Public Quality, Safety & Performance Committee

Thu 16 November 2023, 10:00 - 13:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

1. PRESENTATIONS

1.1. Velindre Cancer Service - Patient Story

To be led by Kate Baker, Macmillan Head of Therapies

📄 1.1.0 VCS Patient Story link.pdf (1 pages)

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

2.4. Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 14th September 2023

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

📄 2.4.0 DRAFT Minutes - Public Quality Safety and Performance Committee 14th September 2023 (v3).pdf (18 pages)

2.5. Review of Action Log

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

📄 2.5.0 PUBLIC QSP Action Log Oct-Nov (v2).pdf (4 pages)

2.6. Matters Arising

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

3. MAIN AGENDA

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

3.1. Trust Risk Register

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

📄 3.1.0a TRUST RISK REGISTER -QSP - 16.11.2023- vfinal.pdf (8 pages)
📄 3.1.0b QSP - RISK REPORT - 10.11.2023.xlsx (8 pages)

3.1.1. Trust Assurance Framework

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

📄 3.1.1a TAF Paper -QSP - 16.11.2023 - final.pdf (7 pages)
📄 3.1.1b TAF DASHBOARD 2.0 - 10.11.2023.xlsx (19 pages)

3.2. Workforce Supply & Shape and Associated Finance Risks

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

📄 3.2.0 Supply and Shape Paper QSP November 2023 final (002).pdf (13 pages)

3.2.1. Anti-Racist Wales Action Plan - Progress Report

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

📄 3.2.1a QSP Anti-racist Action Plan 16.11.23.pdf (8 pages)
📄 3.2.1b Appendix 1 Anti-racist Action Plan Progress20.10.23.pdf (6 pages)

3.2.2. Finance Report for the Period Ended 30th September 2023 (M6)

To be led by Matthew Bunce, Executive Director of Finance

📄 3.2.2a Month 6 Finance Report Cover Paper - QSP.pdf (10 pages)
📄 3.2.2b M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPTEMBER 2023 - QSP.pdf (24 pages)
📄 3.2.2c Appendix 1 - TCS Programme Board Finance Report (September 2023) - Main Report.pdf (15 pages)

3.3. Workforce Planning Audit and Action Plan

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

📄 3.3.0 Workforce Planning Audit and Action plan QSP November 2023 final.pdf (8 pages)
📄 3.3.0 3684A2023_VUNHST_Review_of_Workforce_Planning_Report.pdf (30 pages)

3.4. Quality, Safety and Performance Reports

3.4.1. Velindre Cancer Service Quality & Safety Divisional Report

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

📄 3.4.1 FINAL DRAFT VERSION QSP April - Sept 23.pdf (168 pages)

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

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

📄 3.4.2 QSP Cttee 16.11.23 SEPT PMF Performance Report version 005.pdf (69 pages)

3.5. Integrated Medium Term Plan 2023-2024

3.5.1. Trust Integrated Medium Term Plan – Progress Against Quarterly Actions for 2023/2024 (Quarter 2)

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

📄 3.5.1 QSP Cttee 16.11.23 IMTP 2023.24 Quarter 2 Update FINAL version 006.pdf (40 pages)

3.5.2. Integrated Medium Term Plan - Accountability Conditions

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

📄 3.5.2 IMTP - Reporting Against our Accountability Conditions - QSP 16th November version - final.pdf (5 pages)

BREAK - 10 minutes

3.6. Integrated Quality & Safety Group Highlight Report

To be led by Tina Jenkins, Deputy Director of Nursing, Quality & Patient Experience

📄 3.6.0 IQS Hilightlight report QSP.pdf (23 pages)

3.7. Quality & Safety Framework & Quality Priorities Update

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

📄 3.7.0 Quality Safety Framework Report.pdf (11 pages)

3.8. 2023-24 Quarter 2 Quality & Safety Report

To be led by Tina Jenkins, Deputy Director of Nursing, Quality & Patient Experience

📄 3.8.0 Quarter 2 Quality Safety Report 24.10.23.pdf (51 pages)

3.9. Private Patient Service Improvement Group Highlight Report & Improvement Plan Update

To be led by Rachel Hennessy, Interim Director, Velindre Cancer Service and Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

📄 3.9.0a 10.10.23 PPS Imp Group Highlight Report.pdf (4 pages)
📄 3.9.0b PP Action Plan 281222 (1).pdf (6 pages)

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4. NHS WALES SHARED SERVICES PARTNERSHIP

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

To be led by Gareth Tyrrell, Accountable Pharmacist, NWSSP

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

4.2. Duty of Quality NWSSP Update

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

📄 4.2.0 QSP Velindre Nov 23 DoQ Update.pdf (8 pages)

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5. CONSENT ITEMS FOR APPROVAL

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

5.1. Trust Policies and Procedures for Approval

5.1.1. National Policy on Patient Safety Incident Reporting and Management

To be led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience

📄 5.1.1 National Incident Reporting and Management Policy QSP September 2023 (002).pdf (27 pages)

5.1.2. Freedom of Information/Environmental Information Regulations Standard Operating Procedure

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

📄 5.1.2a FOI EIR SOP Cover Report QSPC v1_Oct 2023.pdf (6 pages)
📄 5.1.2c APPENDIX 2 - IG08a FOI EIR SOP v2_Oct 2023.pdf (34 pages)

5.2. Revised Committee Cycle of Business

To be led by Emma Stephens, Head of Corporate Governance

📄 6.3.0 QSP Cycle of Business Interim Amendments.pdf (15 pages)

6. CONSENT ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

6.1. Trust Policies for Endorsement

6.1.1. Trust Claims Policy

To be led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience

📄 6.1.1 Claims Policy QSP October2023.pdf (46 pages)

6.1.2. Handling Concerns Policy

To be led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience

📄 6.1.2 Concerns Policy QSP November 2023.pdf (28 pages)

6.2. NHS Wales Red Cell Shortage Plan

To be led by Alan Prosser, Director, Welsh Blood Service

📄 6.2.0a QSP Committee paper 16.11.2023.docxAP.pdf (7 pages)
📄 6.2.0b NHS Wales Red Cell Shortage Plan 2023.pdf (24 pages)

7. CONSENT ITEMS FOR NOTING

7.1. Policy Management Review and Compliance Status: November 2023

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

📄 7.1.0 Policy Compliance Report QSPC November 2023 v1.pdf (32 pages)

7.2. Patient Nosocomial COVID-19 Update

To be led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience

📄 7.2.0 Nosocomial update - QSP (002).pdf (6 pages)

7.3. Safeguarding & Vulnerable Adults Management Group Highlight Report

To be led by Fiona Davies, Head of Safeguarding & Vulnerable Persons

📄 7.3.0 Safeguarding Highlight report Nov 23.pdf (10 pages)

7.4. Highlight Report from the Radiation Protection and Medical Exposures Strategic Committee (RPMESC)

To be led by Jacinta Abraham, Executive Medical Director

📄 7.4.0 RPMESC Highlight Report 16.11.23 QS&PC.pdf (3 pages)

7.5. Internal Audit Report: Digital Strategy & Transformation Programme

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

📄 7.6.0a Digital Transformation Cover Paper.pdf (6 pages)
📄 7.6.0b digital final IA report.pdf (20 pages)

7.6. Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee - 21st

September 2023

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

📄 7.7.0 Highlight Report - PUBLIC TCS 12.10.2023.pdf (3 pages)

8. INTEGRATED GOVERNANCE

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

8.1. November 2023 Analysis of triangulated meeting themes

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

8.2. November 2023 Analysis of Quality, Safety & Performance Committee Effectiveness

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

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

9. HIGHLIGHT REPORT TO TRUST BOARD

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

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

10. ANY OTHER BUSINESS

Prior approval by the Chair required.

11. DATE AND TIME OF THE NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 16th January from 10:00-13:00.

PATIENT STORY

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

https://www.youtube.com/watch?v=ObhS6zdgbx4

Date:	14th September 2023	
Time:	10:00 – 13:00	
Location:	Microsoft Teams	
Chair:	Mrs Vicky Morris, Independent Member	

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Carl James	Executive Director of Strategic Transformation, Planning & Digital	CJ
Jacinta Abraham	Executive Medical Director	JA
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Cath O'Brien	Chief Operating Officer	COB
Matthew Bunce	Executive Director of Finance	MB
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
Emma Stephens	Head of Corporate Governance	ES
Tina Jenkins	Interim Deputy Director Nursing, Quality & Patient Experience (for item 4.2.2, 4.2.3, 6.1.0 & 8.3.0)	TJ
Zoe Gibson	Interim Head of Quality & Safety, Welsh Blood Service (for item 8.3.0)	ZG
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Emma Rees	Deputy Head of Internal Audit (NWSSP)	ER
Mel Findlay	Business Support Officer (for item 3.1.0)	MF
Jason Hoskins	Assistant Director of Estates, Environment & Capital Development	JH
Susan Thomas	Deputy Director of Workforce and Organisational Development, (Deputising for Sarah Morley)	ST
Ruth Alcolado	Medical Director, Corporate Services, NWSSP	RA
Stephen Allen	Regional Director, Llais Cymru	SA
Hayley Harrison Jeffreys	Head of Infection Prevention and Control	HHJ
Maria Roberts	Quality & Safety Lead, NHS Executive (observing)	MR

APOLOGIES:		
Steve Ham	Chief Executive Officer	SHam
Sarah Morley	Executive Director of Workforce & Organisational Development	SfM

1.0.0	PRESENTATIONS	
		ACTION
1.1.0	**Welsh Blood Service - Donor Story** Led by Alan Prosser, Director, Welsh Blood Service The Committee received a video donor story prior to the meeting which outlined the post-COVID recommencement of the Donor Awards and the importance that these events have in retaining donors. The video outlined the experiences of a number of long-serving donors and how much intrinsic reward and benefit they feel from giving blood.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** Apologies were noted as above.	
2.2.0	**In Attendance** Attendees were noted as above.	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were received.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 13th July 2023** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from the 13th July 2023 Public Committee.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed in detail and Committee members confirmed that they were assured that all actions identified as closed on the action log had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed and will remain open. The remaining action log was reviewed and the following was agreed: ***3.1.0 (16/05/2023) - Risk 2465 – PW to establish whether medics are being distracted by emails arriving during consultations*** - as	

	an audit is currently being conducted by the Head of Information Governance in respect of emails, it was agreed to close this action and open a new action in respect of the Committee receiving the results of the audit along with an overview of the aligning work around the business conducted via email, currently underway within the Cancer Service.	**Secretariat**
	2.6.1 (13/07/2023) - LF to provide full breakdown of the nature of FOI requests received and length of delays for those that were responded to outside of the required timescale - as the Freedom of Information report is included within the agenda it was agreed that **this action could be closed.**	**Secretariat**
	3.1.0 (13/07/2023) - IMs and Committee members to receive TAF as soon as completed in late July, with a formal return to the Committee in September - the Committee were advised that due to the timescales of the Executive Management Board and subsequent Strategic Development Committee, it had not been possible to previously circulate the Trust Assurance Framework. The Strategic Risk Refresh was circulated to the Committee and is included in the agenda for later discussion.	
	HJ highlighted an omission from the July meeting, as SA had suggested that it would be useful, from a public perspective, to see how the considerable steps the Trust is taking towards staff wellbeing are impacting on the overall risk level and this was to be taken away for consideration. It was agreed that this should be reflected in the action log and an update provided at the next meeting.	**Secretariat**
2.6.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
2.6.1	**Freedom of Information Requests Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Committee received a brief report providing answers to questions previously raised, offering more detail around the quarter-by-quarter view of compliance and the types of Freedom of Information (FOI) requests received by the Trust. SA highlighted the formatting and colour choice in some areas of the report which could potentially present an issue, particularly to those with a visual impairment. SA also noted the omission of narrative to explain why the FOI breaches occurred. LF advised that this report was produced to address queries raised at the previous meeting and that future FOI reports would contain this information, whilst ensuring the anonymity of the individuals concerned. The Committee **NOTED** the Freedom of Information Requests Report.	

2.6.2	**Fuller Inquiry Action Plan (Body Storage) – Interim Progress Report** Led by Cath O'Brien, Chief Operating Officer The Committee received the Fuller Inquiry Action Plan and noted the progress made towards meeting the recommendations in the report. All but five recommendations (76.2%) had been completed and 5 remain outstanding. All outstanding recommendations are due to be completed by December 2023. The Committee **APPROVED** that all remaining actions be moved across to the Quality & Safety Tracker for continued monitoring. The Chair of the Committee identified that the level 6 assurance level assigned to the report did not reflect the position given that not all recommendations had been concluded and no audit undertaken to evidence sustained implementation. The Committee were advised that two refresher "seven levels of assurance" training sessions are being arranged for Trust officers who require further training. This will be completed by the end of November 2023. DM requested that 1.2 of the action plan be amended to read: *"Systems to track each body from admission to the body storage facility to release for burial or cremation…"* to also include *"or transfer to a health board [where post-mortem is required]"*. SA highlighted points 8.1 and 8.2 (CCTV) which states that an audit had been conducted in April 2023, however noted that the purpose of the audit and outcome had not been reported. Whilst it was understood that the CCTV had been included as part of a Trust-wide audit, the final report of which had not yet been received, SA suggested that the outcome to provide assurance for this particular issue should be easily obtainable. VM requested that the action plan be updated in light of the discussions at this meeting, and recirculated to the Committee within two weeks, in order to offer assurance to the points raised above. SH gave assurance that the new Velindre Cancer Centre will be compliant with the standards and expectations arising out of this report. CJ confirmed that the new facility will indeed be compliant with all regulations related to mortuary however the report would be reviewed against the building design to provide full assurance to the Committee. VM requested that this also be added to the Quality & Safety Tracker. The Committee **NOTED** the progress of the Operational Teams against the recommendations to date.		**RH** **RH** **CJ**
3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).		
3.1.0	**Trust Risk Register**		

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

The Committee received an update on the Risk paper following the discussions at the July meeting and subsequent further discussion at Audit Committee, where it was requested that due-by dates to reach the target risk score be included in the report. These dates have now been included, where possible, and this will also be included as a field in DATIX to appear as a column in future reporting.

The Committee were advised that deep dives were focused on the two longest open risks: the use of email for clinical processes and inflation for the new Velindre Cancer Centre programme, the latter of which is reducing along with the proximity to financial close.

In terms of Digital risks which had been highlighted as a key theme of triangulated risks during the July cycle, SA raised concern around the potential for patient harm arising from risks **2774, 2776** and **3092** and queried the mitigation against these risks. CJ advised that some progress towards addressing these risks has been made and suggested that the Committee be provided with regular updates on the progress of all Digital-related risks.

CJ

In reference to risk **2774** which is currently rated as 20, one of the highest levels of risk, is not expected to reach its target risk score until March 2025. AP reported that this is a significantly long-standing risk (>10 years) and assured the Committee that although significant improvements are needed, it should not be considered an unsafe service.

With reference to risk **2465** around levels of email traffic, SH queried the likelihood of colleagues resorting to alternative forms of communication, such as WhatsApp and text messaging, to obtain or share clinical information. MB assured the Committee that this question is included within the audit, and the Head of Information Governance has given initial confirmation that no patient information is being transmitted by WhatsApp.

HJ queried the compliance rate for risk training and what is in place to improve it. LF advised that good progress has been made with mandatory training completion and although this has slowed slightly as a result of the annual leave period work is continuing on an individual level to ensure the compliance rate is reached by the end of the designated six-month period.

SA queried progress of risk **2515** as the target date has now elapsed. RH advised that unfortunately the risk does remain static due to recruitment challenges, although steps are being taken to address this as far as possible and the risk would be updated to reflect this.

Trust Assurance Framework
Following a strategic risk refresh, LF presented a paper which outlined which Committee would provide oversight on these strategic risks and

	highlighted the wording review. The paper outlined that two strategic risks were reportable to this Committee – service capacity and patient outcomes – which had been endorsed by the Strategic Development Committee at their meeting on 5th September 2023. It was agreed, however, after discussion, that the Quality, Safety and Performance Committee should also have oversight of the Workforce Supply and Shape risk due to its potential impact on patients and donors and as reflected in the Committee's Terms of Reference. The chair expressed concerns that the Committee had still not seen the actual refreshed Trust Assurance Framework (TAF) (Strategic objectives aligned with the risks against delivery, with actions and assurances against each area) and asked for confirmation that the Trust Board in September and the Audit Committee at the beginning of October would be receiving the full TAF. This assurance was given. The Committee: • **NOTED** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework. • **REVIEWED** the Strategic Risk Refresh and **NOTED** the next steps.	
3.2.0	**Workforce Supply and Shape & Associated Finance Risks** Led by Susan Thomas, Deputy Director of Workforce & Organisational Development • Workforce • Finance The Committee received the report, the purpose of which is to provide an update on the key strategic integrated actions the Trust is taking to address the challenges of the supply and shape of the workforce, to ensure the mitigation of risks and to understand how actions are impacting on performance. Various existing and upcoming challenges were highlighted, along with wellbeing interventions implemented to address these. ST advised that as the British Medical Association (BMA) are due to ballot on strike action, a forthcoming period of Industrial Action is highly likely and partnership working with Trade Unions is challenging. Performance data was highlighted, showing a declining trend in sickness absence – currently at 5.7% and workforce feedback via exit strategies, staff surveys and pulse surveys indicate that staff are suffering from fatigue. The Committee heard that key areas of recruitment have been undertaken over the past few months and a move towards international recruitment has been made.	

		The chair requested that future papers outline performance indicators in order to clearly demonstrate the pace of key actions within the strategy, what has and has not been achieved as expected and any improvement outcomes and to ensure that levels of assurance are included.	
		DM suggested that the paper lacked detail around the work being undertaken in terms of upskilling the workforce and the funds being generated to support this. It was also noted that some of the information was outdated. ST acknowledged the need for further detail in order to provide appropriate assurance to the Committee.	
		The two key financial risks were outlined: the first around the significant investment made to provide additional capacity during COVID to deal with the increased demand on the service. This was initially funded by Welsh Government during the pandemic, however this funding ceased during this financial year. MB advised that based on the current forecast and trajectory to the end of the year in terms of activity performance, the financial risk initially flagged at potentially £1.5M is currently at £500K and anticipated to disappear completely during this financial year.	
		The second financial risk under continual review is vacancy rate and sickness and absence levels and the impact on variable pay – essentially agency costs – although this is reducing as a result of successful recruitment efforts.	
		The Committee **NOTED** the Workforce Supply and Shape updates and associated financial impacts as outlined within the contents of the report.	
3.2.1	**Finance Report for the period ended 31ˢᵗ July 2023 (M4)** Led by Matthew Bunce, Executive Director of Finance MB presented the Finance Report which demonstrates that the revenue position is on track to deliver. A significant number of ongoing financial risks exist across the financial landscape and NHS Wales, although the Trust has a balanced Integrated Medium-Term Plan which was recently approved by the Minister and the trajectory remains to be balanced by the end of the year. It was noted that for this month a year forecast deficit has been flagged, this was to ensure that Welsh Government are clearly sighted on the additional funding requested in relation to the new Velindre Cancer Centre project management costs. Welsh Government are aware that these costs have moved on and have requested an update which will be submitted this week. The Committees attention was drawn to the information around the NHS Wales financial pressures which, agreed by the Board, demonstrates the measures to be taken by the Trust in terms of contributing to the all-Wales financial challenge – specifically foregoing contract income protection which will release £1.2M benefit	

	to Health Board colleagues, and the reduction in prices around energy and improvement in our forecast. The Committee **NOTED** the contents of the July 2023 financial report and in particular the yearend financial performance which at this stage is reporting a breakeven position.	

3.3.0	**Value Based Healthcare Report**
	Led by Matthew Bunce, Executive Director of Finance
	
	The Committee received the Value Based Healthcare Report, a bi-annual update to reflect the work undertaken over the past eight months and forms part of the Trust's Building Our Future Together programme and should not be seen as an isolated piece of work.
	
	The Committee noted that Welsh Government funded two specific projects for the Trust in the Value Based Healthcare monies that were available in the last financial year:
	    o **Preoperative Anaemia Pathway**, led by Welsh Blood Service which is already showing improvements across Wales in terms of use of blood, and
	    o **Value Intelligence Centre**, essentially the staffing infrastructure (i.e., additional Business Intelligence, Digital and Project Management staff, backfilling clinical inputs into value-based healthcare improvements) to drive forward the value-based healthcare agenda.
	
	MB brought the Committee's attention to the Value Intelligence Centre **Phase 1** work undertaken and briefly outlined plans for **Phase 2** which focuses on governance, training and change management and will continue until the end of October 2023. A small bespoke project around food and value, looking at some more environmentally friendly and shortened food supply chains for Velindre was also noted.
	CJ gave assurance of alignment with the organisation's overall data insight intelligence approach, with work well on the way and advised that recruitment into the new role of Head of Data Insight and Intelligence is anticipated at the end of the month.
	
	With regards to the Velindre Food Strategy, SA queried the engagement process, noting that a staff survey had been carried out however that engagement with patients, who would be directly affected, had not, and offered the support of Llais with regards to obtaining the views of patients and service users. MB to discuss with the Deputy Director of Finance.
	
	The Committee **NOTED** the continued development of the Value Based Healthcare Programme including:
	• **Phase 1** completion and Executive Summary in Appendix 1
	• **Phase 2** extension of third-party support until October 2023 to continue the development of the Value Intelligence Centre
	• The development of a Velindre Food Strategy with Welsh Government support.
		MB

3.4.0	**Information Governance Assurance Report** Led by Matthew Bunce, Executive Director of Finance The Committee received the report which highlights compliance with Information Governance legislation and standards, details actions to improve management of associated risks, reporting of incidents and actions from lessons learned. The report focuses on three of the four Information Governance domains: NHS Wales Information Governance Toolkit, Information Management and Information Security. VM noted that no Data Protection Impact Assessments had been completed between April-June. It was understood that this was a result of issues around capacity and complexity and is anticipated to pick up upon completion of other workstreams, although the need for increased resilience was noted. The Committee **NOTED** the contents of this report for **ASSURANCE**.	
3.5.0	**Highlight Report from the Trust Estates Assurance Group** Led by Carl James, Director of Strategic Transformation, Planning & Digital CJ presented the report to the Committee, noting in particular the items for alert/escalation in respect of health & safety/fire safety training compliance figures and inflated utilities costs. Attention was drawn also to the issues around staffing levels as it was noted that significant recruitment challenges remain, largely due to the higher salaries offered for the same or similar roles in non-NHS organisations. NW highlighted an issue around flooring which is included within the Infection Prevention and Control (IPC) report, however this should also be noted as a health and safety risk. NW queried whether there was a link between the two incidents relating to chairs within the waiting areas at VCS and a claim relating to a chair which was received around a year ago, following which an audit was conducted. CJ to review the detail of these incidents and report back to the Committee in order to ascertain whether there are any issues around the audit process. VM noted that the Health & Safety Risk Register does not appear on the Corporate Risk Register, although the scores would indicate that it should be included. CJ to review risks over 15 not currently included within the Trust Risk Register. The Committee **NOTED** the contents of the report and the actions which are being taken.	**CJ** **CJ**
3.6.0	**Quality, Safety & Performance Reports**	
3.6.1	**Welsh Blood Service Quality, Safety & Performance Report**	

Led by Alan Prosser, Director, WBS

A comprehensive WBS Quality & Safety Report covering the six-month period February 2023 to July 2023 was discussed. The report included positive donor experience outcomes and good compliance with investigations.

Three SABRE (Serious Adverse Blood Reactions and Events) incidents were reported during the period. All had been fully investigated and no harm occurred.

The Duty of Candour had not been triggered during this period.

VM sought further detail around the health and safety inspection of irradiation facilities. PR advised that a report had been received and an action plan submitted which has since been closed out as complete. PR to circulate the report and action plan to the Committee.

PR

A small number of incidents of violence and aggression towards staff were noted. PR advised that these were largely as a result of donor dissatisfaction (arriving significantly late for their appointment or being unable to donate due to their donor health screening assessment), although a number of instances were as a result of staff being aggressively challenged by individuals opposed to blood donation by donors who have received the MRNA vaccines. In terms of the late arrival of donors, SA suggested that the new 20mph speed limit coming into force could be a contributor. AP agreed that this would be taken into consideration.

AP

The Committee **NOTED** the information in the report.

3.6.2 Quality, Safety & Performance Report
Led by Cath O'Brien, Chief Operating Officer

The Committee received a comprehensive Trust-wide report covering the July 2023 period that highlighted some of the current challenges. Fragility of the workforce was noted as a common theme, although it was understood that this had been exacerbated due to the high number of annual leave days taken during the summer period.

- Radiotherapy capacity continues to present challenges and although largely affected by LINAC capacity, late delineation and repeat scan requests, staff are working extended days and weekends in order to mitigate the impact of summer annual leave.

- Issues experienced by the wider healthcare system around delayed transfers of care were also highlighted. Velindre nurse leads are active members of the All-Wales Pathways of Care Delays (PoCD) National Group who are working to manage this.

- Validation work is still underway to ensure all patients are being appropriately managed during the transfer to the Digital Health and Care Record (DHCR). Clinical Harm Reviews have been

carried out for the small number of patients who have waited slightly longer than the target times, concluding that no patient harm has occurred in these cases.

- Continued improved performance in Systemic Anti-Cancer Therapy (SACT) was noted.

In terms of the national concerns around the use of Reinforced Autoclaved Aerated Concrete (RAAC) the Committee were given assurance that, following an initial assessment, no RAAC had been identified. The final report to confirm this is expected to be received at the end of this month.

In terms of the dietetic and physio gaps, VM queried the impact of annual leave on patient waiting times. RH advised that one or two patients had been slightly delayed with no significant impact to their care.

DM raised concern of the unusually high number (8) of delayed transfers and sought further detail on the circumstance of these delays. COB advised that as these infrequent delays had never before been considered an issue and had only arisen as a result of the national programme, it had not previously been an area of focus. However, significant learning has been obtained as a result of engaging with the programme which has given a better understanding of the challenges faced by health boards and how these can be facilitated.

SA queried whether delayed transfers of care were related to social care issues as Llais would be able to offer support with this. COB to link SA with the Head of Nursing as the appropriate contact to manage this.

COB

With regards to the national issue around Reinforced Autoclaved Aerated Concrete (RAAC), SA queried whether outreach services had been impacted by this. COB advised that no issues had been raised and none were anticipated at this stage. CJ advised that initial assessment had been completed and no issues with RAAC had been identified. A final report is expected in due course which is anticipated to confirm this.

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

| 3.6.3 | **Sickness Absence Key Performance Indicator**
Led by Susan Thomas, Deputy Director of Workforce & Organisational Development | |

	The Committee reviewed the paper which considers the current Welsh Government-set Key Performance Indicator (KPI) for sickness absence of 3.54% and looks to consider whether an additional, more realistic, internal KPI (4.7%) should be used when assessing the performance of the divisions in respect of sickness absence management. The paper benchmarks the KPI figure against the current labour market and sickness absence rates amongst health and social care and summarises that the 3.54% figure is not an achievable measure.

SH highlighted an error in the report with the use of percentages and percentage points, leading to a misrepresentation of the actual figures. ST noted the error and agreed to amend the paper accordingly.

The Quality, Safety and Performance Committee **APPROVED** an internal sickness target of 4.7%, as a steppingstone towards improvement, while Welsh Government are considering targets nationally. | **ST** | |
| 3.7.0 | **Integrated Quality & Safety Group Highlight Report**

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

The Integrated Quality & Safety Group Report covering the period May-July 2023 was discussed in detail.

The report included the current status of the Quality & Safety Tracker and the Committee were advised of the further work planned (due to the current gaps in the tracker) so that the Committee can, from the next meeting, begin to receive the required level of assurance from the tracker.

The Committee were advised that the Duty of Quality "always on reporting" had commenced on the Trust website with patient and donor experience information. The development of the Trust's Quality Management System is underway and significant work has been undertaken to agree the additional quality metrics.

