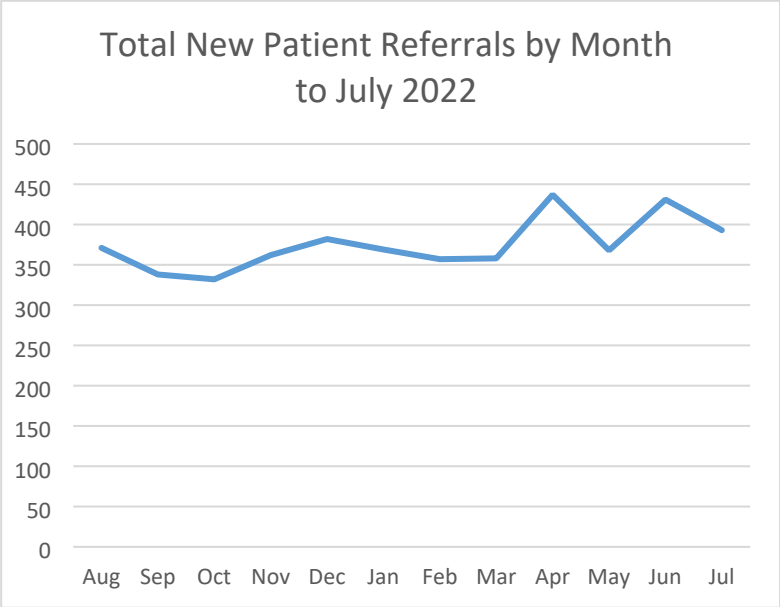
21 patients were referred for emergency treatment. 3 did not receive treatment within 2-days of referral for emergency radiotherapy treatment (performance 86%).
Of these 3 patients:
1 was treated within 3 days, 1 treated within 4 days and 1 treated within 6 days.

1 as a result of the patient requiring assessment prior to treatment,
1 as a result of pre-treatment capacity (Covid absence for out of hours service), and
1 due to change of intent from palliative to emergency- treated on the same day

Action:

Service capacity challenges across all services are causing a number of breaches that are not specifically due to radiation services capacity. As a result, further active engagement of the Site Specific Team (SST) leadership in monitoring and responding to capacity and planning to avoid breaches is being undertaken.

SACT Referral Trends - Overall



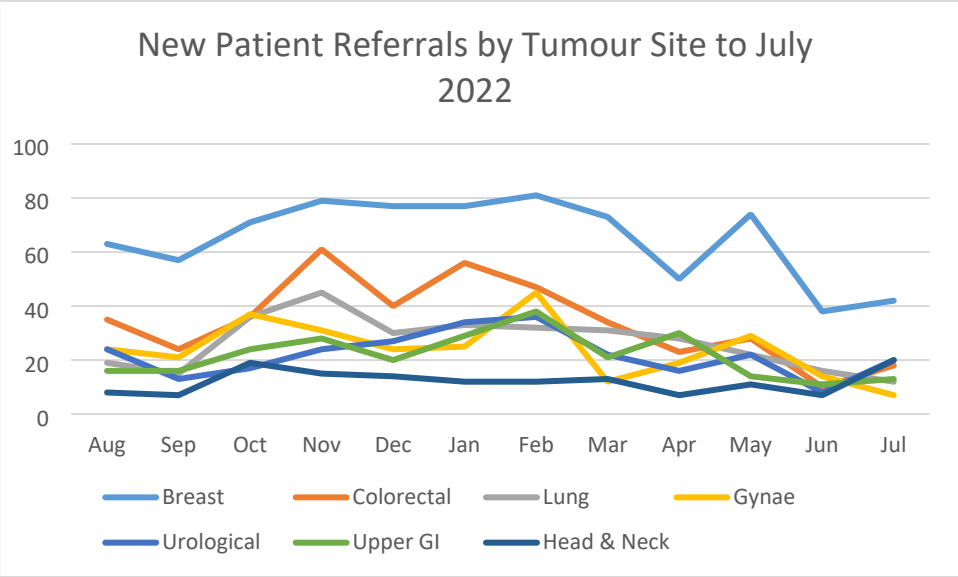
Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (July 2022)
300	345	389

The total number of SACT referrals received in July 2022 (389) was greater than the average number received in any given month during 2021-22 (345), but was less than the total received in June 2022 (393).

Increased cycles of treatment per patient is a major factor driving SACT demand, compared to the rate of new patient referrals, which has not increased significantly from pre covid levels to date across the board.

There are a few exceptions such as Breast, where patients requiring neo adjuvant treatment are increasing. This group of patients requires timely treatment pre surgery within 14 days, much shorter than the overall 21 day wait and this places increasing pressure on the service at the moment. We are currently managing 67% of these patients to treatment within 14 days. (Up from 60% in June 2022.)

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patient Referrals (July 2022)
Breast	**92**	**76**	**90**	**+16%**	42
Colorectal	**54**	**55**	**50**	**-10%**	18
Lung	**33**	**32**	**38**	**+16%**	20
Gynaecological	**31**	**31**	**30**	**-3%**	12
Urological	**36**	**26**	**27**	**+4%**	20
Upper Gastrointestinal	**18**	**26**	**30**	**+14%**	13
Head and Neck	**16**	**14**	**13**	**-8%**	7
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**	**89%**		**88%**

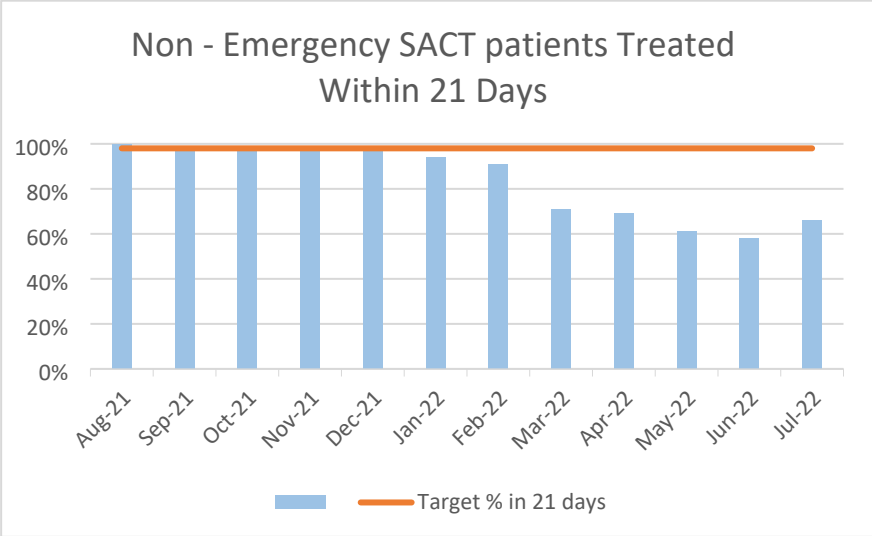
The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98% | **SLT Lead: Chief Pharmacist**

Current Performance



The number of patients scheduled to begin non-emergency SACT treatment in July 2022 (389) was higher than the number in June (355).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (July 2022)
Non -	299	345	389

Trend

Of 389 patients treated, 134 patients waited over 21 days = performance of 66%.

Intent / Days -	22-28	29-35	36-42	43-49	50-56	57-59
Non-emergency (21-day target)	33	47	22	20	11	1

The longest wait experienced by any patient to begin treatment was 59-days. The length of wait is also reducing overall with 60% of breaches in July within 35 days (80 0f 134) compared to only 37% in June (55 of 147).

This is the first month since December 2021 where performance has improved from the previous month, arresting a 7 month decline. Breach numbers have also reduced to 134 in July from 147 in June and 158 in May.

Shortage of capacity in the service to deliver the volume of referral increase is the reason for the number of patient breaches. Plans are in place as outlined below to address the capacity challenge.

All patients within a Clinical Trial are booked within the trial timeframes.

Due to current capacity constraints within the SACT & Medicines Management team, all new patients and urgent patients are prioritised

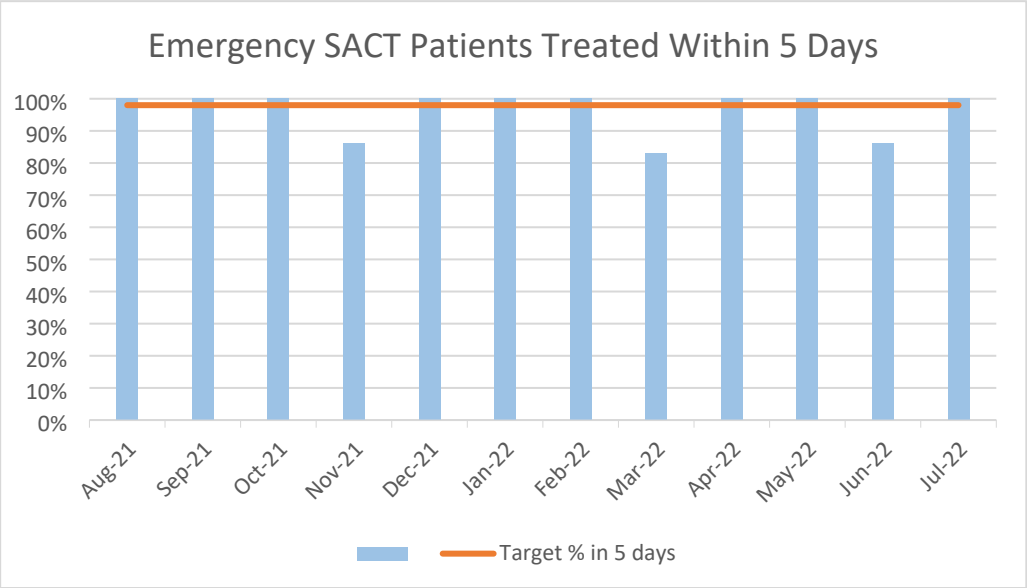
emergency	Patients Scheduled to Begin Treatment (July 2020)	Patients Scheduled to Begin Treatment (July 2021)	
	279	383	

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.

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. This will be concluded in early September.

Short Term Actions

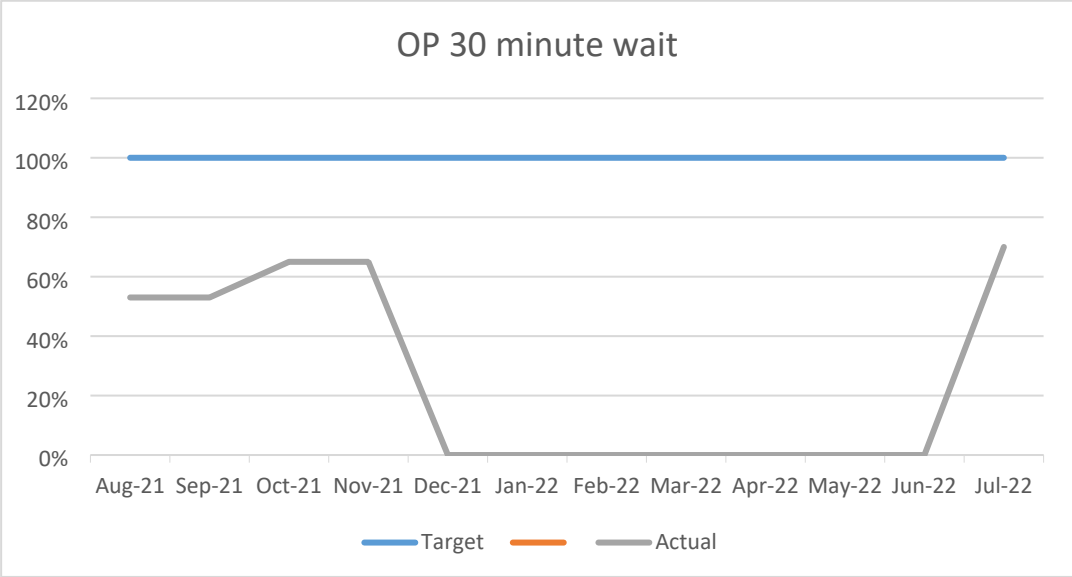
- SACT taskforce established (June 2022) and activity plan developed which includes weekend clinics from August and plans to expand capacity at PCH from October.
- Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision.
- Additional capacity for new patients sourced from RD&I (8 attendances per week)
- Modelling work of booking clerks has been completed and similar work will take place for nursing and pharmacy to ensure that staffing is available to support additional clinics and maximising throughput.
- Ongoing management within the week is supported by mutual aid from other parts of the centre
- 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.
- Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend
	5 patients referred for emergency SACT treatment were scheduled to begin treatment in July 2022. All were treated in target with 100% performance.
The number of patients scheduled to begin emergency SACT treatment in July 2022 (5) was lower than in June (7).	Actions
	• Continue to balance demand and ring fencing with capacity.

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (July 2022)
Emergency	4	5	5

	Patients Scheduled to Begin Treatment (July 2020)	Patients Scheduled to Begin Treatment (July 2021)	
		10	

Outpatient 30 minute wait

Target: 100%	**SLT Lead: Outpatient Manager**
Current Performance	Trend
 Performance reported for July 2022 was 70%. Note: This is based on a sample size of 2% of the total number of patients seen at outpatients in July. (208 of 9412 patients)	Performance was the highest reported in the last twelve months. Monitoring of indicator reinstated but remains limited as only a snapshot of clinics at particular times. 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.

Reporting had been paused between December 2021 and June 2022 over concerns regarding the representativeness of the sample size and ongoing discussions to move the data collection to an integral part of outpatient processes. These discussions have not produced a sustainable solution to date.	

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

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

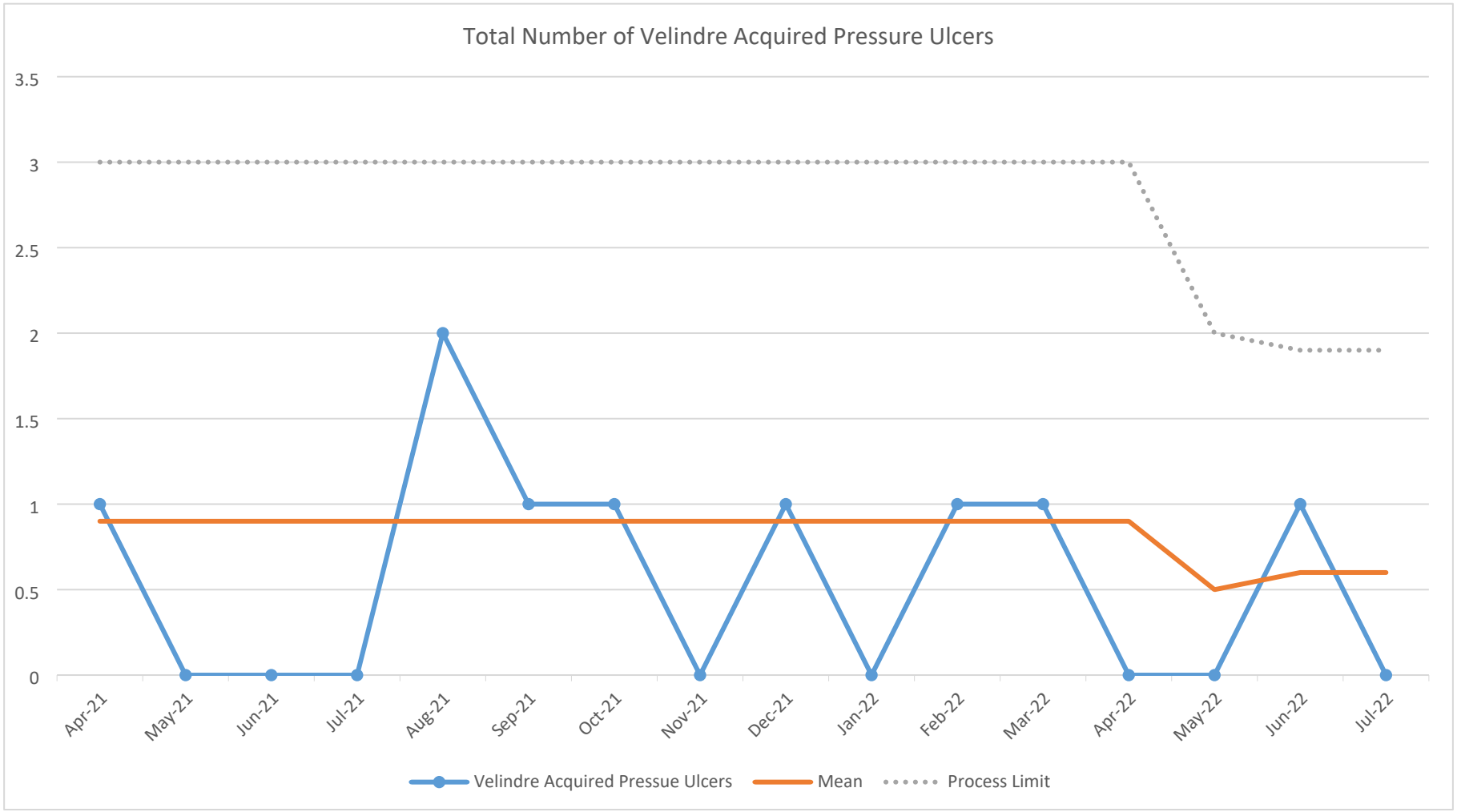
	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Dietetics	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%
OT	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%
SLT	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%

Therapies had the following breaches: • OT routine outpatients x 1 patient breach. 9 day delay, seen on day 39. Communication oversight within the team. • SLT routine outpatients x 1 patient breach. 4 day delay, seen on day 34. Communication oversight within the team.	Actions: Review processes for communication regarding appointments.

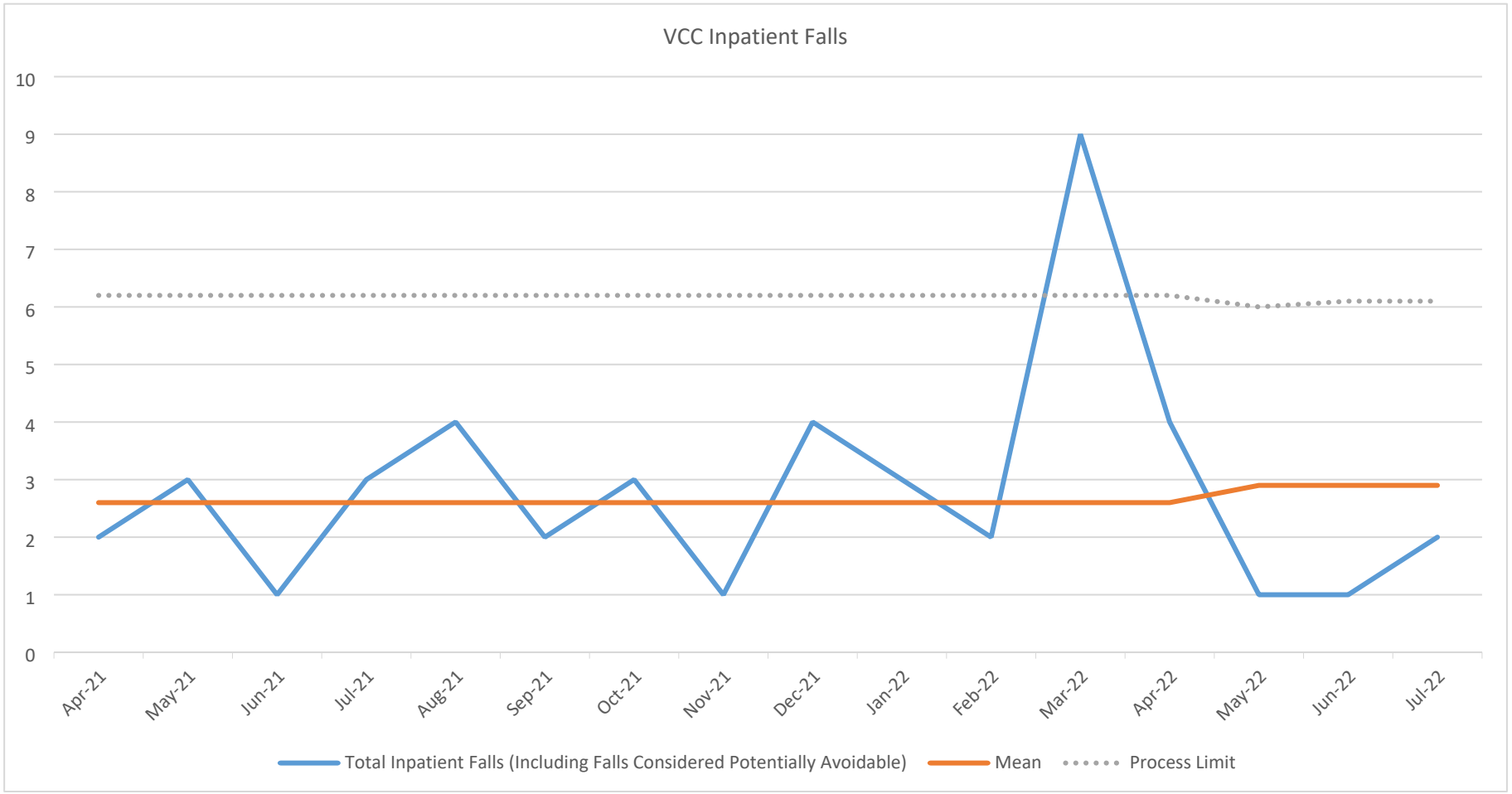
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	May-21	Jun-21	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
Velindre Acquired Pressure Ulcers (Total)	1	0	0	0	2	1	1	0	1	0	1	1	0	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0

Trend	Action
• During July 2022, there were 0 Velindre acquired pressure ulcers on first floor ward.	No specific action in month

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



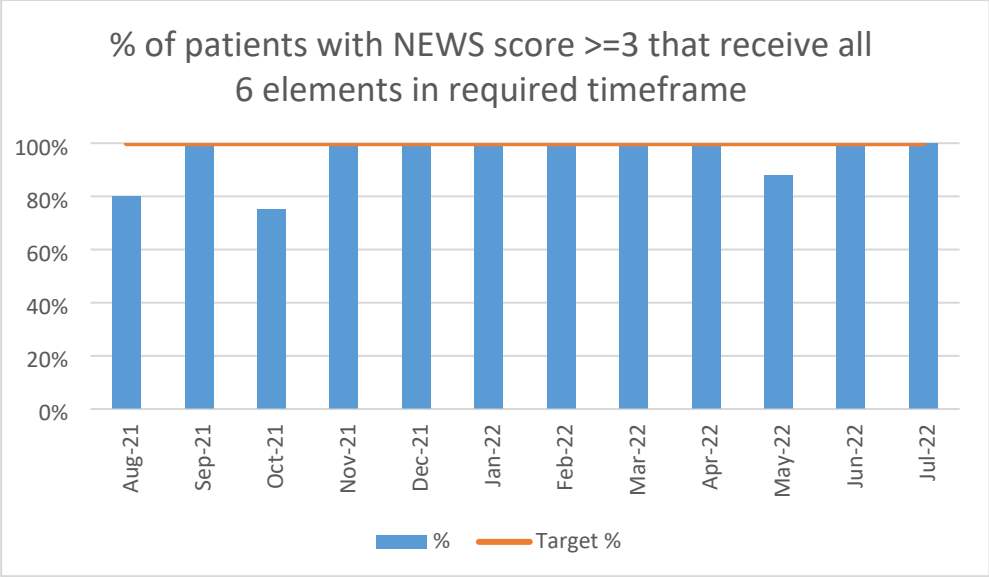
	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov - 21	Dec - 21	Jan - 22	Feb - 22	Mar - 22	Apr - 22	May - 22	Jun - 22	Jul - 22
Total Inpatient Falls	3	1	3	4	2	3	1	4	3	2	9	4	1	1	2
Potentially Avoidable Inpatient Falls	0	0	0	0	1	0	0	0	1	0	0	1	1	0	2

Trend	Action
Patient A – Falls risk assessment completed on admission and the patient was identified as a risk of falls. Patient did not have any cognitive impairment therefore deemed to have capacity. Patient mobilised without calling for assistance. Falls care pathway commenced. No injury sustained. Notably neuro observations were ceased on medical advice out with policy and this has been taken forward as a learning action for reinforcement of policy. **Outcome of scrutiny panel review: UNAVOIDABLE** because patient had capacity and attempted by himself to get out of bed and did not use the call bell that was available to him. Patient B - Falls risk assessment completed on admission and patient deemed at risk of fall due to a previous syncopal episode on the ward. Call bell was in reach but not used by patient. **Outcome from the scrutiny panel review: UNAVOIDABLE** because the patient got up without assistance and did not use the call bell to hand.	**Learning:** • Staff to continue neuro observations as per falls policy regardless if medical staff suggest discontinuing early. • Further, work to investigate if there is a correlation between falls when patients get out of bed and no longer using slipper socks (All Wales decision to stop using slipper socks). The outcome of this work will be reported back to the falls scrutiny panel. •

Delayed Transfer of Care

Target: 0	SLT Lead: Head of Nursing
Current Performance	
No Delayed Transfers of Care (DToC) were reported in July 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:
= 14 patients met criteria for response to sepsis and all 14 received antibiotics within 1 hour where appropriate = 100%

Measure 24 - % of patients who receive diagnosis of sepsis & all 6 elements within 1 hour
= 6 patient received diagnosis of sepsis all 6 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

No improvement actions required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**
Current Performance	

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
C.diff	1	0	0	0	0	1	0	1	0	0	0	0
MRSA	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
E.coli bacteremia	0	0	0	0	0	0	0	0	0	0	0	1
Klebsiella	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

Trend	Action
There was 1 reported E.coli bacteremia in July 2022. The root cause analysis and review by MDT identified it as bowel source probable malignant translocation.	No specific action required.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Velindre Cancer Service (VCS)
Demand and Capacity Update for Radiotherapy and SACT

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	LISA MILLER/WAYNE JENKINS
PRESENTED BY	Rachel Hennessy, Acting Director
SMT 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**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
VCC	Velindre Cancer Centre
SACT	Systemic Anti-Cancer Therapy

RCC	Rutherford Cancer Centre
DHCR	Digital Health and Care Record

1. SITUATION

1.1 Waiting times for patients obtaining a cancer diagnosis and receiving cancer treatment have been increasing across all Health Boards and Trusts in Wales as recovery from the COVID-19 Pandemic continues and recovery plans to reduce the backlog of patients are being delivered.

1.2 The Cancer Service has faced challenges in delivering timely SACT and radiotherapy treatments which have been impacted by limitations in capacity, growth and variation in demand, particularly following the loss of the opportunity to use the Rutherford Cancer Centre which had been a key part of the plan for the year. This has resulted in increases in waiting times for patients

2. BACKGROUND

2.1 Radiotherapy

Wales Cancer Network and Cancer Research UK have forecast an increase in demand for Radiotherapy services of 8% by the end of March 2023 from outturn at the end of March 2022. In year to July 2022, referrals for radiotherapy are up by 3%.Demand into the radiotherapy service has been fairly consistent in quarter 1 and 2 of 2022 at circa 97% of 2019/20 levels for the same period.

Capacity restrictions have been experienced as a result of increased sickness absence rates and the need for the newly qualified staff to take up the hard to fill specialist posts. Discussions are currently ongoing with HEIW in relation to understanding the number of vacancies, which will be filled from the new cohort of qualified student in September 2022. It is anticipated that there will remain a number of vacant post but this is under discussion and a clear picture should be available by the end of September. The service continues to use long-term agency staff in specialist areas to support capacity across pre-treatment, radiotherapy physics planning and treatment delivery. We are undertaking a recruitment campaign on an ongoing basis for the specialist post, but there are national shortages in these roles.

A Task and Finish group is focusing on improving patient flows and improving efficiency through new ways of working such as extended days and reviewing existing pathways, which should lead to increased capacity.

Increase in Breast Referrals

Within the overall position there has been a higher than anticipated increase in demand in breast referrals as a result of additional surgical treatment for breast cancer patients. As the number of referrals to VCC varies depending on the additional work being undertake this has led to increased pressure on radiotherapy.

This increase in demand for radiotherapy services for breast patients has coincided with the loss of additional capacity, which had been contracted from the Rutherford Cancer Centre (RCC) for breast treatment this financial year. This activity was lost as a result of the company going into administration in June 2022.

Constraints on Linac capacity for the relevant machines and treatment planning capacity to manage breast patients at VCC has also had an impact on breast cancer treatments, which in turn has impacted on the overall waiting times.

2.2 SACT

Wales Cancer Network and Cancer Research UK have forecast an increase in demand for SACT services of 12% by the end of March 2023 from outturn at the end of March 2022. Referrals for SACT have increased by 2% in year up to end of July.

Demand into the SACT service has been growing consistently and in quarter 1 and 2 of 2022 was at circa 108% of 2019/20 levels for the same period. The demand for oral SACT has increased circa 30% since 2019/20.This has presented significant challenges within the service to manage demand with the limits of its capacity.

A multi-disciplinary task and finish group has been working on a revised plan for the year to increase available capacity and compensate for the planned utilization of the Rutherford Cancer Centre. The task and finish group has been focused on building increased capacity at VCC and in outreach units whilst also continuing to work on improving efficiency through reviewing working practices and utilising other areas within VCC to deliver SACT treatments.

3.0 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Radiotherapy Recovery Plan

Following the loss of the capacity, which was planned to be delivered in the Rutherford Cancer Centre, there has been a focus on developing a revised capacity plan to address the immediate future. The immediate changes which have been implemented are as follows:

- In order to increase activity within Radiotherapy, a phased extension of working hours of the LINAC has been taking place. This commenced in July and is due to reach maximum capacity in September/October 2022. However delivery of this model is subject to identifying additional treatment planning capacity and the recruitment of newly qualified trainees in September 2022

In addition the Task and finish group has been reviewing pathway issues where particular bottlenecks can be improved on to improve flow where planning may not be ready on time or where rescan or re-planning is required.

3.3 Impact of Initiatives on waiting times

Initial modelling identified that with extended working days, which supports increased activity on the LINAC machines, waiting time breaches should be minimized and mitigated from October 2022. The extended working days are being supported by staff working additional hours and temporary changes to working patterns (e.g. part time staff moving to full time on a temporary basis). The ability to deliver the extended hours by October 2022 is reliant on the contingent of newly qualified students being secured in to the vacancies during the month of September. As discussed earlier discussions are ongoing with HEIW to understand our allocation and it will be possible to provide more detail in the November Committee meeting.

However, further work is being developed to model the impact of both the implementation of the Digital Health and Care Record in November and the planned Linac replacement programme in the New Year and consider options for meeting demand and the Committee will be updated at its next meeting

3.4 Risks to recovery plan

- Delivery of extended working days and utilization of the LINAC capacity is subject to recruitment and identification of treatment planning capacity and recruitment to key posts by the end of September 2022.

4. SACT Recovery Plan

Detailed capacity planning has identified the requirement for a 12% increase in non-oral SACT treatment over the year to meet demand.

The work of the task and finish group has focused on delivering the following changes which will increase capacity:

	Action	Start Date
1.	Review of booking capacity, practices and processes, which concluded 20th July 2022	6th July 2022
2.	Utilisation of clinical trials unit to deliver SACT treatments on a regular basis	1st August 2022
3.	Increased use of ambulatory care and outpatient treatment areas to deliver injectable or short regimens	29th August 2022
4.	Establishing Saturday clinics to increase capacity which are planned to be in place until 29th October whilst other capacity is established.	6th August 2022
5.	Changes to to the way in which presciptions are issued. This will release pharmacy staff to support additional SACT activity.	8th August 2022
6.	An increase from 5 to 10 chairs in Prince Charles Hospital (PCH).	October 2022 (exact date to be confirmed)

Note: Actions 1 to 5 have been fully implemented at the identified date.

4.1 Impact of Initiatives on waiting times

The initiatives introduced to date have had a positive impact on reducing the number of patients waiting longer than 21 days for patients waiting for non-emergency SACT. However, it is anticipated that re-instating the ten chairs at Prince Charles Hospital in October 2022 will provide the additional capacity needed to address the remaining backlog and ensure that patients will be seen within the required 21 days on a sustainable basis given current forecast demand.

4.2 Risks to Delivery of Recovery Model

- The ability to support the increase in chairs in Prince Charles Hospital is reliant on the newly appointed nursing being fully trained and introduction of the Organisational Change Process (OCP) undertaken in pharmacy.

- There are four nurses in total of which one has started, two will be in post by the 26th September, and the fourth will start in October. A training needs analysis will be undertaken as it is understood that they have previous experience and therefore training needs to be adapted appropriately. The nursing review will also be concluded by end of September. Together we will have a clear picture of the workforce available to support PCH

  The Pharmacy OCP concluded in September. Implementation of the OCP will change the working patterns of pharmacy staff (to routinely include Saturday and bank holidays and longer working days), which will support the proposed increase in treatments as part of this development. This should be fully implemented by the end of September 2022.

4.3 Next steps

There is ongoing work to further develop a sustainable SACT service for patients referred to the Velindre Cancer Service. This includes:

- Review being undertaken of nursing workforce capacity
- Pharmacy capacity review due to commence September 2022
- Further discussions have been held with Aneurin Bevan University Health Board and Neville Hall Hospital representatives to plan a return to that unit. These proposals are being developed at present.
- Review to determine which treatments can only be undertaken in the SACT assessment unit and which treatments can be undertaken elsewhere due to the fact they are less complex or are not a first treatment in which case they can attend the service provided in the Tenovus bus.

5.0 IMPACT ASSESSMENT

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

RELATED HEALTHCARE STANDARD	Timely Care Safe care Staff and Resources Individual care Effective care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

6.0 RECOMMENDATION

The Committee is asked to:

- **NOTE** the developments established in respect of SACT and radiotherapy waiting times capacity and the planned impact of these plans on waiting times.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

MEDICAL EDUCATION GOVERNANCE REPORT

DATE OF MEETING	15/09/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Dr Louise Hanna, Associate Medical Director of Medical Education
PRESENTED BY	Dr Louise Hanna, Associate Medical Director of Medical Education
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

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	01/09/2022	NOTED

ACRONYMS	
GMC	General Medical Council
HEIW	Health Education and Improvement Wales
WBS	Welsh Blood Service
VCC	Velindre Cancer Centre

1. SITUATION

This paper is provided to the Quality, Safety and Performance Committee to provide **ASSURANCE** to the governance relating to Medical Education activities including assurance in relation to progress made since the last update was provided and the priorities and plans for the next year.

This is the First Annual Report for Medical Education Governance for the whole Trust covering WBS & VCC) for the reporting period July 2020 to August 2022 and covers and includes the 2021 and 2022 GMC Survey Results 2021 and 2022.

2. BACKGROUND

The last report was submitted in July 2020 which only focussed on VCC, as this is the only area of the Trust that had been reported previously. Subsequent reporting has been delayed due to the impact of the COVID-19 pandemic. However, the 2021 GMC survey results were analysed and circulated/discussed among the training team. It is anticipated that this will now revert to an annual reporting cycle.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

This report summarises the key activities and performance undertaken by the Medical Education Board from July 2020 to August 2022, and highlights some of the key issues that will progress over the next 12 months and beyond.

2.1 Notable Highlights for this reporting period:

The 2022 GMC Survey

- A large number of 'above outlier' green flags with good response rate signifying engagement
- No patient safety concerns are raised or any bullying or undermining concerns

Undergraduate commissioning visit: Many areas of positive feedback are reported with no areas for escalation.

Postgraduate commissioning visit: No areas for escalation at the time of the visit, May 2022

2.2 Notable concerns for this reporting period:

The 2022 GMC Survey

- Inadequate time for training reported by Clinical and Medical Oncology consultants - As a consequence of this Medical Oncology Trainers are now on

the HEIW risk register for Overall Satisfaction, Time and Training Resources, and Support and Appraisal.

2.3 Priorities for the next period

An action plan is being developed to address the areas of concern raised around time for training and to address the HEIW risk register and will be implemented in 6 months

Important changes will take place in Medical Education occurring in 2022 and beyond. These include:

- Transforming Cancer Services and review of Acute Oncology Service Provision
- Proposed construction of a new Velindre Cancer Centre
- Move to single lead employer
- Need for excellence in medical education despite workforce and capacity pressures compounded by pandemic
- Continued need to recruit to support the service

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	GMC standards for medical education and training
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The GMC standards are the legal framework for standards in medical education (both undergraduate and postgraduate)
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 Medical Educational Governance Report.

Medical Educational Governance Report
July 2020 - August 2022

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Acronyms

GMC	General Medical Council
HEIW	Health Education and Improvement Wales

Purpose of Document

To report to the Velindre Quality and Safety Committee on Medical Education within Velindre University NHS Trust. This is the fifth report.

The original purpose of the document was to report on the state of medical education in Velindre with respect to the 2016 GMC standards for training. These standards refer specifically to curriculum-based learning and assessments for medical students and doctors on training programmes, such as the training and education that is commissioned by Health Education and Improvement Wales (postgraduate) and Cardiff University (undergraduate). This remains the primary aim of the document, however the scope of the document is now broadened to include other aspects of medical education not necessarily linked to commissioned training programmes.

The most recent report was submitted in July 2020. Submission of a further report was due in 2021 and was delayed due to the COVID-19 pandemic, however the 2021 GMC survey results were analysed and circulated/discussed among the training team. The scope of this report will therefore cover from July 2020 to August 2022. It is planned that future reports will run in full years.

Background

In 2015 the General Medical Council published new standards for medical education and training that incorporated both undergraduate and postgraduate training and included a requirement that educational and clinical governance systems are integrated.[1] These standards came into effect on 1st January 2016. In response, the Velindre NHS Trust Medical Educational Governance Framework was written that includes the requirement of an annual report to be submitted by the Medical Education Board to the Safety, Quality and Performance Committee on the state of medical education within Velindre.[2] The report should include:

- Results of surveys (undergraduate, postgraduate, trainer), with particular focus on any areas of exception (positive or negative)
- Any items relating to Velindre NHS Trust that appear on the Health Education and Improvement Wales (HEIW) Risk Register
- Any other points considered important to highlight

[1] 2015. Promoting excellence: standards for medical education and training. GMC.
[2] 2016. Medical Educational Governance Framework. Velindre NHS Trust.

Previous reports have covered the time periods:
2016
2017
2018
2019 to mid-2020

Overview of Training

Velindre Cancer Centre/Hospices

The GMC survey considers 'Velindre NHS Trust' to have two training locations – 'Velindre Hospital' and 'Holme Tower Marie Curie Hospice'. Although these are separate organisations, there are strong links between Velindre and the Cardiff Hospices and the training teams meet in a single Medical Education Board.

Velindre Cancer Centre has trainees within the following GMC-approved postgraduate training schemes that are commissioned by HEIW: Clinical Oncology; Medical Oncology; Palliative Medicine; Clinical Radiology; Internal Medicine Training (IMT); General Practice; Foundation Programme Year 2. Some trainees in Palliative Medicine at Specialty Registrar, IMT and Foundation Programme levels are based in other locations such as Marie Curie Hospice or City Hospice.

Velindre University NHS Trust also provides undergraduate training and education by agreement with the Cardiff University Medical School. This training includes the Oncology Project, Student Selected Components (SSCs) and Non-surgical Bookends.

Velindre University NHS Trust is visited annually by Health Education and Improvement Wales (commissioning visit and faculty team appraisal) with regard to postgraduate medical education and training, and Cardiff University for an undergraduate teaching review.

Other aspects of medical education include non-commissioned elements such as sixth form work experience, taster experiences, out of programme experiences and training courses such as the FRCR course.

With the establishment of Health Education and Improvement Wales, and in keeping with national trends, there is an increasing emphasis on multidisciplinary and multi-professional teaching and training. Velindre also provides and takes part in and multi-professional training.

For information, HEIW, the new Special Health Authority, started on 1st October 2018, having worked in shadow form since 1st April 2018. This was formed by amalgamating the Wales Deanery, NHS Wales's Workforce Education and Development Services (WEDS) and the Wales Centre for Pharmacy Professional Education (WCPPE).

Welsh Blood Service

The Welsh Blood Service undertakes an extensive programme of training throughout Wales. This includes teaching specialty registrars, medical students, nurses and clinical scientists. All the consultants are involved in teaching and two consultants are RCPath examiners. The

medics together with nurses are responsible for cascading learning to WBS staff, including on adverse events management.

Sources of Evidence

Evidence	Examples
Primary evidence	GMC survey of trainees GMC survey of trainers Internal questionnaires End of placement evaluation forms Feedback questionnaires Informal feedback
Secondary evidence	Wales annual specialty report on Clinical Oncology Wales annual specialty report on Medical Oncology HEIW Medical Deanery Risk Register

Results of the 2021 and 2022 GMC survey of trainees and trainers are shown in Appendices A-H. The colour codes are as given in the following table:

Type	Colour code
Green flag (above outlier)	
Upper quartile	
Within interquartile range	
Lower quartile	
Red flag (below outlier)	
Insufficient responses for results	

The numerical scores are out of 100 and are calculated by the GMC using responses to questions.

Contributors

Contributions to this report have been gratefully received from members of the Velindre Medical Education Board and others involved in medical education.

Notable Events and Highlights

Notable events and highlights in 2020-2022

- Large number of 'above outlier' green flags in 2022 GMC survey
- Engagement: good response rates to GMC surveys
- No patient safety concerns reported in GMC trainee surveys
- No undermining or bullying concerns reported in GMC trainee surveys
- Completed transition from Core Medical Training to Internal Medicine Training
- Further development of Specialty doctor posts which help with rota gaps but increasingly seen as valuable training experiences
- Collaboration with Cardiff and Vale Leadership fellow, Jack Boylan, to evaluate medical educational governance

- Commissioning meeting between HEIW and Velindre (May 2022)
- Undergraduate teaching review meetings undertaken (January 2022)
- Local Faculty Team appraisal undertaken in 2022 (report awaited)
- Continuing Junior Medical Staff Committee
- Junior medical staff representatives on Local Negotiating Committee (LNC)
- Trainers have national roles in medical education e.g. College examiners, membership of Royal College Training Committees, UK clinical leadership roles for national recruitment and quality of medical education, Wales Training Programme Directorships
- Involvement of audit department in medical student SSC projects and showcase presentation event with awards
- Special Grand Round event for the presentation of the Cardiff FRCR Award winners in improvement, innovation and research, August 2022
- Work done on areas of concern on previous GMC surveys (e.g. reporting systems and induction) - these are no longer showing as concerns on the 2022 GMC survey
- Dr Seema Arif awarded MBE for services to healthcare in Black, Asian, and Minority Ethnic communities in Cardiff
- Dr Louise Hanna awarded The Royal College of Radiologists COVID-19 Outstanding Contribution Award for co-leading the rapid change of approach to national recruitment following the cancellation of recruitment at the start of the first lockdown
- Blood Health Team won 'Best Educational Poster' award at the British Blood Transfusion Society Annual Conference in 2019 for work on the senior studentship training and competency assessment (SSA) programme (not mentioned in previous report so highlighted here)
- Trainees and students authors in peer review publications
- Award for outstanding medical student report for teaching during the Oncology/Palliative Care week (3rd year)
- Appointment of new Faculty Lead (March 2021) and Assistant Medical Director for Medical Education (September 2021)

Summary of Challenges including from 2022 GMC Survey

- Time for training (clinical and medical oncology)
- High burnout among oncology trainers in Wales (clinical and medical oncology)
- Support and appraisal for trainers (medical oncology)
- Workload in clinical oncology trainees
- Medical oncology trainers added to HEIW Risk Register in August 2022 with regard to Time and Training Resources, Support and Appraisal, and Overall Satisfaction
- Managerial/admin support for medical education

Postgraduate Medical Specialty Training Programmes

Clinical Oncology Training Programme – Velindre Cancer Centre 2020-22
Positives
• Introduction of acute oncology training within Cardiff and Vale to fulfil curriculum requirements • Involvement of trainees in leadership roles – induction programme, undergraduate teaching

- Introduction of palliative radiotherapy service
- Many 'above outlier' and 'upper quartile' results in 2021 and 2022 GMC surveys (including consistent results for Handover and Teamwork since 2018)
- Consultant post take ward round and acute oncology morning session continue to be a priority for clinical directorate
- Specialty doctor posts fill rota gaps
- Programme of training number expansion in Wales agreed with Welsh Government
- Provision of internationally renowned FRCR course for local trainees and excellent examination pass rates for the FRCR Part 2 examination

Challenges

- 'Below outlier' in 2022 GMC survey for Workload (trainees)
- 45.5% of clinical oncology trainees in Wales report high or moderate burnout (9.1% high, 36.4% moderate)
- Rota coordination providing acute oncology/on-call cover in Velindre and providing acute oncology experience within Health Board

Actions

- Monitor acute oncology training experience in Cardiff and Vale
- Monitor trainee workload
- Work within the Trust on employer well-being

Medical Oncology Training Programme – Velindre Cancer Centre 2020-22

Positives

- Introduction of acute oncology training within Cardiff and Vale to fulfil curriculum requirements
- Involvement of trainees in leadership roles
- Specialty doctor posts fill rota gaps
- Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate
- Programme of training number expansion in Wales agreed with Welsh Government

Challenges

- 75% of Medical Oncology trainees in Wales have moderate burnout
- Not enough trainees to provide reportable results in GMC survey for training experience in 2021 and 2022

Actions

- Work within the Trust on employer well-being

Palliative Medicine Training Programme – 2020-22

Positives

- Two 'above outlier' responses in 2021 GMC survey
- Training Programme Director role now joint with colleague from N Wales

Challenges

- Difficulties recruiting to specialty training – likely linked to national curriculum changes meaning dual accreditation with medicine
- 25% of Palliative Medicine trainees in Wales have moderate burnout

• 'Lower quartile' in 2021 GMC survey for Curriculum Coverage and feedback (likely caused by re-allocation of trainees during pandemic) • Not enough trainees in the training programme to provide reportable results in GMC survey for training experience in 2022 (although feedback for all trainees within Palliative Medicine regardless of training programme is excellent)
Actions
• Link with national training committees to look at issues relating to specialty recruitment

Radiology Training Programme – Velindre Cancer Centre 2020-22
Positives
• Established training placement for senior registrar
Challenges
• Not enough trainees for results from GMC survey
Actions
• Continue to provide placement

Postgraduate Medical Training – Welsh Blood Service
Positives
• Haematology StRs: A twice-yearly course is provided with practical work, lectures, and case-based theory. Each course lasts for 2 weeks. Each SpR attends once during training • A monthly lunchtime hour of transfusion CPD is provided for all haematology trainees in Wales via Teams • Haematology SpRs also have training half days throughout the year and at least one (typically 2) will be focussed on transfusion related topics
Challenges
• Transfusion is ¼ of the FRCPath Haematology examination (and curriculum) whereas the trainees have much less than ¼ of their time spent within transfusion, although acknowledge that will also gain experience through their other placements • The training is provided by a small team with finite resources
Actions
• We are looking to develop a formal rotational post in transfusion for 3-6 months to be more consistent with other parts of the curriculum (e.g. haemostasis, malignant haematology)

Internal Medicine Training – Velindre Cancer Centre and Marie Curie Hospice – 2020-22
Positives
• Clinical fellows doctor posts to help fill rota gaps • Many 'above outlier' and 'upper quartile' responses in 2021 and 2022 GMC surveys • Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate • Joint working with Velindre and Hospice for clinic attendance • Provision of clinic experience in Velindre adds value to the rotation

• Previous IMT trainees have joined Velindre in specialty training posts
Challenges
• Rota gaps
Actions
• Medical business team to continue recruitment drives for non-training specialty doctors to cover rota gaps

GP Training – Velindre Cancer Centre 2020-22
Positives
• Many 'above outlier' and 'upper quartile' responses for 2021 and 2022 GMC surveys • Clinical fellow posts to help fill rota gaps • Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate • Provision of clinic experience adds value to rotation
Challenges
• Rota gaps
Actions
• Medical business team to continue recruitment drives for specialty doctors to cover rota gaps

Foundation Programme – 2020-22
Positives
• Three new F2 posts established in August 2022 – two based in Velindre Cancer Centre and one based in Marie Curie Hospice • Educational and clinical supervisors identified
Challenges
• Incorporating new posts and ensuring learning needs are met • Core post only is funded (no on-call) • Identifying additional resource for supervision and admin support
Actions
• Close monitoring of trainee experience

Undergraduate – Medical Student Teaching and Training

Undergraduate Training – Oncology Project 2020-22
Positives
• Lead role for trainees in management of project • Highly regarded part of undergraduate curriculum • Provision of project in Welsh
Challenges
• Recruiting tutors
Actions
• Proactive work to recruit tutors • Review documentation re: Welsh language • Look at possibilities for virtual working/marking

Undergraduate Training – Non-Surgical Bookends 2020-22
Positives
• Lead role for trainee in management of project • Widening exposure of students to aspects of oncology that they might not see much of in their training elsewhere • Consultant and trainee oncologists contributing to plenary lectures in bookend weeks
Challenges
• Recruiting tutors
Actions
• Structure for coming year including whether any changes needed to sessions

Undergraduate Training – SSC Projects- Palliative Care and Oncology
Positives
• Many projects undertaken, resulting in national/international presentations for students • Lead role for trainee in management of project • Excellent support from VCC audit department • Opportunity to present work at virtual showcase event, and local Velindre prize • Ten year 3 and ten year 4 students • Starting to take year 2 students (one week experience)
Challenges
• Popularity of placements requires adequate resource and support
Actions
• Highlight the work of the audit department in supporting the projects

Undergraduate Training – Welsh Blood Service
Positives
• All medical students in Wales have to complete senior studentship training and competency assessment (SSA) prior to qualification and commencing as junior doctors. This is organised by the WBS. Lectures and 4 rotational practical workstations (manned by two staff members each) are provided during whole days of training at all Health Boards in Wales. WBS Blood Health Team staff and Transfusion Practitioners from other Health Boards mutually assist each other in delivering these across Wales
Challenges
• There is a small team delivering the training with finite resources. Travel is required for SSA
Actions
• We will continue to support these sessions as the feedback is very good from the students

Trainers

Trainers
Positives
• Palliative Medicine commended by HEIW as for several ‘above outlier’ responses in the 2022 GMC survey

• Palliative Medicine trainers nominated for Surgam award for contribution to student experience • Trainers have national roles in medical education e.g. College examiners, membership of Royal College Training Committees, UK clinical leadership roles for national recruitment and quality of medical education, Wales Training Programme Directorships, keeping them up to date with medical education developments
Challenges
• 'Below outlier' for Clinical Oncology and Medical Oncology in Velindre Hospital for 2022 GMC survey for Time for Training and Resources • 'Below outlier' for Medical Oncology in Velindre Hospital for 2022 GMC survey for Overall Satisfaction, Time for Training and Resources, and Support and Appraisal • Medical oncology trainer added to HEIW risk register in August 2022. Requirement to look at time for training within current service demand
Actions
• Work with clinical directorate and appraisal lead. Highlight educational aspects of appraisal and use of 'constraints' section within appraisal. Work with clinical directorate to quantify time for training within wider work looking at supporting professional activities

Non-Commissioned Posts

Specialty Doctors and Clinical Fellows
Positives
• Ongoing appointment to these posts which supports the on-call rota and provides education experience/career development opportunities for doctors • Specialty doctor positions to support new Immuno-oncology toxicity service
Challenges
• Limited budgets
Action
• Continue to provide and recruit to these roles

International Clinical Fellows
Positives
• International clinical fellows in oncology and radiology • FRCR exam success
Challenges
• Admin and set-up
Action
• Continue to promote these posts

Physicians Associates
Positives
• Physician Associate training placements • Two new PA posts appointed • Very positive feedback from training attachment

Challenges
• How to incorporate new posts into service
Action
• Plan to create new PA posts – interviews have taken place and new appointees will join the Cancer Centre soon

Library

Library
Positives
• Library funding is now being delivered centrally rather than from charitable funds. • Introduction of face-to-face induction sessions post COVID-19 • Education/training sessions are still largely virtual. This has presented the opportunity to widen our offer to larger groups off site and to design a series of sessions to support all our users through all aspects of information literacy • Working closely with Transforming Cancer Services team to support the new build. We have been involved in all areas of the process by providing literature searches looking at various aspects of research in modern sustainable hospital design – an area which has challenged and improved our searching skills in subjects not faced before • Continued support of systematic review work – library staff named as co-authors on 5 published papers in 2021-2022
Challenges
• Lack of clarity on funding around the library make the consideration of new and larger purchases difficult
Actions
• Focus on ensuring that library facilities in the new Velindre Cancer Centre can support our educational provision going forwards • Clarify funding arrangements with the Trust

FRCR Course

FRCR Course
Positives
• Internationally renowned course, attended by over 60 trainees each year • Leadership opportunity for trainees in course organisation/development • Mirrors the examination format well • Velindre course ran during pandemic, converting to a fully on-line course. This does have environmental benefits and cost benefits for trainees (don't have to pay for accommodation) • Extra course added (Spring 2021) during COVID-19 at break-even price to support trainee's mid pandemic as all other revision courses were cancelled • High quality bank of lectures available for local trainees • Faculty up to date with exam content • Bespoke additional sessions for international trainees ahead of the main course to help them with communication skills, viva techniques, principles and practice in the UK etc. • Second Velindre – Kolkata FRCR course held in 2022 – combination of face to face and virtual • Excellent collaboration between Velindre and Kolkata

• Bespoke Hong Kong course last year during pandemic – and this year will be combined with UK course • Supports QI and undergraduate prizes
Challenges
• Delivering the course during the pandemic and with other time pressures
Actions
• Continue to develop course taking into account global situation (pandemic) and build international links

Other Education and Training Activities

Work Experience – Sixth Form
Positives
• Week-long experience • Excellent feedback
Challenges
• Became virtual due to COVID-19. • Admin support – no-one currently in work experience admin role
Actions
• Plan for next year

Taster Weeks
Positives
• Demand for taster weeks – popular • Some sessions offered despite pandemic • Bespoke experience • Important experience to help recruitment
Challenges
• COVID-19 has restricted ability to offer taster sessions especially to international applicants
Actions
• Continue to provide as allowed by pandemic restrictions

Multi-Professional Training – Advanced Nurse Practitioners
Positives
• Core workforce for Assessment Unit • Completion of Higher Training qualifications including Masters degrees • Designated clinical examination teaching time • ANP development roles
Challenges
• Time for training/clinical supervision • Time to co-create scopes of practice and summative examinations • Staff retention
Actions
• Review of training structure and resource for training

Multi-Professional Training - Other
Positives
• Numerous examples of multi-professional training – supervision of non-medical outliners (NMO) in radiotherapy; non-medical prescribers (NMP), expert practice modules, paramedics • Other professional groups have role in training medics – e.g. paracentesis, radiotherapy planning • Multi-professional study events e.g. acute oncology
Challenges
• Time for training
Actions
• Continue to promote multi-professional training. This aligns with HEIW focus

Grand Round
Positives
• Multi-disciplinary event with the aim of promoting education and research • Mixture of internal and external speakers, including international speakers, which promotes collaboration and networking • Free lunch helps support lunchtime attendance • Sessions are recorded so can be listened to again or if unable to attend the live presentation • Opportunity to showcase local developments
Challenges
• Finding speakers • Ensuring talks remain relevant to all attendees
Actions
• Encourage SSTs to find speakers.

Organisational
Positives
• This is the 5th annual Medical Educational Governance report which is reported through the Trust structure • Welsh Blood Service included in this report. (Previous reports have focussed on the Cancer Centre and Hospice) • New post of second on-call for Advanced Life Support
Challenges
• Medical education administrative support • Ensuring high quality medical training is carried forward in future reconfiguration plans (e.g. Transforming Cancer Services programme) • Trainer burnout in particularly in clinical and medical oncology • Assistant Medical Director unable to take up full duties due to time constraints
Actions
• Continue to highlight challenges within VUHNSHT because many potential solutions lie within the organisation as a whole, not just in the Education Department

National and Local Changes Coming up in 2022 and Beyond

Important changes will take place in medical education are occurring in 2022 and beyond. These include:

1) Transforming Cancer Services and review of Acute Oncology Service Provision
2) Proposed construction of a new Velindre Cancer Centre
3) Move to single lead employer for trainees
4) Need for excellence in medical education despite workforce and capacity pressures compounded by pandemic
5) Continued need to recruit to support the service

Appendix A - GMC Survey Results 2022 – Trainees

Velindre NHS Trust – programme group (all those within a training programme)

Programme Group	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Clinical oncology	90.00	94.55	90.63	80.50	48.30	87.88	82.95	85.91	80.00	87.50	81.82	85.23	84.90	79.09	71.97	69.32	71.40	68.50
Clinical radiology																		
GP Prog - Radiology	76.00	85.00	91.25	73.75	78.75	85.00	76.25	75.00	71.00	70.00	73.33	85.00		72.67	51.67	73.75	70.00	
IMT stage 1	81.25	91.25	87.50		70.31		78.65	80.00	81.25	71.88	85.42	75.00		75.42	55.21	74.48	64.06	78.75
Medical oncology																		
Palliative medicine																		

Velindre NHS Trust – post specialty (all those working in a specialty regardless of the training programme they are in)

Post Specialty	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Clinical oncology	83.95	91.05	89.58	78.13	60.20	87.96	81.14	81.05	76.84	78.95	79.39	84.87	74.62	75.53	63.38	71.27	68.97	72.23
Clinical radiology																		
Medical oncology																		
Palliative medicine	88.33	95.00	93.75		58.33			91.67	88.33	87.50	86.11	75.00		81.67	72.22	79.17	77.08	

Points to note:

- 19 ‘above outlier’ results
- 4 ‘upper quartile’ results
- 1 ‘lower quartile’ result – feedback in clinical oncology
- 1 ‘below outlier’ result – workload in clinical oncology
- Insufficient responses/trainees to give results in Medical Oncology and Clinical Radiology

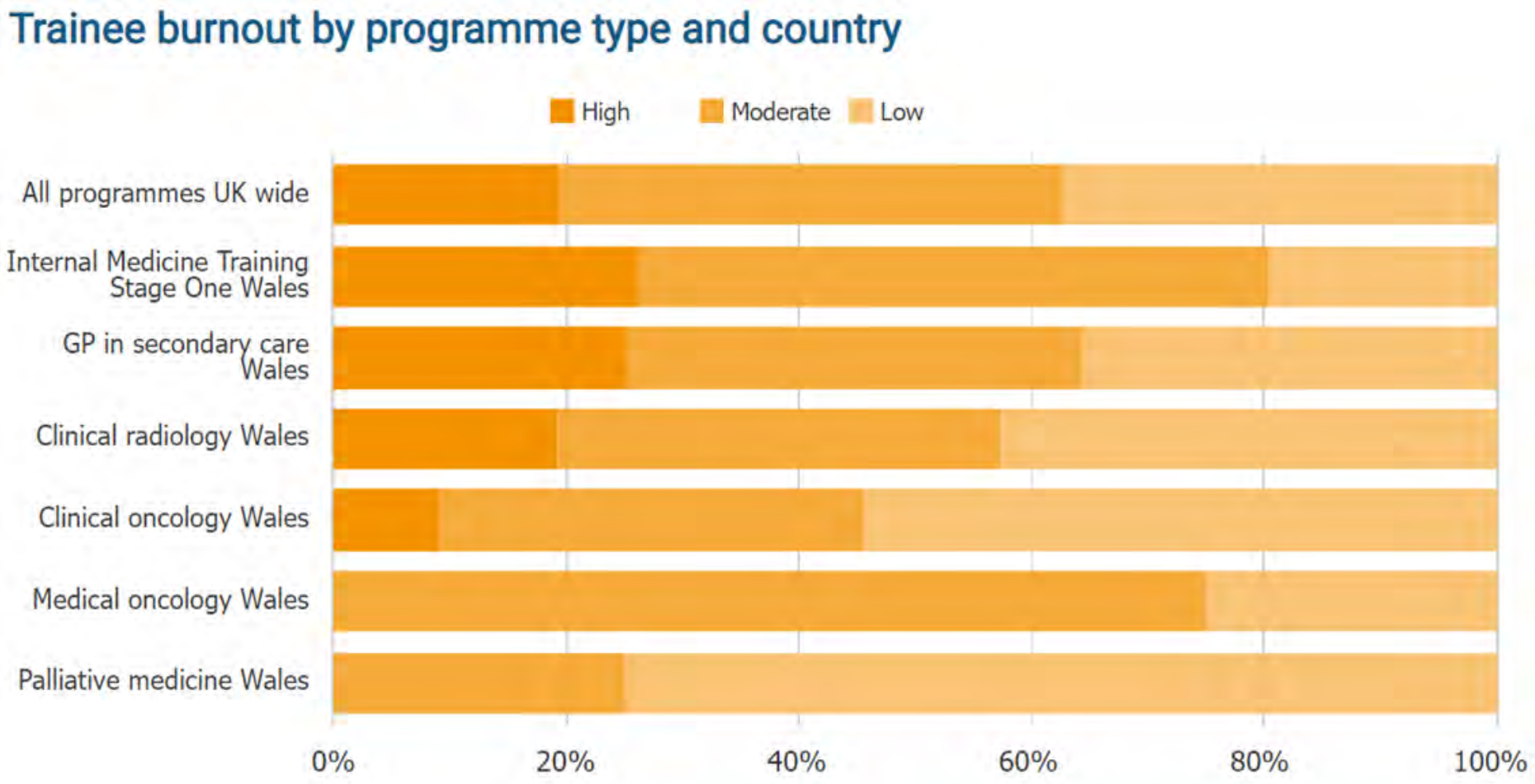
Appendix B - GMC Survey Results 2022 – Trainers

Trainer Specialty	Trust / Board	Response Rate	Overall Satisfaction	Supportive environment	Educational Governance	Support & appraisal	Professional development	Time & training resources	Handover & rota design
Clinical oncology	Velindre NHS Trust	67%	62.50	66.96	61.06	53.48	65.03	39.14	68.75
Clinical radiology	Velindre NHS Trust	67%							
Medical oncology	Velindre NHS Trust	100%	56.25	64.06	59.38	36.56	75.00	42.19	84.38
Palliative medicine	Velindre NHS Trust	100%	83.33	79.17	78.13	88.54	88.54	72.92	72.92

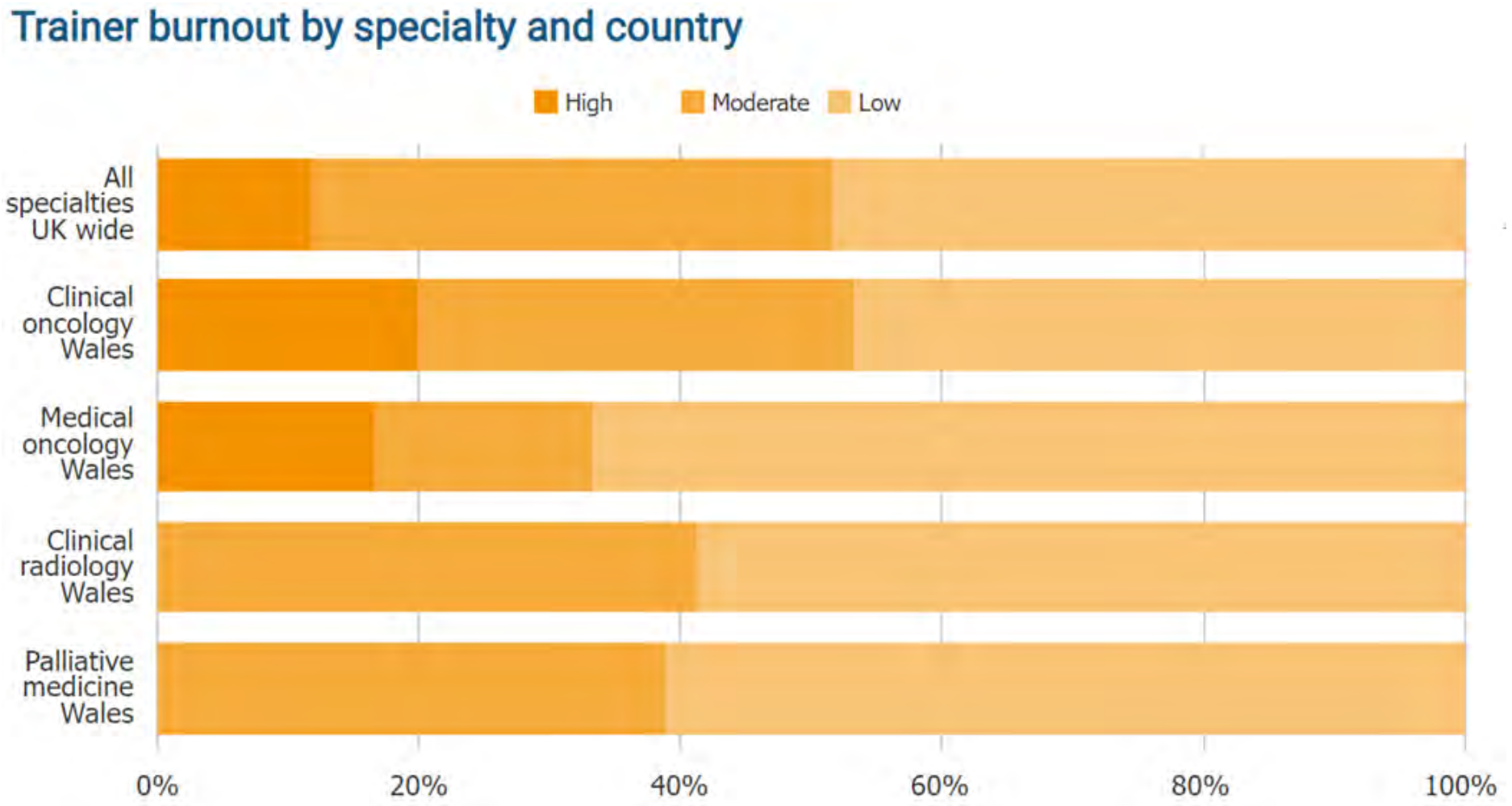
Points to note:

- 5 ‘above outlier’ results
- 4 ‘below outlier’ results
- Insufficient responses/trainers to give results for Clinical Radiology

Appendix C – GMC Survey Results 2022 – Burnout in Trainees in Wales



Appendix D – GMC Survey Results 2022 – Burnout in Trainers in Wales



Appendix E – GMC Survey Results 2021 – Trainees

Velindre NHS Trust – programme group (all those within a training programme)

Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Curriculum Coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Role Design	Facilities
Clinical oncology																			
Velindre NHS Trust	91.92	97.69	93.75	74.17	59.46	83.97	85.74	85.38	85.73	87.50	86.54	87.18	87.02	85.94	79.62	70.19	80.45	79.17	77.31
Clinical radiology																			
Velindre NHS Trust																			
GP Prog - Radiology																			
Velindre NHS Trust	84.00	92.00	89.06		58.75	91.67	74.58	78.00	84.00	77.50	78.33	78.33	80.00		73.00	53.33	42.50	66.25	
Internal Medicine Training Stage One																			
Velindre NHS Trust	83.75	96.25	93.75		62.50	87.50	83.34	81.25	87.50	78.13	72.92	81.25	81.25	63.89	79.17	68.75	46.53	73.44	
Medical oncology																			
Velindre NHS Trust																			
Palliative medicine																			
Velindre NHS Trust	83.33	96.67	95.83		52.08	80.55	75.00	80.00	83.33	70.83	65.28	69.45	93.75	72.22	81.66	75.00	75.00	62.50	