The Committee **DISCUSSED** the report and **NOTED** the content, in particular:
• The commencement of 'Always on Reporting' on the Trust's website and the further development work that is required.
• The closedown of the Duty of Quality & Duty of Candour Implementation Group.
• The work to develop the Trust's Quality Management system. | | |
| 3.8.0 | **Trust Infection Prevention Management Group Highlight Report**
Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Hayley Harrison Jeffreys, Head of Infection Prevention and Control | | |

The highlight report from the Infection Prevention and Control Management Board meeting held on 17th August 2023 was presented to the Committee.

HHJ gave an overview of the five matters for alerting to the Committee contained within the report and the work underway to address each of them:

- Compliance with uniform standards in clinical areas – escalation to responsible managers and Divisional Senior Teams has taken place.
- VCC Flooring in Radiotherapy – will be repaired / replaced by the 27th November 2023.
- Repeated positive Legionella water samples in the Talbot Green Headquarters at the Welsh Blood Service, risk mitigation in place through flushing and filters and a long-term solution to replace piping is being planned.
- Infection Prevention & Control Training Compliance – robust escalation to managers taken place and a recovery plan is in place.
- New Cancer Centre- resolution has been reached on a number of Infection Prevention and Control design matters that had been escalated and a plan in place to address those that remain outstanding.

In addition, there had been fungal environmental deviations in the aseptic unit at Velindre Cancer Service Pharmacy Department identified through monitoring systems. Risk reduction action has been taken including regular fogging with Hydrogen Peroxide. All present, at the Infection Control meeting including the Infection Control Doctor, were assured in respect of actions taken at the time to reduce risk, ongoing actions and functioning of the Unit.

The Committee:
- **DISCUSSED** the Infection Prevention & Control Highlight Report, from the Infection Prevention & Control Management Group meeting held on the 17th August 2023 and actions being taken to address the areas where compliance / standards are not at the required level.
- **ENDORSED** that IPC 00 – Framework Policy for Infection Prevention and Control and IPC 11 – Transport of Specimens remains extant until November 2023.
- **ENDORSED** that IPC Policy 09 – Infection Prevention and Control in the Built environment is removed as a Trust policy as the requirements are now covered adequately as a chapter in the National Infection Prevention ynd Control Manual (IPC 05).

3.9.0	**Quality and Safety 2023-24 Quarter 1 Report** Led by Tina Jenkins, Deputy Director of Nursing and Patient Experience	

	The Quality & Safety Quarter 1 report provided an overall positive overview of delivery against the Trust's responsibilities in relation to key elements of Quality & Safety for the period 01/04/2023 - 30/06/2023 and for the first time includes safeguarding and infection prevention & control data. The Committee were advised that: • Good compliance with Putting Things Right in line with complaints had been achieved, with 100% compliance on timescales. • There were no new Ombudsman cases referred to the Trust. • There were no National Reportable Incidents in quarter 1 in line with Putting Things Right, although 3 IRMER incidents had been reported. • One moderate incident was reported in quarter 1, however the Duty of Candour was not triggered until quarter 2 and as such will be included in the next report. The Committee **DISCUSSED** the Quality and Safety 2023-24 Quarter 1 Report and its findings.	
3.10.0	**The Medical Examiner Service and Velindre University NHS Trust** Led by Jacinta Abraham, Executive Medical Director JA presented the six-monthly report which provided an update regarding the implementation of the Medical Examiner Service (MES) and the wider work of mortality and morbidity within Velindre Cancer Service. Statutory requirements around the MES continue to be met, with progress being made in the formal reviews of mortality and morbidity, with work now anticipated to gather pace following the recent appointment of a Mortality and Improvement Facilitator. An issue on the accuracy of death data recorded within Velindre's Welsh Patient Administration System (WPAS) since the implementation of the Digital Health & Care Record was highlighted. This is urgently being investigated and inpatient data is not affected. A contingency has been put in place for the affected 30-day mortality data to be checked and validated before publishing and this is expected to be completed within the next two weeks. VM requested that this be added to the action log and the Committee updated accordingly. The Committee **NOTED** the contents of the report.	Secretariat/ JA
3.11.0	**Annual Medical Education Governance Report** Led by Jacinta Abraham, Executive Medical Director This report is the second annual report for medical education governance for the Trust and details the activities and performance for the reporting period August 2022 to August 2023 for both WBS and VCS. The report provides assurance that the Trust is meeting its	

	commissioning and General Medical Council (GMC) requirements for Medical Education. Many of the emerging themes received from the recent GMC survey around burnout of trainees, time for training, etc. are reflective of many of the pressures currently experienced throughout the service. An action group has been established to work with trainees, gain an understanding of the issues and put mitigations in place to address them. The Committee **NOTED** the Medical Education Governance Report.	
4.0.0	**2022-2023 Annual Reports**	
4.1.0	**FOR APPROVAL**	
	Nil items	
4.2.0	**ENDORSE FOR TRUST BOARD APPROVAL**	
	Nil items	
4.3.0	**FOR NOTING**	
4.3.1	**Health & Safety Annual Report** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital CJ gave a comprehensive overview of an overall positive report covering the period 1st April 2022-31st March 2023. It was noted that the cover paper requested that the Committee note the Health & Safety Report. However, this was highlighted as an inaccuracy, and the Health and Safety Annual Report was subsequently **ENDORSED** for Trust Board approval.	
5.0.0	**NHS WALES SHARED SERVICES PARTNERSHIP**	
5.1.0	**Surgical Materials Testing Laboratory (SMTL) Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services NWSSP The report, presented for the first time at this Committee, provided an overview of the key aspects of the SMTL Service for NHS Wales, the significance of medical device testing and the quality management system employed to provide assurance on laboratory output. The Committee **NOTED** the contents of the report.	
5.2.0	**Medical Examiner Service (MES) Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services NWSSP The Committee received the first Medical Examiner Service (MES) report which provided an overview of implementation of the MES and work undertaken in preparation for anticipated statutory status in early 2024.	

	The Committee **NOTED** the contents of the report.		
6.0.0	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).		
6.1.0	**Trust Policies for Approval** • Recruitment and Selection Policy • Annual Leave Policy • National Policy on Patient Safety Incident Reporting and Management • NWSSP – Registration Authority Policy • Sharps Policy and Divisional Sharps Exposure Procedures The Committee were unable to **ENDORSE/APPROVE** several Trust policies as the Equality Impact Assessment process had not been completed. The Committee requested that a review of the Equality Impact Assessment process is undertaken to ensure that these are all fully completed in advance of any policies being provided to the Committee for **ENDORSEMENT/APPROVAL** The Committee deferred approval of the revised Policies prior to publishing on the Trust Intranet site and circulation to the policy distribution list, due to incompletion of EqIAs. DM expressed disappointment in the issue around EqIAs having raised the concerns on several previous occasions. It was agreed that Equality Impact Assessments are to be completed prior to policies being presented to the Committee for **ENDORSEMENT/APPROVAL**. VM requested that this be included within the action log.	**Secretariat**	
7.0.0	**CONSENT ITEMS FOR ENDORSEMENT**		
7.1.0	**Revised Trust Handling Concerns Policy** Led by Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance In line with the discussions at **6.1.0** and due to uncertainty around the need for an EqIA it was agreed to defer this policy until this matter was addressed accordingly.		
7.2.0	**Quality Impact Assessment Tool** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **ENDORSED** the use of the national beta version of the Quality Impact Assessment Tool for all strategic decisions at Divisional, Executive and Board level and to request hosted bodies to also adopt the tool.		

8.0.0	**CONSENT ITEMS FOR NOTING**	
8.1.0	**Professional Nursing Forum Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the Professional Nursing update for the period March 2023 to August 2023.	
8.2.0	**Medicine Management Group Assurance Report** Led by Jacinta Abraham, Executive Medical Director The Committee received the report which provided assurance that the roles and responsibilities of the Medicines Management Group are being executed in line with accepted current best practices. The Committee **NOTED** this report as one that provides assurances of the ongoing work of the Medicines Management Group in line with its main functions.	
8.3.0	**RD&I Sub Committee Highlight Report** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the contents of the report and actions being taken.	
8.4.0	**Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report - 19th June 2023** Led by Stephen Harries, Vice Chair & Chair of the Transforming Cancer Services Programme Scrutiny Sub Committee The Committee **NOTED** the Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report - 19th June 2023.	
9.0.0	**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).	
9.1.0	**September 2023 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members Note the risk updates in the TAF and need to see completed TAF at November 2023 meeting. No additional views were expressed. Upon review of the discussions held at this meeting, VM suggested that a number of reports within the main agenda could have been effectively received under the consent agenda and requested all authors to consider this when submitting papers to the Committee.	

9.2.0	**September 2023 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members • Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee? • Were papers concise and relevant, containing the appropriate level of detail? • Was open and productive debate achieved within a supportive environment? • Was it possible to identify cross-cutting themes to support effective triangulation? • Was sufficient assurance provided to Committee members in relation to each item of business received? Following the July Committee some members indicated a preference for fully anonymised data collection. We will now be using the CIVICA system to collate responses, this is 100% anonymous. The link will be circulated following this meeting and all attendees are encouraged to respond.	
9.3.0	**Committee Effectiveness Survey Report – Reflective Feedback from July 2023 Committee** Led by Emma Stephens, Head of Corporate Governance The Committee **REVIEWED** the July 2023 feedback results.	
10.0.0	**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	
11.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
12.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **16th November 2023 from 10:00-13:00**	
CLOSE		

QUALITY, SAFETY AND PERFORMANCE - PART A

Minute ref	Action	Action Owner	Progress to Date	Target Date	Status (Open/Closed)
**Actions agreed at the 13th July 2023 Committee**				
3.1.0	IM's and Committee members to receive TAF as soon as completed in late July, with a formal return to the Committee in September.	Lauren Fear	Update on agenda for meeting 14/09/23	31/07/23	OPEN
3.1.0	Risk 3001 - impact of actions and interventions taken towards staff wellbeing to be provided to the Committee	Sarah Morley	Update 25/10/23: There is work underway to develop measures that will evaluate the impact of wellbeing interventions. The process and current progress made in this work will be brought to QSP in January 2024.	16/11/23 Now 16/01/24	OPEN
9.1.0	Trust Annual report template to be developed and Trust style determined to facilitate consistency for future annual reports	Emma Stephens	Update: 31/08/23 - Task & Finish group to be established to take forward.	31/01/24	OPEN
**Actions agreed at the 14th September 2023 Committee**				
2.5.0	Committee to receive the outcome of the Risk 2465 audit	Rachel Hennessy	**Update 09/11/23** - – report still awaited. Delivery date not yet reached Update: 23/10/23 - Audit still on track to be completed 31st October, following which it will be presented to the Director and SLT for consideration	16/11/23	OPEN
2.6.1	Further detail with regards to the nature of FOI breaches, action taken and timeliness to be provided to the Committee	Lauren Fear		16/11/23	OPEN

2.6.2	Remaining actions on Fuller Inquiry to be moved over to the Q&S Action Tracker	Nicola Williams		16/11/23	CLOSED
2.6.2	Outcome of CCTV system audit to be circulated to the Committee	Rachel Hennessy	**Update 09/11/23** - paper postponed. Due SLT beginning December Update: 23/10/23 - CCTV audit and action plan to be considered by SLT 9/11/23	28/09/23	OPEN
2.6.2	Fuller Inquiry report to be reviewed to ensure compliance with proposed nVCC facilities	Carl James	The report is currently being reviewed against the building design. QSP Committee will be updated once confirmation has been received.	16/11/23	OPEN
3.1.0	Detailed presentation on progress of Digital risks to be presented to November Committee	Carl James	Currently there are no digital risks over 15 relating to Digital Services. A presentation can be provided on the broader digital thematic risks if the QSP Committee found it helpful.	16/11/23	OPEN
3.5.0	Claim related to chairs to be reviewed to ensure robust audit process is being followed	Carl James	Estates Department are completing an initial inspection and to date have carried out maintenance on the stock of the chairs we have, which has mainly involved tightening up the screws that were loose. Currently approximately halfway through the inspections and summary to date: • No of chairs condemned = 2 • General maintenance = 217 Ongoing maintenance to be completed by end of February 2024.	16/11/23	OPEN

			This will inform next steps i.e. replacements chairs or ongoing maintenance based on Health & Safety risk assessment.		
3.5.0	Review - Health & Safety Risk Register risks over 15 not currently included within Trust Risk Register	Carl James	The Health & Safety risk register risks are currently being reviewed. These risks will be reviewed by the action owners by 30/11/2023.	16/11/23	OPEN
3.6.1	Ensure new 20mph speed limit is taken into consideration with regards to late arrivals for appointment times	Alan Prosser	**Update 25/10/23:** Watching brief at this point in time. No concerns raised by donors at time of writing	16/11/23	OPEN
3.6.2	Committee to have sight of final RAAC report when received	Carl James	Arup have confirmed there is no RAAC in Velindre Cancer Centre. The report from Arup has been circulated to the QSP Committee. Estates Department are awaiting response from Arup regarding Welsh Blood Service Buildings. This will be circulated once received.	16/11/23	OPEN
3.10.0	Revalidation of mortality data to be completed within two weeks	Jacinta Abraham	Following the resolution of the integration issues that were impacting on the accuracy of death data in WPAS, an initial validation of mortality data was carried out and completed on 20/09/23. However subsequent work on the accuracy of BI mortality reporting has also identified discrepancies with data entry due to a clinical coding issue. This is now being fixed by 10/11/23 and a further re-run of mortality data is planned for 24/11/23	28/09/23	OPEN

6.1.0	Equality Impact Assessments to be completed prior to policies being presented to the Committee for approval/endorsement	ALL		From 16/11/2023	OPEN

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	16.11.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	LAUREN FEAR, DIRECTOR OF GOVERNANCE AND CHIEF OF STAFF
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Audit Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Summarise the final phase in implementing the Risk Framework.

1

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **NOTE** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board – Run	02.11.2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Detailed information was submitted to EMB in respect of ongoing management of each risk detailed on the risk register, providing assurance that risks are being actively managed and reviewed.

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0

ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

2. BACKGROUND

The risks currently held on Datix for the Trust are to be considered by the Quality, Safety and Performance Committee.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 5 risks to report to Board and Committee on Datix 14, this includes 3 risks with a current score over 15, one of which is a private risk, and 2 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register
- The risk register detail in Appendix 1 is for consideration by the Quality, Safety and Performance Committee.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- The Quality, Safety and Performance Committee and the Audit Committee requested the inclusion of a date by which the target rating will be received. A field has now been added to Datix for this information to be included in reports to Trust Board and Committees.
- Executive Management Board conducted a detail risk review on 6th November, following the October work. There was significant challenge on some scoring and also target scores. This has resulted in the target score on two risks being challenged and now will be reconsidered through Divisional governance prior to Executive Management Board sign off.

4.2 Risk Progress Updates

The Executive Management Board paper included additional information detailing the progress against risk, as well as actions. The information included in the document was drawn from Datix. The additional information was intended to provide assurance to the Executive Management Board and thereby through to governance cycle for November. The Executive Management Board reviewed and discussed the information.

4.3   Digital Risks

In consideration of risks at the July Quality, Safety and Performance Committee there was a request to reflect on risks relating to digital systems. Following review of the risks it was reported to the September Committee that there are no evident trends in digital risks and individual risks related to digital development are unique to each system.

In response to this, the September Quality, Safety and Performance Committee raised a question to whether the multiple digital risks were primarily a result of legacy systems or the workarounds and impact to the service as a result. It was agreed that a detailed presentation on digital risks would be shared at the Committee in November 2023 and an update will then be included in the November Trust Board paper. The Head of Digital undertook a review of digital risks in early October, which identified there were no digital risks reportable to Trust Board at this time.

4.4   Next Steps in Engagement and Embedding
- The Datix 'How To' guide has been updated and can be accessed via the intranet: DATIX How To Guide
- Level 1 mandatory training for all staff has been live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board.
- Regular reminders are shared in communications across the Trust to remind staff to complete the Introduction to Risk Training.
- As of 25th October 2023 an Introduction to Risk training has a completion rate of 73.11% across VCS, WBS and Corporate.
- As we approach the six month initial completion deadline (end November) work is being undertaken with managers to ensure completion of level one training, as well as sharing the training through Trust wide communications.

5.   IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here

Please tick all relevant goals:
- . Outstanding for quality, safety and experience ☒
- . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
- . A beacon for research, development and innovation in our stated areas of priority ☐
- . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- . A sustainable organisation that plays its part in creating a better future for people across the globe ☐

RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.

SOCIO ECONOMIC DUTY	Not required

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ASSESSMENT COMPLETED	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.

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

6. RISKS

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

APPENDIX 1

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

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

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Risk Type	Opened	Amount of Days Open	Division	Is this a Private & Confidential Risk?	Likelihood (Initial)	Impact (Initial)	Rating (initial)	Likelihood (Current)	Impact (Current)	Rating (current)	Likelihood (Target)	Impact (Initial)	Rating (Target)	Date Target Risk Due to be achieved	Review date	Due date	Actions	Trend Graphs
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service.	Safety	14/09/2020	1137	Velindre Cancer Centre		5	5	25	3	5	15	2	5	10	31/10/2024	29/12/2023	31/10/2023	5 year workforce programme - Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC.	**2187**
																				30/11/2023	Readvertise post which did not recruit - Re-advertise IRS implementation lead for the development of novel techniques.	
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team.	Performance and Service Sustainability	09/02/2022	624	Velindre Cancer Centre		4	5	20	3	5	15	2	5	Challenged by EMB	25/10/2024	30/12/2023	30/09/2023	Brachy Workforce	**2515**

			to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.	A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due September 2023									🟥			🟧					14/03/202 3	The risk review is overdue	
																				28/03/2023	A SMART Action Plan needs to be developed	
																				31/07/2023	Insufficient brachy MPE	

ID	Risk Title - New	RR - Current Controls	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	Is this a Private & Confidential Risk?	Likelihood (initial)	Impact (Initial)
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Safety	09/12/2022	321	Corporate Services	No	4	4

2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	Safety	05/11/2021	720	Velindre Cancer Centre	No	4	4

Rating (initial)	Likelihood (Current)	Impact (Current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Date Target rating will be achieved	Review date	Due date	Description
16	4	3	12	3	3	9	31/03/2024	31/12/2023	31/03/2024	Divisions/Departments should have proactive stress risk assessments
									09/12/2022	Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions Steering Group to
									21/03/2023	This risk needs a SMART action plan
									22/12/2023	Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed

16	3	4	12	2	2	Challenged by EMB		29/12/2023	09/10/2023	IB to undertake an audit into the use of email within the medical directorate across VCC
									31/03/2024	Develop management training in managing stress

3001

APR   MAY   JUN   JUL   AUG   CURRENT

2465

16　16　16　16　16　16

APRIL　MAY　JUNE　JULY　AUGUST　CURRENT
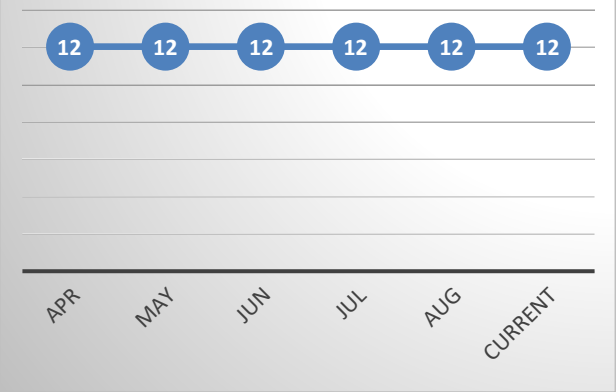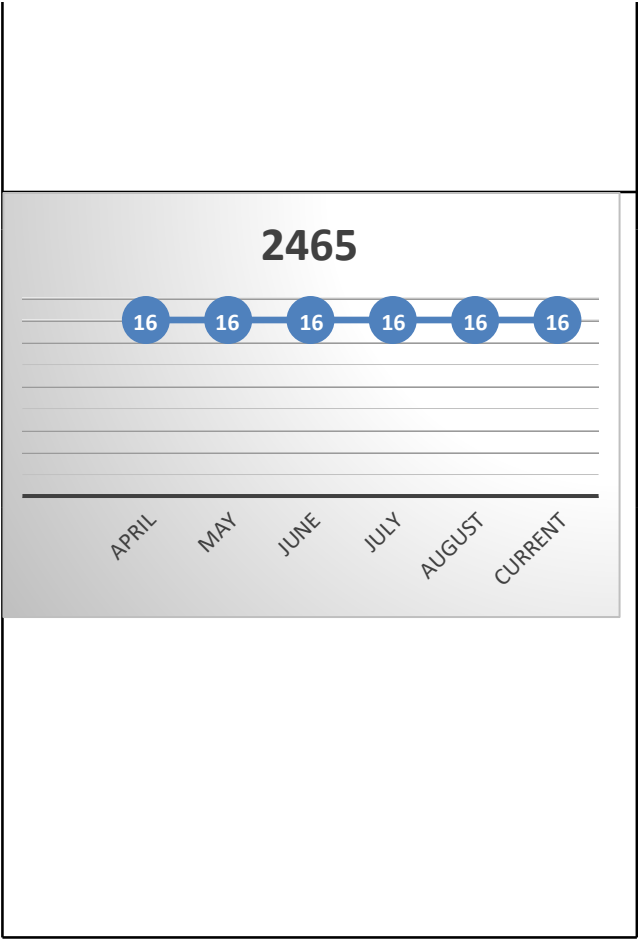
QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Assurance Framework

DATE OF MEETING	16.11.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and this paper provides an update to the Executive Management Board, following Trust Board in September and Audit Committee in October.

RECOMMENDATION / ACTIONS	The Committee is asked to **NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	13.11.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	*Report for Noting*

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

1. SITUATION

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

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

The revised Trust Assurance Framework is appended for 6 of the 8 of the strategic risks. These risks are being considered at Executive Management Board on 13th November and feedback will be provided to the Committee, as it was important to share this draft with the Committee. The updated version will then be presented to Trust Board in November.

Going forwards in each Quality, Safety & Performance Committee, two strategic risks will be discussed in more detail.

2.   BACKGROUND

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

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

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

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

A final review of the Strategic Risks took place on 21st August 2023 with Executives and key colleagues to conclude the refresh for Executive Management Board endorsement and Trust Board approval.

3.   ASSESSMENT

3.1   Following the Strategic Risk Refresh the outcome has been shared with the Trust Board is included in Appendix 1.

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

3.2 The next steps agreed with QSP and Audit Committee are:

- Continue to progress with the population of the new template based on the strategic risk refresh outlined in Appendix 1.
- Populate the automated system in order to operationalise the Trust Assurance Framework for ongoing managements. This to be governed via the Divisional and Corporate Senior Leadership Teams and then to Executive Management Board.
- Engage with Executives and teams to embed a review process for the Trust Assurance Framework in line with the Integrated Medium Term Planning process and update this in the Trust Assurance Framework guidelines and Integrated Medium Term planning guidelines – by end December.
- Embed the new automated Trust Assurance Framework through Divisional and Corporate Senior Leadership Teams governance processes in order to support Executive Management Board and Trust Board role. To be updated in the Trust Assurance Framework guidelines – by end January.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Committee are asked to:

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

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience	☒

- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
- A beacon for research, development and innovation in our stated areas of priority ☐
- An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- A sustainable organisation that plays its part in creating a better future for people across the globe ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required	

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

For more information: *https://nhswales365.sharepoint.com /sites/VEL_Intranet/SitePages/E.asp x*	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.		Senior Leadership Team, COO and EMB Review, QSP committee and Board.		Welsh Government Quality, Planning and Delivery Review.	
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Weekly meetings with UK	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.		Performance Report to Senior Leadership Team and EMB Review, QSP committee		Welsh Government Quality, Planning and Delivery Review	
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and WBMDR.	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.		Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.		Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government EPRR for Health, Local Resilience Forum - SCG.	
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.		Highlight and performance reports to Senior Leadership Team and EMB Review.		QSP committee and Board and external stakeholders if required.	

C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCC	X			E	Horizon scanning and representation at key forums including UK Forum, JPAC, Sabato. Regular liaison with Blood Policy and Tissue, Cells and Organs team in Welsh Government.	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	QSP, SDC	
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Performance Report - SLT, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review	
C7	Demand and Capacity Plan for each service area	Heads of Service - each area	X	X		PE	Service area operational planning meeting	Performance Report - SLT, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally.		
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3184	There is a risk to VCC as a result of no Lead Digital Pharmacist in post resulting in multiple risks for VCC and the trust. These include for example lack of Medicines management clinical leadership for the implementation and ongoing use of general medicines EMPA, update of current chemocare and implementation of new all wales SACT EMPA. Implementation of pharmacy robot nVCC.	20	Risk Increasing
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/No Movement
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong		Jul-25	Vein - 2 - Vein programme (patient pathway) submitted for funding to Welsh Government in August 2022. Programme led by C&VUHB on behalf of all Health boards in Wales and is supported in an oversight capacity by the Blood Health National Oversight Group. Initial funding bid declined with caveats. These are currently being progressed with re-submission date of February 2023.	6.11.23		
	Blood Health National Oversight Group project is underway identifying inappropriate use of blood.				Self assessment Gap analysis for Patient Blood Management Conservation strategies completed in August 2022 and submitted to Blood Health National Oversight Group in Sept 2022. This has been further supported by key PBM audits undertaken from October - November 2022. These have been tabled for BHNOG meeting in January 2023. Ongoing funding via the Value Based Healthcare (VBHC)programme for pre-operative anaemia work is progressing and will link in with both the PBM conservation strategies and the audits.	6.11.23		

SECTION 1

RISK ID	02	RISK TITLE	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	STRATEGIC GOAL	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	
RISK LEADS	Carl James	Jacinta Abraham	Nicola Williams	RISK THEME	Partnership Alignment		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS — SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	IA	Strategic Development Committee/ Quality Safety and Performance	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of Executive Function in Welsh Government in April 2023	PA	Strategic Development Committee/ Quality Safety and Performance Committee; introduction of Executive Function in WG will support effective system	PA	Regulatory scope re MHRA tbc; clear standards for services understood and supported by commissioning arrangements across NHS Wales	PA
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region			X		PE	Agreed to model for next phase	IA	Strategic Development Committee/ Quality Safety and	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety and Performance	PA	Wales Audit Office/Welsh Government	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Development of Phase 2 of PMF with additional performance measures/quality metrics	Carl James		Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce		Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liaison)		tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identified 3. Programme Manager and resources partially identified 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangements and the	The level of assurance should increase

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS | SOURCES OF ASSURANCE

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged work plan to be implemented to support workforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual work plan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	8.11.23	Plan is monitored via Health and Engaged Steering group and plan in place to March 2024	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	IA	Mar-23	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	8.11.23	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA	Mar-24	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB			
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	IA	Dec-23	A plan to implement the People Strategy will be presented to EMB in December.			
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Mar-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy			
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Feb-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly			
1.7	Review Exit Interview Process	Susan Thomas	IA	Jan-24	Task and Finish group to consider Exit interview process			

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

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

SECTION 4									
ASSOCIATED OPERATIONAL RISKS - According to risk appetite									
DATIX RISK REF	**RISK TITLE**				**INTIAL RISK RATING**	**CURRENT RISK RATING**	**TARGET RISK RATING**	**RISK TREND**	
	There are currently no associated operational risks according to the risk appetite to								
SMART ACTION PLAN									

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		Mar-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These began in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message.	09/11/2023		
1.2	Consider feedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive culture within the organisation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey will be distilled to further develop our work programme	09/11/2023		
1.3	A staff engagement project to understand levels of staff engagement and also review the Trust Values	Sarah Morley		Jan-24	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were built on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in	09/11/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	09/11/2023		

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	9
	4	4				3	4				3	3		

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital Officer		X		E	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP	PA	Wales Audit Office	Not Assessed
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	IA	Wales Audit Office	Not Assessed
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	Feedback and progress working with universitues	IA	Wales Audit Office	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	IA	Wales Audit Office	Not Assessed
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	PA	Wales Audit Office/ Centre for Digital Public Services	PA
C7	Digital inclusiion in wider community	Chief Digital Officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	IA	Wales Audit Office	PA

Ref	Description	Owner					Controls		Assurance sources	IA/PA		IA/PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	IA	Wales Audti Office	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	PA	Wales Audit Office	PA
C11	Trust digital Governance	Carl James		X		PE	Trust Digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	IA	Wales Audit Office	IA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	Review via EMB/Board	PA	Wales Audit Office	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		PE	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	PA	Wales Audit Office / WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme established/ Architectural Review Board	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audti Office	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Each of the controls (with exception of c1,c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2	
Digital architecture needs to be developed to guide digital transformation activities.	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls,	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/ No Movement

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer		Nov-22	Digital Programme has now been established from Oct '23	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer		Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The Digital Strategy has now been published and a draft insfrastructure strategy (reference architecture) is available.	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey / Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee / Trust Board	6	Internal Audit Reports / Audit Wales Structured Assessment Programme / Reports / Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee / Trust Board	4	Internal Audit of Board Committee Effectiveness / Audit Wales Structured Assessment / Audit Wales Review of Quality Governance Arrangements	4
C5	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Independent Member Group repurposed and second meeting now held. Further	4		
C6	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self- assessment exercise. All actions complete /on track to complete by end of this financial year.	5			Audit Wales review of Quality Governance Arrangements	5
C7	Quality of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

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

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

DEFINITIONS
CONTROL EFFECTIVENESS

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

ASSURANCE RATING

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

LEVELS OF ASSURANCE DESCRIPTORS

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

STRATEGIC GOALS

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

RISK SCORE
LIKELIHOOD MATRIX

LIKELIHOOD (*)				
LIKELIHOOD SCORE	1	2	3	
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	PR
Frequency: How				Expecte... lea...