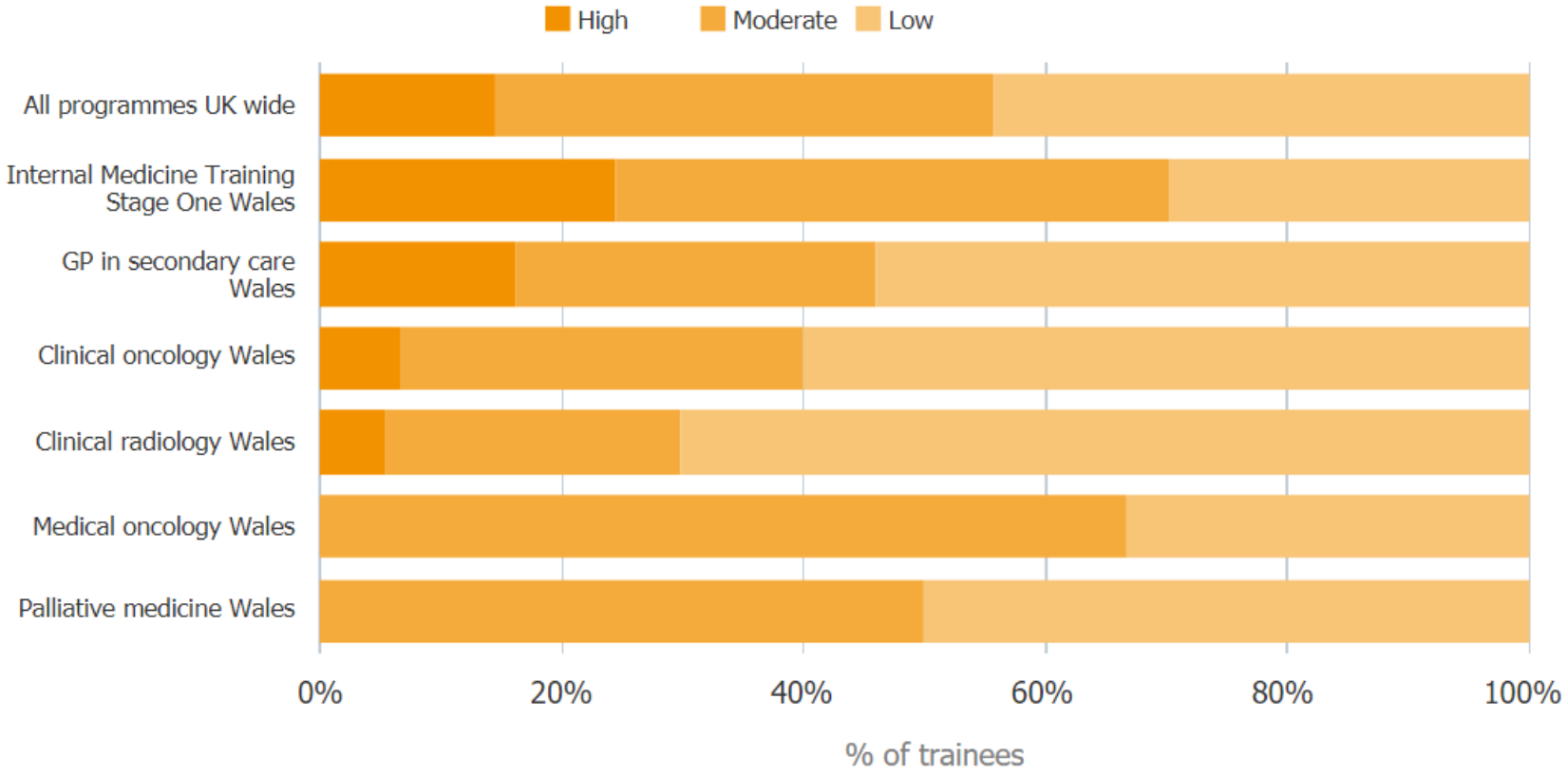
Velindre NHS Trust – post specialty (all those working in a specialty regardless of the training programme they are in)

Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Curriculum Coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Role Design	Facilities
Clinical oncology																			
Velindre NHS Trust	88.10	95.95	92.76	73.13	59.42	85.71	82.34	82.14	84.94	83.33	82.14	83.33	83.63	73.27	76.98	65.68	66.57	75.00	78.67
Clinical radiology																			
Velindre NHS Trust																			
Medical oncology																			
Velindre NHS Trust																			
Palliative medicine																			
Velindre NHS Trust	87.50	97.50	95.83		56.25	85.42	79.17	85.00	87.50	75.00	69.79	77.09	95.31	79.17	86.25	75.00	75.00	65.63	62.92

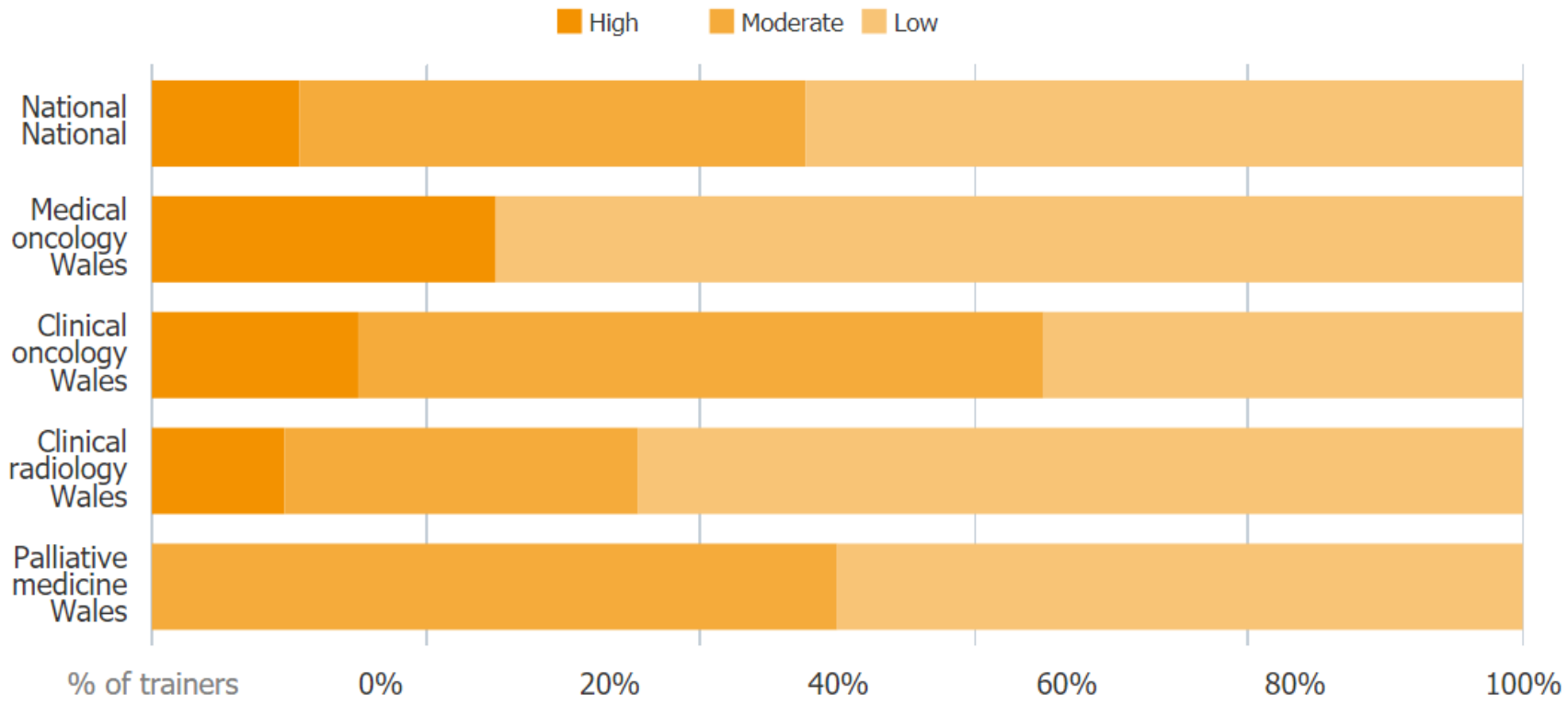
Appendix F – GMC Survey Results 2021 – Trainers

Trust / Board	Response Rate	Overall Satisfaction	Work Load	Handover	Supportive environment	Curriculum Coverage	Educational Governance	Time for training	Rota Design	Resources for trainers	Support for trainers	Trainer Development
Clinical oncology												
Velindre NHS Trust	75%	64.00	48.06	83.61	67.67	76.50	75.83	25.56	70.42	71.67	59.67	65.83
Clinical radiology												
Velindre NHS Trust	67%											
Medical oncology												
Velindre NHS Trust	33%											
Palliative medicine												
Velindre NHS Trust	100%	80.83	48.96	80.00	80.83	84.03	77.09	55.56	75.00	85.42	79.17	77.08

Appendix G – GMC Survey Results 2021 – Burnout in Trainees in Wales



Appendix H – GMC Survey Results 2021 – Burnout in Trainers in Wales



QUALITY, SAFETY & PERFORMANCE COMMITTEE

THE MEDICAL EXAMINER SERVICE AND VELINDRE UNIVERSITY NHS TRUST

DATE OF MEETING	15/09/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Viv Cooper, Head of Nursing & Integrated Care
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
SLT	06/01/2022	NOTED
EMB	04/03/2022	NOTED
EMB	01/09/2022	NOTED

ACRONYMS	
MES	Medical Examiner Service
SACT	Systemic Anti-Cancer Therapy
RT	Radiotherapy
SST	Site Specific Teams
VCC	Velindre Cancer Centre

1. SITUATION / BACKGROUND

1.1 This report is an update to the Quality, Safety & Performance Committee on the implementation of the Medical Examiner Service requirements within Velindre University NHS Trust.

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

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

This paper is provided for the Committee to:

- Have an overview of the high level outcomes
- **NOTE** the progress that has been made in implementing the revised mortality review process, the progress made since the last update was provided and the priorities and plans for the next period and to receive regular updates at future meetings.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last update a letter has been received from the National Medical Examiner and Welsh Government, dated 26th July 2022 which sets out what NHS Wales needs to do to prepare for the statutory introduction of the medical examiner system which UK Ministers would hope to commence from April 2023 (letter available on request). In summary, the requirements Health Boards and Trusts within Wales must have in place by April 2023 to meet statutory requirements are:

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

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

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

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

2.3 The Trust is currently meeting all these requirements through interim arrangements. Following receipt of this letter stipulating the long-term requirements the Cancer Service is now finalizing the proposed sustainable delivery model. This is detailed in section 2.6.

2.4 Summary of steps taken since the introduction of the MES service at Velindre Cancer Service.

- The introduction of the MES for death certification and Part 1 mortality reviews for patients who die in Velindre University NHS Trust was introduced in 2021, using an incremental approach to allow time for capacity and processes to be put in place.
- To support the introduction of the new MES process and improved mortality reporting within VCC, the VCC MES and Mortality Project Group was established and led by Dr. Jillian MacLean. The work of the group was underpinned by a robust project plan and support provided by the Programme Management Office.
- Six-week pilot was undertaken in Velindre Cancer Centre on the First-Floor ward which commenced in October 2021. The pilot included the reporting of all deaths occurring in VCC to the MES and the sharing of all relevant documentation for death certification and Part 1 mortality review. The pilot was successful and positive feedback has been received from the Medical Examiner's office
- Following the successful pilot, the service fully implemented the new process and is working closely with the MES to review all patient deaths that occur in VCC. The MES will discuss the circumstances of patients' deaths with the treating teams at Velindre (even when patients die outside of Velindre) to facilitate the MES mortality reviews.
- The Once for Wales (OfW) DATIX Mortality Module is now available for use. The Cancer Service Quality & Safety team are working with the OfW DATIX team to agree roles and responsibilities and to schedule training for relevant staff.
- The MES are feeding back to VCC findings they have identified, concerns or questions regarding care at Velindre University NHS Trust from mortality reviews they have carried out when patients have died elsewhere (via a dedicated inbox). In certain circumstances these findings will also be reported to Welsh Government and Velindre will be required to demonstrate actions and learning from this feedback.
- Whilst the MES main role is regarding statutory requirements of death certification and mortality review, there is an opportunity for the MES and VCC to work together to

improve information sharing regarding patients under the care of VCC who die outside of VCC (the majority of VCC patient deaths). To this end the MES has agreed to share information with VCC regarding certain patients under the care of Velindre who die in the Health Boards (in hospital, hospice or at home) to facilitate Velindre reviews of deaths within 30 days of systemic anti-cancer therapy (SACT), or where non-surgical cancer treatments are deemed to be a cause of death.

2.5 Progress achieved since the last reporting period

2.5.1 The MES & Mortality Project Group have developed a Standard Operating Procedure for the new process and have reviewed the Terms of Reference for the MES Case Review Panel although these have yet to be formally signed off.

2.5.2 The Terms of Reference for the Serious Clinical Incident Forum (SCIF) have also been reviewed and ratified.

2.5.3 **The MES Case Review Panel**

This panel meets when required to discuss any referrals from the MES. In the period January – June 2022, there were 18 deaths in VCC and only one referral from the MES. This is in line with the number of referrals seen across Wales, with Health Boards reporting approx. 8-10% of inpatient deaths being referred by MES for further review.

In the one case referred back to VCC by the MES there were no issues with care identified but the family had raised a comment around communication issues and this was fed back to the team involved in the patients care. This case was discussed in the MES Review Meeting and also managed through the Concerns process and subsequently resolved.

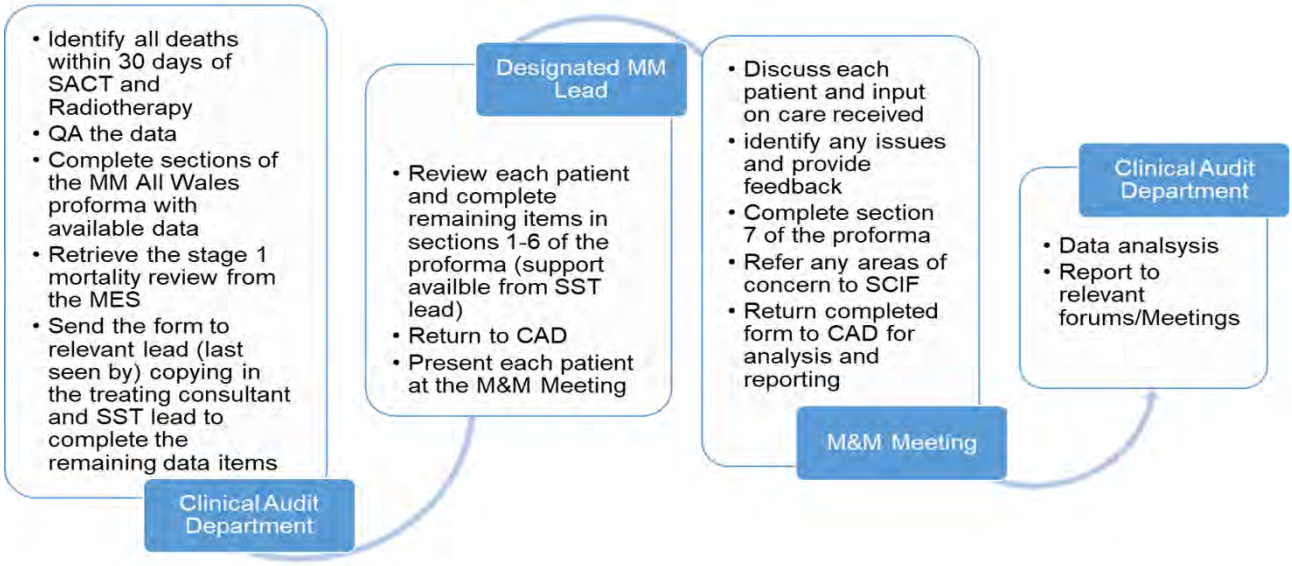
2.5.4 **Pilot Update**

A Mortality and Morbidity Review pilot within the Colo-rectal SST has commenced and reviews include data on deaths within 30 days of SACT; death within 30 / 90 days of palliative / radical radiotherapy; sharing of best practice and lessons learnt.

Mortality and Morbidity (M&M) meetings provide an appropriate forum for relevant episodes of patient morbidity, ‘near misses’ or patient / Medical Examiner feedback to be discussed within Site Specific Teams (SSTs).

The focus of these meetings is primarily educational and to improve patient care. They are delivered in a supportive and confidential manner. In any cases where

learning is identified that could benefit other SSTs or where deficiencies in care are identified, the case is referred to SCIF. The pilot has adopted the methodology below:



The pilot has identified a few issues, primarily a lack of resources within the clinical and administration teams. The form currently in use requires modification to ensure ease of use and to remove fields that are not relevant to VCC. A report summarising the findings of the pilot is currently being drafted by the Clinical Audit Manager to highlight the key issues and will be submitted to VCC SLT in due course for consideration and before rolling out to other sites.

The issues identified by the MES regarding the transfer of patient information from VCC to the ME office have now been resolved through the establishment of a 'Secure File Share Portal' (SFSP). This has streamlined the process significantly.

2.5.5 Reporting and Learning

Reporting of all VCC deaths is ongoing with regular reports being submitted to the VCC Quality & Safety Management Group. Deaths within 30 days of SACT are also reported via the SST Annual Review and the Divisions Quality & Safety function.

The Trust continue to work with the MES to refine our processes and learn from any issues highlighted by them. VCC has requested that the MES share their

mortality reviews for all deaths and not just those requiring referrals so that learning and good practice can be shared.

These reviews will then be discussed so that the VCC mortality review process can be completed and also encourage input from other healthcare professionals involved in the patient's care. The MES agreed to do this but to date there has been little information received from the MES. This is being followed up by the VCC Quality & Safety Manager. Any significant issues or findings will be referred to SCIF.

2.6 Sustainable Delivery Model

A review of the work needed to support the requirements of the All-Wales Medical Examiner Service has been completed. It has been identified that the following is required::

- A dedicated resource within the VCC Clinical Audit team to support the increased requirements of the MES and mortality reporting requirements (1 day a week)
- Dedicated Administrative and clinical review support

These are being currently considered by Velindre Cancer Service Senior Leadership Team.

2.7 Priorities for the next period

- To continue to work closely with the MES to ensure robust investigations are undertaken where indicated with any learning identified and shared.
- The VCC Quality & Safety Team plan to re-establish the VCC Inpatient Mortality Review Group who will review all deaths in VCC. This will ensure that all learning, feedback and good practice is captured and documented. Reviews undertaken by the MES will also be reviewed in this forum.
- Establish an overarching VCC Mortality Group whose role will be to review all inpatient deaths, review deaths within 30 days of SACT and 30 / 90 days of palliative / radical radiotherapy and also to review any MES referrals. This group will meet quarterly and identify trends, themes, capture actions and learning. It will report into the VCC Quality & Safety Management Group and Trust Quality, Safety & Performance Committee.
- To review the findings of the Mortality and Morbidity Review pilot within the Colo-rectal SST and develop a plan for roll out to other teams.
- To secure / reassign the required implementation resources as detailed in section 2.6.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Staff and Resources, Safe Care, Individual Care, Timely Care, Dignified Care, Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Currently scoping out the need for resourcing to fulfill this implementation

4 RECOMMENDATION

The Quality, Safety and Performance Committee are asked to **NOTE** the developments to date and the next steps being taken to ensure the Trust is meeting fully its Medical Examiner / Mortality responsibilities.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HEALTH AND SAFETY ANNUAL REPORT

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	HELEN JONES
PRESENTED BY	CARL JAMES – Director of Strategic Transformation, Planning & Digital, Corporate Services
EXECUTIVE SPONSOR APPROVED	CARL JAMES – Director of Strategic Transformation, Planning & Digital, Corporate Services

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Health Safety and Fire Board	08/09/2022	NOTED

ACRONYMS	

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with sight of the Health and Safety Annual Report for 2021/2022

2. BACKGROUND

As part of the governance of the Health and Safety management system a Health and Safety Report is produced each year.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Health and Safety report contains information on the following areas for the years 2021/2022.

- Health and Safety management
- Health and Safety Priority Improvement Plan
- Health and Safety related policies
- Staff incidents
- Reporting of Incidents, Diseases and Dangerous Occurrences Regulations
- Violence and Aggression
- Sharps incidents
- Recording of risks
- Health and Safety statutory and mandatory training compliance
- Manual handling training
- Progress against Health and Safety strategic goals
- Health and Safety related personal injury claims

4. 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	Yes (Include further detail below)
	Assurance of compliance with Health and Safety requirements
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 For Board Approval** the **Health and Safety Annual Report**.

HEALTH AND SAFETY ANNUAL REPORT 2021/2022

1 Introduction

1.1 This Health and Safety annual report has been produced to provide an overview of the management of Health and Safety within Velindre University NHS Trust for the period 1st April 2021 – 31st March 2022.

2 Health and Safety Management

2.1 Health and Safety governance was strengthened during with the year by the establishment of a framework of Health, Safety and Fire meetings at both divisional and Trust level. The Trust meeting consists of senior managers and reports to the Executive Management Board. A divisional Health Safety and Fire meeting was established at Velindre Cancer Centre bringing together management level representatives from departments on that site to monitor and actively engage in health and safety planning and management. This meeting is supported by a monthly Health, Safety and Fire subgroup who provides operational support to the Health and Safety Lead for the division. Health and Safety was established as a standing agenda item at the monthly Estates and Facilities Management (Cynefin Group) meetings at the Welsh Blood Service.

2.2 In recognition of the synergy between Health and Safety and Fire Safety, and in order to run streamlined and effective management arrangements, a joint governance structure of Health, Safety and Fire meetings has been established.

2.3 There has been some initial disruption to the timetabling of meetings due to Covid-19 related pressures and the need to align the meetings to the wider cycle of business.

2.4 The Velindre Cancer Centre, Welsh Blood Service and Trust meetings for 2022/23 are scheduled quarterly and dates are in the diary.

Table 1 – Health and Safety governance – meeting schedule

Health and Safety Governance	Chair	Agreed Frequency	Initial meeting	Number of meetings held 2021/22
Trust Health Safety and Fire Board	Director of Strategic Transformation, Planning & Digital, Corporate Services	Quarterly	28/09/2021	2
VCC Health and Management Group	Operations Manager	Quarterly	21/10/2021	2
WBS Estates and Facilities management Group. (Cynefin Group)	Interim General Services Manager	Monthly	Established meetings already in place	8

2.5 The Cynefin Group in 2022/2023 will be held quarterly and will be chaired by the Operations Manager. This will continue the process of alignment of health and safety management across the divisions.

Table 2 – Health and Safety Groups providing specialist advice and governance

Health and Safety Strategic Groups	Chair	Agreed Frequency	Actual
Electrical Safety Group	Head of Estates	6 monthly	2
Water Safety Group	Head of Estates	3 monthly	4
Ventilation Group	Assistant Director of Estates, Environment & Capital Development, Corporate Services	3 monthly	4

2.6 The Trust identified the need for additional Health and Safety resource at Velindre Cancer Centre to ensure equity of provision of health and safety advice across the divisions. To address this an additional Health and Safety Advisor was appointed in February 2022.

2.6 The Health and Safety Advisors for both Velindre Cancer Centre and Welsh Blood Service are currently studying for the NEBOSH Diploma in Health and Safety Management further developing and enhancing the professional expertise available to the Trust and reflecting the Trust's commitment to professional development.

Table 3 – Health and Safety resource

Trust	Trust Health and Safety Manager
VCC	Health and Safety Advisor
WBS	Health Safety and Environment Manager

3 Health and Safety Priority Improvement Plan

3.1 An independent Gap Analysis was undertaken by the Interim Trust Health and Safety Manager in March 2021 and this has been further refined and developed into a Priority Improvement Plan by the current Trust Health and Safety Manager.

3.2 There has been sustained progress with the development and implementation of the Plan. The Trust Health, Safety and Fire Board have been provided with updates on progress to enable monitoring. The Priority Improvement Plan will be reviewed and refreshed in Quarter 3 2022 to build on the work that has already been completed and submitted to the Trust Health Safety and Fire Board for approval.

4 Health and Safety Related Policies

4.1 All Trust Health and Safety policies are up-to-date and are published on the Trust web-site. The Health Safety and Wellbeing Policy has been redrafted and refreshed to reflect the developments in governance arrangements and to ensure clarity of responsibilities. The Policy has been approved through the Trust governance process.

5 Staff incidents

Table 4 – Number of incidents by division by month

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
VCC	12	8	12	10	5	12	17	7	11	4	7	5	**110**
WBS	7	6	10	12	5	5	5	11	8	7	4	10	**90**
Corporate Division	0	0	0	2	0	1	0	0	0	0	1	0	**4**
Total	0	14	22	24	10	17	22	18	19	11	12	15	**203**

5.1 Table 4 shows the number of incidents which occurred in each month and were recorded on the Datix system. Incidents are investigated, additional control measures are implemented when required and lessons learned are shared.

5.2 The new Once for Wales (OFW) Datix Cymru system was introduced in the Trust in May 2021. It replaced previous versions of Datix used by the Trust and provided an additional level of consistency across the NHS in Wales. The benefits of the system include:

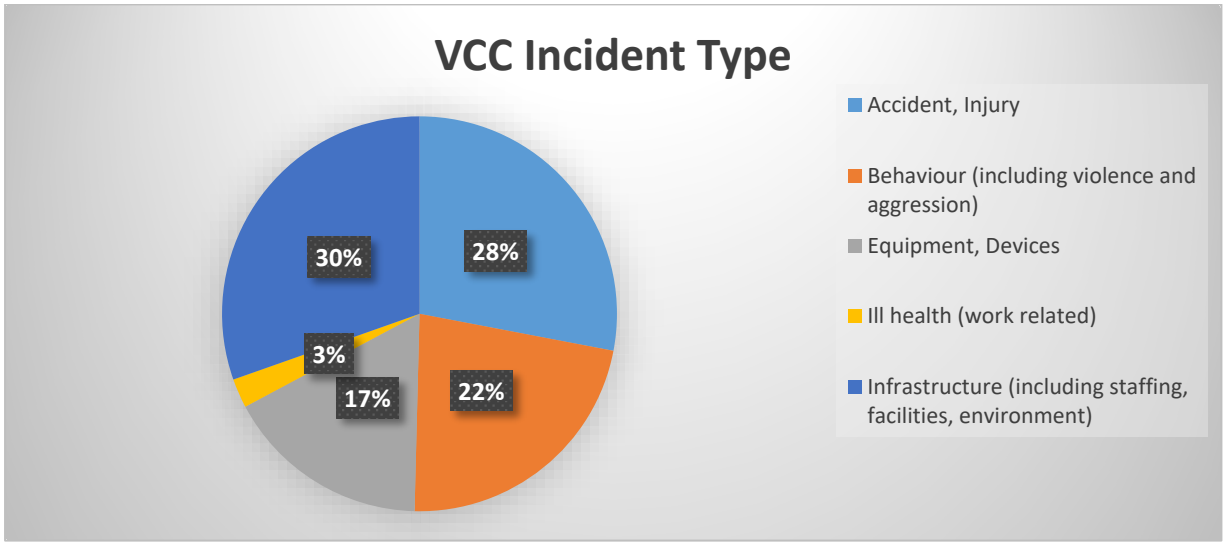
- Easier to log in - Nadex/Windows login can be used to access the system.
- Quicker process – The flow and layout of the incident form has been designed to make it more user friendly.
- Business Intelligence tool – simpler process to access reports from the system which will improve efficiency.

5.3 Incidents from 1st April 2021 to 16th May 2021 were transferred over to the new system so that all data for the reporting period 2021 – 2022 is on the new system.

5.4 Incidents are monitored by the Trust and divisional Health, Safety and Fire meetings and by the Estates Management Group. The manager responsible for the area/activity where the incident occurred is responsible for allocating a manager to investigate. Investigation training organised by Quality and Safety has been rolled out to a cohort of managers across the Trust to enhance the quality of incident investigations. Further support for incident investigation and recording on the Once for Wales Datix system is provided by the Health and Safety team.

5.5 Charts 1 shows the percentage of incidents by type in VCC. The Accident/Injury coding has the largest percentage of incidents and contains the highest number of subtypes related to health and safety.

Chart 1 – VCC incidents by type (%)



5.6 Chart 2 provides further details of the accident/incident coding. A further breakdown of sharps incidents and information about actions to address these incidents is contained in section 8.

Chart 2 – VCC accidents by subtype (%)

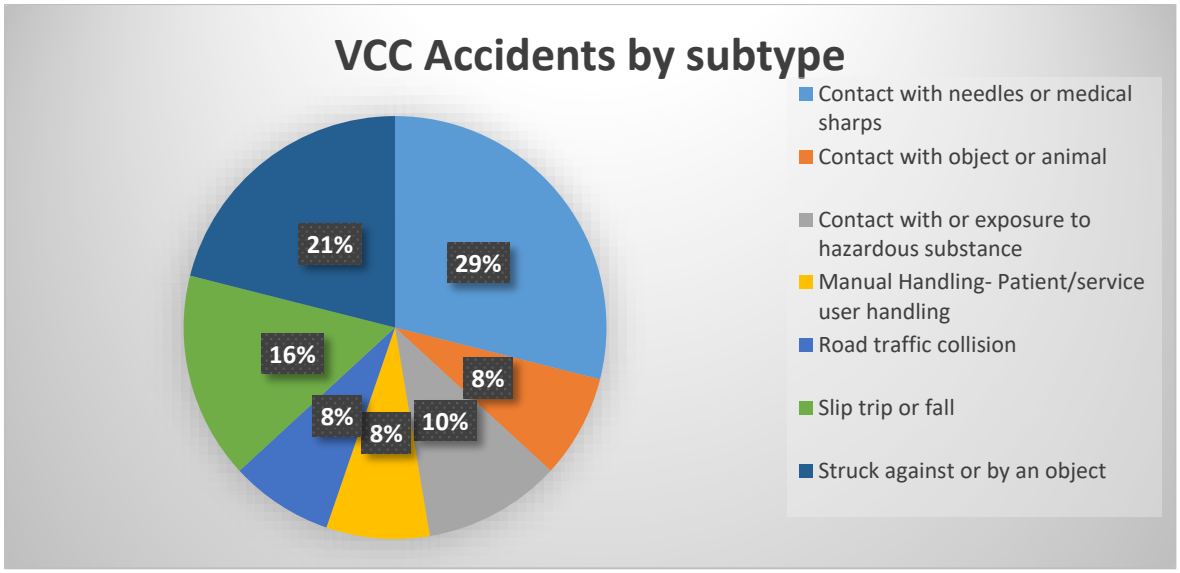
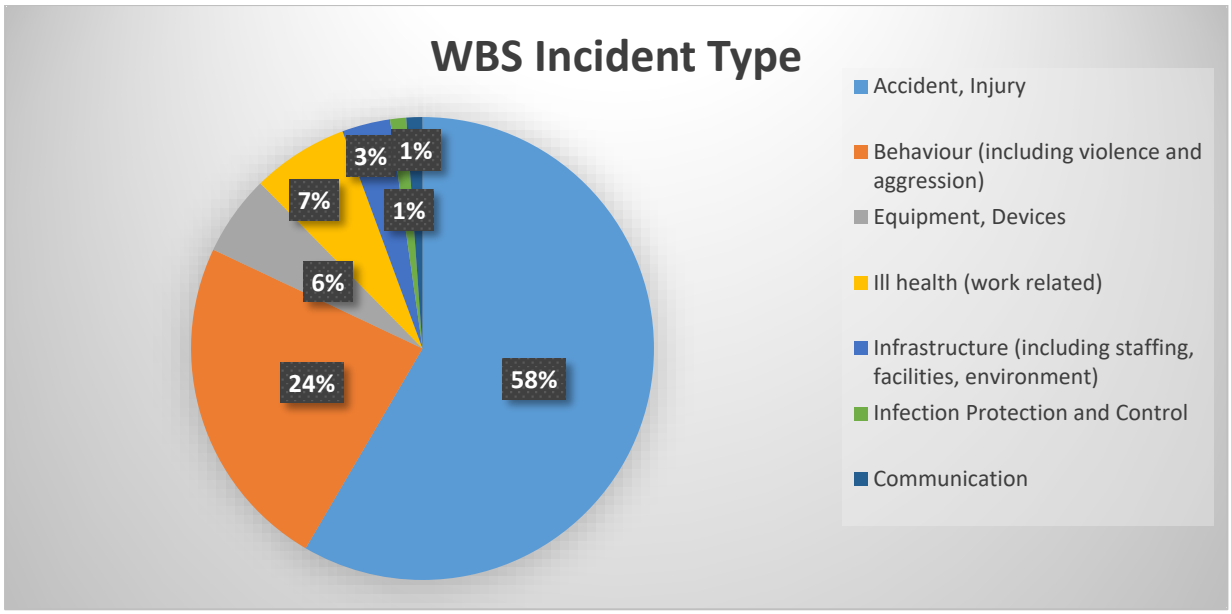


Chart 3 – WBS Incidents by type



5.7 At WBS Accident/injury is the highest incident type which reflects the pattern in previous years and the high number of incident subtypes contained within this Datix OFW code.