RISK DESCRIPTORS

Inherent Risk	Score the exposure before any action has been taken to

KEY CONTROLS

CONTROL TYPE	DESCRIPTION	EXAMPLES
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff

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

	1	2	3
1 - Negligible	1	2	3
2 - Minor	2	4	6
3 - Moderate	3	6	9
4 - Major	4	8	12
5 - Catastrophic	5	10	15

IMPACT MATRIX

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / C…

Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

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

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

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan; Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals; For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example; other competent authorities, other government departments or UK NHS Research Ethics Committees; Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions; Infringement Notice; Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or...*	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity /disability	Incident leading to death

or public (physical or psychological harm)	No time off work	Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors	
11 Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis	

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Susan Thomas, Deputy Director of W&OD Chris Moreton, Deputy Director of Finance
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Matthew Bunce, Executive Director of Finance
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The workforce challenges in Velindre are centered around the Supply and Shape of the workforce. The availability (**Supply**) of the right workforce in the right place with the right skills and the need to move away from traditional staffing models to deliver a changing service requires a different **shape** to the workforce. This will require finance to be allocated across different teams and different staff groups. The purpose of this report is to highlight the key integrated actions the Trust is taking to address the workforce challenges, to

	ensure risk mitigation and performance improvement. The associated financial risk of supply issues is also noted in this paper.

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

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

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

APPENDICES	
	No Appendices

GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

1. SITUATION/BACKGROUND

The workforce challenges in Velindre are centered around the Supply and Shape of the workforce. The availability (**Supply**) of the right workforce in the right place with the right skills and the need to move away from traditional staffing models to deliver a changing service requires a different **shape** to the workforce. This will require finance to be allocated across different teams and different staff groups. The purpose of this report is to highlight the key integrated actions the Trust is taking to address the challenges, to ensure risk mitigation and performance improvement. The associated financial risk of supply issues is also noted in this paper.

The key to ensuring a robust plan around workforce supply and shape is to strengthen our current workforce planning approach. A workforce development framework has been approved by the Trust to support this.

The framework includes a series of workforce levers – (see figure 1) to ensure we plan, recruit, retain, skill and develop our workforce and manage the health and engagement of our staff effectively to ensure we are the employer of choice, meeting the commitments laid out in our people strategy. This report highlights the actions we are taking to address the effective supply and shape of the workforce.

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

Workforce Development Framework
Using the structure of the workforce development framework (below) the narrative below provides a high level update on interventions to progress against the workforce levers (what we are doing to Buy, Boost, Build and Bind our workforce).

Workforce Development Framework- Workforce Levers

Buy
•To recruit the right workforce through our internal and external labour market, whilst creating opportunities that allows individuals from local communities to joining the Trust and develop themselves in a way that satisfies both the individual and the organisation

Boost
•Using creative and transformative means to accelerate or improve ways of working through collaborative partnerships, experimental pathways, technology or other means. Whilst anticipating future trends/needs through data modelling techniques and being innovative in meeting those. Also working with services to facilitate transformative and integrated working to provide high quality service user experience with realistic resources

Bind
•Retain valued and critical colleagues by optimising their skills/talents and opportunities to enrich roles and pathways whilst creating a positive culture that enables good performance. Also developing and delivering retention strategies that allow staff to feel listened to and valued and providing opportunities for development, progression and stability.

Bounce
•A resource for colleagues in the positive management of absence and performance, ensuring appropriate standards of behaviour throughout the Trust. Appreciating the skills and recognising talent of existing colleagues and using this in the best way through positive management. Fully engaging with colleagues to understand what they want and can offer and being flexible in meeting those requirements. Whilst ensuring that policies and procedures are people centred, flexible, relevant and help the Trust to achieve its strategic objectives. Also, providing an accessible and professional Occupational Health and Wellbeing service to assist in recovery and wellbeing.

Build
•To create and develop capacity of existing staff through short and long-term programmes. By delivering programmes that build on the existing skills and knowledge of colleagues to enhance and expand their competencies through theoretical and practical learning.

Borrow
•A temporary method of accessing talent to meet the urgent and short-term needs of the service/organisation. The continuing of the relationships built through partnerships with external agency organisations and engaging with individuals benefiting from flexible circumstances to assist services when a need arises.

2.1 Buy/Build the Right Workforce

In order to a promote Velindre as an 'Employer of Choice' and enhance supply routes for recruitment the following interventions have been undertaken:

2.1.1. **Targeted recruitment campaign** in VCC and WBS have been completed to focus on our hard to fill roles. This has been the output of the Attraction and Retention Task and Finish group. The work of this group has involved development of careers pages and marketing materials. The Trust are also linking in with HEIW and national recruitment events to support all routes of recruitment. Vacancy and turnover rates are monitored via the Trust Performance Reports. Granular workforce dashboards are provided to Senior Leadership teams monthly.

2.2.2 **International nurse recruitment** has also commenced to recruit 17 WTE nurses within the Trust to start in post next year. Following recruitment, work will be ongoing to transition the nurses into the Trust, ensuring effective pastoral care is in place. Progress in this recruitment process is monitored via EMB Run.

2.2.3 **Widening Access Programme** ongoing Programme ensuring access routes to the Trust are in place for nurse cadets and army veterans. Ongoing work with local apprenticeship education providers allows access routes for apprentices. As a Disability Confident Employer the Trust has in place supported learning and

recruitment routes. Working closely with HEIW the Trust also support the NHS Wales Graduate Programme. The Trust Education and Steering group monitor the work Programme for Widening Access.
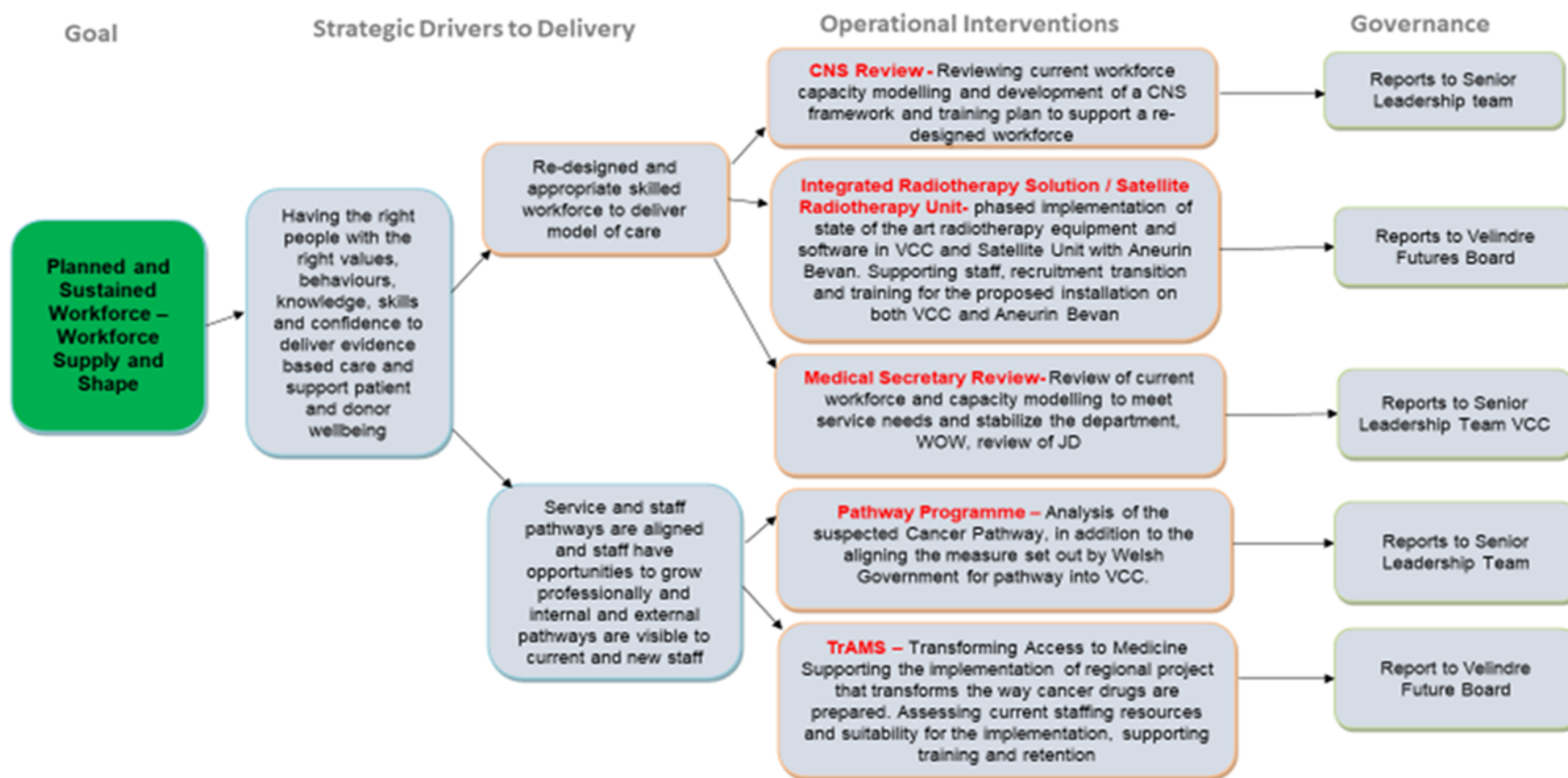
2.2 Boost the Workforce – Interventions to Deliver Services

A planned and sustained workforce is key to delivering services for our patients and donors. An overview of the operational and strategic interventions to boost the workforce in both divisions is highlighted below. The diagrams highlight the Programmes of work being taken forward in the Divisions to boost the workforce and notes how the programmes are monitored. Alongside the operational work ongoing the Trust is developing a Clinical and Scientific Strategy to articulate the service direction and service models moving forward. Workforce is working closely with colleagues to ensure the development of a future workforce model is aligned to service development. An update on the progress towards a Strategic Workforce plan is being taken to EMB Shape in November.

2.2.1 At Velindre Cancer Service

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

2.2.2 At the Welsh Blood Service

Planned and Sustained Workforce – Overview of the Strategic and Operational Interventions to Boost the Workforce – **WBS** – November to March 2024
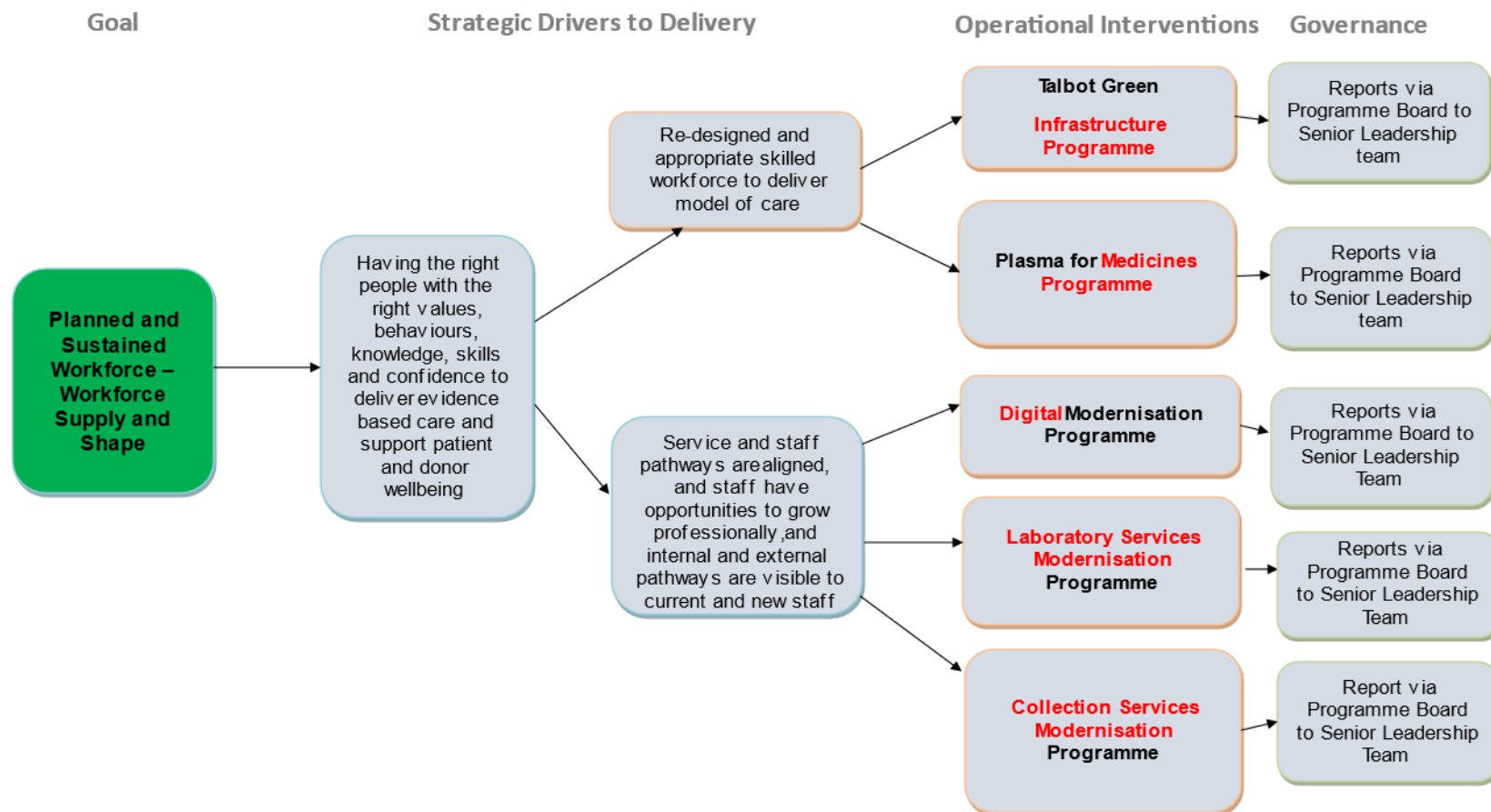
2.3 Bind the Workforce – Keeping our Valued Staff and Supporting Wellbeing

A Healthy and Engaged workforce is key to blinding our workforce, ensuring we keep our valued staff. The following interventions are being taken forward:

2.3.1. A Psychologically Safe Place to work

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

2.3.2 Our Retention plan

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

2.3.3. Wellbeing

A raft of wellbeing interventions is in place within the Trust to support staff wellbeing. The Staff Psychologist works closely with the Workforce function to review the effectiveness of interventions. The Health and Wellbeing Work plan is monitored via the Healthy and Engaged Steering group.

As noted in the narrative above the overarching Workforce Development Framework has a number of work programmes that are delivering outputs, all of which are interconnected and support each other. The narrative above highlights the governance routes to each area of work.

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

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

Pay Budget 2023/24

The full year pay budget as at end of September 2023 is £83.88m based on 1,6097 WTE. The Trust has reported cumulative year to date spend of £41.419m on pay against a budget of 41.780.m resulting in an underspend of £0.361m as at September 2023. The pay costs include the costs of agency staff, on-call and overtime.

As at September 2023, the current staff in post is 1,497 WTE. The number of vacancies is 112 WTE, which represents a vacancy rate of 7%. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

Vacancies throughout the Trust remain high particularly in Nursing, however last year significant improvement was made through targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. Ongoing recruitment interventions are being assessed for SACT nursing with the Trust exploring the international recruitment scheme. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to September 2023:

Changes in Total Vacancies by 2022-23 to 2023-24
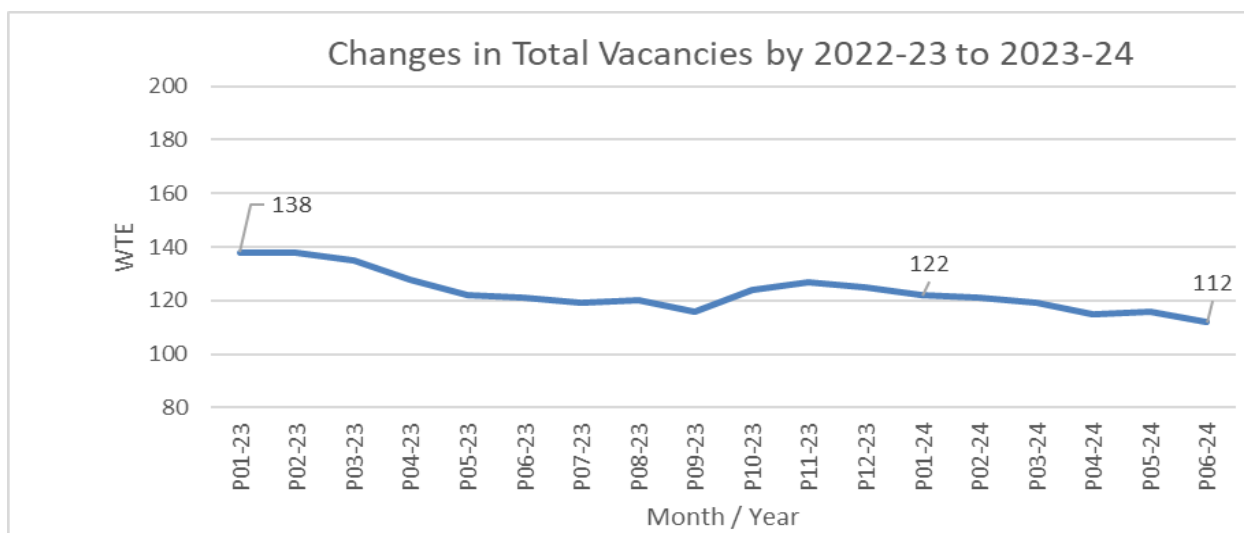
The service is exploring workforce and service redesign with the intention to take forward some fundemental changes that will enable a more efficient and productive service.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments. This investment was committed without certainty around the source of funding either through the LTA income from additional activity or Full Business Case funding approval by WG and Commissioners. The latest position is that the contract performance income has recovered however the full year position is reliant on forecast activity levels from Commissioners for Velindre Cancer Services and will need to be closely monitored over the coming months. Work is therefore continuing in VCS to understand the likely cancer activity demand / associated income and identify further sources of funding to support these posts. VCS are also assessing options to migrate staff into vacancies should it be required to help mitigate the financial risk exposure.

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

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

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3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	⊠
	Timely	⊠
	Effective	⊠
	Equitable	⊠
	Efficient	⊠
	Patient Centred	⊠
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosporous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Covid staff costs that may not be fully covered by WG or Commissioner income

Ongoing premium cost of agency |
| EQUALITY IMPACT ASSESSMENT
For more information:
https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx | Yes - please outline what, if any, actions were taken as a result |
	Individual elements of work described in this paper may be subject to EQIA.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*This is reflected in the Trust Assurance Framework Risk 03*
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.*

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Anti-racist Wales Action Plan - Progress Report

DATE OF MEETING	16 November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce.
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	In line with Welsh Government policy, the Trust agreed an Anti-racist Action Plan in December 2022. The Trust has made progress with putting strong foundations in place and is now looking to develop further. Some areas of action are dependent on national resources which are still under development.

RECOMMENDATION / ACTIONS	To note the progress in the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	30/10/23
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB Noted Update Report	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed Initial actions are determined – more comprehensive action will be undertaken through implementation all All Wales products and cultural competence education.

APPENDICES	
1	Appendix 1 – progress as at 20.10.23

1.   SITUATION

In July 2022 Welsh Government published the Anti-racist Wales Action Plan. This plan is shaped by three factors:

- It is built on the desire to strive for a nation in which there is zero tolerance of racism in all its guises
- It has been developed through co-creation with stakeholders from the breadth of racial and ethnic groups in Wales
- It is designed as a stepping stone between the legal requirements under the Equality Act 2010 and the practical implementation of racial equality in day-to-day life

To this end, all public sector organisations in Wales have concurrently created plans to make Wales an anti-racist country by 2030. Progress with the Trust's plan is communicated through this paper.

2. BACKGROUND

The Trust agreed it's response the Welsh Government Anti-racist Wales Action Plan in December 2022. Progress with the specific actions is reflected in Appendix 1. Key points within this are:

- Strong foundations with our plan have been put in place with the commitment of the Chair and Independent Members in agreeing personal objectives linked to anti-racism.

- The Board has started to reflect on their cultural competency as a group, recognising their collective knowledge and understanding will shape how the Trust embeds anti-racism. A development session took place in 2022 which has provided the foundations for establishing a Cultural Competency Audit in the Trust. The deployment of this audit process is currently being planned.

- Planning for the review of the Strategic Equality Plan for the period 2024 to 2028 has been started with a discussion with the Executive Management Board. This discussion will be extended with the Trust Board at their development session in December 2023. Race is a key factor within this plan and offers a key anchor for future changes.

- Implementing the Workplace Race Equality Standard (WRES) in Wales depends on the Trust understanding its data in relation to race. This part of the anti-racist action plan is being coordinated centrally for all NHS organisations. Further actions in relation to implementing WRES will flow from when the reports are made available.

- A campaign is underway to build a range of Diversity Forums to represent staff across the Trust. A recruitment event for the Race Forum has included coffee mornings in WBS and VCC which give people an opportunity to connect with others regarding racial equality.

- The Trust supported Diverse Cymru in undertaking a review of the All Wales People Policies. Once published, the Trust will use the findings of the national review in reviewing its own policies.

- Within the Trust, work is underway to understand the data available and required relating to patients, donors and staff in order to measure racism and thereby take action to reduce discrimination. This will be complemented by the WRES reporting. More broadly, as part of the Values and Culture development work, a Culture Dashboard, or set of metrics which reflect progress with embedding a positive culture, is being developed to work alongside existing Trust reports.

However, success with the specific actions in the plan are dependent on there being a conducive environment in which the changes can flourish. This means that some of the wider projects currently underway play a part in securing our success. These include:

- The review of the Trust Values and Culture under Building Our Future Together. It is imperative that the Values and Behaviour Framework that is agreed by the Board in January 2024 takes into account the fairness implicit in creating an anti-racist organisation.

- The implementation of a Speaking Up Safely Framework that was launched in Wales in September 2023. This will help build a positive culture around raising issues and put in place clear pathways for raising concerns. Whilst not specifically designed around race, this will be an important part of the landscape in making our anti-racist plan a success.

- The NHS Staff Survey which is running during October - November 2023. Data from the survey will be reflected in our WRES reporting and can also paint a picture for us more generally of the experiences of staff.

- The promotional activities delivered throughout Black History Month which includes coffee mornings at WBS and VCC. A particular focus on bone marrow donors from specific ethnic groups is included in this work. Whilst this might sound a small example, success will only come through building strong relationships with everyone in our communities.

The Trust took the opportunity to respond to a Welsh Government consultation exercise on 6 October 2023 seeking feedback on the national arrangements around the anti-racist plan. The Trust responding suggesting it would be beneficial to have more in-depth training resources available, that we would benefit from guidance on using population data and benchmarking and also any support to reducing barriers to engagement for anyone in the community.

3. ASSESSMENT

The Trust is on track with its actions against this plan. However, some areas are dependent on external actions to be completed before we can progress internally.

4. SUMMARY OF MATTERS FOR CONSIDERATION

To note the progress report.

5. IMPACT ASSESSMENT

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

	Patient Centred ☐
	The Anti-racist Action Plan is designed to create a more equitable organisation for patients, donors and staff; one in which race does not affect your experience.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required
	This is a progress report on a previously-agreed action plan

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	This is a progress report on a previously-agreed action plan
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	

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

Velindre University NHS Trust

Anti-Racist Action Plan 2022-23

Aim

This plan aims to create an organisational culture in which all members of staff are able to enjoy working free from discrimination and where ethnic background is a source of strength, not a barrier. The plan aims to ensure that anyone who interacts with our blood or cancer services can be confident that they will be treated without any form of discrimination related to their race or ethnic background. It also aims to reduce differential outcomes for patients relating to their ethnic group and to ensure a wide cross-section of ethnic groups are actively engaged in being blood and bone marrow donors.

Ref	National Actions	Date	Trust Actions	Progress 20.10.23
1	Trust Chair's objective to be set in support of this anti-racism work, to be discussed by relevant stakeholder groups and agreed by Ministers or Welsh Government Senior officials.	September 2023	• Share the Chair's objectives with all Board members to highlight Anti-racism commitments	• Completed
2	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	December 2022 December 2022 March 2023	• Map Anti-racist goals against the goals of the Strategic Equality Plan and set out how the two work together • Include Anti-racism within the IMTP process using the Equality Impact Assessment. • Consult with staff, patients and donors to test what their	• To be combined with the review of the Strategic Equality Plan during October/November 2023 • Met with Planning and Performance Assistant Director to create process for embedding EQIA into IMTP

		March 2023	experience is and what needs to change	• This is part of the engagement exercise on the SEP, Oct/Nov 2023
		December 2022 and ongoing	• Establish a current baseline set of data relating to staff, patients and donors in respect of race. Compare this data with local demographic data relating to racial diversity. • Develop, implement and monitor the plan through the Healthy and Engaged Steering Group.	• Initial stages of identifying options underway • Completed
3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	Summer 2023 December 2023	• Deliver Board Development awareness session on importance of cultural competence • Deliver Board development programme during 2023 commissioned by Public Bodies Unit, WG	• Introductory presentation from Diverse Cymru presentation 27.10.22. • Agreement in place to use the Diverse Cymru Cultural Competency Audit more widely in the Trust • Awaiting on materials from Welsh Government
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	December 2022	• Establish personal objective in support of Anti-racist Wales for each Board member • Board members will role model anti-racist practices by challenging	• Completed • To be addressed via the Cultural Competency Audit

		December 2022 and ongoing December 2023	discrimination, listening to lived experiences and considering racial perspectives when making decisions. • Anti-racist objectives to be cascaded through every level of the organisation and made relevant to each job role.	• To be included in the review of the Strategic Equality Plan
5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	December 2023 June 2023 June 2023 June 2023	• Implement programme when available • Embed anti-racism into management and leadership development activities • Offer coaching to support leaders implement and enhance practice in supporting their Black, Asian and racially minoritised colleagues • Embed anti-racism into staff induction by developing a welcome programme of activities for staff joining the organisation via international recruitment activities. This may involve establishing a buddying / support network for staff and drawing on experience of other Health organisations who have established such an approach.	• Not yet available • Included in Inspire module. Can be widened • To be developed • To be developed in line with International Recruitment plans
6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	September 2023	• Build on existing role of Executive Equality Ambassador	• The Executive Equality Ambassador has been nominated and has presented to

Page 3 of 6

		September 2023		the Board on the topic of Race.
			• Develop Cultural Ambassador role once role profile is available	• Not yet available
7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	September 2023

September 2023 | • Establish a pipeline for Black, Asian and Minority Ethnic staff as part of Trust talent management approach
• Review promotion and development process to ensure there is no bias or bias is mitigated | • The Talent Management approach is under development

• Methodology for gathering data is being developed and will complement the Performance Management Framework |
| 8 | Review People policies to ensure they fully support all employees | December 2023
December 2023

December 2023 | • Support All Wales programme of review of national policies
• Review Trust level policies through active use of an Equality Impact Assessment for each policy
• Examine all Trust recruitment processes through an anti-racist lens | • Completed – VUNHST HQ hosted an engagement event
• Completed. All policies are now accompanied by an EQIA

• Awaiting report from National review as a basis for the review of Trust processes |
| 9 | Implement an anti-racist communication plan and create forums for Black, Asian and Minority Ethnic staff to communicate their experiences and ideas.