Chart 4 Accidents by subtype

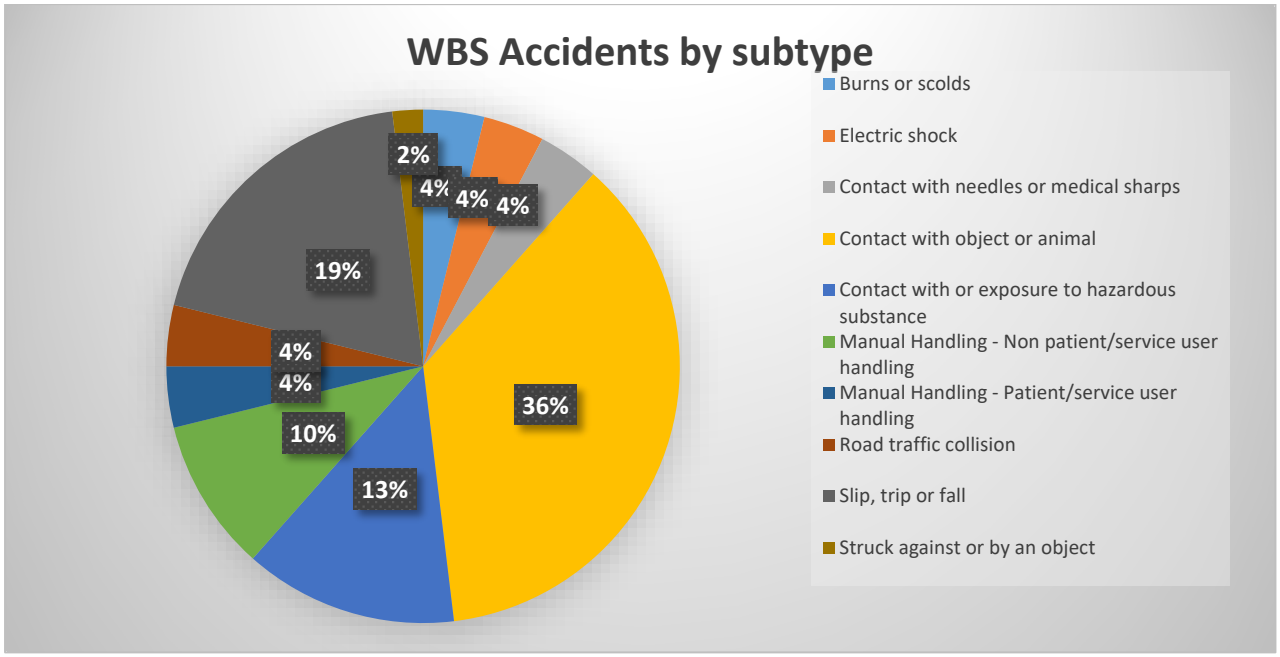
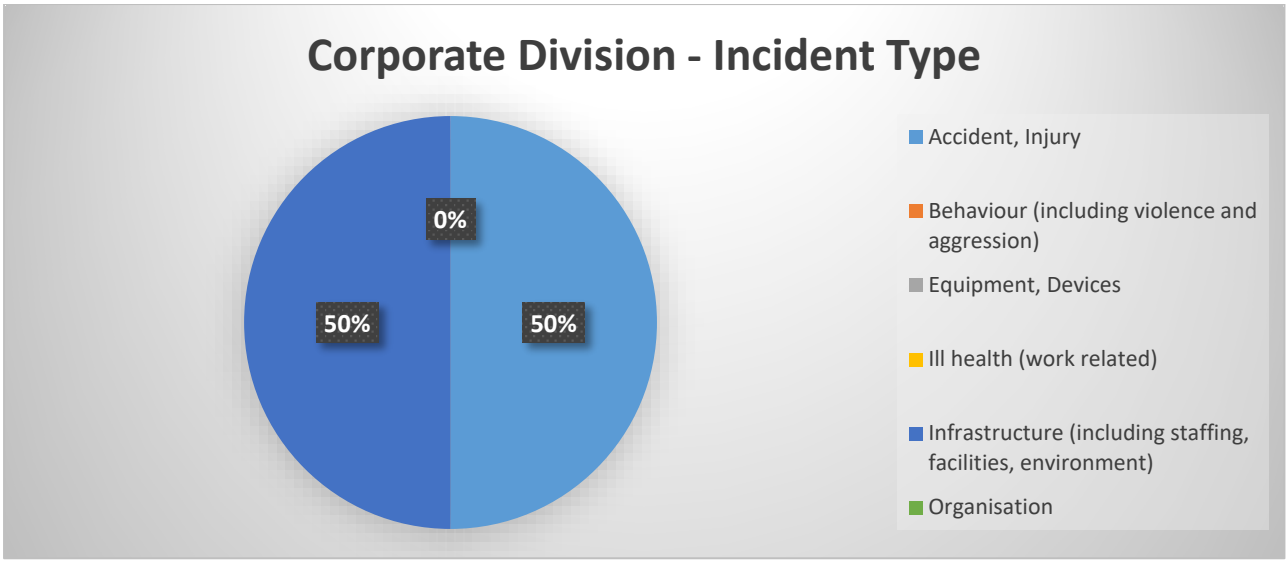


Chart 5 Corporate Division Incidents by type



5.8 There were only four incidents recorded in Corporate Division – thermal comfort, a road traffic incident, theft of earthing cables at Velindre Cancer Centre and one sharps incident.

6 Reporting of Incidents Diseases and Dangerous Occupancies Regulations 2012 (RIDDOR)

6.1 The Welsh Blood Service reported two incidents to the Health and Safety Executive during 2021-2022. The Health and Safety Executive took no further action on either occasion.

Table 5

Date	Incident
10/2021	During a break time walk a member of staff slipped and fell on a path that runs along the boundary of the Welsh Blood Service site. The staff member attended A&E where a fractured wrist was confirmed. This is a reportable injury as defined by the Regulations. Signage warning staff of the hazards was in place at the time and works have since been completed on the path to remove moss. Further remedial work has been identified but has not been completed due to funding constraints.
01/2022	A member of the Welsh Blood Service Collection Team staff fell from a faulty chair belonging to a venue. The chair collapsed when he sat on it. An existing back injury was aggravated during the fall resulting in the staff member being off work for 9 days. As a result an over 7 day injury was reported under RIDDOR. The member of the team returned to work and resumed normal duties with supervision by Team Supervisor

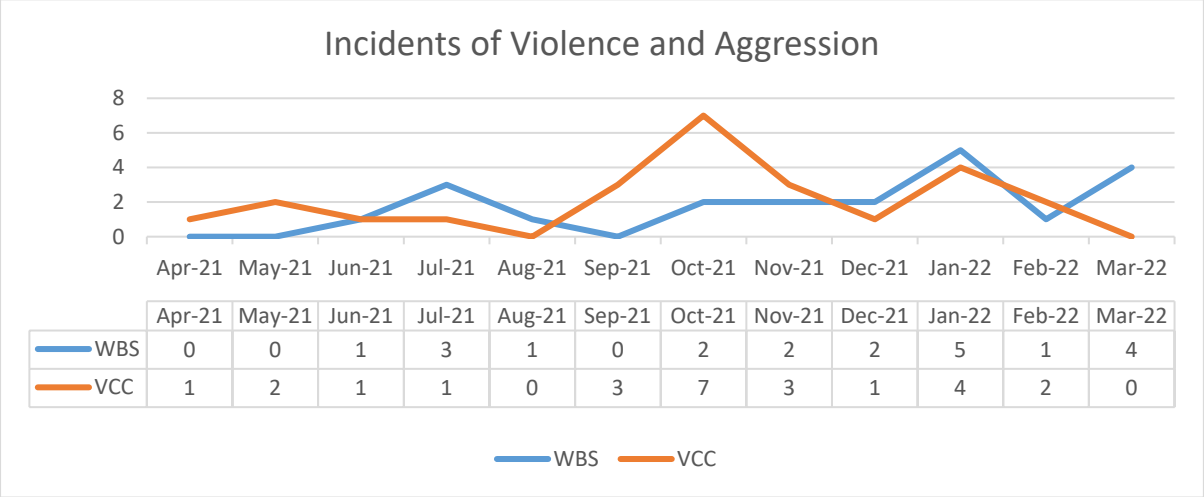
7 Violence and Aggression

7.1 Incidents of violence and aggression remain at relatively low levels across the Trust. The spike in recorded incidents from September to November 2021 represents a series of

incident involving an individual patient who was verbally aggressive to staff both other the telephone and when attending clinic. Case management support was provided by the Trust Health and Safety Manager and advice was taken from the Case Management team at Cardiff and Vale University Health Board. Action was escalated and a letter and Behaviour Agreement issued to the individual concerned. Continued Case Management support for Velindre Cancer Centre is provided by the Health and Safety Advisor and staff are actively encouraged to report incidents.

7.2 At Welsh Blood Services cases of verbal aggression by donors often relate to frustration around donation and Covid19 protocols. A revised SOP has been drafted and an escalation procedure is in place for repeated/serious incidents.

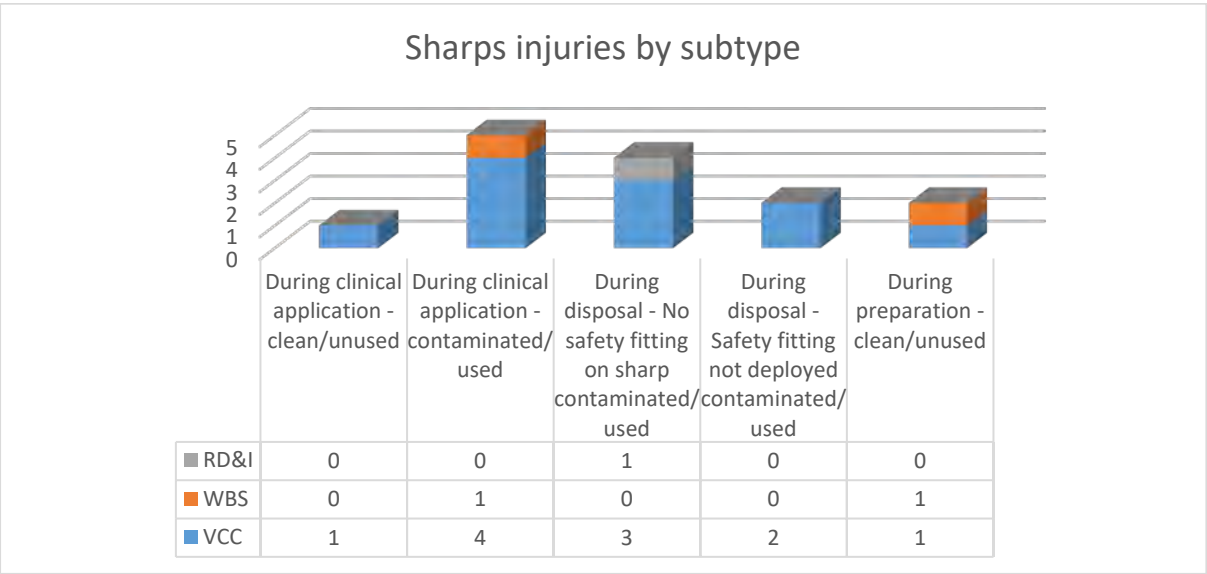
Chart 6 and Table 6 – Incidents of Violence and aggression at VCC and WBS by month



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
WBS	0	0	1	3	1	0	2	2	2	5	1	4
VCC	1	2	1	1	0	3	7	3	1	4	2	0

8 Sharps injuries

Chart 7 and Table 7



	During clinical application - clean/unused	During clinical application - contaminated/ used	During disposal - No safety fitting on sharp contaminated/ used	During disposal - Safety fitting not deployed contaminated/ used	During preparation - clean/unused
RD&I	0	0	1	0	0
WBS	0	1	0	0	1
VCC	1	4	3	2	1

8.1 In all cases the referral process to Occupational Health has been followed. Infection Protection and Control are working with Health and Safety to review non-safety sharps risk assessments, and to review of areas ordering non safety to identify any gaps. Where

appropriate the 'Focused Review' function is used on Datix to enhance investigations and guidance is provided to departments to support investigations to ensure causes are identified and lessons learned.

9 Recording of risks

9.1 Velindre Cancer Centre and Corporate Division migrated to Datix v14 in May 2021. Welsh Blood Service continued to use Datix v12 whilst assurance around risk management processes where finalised. All Health and Safety risks rated above 12 were reported to divisional Health, Safety and Fire meetings and to the Trust Health Safety and Fire Board for scrutiny.

9.2 The adequacy of Health and Safety risk assessments is captured as part of the departmental HSG65 audits currently being scheduled and undertaken.

9.3 It is planned to roll out additional risk assessment training during 2022-2023.

10 Health and Safety Statutory and Mandatory Training Compliance

10.1 Health and safety training requirements are identified by training needs analysis. Table 8 shows the training compliance for individual courses for the Trust as a whole. The majority of courses are provided on-line through the ESR system with two moving and handling courses (inanimate loads and people handling) provided face to face in line with the requirements of the All Wales Passport Scheme.

10.2 Compliance on most courses have risen steadily during the year but remains below the 85% target set by the Welsh Government. Multiple channels are used to communicate with managers and staff to enable increased compliance including monitoring at Trust and divisional health and safety meetings, escalation to senior management meetings, auditing of compliance during departmental HSG65 audits and contact with individual managers.

Table 8 – Trust wide compliance with Health and Safety statutory and mandatory training

	Health Safety and Welfare	Moving & Handling module A	Moving & Handling Inanimate load	Moving &Handling People Handling	Display Screen Equipment	Violence and Aggression module A	Violence and Aggression module B	Trust Compliance
Apr-21	86%	71%	49%	61%	64%	88%	27%	67%
May-21	87%	58%	50%	61%	65%	89%	28%	67%
Jun-21	86%	63%	56%	49%	66%	90%	29%	70%
Jul-21	85%	68%	64%	82%	67%	90%	44%	74%
Aug-21	86%	71%	66%	90%	68%	90%	51%	75%
Sep-21	84%	74%	71%	90%	67%	90%	55%	77%
Oct-21	84%	74%	72%	92%	66%	90%	59%	77%
Nov-21	85%	75%	70%	95%	68%	91%	65%	79%
Dec-21	86%	74%	69%	95%	69%	92%	67%	79%
Jan-22	86%	73%	66%	95%	69%	82%	72%	79%
Feb-22	85%	73%	65%	91%	70%	92%	73%	79%
Mar-22	83%	75%	64%	87%	70%	93%	75%	79%

Table 9 - Health and Safety statutory and mandatory training compliance by division

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Corporate	68%	68%	68%	69%	69%	70%	74%	73%	75%	73%	74%	75%
RD&I	75%	78%	83%	82%	84%	84%	86%	86%	85%	82%	81%	81%
TCS	72%	72%	74%	75%	81%	77%	77%	77%	75%	74%	76%	74%
VCC	63%	64%	65%	68%	70%	72%	72%	74%	75%	76%	77%	78%
WBS	70%	71%	77%	83%	85%	86%	86%	86%	86%	85%	83%	83%
Trust	67%	67%	70%	74%	75%	77%	77%	79%	79%	79%	79%	79%

11 Manual Handling Training

11.1 There are three levels of manual handling training provided to staff across the Trust, the syllabus for which is defined in the All Wales Manual Handling Passport Scheme which is adopted by all NHS Trusts and Health Boards in Wales. The requirement for each course is identified by Training Needs Analysis

- Module A – available on-line
- Inanimate Load – face to face training
- Patient Handling – face to face training

11.2 The training compliance in some divisions is below the target level of 85% set by the Welsh Government.

11.3 Training compliance is monitored at divisional Health Safety and Fire meetings/ Cynefin Group, at the Joint Estates Management Group meeting and at the Trust Health, Safety and Fire Board. Health and Safety training compliance has also been escalated to Senior Management meetings within the divisions. Compliance is also discussed during the HSG65 Health and Safety Audit.

11.4 Module A – compliance is monitored and managers continue to be reminded to ensure that staff complete mandatory training. Arrangements are in place to enable access to IT to enable completion of the training.

11.5 Inanimate Load Training – Courses have been run in house, further courses are planned using an external provider although in Velindre Cancer Centre/Corporate Division take up is not always to capacity due to operational staff pressures. In future, plans are in place to re-establish in house provision.

11.6 Eight members of staff at Velindre Cancer Centre have been trained as Manual Handling Workplace Assessors through an initiative piloted by Cardiff and Vale University Health Board.

These staff are able to assess staff patient handling competence in the workplace on a three year alternating cycle with class room refresher training.

11.7 People Handling – the Service Level Agreement with Cardiff and Vale University Health Board remains in place and offers places on training course. Plans are also in hand to also be able to offer in house training from September 2022 onwards. People handling training at WBS will continue to be delivered by the Clinical Training Team to the Collection Teams.

11.8 Further discussions are continuing with operational departments and support services to identify any / more flexible solutions that enable higher numbers of staff to attend the training courses available.

Table 10 – Manual Handling training compliance year end March 2022 (%)

	Moving and Handling Module A	Moving and Handling Inanimate Load	Moving and Handling – People Handling
Corporate Division	65.24%	56.52%	
RD&I	80.95%	100%	62.5%
TCS	70.83%	20%	
VCC	69.57%	58.72%	58.48%
WBS	89.21%	63.33%	86.4%

12 Progress against Health and Safety Strategic Goals 2020 -2023

12.1 There has been good progress against the Health and Safety Strategic Goals with further action schedules until the end of the period (2023) for which these goals have been set.

Table 11 – Progress with Health and Safety Strategic Goals 2020-2023

	Topic area	Strategic Goal	Progress	Timescale
1	Leadership	To demonstrate strong and effective health and safety leadership across the Trust	Introduction of Trust and divisional Health, Safety and Fire Management meetings.	Complete
2	Mangers	To develop Health and Safety training course for managers	Development and roll out of VUNHST specific course for managers. Flexible mode of delivery to account for covid19 pressures. Supported by managers information on staff intranet.	Q3, Q4 2022 Q1 2023

3	Management System	To ensure that the Trust has an effective health and safety management system across all divisions	Review and refresh of Health Safety and Welfare Policy. Appointment of H&S Advisor at VCC. Update of H&S procedures at VCC and ongoing review and rationalisation of procedures at WBS.	Q3, Q4 2022
4	Monitoring	To ensure that health and safety performance is monitored and reported and that opportunities for continual improvement are actioned.	Continuation of audit programme in WBS. Scheduling and implementation of HSG65 audit in Corporate Division and VCC. Report provided to Trust Health, Safety and Fire Board	Q3, Q4 2022 Q1, Q2 2023

13 Health and Safety Related Personal Injury Claims

13.1 During the reporting period for 2021-2022, the main type of personal injury claims (excluding product liability) relate to:

Data Protection Breach	Repetitive Strain	Poor Record Keeping	Defective Equipment	Slips, Trips and Falls
1	1	1	3	2

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Welsh Language Annual Report 2021-22

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Jo Williams, Welsh language Manager
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

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	01/09/22	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 We are required to produce an annual report each year detailing the Trust's compliance against the Welsh Language Standards. The format of the report has been followed under the guidance set out by the Welsh Language Commissioner.

1.2 QSP have previously seen this report as part of the Trust's Annual Report 2021-22, accepted at the Annual General meeting earlier this year. It is an account of the previous year's activity relating to the compliance against the Welsh Language Standards.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The ethos of the Welsh language cultural plan was agreed during year. Further work on this will continue running alongside the conversation around the Trust values and how Welsh language and Welsh culture can enhance the work that the Trust currently does to support patients and donors.

2.2 Welsh language training was increased during the year and again further support for successful learners continues.

2.3 The recruitment process was strengthened and embedded in how the Trust advertises and recruits for Welsh language skills within new posts. It provides the Trust with a more detailed view of when and why Welsh language skills are required, supporting our workforce planning needs.

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	Yes (Include further detail below)
	The non-production of a report could result in a £5,000 fine relating to non-compliance of the Welsh Language Policy Standards
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As above

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **ENDORSE FOR BOARD APPROVAL** the Welsh Language Annual Report 2021-22

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Cymraeg

WELSH LANGUAGE ANNUAL REPORT 2021/22

Welsh language Annual Report

2021-2022

Introduction

This report will focus on the importance the Trust gives to enhancing bilingual provision. It will demonstrate a commitment to the Welsh language standards but also highlight the work we are currently doing on our Welsh language Cultural plan, which is our platform for celebrating and recognising the cultural importance of Wales.

We continue to to provide support for the needs of our bilingual patients and donors. We are keen to ensure the services we provide are even more visible than previously especially at a time where the pandemic has made it difficult to communicate face to face.

We continue to strenthen the Governance around this area and recognise the importance of the Welsh language Standards but are also eager to do more than is required of us. We have began a Trust wide converstation this year on the meaning of Culture and have recognised that our values need to emulate what it means for our staff to provide a bilingual service under continued pressures that the pandemic has brought to us.

We value the work of our staff and at a time of continued change we seek to support them with all that they need to belong to an organisation with true values of Welsh language and Culture. The ethos of our new Cultural plan was accepted by the Executive Board and moving forward we will embace its aims and objectives and seek to further integrate our support for staff, patients and donors who need or chose to use the Welsh language.

Steve Ham

Chief Executive

Celebrating Welsh culture

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its languages. We recognise the need to comply with its legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have drafted a Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive management board have taken on roles of responsibility for certain aspects of the Equality and Diverstity agenda and this includes an Ambasador role responsible for the Welsh language.

The Trusts draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Board.

Strengthening the Governance

Welsh language Standards Compliance

As of November 2021 our Trust compliane of the Welsh language Standards stands at over 50%. This evidence is collected through our internal divisional working groups and reported to our Trust wide Welsh language development group. It is our way of ensuring we can build on the regulated compliance year on year and put projects in place to ensure we focus our provision productively.

Patient and donor correspondence

We previosuly reported on a systematic approach to ensuring out patient correspondence was bilingual. Since last year this has been put on hold in a number of areas as the old system generating the letters has been put on hold. All development initiatives were ceased due to the pandemic and the roll out of the new new patient system has also been slower than anticipated.

As a Trust we are determined to ensure our bilingual correspondence is accessible and although at the Welsh Blood Service this is a process historically followed we have some way to go to ensure Velindre Cancer Centre are in line with our ambitions.

One of our departments are leading the way in this. Radiotherapy have translated and are using biligual letters as standard and they have also ensured that reception is supported by Welsh speaking triage staff as the number of Welsh speaking reception staff continues to be low. This is a positive way to ensure a department is supported when needed by other members of staff which is the ethos that underpins the 'more than just words' framework.

Monitoring telephone calls to and from the Trust is extremely challenging. At the Welsh Blood Service this is more achievable. In this reporting year, calls to the Donor Collection team was 1004. This is 2% of the overall calls into the donor contact centre.

Our Welsh language Working group at Velindre Cancer Centre will take the monitoring of this on board as a matter of urgency this reporting year.

Meetings

In light of the continued change to working arrangements under the pandemic it has been necessary to think of ways in which we can internally support bilingual staff at meetings if they wish to use the Welsh language.

For external meetings we continue to be mindful of the ongoing work underway by Welsh Government with Microsoft and look forward to hearing how this progresses over the coming months. Internally we are piloting a method of language identification within Teams (at the Welsh Blood Service) and will monitor the take up of this. The process will then be diseminated Trust wide as an option for language identification at internal meetings.

Recruiting Welsh speakers

As we stated in last's years report our aim in this reporting year was to finalise our recruitment and language assessment process. We have completed this and are now ensuring that ALL posts going out for recruitment complete a language assessment table that is discussed with the Welsh language manager should questions arise. It has taken some time to integrate this process but we are confident that this will change the way in which we assess the need for language skills, not only as part of the individual post but for the wider teams across the Trust.

The process is in its infancy but will over time give us the data we need to evaluate its success.

As you will see from the figures below the pandemic has placed clinical priorities over language needs and we will be monitoring the increase in the number of 'essential' roles once the recruitment process has embedded.

Moving forward we will also be looking at the translation of our adverts and supporting materials. This will begin in 2022.

Velindre University NHS Trust 2021-2022

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh language skills are desirable	98
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	6

Total Number of vacancies advertised 01/04/2021 to 31/03/2022	105

Welsh Blood Service 2021-2022

Total number of vacancies advertised as:	
Welsh language skills are essential	0
Welsh language skills are desirable	97

Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	1

Total Number of vacancies advertised 01/04/2021 to 31/03/2022	98

Velindre Cancer Centre 2021-2022	

Total number of vacancies advertised as:	
Welsh language skills are essential	0
Welsh language skills are desirable	269
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	23

Total Number of vacancies advertised 01/04/2021 to 31/03/2022	292

Communication

Translation

The Trust has committed additional financial support to translation and we now have two dedicated translators to support our work. We also have a translation agreement with one of our hosted organiations for additional support when needed.

This has meant that we can focus our translation priorities more and has enabled us to begin to translate important documentation such as Job descriptions and build a bank of dedicated bilingual descriptions for future use.

Translation figures continue to demonstrate the commitment given by the Trust to provide bilingual internal and external information and services. This reporting year we have progressed with the purchase of a memory software and are in the process of using this to ensure consistency with translaton and as a time saving of resource. Liaising with our translation colleagues across the NHS we can move this forward again this year and share a productice reasource with other translation teams.

Websites

Work continues on the Trust Website and the Welsh Blood Service have updated their site in line with priorities and bilingual requirements. This year they have also developed a dedicated Welsh langauge page mirroring that of the Trust's but specific to local requirements. The Promotion of this was extremely successful on St David's day as was the celebration of its dedicated Welsh language working group.

1.12% (3,390) of the Welsh Blood Service website booking portal users (April 2021 to March 2022) have their browsers set in Welsh.

Overall, the Trust main website has received 3,200 Welsh language hits in the reporting year.

Welsh language Education

This year we have been actively promoting providing Welsh language training in the workplace. In addition to regularly advertising the opportunities provided by 'Iaith Gwaith' we have been supported by Cardiff University to run two courses for our staff.

Providing in house training is not as simple as ensuring financial support it is crucial that staff are able to attend classes and are supported to do so. Unfortunately within a clinical setting this is not as successful as we would like, however, we are proud to announce that eight of our staff have successfully completed their first year and will be further supported by us to proceed to the next level of training.

Providing continued training and support to a small number of staff is more productive for the them and the needs of the services we provide. Our focus in the coming year is to further promote e-learning opportunities and a stronger in house support for those who wish to pracice and become more confident in the work place.

We are pleased to note that the new Welsh language awareness package supported by the Welsh Government is now completed. The Trust has been eager to recieve this and will now be integrating this as part of its regular training Trust wide initiatives.

Welsh language Skills

We have increased our data entry compliance this year and are now showing an 84.5% compliance within ESR.

Collecting the language data is extremely important, however we are aware that even though our recruitment processess use this information to ensure future recruitment needs, we now need to use this data to enable us to strengthen our services further.

Workforce planning and our People Strategy are central to this, being drafted with

'A Healthy and Engaged workforce, within a culture of true inclusivty, fairness and equality acoss the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and Cultural identity'

The Trust is demonstrating its commitment to ensuring the bilingual needs of its staff and services are central to planning at all levels and will continue this year to integrate these aims across the Trust.

	Assignment Count	Required	Achieved	Compliance %
	1587	4761	4027	84.58%
Org L4	**Assignment Count**	**Required**	**Achieved**	**Compliance %**
120 Corporate Division	172	516	442	85.66%
120 Research, Development and Innovation Division	51	153	137	89.54%
120 Transforming Cancer Services Division	25	75	54	72.00%
120 Velindre Cancer Centre	860	2580	2193	85.00%
120 Welsh Blood Service	479	1437	1201	83.58%

Promotion

Our Trust wide promotion continues with celebrations such as 'Diwrnod Shwmae / Sumae' and St David's day. This year we had an excellent colourfull day at the Cancer Centre with a themed menu at the restaurant and a drop in opportunity for staff.

At the Welsh Blood service the launch of a dedicated Intranet page to assist staff was the main theme and an opportunity once again for staff to hear about the work of the Welsh language working group. It was also a great opportunity to congratulate the Welsh language learners who have completed the first year of their courses.

They will progress this coming year to a second level giving them opportunity to further develop their Welsh language skills.

Concerns and Complaints

The Welsh Blood Service

Three donor complaints were recieved by the Welsh Blood Service this reporting year.

The first two were relating to text messaging errors and the standard of Welsh sent and the other relating to a website error. Unfortunately an old message had been used and not a professionally translated message but this was rectified.

All three complaints were investigated thoroughly and as a consequence changes have been made to the service and checking processes.

None of the complaints resulted in a formal investigation being undertaken by the Welsh language Commissioner.

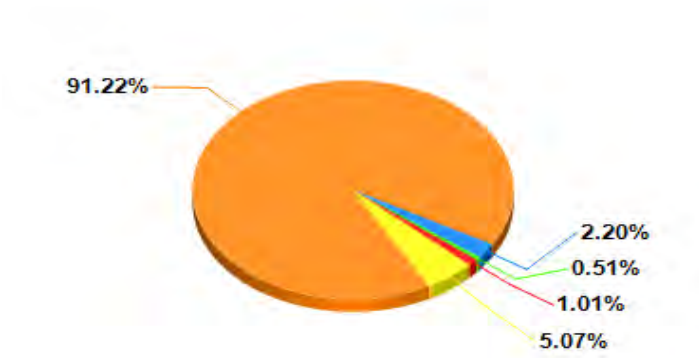
Velindre Cancer Centre

Patient Experience

During this reporting period, we have introduced a new digital feedback system at Velindre Cancer Centre. CIVICA Experience is a cloud-based insights platform which supports multi-channel survey data collection, real-time reporting, smart text analytics, workflow tools, event-driven alerts and push reporting. It was procured in 2021 as part of a Once for Wales exercise to support improvement across NHS Wales.

Capturing feedback from patients and their families in line with the National Framework for Assuring Service User Experience can now be conducted digitally and in real-time, enabling us to capture more data in a timely and responsive system. The CIVICA Experience implementation has seen an increase in survey responses and in particular Question 3 which references the Welsh language.

A total of 592 people answered the question "*Were you able to speak Welsh to staff if you needed to*?" with 5% of respondents saying "Never". This equates to 30 patients who feel they were never able to use Welsh in Velindre. This powerful data is now informing our local improvement plans and will be used to continually monitor the impact and progress of service developments.



Hosted organisations

The Trust continues to host Health Technology Wales (HTW) and the Shared Services Partnership (NWSSP). Both organisations are committed to ensuring the Welsh language standards are a high priority.

HTW have been actively translating Job descriptions in line with the requirements of the Welsh language standards.

NWSSP have ensured that staff across the NHS can now access the opening page of the Electronis Staff record system in Welsh and in English. This is a really positive step forward as the system has been monolingual since its inception. Being able to access personal employee information in the language of choice demonstrates a commitment to the language needs of the NHS employees and NWSSP have provided this.

Other areas of development have included:

- **Translation Support Services**
  The Welsh Language Unit, in NHS Wales Shared Services Partnership have provided translation services for the following NHS organisations during 2021/22:

- NHS Wales Shared Services Partnership's divisions and hosted programmes
- Public Health Wales NHS Trust
- Digital Health and Care Wales
- Velindre University NHS Trust
- Health Education Improvement Wales
- Wales Ambulance Service Trust in the translation of the 111 Website
- Welsh Health Specialised Services Committee
- The All Wales Value in Health Care programme
- Supported NHS Employers in the translation of Job Descriptions and Person Specifications

Totalling over 3.7 million words translated during 2021/22.

- **Translation Bank**
  The NHS is facing unprecedented demand for translation services, this is in response to meeting the requirements of the Welsh language standards in the most part, but also to respond to the need/demand amongst patients and the public.
  It is becoming increasingly difficult to recruit qualified and experienced translators to full-time permanent vacancies, and it is also becoming challenging to retain staff, due to the recruitment market being extremely competitive.
  To be able to respond to this situation we've established a bank of translators who can work flexibly for us as we require their services. The bank was established in autumn 2021, and our existing arrangements are working well to date. Our approach to agile working also means that we can recruit translators from different parts of Wales and beyond to assist us with our ability to respond to the demand for translation services.
- **Student Streamlining**
  NHS Wales Shared Services have improved the customer journey through Student Streamlining Service by ensuring the system provides a Welsh language journey throughout the process.
  We audited and reviewed our processes, automated services and templates to ensure that there is now a seamless Welsh language offer to students engaging with our service.
  As part of this project, we also translated adverts and job descriptions to enable Health Boards to be able to advertise the opportunities through the Student Streamlining programme through both the medium of Welsh and English.
- **All Wales Patient Information Leaflets**
  We undertook a comprehensive audit and review of over 350 Patient Information Leaflets during 2021/22. The leaflets are given to patients as part of the consent process. The audit and review enabled us to make improvements to the language used in the leaflets, to have consistency in terminology as well as making the leaflets wholly bilingual for patients in Wales. Previously Welsh and English versions were available separately. This work will continue in 2022/23 with work being undertaken in partnership with Eido Healthcare to translate easy read versions of the leaflets.
- **ESR Portlets available in Welsh**
  The Welsh Language Unit and the Workforce Information Systems team worked collaboratively with the NHS Business Services Authority and IBM on the development of Welsh Language Portlets on ESR in the autumn of 2021. This now means that the portals on ESR are available to NHS Staff in both Welsh and English to satisfy the requirements of Standard 81 of the Operational Standards.
- **Contact Centre Review Project**
  The purpose of this review project was to audit our existing centre services, establish how our customers currently engage with us, identify improvements, and to increase and improve the self-serve element of the services we provide.