Providing Ethnic Minority Networks appropriate levels of resource and access to the Board. | September 2023

September 2023 | • Re-Establish Black and Ethnic Minority staff group. Terms of Reference to set out how they have access to the Board and that they are a resource for consultation and communication.
• Standardise the consideration of staff, patient and donor stories setting out the lived experience of | • Recruitment underway with active sessions throughout Black History Month (October 2023). Coffee mornings at WBS and VCC.

• Patient and staff surveys are expected elements of Board meetings. Further stories to be gathered through Velindre |

			people from different racial backgrounds.	Voices, the Donor Engagement Group and staff forums
10	Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)	September 2023 September 2023 September 2023 September 2023	• Request all staff to update their demographic information on ESR • Work with NHS colleagues in adopting the WRES, ensuring ESR is able to produce the reports • Use WRES to understand the experience of ethnic minority staff in relation to pay and treatment • Ensure monitoring is in place and includes Leavers, Promotions, Training Opportunities, Grievances, Complaints, recruitment applications v shortlisted v successful and staff engagement surveys	• ESR has a regular prompt to all staff to review their data. • On-going, All Wales group • Awaiting National guidance on undertaking WRES • The methodology for this is being developed

| 11 | Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process. Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours. | December 2023 December 2023 December 2022 and ongoing December 2023 | • Capture and include discrimination and bullying data within Workforce Reports.
 • Develop clear robust processes and provide sufficient channels for staff to record and report racial discrimination and for the Trust to take action
 • Issue regular communications regarding zero tolerance of inappropriate behaviour
 • Work with Trades Unions to find ways for lower paid workers from ethnic minorities to raise concerns such as Speak Up initiatives, surveys and networks. Monitor uptake and remove barriers to access. | • The methodology for this is being developed • To be commenced   • To be commenced   • To be commenced |
| 12 | Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision. | September 2023 | • Apply Equality Impact Assessment to COVID 19 recovery plans and link to known health inequalities. | • To be checked |

QUALITY, SAFETY & PERFORMANCE

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

DATE OF MEETING	16/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of September 2023.

RECOMMENDATION / ACTIONS	**QSP** is asked **NOTE** the contents of the September 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – EMB Run	30/10/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE REPORT WAS NOTED AND DISCUSSED AT EMB	

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

APPENDICES	
	Trust Finance Report - September 2023
Appendix 1	TCS Finance Report – September 2023

1.   SITUATION/ BACKGROUND

1.1   The attached report outlines the financial position and performance for the period to the end of September 2023.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 . Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.639	11.326	27.372
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.9%	97.8%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of September'23 is an underspend of **£0.007m**, with an outturn forecast of **Breakeven** expected.

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

LTA Contract Performance

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a risk that planned growth for the period October to March may not transpire at the planned levels, compounded by potential reporting issues due to the implementation of DHCR which is highlighted as a financial risk for the Trust.

NHS Wales Financial Pressures

On the 31st July the Trust received a letter from NHS Wales Chief Executive Judith Paget, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services in view of the overall financial position of Welsh NHS organisations in 2023-24. In response to the financial pressures faced by the system, the Trust has been asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the following options were considered to contribute to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.991**	

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2023-24.

2.3   Savings

At this stage the Trust is currently planning to fully achieve the revised savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were

identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

Delivery of service re-design and supportive structures continues to be a challenge due to the high level of vacancies and sickness with the Trust.

The procurement supply chain saving schemes have again been affected by procurement team capacity constraints and current market conditions during 2023-24.

2.4   PSPP Performance

PSPP performance for the whole Trust is currently 97.8% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently also achieving a target of 97.8% as at the end of September.

2.5   Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023-24 reduced to £0.078m.

Covid Recovery and Planned Care Capacity

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position is that the contract performance has recovered however this is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The activity levels and Commissioner demand for services will continue be closely monitored over the coming months. Any risk should it materialise will be managed through the Trust's budgetary control procedures.

2.6   Reserves

The financial strategy for 2023-24 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.

The Trust reserves and previously agreed unallocated investment funding continues to be on hold and under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

2.7 **Financial Risks**

The financial risks for 2023-24 rated high or medium are as follows:

DHCR – Risk £0.500m / Likelihood – Medium

The Digital Health Care Record system was implemented in 2022-23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a reduced risk that c£0.500m income related to unrecorded activity could be lost.

There are several potential opportunities that are described in the report which could be utilised to support any risks should they crystallise.

NEW RISK - Whitchurch Site Security – Risk £0.143m for 2023/24 (Medium)

The annual cost of maintaining security on the Whitchurch land is expected to be c£600k.The   does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs. The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre from C&VUHB. The official transfer will be dependent on the WG formal process for transfer which is currently anticipated to take place in quarter 4, however this could be delayed into next financial year.

There are several opportunities has highlighted in the main body of the report including utilisation of the uncommitted reserve which would be used to support these risks should they crystallise.

2.8 Capital

All Wales Programme

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

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

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.

Other Major Schemes in development that are detailed in the main finance report will be considered during 2023-24 or beyond in conjunction with WG.

Discretionary Programme

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022-23.

The allocation of the discretionary programme for 2022-23 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB in August.

At this stage the discretionary programme is expected to deliver to budget.

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

3.   **IMPACT ASSESSMENT**

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐ ☐

- A beacon for research, development and innovation in our stated areas of priority ☐
- An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- A sustainable organisation that plays its part in creating a better future for people across the globe ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:

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	N/A
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a financial position of **£0.007m** for September'23 which is in line with the IMTP
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item

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

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED SEPTEMBER 2023/24

**QUALITY, SAFETY & PERFORMANCE**
16/11/2023

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2023-24.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2023-2026 was set within the following context.

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

- For 2023-24 the Plan included;
  - an underlying **Surplus of £0.684m** brought forward from 2022-23,
  - FYE **of new cost pressures / Investment** of -**£17.514m,**
  - offset by **new recurring Income** of **£16.221m,**
  - and Recurring FYE **savings schemes** of **£1.000m,**
  - Allowing **a £0.391m surplus position** to be carried into 2023-24.

- The Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 discretionary uplift funding that was held due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period. IMTP planning assumptions assumed that a £0.391m underlying surplus will be c/fwd into 2024-25.

- **In order to achieve the c/fwd underlying surplus of £0.391m the savings target set for 2023-24 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**

IMTP Underlying Revenue Position +'ve Surplus / -'ve Deficit Velindre Trust £Ms
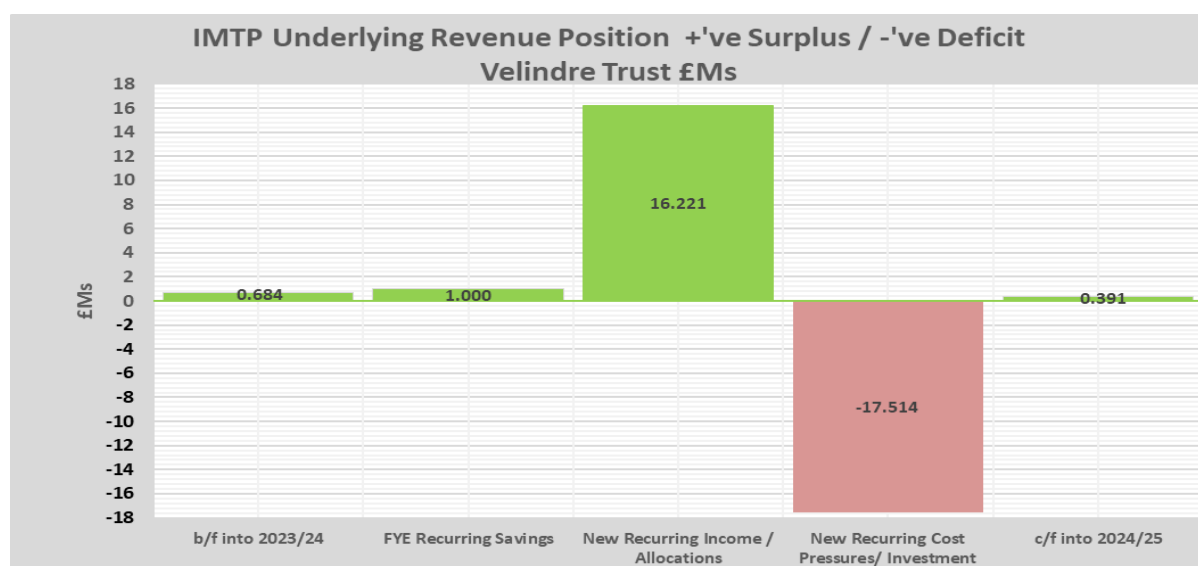
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1000	16.221	-17.514	0.391

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.639	11.326	27.372
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.9%	97.8%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.035)	(0.082)	0.000

Revenue

The Trust has reported a **£0.002m** in-month underspend position for September'23, which gives a year to date cumulative underspend of **£0.007m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to September'23 of £11.326m and is forecasting to remain within the CEL of £24.516m.

The Trust's current CEL and in year movement is provided below:

	£m Opening	£m Movement	£m Current
Discretionary Capital	1.683	-	1.683

3

All Wales Capital:

nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Works		3.800	3.800
IRS	10.326	(2.500)	7.826
Digital Priority Investment	0.164	-	0.164
RSC Satellite Centre	1.347	(1.200)	0.147
Total All Wales Capital	**22.733**	**0.100**	**22.833**
Total CEL	**24.416**		**24.516**

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during September, with the caveat that the funding will be re-provided in future years.

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m.

PSPP

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 6, and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast			
£0.007m Underspent				Breakeven			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)	
Income	(94.627)	(95.599)	0.972	(194.655)	(194.655)	0.000	
Pay	41.780	41.419	0.361	83.877	83.877	0.000	
Non Pay	52.848	54.173	(1.325)	110.777	110.777	0.000	
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 September 2023 is an underspend of **£0.007m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2023-24.

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4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

On the 31st July the Trust received a letter from NHS Wales Chief Executive Judith Paget, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services in view of the overall financial position of Welsh NHS organisations in 2023/24. In response to the financial pressures faced by the system, the Trust has been asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust has reviewed its cost control mechanisms and implemented Enhanced Monitoring arrangements which are intended to ensure savings delivery to meet the Trust's financial plan, oversee cost control mechanisms and assess choices / options and impacts of further cost saving opportunities. Following a review of the financial plan and savings position, an extraordinary Board meeting on the 09th August considered the further options for Velindre to contribute towards reducing the financial pressures in the system. The following financial improvement options were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.991**	

Underlying Position

As highlighted above in the IMTP Financial plan the Trust brought forward a surplus of £0.684m from 2022-23 and is forecast to reduce year-on-year as additional cost pressures arise over the 3-year planning period.

The expected underlying surplus to be carried into 2024-25 has reduced from £0.391m to £0.086m following the inability to enact several savings schemes, which results in underlying recurrent cost pressures forecast exceeding the recurrent savings schemes.

The ability to carry forward a surplus into 2024-25 will still depend on energy cost volatility, and the Trusts capacity to fund or mitigate current and potential new cost pressures which may emerge over the course of the year.

Income Highlights / Key Issues

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises.

VCS and WBS overachievement from Private Patient, SACT Homecare and Plasma sales.

LTA Contract Performance

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position is that the contract performance has recovered however full year position is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The activity levels and Commissioner demand for services will continue to be closely monitored over the coming months.

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Hywel Dda	0.283	(0.051)	0.232	-18%
Swansea Bay	0.294	(0.048)	0.246	-16%
Cardiff & Vale	15.036	1.447	16.483	10%
Cwm Taf Morgannwg	13.221	1.275	14.497	10%
Aneurin Bevan	17.344	1.301	18.645	8%
Powys	0.758	0.171	0.929	23%
WHSSC	2.633	(0.127)	2.506	-5%
	49.569	3.969	53.539	8%

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a risk that planned growth for the period October to March may not transpire at the planned levels, compounded by potential reporting issues due to the implementation of DHCR which is highlighted as a financial risk for the Trust.

Pay Highlights / Key Issue

At this stage the Trust is expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m) and 5% (c£3.5m) consolidated pay award which was processed in July. Pay award budget has been allocated to Divisions on assumption of WG matched funding.

The recently announced medical pay award of 5% is expected to be processed in October and back dated to April. The Trust is currently assuming that this will be fully funded by WG.

The Trust has received full funding for the one off recovery pay award which was paid in June.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in VCS to understand the likely cancer activity demand and associated income, secure additional funding to support these posts and assessing options to migrate staff into vacancies to help mitigate the financial risk exposure.

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On top of the savings plans VCS (£0.600m) and WBS (£0.450m) hold a vacancy factor target, which will need to be achieved during 2023-24 in order to balance the overall Trust financial position.

Non-Pay Key Issues

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

As part of the IMTP the Trust included £1.191m for the anticipated increase in energy prices during 2023-24. Latest projection from NWSSP suggests that the stepped increase will be c£0.700m. As above this potentially releases c£0.491m back into the system to support the NHS Wales Financial Pressures.

The Trust reserves and previously agreed unallocated investment funding continues to be on hold and under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit. The budget for the reserves is held in month 12 and will be released into the position to match agreed spend as it occurs throughout the year.

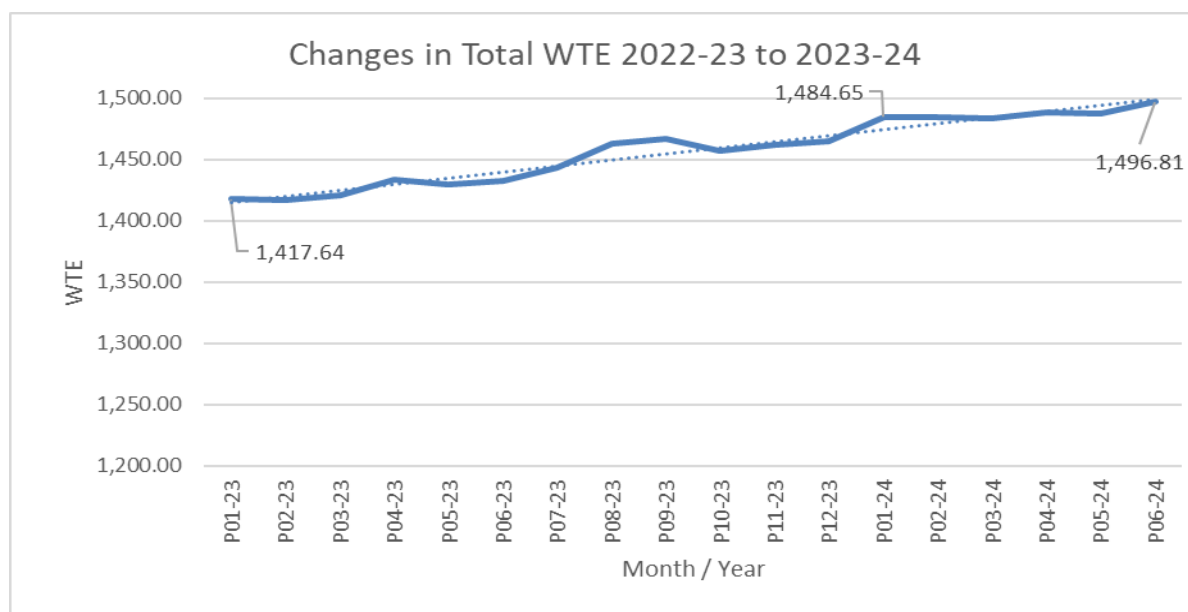**4.2 Pay Spend Trends (Run Rate)**

Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.
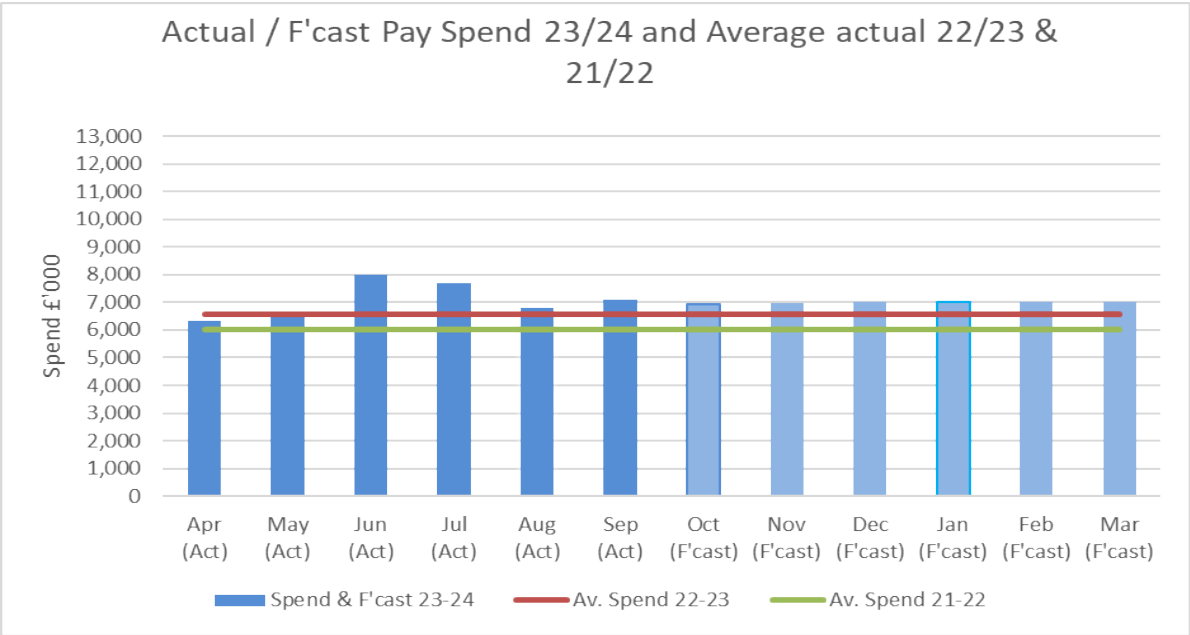
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% consolidated pay award backdated to April 2023.
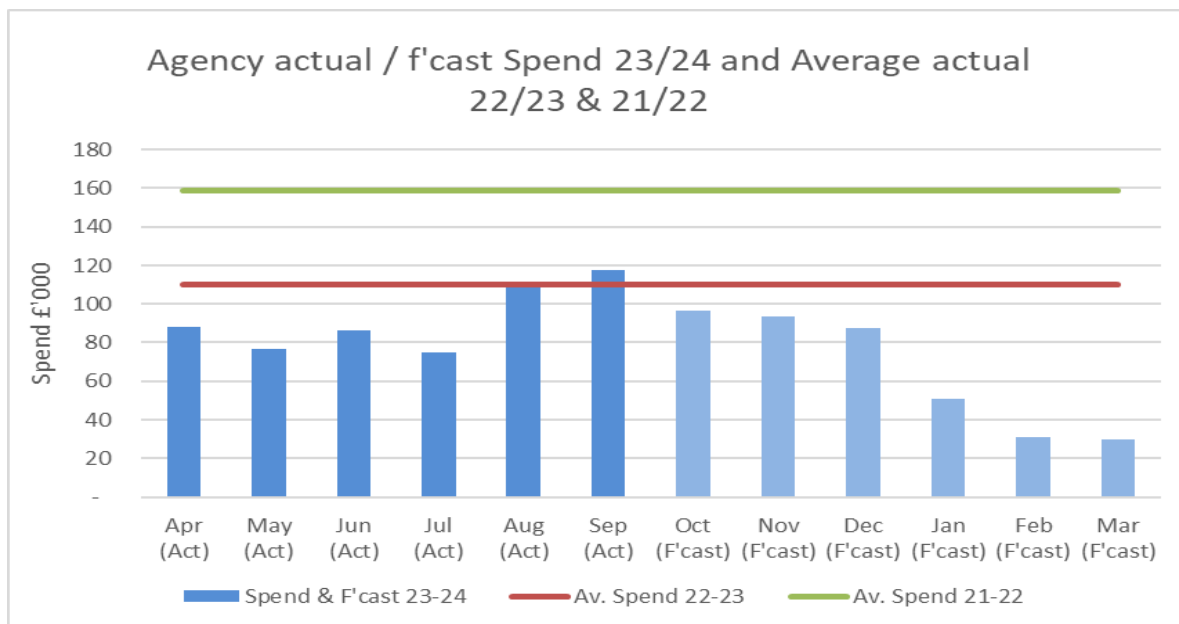
Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

The spend on agency for Sept'23 was **£0.117m,** which gives a cumulative year to date spend of £0.552m and a current forecast outturn spend of circa **£0.940m** (£1.323m 2022/23).

Changes in Total WTE 2022-23 to 2023-24

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Changes in Actual WTE 2022-23 to 2023-24 By Division

834.35
779.85
815.28
411.39
405.077
394.22
160.03
182.05
191.28
40.45
50.93
47.50
23.91
20.7
23....

Legend: VCC WTE, Corp WTE, R&D WTE, TCS WTE, WBS WTE, HTW WTE

Y-axis: WTE
X-axis: Month / Year (P01-23 ... P06-24)

Total Vacancies by Period 2023-24

| Period	WTE
P01-24	122
P02-24	121
P03-24	119
P04-24	115
P05-24	116
P06-24	112

Y-axis: WTE
X-axis: Month / Year
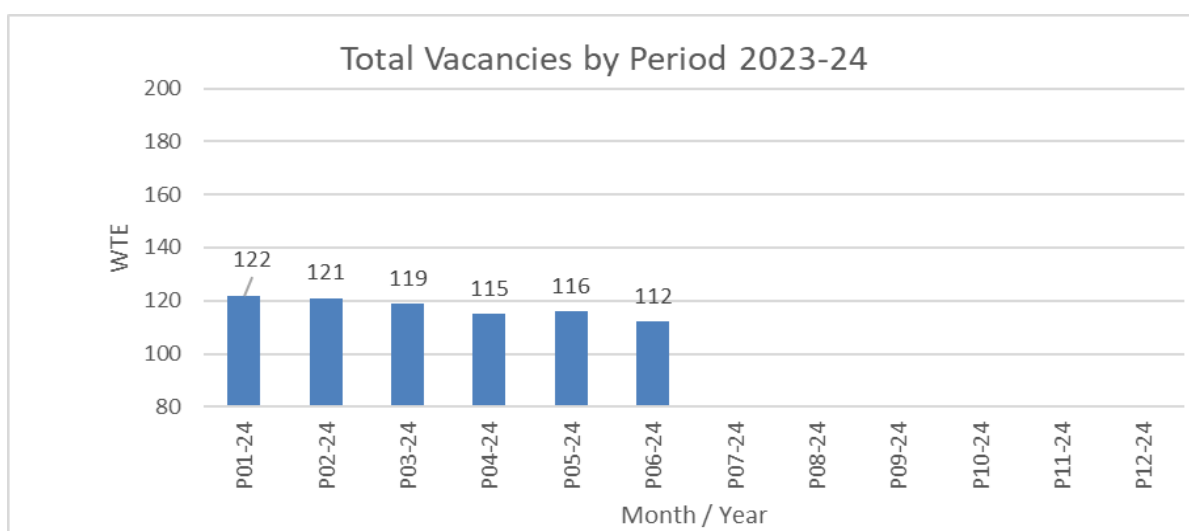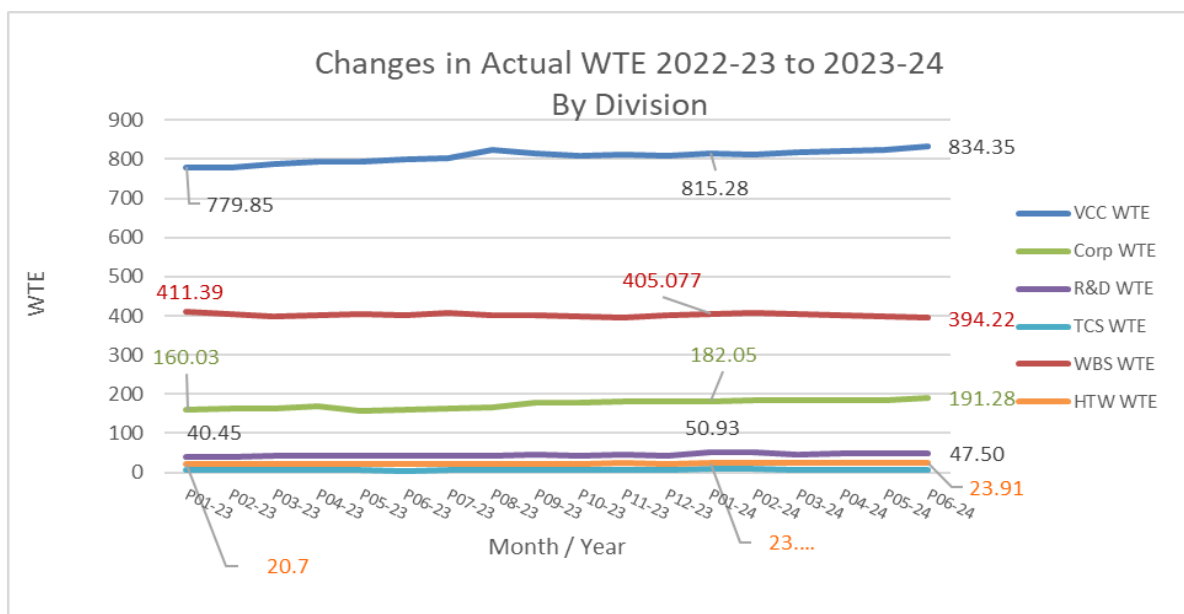
The total Trust vacancies as of September 2023 is 112wte, VCC (64wte), WBS (32wte), Corporate (9wte), R&D (3wte), TCS (2wte) and HTW (2wte).

4.3 Non-Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £9m per month which is a £0.5m increase from the previous whole year average. Largest movement is in drug spend which has increased by £4.9m ytd, or £0.8m average per month when compared with the previous year's spend for the same period. Energy costs have decreased by £0.141m ytd.

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Monthly Non Pay Spend 2023-24 compared to Average 22-23 & 21-22
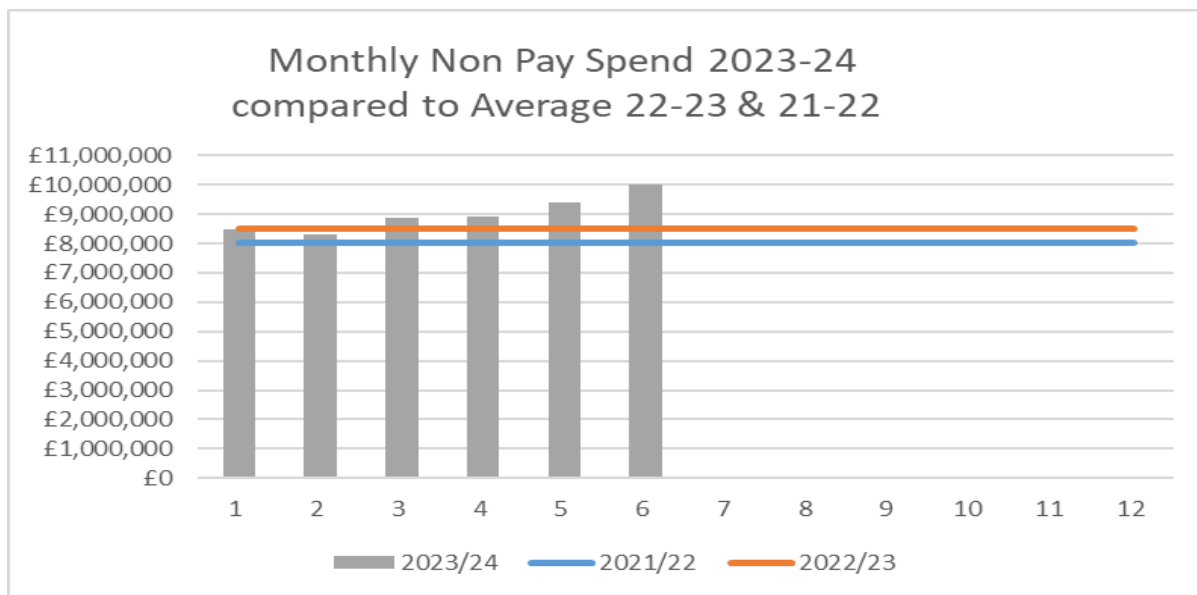
4.4 Covid-19

Covid Programme Costs

Last year there was clear expectation from WG that following issue of their Covid de-escalation letter that organisations would be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of certain ongoing Covid response and national programme costs as set out in the Director General of Health & Social Services letter dated 22nd December 2022. These programme costs will include support towards mass vaccination, and the provision of PPE which will be funded to the Trust based on actual spend during 2023/24.

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at September 23 being £0.078m, which is a reduction of £0.162m from the £0.240m requested as part of the IMTP. However, whilst unlikely if the Trust is required to support the HBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m for 2022-23. The income funding for this additional capacity flows via performance related LTA contracting income from Commissioners and is dependent upon activity levels. The LTAs approved by LHBs in June 2023 included a level of income protection for the Trust. Recognising the financial pressures faced by the system in NHS Wales, the Trust Board made a decision in August to concede the income protection arrangements in order to contribute to the reduction of the planned deficit. This was formally communicated with Commissioners and transacted following updated LTAs in September.

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position

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is that the contract performance has recovered however full year position is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The activity levels and Commissioner demand for services will continue to be closely monitored over the coming months.

Whilst the year to date gap in funding has recovered since the IMTP planning stage work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing or repurposing these costs.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.
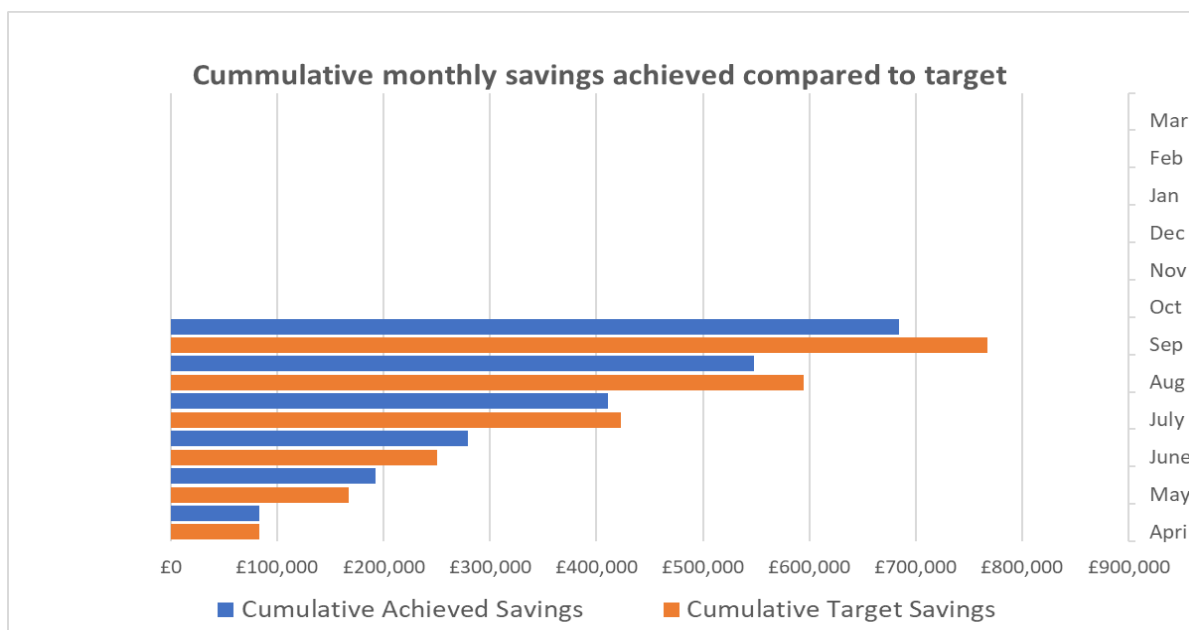
Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

There is a small year to date underachievement against the planned savings target with the commencement of two schemes expected later in the year.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met for 2023-24.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	950	396	415	19	950	0
			105%		100%	
WBS TOTAL SAVINGS	700	296	195	(101)	700	0
			66%		100%	
CORPORATE TOTAL SAVINGS	150	75	75	0	150	0
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	1,800	767	685	(82)	1,800	0
			89%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Establishment Control (N/R) (Corporate)	Green	75	38	38	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	33	0	(33)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	5	5	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	4	4	0	8	0
Establishment Control (R) (WBS)	Green	60	30	30	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	18	0	(18)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	13	0	(13)	25	0
Stock Management (NR) (WBS)	Green	125	63	63	0	125	0
Reduced Transport Maintenance (NR) (WBS)	Green	30	10	0	(10)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Green	137	46	0	(46)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	17	0	(17)	0	(50)
Establishment Control (NR) (VCS)	Green	175	58	77	19	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Green	150	50	50	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	63	63	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	25	25	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	33	0	(33)	0	(100)
Total Saving Schemes		**1,275**	505	354	(151)	970	(305)

Income Generation		TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Bank Interest (R) (Corporate)	Green	75	38	38	0	75	0
Sale of Plasma (R) (WBS)	Green	150	75	75	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	100	100	0	200	0
Private Patient Income (R) (VCS)	Green	50	25	25	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	25	25	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	50	50	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	18	18	155	155
Total Income Generation		**525**	263	331	68	830	305
TRUST TOTAL SAVINGS		**1,800**	767	685	(82)	1,800	0
				89%		100%	

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Cummulative monthly savings achieved compared to target

Mar	
Feb	
Jan	
Dec	
Nov	
Oct	
Sep	
Aug	
July	
June	
May	
April	

Axis: £0 £100,000 £200,000 £300,000 £400,000 £500,000 £600,000 £700,000 £800,000 £900,000

■ Cumulative Achieved Savings ■ Cumulative Target Savings

5. Reserves

The financial strategy for 2023-24 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.

As highlighted earlier further allocation of the reserves is currently on hold and continues to be under review in conjunction with the overall Trust position which is in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

6. End of Year Forecast / Risk & Opportunities Assessment

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the Trust the majority of these risks have either been managed or mitigated for 2023/24.

The remaining key financial risks & opportunities highlighted to Welsh Government are provided below:

Risks

DHCR activity data income risk – *Risk £0.500m / Likelihood – Medium*

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a reduced risk that c£0.500m income related to unrecorded activity could be lost.

<u>Management of Operational Cost Pressures</u> – *Risk £0.500m / Likelihood - Low*

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

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

<u>NEW RISK - Whitchurch Site Security</u> – Risk £0.143m for 2023/24 (Medium)

The annual cost of maintaining security on the Whitchurch land is expected to be c£600k.The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs. The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre from C&VUHB. The official transfer will be dependent on the WG formal process for transfer which is currently anticipated to take place in quarter 4, however this could be delayed into next financial year.

<u>SDEC Funding 2024/25</u> – *Risk £0.935m / Likelihood - Medium*

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

Opportunities

There are several potential opportunities which are in addition to those contributions that have been identified and shared with WG to support the delivery of a reduction in the NHS Wales deficit which could be utilised to support any risks should they crystallise. These include:

<u>Recovery and Planned Care Capacity</u>- *Opportunity / Likelihood - Medium*

An income generation opportunity will arise if the forecast activity performance continues to increase throughout the year. A continued increase in activity levels could mean that the Trust's investment in Covid Capacity and backlog infrastructure can be covered on a non-recurrent basis for 2023/24.

In addition, the Trust continues to review the service model that has been implemented to support backlog activity and where possible reduce or mitigate costs.

<u>Vacancy Turnover</u> – *Opportunity / Likelihood - Low*

There is a potential non-recurrent cost saving opportunity if the Trust cannot recruit to posts over and above the vacancy factor, which is held by the Divisions and Corporate Services.

<u>Contract Currency Review</u> – *Opportunity / Likelihood - Low*

An opportunity may develop from a review of the Time Driven Activity Based Costing Model for contract currencies where Service Developments or changes have impacted the underlying cost base.

Finance continues to work with the service to understand changes to contract currencies which would be put to our commissioners as business case for change control.

7. CAPITAL EXPENDITURE

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

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.508	0.000	3.388	10.896	0.000
nVCC - Project costs	0.000	1.573	0.000	(1.573)	2.856	(2.856)
nVCC - Advanced Works	3.800	0.000	0.000	3.800	3.800	0.000
Integrated Radiotherapy Solutions (IRS)	7.826	2.137	0.000	5.689	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.833	11.218	0.000	11.615	25.689	(2.856)
Discretionary Capital	1.683	0.108	0.000	1.575	1.683	0.000
Total	24.516	11.326	0.000	13.190	27.372	(2.856)

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

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

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2022/23 was agreed at the Capital Planning Group on the 11th of July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m has been ring fenced to support the nVCC enabling works and project costs with expectation that this funding will be reimbursed from additional funding requested from WG for the nVCC enabling works.

Performance to date

The actual expenditure to September 2023 on the All-Wales Capital Programme schemes was £11.218m, this is broken down between spend on the nVCC enabling works £7.508, nVCC Project Costs £1.573m, and the IRS £2.137m.

Spend to date on Discretionary Capital is currently £0.108m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.

All other schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.

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

Major Schemes in Development

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

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. The financial year cash flows for many of these schemes including the IRS and IRS Satellite projects require re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will be revised due to the VCC project delays for inclusion in the final FBC. The Digital and Digital scanning infrastructure schemes are also being revised with expectation that costs will now land in future years. All schemes will be reviewed and updated as part of the IMTP process which is underway.

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

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

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 23	Closing Balance End of Aug-23	Movement from 1st April Aug-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	£'m	£'m	£'m	£'m
Property, plant and equipment	170.418	175.583	5.165	175.583
Intangible assets	11.194	11.062	(0.132)	11.062
Trade and other receivables	1,107.047	1,111.830	4.783	1,111.830
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	**1,288.659**	**1,298.475**	**9.816**	**1,298.475**
Current Assets				
Inventories	34.070	31.280	(2.790)	31.280
Trade and other receivables	565.742	540.982	(24.760)	551.792
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	21.210	(9.926)	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	**630.948**	**593.472**	**(37.476)**	**593.472**
TOTAL ASSETS	**1,919.607**	**1,891.947**	**(27.660)**	**1,891.947**
Current Liabilities				
Trade and other payables	(226.254)	(202.382)	23.872	(202.382)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(432.039)	(39.514)	(432.039)
Current Liabilities sub total	**(619.902)**	**(634.421)**	**(14.519)**	**(634.421)**
NET ASSETS LESS CURRENT LIABILITIES	**1,299.705**	**1,257.526**	**(42.179)**	**1,257.526**
Non-Current Liabilities				
Trade and other payables	(3.092)	(3.092)	0.000	(3.092)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,108.919)	(1,069.028)	39.891	(1,069.028)
Non-Current Liabilities sub total	**(1,114.432)**	**(1,072.120)**	**42.31**	**(1,072.120)**
TOTAL ASSETS EMPLOYED	**185.273**	**185.406**	**0.133**	**185.406**
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	131.047	(0.414)	131.047
Retained earnings	19.104	19.526	0.422	19.526
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	**185.273**	**185.406**	**0.133**	**185.406**

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

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

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

In order to support interim cash flow pressures the Trust has agreed with WG and drawn down on the forecast £8.881m of PDC for 2023/24. The Trust cash position has been further escalated recently following announcement that the medical pay award will be processed in October which is in addition to the impact of the AFC pay award and has been carried since July. The Trust is yet to receive funding for either of these pay awards which will leave a negative cash flow of c£13m as at the October pay date.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	37.581	38.378	41.097	40.905	41.581	41.028	40.500	40.980	42.697	43.602	43.277	43.835	495.460
2	WG Income	14.460	18.799	9.707	42.966	22.143	2.138	24.832	40.325	27.825	23.486	25.525	24.800	277.006
3	Short Term Loans													0.000
4	PDC							8.881					0.000	8.881
5	Interest Receivable	0.149	0.162	0.143	0.126	0.106	0.117	0.060	0.060	0.060	0.060	0.060	0.060	1.163
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	5.886	12.689	6.300	6.150	6.050	6.350	6.250	9.325	77.512
8	TOTAL RECEIPTS	58.346	61.092	53.900	89.648	69.716	55.971	80.573	87.515	76.632	73.498	75.112	78.020	860.022
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	34.922	34.500	41.566	36.088	36.110	36.138	36.154	36.109	431.903
10	Non pay items	28.883	34.362	26.186	46.813	35.820	9.253	42.005	43.500	38.500	39.600	39.450	37.602	421.974
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment		0.000											0.000
14	Capital Payment	1.122	0.394	2.160	1.949	0.824	1.094	6.651	3.411	1.639	1.783	2.185	3.669	26.881
15	Other items													0.000
16	TOTAL PAYMENTS	61.807	69.477	67.339	83.564	71.566	44.847	90.222	82.999	76.249	77.521	77.789	77.380	880.758
17	Net cash inflow/outflow	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(9.649)	4.516	0.383	(4.023)	(2.677)	0.639	
18	Balance b/f	31.136	27.675	19.290	5.851	11.936	10.086	21.210	11.561	16.077	16.460	12.438	9.761	
19	Balance c/f	27.675	19.290	5.851	11.936	10.086	21.210	11.561	16.077	16.460	12.438	9.761	10.400	

Monthly Cash Flow Forecast

Cash Receipts — Cash Payments — Monthly Cash Balance

20
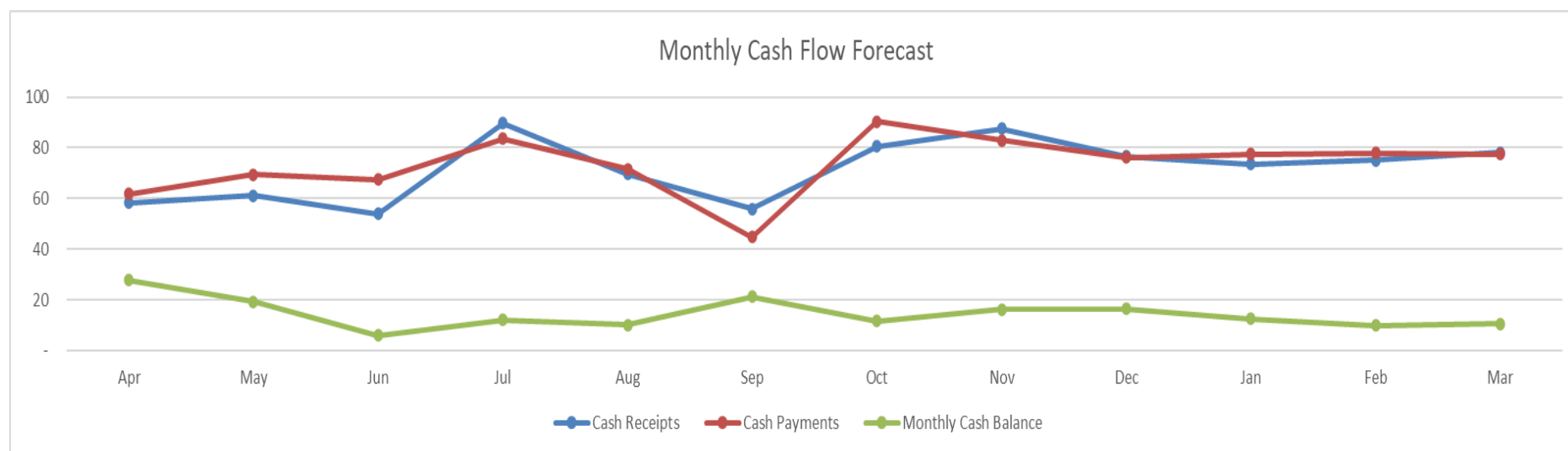
DIVISIONAL ANALYSIS

(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	(21.191)	(21.190)	0.001	(40.123)	(40.123)	0.000
RD&I	(0.538)	(0.538)	(0.000)	0.091	0.091	0.000
WBS	(11.065)	(11.066)	(0.000)	(21.532)	(21.532)	0.000
Sub-Total Divisions	**(32.795)**	**(32.794)**	**0.000**	**(61.564)**	**(61.564)**	**0.000**
Corporate Services Directorates	**(6.639)**	**(6.615)**	**0.024**	**(12.956)**	**(12.956)**	**0.000**
Delegated Budget Position	**(39.433)**	**(39.409)**	**0.025**	**(74.520)**	**(74.520)**	**0.000**
TCS	(0.386)	(0.404)	0.018	(0.744)	(0.744)	0.000
Health Technology Wales	(0.071)	(0.071)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	39.891	39.891	0.000	75.381	75.381	0.000
Trust Position	**(0.000)**	**0.007**	**0.007**	**0.000**	**0.000**	**0.000**

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**36.040**	**36.596**	**0.556**	**74.333**	**74.333**	**0.000**
Expenditure						
Staff	**25.017**	**24.923**	**0.094**	**48.838**	**48.838**	**0.000**
Non Staff	**32.214**	**32.864**	**(0.650)**	**65.619**	**65.619**	**0.000**
Sub Total	**57.231**	**57.787**	**(0.556)**	**114.457**	**114.457**	**0.000**
Total	**(21.191)**	**(21.191)**	**0.000**	**(40.123)**	**(40.123)**	**0.000**

VCS Key Highlights/ Issues:

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

Income at Month 6 represents a surplus of **£0.556m**. Overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare, which is offsetting and providing a significant surplus above the divisional management savings target. Other small income overachievements in areas such as Catering which are offset with non pay costs.

VCS have reported a year to date underspend of **£0.094m** against staff. The division continues to have high levels of vacancies, sickness, and maternity leave across several services and

particularly across Nursing budgets, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme is being explored within Nursing to help fill current vacancies.

Non-Staff Expenditure at Month 6 was **£(0.650)m** overspent which is a result of increased activity pressures which can be linked to contract performance and in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	13.433	13.511	0.077	27.085	27.085	0.000
Expenditure						
Staff	9.352	9.255	0.096	18.389	18.389	0.000
Non Staff	15.147	15.320	(0.173)	30.228	30.228	0.000
Sub Total	24.499	24.575	(0.077)	48.617	48.617	0.000
Total	(11.065)	(11.065)	0.000	(21.532)	(21.532)	0.000

Key Highlights/ Issues:

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

Income overachievement of **£0.077m** to month 6. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities for consideration. This is being partly offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is still yet to see signs of recovery. WBS have previously run campaigns to try and grow the panel in sites such as schools and universities, however the year to date target is currently underachieving by c35%.

Staff reported a **£0.096m** underspend to September. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured.

Discussions ongoing within WBS SMT to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff reported an overspend of **£(0.173)m** to September. Energy price rises which we be funded centrally by the Trust as agreed at the IMTP planning stage, along with venue hire costs pressures previously funded by WHSSC, are being partly offset by reduced spend from lower activity.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**1.252**	**1.555**	**0.303**	**2.126**	**2.126**	**0.000**
Expenditure						
Staff	**6.042**	**5.874**	**0.168**	**11.735**	**11.735**	**0.000**
Non Staff	**1.849**	**2.296**	**(0.446)**	**3.347**	**3.347**	**0.000**
Sub Total	7.891	8.169	(0.278)	15.082	15.082	0.000
Total	(6.639)	(6.615)	0.024	(12.956)	(12.956)	0.000

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of September 2023 was an underspend of **£0.024m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to significantly benefit from receiving greater returns on cash being held in the bank due to the rise in interest rates.

For staff the expectation is that vacancies within the division will help offset the cost of use of agency and the divisional savings target.

Non pay overspend largely relates to the divisional savings target and the increased running costs associated with the ageing hospital estate.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.971**	**1.009**	**0.038**	**3.247**	**3.247**	**0.000**
Expenditure						
Staff	**1.398**	**1.403**	**(0.005)**	**2.891**	**2.891**	**0.000**
Non Staff	**0.111**	**0.144**	**(0.033)**	**0.264**	**0.264**	**0.000**
Sub Total	1.509	1.548	(0.038)	3.155	3.155	0.000
Total	(0.538)	(0.538)	0.000	0.091	0.091	0.000

RD&I Key Highlights / Issues

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

Trials Income fluctuations expected throughout the year.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m		Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	0.000	0.260	0.260		0.000	0.000	0.000
Expenditure							
Staff	0.376	0.371	0.005		0.730	0.730	0.000
Non Staff	0.010	0.293	(0.283)		0.015	0.015	0.000
Sub Total	0.386	0.664	(0.278)		0.744	0.744	0.000
Total	(0.386)	(0.404)	(0.018)		(0.744)	(0.744)	0.000

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of September 2023 is **£(0.018)m** overspent with a forecasted outturn position of **Breakeven.**

The TCS report is including Escrow interest within the overall financial envelope which is not yet reflected within the budgets and intention is that this will be used to mitigate the current overspend.

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	0.771	0.768	(0.003)		1.677	1.677	0.000
Expenditure							
Staff	0.769	0.766	0.003		1.545	1.545	0.000
Non Staff	0.073	0.073	0.000		0.248	0.248	0.000
Sub Total	0.842	0.839	0.003		1.794	1.794	0.000
Total	(0.071)	(0.071)	(0.000)		(0.117)	(0.117)	0.000

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of September 2023 was **breakeven,** with a forecasted outturn position of **breakeven.**
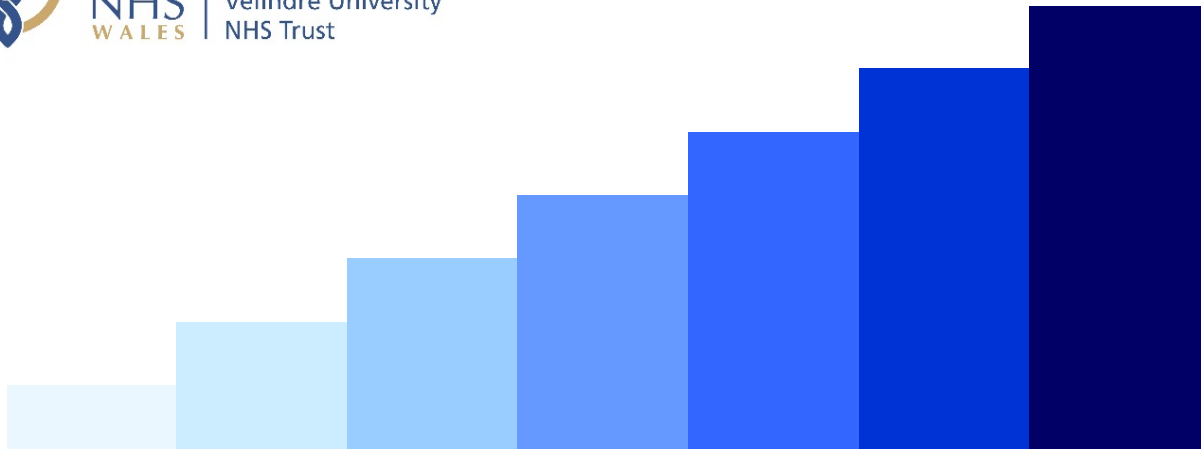
HTW programme costs are funded directly by WG.

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

TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 30th September 2023

**Presented to EMB Shape on
16th October 2023**

Contents   Page

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2023-24, outlining spend against budget as at 30th September 2023 and the current year-end forecast.

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

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2023-24 as at 30th September 2023 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Capital	£9.082m	£10.896m	£13.749m	-£2.853m
Revenue	£0.404m	£0.744m	£0.785m	-£0.041m
Total	**£9.486m**	**£11.641m**	**£14.534m**	**-£2.894m**

2.2 The overall forecast outturn for the Programme is an overspend of £2.894m for the financial year 2023-24 against a budget of £11.641m.

2.3 Capital funding has not been allocated for the OBC phase of the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.800m has been made to WG.

2.4 Capital funding of £3.882m has been allocated to the nVCC Project by WG for advanced works for the FBC stage, to be confirmed by letter in October 2023. Both the funding and spend will be reported from October onwards, with an expected break even position for this financial year.

2.5 No revenue funding has been allocated for Project Deliver and Judicial Review elements of the nVCC project for this financial year. A funding request of £0.041m is being made to the Trust.

2.6 There are currently three financial risks associated with TCS:

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

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.000m. Ministerial approval will be sought for this additional funding.

- Capital funding has not been allocated to the nVCC Project, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of £2.800m.

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3. BACKGROUND

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

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

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

3.4 The current funding provided to support the TCS Programme in 2023-24 is £10.896m capital and £0.689m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding
Initial Allocation (as at 1st April 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
Total	**£10.896m**	**£10.896m**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Total	**£0**	**£0**

Current Allocation (as at 30th September 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
Total	**£10.896m**	**£10.896m**

Sources of Revenue Funding
Initial Allocation (as at 1st April 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.024m	£0.060m	£0	£0.084m
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.131m	£0	£0.311m
Total	**£0.204m**	**£0.204m**	**£0**	**£0.395m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.216m	£0	£0.028m	£0.244m
nVCC Project	£0	£0	£0.096m	£0.096m
SDT Project	£0	£0	£0.009m	£0.009m
Total	**£0.216m**	**£0.204m**	**£0.133m**	**£0.349m**

Current Allocation (as at 30th September 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.240m	£0.060m	£0.028m	£0.328m
nVCC Project	£0	£0	£0.096m	£0.096m
SDT Project	£0.180m	£0.131m	£0.009m	£0.320m
Total	**£0.420m**	**£0.204m**	**£0.133m**	**£0.744m**

4. CAPITAL POSITION

4.1 The current capital funding for 2023-24 is outlined below:

- Enabling Works Project   £10.896m
- nVCC Project   £0
 **Total**   **£10.896m**

4.2 The capital position as at 30th September 2023 is outlined below, with a forecast overspend of £2.853m for 2023-24 against a budget of £10.896m. This is due to the lack of capital funding being allocated to the nVCC Project for this financial year.

Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£7.509m	£10.896m	£10.893m	£0.004m
nVCC Project	£1.574m	£0	£2.856m	-£2.856m
Total	**£9.082m**	**£10.896m**	**£13.749m**	**-£2.853m**

4.3   A funding request has been made to WG for c£2.700m for the nVCC Project.

4.4   There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £1.150m. This additional capital funding will require Ministerial approval.

5.   REVENUE POSITION

5.1   The revenue funding for 2023-24 is outlined below:

- PMO   £0.328m
- nVCC Project   £0.096m
- SDT Project   £0.320m
  Total   **£0.744m**

5.2   The revenue position as at 30th September 2023 is outlined below, with a forecast overspend of £0.041m for 2023-24 against a budget of £0.313m. This is due to the lack of funding for the nVCC revenue non-pay costs for this financial year.

| Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	**Forecast**	**Variance**
PMO	£0.165m	£0.328m	£0.328m	£0
nVCC Project	£0.082m	£0.096m	£0.137m	-£0.041m
SDT Project	£0.156m	£0.320m	£0.320m	£0
Total	**£0.404m**	**£0.744m**	**£0.785m**	**-£0.041m**

5.3   A revenue funding request for £0.041m for 2023-24 is being made to the Trust for the Project Delivery and Judicial Review elements of the nVCC Project.

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

6.   CASH FLOW

6.1   The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that the majority of costs will have been incurred within the first half of the financial year.