As part of this work, the Welsh language provision of services was also scrutinised, and a survey circulated to NHS staff identified that between 10% and 20% of NHS staff wished to engage with us through the medium of Welsh.
Further work will be undertaken with contact centres throughout NWSSP over the coming years.

- **TRAC Recruitment system updates**
  We have continued to work with the developers of the TRAC system to ensure that the interface for the system continues to be up-to-date and consistent in both Welsh and English.

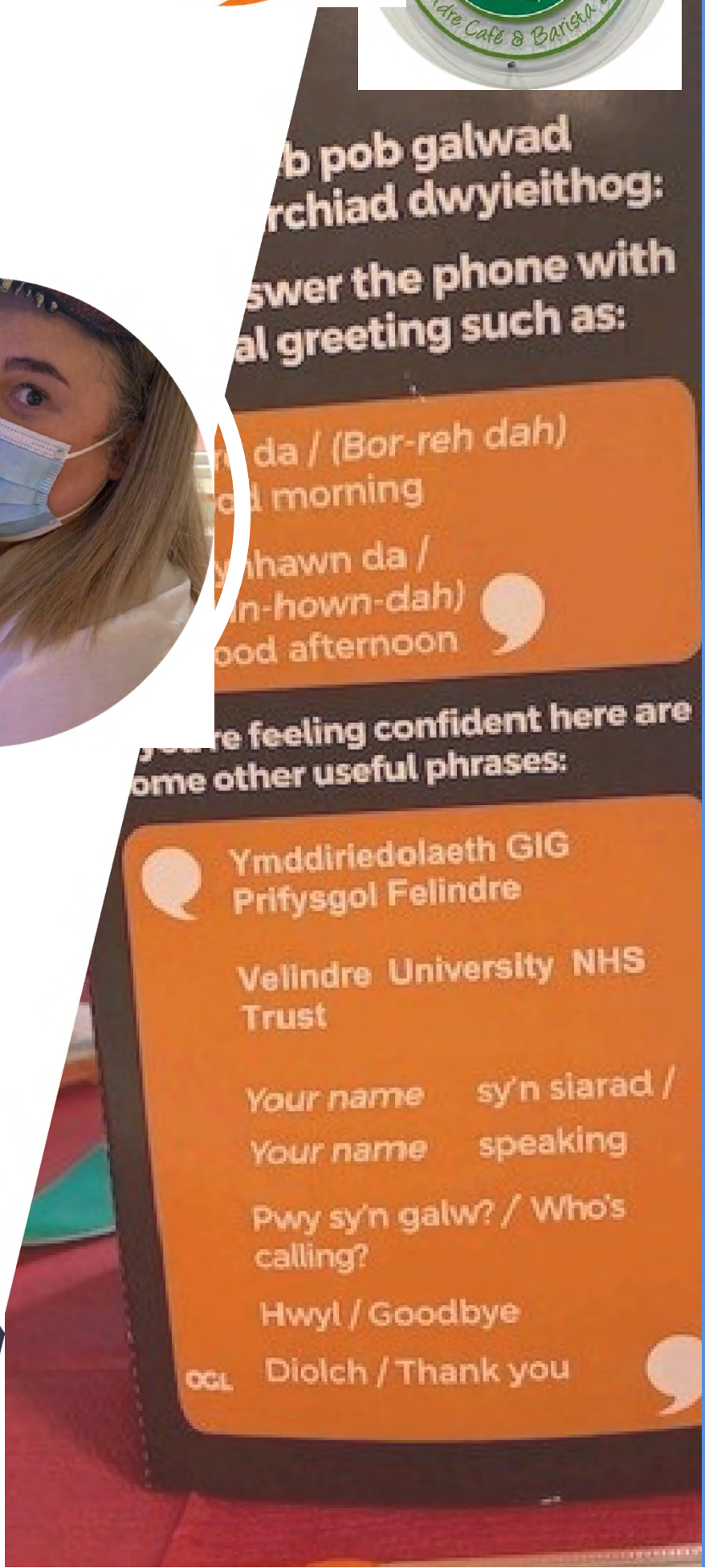
Moving forward

Over the coming year the Trust will revisit its Values and consult practively with its staff. Culture is central to these values and as we know a positive culture drives better care. We will be considering how we can further integrate our Welsh language and our divisional groups will take forward specific aims and objectives in order to strenghten provision locally.

Nationally we will continue to work with our partners, Local Health Boards and Welsh Government. The language and Culture of Wales belongs to us all and as a Trust we strive to provide the best bilingual care that we can.

ADRODDIAD
BLYNYDDO
GYMRAEG 20

Cymraeg



RHEOLIADAU'R GYMRAEG A CHYDYMFFURFEDD

Cyflwyniad:

Bydd yr adroddiad hwn yn canolbwyntio ar y gwerth y mae'r Ymddiriedolaeth yn ei roi i wella'r ddarpariaeth ddwyieithog. Bydd yn dangos ymrwymiad i Safonau'r Gymraeg ond hefyd yn tynnu sylw at y gwaith rydym yn ei wneud ar hyn o bryd ar ein Cynllun Diwylliannol Cymraeg, sef ein llwyfan ar gyfer dathlu a chydnabod pwysigrwydd diwylliannol Cymru.

Rydym yn parhau i ddarparu cymorth ar gyfer anghenion ein cleifion a'n rhoddwyr dwyieithog. Rydym yn awyddus i sicrhau bod y gwasanaethau a ddarparwn hyd yn oed yn fwy gweladwy nag o'r blaen yn enwedig ar adeg lle mae'r pandemig wedi ei gwneud yn anodd cyfathrebu wyneb yn wyneb.

Rydym yn parhau i ymestyn y Llywodraethiant o amgylch y maes hwn ac yn cydnabod pwysigrwydd Safonau'r Gymraeg ond rydym hefyd yn awyddus i wneud mwy na'r hyn sy'n ofynnol gennym. Rydym wedi dechrau sgwrs ar draws yr Ymddiriedolaeth eleni ar ystyr Diwylliant ac wedi cydnabod bod angen i'n gwerthoedd efelychu'r hyn y mae'n ei olygu i'n staff ddarparu gwasanaeth dwyieithog o dan y pwysau parhaus y mae'r pandemig wedi'u dwyn i ni.

Rydym yn gwerthfawrogi gwaith ein staff ac ar adeg o newid parhaus rydym yn ceisio eu cefnogi gyda phopeth sydd ei angen arnynt i berthyn i sefydliad sydd â gwir werthoedd iaith a diwylliant Cymru. Cafodd ethos ein cynllun Diwylliannol newydd ei dderbyn gan y Bwrdd Gweithredol ac wrth symud ymlaen byddwn yn ymgorffori ei nodau a'i amcanion ac yn ceisio integreiddio ein cefnogaeth ymhellach i staff, cleifion a rhoddwyr sydd angen neu sy'n dewis defnyddio'r Gymraeg.

Steve Ham

Prif Weithredwr

Dathlu Diwylliant Cymru:

Mae'r Ymddiriedolaeth yn parhau i chwilio am ffyrdd o ennyn diddordeb ei staff yn niwylliant Cymru yn ogystal â'i hieithoedd. Rydym yn cydnabod yr angen i gydymffurfio â'i rwymedigaethau cyfreithiol ond ein nod yw gwneud mwy na'r hyn sydd ei angen gan fod hyn yn dathlu amrywiaeth ein staff a'n gwasanaethau.

Y flwyddyn adrodd hon rydym wedi drafftio Cynllun Diwylliannol sy'n anelu at gryfhau ein hymgysylltiad â staff ynghylch iaith a diwylliant Cymru a hyrwyddo gwerth cynhwysiant sy'n cwmpasu popeth a gredwn. Mae'r bwrdd rheoli gweithredol wedi ymgymryd â rolau cyfrifoldeb am rai agweddau ar yr agenda Cydraddoldeb ac Amrywiaeth ac mae hyn yn cynnwys rôl Llysgennad sy'n gyfrifol am y Gymraeg.

Nod cynllun Diwylliannol drafft yr Ymddiriedolaeth yw bod mor gynhwysol â phosibl a bydd Llysgennad y Gymraeg yn hyrwyddo ethos y cynllun hwn drwy gydol gwaith y Bwrdd Gweithredol.

Cydymffurfio â Safonau'r Gymraeg:

O fis Tachwedd 2021 ymlaen, mae cydymffurfiad ein Hymddiriedolaeth â Safonau'r Gymraeg dros 50%. Cesglir y dystiolaeth hon trwy ein gweithgorau is-adrannol mewnol a bydd y dystiolaeth yn cael ei hadrodd i'n grŵp datblygu'r Gymraeg ar draws yr Ymddiriedolaeth. Dyma'n ffordd ni o sicrhau y gallwn ddatblygu ar y cydymffurfedd a reoleiddir flwyddyn ar ôl blwyddyn a rhoi prosiectau ar waith i sicrhau ein bod yn canolbwyntio ein darpariaeth mewn ffordd gynhyrchiol.

Gohebiaeth cleifion a rhoddwyr:

Gwnaethom adrodd yn flaenorol ar ddull systematig o sicrhau bod gohebiaeth cleifion yn ddwyieithog. Ers y llynedd, mae hyn wedi cael ei ohirio mewn nifer o adrannau gan fod yr hen system sy'n cynhyrchu'r llythyrau yn dal i weithredu. Daeth yr holl fentrau datblygu i ben oherwydd y pandemig ac mae cyflwyno'r system cleifion newydd hefyd wedi bod yn arafach na'r disgwyl.

Fel Ymddiriedolaeth, rydym yn benderfynol o sicrhau bod ein gohebiaeth ddwyieithog yn hygyrch ac er bod hyn yng Ngwasanaeth Gwaed Cymru yn broses a ddilynwyd yn hanesyddol mae gennym beth ffordd i fynd i sicrhau bod Canolfan Ganser Felindre yn cyd-fynd â'n huchelgeisiau.

Mae un o'n hadrannau yn arwain y ffordd yn hyn o beth. Mae radiotherapi wedi cyfieithu llythyrau dwyieithog fel safon ac yn eu defnyddio, ac maent hefyd wedi sicrhau bod staff brysbennu sy'n siarad Cymraeg yn cefnogi'r dderbynfa gan fod nifer staff y dderbynfa sy'n siarad Cymraeg yn parhau i fod yn isel. Mae hon yn ffordd gadarnhaol o sicrhau bod adran yn cael ei chefnogi pan fo angen gan aelodau eraill o staff, sef yr ethos sy'n sail i'r fframwaith 'mwy na geiriau'.

Mae monitro galwadau ffôn i'r Ymddiriedolaeth ac oddi yno yn heriol dros ben. Yng Ngwasanaeth Gwaed Cymru, mae hyn yn fwy cyraeddadwy. Yn y flwyddyn adrodd

hon, nifer y galwadau [Cymraeg] i'r tîm Casglu Rhoddwyr oedd 1004. Mae hyn yn 2% o'r galwadau cyffredinol i'r ganolfan gyswllt rhoddwyr.

Bydd y Gweithgor Cymraeg yng Nghanolfan Ganser Felindre yn ystyried y gwaith o fonitro hyn fel mater o frys yn ystod y flwyddyn adrodd hon.

Cyfarfodydd:

Yng ngoleuni'r newid parhaus i drefniadau gweithio o dan y pandemig bu'n rhaid meddwl am ffyrdd y gallwn gefnogi staff dwyieithog yn fewnol mewn cyfarfodydd os ydynt yn dymuno defnyddio'r Gymraeg.

Ar gyfer cyfarfodydd allanol rydym yn parhau i fod yn ymwybodol o'r gwaith sy'n mynd rhagddo gan Lywodraeth Cymru gyda Microsoft ac edrychwn ymlaen at glywed sut mae hyn yn mynd rhagddo dros y misoedd nesaf. Yn fewnol rydym yn treialu dull adnabod iaith o fewn Teams (yng Ngwasanaeth Gwaed Cymru) a byddwn yn monitro'r defnydd o hyn. Bydd y broses wedyn yn cael ei dosbarthu ar draws yr Ymddiriedolaeth fel opsiwn ar gyfer adnabod iaith mewn cyfarfodydd mewnol.

Recriwtio Siaradwyr Cymraeg:

Fel y dywedasom yn yr adroddiad diwethaf, ein nod yn y flwyddyn adrodd hon oedd cwblhau ein proses recriwtio ac asesu iaith. Rydym wedi cwblhau hyn ac yn awr rydym yn sicrhau bod POB swydd sy'n mynd allan i recriwtio yn cwblhau tabl asesu iaith sy'n cael ei drafod gyda'r rheolwr iaith pe bai cwestiynau'n codi. Mae wedi cymryd peth amser i integreiddio'r broses hon ond rydym yn hyderus y bydd hyn yn newid y ffordd yr ydym yn asesu'r angen am sgiliau iaith, nid yn unig fel rhan o'r swydd unigol ond ar gyfer y timau ehangach ar draws yr Ymddiriedolaeth.

Mae'r broses yn ei babandod ond dros amser bydd yn rhoi'r data sydd ei angen arnom i werthuso ei llwyddiant.

Fel y gwelwch o'r ffigurau isod mae'r pandemig wedi gosod blaenoriaethau clinigol dros anghenion iaith a byddwn yn monitro'r cynnydd yn nifer y rolau 'hanfodol' unwaith y bydd y broses recriwtio wedi ymwreiddio.

Wrth symud ymlaen byddwn hefyd yn edrych ar gyfieithu ein hysbysebion a'n deunyddiau ategol. Bydd hyn yn dechrau yn 2022.

YMDDIRIEDOLAETH GIG PRIFYSGOL FELINDRE

Cyfanswm nifer y swyddi gwag a hysbysebwyd fel:	
Mae sgiliau Cymraeg yn hanfodol	1
Mae sgiliau Cymraeg yn ddymunol	98
Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd;	0
Nid yw sgiliau Cymraeg yn angenrheidiol.	6

Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022	105

Gwasanaeth Gwaed Cymru 2021-2022

Cyfanswm nifer y swyddi gwag a hysbysebwyd fel:	
Mae sgiliau Cymraeg yn hanfodol	0
Mae sgiliau Cymraeg yn ddymunol	97
Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd	0
Nid yw sgiliau Cymraeg yn angenrheidiol.	1

Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022	98

Canolfan Ganser Felindre 2021-2022

Cyfanswm nifer y swyddi gwag a hysbysebwyd fel:	
Mae sgiliau Cymraeg yn hanfodol	0
Mae sgiliau Cymraeg yn ddymunol	269
Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd	0
Nid yw sgiliau Cymraeg yn angenrheidiol.	23

Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022	292

Cyfathrebu

Cyfieithu:

Mae'r Ymddiriedolaeth wedi ymrwymo cymorth ariannol ychwanegol i gyfieithu a bellach mae gennym ddau gyfieithydd penodol i gefnogi ein gwaith. Mae gennym hefyd gytundeb cyfieithu gydag un o'n sefydliadau a letyir i gael cymorth ychwanegol pan fo angen.

Mae hyn wedi golygu y gallwn ganolbwyntio ein blaenoriaethau cyfieithu yn fwy ac mae wedi ein galluogi i ddechrau cyfieithu dogfennau pwysig fel swydd ddisgrifiadau a datblygu cronfa o ddisgrifiadau dwyieithog pwrpasol i'w defnyddio yn y dyfodol.

Mae ffigurau cyfieithu yn parhau i ddangos ymrwymiad yr Ymddiriedolaeth i ddarparu gwybodaeth a gwasanaethau mewnol ac allanol dwyieithog. Y flwyddyn adrodd hon rydym wedi symud ymlaen gyda phrynu meddalwedd cof cyfieithu ac rydym yn y broses o ddefnyddio hwn i sicrhau cysondeb gyda chyfieithu ac fel adnodd i arbed amser. Drwy gysylltu â'n cydweithwyr cyfieithu ar draws y GIG, gallwn symud hyn ymlaen eto eleni a rhannu adnodd defnyddiol gyda thimau cyfieithu eraill.

Gwefannau:

Mae'r gwaith yn parhau ar Wefan yr Ymddiriedolaeth ac mae Gwasanaeth Gwaed Cymru wedi diweddaru eu safle yn unol â blaenoriaethau a gofynion dwyieithog. Eleni maent hefyd wedi datblygu tudalen Gymraeg sy'n adlewyrchu gofynion yr Ymddiriedolaeth ond sy'n benodol i ofynion lleol. Bu hyrwyddo hyn yn hynod lwyddiannus ar Ddydd Gŵyl Dewi yn ogystal â dathlu ei gweithgor Cymraeg.

Mae gan 1.12% (3,390) o ddefnyddwyr porth archebu gwefan Gwasanaeth Gwaed Cymru (Ebrill 2021 i Fawrth 2022) eu porwyr wedi'u gosod yn y Gymraeg.

Yn gyffredinol, mae prif wefan yr Ymddiriedolaeth wedi derbyn 3,200 o ymweliadau Cymraeg yn y flwyddyn adrodd.

Addysg Gymraeg:

Eleni rydym wedi bod wrthi'n hyrwyddo darparu hyfforddiant Cymraeg yn y gweithle. Yn ogystal â hysbysebu'r cyfleoedd a ddarperir gan 'laith Gwaith' yn rheolaidd, rydym wedi cael cefnogaeth gan Brifysgol Caerdydd i gynnal dau gwrs i'n staff.

Nid yw darparu hyfforddiant mewnol mor syml â sicrhau cymorth ariannol, mae'n hanfodol fod staff yn gallu mynychu dosbarthiadau ac yn cael eu cefnogi i wneud hynny. Yn anffodus, mewn lleoliad clinigol, nid yw hyn mor llwyddiannus ag yr hoffem, fodd bynnag, rydym yn falch o gyhoeddi bod wyth o'n staff wedi cwblhau eu blwyddyn gyntaf yn llwyddiannus ac y byddant yn cael cefnogaeth bellach gennym i symud ymlaen i'r lefel nesaf o hyfforddiant.

Mae darparu hyfforddiant a chymorth parhaus i nifer fach o staff yn fwy cynhyrchiol iddynt hwy ac i anghenion y gwasanaethau a ddarparwn. Ein ffocws yn y flwyddyn i ddod yw hyrwyddo cyfleoedd e-ddysgu ymhellach a chefnogaeth fewnol gryfach i'r rhai sy'n dymuno ymarfer a dod yn fwy hyderus yn y gweithle.

Rydym yn falch o nodi bod y pecyn ymwybyddiaeth o'r Gymraeg newydd a gefnogir gan Lywodraeth Cymru bellach wedi'i gwblhau. Mae'r Ymddiriedolaeth wedi bod yn awyddus i dderbyn hyn a bydd nawr yn integreiddio hwn fel rhan o'i hyfforddiant rheolaidd ledled yr Ymddiriedolaeth.

Sgiliau Cymraeg:

Rydym wedi cynyddu ein cydymffurfedd cofnodi data eleni ac rydym bellach yn dangos cydymffurfedd o 84.5% o fewn ESR.

Mae casglu'r data iaith yn hynod bwysig, ond rydym yn ymwybodol, er bod ein proses recriwtio yn defnyddio'r wybodaeth hon i sicrhau anghenion recriwtio yn y dyfodol, bod angen i ni nawr ddefnyddio'r data hwn i'n galluogi i gryfhau ein gwasanaethau ymhellach.

Mae cynllunio'r gweithlu a'n Strategaeth Pobl yn ganolog i hyn, a fydd yn cael ei drafftio gyda

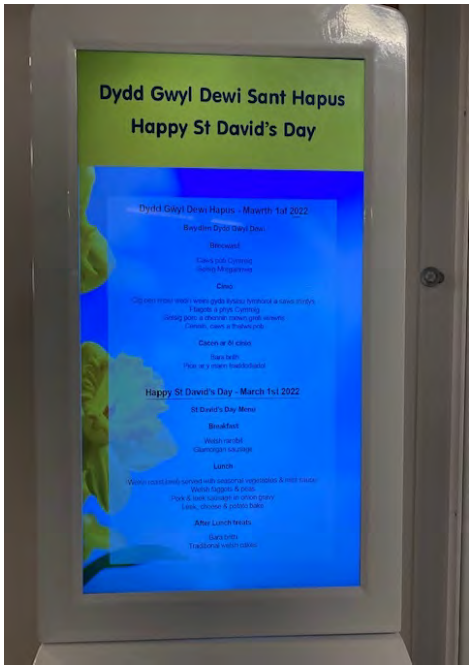
'Gweithlu Iach ac Ymgysylltiedig: o fewn Diwylliant o wir gynwysoldeb, tegwch a chydraddoldeb ar draws y gweithlu. Gweithlu sy'n adlewyrchu amrywiaeth a hunaniaeth poblogaeth Cymru o ran y Gymraeg a'i diwylliant'

Mae'r Ymddiriedolaeth yn dangos ei hymrwymiad i sicrhau bod anghenion dwyieithog ei staff a'i gwasanaethau yn ganolog i gynllunio ar bob lefel a bydd yn parhau eleni i integreiddio'r nodau hyn ar draws yr Ymddiriedolaeth.

	Nifer yr Aseiniadau	Angenrheidiol	Wedi'i gyflawni	Cydymffurfedd %
	1587	4761	4027	84.58%
Org L4	**Nifer yr Aseiniadau**	**Angenrheidiol**	**Wedi'i gyflawni**	**Cydymffurfedd %**
120 Is-adran Gorfforaethol	172	516	442	85.66%
Is-adran Ymchwil, Datblygu ac Arloesi	51	153	137	89.54%
Is-adran Trawsnewid Gwasanaethau Canser	25	75	54	72.00%
120 Canolfan Ganser Felindre	860	2580	2193	85.00%
120 Gwasanaeth Gwaed Cymru	479	1437	1201	83.58%

Hyrwyddo:

Mae ein gwaith hyrwyddo ar draws yr Ymddiriedolaeth yn parhau gyda dathliadau megis 'Diwrnod Shwmae /Sumae' a Dydd Gŵyl Dewi. Eleni cawsom ddiwrnod lliwgar ardderchog yn y Ganolfan Ganser gyda bwydlen thematig yn y bwyty a chyfle i staff i gyd alw heibio.



Yng Ngwasanaeth Gwaed Cymru lansio tudalen benodol ar y Fewnrwyd i gynorthwyo staff oedd y brif thema ac roedd yn gyfle unwaith eto i staff glywed am waith y gweithgor Cymraeg. Roedd hefyd yn gyfle gwych i longyfarch y dysgwyr Cymraeg sydd wedi cwblhau blwyddyn gyntaf eu cyrsiau.

Byddant yn symud ymlaen y flwyddyn nesaf i ail lefel gan roi cyfle iddynt ddatblygu eu sgiliau Cymraeg ymhellach.

Pryderon a Chwynion

Gwasanaeth Gwaed Cymru:

Cafodd tair cwyn gan roddwyr eu derbyn gan Wasanaeth Gwaed Cymru yn ystod y flwyddyn adrodd hon.

Roedd y ddwy gyntaf yn ymwneud â gwallau mewn negeseuon testun a safon y Gymraeg a anfonwyd, a'r llall yn ymwneud â gwall ar y wefan. Yn anffodus roedd hen neges wedi'i defnyddio ac nid oedd yn neges wedi'i chyfieithu'n broffesiynol ond cafodd hyn ei gywiro. Ymchwiliwyd yn drylwyr i'r tair cwyn ac o ganlyniad gwnaed newidiadau i'r gwasanaeth a'r prosesau gwirio.

Nid oedd yr un o'r cwynion wedi arwain at ymchwiliad ffurfiol gan Gomisiynydd y Gymraeg.

Canolfan Ganser Felindre: Profiad y Cleifion:

Yn ystod y cyfnod adrodd hwn, rydym wedi cyflwyno system adborth ddigidol newydd yng Nghanolfan Ganser Felindre. Mae CIVICA Experience yn blatfform mewnwelediadau yn y cwmwl sy'n cefnogi casglu data arolwg aml-sianel, adrodd mewn amser real, dadansoddeg testun craff, offer llif gwaith, rhybuddion sy'n cael eu

gyrru gan ddigwyddiadau a *push reporting.* Cafodd ei gaffael yn 2021 fel rhan o ymarferiad Unwaith i Gymru i gefnogi gwelliannau ar draws GIG Cymru.

Gall casglu adborth gan gleifion a'u teuluoedd yn unol â'r Fframwaith Cenedlaethol ar gyfer Sicrhau Profiad Defnyddwyr Gwasanaeth gael ei wneud yn ddigidol ac mewn amser real, gan ein galluogi i gasglu mwy o ddata mewn system amserol ac ymatebol. Mae gweithredu CIVICA Experience wedi gweld cynnydd yn nifer yr ymatebion i'r arolwg ac yn benodol Cwestiwn 3 sy'n cyfeirio at y Gymraeg.

Atebodd cyfanswm o 592 o bobl y cwestiwn "*Oeddech chi'n gallu siarad Cymraeg â staff os oedd angen i chi*? " gyda 5% o'r ymatebwyr yn dweud "Byth". Mae hyn yn cyfateb i 30 o gleifion sy'n teimlo nad oeddent fyth yn gallu defnyddio'r Gymraeg yn Felindre. Mae'r data pwerus hwn bellach yn llywio ein cynlluniau gwella lleol a bydd yn cael ei ddefnyddio i fonitro effaith a chynnydd datblygiadau gwasanaeth yn barhaus.

Sefydliadau a Letyir:

Mae'r Ymddiriedolaeth yn parhau i letya Technoleg Iechyd Cymru (HTW) a'r Bartneriaeth Cydwasanaethau (NWSSP). Mae'r ddau sefydliad wedi ymrwymo i sicrhau bod safonau'r Gymraeg yn flaenoriaeth uchel.

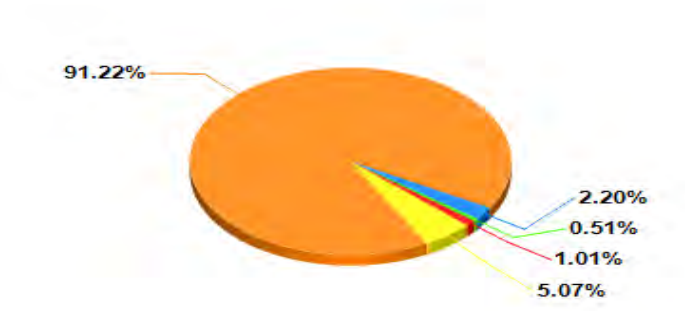
Mae Technoleg Iechyd Cymru wedi bod wrthi'n cyfieithu swydd ddisgrifiadau yn unol â gofynion Safonau'r Gymraeg.

Mae Partneriaeth Cydwasanaethau GIG Cymru (NWSSP) wedi sicrhau bod staff ar draws y GIG bellach yn gallu cael mynediad at dudalen agoriadol y system Cofnod Staff Electronig yn Gymraeg ac yn Saesneg. Mae hwn yn gam cadarnhaol iawn ymlaen gan fod y system wedi bod yn uniaith ers ei sefydlu. Mae gallu cael gafael ar wybodaeth bersonol cyflogeion yn yr iaith o ddewis yn dangos ymrwymiad i anghenion iaith gweithwyr y GIG ac mae Partneriaeth Cydwasanaethau GIG Cymru wedi darparu hyn.

Mae meysydd datblygu eraill wedi cynnwys:

- **Gwasanaethau Cymorth Cyfieithu:**

  Mae Uned y Gymraeg, ym Mhartneriaeth Cydwasanaethau GIG Cymru wedi darparu gwasanaethau cyfieithu ar gyfer y sefydliadau GIG canlynol yn ystod 2021/22:



- Is-adrannau a rhaglenni a letyir gan Bartneriaeth Cydwasanaethau GIG Cymru
- Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru
- Iechyd a Gofal Digidol Cymru

- Ymddiriedolaeth GIG Prifysgol Felindre
- Addysg a Gwella Iechyd Cymru
- Ymddiriedolaeth Gwasanaeth Ambiwlans Cymru o ran cyfieithu Gwefan 111
- Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
- Rhaglen Gwerth mewn Gofal Iechyd Cymru
- Cefnogwyd Cyflogwyr y GIG i gyfieithu Swydd Ddisgrifiadau a Manylebau'r Person

Cyfieithwyd cyfanswm o dros 3.7 miliwn o eiriau yn ystod 2021/22.

- **Banc Cyfieithu:**
  Mae'r GIG yn wynebu galw digynsail am wasanaethau cyfieithu. Mae hyn mewn ymateb i fodloni gofynion Safonau'r Gymraeg yn bennaf, ond hefyd i ymateb i'r angen/galw ymysg cleifion a'r cyhoedd.
  Mae'n dod yn fwyfwy anodd recriwtio cyfieithwyr cymwys a phrofiadol i swyddi gwag parhaol llawn amser, ac mae cadw staff yn mynd yn heriol hefyd, oherwydd bod y farchnad recriwtio yn hynod gystadleuol.
  Er mwyn gallu ymateb i'r sefyllfa hon rydym wedi sefydlu banc o gyfieithwyr sy'n gallu gweithio'n hyblyg i ni wrth i ni fod angen eu gwasanaeth.
  Sefydlwyd y banc yn hydref 2021, ac mae ein trefniadau presennol yn gweithio'n dda hyd yma. Mae ein dull o weithio'n ystwyth hefyd yn golygu y gallwn recriwtio cyfieithwyr o wahanol rannau o Gymru a thu hwnt i'n cynorthwyo gyda'n gallu i ymateb i'r galw am wasanaethau cyfieithu.

- **Y Cynllun Symleiddio i Fyfyrwyr:**
  Mae Cydwasanaethau GIG Cymru wedi gwella taith y cwsmer drwy Wasanaeth Symleiddio i Fyfyrwyr drwy sicrhau bod y system yn darparu taith Gymraeg drwy gydol y broses.
  Gwnaethom archwilio ac adolygu ein prosesau, ein gwasanaethau awtomataidd a'n templedi er mwyn sicrhau bod cynnig Cymraeg di-dor bellach ar gael i fyfyrwyr sy'n ymgysylltu â'n gwasanaeth.
  Fel rhan o'r prosiect hwn, gwnaethom hefyd gyfieithu hysbysebion a swydd ddisgrifiadau i alluogi Byrddau Iechyd i hysbysebu'r cyfleoedd drwy'r rhaglen Symleiddio i Fyfyrwyr drwy gyfrwng y Gymraeg a'r Saesneg.

- **Taflenni Gwybodaeth i Gleifion Cymru Gyfan:**
  Gwnaethom gynnal archwiliad ac adolygiad cynhwysfawr o dros 350 o Daflenni Gwybodaeth i Gleifion yn ystod 2021/22. Mae'r taflenni yn cael eu rhoi i gleifion fel rhan o'r broses gydsynio. Galluogodd yr archwiliad a'r adolygiad i ni wneud gwelliannau i'r iaith a ddefnyddir yn y taflenni, sicrhau cysondeb o ran terminoleg yn ogystal â gwneud y taflenni yn gwbl ddwyieithog i gleifion yng Nghymru. Cyn hynny roedd fersiynau Cymraeg a Saesneg ar gael ar wahân. Bydd hyn yn parhau yn 2022/23 gyda gwaith yn cael ei wneud mewn partneriaeth ag Eido Healthcare i gyfieithu fersiynau hawdd eu deall o'r taflenni.

- ***Portlets* ESR ar gael yn Gymraeg:**
  Gweithiodd Uned y Gymraeg a thîm Systemau Gwybodaeth y Gweithlu ar y cyd ag Awdurdod Gwasanaethau Busnes y GIG ac IBM ar ddatblygu *Portlets* Cymraeg ar ESR yn hydref 2021. Mae hyn bellach yn golygu bod y *portlets* ar ESR ar gael i Staff y GIG yn Gymraeg ac yn Saesneg i fodloni gofynion Safon 81 y Safonau Gweithredol.

- **Prosiect Adolygu'r Ganolfan Gyswllt:**
  Diben y prosiect adolygu hwn oedd archwilio gwasanaethau ein canolfannau presennol, sefydlu sut mae ein cwsmeriaid yn ymgysylltu â ni ar hyn o bryd, nodi gwelliannau, a chynyddu a gwella elfen hunanwasanaethu'r gwasanaethau a ddarparwn.
  Fel rhan o'r gwaith hwn, craffwyd hefyd ar y gwasanaethau Cymraeg a ddarperir, a nododd arolwg a ddosbarthwyd i staff y GIG fod rhwng 10% ac 20% o staff y GIG yn dymuno ymgysylltu â ni drwy gyfrwng y Gymraeg.
  Bydd rhagor o waith yn cael ei wneud gyda chanolfannau cyswllt trwy bob rhan o PCGC dros y blynyddoedd nesaf.

- **Diweddariadau i System Recriwtio TRAC:**
  Rydym wedi parhau i weithio gyda datblygwyr system TRAC i sicrhau bod y rhyngwyneb ar gyfer y system yn parhau i fod yn gyfoes ac yn gyson yn y Gymraeg a'r Saesneg.

Symud Ymlaen:

Dros y flwyddyn i ddod bydd yr Ymddiriedolaeth yn ailedrych ar ei Gwerthoedd ac yn ymgynghori'n ymarferol â'i staff. Mae diwylliant yn ganolog i'r gwerthoedd hyn ac fel y gwyddom mae diwylliant cadarnhaol yn arwain at well gofal. Byddwn yn ystyried sut y gallwn integreiddio ein Cymraeg ymhellach a bydd ein grwpiau is-adrannol yn datblygu nodau ac amcanion penodol er mwyn cryfhau'r ddarpariaeth yn lleol.