EW Project Cash Flow 2023-24
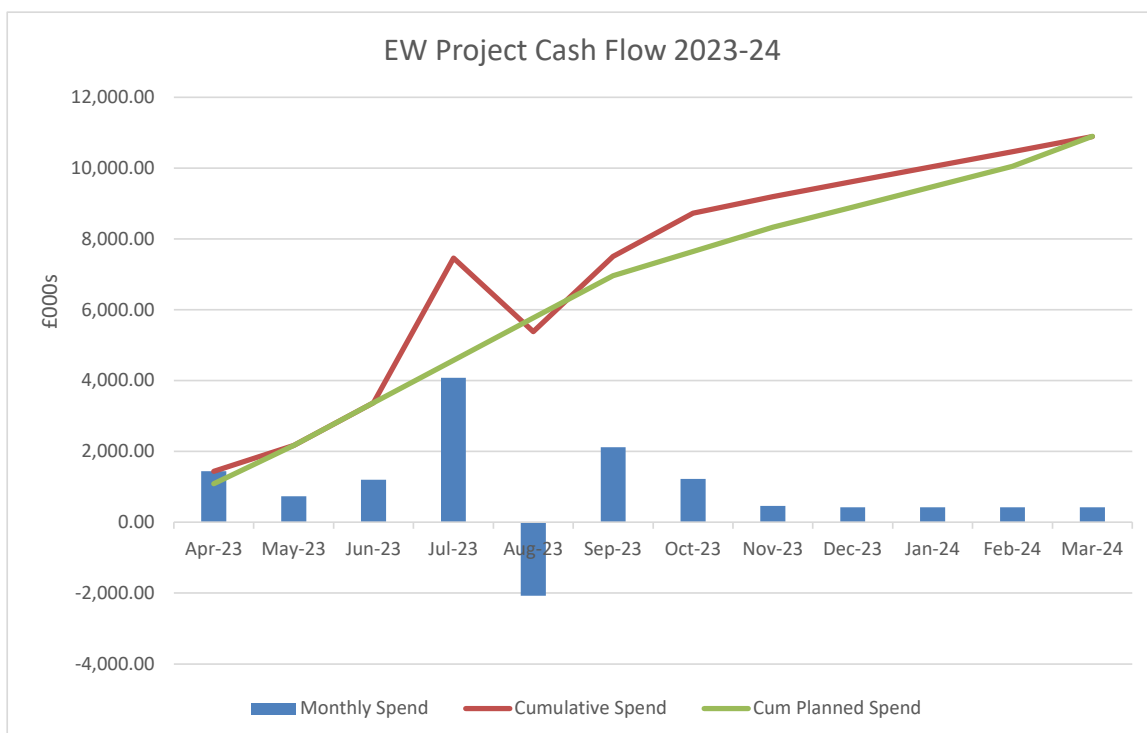
6.2 The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher in the second half of the financial year, which reflects the delay in financial close.

nVCC Project Cash Flow 2023-24
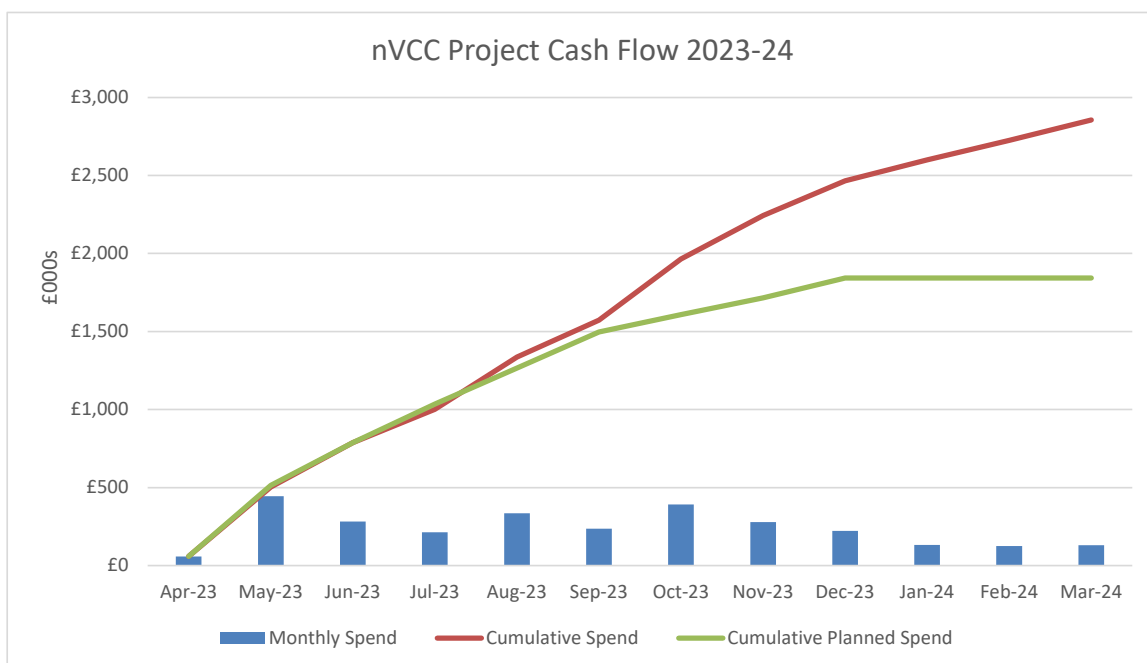
6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 The current revenue funding for the PMO for 2023-24 is £0.328m. £0.240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.028m from WG 2022-23 for pay awards.

7.3 There has been no capital funding requirement for the PMO in 2023-24.

7.4 The revenue position for the PMO as at 30th September 2023 is shown below, showing a forecast breakeven positon for the year against a budget of £0.328m.

PMO Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.164m	£0.327m	£0.327m	£0
Non Pay	£0.001m	£0.001m	£0.001m	£0
Total	**£0.165m**	**£0.328m**	**£0.328m**	**£0**

7.5 There are currently no financial risks associated with the PMO for 2023-24.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC. This has provided capital funding of £28.089m in total, with £10.896m provided in 2023-24.

7.7 The Project's financial position for 30th September 2023 is shown below. The forecast position reflects an expected underspend of £0.004m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.162m	£0.230m	£0.277m	-£0.047m
Non-Pay	£7.346m	£10.667m	£10.616m	£0.051m
Total	**£7.509m**	**£10.896m**	**£10.893m**	**£0.004m**

7.8 There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.000m. This additional capital funding will require Ministerial approval. The elements are:

- Water Main Diversion   £0.850m inc VAT
- S278 Works – Longwood Drive   £0.900m inc VAT
- Off Site Habitat Creation   £0.250m inc VAT
  Total   **£2.000m inc VAT**

7.9 The Project spend relates to the following activities:

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

Description		Year to Date			Financial Year		
		Budget Sep-23 £	Spend Sep-23 £	Variance Sep-23 £	Annual Budget £	Annual Forecast £	Annual Variance £
PAY							
Project 1b - Enabling Works FBC		140,382	162,431	-22,049	229,841	276,741	-46,900
Pay Capital Total		**140,382**	**162,431**	**-22,049**	**229,841**	**276,741**	**-46,900**
NON-PAY							
EF02	Utility Costs	1,546,163	1,091,385	454,779	2,873,927	2,641,385	232,542
EF03	Supply Chain Fees	175,000	379,302	-204,302	375,000	537,802	-162,802
EF04	Non Works Costs	156,253	75,095	81,158	312,505	231,347	81,158
EF05	ASDA Works	1,906,946	2,336,191	-429,245	3,813,893	3,036,343	777,550
EF06	Walters D&B	3,033,982	3,463,634	-429,652	3,033,982	4,033,634	-999,652
EFQR	Quantified Risk	6,247	512	5,735	257,245	135,512	121,733
EFRS	Enabling Works FBC Reserves	0	0	0	0	0	0
Enabling Works FBC Project Capital Total		**6,824,591**	**7,346,119**	**-521,528**	**10,666,552**	**10,616,023**	**50,529**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**6,964,973**	**7,508,550**	**-543,576**	**10,896,393**	**10,892,763**	**3,629**

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

- Financial support may be required to the nVCC Project. As at September 2023 the financial support is c£1.600m, with a total requirement of c£2.800m. The nVCC Project has made an interim capital funding request to WG for c£2.800m.

- There are three new elements that require additional funding as noted above, totalling £2.000m. Ministerial approval will be sought for this additional funding.

New Velindre Cancer Centre Project
Capital
7.11   The nVCC Project has not been allocated capital funding for this financial year. A funding request has been made to WG for c£2.800m.

7.12   The capital financial position for the nVCC Project for 30th September 2023 is shown below, with a forecast overspend of £2.856m. This is due to the delay of the nVCC Financial Close into 2023-24 with no funding for the Project at this stage.

nVCC Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.562m	£0	£1.186m	-£1.186m
Non-Pay	£1.012m	£0	£1.670m	-£1.670m
Total	**£1.574m**	**£0**	**£2.856m**	**-£2.856m**

7.13 The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Budget Sep-23 £	Year to Date Spend Sep-23 £	Variance Sep-23 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project Leadership nVCC OBC	0	105,521	-105,521	0	213,143	-213,143
Project 2a - New Velindre Cancer Centre OBC	0	456,370	-456,370	0	972,953	-972,953
Pay Capital Total	**0**	**561,890**	**-561,890**	**0**	**1,186,097**	**-1,186,097**
NON-PAY						
nVCC OBC Project Delivery	**0**	**20,855**	**-20,855**	**0**	**64,000**	**-64,000**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	0	881,819	-881,819	0	1,344,735	-1,344,735
VC10 Legal Advice	0	17,398	-17,398	0	24,898	-24,898
VC11 S73 Planning	0	14,437	-14,437	0	14,437	-14,437
VC12 nVCC FBC	0	57,687	-57,687	0	147,687	-147,687
VCRS nVCC OBC Reserves	0	19,480	-19,480	0	74,480	-74,480
nVCC Project Capital Total	**0**	**990,821**	**-990,821**	**0**	**1,606,236**	**-1,606,236**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**1,573,566**	**-1,573,566**	**0**	**2,856,333**	**-2,856,333**

7.14 The current risk to the Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£2.800m.

Revenue

7.15 The current revenue funding for the nVCC Project for 2023-24 is £0.096m, provided from WG 2022-23 for pay awards. A funding request is

7.16 The revenue financial position for the nVCC Project for 30th September 2023 is shown below, reflecting a current overspend of £0.041m for the year against budget of £0.096m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.057m	£0.096m	£0.096m	£0.000m
Project Delivery	£0.014m	£0	£0.030m	-£0.030m
Judicial Review	£0.011m	£0	£0.011m	-£0.011m
Total	**£0.082m**	**£0.096m**	**£0.137m**	**-£0.041m**

7.17 The Judicial Review matter is now closed, with the final costs being submitted in July 2023. The final cost in 2023-24 is £0.011m, with a total cost for this matter of £0.138m.

7.18 The only revenue financial risk associated with the nVCC Project at present is the lack of funding, which is being mitigated with a funding request to the Trust.

Service Delivery and Transformation Project

7.19 The revenue funding for the Project for 2022-23 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.009m from the WG 2022-23 one-off recovery payment funding. The resulting budget is £0.320m for this financial year.

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

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

| SDT Expenditure | Year to Date Spend | 2022-23 Full Year | | |
		Budget	Forecast	Variance
Pay	£0.150m	£0.306m	£0.306m	£0
Non-Pay	£0.007m	£0.013m	£0.013m	£0
Total	**£0.156m**	**£0.320m**	**£0.320m**	**£0**

7.22 There are currently no financial risks associated with the Project for 2023-24.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently three financial risks associated with TCS:

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

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.000m. Ministerial approval will be sought for this additional funding.

    Capital funding has not been allocated to the nVCC Project, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of £2.800m.

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2 Appendix 3 provides cumulative report to 31st March 2022. The report for the financial year 2022-23 is currently being produced.

9.3 The cumulative report shows a total spend for the TCS Programme of £30.352m (£26.481m Capital, £3.871m Revenue). The total pay costs for this period were £11.303m.

9.4 The spend to 31st March 2022 for each Project within the Programme is summarised below.

Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC...£13.234m

Project 3a Integrated Radiotherapy Solution.............£0.1.049m
Project 3b Digital Strategy..£0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning £0m

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

Project Control..£4.390m
Feasibility Studies...£2.734m
Planning and Design £2.669m
Outline Business Case (inc revision and approval)......£2.456m
Project Agreement...£1.838m

APPENDIX 1: TCS Programme Budget and Spend as at 30th September 2023

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date Budget Sep-23	Year to Date Spend Sep-23	Year to Date Variance Sep-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	01-Aug	£	£	£	£	£
PAY						
Project Leadership nVCC OBC	0	105,521	-105,521	0	213,143	-213,143
Project 1b - Enabling Works FBC	140,382	162,431	-22,049	229,841	276,741	-46,900
Project 2a - New Velindre Cancer Centre OBC	0	456,370	-456,370	0	972,953	-972,953
Capital Pay Total	**140,382**	**724,321**	**-583,939**	**229,841**	**1,462,837**	**-1,232,996**
NON-PAY						
nVCC OBC Project Delivery	0	20,855	-20,855	0	64,000	-64,000
Project 1b - Enabling Works FBC	6,824,591	7,346,119	-521,528	10,666,552	10,616,023	50,529
Project 2a - New Velindre Cancer Centre OBC	0	990,821	-990,821	0	1,606,236	-1,606,236
Capital Non-Pay Total	**6,824,591**	**8,357,794**	**-1,533,203**	**10,666,552**	**12,286,259**	**-1,619,708**
CAPITAL TOTAL	**6,964,973**	**9,082,115**	**-2,117,142**	**10,896,393**	**13,749,096**	**-2,852,704**

REVENUE	Year to Date Budget Sep-23	Year to Date Spend Sep-23	Year to Date Variance Sep-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
nVCC Pay Award	57,423	57,423	0	96,408	96,408	0
Programme Management Office	164,571	163,787	785	326,890	327,095	-205
Project 6 - Service Change Team	153,983	149,850	4,134	306,290	306,290	0
Revenue Pay total	**375,978**	**371,059**	**4,918**	**729,589**	**729,793**	**-205**
NON-PAY						
nVCC OBC Project Delivery	0	14,029	-14,029	0	30,000	-30,000
nVCC OBC Judicial Review	0	11,000	-11,000	0	11,000	-11,000
Programme Management Office	1,410	1,481	-71	1,410	1,205	205
Project 6 - Service Change Team	9,000	6,522	2,478	13,340	13,340	0
Revenue Non-Pay Total	**10,410**	**33,032**	**-22,622**	**14,750**	**55,546**	**-40,796**
REVENUE TOTAL	**386,388**	**404,092**	**-17,704**	**744,339**	**785,339**	**-41,000**

APPENDIX 2:   TCS Programme Funding for 2022-23

Description	Funding Type	
	Capital	**Revenue**
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2022-23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£0**	**£0.096m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Radiotherapy Satellite Centre	**£0**	**£0**
No funding requested or provided for this project to date		
SACT and Outreach	**£0**	**£0**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0**	**£0.320m**
Commissioner's Funding		£0.180m
Trust Revenue Funding		£0.131m
WG One Off Pay Award 2022/23 Funding		£0.002m
WG Recurrent Pay Award Funding		£0.007m
VCC Decommissioning	**£0**	**£0**
No funding requested or provided for this project to date		
Total	**£10.896m**	**£0.744m**

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

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

SPEND PER PROJECT PER YEAR

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Intergarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH PROJECT ACROSS ALL YEARS

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

£328,459 £2,398,448
£6,428,671
£6,167,590
£3,924,181
£3,909,063
£2,928,426
£4,267,262

Legend:
- 2014-15
- 2015-16
- 2016-17
- 2017-18
- 2018-19
- 2019-20
- 2020-21
- 2021-22
- 2022-23
- 2023-24
- 2024-25
- 2025-26

TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Intergarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,266,123
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£11,048,740
2	Mott MacDonald	£5,614,021
3	DLA Piper	£3,398,669
4	Non Pay Costs	£1,043,962
5	Price Waterhouse Coopers	£848,084

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE PLANNING AUDIT AND ACTION PLAN

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Susan Thomas, Deputy Director of W&OD
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	Following an Audit Wales review of Workforce Planning in the Trust a number of recommendations have been made in relation to strategic and operational interventions to support a Planned and Sustained workforce across the Trust. The purpose of this paper is to outline the Audit recommendations and update on the subsequent action plan in place noting governance routes for updates and escalation

RECOMMENDATION / ACTIONS	The Executive Management Board is asked to **NOTE** the audit and action plan in place

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

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

APPENDICES	
Appendix A	Welsh Audit – Review of Workforce Planning Arrangements – Velindre University NHS Trust

1. SITUATION/BACKGROUND

Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. A Planned and Sustained workforce is one of the key strategic drivers of the People Strategy and has been a focus of a recent Welsh Audit review.

A focus of the review has been on whether the Trust's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, the Audit looked at the Trust's strategic approach to workforce planning,

operational actions to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce Planning Arrangements such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing fall outside the scope of the review.

2.   ASSESSMENT

The Audit found that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However the report found that the impact of its workforce initiatives needs to be considered to evidence the capacity and capability to deliver longer term workforce priorities. Findings can be categorized under three headings – (1) Trust Strategic Approach to Workforce planning (2) Operational Action to manage workforce challenges (3) monitoring and oversight of the workforce plan/strategy delivery.

2.1   Trust Approach to Workforce Planning

The Audit report found that the Trust has a clear strategic vision for its workforce however, to effectively deliver it, it needs to develop its strategic workforce planning approaches and develop an underpinning implementation plan. The report noted the Trust has a reasonable understanding of its current service demands, based on its current service models and is working well with internal and external stakeholders to find shared solutions to workforce challenges. However, the report concluded that there is scope for the Trust to strengthen its analysis of anticipated future demands to shape future workforce requirements and inform workforce modelling.

2.2   Operational Action to Manage Workforce Challenges

The report found he Trust has clear intent to improve workforce planning capacity and capability. However, limited corporate capacity and operational pressures mean that service leads do not have sufficient time to develop workforce planning solutions to help address operational challenges. The Trust understands high-level workforce risks associated with delivering its People Strategy, but actions to mitigate these risks have had minimal effect to date. The report noted that the Trust is taking steps to help it respond to current workforce challenges through a range of recruitment and retention activities.

2.3.1 Monitoring and oversight of workforce plan/strategy delivery

The report noted that whilst Board and committee maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks.

Whilst the Quality, Safety and Performance Committee receives timely workforce performance reports, the Trust needs to strengthen how it reports on the impact of the People Strategy's delivery i.e., what difference it is making. Where possible the Trust benchmarks its workforce performance with other health bodies in Wales and networks with comparing organisations across the UK.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Further to the report, the following areas are the focus of the Trust action plan on Workforce planning. The narrative below highlights the current position with regards to the actions and recognizes the work that has been ongoing since the completion of the audit in August 2023. Updates on the action plan are currently being monitored via Audit Committee, however some key action are being operationally addressed via Senior Leadership Teams and Workforce teams working collectively.

Focus for action is:

3.1 Developing an Implementation plan for the People Strategy utilizing workforce intelligence
A plan to implement the People Strategy has been drafted and will be presented to EMB run in December. Alongside this plan the workforce team are engaging closely with the development of the Clinical Service strategy to ensure alignment with service and workforce model development. An outline action plan for the development of a strategic workforce plan to support the clinical service strategy will be presented to EMB Shape in November. A summary of the current operational workforce plans in place will be presented to QSP in November.

3.2 Managing Risk
The current Trust workforce risks have been reviewed in its corporate and strategic risk registers using fresh insight from the Supply and Shape document.

3.3 Exit Surveys

The Trust has established a Task and Finish Group to address the process with regards to Exit Surveys, to ensure an increased take up and to provide escalation and triangulation of themes.

3.4 Education Commissioning Process

The Trust has in place process to agree education commissioning. Following the audit this process will be ameliorated to develop mechanisms to triangulate the number of staff it trains through the education commissioning process, reporting on how many students it has retained. This will be reported via the Education and Training Steering group and through EMB Run.

3.5 Monitoring and Oversight

Since the Audit the Trust has improved on its reporting of key workforce initiatives. The Supply and Shape paper has been improved to report on the outputs of the People Strategy. This paper is reported quarterly to EMB Run and QSP. An annual report on the delivery of the People's Strategy has been developed this year also.

4. IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*This is reflected in the Trust Assurance Framework Risk 03*
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.*

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

Review of Workforce Planning Arrangements – Velindre University NHS Trust

Audit year: 2023

Date issued: August 2023

Document reference: 3684A2023

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Reedy yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Once this report is finalised, this document will also be available in Welsh.

Contents

Summary report

Introduction

1   An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector, which is complimentary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2   Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3   National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long-term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pensions taxation issues.
- shifts in attitudes towards full and part time working.
- developing home grown talent and the ability to attract talent from outside the country into Wales.
- service transformation which can change roles and result in increasing specialisation of roles.

4   Velindre University NHS Trust (the Trust) provides specialist services across Wales. The operational delivery of services is managed through two divisions, Velindre Cancer Service and the Welsh Blood Service. The Trust's 10-year People Strategy, Employer of Choice - Helping Each Other Be Great (the People Strategy), was approved by the Board in May 2022. The People Strategy is one of a suite of enabling strategies underpinning the Trust's corporate strategy, Destination 2032.

5   The key focus of our review has been on whether the Trust's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Trust's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management

arrangements such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing, fall outside the scope of this review.

6   The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7   Overall, we found **that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities**.

Key workforce planning challenges

8   At the time of writing this report, the key workforce issues at the Trust related to filling vacancies for professions in areas with longstanding national challenges. Vacancy levels, for the period that we collected data, were higher than average across Wales, with some notable gaps including consultant radiologists, acute oncology consultants and medical physicists[1] and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness in some service areas. Spending on agency staff increased considerably in 2020-2021 to £2.7 million but has since fallen to £1.3 million in 2022-23 (**Exhibit 6**). The Trust is currently building a new Velindre Cancer Centre, this provides opportunities to develop new workforce models.

Strategic approach to workforce planning

9   **The Trust has a reasonably good workforce strategy but, it needs to be underpinned by a robust delivery plan, supported by service modelling.**

10   The Trust has a clear strategic vision for its workforce however, to effectively deliver it, it needs to develop its strategic workforce planning approaches and develop an underpinning implementation plan. The Trust has a reasonable understanding of its current service demands, based on its current service models. It is working well with internal and external stakeholders to find shared solutions to workforce challenges. However, there is scope for the Trust to strengthen its analysis of anticipated future demands to shape future workforce requirements and inform workforce modelling. The Trust is currently working on this, and the position should improve once the Trust has finalised its Supply and Shape Framework[2], which it expects to complete in September.

[1] Medical Physics is the application of physics to medicine. It uses physics concepts and procedures in the prevention, diagnosis, and treatment of disease.

[2] The framework will include workforce analysis and service modelling, including scenario and service change mapping. There are six principles to model the workforce, these are: 1. Resource and Replenish (Buy), 2. Redevelop and Reskill (Build), 3. Reposition and Renew (Borrow), 4. Retain and Reward (Bind), 5. Resolve and Revive (Bounce) and 6. Rediscover and Reinvent (Boost).

Operational action to manage workforce challenges

11 **The Trust is taking some positive action to manage current and future workforce challenges but recognises it is in the early stages of developing a more robust and effective approach to workforce planning.**

12 The Trust has clear intent to improve workforce planning capacity and capability. However, limited corporate capacity and operational pressures mean that service leads do not have sufficient time to develop workforce planning solutions to help address operational challenges. The Trust understands high-level workforce risks associated with delivering its People Strategy, but actions to mitigate these risks have had minimal effect to date. The development of the Supply and Shape Framework should also help to identify workforce gaps and inform future corporate risk assessment. The Trust is taking steps to help it respond to current workforce challenges through a range of recruitment and retention activities.

Monitoring and oversight of workforce plan/strategy delivery

13 **Whilst Board and committee maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks.**

14 Whilst the Quality, Safety and Performance Committee receives timely workforce performance reports, the Trust needs to strengthen how it reports on the impact of the People Strategy's delivery i.e., what difference it is making. Where possible the Trust benchmarks its workforce performance with other health bodies in Wales and networks with comparing organisations across the UK.

Recommendations

Exhibit 1: recommendations

15   **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**. [Appendix 3 will be completed once the report and organisational response have been considered by the relevant committee.]

Recommendations

Developing an implementation plan

R1   The Trust's People Strategy is not effectively supported by an implementation plan. This limits the Trust's ability to ensure it has sufficient resource to deliver the strategy, manage risks associated with its delivery, and provide effective oversight of its implementation at committee. The Trust should develop a plan to implement the People Strategy. The plan should include a section that identifies the costs, staff capacity, skills and other resources associated with implementing the People Strategy (**high priority**).

Developing workforce intelligence

R2   The Trust is developing a baseline of current workforce capacity to inform its Supply and Shape framework. The Trust should do more to understand the extent of workforce planning activity across its business and to understand future service demand and risk. The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and potential risks to the organisation (**medium priority**).

Managing risk

R3   The Trust's Supply and Shape Framework has the potential to highlight new workforce risks. The Trust should review the information in its corporate and strategic risk registers using fresh insight from the Supply and Shape document to identify potential additional sources of assurance and new risks (**high priority**).

Exit surveys

Recommendations

R4   Whilst the Trust uses exit surveys to understand the underlying reasons for staff turnover, we found that the Trust could do more to actively encourage survey completion. The Trust should develop an approach to increase exit survey response rates and ensure feedback feeds into retention activities **(medium priority)**.

Education commissioning process

R5   We found that the Trust is working on improving the basis of its education commissioning. The Trust should develop mechanisms to triangulate the number of staff it trains through the education commissioning process and how many it then employs which will provide the Trust with important intelligence to further strengthen its basis (**medium priority**).

Monitoring and oversight

R6   We found weaknesses in the Trust's approach to monitoring and overseeing delivery of its People Strategy. It does not understand the impact of its efforts and a lack of clear information limits thorough scrutiny by the Quality, Safety and Performance Committee. The Trust should develop an approach to better understand the impact of key workforce initiatives and the extent that they are delivering the intended improvements and outcomes. Going forward this should be reported in the annual report on the delivery of the People's Strategy (**medium priority**).

Detailed report

Our findings

16   The following three tables set out the areas that we have reviewed and our findings. These focus on:

- The Trust's approach to strategic workforce planning (**Exhibit 2**).
- Operational action to manage workforce challenges (**Exhibit 3**).
- Monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: The Trust's approach to strategic workforce planning

This section focusses on the Trust's approach to strategic planning. Overall, we found that **the Trust has a reasonably good workforce strategy, but it needs to be underpinned by a robust delivery plan, supported by service modelling.**

What we looked at	What we found
We considered whether the Trust's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • Identifies current and future workforce challenges. • Has a clear vision and objectives. • Is aligned to the organisation's strategic objectives and wider organisational plans.	We found **the Trust has a clear workforce vision and strategy. However, it does not yet have a sufficiently mature supporting implementation plan to address its current and future workforce challenges and opportunities.** The Trust's 2022-32 People Strategy clearly sets out the Trust's ambition to be an 'employer of choice'. To help achieve its ambition, the People Strategy focuses on six key priorities, these being: workforce engagement, workforce modelling, workforce development, leadership and succession planning, a digital ready workforce, and recruitment and retention. While not explicitly identifying the Trust's workforce challenges, these priorities seem logical given the workforce challenges it faces. The Trust's division level strategies for Velindre Cancer Service and the Welsh Blood Service highlight some key workforce challenges and opportunities. The People Strategy appropriately

What we looked at	What we found
• Is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care. • Is supported by a clear implementation plan.	supports the ambitions set out in the national Workforce Strategy for Health and Social Care[3] and aligns to relevant legislation, such as the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014. It also supports the delivery of the Trust's long-term ambitions as set out in its corporate strategy, Destination 2032 and its Integrated Medium-Term Plan (IMTP). The People Strategy does not have a standalone implementation plan to support its delivery, instead actions are included in the Trust's 2023-2026 IMTP. However, the actions are at a high-level and provide little detail about how the Trust plans to implement the ambitions set out in the strategy or measure the impact of its delivery (**Recommendation 1**). The Trust recognises that it needs to strengthen its implementation plans.
We considered whether the Trust has a good understanding of current and future service demands. We expected to see: • Use of reliable workforce information to determine workforce need and risk in the short- and longer-term. • Action to improve workforce data quality and address any information gaps.	We found that **the Trust has a reasonable understanding of its current service demands, based on current service models, but there is scope to strengthen future demand modelling to inform future workforce requirements.** The Trust is looking to improve its workforce intelligence by developing an ambitious Supply and Shape Framework[4]. This Framework will be presented to the Executive Management Board in September. Once finalised, this Framework should enable the Trust to appropriately identify its workforce gaps. The Corporate Planning Team has initially undertaken horizon scanning exercises[5] to inform the Supply and Shape Framework. This will help to provide a stronger basis to predict future service need and shape future workforce requirements. Currently, demand and capacity planning at the Trust is inconsistent, with different methods used by the divisions. The Welsh Blood Service has an agile approach based on data from its Business

[3] 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' is a 10-year strategy was launched in October 2020 by us (HEIW) and Social Care Wales

[4] The framework will include workforce analysis and service modelling, including scenario and service change mapping. There are six principles to model the workforce, these are: 1. Resource and Replenish (Buy), 2. Redevelop and Reskill (Build), 3. Reposition and Renew (Borrow), 4. Retain and Reward (Bind), 5. Resolve and Revive (Bounce) and 6. Rediscover and Reinvent (Boost).

[5] Using NICE guidelines, Macmillan index, Population Health Assessments, and information from Commissioners

What we looked at	What we found
	Intelligence Service, whilst Velindre Cancer Service uses a predictive model based on pre-pandemic baseline data and data from a recent exercise with commissioners[6]. There are merits to both models, with opportunities for the divisions to share learning and for the Trust to use these tools to build and maintain its supply and shape framework **(Recommendation 2)**.
	The Trust has reasonable operational workforce data, such as sickness levels, vacancy and appraisals rates which are sourced from the Electronic Staff Record system (ESR). However, in some instances the quality and consistency of certain metrics could be improved. For example, whilst there is an agreed funded establishment[7], we understand that financial data and workforce data do not always align. The Trust is taking steps to improve data quality, as some of these issues are common across NHS Wales. The Trust is involved in appropriate national working groups to find shared solutions such as the All-Wales Data Quality Group. The Trust is also taking steps to improve service-level access to workforce data using management dashboards.
We considered whether the Trust is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • Effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues.	We found that **the Trust is engaging well with internal and external partners to find shared solutions to address current workforce challenges.** Within the organisation, the Workforce Planning Manager and HR Business Partners engage well with the Trust's service leads. They provide workforce planning training and support service level workforce plan development. However, there are some constraints. We understand that due to service pressures, service level engagement in workforce planning can be variable. The Trust has a good understanding of issues affecting its workforce and their wellbeing. There are with good arrangements to hear from staff-side representatives and good relationships with trade

[6] Health boards in South-East Wales commission specialist cancer services from Velindre Cancer Service.

[7] Establishment is the term for the workforce levels, staff roles and the NHS Agenda for Change banding which is financially budgeted for.

What we looked at	What we found
• Shared solutions identified with key stakeholders to help address workforce challenges.	unions through the Local Partnership Forum. This helps to target its HR workforce initiatives with an aim of tackling workforce challenges, for example where staff sickness and staff turnover is high. Externally, the Trust recognises the importance of working with regional partners to support the development of sustainable services. We found positive examples of the Trust working in collaboration to address current workforce gaps. For example, a joint appointment with Cardiff and Vale University Health Board of a medical physicist for the regional programme on acute oncology service. In addition, there are several regional transformation projects at various stages, which have workforce implications and will need workforce modelling and plans. These include designing a paperless working environment at the new Velindre Cancer Centre, a new Radiotherapy Satellite Centre at Neville Hall Hospital and modernisation of Welsh Blood Service laboratory in Talbot Green. Velindre Cancer Service has also linked in with other cancer centres across the UK and undertook a peer review with Clatterbridge Cancer Centre. The Trust's also engages well with Health Education Improvement Wales (HEIW) and has co-opted a HEIW representative to the Trust's Education Steering Group[8]. We saw evidence of open and honest discussions between the Trust and key stakeholders on challenges such as the decision to stop the streamlining process for radiography[9] as it was not addressing immediate workforce shortages.

[8] The Group's remit is to: identify areas of priority for educational intervention through the IMTP and strategic operational plans and monitor and agree work plans; agree KPI's for work plans and hold to account; support Divisions to provide detailed plans for educational support; and be accountable for equitable and allocation of educational spend.

[9] The Student Streamlining Scheme was developed by NHS Wales Shared Service Partnership, in agreement with NHS Wales Health Bodies and Universities across Wales and is a matching process meaning Student Nurses and Allied Health Professions & Healthcare Science graduates do not need to submit multiple applications via NHS Jobs to secure their first job in NHS Wales after graduating.

Exhibit 3: Operational action to manage workforce challenges

This section focusses on the actions the Trust is taking to manage workforce challenges. Overall, we found that **the Trust is taking some positive action to manage current and future workforce challenges but recognises it is in the early stages of developing a more robust and effective approach to workforce planning.**

What we looked at	What we found
We considered whether the Trust has identified sufficient resources to support workforce planning over the short, medium and long-term. We expected to see: • Clear roles and responsibilities for workforce planning. • Appropriately skilled staff to ensure robust workforce planning. • Sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan. • Sufficient financial resources to deliver the workforce strategy or plan.	We found that **the Trust has clear intent to improve workforce planning capability but should ensure it has the resources to support the delivery of its People Strategy** Corporately, roles and responsibilities for workforce planning are clear within the People and Organisational Development team. The Trust appointed a permanent Workforce Development Manager earlier this year, although only part of the Workforce Development Manager's role is dedicated to workforce planning. Similarly, the two corporate human resources business partners that support directorates' workforce planning also deal with operational HR matters. This limited capacity may inhibit the extent that the corporate team can help services plan for their current needs and modernise services. At an operational level, our fieldwork identified that service leads generally understood their role in workforce planning. However, service managers indicated that service pressures did not allow them sufficient thinking time to develop solutions. This is resulting in a varying degree of service-level involvement in workforce planning. The Trust recognises the need to develop managers capability across the organisation and has started rolling out workforce planning training. Historically, workforce planning within the Trust was ad-hoc and informal. As a result, the Trust does not yet have a clear picture of its skills gap and how it affects the quality of workforce planning. The People and Organisational Development team have

What we looked at	What we found
	developed and is delivering training modules alongside a toolkit based on HEIW's six step model[10] which is being well received.
	The Trust's People Strategy is costed as part of its annual IMTP development process however, this does not allow it to identify the longer-term workforce costs, skills or other resources associated with delivering it over a longer period. Whilst the Trust is working in a challenging financial environment, at the time of writing this report, it does not currently require its Directorates to hold vacancies to meet savings targets. However, we understand that the Trust appointed staff in both directorates at risk in response to the pandemic[11]. It also recruited to support some service developments without agreed permanent ongoing funding. Given the financial pressures across Wales, there may be a need to reassess this position as part of its wider financial planning.
We considered whether the Trust has a good understanding of the short- and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • A good understanding of the barriers that might prevent delivery of the workforce strategy or plan. • Plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions. • Clearly documented workforce risks that are managed at the appropriate level.	We found that **whilst the Trust understands high-level workforce risks associated with delivering its People Strategy, actions to mitigate these risks have had minimal effect to date.** The Trust's workforce ambitions are articulated in its People Strategy, but there are a range of risks which may prevent its delivery. These mainly relate to service pressures such as increased demand, workforce shortages and financial pressures. High-level workforce risks are appropriately reflected and managed through the Trust's Assurance Framework and corporate risk register. However, the scale of the workforce challenges mean that mitigating actions are having minimal effect on reducing workforce risks. Some of the arrangements to manage these risks are relatively new and once embedded and if successful, may help reduce some workforce challenges. These include the work of the Attraction, Retention and Recruitment Programme Group, Healthy and Engaged Steering Group and the hybrid working project. In addition, the development of the Supply and Shape Framework will provide the Trust with a clearer picture of current workforce capacity and challenges and may identify new workforce risks, such as risks associated with meeting future service demand (**Recommendation 3**).

[10] Health Education and Improvement Wales has developed a workforce planning toolkit based on the following six steps: 1, Define your plan, 2. Map the service change, 3. Define the workforce, 4. Workforce supply, 5. Define actions required, 6 Implement and monitor.

[11] At the time of appointment, these posts were funded by supplementary funding from the Welsh Government to cover the additional pressures arising from the pandemic, but it was not clear how they would be funded once the supplementary funding ceased.

What we looked at	What we found
We considered whether the Trust is effectively addressing its current workforce challenges. We expected to see: • Effective reporting and management of staff vacancies. • Action to improve staff retention. • Efficient recruitment practices. • Commissioning of health education and training which is based on true workforce need. • Evidence that the organisation is modernising its workforce to help meet current and future needs.	We found that **the Trust is taking appropriate steps to address current workforce challenges at an operational level through a range of recruitment, retention, and development activities.** As a percentage of its total establishment, the Trust has one of the highest vacancy rates compared to other health bodies in Wales (**Exhibit 7**), as such, the Trust is addressing this workforce gap through overtime arrangements and increasing its use of agency staff. The corporate workforce team provide targeted support to services where the data highlights particular hot spots such as high vacancy rates. Spend on agency staff increased considerably in 2020-21 to £2.7 million but has since reduced to £1.3 million in 2022-23 (**Exhibit 6**). The Trust is starting to take positive action to improve staff retention and build workforce resilience. For example, by offering some bank staff, specifically administrative and facilities staff and flexible working options. The Trust has also reduced nursing and health care support worker vacancy rates in Systemic Anti-Cancer Therapy (SACT)[12] through targeted recruitment interventions. However, as with other parts of the NHS, there are longstanding gaps in parts of the workforce which the Trust will need to manage. We noted specific staffing pressures for consultant radiologists, acute oncology consultants and medical physicists[13] and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness in some service areas. The Trust does not include details on staff turnover in its performance report making it difficult for the organisation to get a clear view if this is improving or deteriorating. The Trust uses exit surveys to

[12] Systemic Anti-Cancer Therapy is any drug treatment used to control or treat cancer. The drug treatment types may include chemotherapy, immunotherapy, targeted therapy, hormonal therapy or a combination of these.

[13] Medical Physics is the application of physics to medicine. It uses physics concepts and procedures in the prevention, diagnosis, and treatment of disease.

What we looked at	What we found
	understand the underlying reasons behind staff turnover but could do more to actively encourage staff to complete surveys and analyse their responses (**Recommendation 4**).
	At 6.3% in 2021-22, the Trust's sickness absence figures are just under the NHS Wales average of 6.9%. Like most other NHS bodies in Wales, it does not meet the Welsh Government's target of 3.54% (**Exhibit 8**). To help address this, the Trust has established its Healthy and Engaged Steering Group that is focussing on improving how staff are supported and valued. The Trust places a great emphasis on staff wellbeing. This is demonstrated in Board and Committee discussions. Staff also have access to a range of physical and mental wellbeing offers, financial support and flexible working, where business needs allow.
	The Trust is strengthening its recruitment approaches. The Trust's recruitment process is managed by NHS Shared Services Partnership. However, recognising there are inefficiencies in its internal process, the Trust has made some improvements. These include, agreeing a standardised Trust recruitment policy. This strengthens arrangements for recruiting timeliness and joined-up service and corporate recruitment processes. In collaboration with NHS Share Services Partnership, the Trust has already improved candidate on-boarding time reducing this from 113.5 days in June 2022 to 70.4 days in March 2023. The Trust has also developed recruitment videos for the Welsh Blood Service, attends recruitment fairs to promote the Trust with school, colleges and universities and is developing targeted recruitment campaigns through social media.
	The Trust is working on improving the basis of its education commissioning and has recently strengthened the process, which is now overseen by the Education Steering Group. Education commissioning numbers are now aligned to the IMTP. However, it needs to triangulate the number of staff it trains through the education commissioning process and how many it then employs (**Recommendation 5**). In recent years the Trust has been seeking alternative solutions to ensure a sustainable workforce. For example, focusing on grow your own schemes and ensuring staff operating at the top of their licence[14]. The Trust is also exploring ways to change the skills mix for various fragile services by exploring the use of new roles such as physicians' associates, advances practitioner nurses and various assistant and technologist roles, but progress is, as yet, limited.

[14] Operating at the top of license means each employee practices to the full extent of their education and training, instead of spending time doing tasks that could be performed by someone else.

Exhibit 4: Monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **whilst Board and Committee maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks.**

What we looked at	What we found
We considered whether delivery of the Trust's workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels. • effective action where progress on elements of the workforce strategy or plan are off-track. • Performance reports showing the impact of delivering the workforce strategy or plan. • The organisation benchmarking its workforce performance with similar organisations.	We found **that whilst there is a reasonable monitoring and oversight of the delivery of key People Strategy actions, the Quality, Safety and Performance Committee and Senior Management need better information on impact that strategy delivery is achieving.** The Quality, Safety and Performance Committee is responsible for scrutinising workforce matters which includes delivery against the People Strategy. At its recent meeting in July 2023, it received an update on the first year of the People Strategy's delivery. While the report is clearly showing progress on key actions, there is currently insufficient analysis on whether the actions are having the desired impact. It could have, for example, made the link to highlight where key workforce metrics changed as a result of strategy action delivery. As highlighted earlier in this report, the IMTP acts as a high-level implementation plan supporting the Trust's People Strategy, but we found the quarterly IMTP performance report has not included any updates against the workforce and organisational development priorities since quarter 1 and 2 reports of the 2022-2025 IMPT. Therefore, this again makes it difficult for the wider Board to understand whether the Trust is successfully delivering its strategic workforce ambitions. As the update on the first year of the People Strategy's delivery focused mainly on delivery against milestones this impedes the Quality, Safety and Performance Committee's ability to effectively scrutinise the impact that strategy delivery is achieving. (**Recommendation 6**). Directorate's Senior Leadership Team receive monthly workforce dashboards allowing them to scrutinise performance such as sickness, vacancy and data on recruitment. Management then take

action for the month ahead where performance is off track. The Trust's workforce steering groups, as mentioned above, submit quarterly highlight reports to the Executive Management Team but our fieldwork found that these concentrate on short-term actions and do not adequately consider the impact of the work undertaken.

Where possible, the Trust benchmarks its workforce performance with other health bodies in Wales, comparing metrics such as turnover, sickness rates and time to hire. The Welsh Blood Service is an active part of UK wide, Europe and further afield comparator networks.

Audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s) • Integrated Medium-Term Plan • Evidence of evaluation of workforce strategy and / or associated initiatives • Information feeding into workforce strategy development e.g., needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning • Evidence of stakeholder engagement • Structure charts for workforce planning functions • Examples of workforce planning training offered to staff e.g., CIPD, other training formal or informal • Workforce finance and resource plans • Corporate and operational risk registers • Document showing recruitment process and recruitment and retention initiatives • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following: • Chair of Quality, Safety & Performance Committee • Deputy Director for Workforce and OD • Director of Welsh Blood Service

| Element of audit approach	Description
	- Medical Business Manager - Executive Director for OD & Workforce - Workforce Information Manager - Workforce Planning Manager - Head of Workforce - Deputy Director Finance - Divisional Senior OD Business Partners x 2 - Executive Director of Nursing, Allied Health Professionals and Health Science - Director of Welsh Blood Service - Chief Operating Officer

Appendix 2

Selected workforce indicators

Exhibit 6: Trend of expenditure on workforce agency (Excluding NWSSP agency costs)
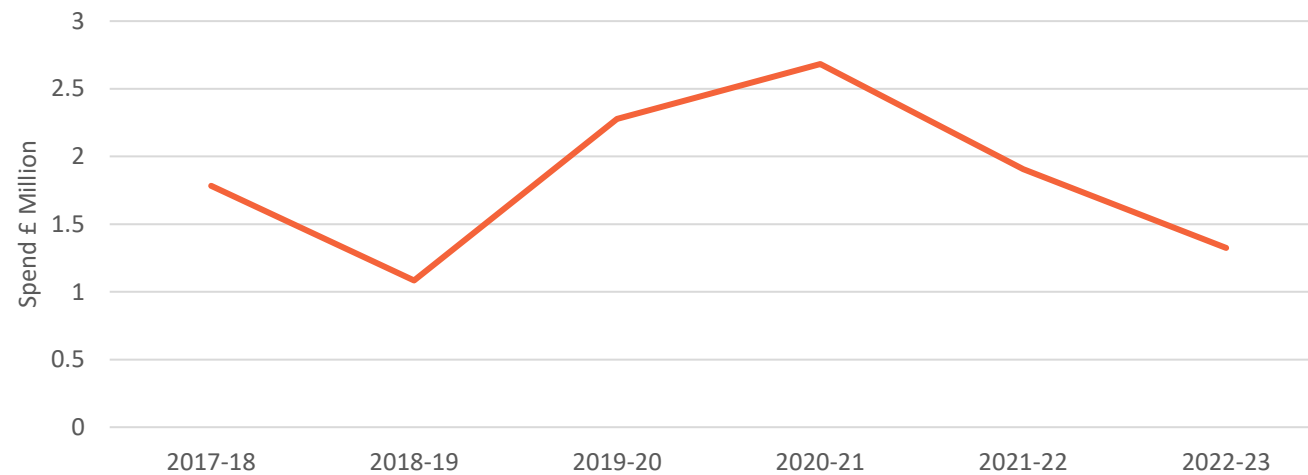
Source: Monthly Monitoring Returns reported to Welsh Government

Exhibit 7: Vacancies as a percentage of total establishment, as of March 2022
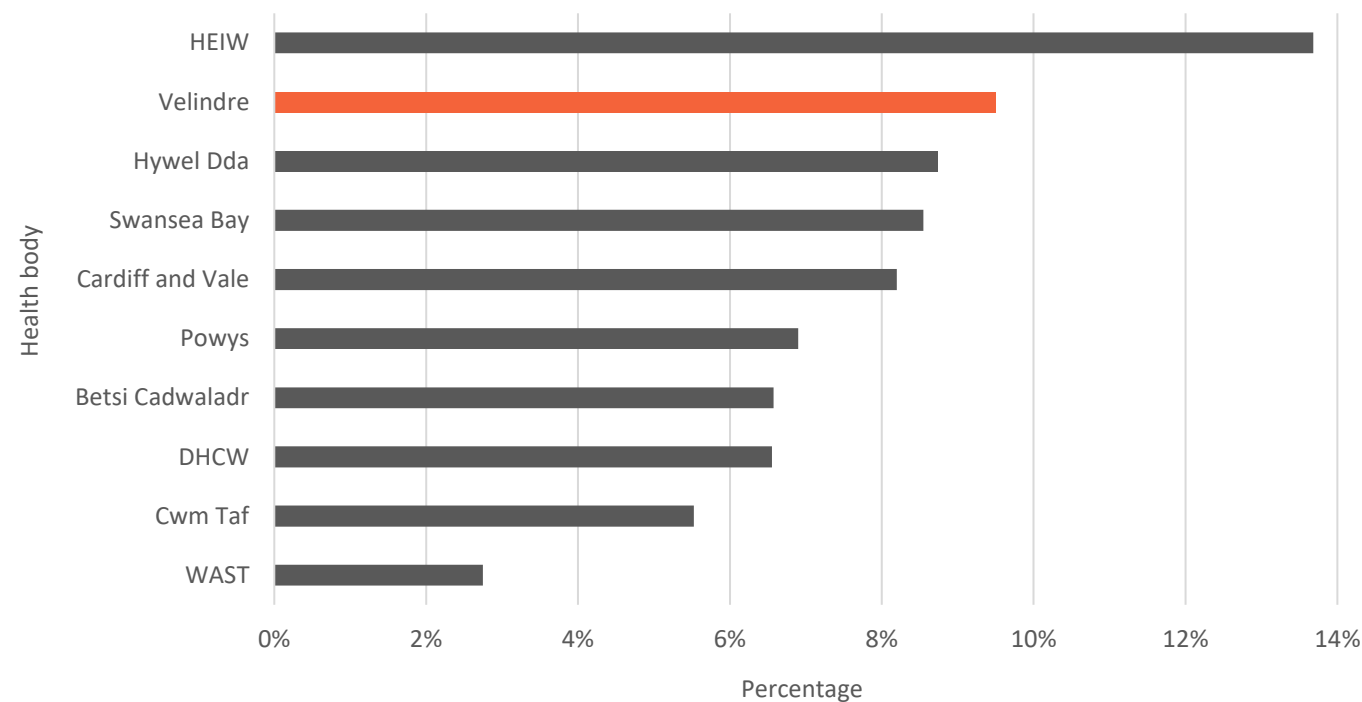
Source: health body data request

Exhibit 8: Percentage sickness absence by organisation, 2022
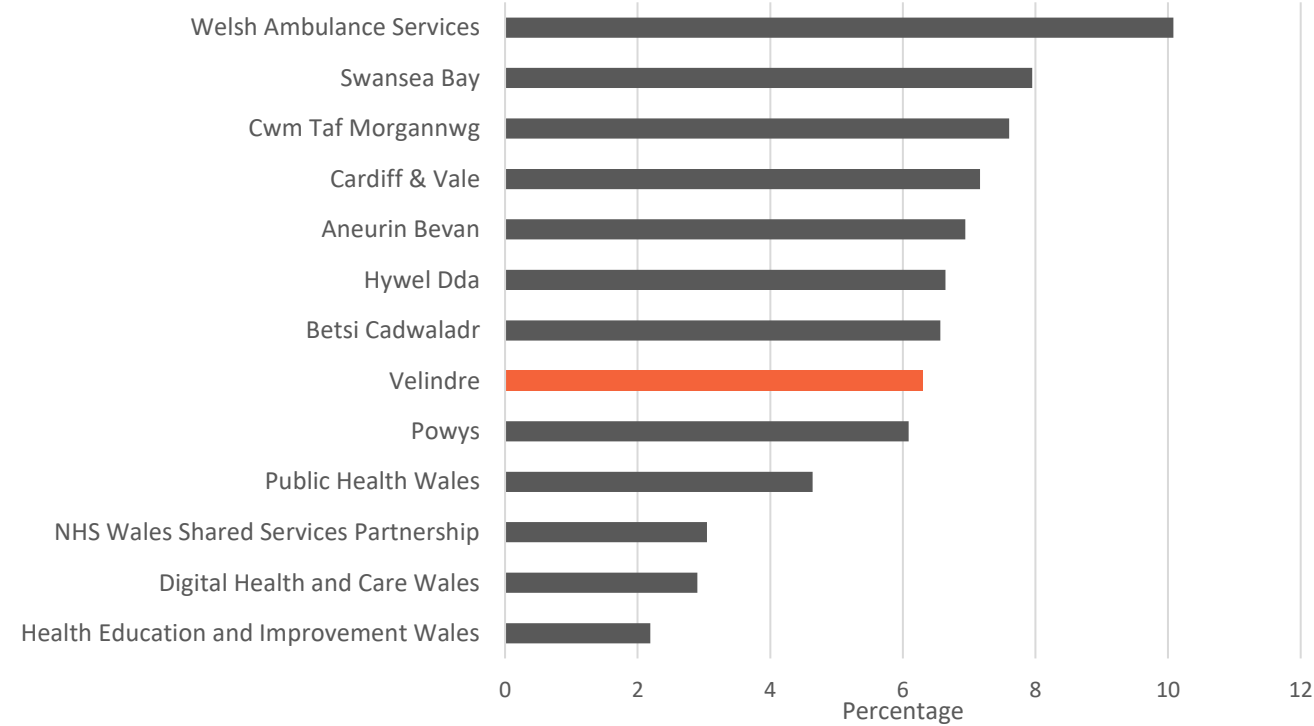
Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 9: Velindre University NHS Trust response to our audit recommendations.

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R1	The Trust should develop a plan to implement the People Strategy. The plan should include a section that identifies the costs, staff capacity, skills and other resources associated with implementing the People Strategy (**high priority**).	An implementation plan for the Strategy has been developed which highlights risk and governance arrangements.	September 2023	Susan Thomas Deputy Director of WOD
R2	The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and	A Supply and Shape governance group is being established to provide governance and accountability regarding the completion of workforce plans across the Trust:	First Workshop in November 2023 A full project plan to be developed	Susan Thomas

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
	potential risks to the organisation (**medium priority**).	• to understand the current workforce programmes; • to understand the collective priorities in the programmes; • to agree the alignment between collective priorities - joining up and aligning initiatives; and • to agree the principles of how we work more effectively in an MDT manner. Phase 1 will be to complete a baseline assessment and ensure all departments have a workforce plan in place. Phase 2 will be to develop longer term plans that centre around each site-specific team and will take into account the projects and programmes of work that have workforce planning implications.	following the November session	Deputy Director of WOD
R3	The Trust should review the information in its corporate and strategic risk registers using fresh insight from the Supply and Shape document to identify potential	The Trust Assurance Framework (TAF) has been under review and is now in the final stages. There has been Strategic Risk refresh working collaboratively with Senior Leadership / Management Teams, Board and Committees	The TAF is due to Trust Board on 28th September	Sarah Morley Exec Director of WOD

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
	additional sources of assurance and new risks (**high priority**).	and the Executive Management Board. The new template has been developed, taking into consideration Trust-wide frameworks.	2023 for approval.	
R4	The Trust should develop an approach to increase exit survey response rates and ensure feedback feeds into retention activities **(medium priority)**.	A project group has been established to review the current exit interview process and create a revised, easy to follow process that utilises technology to its best advantage and avoids single points of failure, resulting in a better experience for the end user and providing informed data for the business to use. The deliverables to achieve this scope are: • clear and easy process – managers guide on importance of termination; • increased uptake of return of completed exit interview forms; • highlight service improvements; • highlight culture and inform culture change requirements; • removes single point of failure / reliance on one person; • provides consistent approach across the whole Trust; • provides valuable information for recruitment and retention;	December 2023	Amanda Jenkins Head of Workforce

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
		• streamlined, digital process, rendered for easy access mobile use, utilising current technology; and • paperless process reduces risk.		
R5	We found that the Trust is working on improving the basis of its education commissioning. The Trust should develop mechanisms to triangulate the number of staff it trains through the education commissioning process and how many it then employs which will provide the Trust with important intelligence to further strengthen its basis (**medium priority**).	Education commissioning places are agreed via the Education and Training Steering group. The students are commissioned by NHS Wales Shared Services Partnership and feedback on progress given to the Steering group. Attrition rates for commissioning are monitored via Health Education and Improvement Wales and fed into the steering group. Moving forward the Supply and Shape report will be developed to include updates on commissioning. Better triangulation with the performance report is also being worked on.	March 2024	Susan Thomas Deputy Director of WOD

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R6	We found weaknesses in the Trust's approach to monitoring and overseeing delivery of its People Strategy. It does not understand the impact of its efforts and a lack of clear information limits thorough scrutiny by the Quality, Safety and Performance Committee. The Trust should develop an approach to better understand the impact of key workforce initiatives and the extent that they are delivering the intended improvements and outcomes. Going forward this should be reported in the annual report on the delivery of the People's Strategy (**medium priority**).	Assurance is provided currently via the Workforce and Operational Design report on KPIs to: • Executive Management Board; • Quality Safety and Performance Committee; • Quarterly supply and shape papers are approved by the Executive Management Board and Quality Safety and Performance Committee. The Trust provides an annual report that summarises KPIs and provides an update on the People Strategy Moving forward the Supply and Shape report will be developed to deliver better triangulation with the performance report to provide details of the benefits of Workforce and Operational Design interventions. This will also be summarised in the Annual report.	March 2024	Susan Thomas Deputy Director of WOD

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

VELINDRE UNIVERSITY NHS TRUST
QUALITY, SAFETY, PERFORMANCE COMMITTEE

VCC DIVISIONAL QSP REPORT
(April 2023 – September 2023)

DATE OF MEETING	16 November 2023

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	VIV COOPER, HEAD OF NURSING, QUALITY, SAFETY AND PATIENT EXPERIENCE SARAH OWEN, QUALITY AND SAFETY MANAGER TRACEY LANGFORD, QUALITY & SAFETY OFFICER KEVIN STAYTE, PATIENT EXPERIENCE AND CONCERNS MANAGER
PRESENTED BY	RACHEL HENNESSY, DIRECTOR OF CANCER SERVICES
EXECUTIVE SPONSOR APPROVED	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
VCC SLT	09/11/2023	Approved

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

1. SITUATION

This purpose of this paper is to provide the Trust Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Velindre Cancer Centre for the period April 2023 – September 2023.