Yn genedlaethol, byddwn yn parhau i weithio gyda'n partneriaid, Byrddau Iechyd Lleol a Llywodraeth Cymru. Mae iaith a Diwylliant Cymru yn eiddo i ni i gyd ac fel Ymddiriedolaeth rydym yn ymdrechu i ddarparu'r gofal dwyieithog gorau y gallwn.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

2022 / 2023 QUARTER 1 PUTTING THINGS RIGHT REPORT

DATE OF MEETING	1st September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Jade Coleman, Quality and Safety Officer
PRESENTED BY	Nigel Downes, 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	01/09/2022	Approved

ACRONYMS	
N/A	

1. SITUATION

The 2022/2023 Quarter 1 Putting Things Right report is provided to the Quality, Safety & Performance Committee to provide a summary of concerns (complaints) and incidents received, themes and improvements made during the 1st April 2022 to the 30th June 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 & Performance Committee is asked to **DISCUSS and APPROVE** 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 1 report:

- **50** concerns were raised during the Quarter, 22 WBS (0.11% of WBS contacts* (20237)) and 27 VCC (0.05% of VCC contacts** (52150)). Overall percentage being 0.07% of contacts (72387).
- **98%** of concerns were graded at level 1 (low level).
- **84%** of the concerns raised were managed via the Early Resolution process, and 16% were managed via the Putting Things Right process (formal).
- There were **3** Concerns raised relating to the COVID Pandemic.
- **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.
- **475** incidents were raised during the Quarter – 388 from the Cancer Centre and **83** from the Welsh Blood Service.
- **96%** of incidents raised were graded as no harm or low harm.
- There was **1** Early Warning Notification submitted to Welsh Government relating to the Trust receiving notification of inquest proceedings, following the death of a patient. The Coroner has requested, and subsequently been provided with, a

witness statement from the treating consultant oncologist, regarding the care and treatment provided by Velindre Cancer Centre. The case is ongoing.

- There were **3** IR(ME)R incidents reported to Healthcare Inspectorate Wales.
- Formal investigation training is underway 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 **APPROVE** the 2022/23 Quarter 1 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.

** VCC 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 1

2022/2023

Learn it Lead it Live it

LEARN TODAY FOR A BETTER TOMORROW

Contents

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Acronyms

VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
SLT	Senior Leadership Team
Q&S	Quality and Safety

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 1 report reflects the period 1st April 2022 to 30th June 2022. The key messages / highlights are:

- **50** concerns were raised during the Quarter, 22 WBS (0.11% of total WBS contacts* (20237)) and 27 VCC (0.05% of total VCC contacts** (52150)). Overall percentage being 0.07% of contacts (72387).
- **98**% of concerns were graded at level 1 (low level)
- **84%** of the concerns raised were managed via the Early Resolution process, and 16% were managed via the Putting Things Right process (formal).
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- **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.
- **475** incidents were raised during the Quarter – 388 from the Cancer Centre and **83** from the Welsh Blood Service.
- **96%** of incidents raised were graded as no harm or low harm.
- There was **1** Early Warning Notification submitted to Welsh Government relating to the Trust receiving notification of inquest proceedings, following the death of a patient. The Coroner has requested, and subsequently been provided with, a witness statement from the treating consultant oncologist, regarding the care and treatment provided by Velindre Cancer Centre. The case is ongoing.
- There were **3** IR(ME)R incidents reported to Healthcare Inspectorate Wales.
- Formal investigation training is underway 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 Centre and Welsh Blood Service

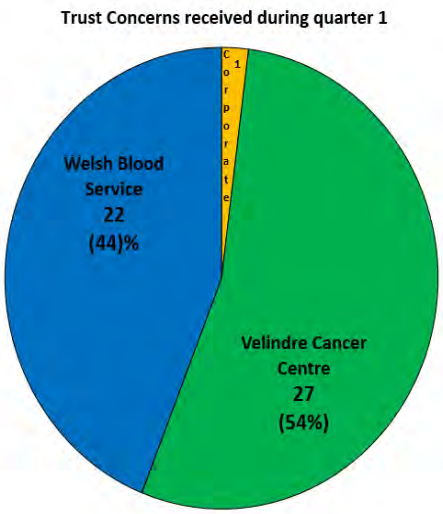
* **WBS Contacts** – had a contact with Welsh Blood Service and either attended a clinic or called the contact centre. This figure covers all sessions in Wales, including East, West and North Wales sessions during the period. This figure related only to blood donors and does not include platelet or bone marrow donor contacts.

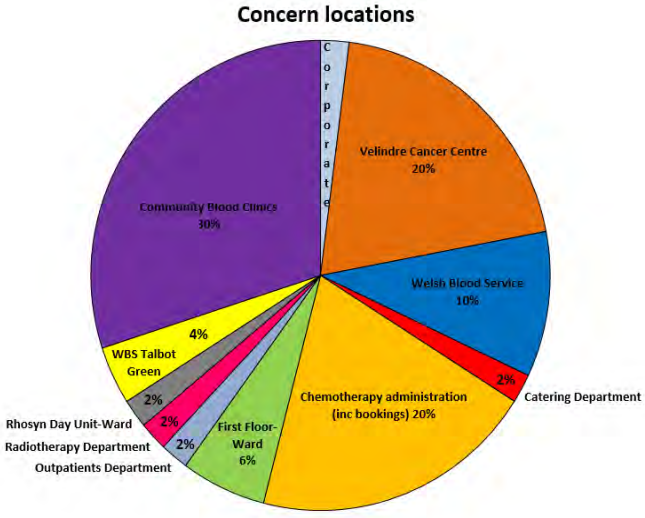
** **VCC Contacts** – include: New Outpatients, Follow Up Outpatients, Ambulatory Care attendances, SACT attendances, Radio-Therapy attendances, Radiology Examinations and Inpatient admissions. Not included: Therapies attendances, telephone helpline contacts, other calls with Clinical Nurse Specialists or consultants, calls relating to appointments.

1. CONCERNS RECEIVED IN QUARTER 1

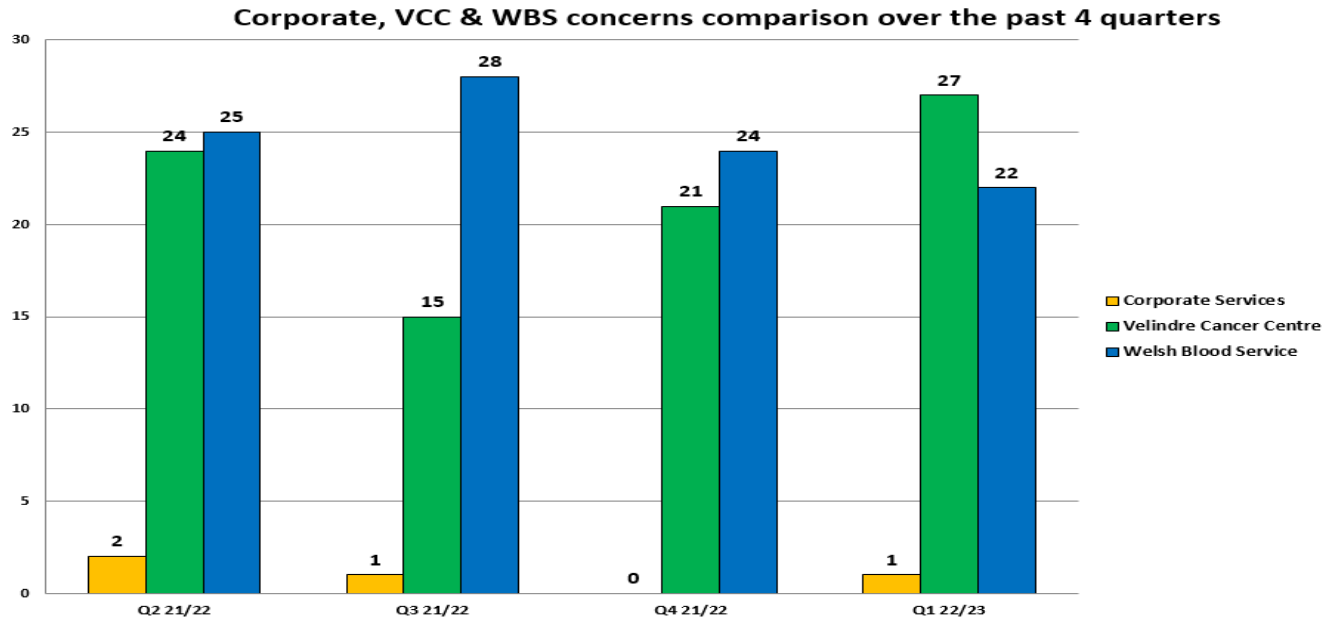
Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

50 concerns were received by the Trust during Quarter 1. In total, 22 Welsh Blood Service concerns were raised (0.11% of WBS total contacts (20237)) 27 Velindre Cancer Centre concerns (0.05% of total VCC contacts (52150)). The below pie charts outline where in the Trust the concerns originated, including a further percentage breakdown of concerns for each location:

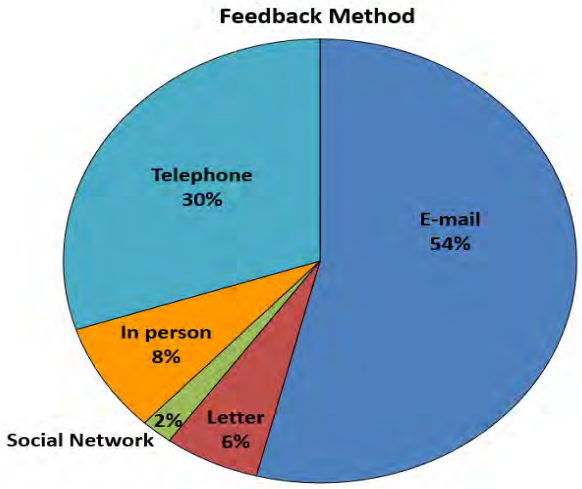




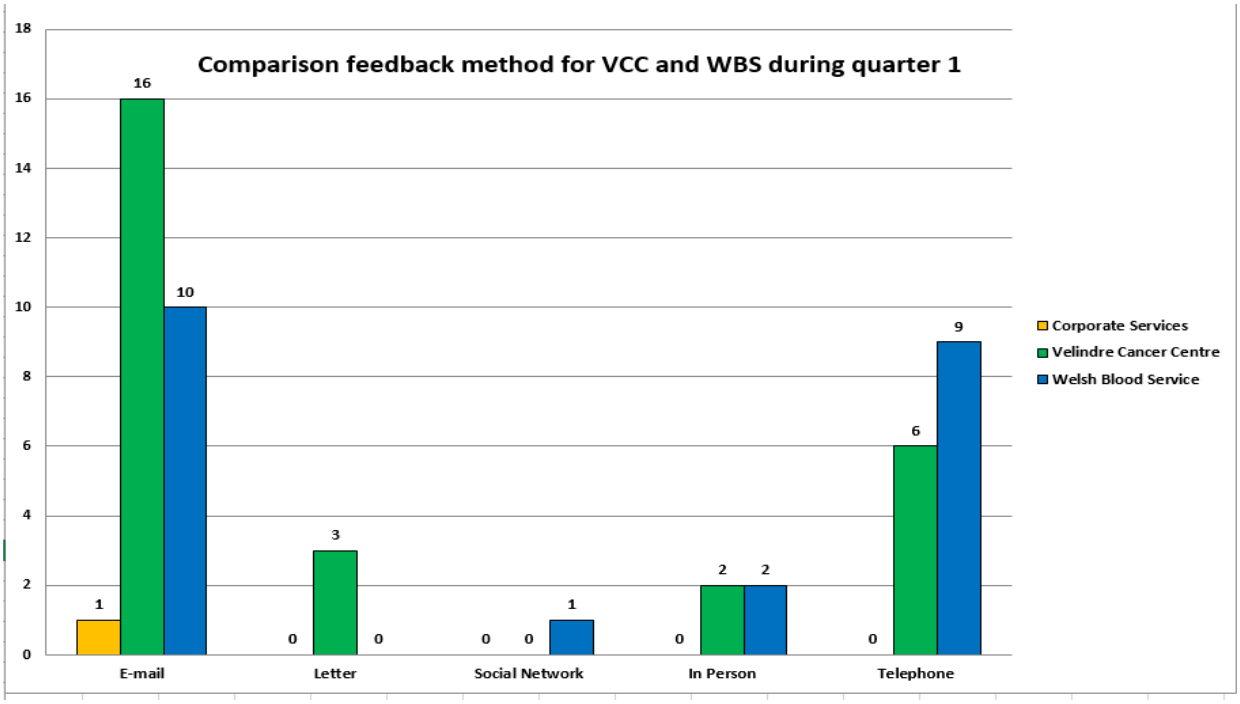
Although the overall number of concerns raised increased in the quarter by 4, the overall numbers remain consistent with previous quarters. There appears to be 'normal variation' across organisation in relation to numbers of concerns received. The chart below displays the concern numbers raised within each division & corporately over the last year.



1.1 Method of receipt for concerns received in Quarter 1



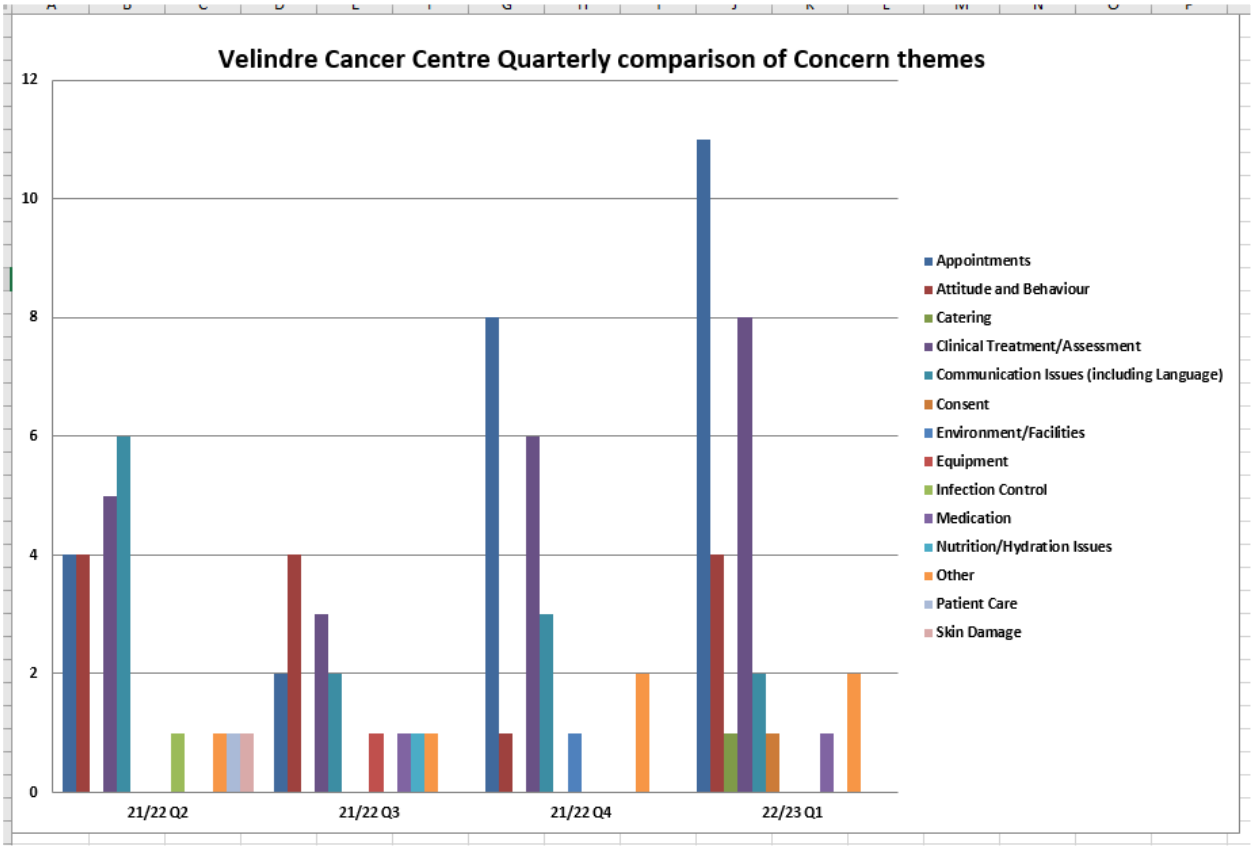
54% of Trust concerns were received via email which remains the preferred method for raising concerns. The number / percentage of concerns being received via telephone is decreasing and via e-mails increasing.



1.2. Thematic review of the concerns received in Quarter 1

The charts below outline concern themes from each Division:

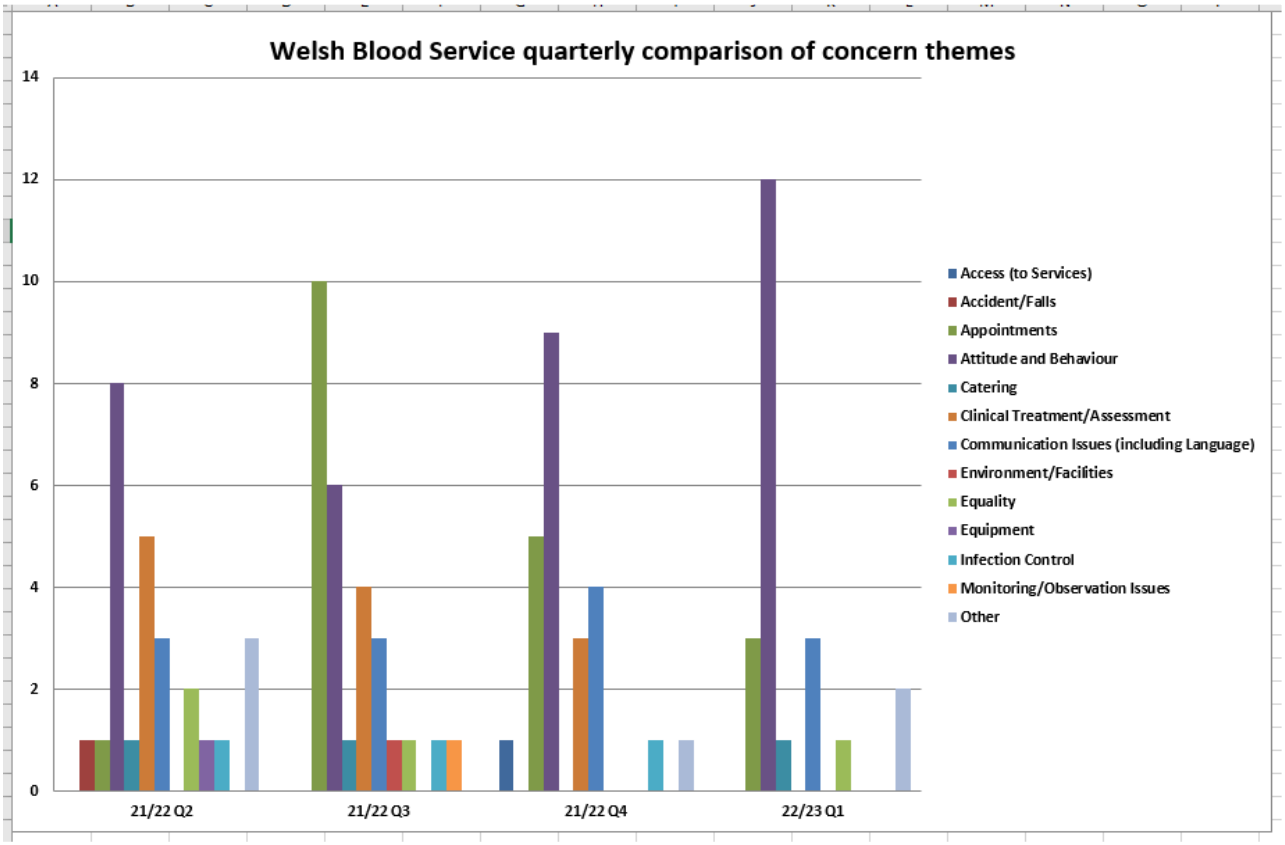
1.2.1 Velindre Cancer Centre



During the quarter: appointment related concerns remain the highest reported at Velindre Cancer Centre. Velindre Cancer Centre 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 Centre 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 below charts provide a breakdown of the themes in relation to concerns raised at the Welsh Blood Service during the quarter.



Attitude and behaviour is a recurring theme at the Welsh Blood Service and remains the highest reported concern that the Welsh Blood Service receive. The total number of concerns received relating to attitude and behaviour increased from six in Quarter 3, to nine in Quarter 4 and a further increase in Quarter 1 to **twelve** concerns received in relation to attitude and behaviour.

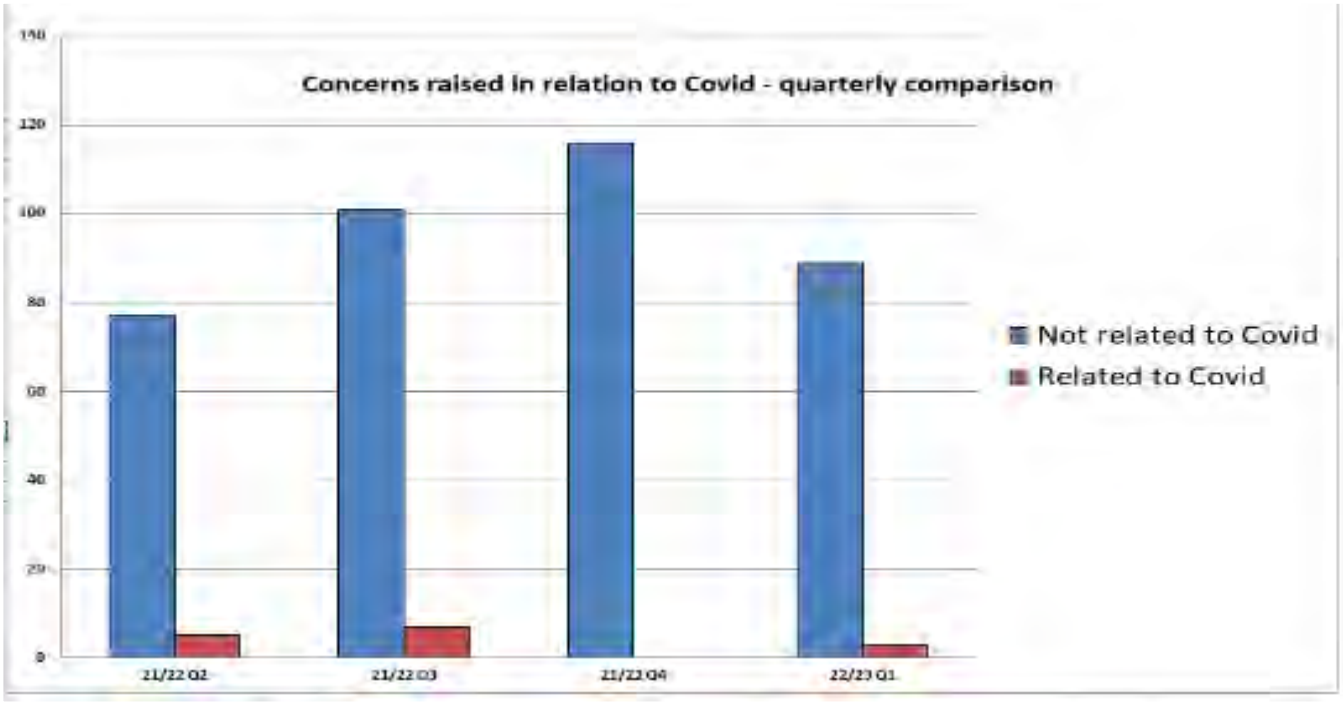
Following a review of these concerns a number of measures have been put in place to efficiently resolve complaints made relating to attitude and behaviour. This has included, a Clinic Lead Registered Nurse being available to support staff members and identify areas of concern. A number of team and individual 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 **3** Covid related concerns reported during Quarter 1 for the Trust.

The three concerns raised in quarter 1 related to:

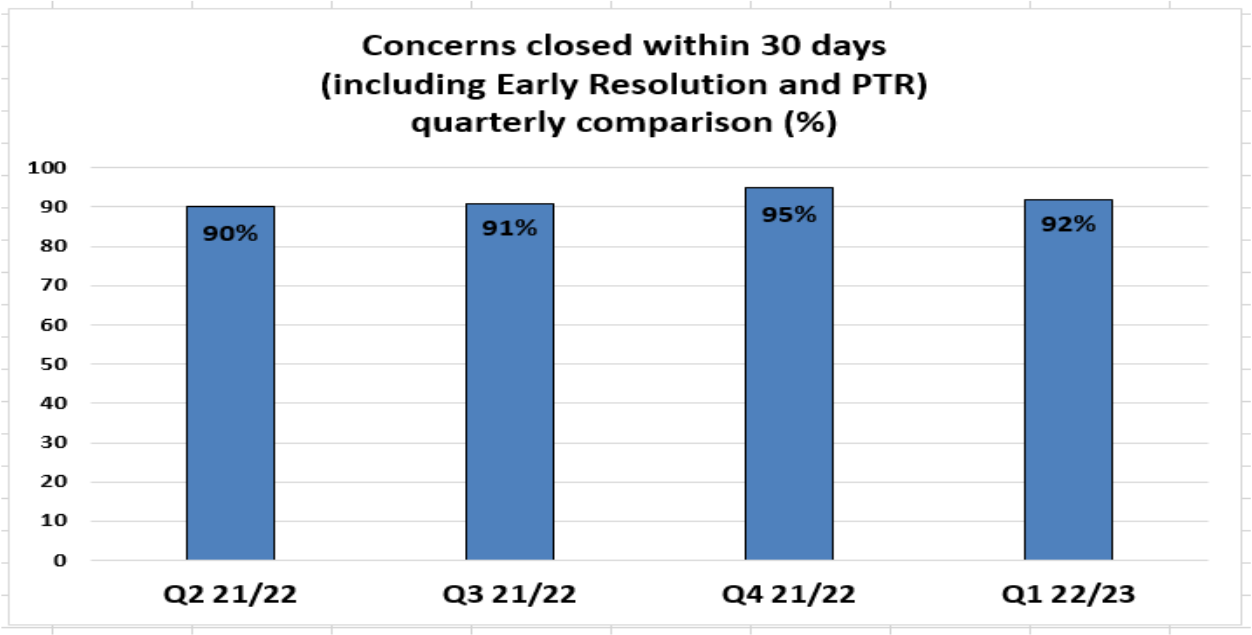
- Two concerns raised at the Welsh Blood Service and related to wearing masks/face coverings
- One concern was raised at Velindre Cancer Centre and related to mRNA Covid vaccines.



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 1 were also closed during the Quarter. **84%** were closed as an Early Resolution, and **16%** 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 increased by a further 3% during Quarter 1, which follows the significant 12% increase reported in Quarter 4 for concerns handled as early resolution. The efficient 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 Centre and Welsh Blood Service. Strong communication channels between Corporate, Velindre Cancer Centre and Welsh Blood Service ensure we continue to drive early resolutions for concerns at source. 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 Centre and Welsh Blood Service during Quarter 1 2022/23.

1.5 Level of investigations undertaken

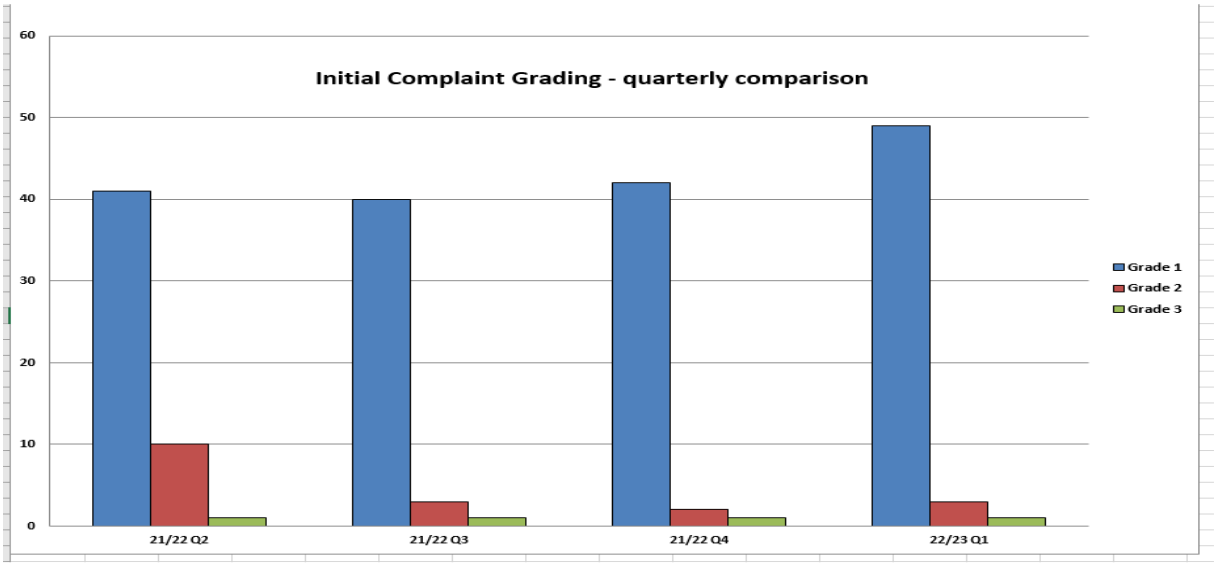
	Concerns will be assessed to determine the level of investigation required *Undertake robust investigations by trained staff* *Being open and transparent throughout the investigation*

	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*

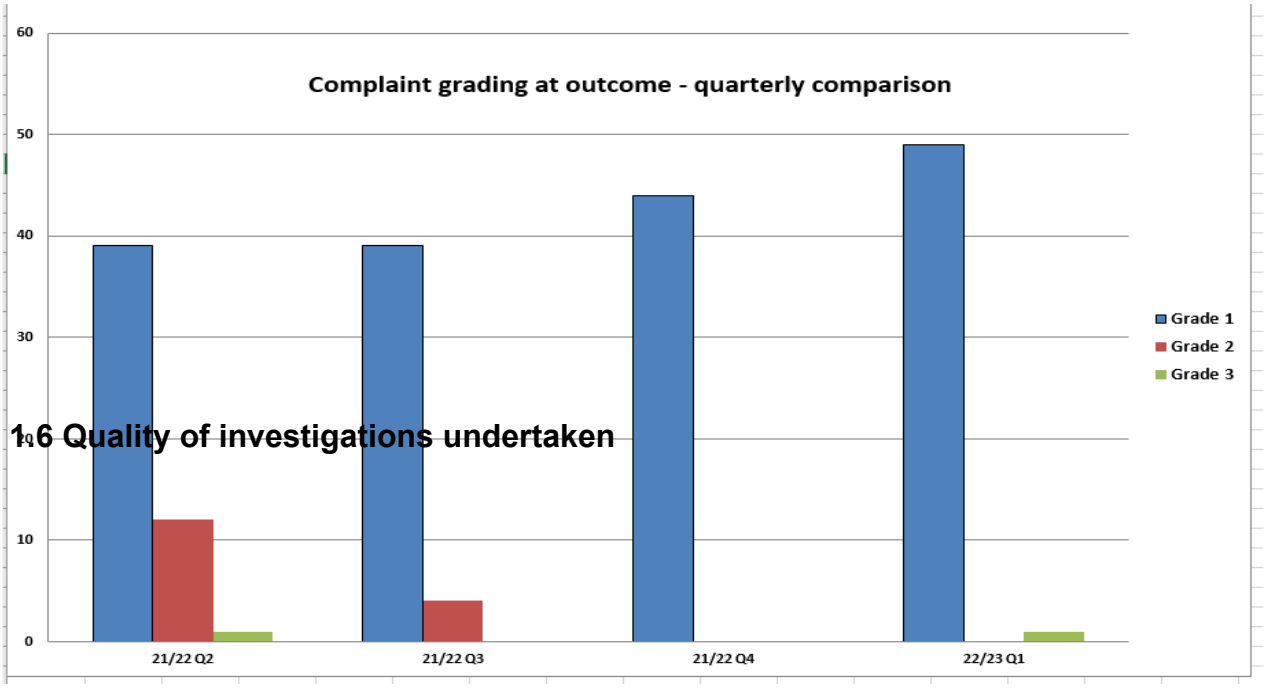
All concerns are graded upon receipt (complaints grading table included as **Appendix 1).**

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 **94%** of all concerns were graded as level 1, 4% grade 2, and 1 (2%) grade 3.

All 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 **47** concerns were initially graded as level 1 on receipt and, 40 concerns were resolved as an Early Resolution, suggesting **85%** 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.



As the below bar charts display, on completion of all Quarter 1 investigations, the Trust subsequently recorded **49** (98%) grade 1 concerns. The two, grade 2 concerns were downgraded following the investigation outcomes. The one, grade 3 concern has remained and has since escalated to a Redress case.



1.6 Quality of investigations undertaken

1.6.1 Public Service Ombudsman: During the quarter:

- The Trust received no new Ombudsman cases
- There was 1 Ombudsman case closed
- 2 Ombudsman cases remained under investigation (case information below):

    - ***Case 1***: Relating to lack of communication with patient and family when multiple Health Boards and multi-disciplinary teams are involved.

    - ***Case 2:*** Relating to a failure to communicate essential information to the medical practice which impacted on the last days of life for the patient; communication issues with the family; and, the postponement of treatment.

1.7 Learning

Identify and implement learning from concerns raised
Updating patients and donors as to how learning has improved services

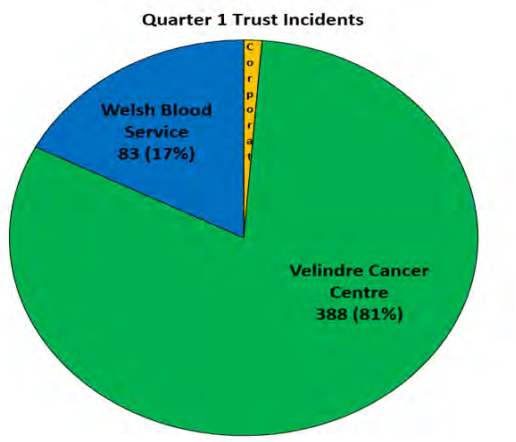
Through the investigation and management of concerns, the Trust continues to closely monitor every concern that is received which helps to identify areas for service improvement. The Divisions have mechanisms in place to share learning from complaints, and for monitoring the implementation of recommendations 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.

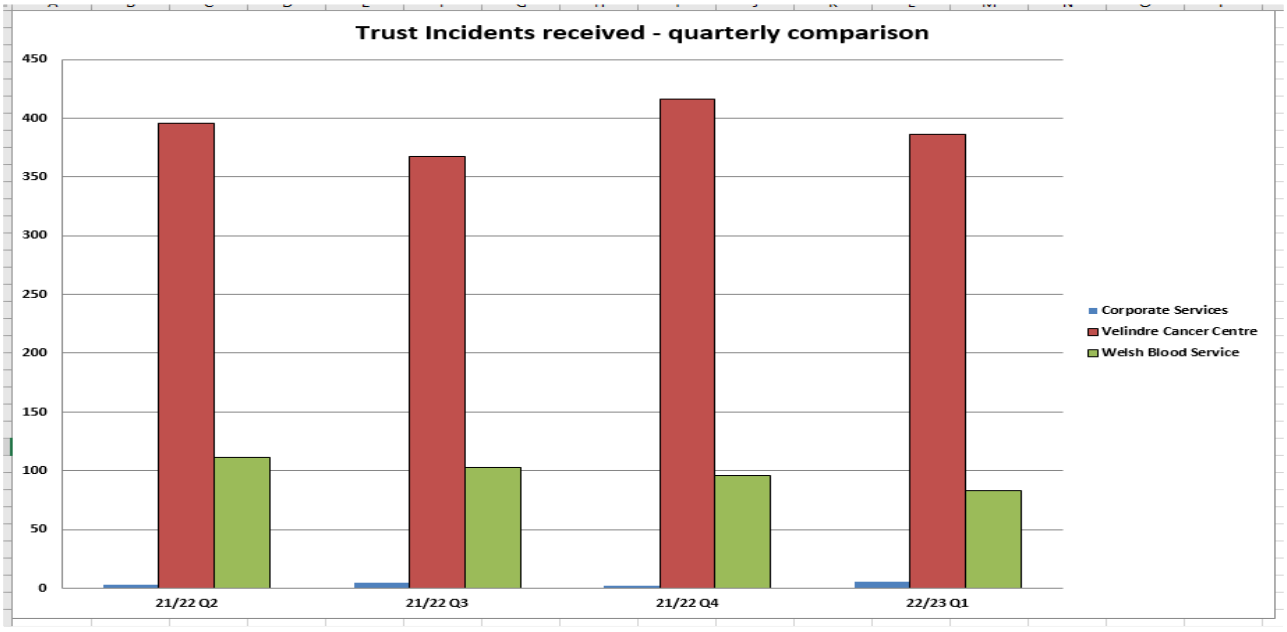
Velindre Cancer Centre
As part of the improvement project to look at SACT booking centre processes Velindre Cancer Centre are developing a formal process for communicating SACT deferrals with patients following MRI and CT scans.
Following a concern raised relating to the missing property of a patient, all admission documents have been amended to include an itemised property list which is completed on patient arrival at the Cancer Centre.
As a result of lack of communication and patient involvement in care decisions, plans have been put in place with individuals to include identified family members in all communication with the clinical team.
The Velindre Cancer Centre have now fully adopted the Royal College of Radiotherapy and Cancer Research UK consent forms when patients need to consent for radiotherapy and SACT treatment, as a result of a patient not being fully consented for a possible long term side effect of radiotherapy treatment.

Welsh Blood Service
Following a donor not being notified as a vulnerable donor (over 70 years of age) in line with Welsh Government guidelines, the Medical Director reviewed the donors' acceptability to donate and as a result the donor was reinstated.
An IT system error was identified and investigated following a donor raising a concern regarding not being notified that the donation session, due to be attended, had been cancelled. The Trust IT team investigated, identified and rectified the error within the IT system to prevent further reoccurrence.
A concern was raised by an upset donor as a result of not being offered or able to have a hot drink post donation. Staff followed protocol and only donors who have not donated within the previous 2 years and new donors, are offered a cold drink post donation to help aid recovery and rehydrate the donor.
An approved response letter was issued to a donor, reinforcing that abusive language will not be tolerated, following an advanced practitioner contacting the donor to explain the acceptance guidelines relating to appointment interval timelines. During the call, the donor became verbally rude, aggressive and ended the call abruptly.

2. QUARTER 1 INCIDENTS

475 incidents were reported during Quarter 1, which is a slight decrease in incidents raised in comparison to the previous quarter, where 493 were recorded. A further breakdown is provided throughout the report and looks specifically at Velindre Cancer Centre and Welsh Blood Service incident data. 4 Corporate related incidents were raised, making up 1% of Trust incidents recorded. The majority of corporate incidents raised related to information governance.





2.1 Nationally reportable Incidents (replaced Serious Incidents in June 2021)

There were **no** National Reportable Incidents reported during the quarter.

2.2 Early warning notifications (replaced 'No Surprises' in June 2021)

There was **1** Early Warning Notification submitted to Welsh Government on the 20th May 2022 in relation to the Trust receiving notification of inquest proceedings, following the death of a patient. The Coroner has requested, and subsequently been provided with, a witness statement from the treating consultant oncologist, regarding the care and treatment provided by Velindre Cancer Centre. The inquest has not yet been heard.

2.3 IRMER Incidents reported to Healthcare Inspectorate Wales (HIW)

There were **3** IR(ME)R related incidents reported to Health Inspectorate Wales (HIW) during the quarter. All were no or low harm but met the HIW reporting classifications. As a result of the Quarter 4 significant increase in IR(ME)R incidents identified as reaching the threshold for reporting, the radiation services department undertook a full review of its incident and reporting arrangements. Following the review the Trust has seen a reduction in IR(ME)R reportable incident submissions during Quarter 1 2022/23 and therefore suggesting that IR(ME)R reportable incidents are being identified and submitted to HIW within the required timescales. A number 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). This review included discussing local management of on-treatment radiotherapy imaging incidents related to equipment failure. Each one of the types of incidents discussed, would not constitute a reportable notification to HIW in their own right, but do become reportable once the repeat imaging thresholds are met or once multiple patients are affected by a similar incident. It was recognised that the Trust was reporting these incidents in line with current HIW guidance and some advise was provided in relation to strengthening the Trusts Risk Assessment Processes.

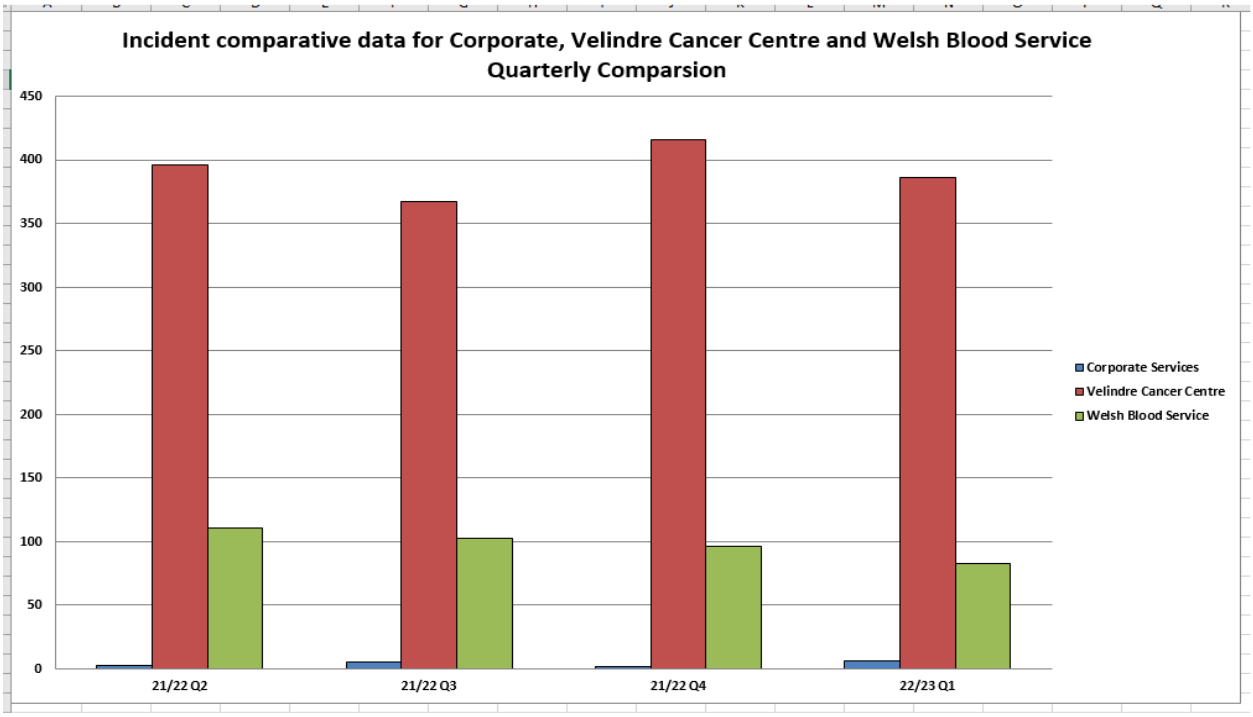
The UKHSA *Safer Radiotherapy* publication series identified that onset imaging processes account for a significant proportion of all error and near miss events shared with UKHSA for analysis. Of these, failure of imaging devices is a recurring theme nationally. UKHSA is in dialogue with the MHRA on how these incidents might be better addressed. The review also identified some ambiguity surrounding the radiotherapy imaging notification criteria nationally with the UK IR(ME)R enforcing authorities are addressing this with HIW.

2.4 Additional Regulatory Incidents

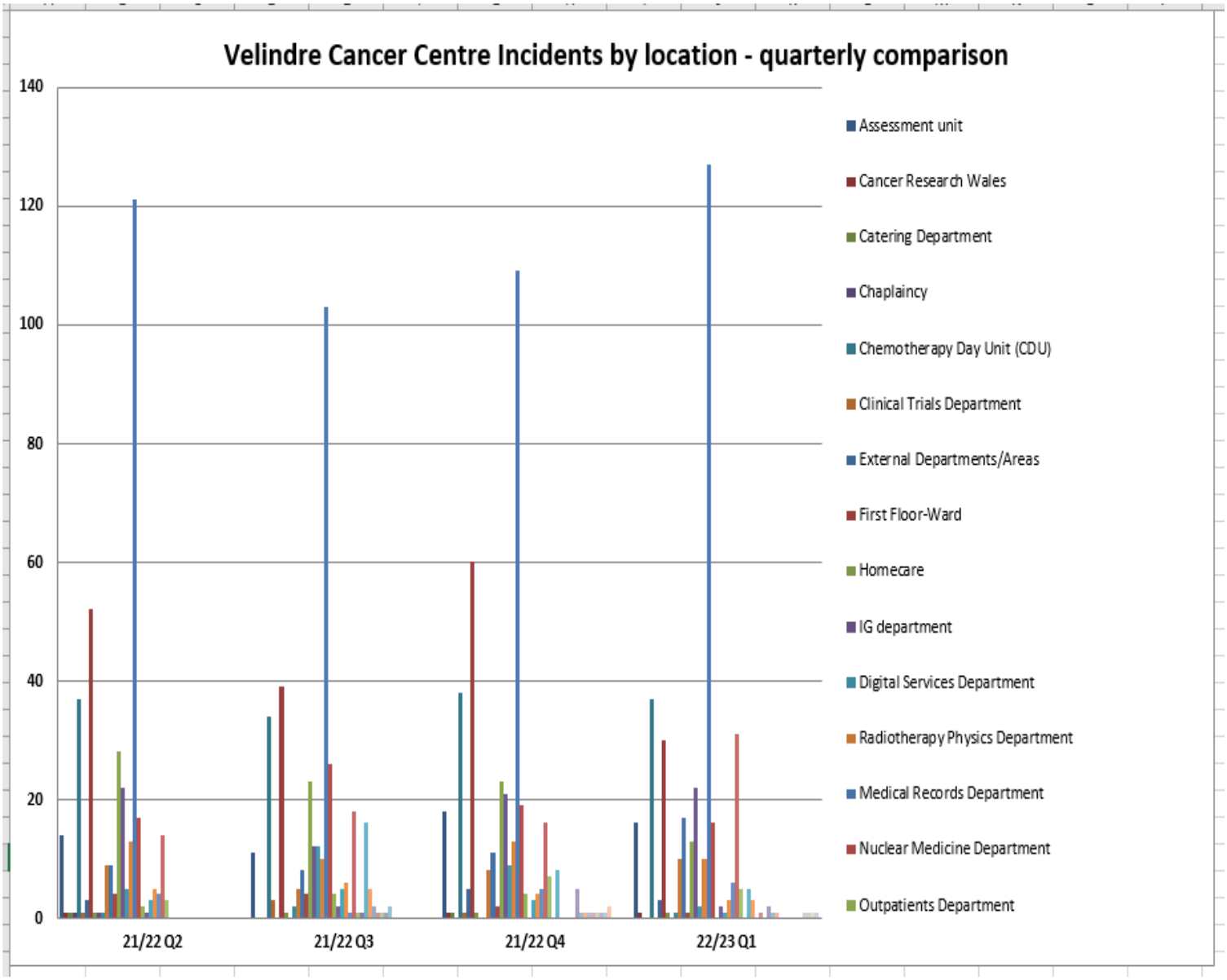
There were no additional regulatory incidents reported during the quarter.

2.5 Velindre Cancer Service Incidents

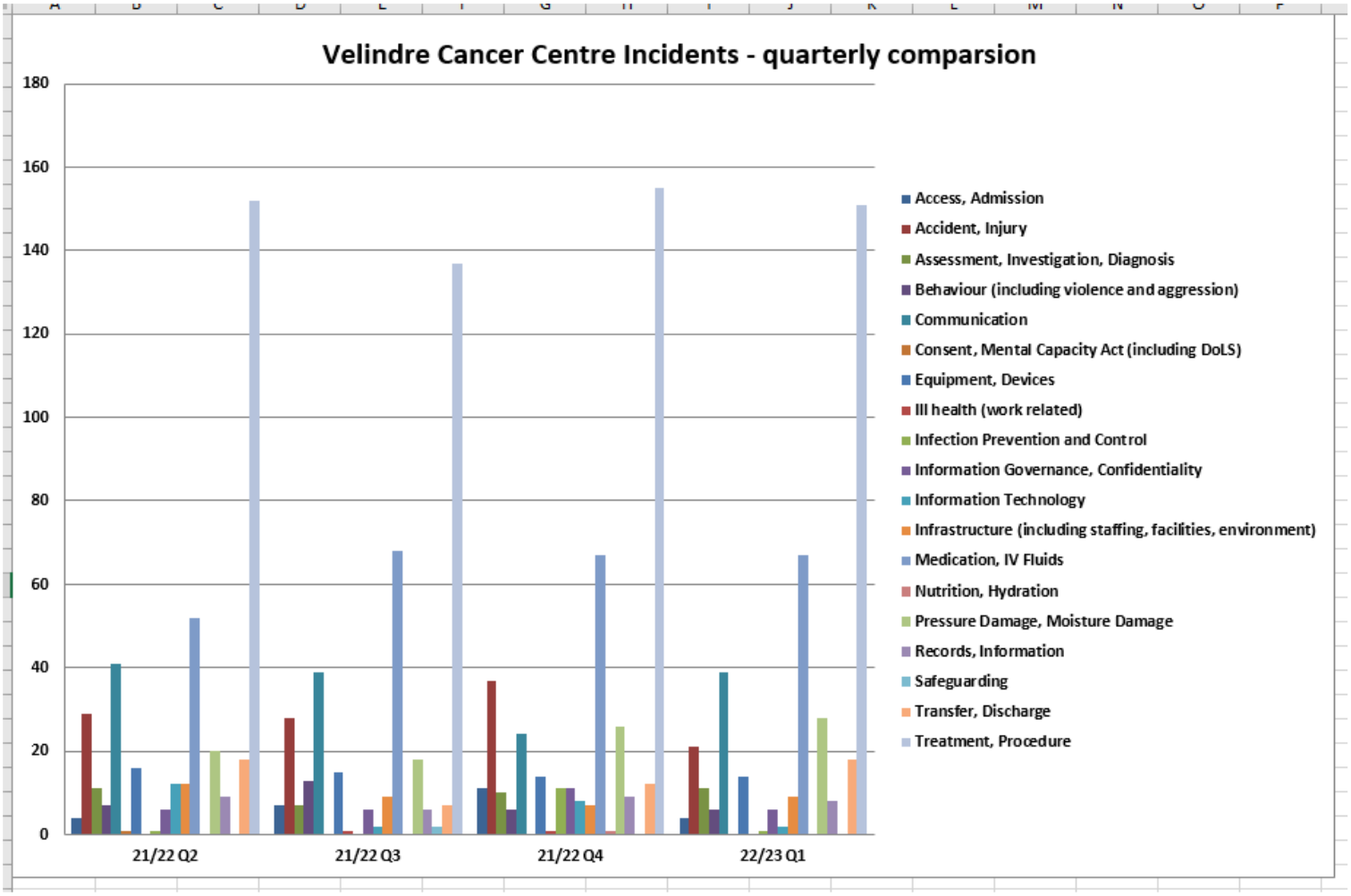
388 incidents were recorded relating to Velindre Cancer Service. The graph below also displays comparative data over the past four quarters. Generally, the number of incidents being reported remains stable.

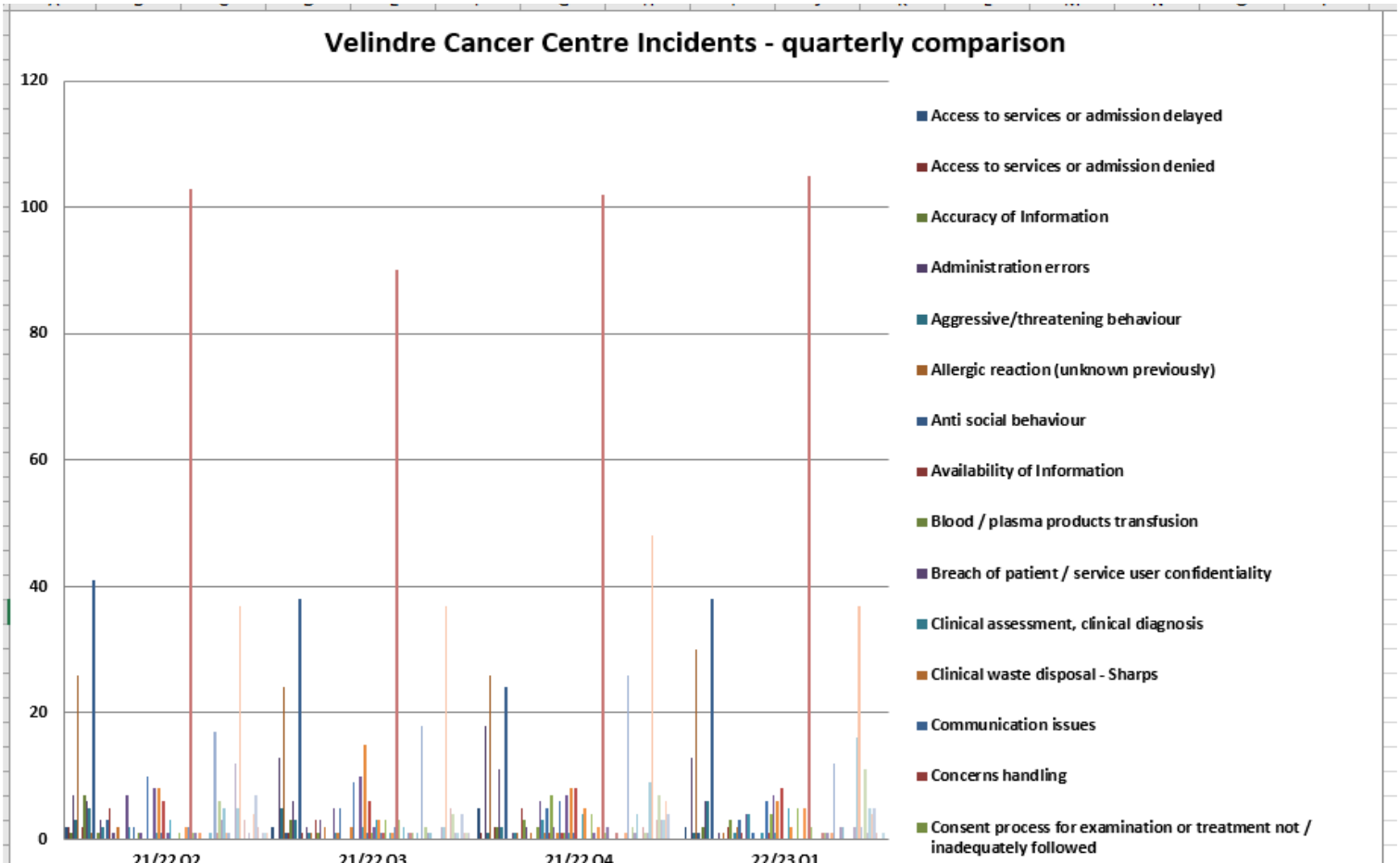


The following bar chart displays the specific location at Velindre Cancer Centre where incidents are recorded. The Radiotherapy department remains the area where the highest number of incidents are reported. These incidents relate to equipment and procedural treatments that are carried out at Radiotherapy 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.



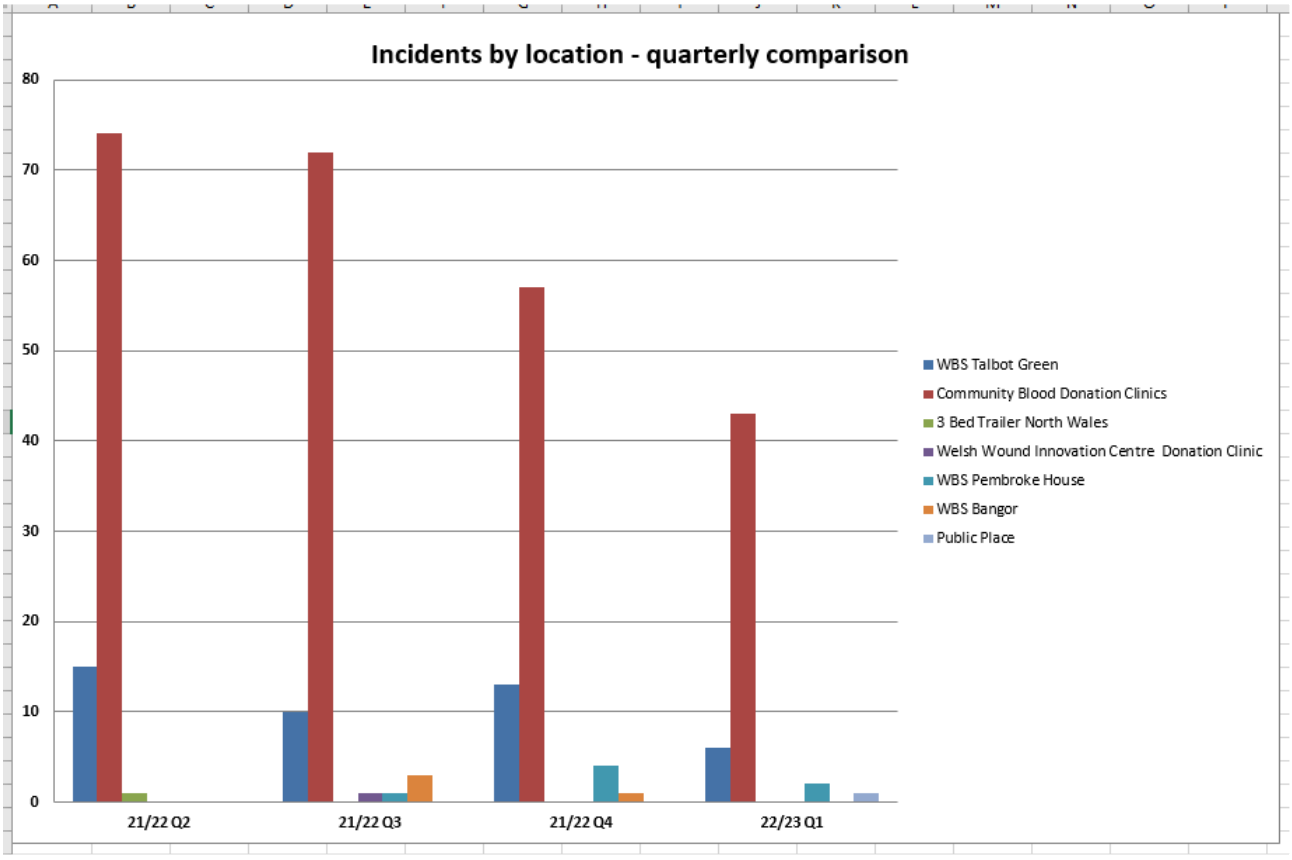
The highest number of reported incidents relate to procedures and treatments received at Velindre Cancer Centre. The below graph displays a breakdown over the last 4 quarters and key themes of the highest numbers of incidents reported, evident that Radiotherapy have continued to record the most incidents during the quarter.


Velindre Cancer Centre Incidents - quarterly comparsion
180
160
140
120
100
80
60
40
20
0
21/22 Q2
21/22 Q3
21/22 Q4
22/23 Q1
Access, Admission
Accident, Injury
Assessment, Investigation, Diagnosis
Behaviour (including violence and aggression)
Communication
Consent, Mental Capacity Act (including DoLS)
Equipment, Devices
Ill health (work related)
Infection Prevention and Control
Information Governance, Confidentiality
Information Technology
Infrastructure (including staffing, facilities, environment)
Medication, IV Fluids
Nutrition, Hydration
Pressure Damage, Moisture Damage
Records, Information
Safeguarding
Transfer, Discharge
Treatment, Procedure

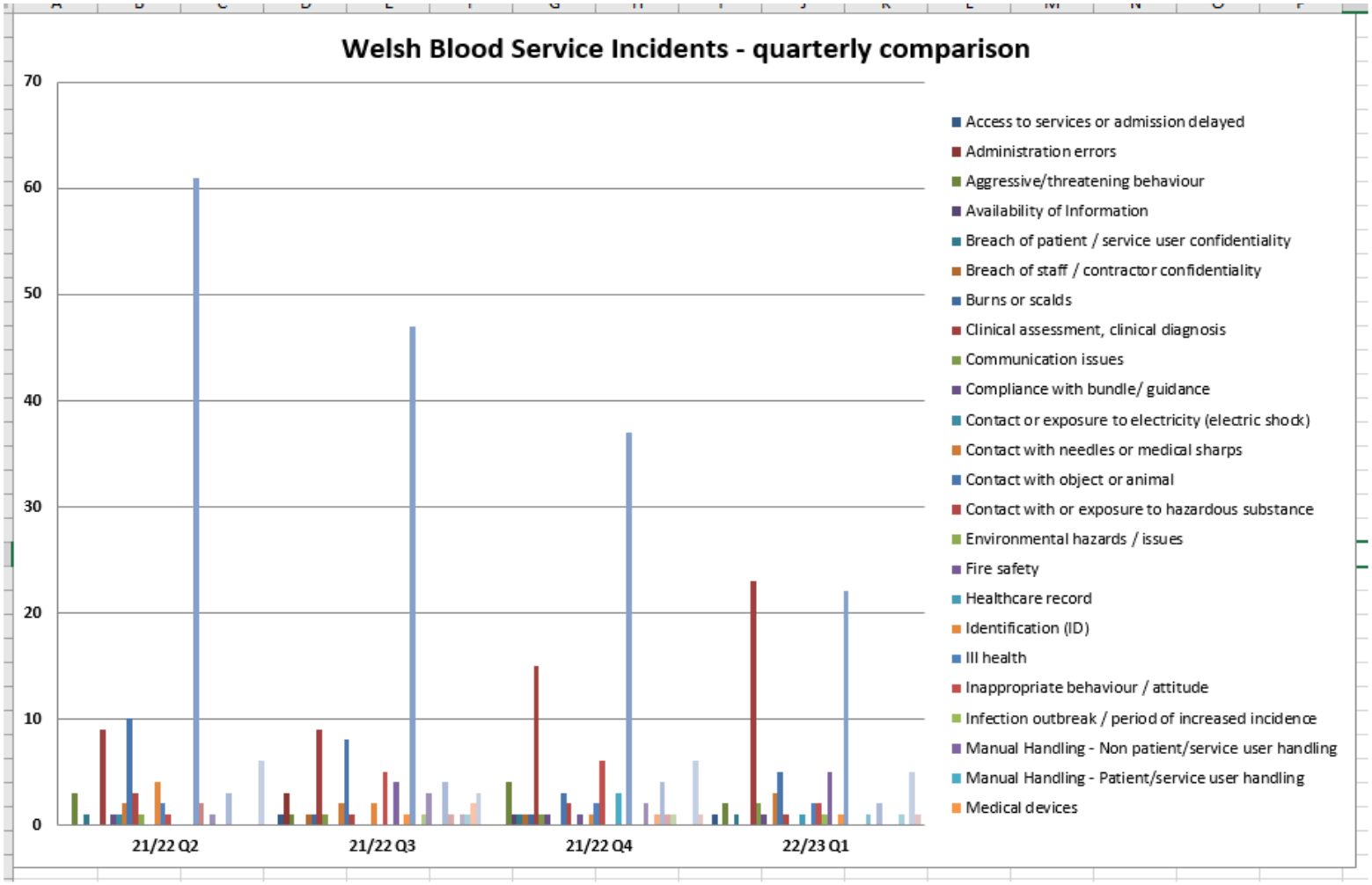

Velindre Cancer Centre Incidents - quarterly comparison
120
100
80
60
40
20
0
21/22 Q2
21/22 Q3
21/22 Q4
22/23 Q1
Access to services or admission delayed
Access to services or admission denied
Accuracy of Information
Administration errors
Aggressive/threatening behaviour
Allergic reaction (unknown previously)
Anti social behaviour
Availability of Information
Blood / plasma products transfusion
Breach of patient / service user confidentiality
Clinical assessment, clinical diagnosis
Clinical waste disposal - Sharps
Communication issues
Concerns handling
Consent process for examination or treatment not / inadequately followed

2.6 Welsh Blood Service

83 incidents were recorded relating to Welsh Blood Service during Quarter 1. 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 July 2021 – 30th June 2022.



43 incidents were recorded for community base blood donation clinics. This makes up **52%**, over half, of Welsh Blood Service incidents being reported. Equipment and device related incidents also continue to be one of the highest number (**28%**) of incidents reported for the Welsh Blood Service. A breakdown of incident types are included below:



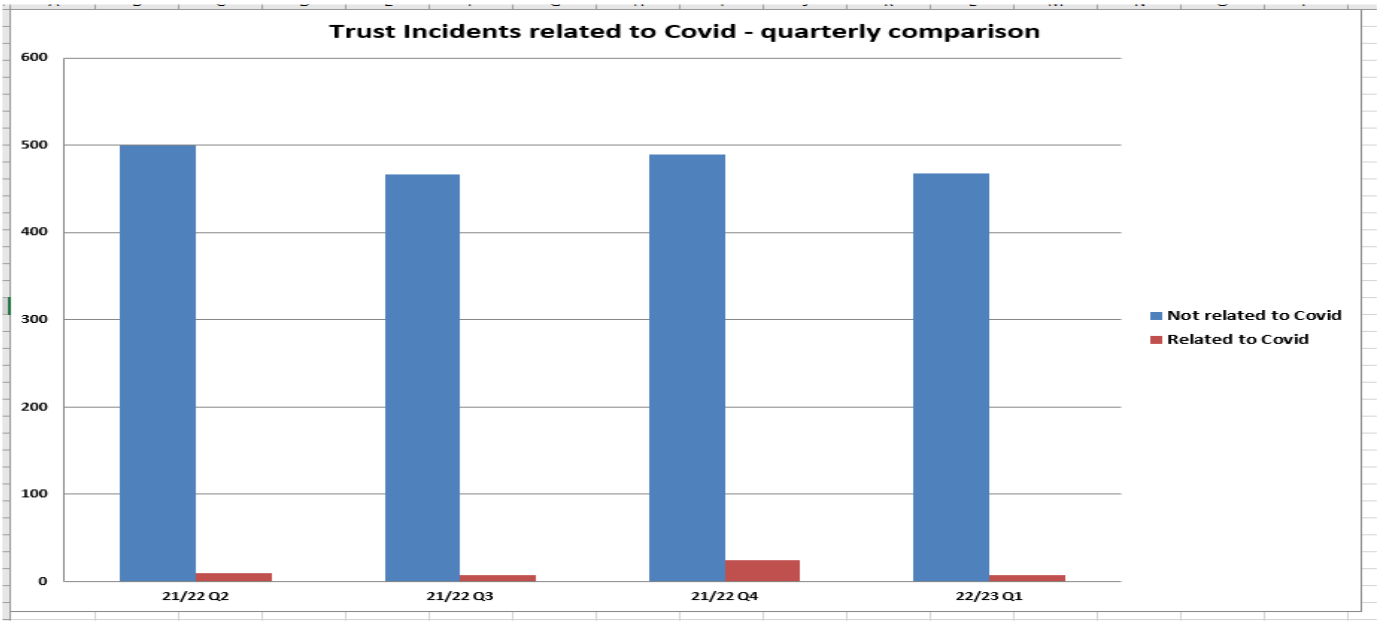
Medical Device incidents remain a consistent theme for Welsh Blood and relate to Centrifuge failures and other equipment failures. Senior leaders and team members are fully aware of the issues with Medical Devices and can specify that the incidents are linked to the collection of blood where an electronic 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 **5** incidents recorded that related to Covid during Quarter.. The adjacent bar chart demonstrates the reduction in Covid related incidents over the course of the three month period id. VCC reported **4** Covid related incidents, all linked to delays in treatment. **1** Covid related incident was reported by the Welsh Blood Service and related to a face to face conference hosted by WBS where 7 employees subsequently tested positive for Covid.



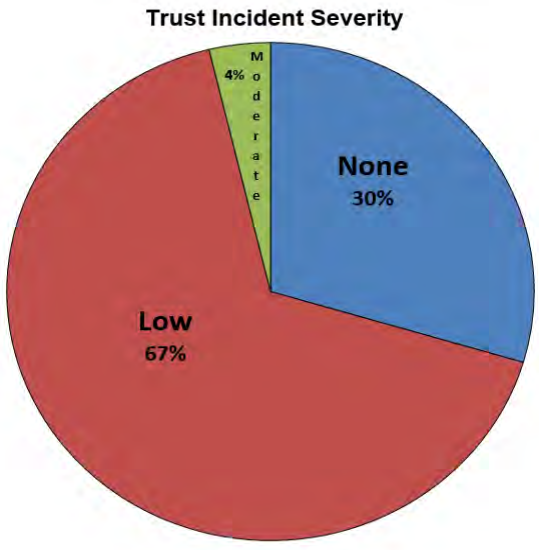
2.8 Incident severity

The majority of incidents reported caused low or no harm (**96%**). There were no severe harm incidents reported, however a number of moderate incidents were reported and consisted of:

VCC: treatment related incidents and 1 incident relating to a telephone line outage.

WBS: donor reactions (feeling unwell) following blood donation and 1 donor inappropriate behaviour incident.

Corporate: an overheated laptop.



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. **475** incidents were closed within the quarter, **385** of which, were closed for Velindre Cancer Centre. **83** incidents were closed relating to the Welsh Blood Service.

The below bar charts further display the number of days it took to investigate and successfully close incidents that were opened during Quarter 1 for Velindre Cancer Centre and Welsh Blood Service. The longest open incident for Velindre Cancer Centre was 90 days.

The longest open incident recorded for Welsh Blood Service was 73 days.

The Velindre University NHS Trust has recognised that the closure rate for incidents that have been open for over 30 days has adversely increased during the quarter, and that both Divisions need to improve 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 Centre
A pressure ulcer of the ear was identified on a patient who had no other skin integrity problems. The pressure ulcer was caused by an overlying medical device - oxygen tubing. Learning from the incident was identified and the medical device process and policy has been updated to include, that where medical devices are used, the skin and surrounding areas are checked for pressure sores at least once in every 24 hours. This update has been circulated within the Velindre Cancer Centre.
Learning has been identified following the initiation of the Covid nosocomial transmission scrutiny panel, that staff are to ensure the Covid testing guidelines are strictly followed in relation to the day 1 and day 5 Covid screening requirements following admission to Velindre Cancer Centre.
Welsh Blood Service
Following an incident involving the behaviour of a Welsh Blood Service vehicle driver the Transport Manager was made aware of the issue and has since discussed the importance of driver behaviour and organisational reputation with the staff members.

Donors continue to be challenged with regards to the grade of face coverings being worn when visiting donation sites. Following some reluctance from donors to wear a face covering or, particular grade of face covering, clarity on challenging inappropriate face masks worn has been provided to Clinic Nurses, supporting collections team members in managing future situations of this nature.

4. CONCLUSION: CONCERNS AND INCIDENTS IN QUARTER 1.

The following overarching conclusions have been drawn for the Trust for Quarter 1:

- Directorate leads are being asked to focus their efforts on learning, retraining and intervention where we have high numbers of incidents and concerns.

- 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.

- 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.

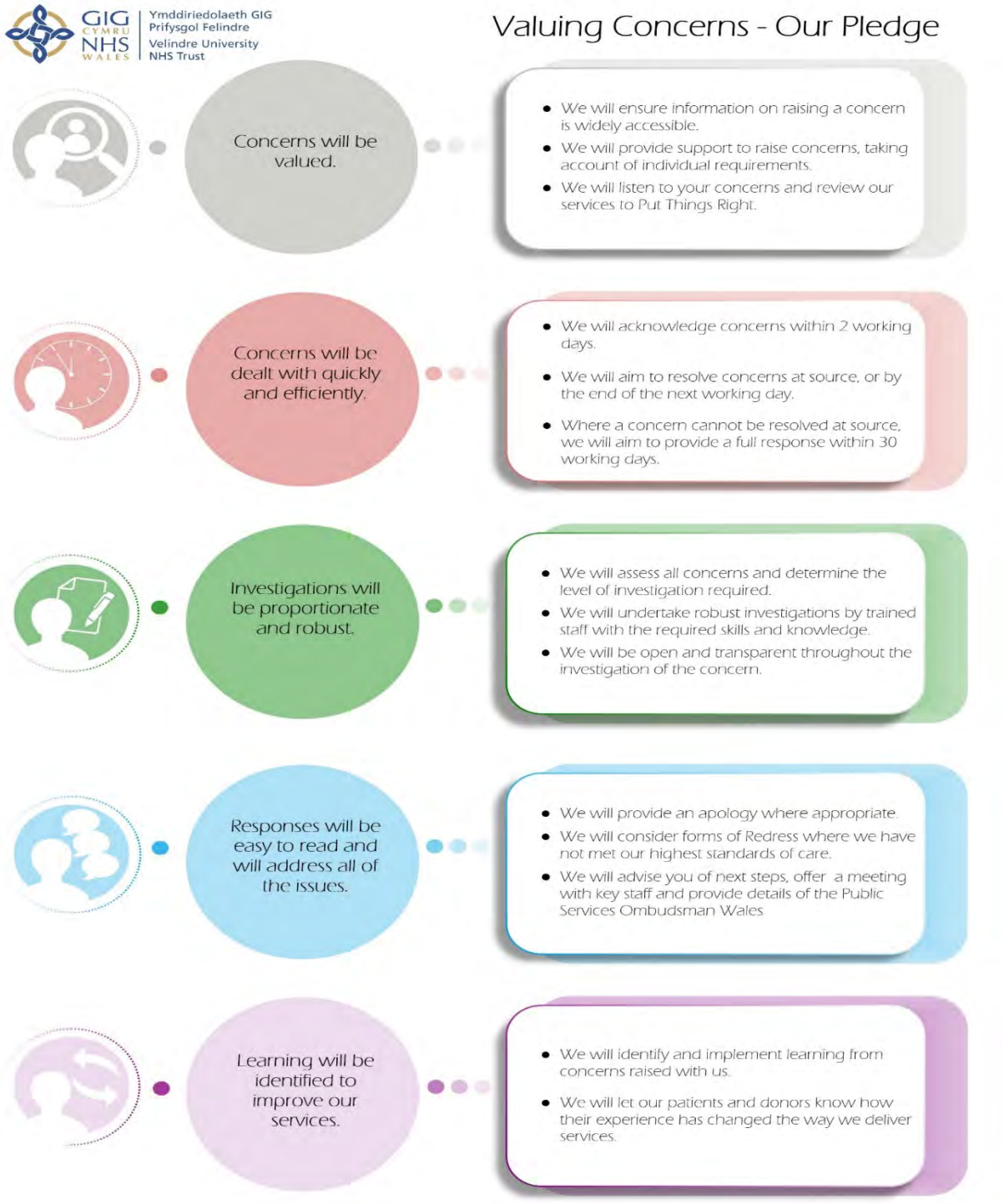
APPENDIX 1: Grading Framework

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 AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	15.09.2022

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	01.09.2022	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.
- Outline approach to risk appetite review for autumn 2022.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

2.1 Key points for the Committee:

- There has been extensive review of the Velindre Cancer Services risks, which are reflected in the profile of risks over 15 recorded in this report. There is a focus on risk in Velindre Cancer Services Senior Leadership Team continuing in the next reporting period, where all actions (shown as blank in this report if not yet completed) will be completed.
- Migration onto Datix 14 complete for WBS for all new risks and Board level reporting risks. Remainder now being migrated.
- Training progressing well - with over 100 “level 2” access manager having completed Teams interactive training session.

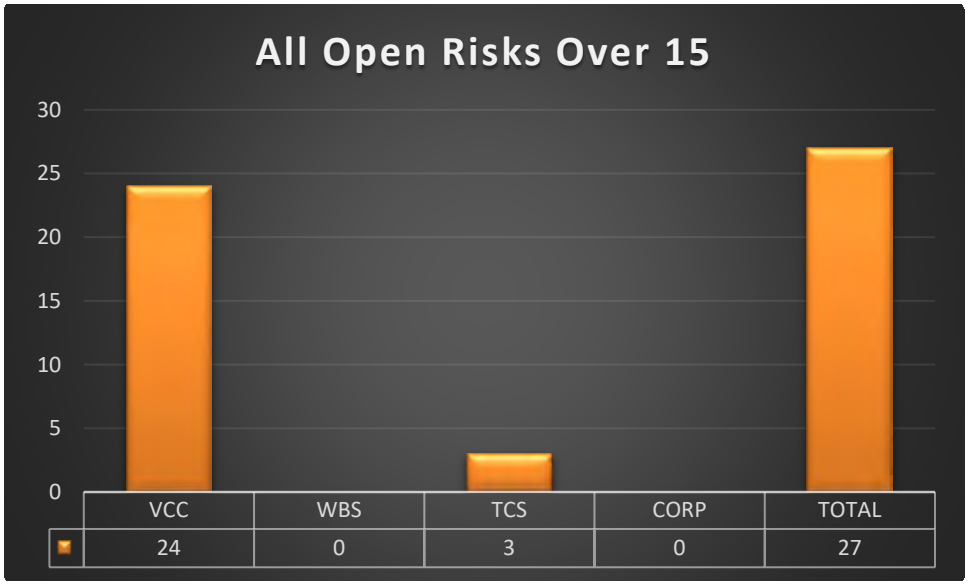
2.4 Trust Risk register.

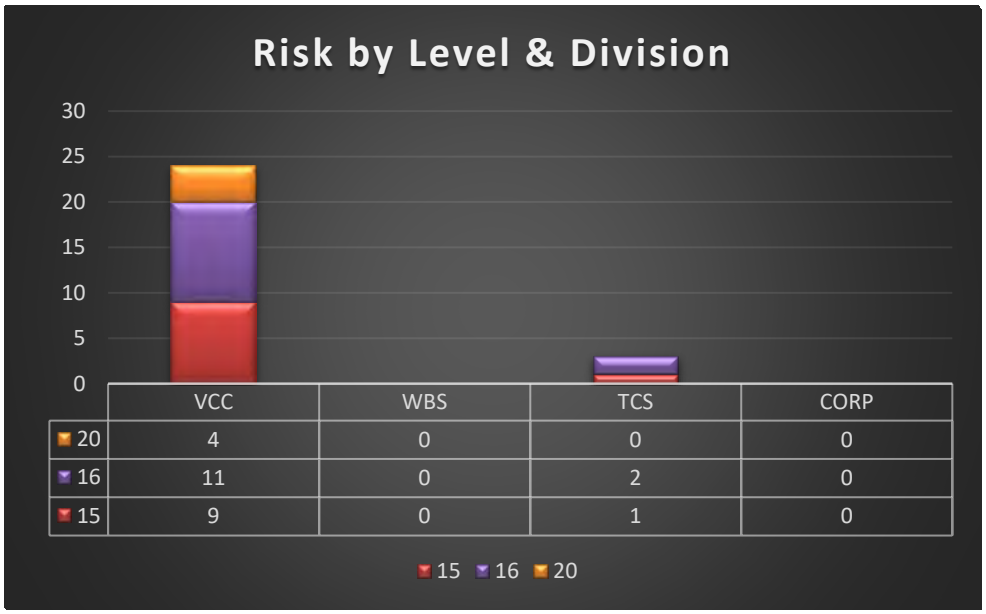
2.4.1 Total Risks

There are a total of 33 risks with a current risk level over 15 recorded on Datix 14.

2.4.2 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 include.





2.4.3 **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 24 risks for Velindre Cancer Centre, three 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	Title	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Summary
2644	Digital Health & Care Record DH&CR080(R) - SACT Treatment Summary PDF displaying 'Authorised' status	Velindre Cancer Centre	An issue has been identified whereby the SACT Treatment Summary PDF is displaying an 'Authorised' status for a cycle where all the drugs within the cycle have been marked as Given or Not Given. The Chemocare application has inbuilt logic to derive the 'Completed' status when the cycle has been Authorised + drugs marked as Given/Not Given. The SACT TS PDF is misleading and could cause the reader to interpret that the treatment was not given to the patient.	20	1	30/09/2022	
2630	Digital Health & Care Record DHCR062(R) - Dual Running timeline - risk of patients in Canisc with not finished treatment	Velindre Cancer Centre	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.	20	15	05/09/2022	

2579	Palliative Care Training posts	Velindre Cancer Centre	Wales been unsuccessful in appointing to any of the pall care registrar posts at the recent round of UK wide recruitment, this appears to be reflected across the UK with posts in all regions unfilled.In addition one of our trainees, Dr Lucy Williams, has been successful in gaining an Inter Deanery Transfer to Severn Deanery (where she lives) which will mean she will leave our training programme in October 2022 and return directly from maternity leave to Severn.2 new palliative care StR training posts have had their funding frozen - which means it isn't lost (this year at least), goes back to Welsh Government, but at present we are told that we cannot access the funding for these 2 posts to appoint locum replacement specialty or LAS doctors. Added to this a further trainee Chris Doyle is likely going for an Intradeanery transfer to London, and if final approval is granted which is likely, will be there for Oct 2022. This leaves us with approximately 4 middle grade doctors on the 1:6 on call rota. There will need to be locum provision into these vacant on call spots, unless we are able to fill the vacant posts with specialty doctors.	20	4	30/09/2022	

2200	Radiotherapy Capacity	Velindre Cancer Centre	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes.2/7/19 updateHazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ).This will be linked to Risk 22455/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.23/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service13/6/2022 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service31/8/2022 - UPDATERisk reviewed and no change to risk rating due to no change in capacity or outsourcing possibilities.	20	6	31/10/2022	

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

ID	Title	Risk Type	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date
2650	Digital Health & Care Record DH&CR094(R) - Non-delivery of interface that pulls clinical annotations from WCP OMN to VCC DMS	Performance and Service Sustainability	Velindre Cancer Centre	A risk has been raised regarding the non-delivery of the interface that pulls clinical annotations from the WCP Outpatient Medical Note (OMN) to the VCC Document Management System (DMS). This is an existing interface that pulls clinical annotations recorded against the outpatient appointment in Canisc into DMS at the point of letter creation.	16	4	05/09/2022
2211	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Performance and Service Sustainability	Velindre Cancer Centre	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. DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	12	05/09/2022

2221	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	Performance and Service Sustainability	Velindre Cancer Centre	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.DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to ‘copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)’.This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding.This functionality is not available within WPAS; therefore it is requested that the functionality be developed.There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales.DHCW confirmed that they can replicate the copy coding functionality but that it could take up to 12 months. They have confirmed a temporary manual copy coding function that will be used in the interim. This will require 2 staff (or equivalent overtime) for up to 12 months.Without the ability to copy the RT Regular Day Admissions (in same sequence of admissions) will have a resource and financial impact.Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. At present, 2 coders code 60,000 episodes of RT Regular Day Admissions. Without the function to copy the coding team would need additional resource to maintain deadlines. A full time coders would generally code approx. 6,000 episodes per year. Therefore an additional 8 full time coders would be required to maintain current levels of productivity. Financials can be calculated if necessary.Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards.	16	12	05/09/2022

2326	Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	Performance and Service Sustainability	Velindre Cancer Centre	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live. A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	9	05/09/2022
2329	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	Performance and Service Sustainability	Velindre Cancer Centre	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.There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required.Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	16	16	12/09/2022
2440	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	Performance and Service Sustainability	Velindre Cancer Centre	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. DHCR046(R) - SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	6	05/09/2022

2499	Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin	Performance and Service Sustainability	Velindre Cancer Centre	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. DHCRO51(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing. * Clinical information will not be available in WCP/WPAS. * VCC runs a clinical safety risk if data is not available for decision support. *Not enough time will be available to provide adequate assurance.	16	8	05/09/2022
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	Velindre Cancer Centre	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.	16	4	30/11/2022
2407	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	Performance and Service Sustainability	Transforming Cancer Services	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.	16	4	20/10/2022
2513	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Performance and Service Sustainability	Velindre Cancer Centre	There is a risk that patient treatment is delayed as a result of a lack of medical work forward holding a prostate brachytherapy practitioners licence	16	10	31/07/2022
2428	There is a risk of increased infection transmission due to poor ventilation.	Compliance	Velindre Cancer Centre	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	16	9	02/09/2022

2554	There is a risk that Patients may not be informed in a timely manner	GDPR	Velindre Cancer Centre	There is a risk that Patients may not be informed in a timely manner as to the loss/damage to their Medical Records caused by the capacity of the Medical Records Department to identify and categorise lost/damaged records. The impact will be a material breach of the Data Protection Act 2018 in that patients who suffer a loss or damage to records may not be informed in line with the requirements of the Act	16	4	30/09/2022
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Transforming Cancer Services	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	16	6	30/06/2022

Risks level 15

Summary of level 15 risks are detailed in the table below.

ID	Title	Risk Type	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date
2187	Radiotherapy Physics Staffing	Safety	Velindre Cancer Centre	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 i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern,	15	5	31/10/2022

				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.			
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	Velindre Cancer Centre	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.	15	6	28/10/2022

2253	Availability of CANISC System	Performance and Service Sustainability	Velindre Cancer Centre	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.	15	5	01/12/2022
2205	CANISC failure	Performance and Service Sustainability	Velindre Cancer Centre	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	15	9	01/12/2022

2638	Digital Health & Care Record DH&CR065(R) - Provision of a DPIA - as WPAS is a national system for the WPAS System.	Compliance	Velindre Cancer Centre	The VCC IG Manager discussed with DHCW IG colleagues about providing a copy of the data protection impact assessment (DPIA - as WPAS is a national system) for the WPAS System. From a DHCW perspective WPAS predates current assurance processes and was introduced before GDPR and the requirement for Data Protection Impact. The NIIAS integration is documented but It is believe there is no formal DPIA for WPAS. The WPAS Applications Manager has stated that the WPAS system has a sophisticated role-based security model and further success controls. When WCP was implemented into VCC a DPIA was provided which provide assurance from an information governance perspective on access controls, role based structure and permission levels etc. The impact is on the DPIA being requested by VCC not being available in the same format as the WCP DPIA with access controls etc. being documented. Currently no IG Manager on post at VCC	15	4	05/09/2022
2649	Digital Health & Care Record DH&CR093(R) - Lack of Administrative Support and associated processing errors using WPAS	Performance and Service Sustainability	Velindre Cancer Centre	Specific Risk raised by Therapies Team regarding the lack of Administrative support for processing their planned and drop in clinics. At present there are 32 members of clinical staff and 0.4 wte of administrative support. The clinical staff process all of their clinics on Canisc themselves. The incoming process with the WPAS system is far more intricate and less forgiving - as it has strict booking and outcoming rules which require skilled and knowledgeable processing. The potential for error is increased - and for clinical staff to be responsible for this will further increase the potential for error. The assistants and Therapies Technician's will have to be removed from their clinical roles, to manage the administrative work.1) They will no longer be working at the top of their banding/liscence2) Patients may not be seen in a timely fashion by therapies teams, impacting their quality of care and potentially their outcomes.3) Increase potential errors by staff who are not employed to do the role they are doing.	15	4	05/09/2022

2512	Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation	Performance and Service Sustainability	Velindre Cancer Centre	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. DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting	15	12	05/09/2022
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Velindre Cancer Centre	"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"	15	5	27/05/2022
2604	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	Workforce and OD	Transforming Cancer Services	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	15	4	30/09/2022

2609	There is a risk to safety as a result of hot weather leading to harm to staff in non clinical areas	Safety	Velindre Cancer Centre	The Met Office have issued an Amber Weather warning for the 17th, 18th and 19th July for extreme heat with temperatures potentially reaching in excess of 360C. It may possibly be hotter in the VCC buildings due to their age, construction, equipment and lack of mechanical ventilation. The Met Office identifies population wide adverse health effects are identified and substantial changes to working practices are likely to be required. VCC is a flat roofed building which does not have air conditioning throughout the building. In addition some air conditioning has been turned off due to NWSSP guidance on control of risks of Covid transmission. Some offices do not have windows that open. Currently following IP&C and NWSSP advice to the Trust Ventilation Group fans are not allowed in both clinical and non clinical areas. Working conditions for staff in non clinical areas are going to be extremely hot over the period of the Amber Weather warning this may have an impact both on health, stress and wellbeing and on the ability of our staff to deliver services. Control measures are already in place but given the extreme nature of the forecast heat event these may not be sufficient in all areas of the buildings and further cooling/air movement may be beneficial which could involve the use of fans during this period.	15	8	01/09/2022

3. Development of Risk Framework

3.1 Three key steps remain for the development of risk framework:

3.1.1 The policy has been approved by the Executive Management Board, out of committee. The policy and procedure will have been distributed to the Audit Committee by the time of the QSP Committee for endorsement for Trust Board approval in September.

3.1.2 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 form which all staff in 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 Service.
- Management level – covering the Policy and Corporate Management Level Procedure and second form of 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, is currently underway for Corporate division, which will be completed by the end of September. Velindre Cancer Centre training will be delivered primarily via their away day but additional sessions will be run.
- 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.

3.1.3 The transition to version 14 of Datix for The Welsh Blood Service is complete.

3.1.4 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.

3.1.5 The review of risk appetite will be discussed with the Board in development session in early November.

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.

ID	Title	Division	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	Review date	Action Summary
2187	Radiotherapy Physics Staffing	Velindre Cancer Centre	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 i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	25	15	5	31/10/2022	
2612	Acute Oncology Service (AOS) Workforce Gaps	Velindre Cancer Centre	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.	15	15	6	28/10/2022	

2253	Availability of CANISC System	Velindre Cancer Centre	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.	15	15	5	01/12/2022		
2205	CANISC failure	Velindre Cancer Centre	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	25	15	9	01/12/2022	Risk to be reviewed following Canisc change	
2638	Digital Health & Care Record DH&CR065(R) - Provision of a DPIA - as WPAS is a national system for the WPAS System.	Velindre Cancer Centre	The VCC IG Manager discussed with DHCW IG colleagues about providing a copy of the data protection impact assessment (DPIA - as WPAS is a national system) for the WPAS System. From a DHCW perspective WPAS predates current assurance processes and was introduced before GDPR and the requirement for Data Protection Impact. The NIIAS integration is documented but It is believe there is no formal DPIA for WPAS. The WPAS Applications Manager has stated that the WPAS system has a sophisticated role-based security model and further success controls. When WCP was implemented into VCC a DPIA was provided which provide assurance from an information governance perspective on access controls, role based structure and permission levels etc. The impact is on the DPIA being requested by VCC not being available in the same format as the WCP DPIA with access controls etc. being documented. Currently no IG Manager on post at VCC	15	15	4	27/09/2022		

2644	Digital Health & Care Record DH&CR080(R) - SACT Treatment Summary PDF displaying 'Authorised' status	Velindre Cancer Centre	An issue has been identified whereby the SACT Treatment Summary PDF is displaying an 'Authorised' status for a cycle where all the drugs within the cycle have been marked as Given or Not Given. The Chemocare application has inbuilt logic to derive the 'Completed' status when the cycle has been Authorised + drugs marked as Given/Not Given. The SACT TS PDF is misleading and could cause the reader to interpret that the treatment was not given to the patient.	20	20	1	30/09/2022	
2649	Digital Health & Care Record DH&CR093(R) - Lack of Administrative Support and associated processing errors using WPAS	Velindre Cancer Centre	Specific Risk raised by Therapies Team regarding the lack of Administrative support for processing their planned and drop in clinics. At present there are 32 members of clinical staff and 0.4 wte of administrative support. The clinical staff process all of their clinics on Canisc themselves. The incoming process with the WPAS system is far more intricate and less forgiving - as it has strict booking and outcoming rules which require skilled and knowledgeable processing. The potential for error is increased - and for clinical staff to be responsible for this will further increase the potential for error. The assistants and Therapies Technician's will have to be removed from their clinical roles, to manage the administrative work. 1) They will no longer be working at the top of their banding/liscence 2) Patients may not be seen in a timely fashion by therapies teams, impacting their quality of care and potentially their outcomes. 3) Increase potential errors by staff who are not employed to do the role they are doing.	15	15	4	27/09/2022	need for review in light of risk read wider than DHCR issue
2650	Digital Health & Care Record DH&CR094(R) - Non-delivery of interface that pulls clinical annotations from WCP OMN to VCC DMS	Velindre Cancer Centre	A risk has been raised regarding the non-delivery of the interface that pulls clinical annotations from the WCP Outpatient Medical Note (OMN) to the VCC Document Management System (DMS). This is an existing interface that pulls clinical annotations recorded against the outpatient appointment in Canisc into DMS at the point of letter creation.	16	16	4	27/09/2022	
2211	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Velindre Cancer Centre	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. DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	16	12	27/09/2022	Risk to be reviewed - rating reviewed and amendments made

2221	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	Velindre Cancer Centre	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. DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'. This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding. This functionality is not available within WPAS; therefore it is requested that the functionality be developed. There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales. DHCW confirmed that they can replicate the copy coding functionality but that it could take up to 12 months. They have confirmed a temporary manual copy coding function that will be used in the interim. This will require 2 staff (or equivalent overtime) for up to 12 months. Without the ability to copy the RT Regular Day Admissions (in same sequence of admissions) will have a resource and financial impact. Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. At present, 2 coders code 60,000 episodes of RT Regular Day Admissions. Without the function to copy the coding team would need additional resource to maintain deadlines. A full time coders would generally code approx. 6,000 episodes per year. Therefore an additional 8 full time coders would be required to maintain current levels of productivity. Financials can be calculated if necessary. Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards.	16	16	12	27/09/2022	
2512	Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation	Velindre Cancer Centre	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. DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting	15	15	12	05/09/2022	
2326	Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	Velindre Cancer Centre	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live. A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	16	9	27/09/2022	
2329	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	Velindre Cancer Centre	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. There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required. Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	16	16	16	27/09/2022	Query re risk rating

2440	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	Velindre Cancer Centre	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. DHCR046(R) - SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	16	6	27/09/2022	Query re risk rating
2499	Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin	Velindre Cancer Centre	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. DHCRO51(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing. * Clinical information will not be available in WCP/WPAS. * VCC runs a clinical safety risk if data is not available for decision support. *Not enough time will be available to provide adequate assurance.	20	16	8	27/09/2022	
2630	Digital Health & Care Record DHCR062(R) - Dual Running timeline - risk of patients in Canisc with not finished treatment	Velindre Cancer Centre	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.	20	20	15	27/09/2022	
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Velindre Cancer Centre	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.	16	16	4	30/11/2022	
2579	Palliative Care Training posts	Velindre Cancer Centre	Wales been unsuccessful in appointing to any of the pall care registrar posts at the recent round of UK wide recruitment, this appears to be reflected across the UK with posts in all regions unfilled. In addition one of our trainees has been successful in gaining an Inter Deanery Transfer to Severn Deanery, the trainee will leave our training programme in October 2022 and return directly from maternity leave to Severn. 2 new palliative care StR training posts have had their funding frozen - which means it isn't lost (this year at least), goes back to Welsh Government, but at present we are told that we cannot access the funding for these 2 posts to appoint locum replacement specialty or LAS doctors. Added to this a further trainee is likely going for an Intradeanery transfer to London, and if final approval is granted which is likely, will be there for Oct 2022. This leaves us with approximately 4 middle grade doctors on the 1:6 on call rota. There will need to be locum provision into these vacant on call spots, unless we are able to fill the vacant posts with specialty doctors.	20	20	4	30/09/2022	

2200	Radiotherapy Capacity	Velindre Cancer Centre	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. 23/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service 13/6/2022 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service 31/8/2022 - UPDATE Risk reviewed and no change to risk rating due to no change in capacity or outsourcing possibilities.	20	20	6	31/10/2022	
2407	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	Transforming Cancer Services	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.	16	16	4	20/10/2022	
2513	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Velindre Cancer Centre	There is a risk that patient treatment is delayed as a result of a lack of medical work forward holding a prostate brachytherapy practitioners licence	20	16	10	31/07/2022	

2428	There is a risk of increased infection transmission due to poor ventilation.	Velindre Cancer Centre	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	16	16	9	02/09/2022	
2554	There is a risk that Patients may not be informed in a timely manner	Velindre Cancer Centre	There is a risk that Patients may not be informed in a timely manner as to the loss/damage to their Medical Records caused by the capacity of the Medical Records Department to identify and categorise lost/damaged records. The impact will be a material breach of the Data Protection Act 2018 in that patients who suffer a loss or damage to records may not be informed in line with the requirements of the Act	20	16	4	30/09/2022	
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Transforming Cancer Services	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	16	16	6	30/06/2022	

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Velindre Cancer Centre	"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"	15	15	5	27/05/2022	
2604	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	Transforming Cancer Services	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	15	15	4	30/09/2022	
2609	There is a risk to safety as a result of hot weather leading to harm to staff in non clinical areas	Velindre Cancer Centre	The Met Office have issued an Amber Weather warning for the 17th, 18th and 19th July for extreme heat with temperatures potentially reaching in excess of 360C. It may possibly be hotter in the VCC buildings due to their age, construction, equipment and lack of mechanical ventilation. The Met Office identifies population wide adverse health effects are identified and substantial changes to working practices are likely to be required. VCC is a flat roofed building which does not have air conditioning throughout the building. In addition some air conditioning has been turned off due to NWSSP guidance on control of risks of Covid transmission. Some offices do not have windows that open. Currently following IP&C and NWSSP advice to the Trust Ventilation Group fans are not allowed in both clinical and non clinical areas. Working conditions for staff in non clinical areas are going to be extremely hot over the period of the Amber Weather warning this may have an impact both on health, stress and wellbeing and on the ability of our staff to deliver services. Control measures are already in place but given the extreme nature of the forecast heat event these may not be sufficient in all areas of the buildings and further cooling/air movement may be beneficial which could involve the use of fans during this period.	15	15	8	01/09/2022	

QUALITY, SAFETY & PERFORMANCE COMMITTEE

15 STEP CHALLENGE UPDATE

DATE OF MEETING	15th September 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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**
		Choose an item.

ACRONYMS	
SACT	Systemic Anti-Cancer Therapy
SLT	Senior Leadership Team
SMT	Senior Management Team

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with the current position in relation to the ’15 step challenge’ process across both divisions during 2022.

2. BACKGROUND

The Trust implemented a limited version of the NHS England in June 2021. It has been limited due to pandemic and was delayed from planned implementation of March 2020. To date it has been undertaken by the Executive Director of Nursing, AHP & Health Science, her Business Support Officer and three Independent Members and a visit planned bi-monthly.

The 15 step challenge was inspired by a mother’s comment at a patient and family involvement workshop. Patients, donors, families and carers very quickly know whether they feel confident about the service they are visiting and as such, a series of 15 Step Challenge Guides have been developed to allow organisations to gain insight into a patient / donor’s first impressions and subsequent experience of the services they receive. Velindre has slightly revised the NHS England documents.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Since June 2021, the process for undertaking these visits at Velindre has matured. To date a number of visits have been carried out across both divisions and related services (including blood collections, SACT outreach). A summary of the visits, details of good practice, recommendations are reported to the relevant Senior Management Teams following which, the reports and agreed actions are / will be provided to the Executive Management Board and a summary of findings and agreed actions to the Quality, Safety and Performance Committee.

A summary of 15 step challenge visits that have taken place during 2022 is detailed below (visits during the early months of 2022 were stood down due to wave 4 of the COVID-19 pandemic):

Date of visit	Division / Location	Recommendations sent to relevant team	Improvement Plan Reported to QSP
19/05/2022	WBS Laboratories	21/06/2022	02/09/2022
26/07/2022	VCC Radiotherapy	05/08/2022	Awaiting – Planned for Nov 2022
23/08/2022	WBS Collections Team - Wrexham	06/09/2022	Awaiting – Planned for Nov 2022

08/09/2022	VCC First Floor Ward	will be provided 16/09/2022	Planned for Nov 2022

4. NEXT STEPS

4.1 A review of actions resulting from all visits conducted to date will be undertaken and thematic review of findings will be included at the November Quality, Safety & Performance Committee.

4.2 Executive Management Board have approved the widening of the 15 step visits to all Executive Directors and Independent Members. The frequency of visits will be increased to monthly and, will also where possible be broadened to incorporate Champion responsibilities. These have commenced from September 2022.

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
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.

6. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the current position in relation to the 15 step challenge process and changes to increase the frequency, engagement and breadth of visits.