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

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

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

2. BACKGROUND

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

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises:

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

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

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

- VCC has reintroduced a monthly MDT Inpatient Mortality Review, the meeting is well attended and members of the MDT are fully engaged in the mortality review process. SST death within 30 days SACT and 30/90 days radiotherapy mortality review meetings are scheduled to begin in November 2023, and VCC continue to meet all of the minimum requirements of the MES service in relation to inpatients.
- Falls and Pressure Ulcer learning panels (previously known as scrutiny panels) continue to meet monthly and examine the documentation, evidence and learning around each individual incident these are reported in the Divisional monthy PMF.
- Compliance with the PTR regulations related to concerns/complaints continues at 100%
- Closure of quality and safety incidents within the required 30 days remains a challenge and action plans are in place to address areas where there is persistent non-compliance.
- VCC Quality and Safety team are meeting regularly with directoare leads where themes from incidents, concerns, and patient feedback have been identified. An agreed action plan is devised and monitored through QSMG.
- Overall patient satisfaction continues to exceed target at 92%.

3.2 The top six matters arising for this period are;

- Positive report following HIW Ionising Radiation Regulations Inspection in Radiotherapy department in May 2023.

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

- A number of patients reporting they are "waiting longer than they would like" in CIVICA feedback surveys. This continues to be a theme from the last reporting period November 2022 to March 2023 and is illustrative of the demand on services. It is an All Wales survey and the question does not specify the time frame they are referring to e.g. waited too long today or waited too long throughout their cancer journey. VCC Quality and Safety team are in discussion with NHS Executive around amending the question to be more specific for our patients.

- The number of Datix incidents open over the 30 days remain high, an action plan has been agreed with Trust Quality and Safety Team

- There is a concerns theme around communication being raised by patients regarding appointments and telephony across the cancer centre e.g. change in appointment time, location, or type (f2f v telephone) without patient being informed by phone or letter. Patients experiencing difficulty getting through to departments on the telephone. A task and finish group has been established to address these matters and devise an improvement plan. The actions will be monitored via QSMG and SLT.

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

3.3 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 does the well-being of our staff. The staff psychologist is working with a number of groups and individuals across the service to help/support following any incidents/concern/challenging clinical scenarios experienced due to high patient acuity.

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

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

CONTENTS PAGE

1.0	Introduction

INTRODUCTION

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

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

2.0	Impact Assessment

2.1 This report covers the period of April , May, June, July, August and September 2023 and therefore retrospectively provides VCC service, quality and safety data and narrative, the purpose of which is to provide assurance. The report is structured around the 6 domains of quality and safety.

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

3.1   There have been three VCC QSMG meetings held during this period and the following matters were escalated to SLT.

- A continuous theme from incidents and concerns around letter, telephone and responses to messages left is adversely affecting communication with patients around appointments
- There is a need for additional manual handling training identified in radiotherapy
- Significant risks around digital records were highlighted, system issues and ways of working have impacted on patients receiving letters for appointments in a timely way. There is a divisional task and finish group set up and working through and action plan to mitigate patient negative experience and avoid harm.

4.0	**Safe Care Descriptor; avoid harm**

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

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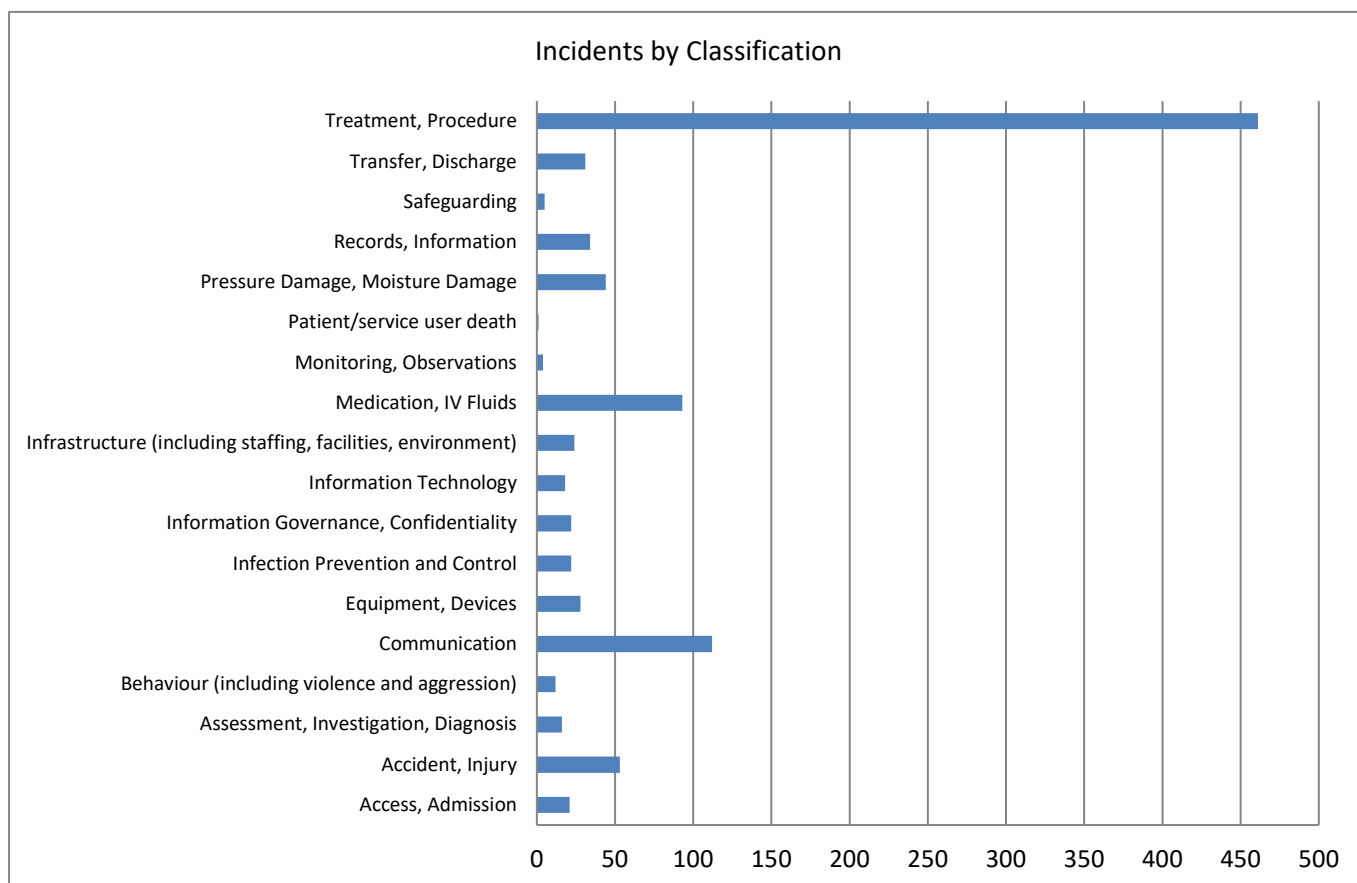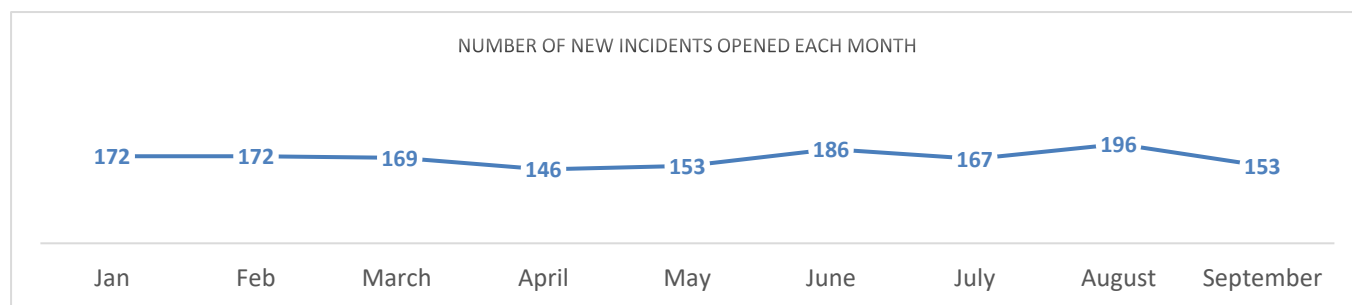- Claims (reported to the Trust QSP)

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

4.1   Incidents

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

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

NUMBER OF NEW INCIDENTS OPENED EACH MONTH

Jan	Feb	March	April	May	June	July	August	September
172	172	169	146	153	186	167	196	153

Incidents by Classification

Classification	Value (approx)
Treatment, Procedure	460
Transfer, Discharge	30
Safeguarding	5
Records, Information	33
Pressure Damage, Moisture Damage	45
Patient/service user death	2
Monitoring, Observations	5
Medication, IV Fluids	93
Infrastructure (including staffing, facilities, environment)	25
Information Technology	18
Information Governance, Confidentiality	22
Infection Prevention and Control	22
Equipment, Devices	28
Communication	112
Behaviour (including violence and aggression)	12
Assessment, Investigation, Diagnosis	17
Accident, Injury	52
Access, Admission	20

The majority of new incidents are related to treatment – the majority of these are related to radiotherapy and require reporting **for notification purposes** to UK Health and Safety Authority (UKHSA) only as per national guidelines, it should be noted the investigation and closure times of incidents requirements are different in relation to UKHSA 90 days and and Datix 30 days.

Themes and learning from incidents
- Communication with patients regarding appointments e.g. change in appointment time, location, or type (f2f v telephone) without patient being informed by phone or letter. A task and finish group has been established.
- Patients experiencing difficulty contacting VCC departments by telephone. SLT members have requested a review on current telephone infrastructure
- Number of incidents related to poor attitude, verbal aggression, and communication by the company providing taxi drivers contracted by WAST. Regular meetings between WAST and VCC to discuss transport challenges. Issue has been raised with the Taxi company.
- A number of incidents have been raised regarding the monitoring and management of blood

glucose while patients are on SACT and/or high dose steroids. Multi-disciplinary task and finish group established to action identified recommendations such as including glucose blood test result as "essential" on Chemocare when prescribing SACT.

- Recognition and management of unwell patients in radiotherapy review clinic. In depth review undertaken with recommendations created. A multi-disciplinary team approach to the actionplan and the learning including vital signs recirding and NEWS Cymru training in radiotherapy review has been agreed.

4.1.1. Level of Harm

Reporter's view of level of Harm	Number	Level of harm post investigation (may have been reported as a different level of harm)	Remain under investigation
None	450	330	98
Low	502	419	120
Moderate	46	6	13
Severe	1	0	0
Catastrophic/ Death	1	0	0

4.1.1 Severe and Catastrophic Incidents

2 incidents were categorised as severe at the time of reporting. Both incidents have been downgraded to no harm following investigation.

4.1.2 Moderate Incidents

46 incidents were categorised as moderate harm when first reported. Of these incident's 4 have been closed as moderate incidents but the duty of candour was not triggered as they did not effect patients - 2 related to electronic systems being out of use, and 1 related to a relative that had an unavoidable fall in the car park. 3 incidents have been classified as moderate harm to the patient and Duty of Candour triggered

4.1.3 Reportable Incidents and Duty of Candour

There were 4 reportable incidents during this reporting period, with 3 incidents triggering the Duty of Candour, and 2 incidents meeting the criteria for Natinally Reportable Incidents (1 incident was both Duty of Candour and NRI)

Duty of Candour – Deranged blood results not reviewed and actioned in a timely manner resulting in a in patient admission. Patient has recovered well. Immediate actions and learning put in place with a speedy cascade communication circulated about the responsibility of the requesting clinician to review any test result in a timely manner, and the role of the laboratory to highlight significantly deranged results to the on call team.

Duty of Candour – Missed opportunities for clinical review of patient's SACT related toxicities as an outpatient (the patient contacted clinical team and treatment helpline). Missed opportunities may have resulted in admission to ITU and emergency surgery. Patient now recovering at home. Immediate learning and actions identified around the use of separate chemotherapy and immunotherapy telephone triage tools for patients on combination therapy and the need to have one amalgamated triage tool which has

been completed. Clarity on escalation process for the Treatment Helpline has been addressed with the publication of the Treatment Helpline Escalation Pathway Guidelines. Work continues on the agreement of appropriate communication pathway e.g. emails to busy clinicians.
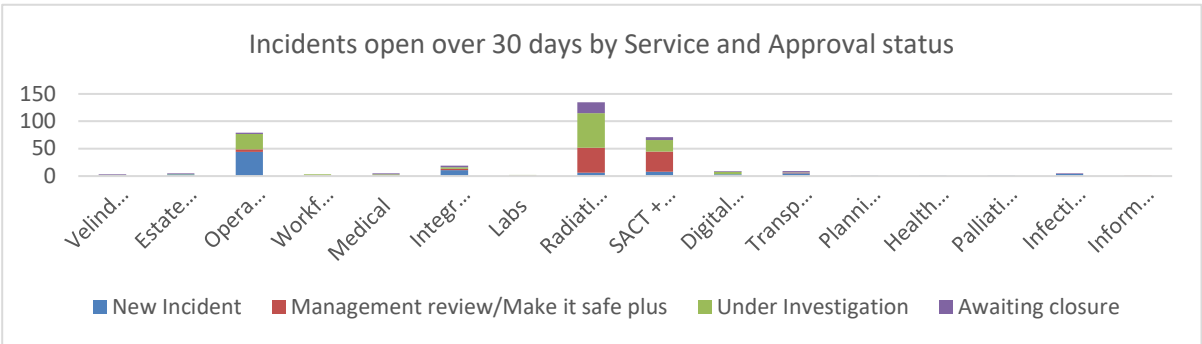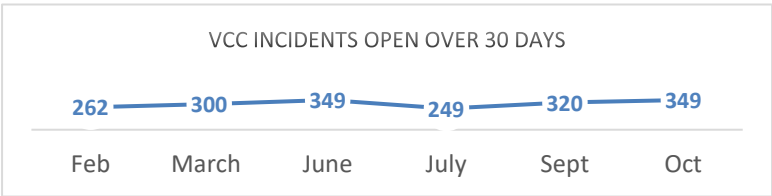
Duty of candour and NRI - Delay in patient's referral to VCC being acted on by approx. Delay of 10 weeks resulting in the patient missing the 12 week window post surgery to start adjuvant treatment. This has also been reported as a NRI the long term harm of this delay is not yet known. Initial review has identified that there is not an electronic process for referring new patients in to VCC and there is no standardreferral process in place, immediate learning and actions in place to review the current process and develop a more robust, electronic referral process.

NRI – Identified 799 annotations/letters awaiting action on DMS system (electronic system for clinic letters to be "signed" by clinician. Due to the risk of harm to patients, a NRI was submitted. A harm review is being undertaken for each patient where a letter was not sent for 30 or more days from the clinic date. A large proportion of the 799 annotations/ letters have now been actioned and urgent communications have been circulated to clinicians about the importance of timely action of letters.

1 NRI investigation was closed during this period, related to a patient being lost to VCC outpatient follow up following his discharge form VCC inpatient services. The key findings and improvements from these investigation are:

Improve the process of registering new emergency patients to the "on call" consultant
Update, review, and circulate the VCC Discharge and Transfer Policy

4.1.2 Open Incidents

VCC INCIDENTS OPEN OVER 30 DAYS

Feb	March	June	July	Sept	Oct
262	300	349	249	320	349

Incidents open over 30 days by Service and Approval status

■ New Incident ■ Management review/Make it safe plus ■ Under Investigation ■ Awaiting closure

An action plan has been devised following the VUNHST WRP audit undertaken which provided limited assurance in relation to the management of incidents including timely review and management. The action plan includes re-establishing regular departmental Incident Lead Review Meeting, strengthening

of the monthly SLT and directorate reports produced by the Quality and Safety Team, and regular Datix Masterclass sessions for all VUNHST staff.

4.2   Falls Learning Panel
There have been 0 avoidable falls on First Floor Ward during this reporting period.

4.2.1   Pressure Ulcer Learning Panel
There was 1 avoidable VCC acquired pressure ulcer during this reporting period. Learning has been identified around applying airflow pump to a mattress at the earliest possible opportunity for patients at risk of pressure damage who have metastatic spinal cord compression.

4.2.2   IR(ME)R HIW Reportable Incidents
The Ionising Radiation (Medical Exposure) Regulations 2017 are designed to protect people while undergoing examinations and treatment. Where there is unintended or accidental exposure to ionising radiation this must be reported and investigated. IR(ME)R notifications are reported to HIW. During the period 5 incidents have been reported and are being investigated (these 5 relate to radiotherapy and radiation physics).

4.2.3   Early Warning Notifications
There are no Early Warning Notifications for this reporting period.

4.3.   IRMER Compliance/ Issues/ Incidents

IR(ME)R Incidents Reportable to HIW 1st April 2023 to 30th September 2023
• There was 1 significant accidental or unintended exposures under IR(ME)R (SAUE) incident reported to Health Inspectorate Wales (HIW) during the period (radiotherapy only). Where a patient received 3 treatment verification images in a single fraction as a result of human error. Harm was assessed as low as additional imaging exposures were given which met the reporting criteria for significant accidental and unintended exposures under IR(ME)R, guidance for employers and duty holders. The incident has been investigated and actions put in place to reduce the risk of a reoccurrence of this type of incident.
• The UKHSA Safer Radiotherapy Triannual RTE analysis and learning report Issue 41 identified that onset imaging process was the most frequently reported event nationally within the Level 1 reportable radiation incident under IR(ME)R SAUE guidance.
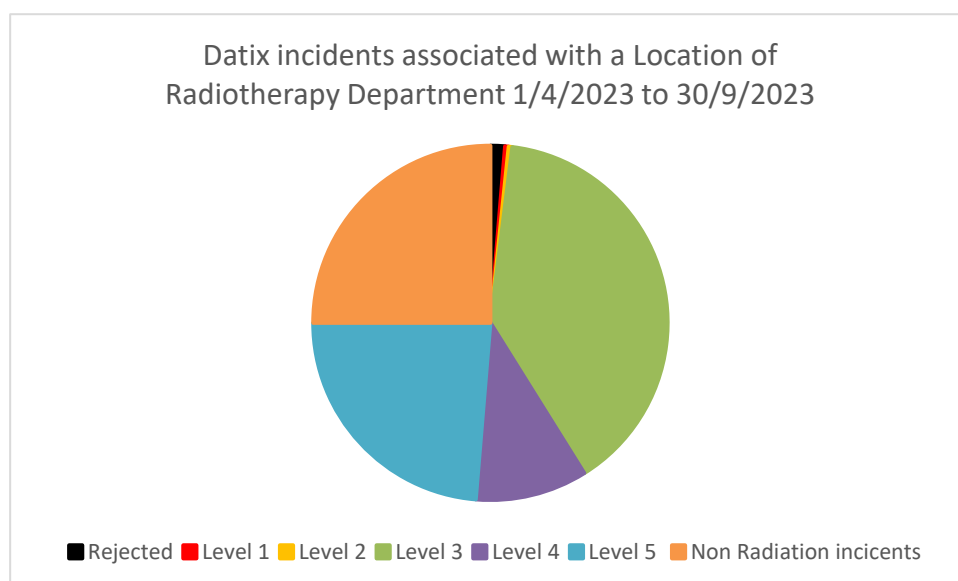
IRMER Compliance/ Issues/ Incidents
Between 1st April and 30th September 2023, 304 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 304 incidents reported, 228 were classed as radiotherapy errors (RTE).
0.4% of radiation incidents were classed as Level 1 and were reportable to HIW as per Significant Accidental Unintended Exposures (SAUE) under IR(ME)R guidance. 0.4% of radiation incidents were classed as Level 2.
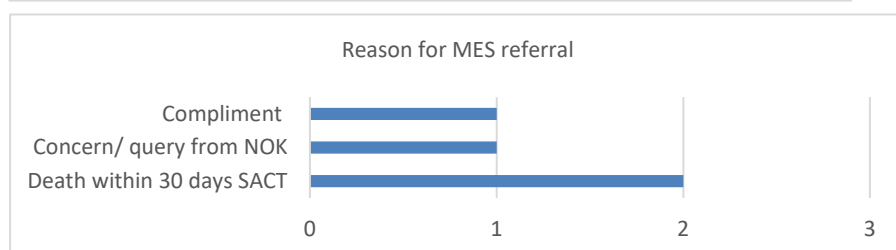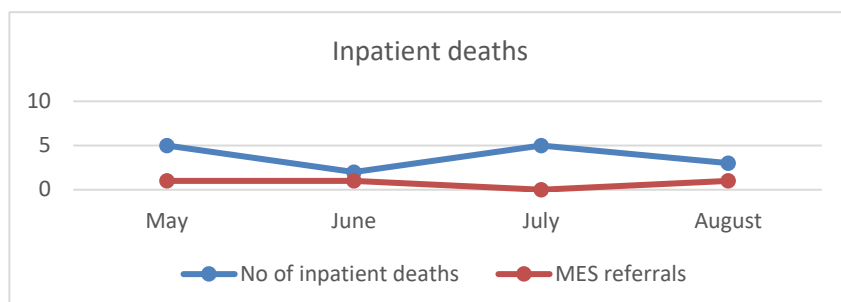99% of radiation incidents were classed as minor radiation incidents (Level 3 - 52%), near misses (Level 4 – 13.6%), or other and non-conformances (Level 5 – 31.6%) for the 6-month period 1/4/2023 to 30/9/2023 compared with the National report of 97.0.%, reported in the UK Health Security Agency (UKHSA) Safer Radiotherapy e-Bulletin #11 September 2023, which reports RTE submitted to UKHSA between April and July 2023.

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

Datix incidents associated with a Location of Radiotherapy Department 1/4/2023 to 30/9/2023

Rejected ■ Level 1 ■ Level 2 ■ Level 3 ■ Level 4 ■ Level 5 ■ Non Radiation incicents

4.4   Mortality

The Inpatient Mortality Review Group was re-established in May 2023. It is a monthly meeting that reviews the inpatient deaths from the previous month by utilising the information provided to the service by the MES reviews, receiving feedback from the patient's consultant and the ward doctors and nurses. The review focuses on identifying areas of good practice and areas for improvement and ensure the learning is actioned. All inpatient deaths from May 2023 have been reviewed by the Inpatient Mortality Review Group as well as the MES (and all cases prior to May 2023 have been reviewed by the MES). Each death was anticipated and had appropriate Do Not Attempt Resuscitation orders in place. There was evidence of good communication with the patients and their families. All patients had a high level of palliative care input. The learning identified from the reviews is mainly around the completion of assessment paperwork and identifying clear referral routes for dietetic input.

Inpatient deaths

No of inpatient deaths   MES referrals

Reason for MES referral

Compliment
Concern/ query from NOK
Death within 30 days SACT

A Welsh Government requirement to report death within 30 days SACT and 30/90 days radiotherapy mortality data was put in place in April 2023. There is a concern that the reporting of mortality data may have been impacted by data quality issues relating to the deaths of patients being treated by VCC, where those deaths occurred outside the Trust – e.g. in another Health Board following the implementation of DH&CR in November 2022.

The VCC Applications team have been working to validate and ensure death data are correct and can be relied upon within VCC IT systems. Once completed the mortality reports for the period April 2023 to August 2023 were re-run, to understand the scale of any impact of these issues on data already reported nationally. This re-run identified a correction in the data quality issue relating to the reporting of mortality data on WPAS/ WCP but identified underreporting of mortality data within BI database due to coding issues. Further validation of data is due to be completed by 24th November 2023. Following a final data validation exercise in conjunction with BI it is anticipated that accurate mortality data will be available in the VCC report in January2024 QSP and will be reported regularly via PMF.

A Mortality Review and Improvement Facilitator has been appointed and in role since August 2023. The priorities for this role are:

a) enable VCC to move forward with the mortality and morbidity review of patients who have died within 30 days of SACT and 30/90 days of radiotherapy. Initial priority work is to review the pilot that was undertaken in colorectal SST and build on that.
b) establish an overarching Mortality Group for VCC which will oversee the delivery of the Trust's mortality review and improvement processes, in line with All Wales Learning from the Mortality Review Model Framework, National Chemotherapy Advisory Group and the Department of Health. This group will support the collation and analysis of all mortality data, providing a statistical and thematic base to support quality improvement and clinical audit and inform the research agenda and aid the development of services.
c) continue the strong working relationship VCC has established with MES
d) support the Inpatient Mortality Review Group

4.4   Divisional Risks

 The risk register currently holds 196 records, 26 of which have been scored 12 and above. During the reporting period April 2023 to September 2023, there were 7 (12 and above) new risks opened and 3 (12 and above) risks closed during the reporting period.

The departments with open risks for that period are Integrated Care, Operational Services, , Digital Services, Radiation Services and Medical services and are mainly related to DHCR, Q-Pulse, workforce challenges, and funding. The need to ensure the risks are updated and managed regularly has been escalated to SLT.

5.0	Effective Care
	Descriptor: evidence based and appropriate

5.1. Complaints

VCC concerns over time

Concerns by subject April to September 2023
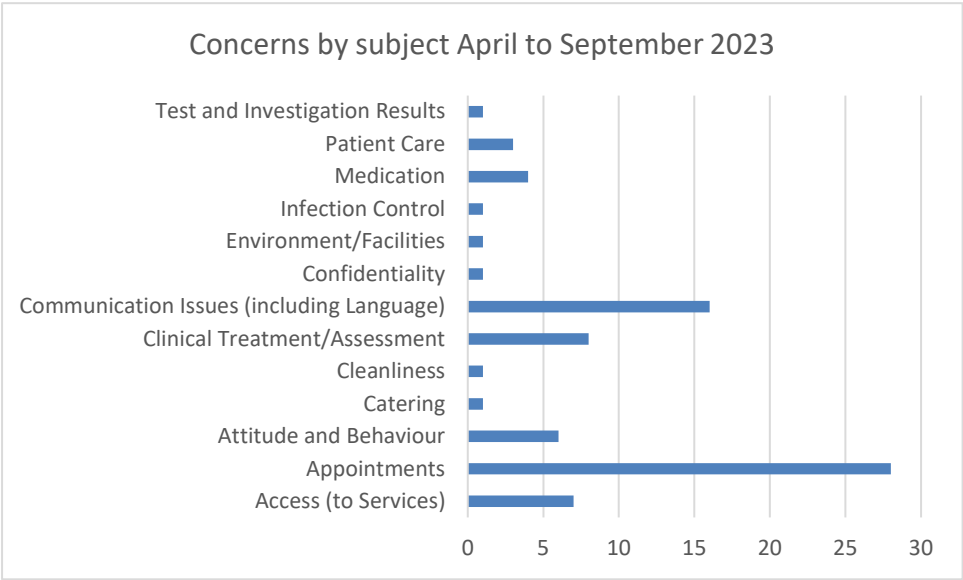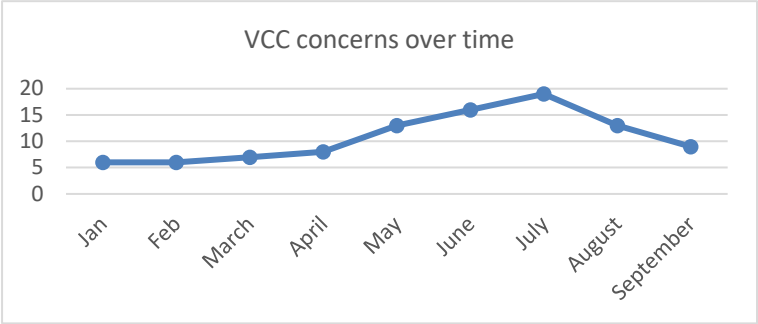
A summary of the key themes is highlighted below. Improvement plans and lessons learnt are being captured and shared where appropriate to demonstrate the learning undertaken.

There were 78 concerns raised for the time period April to September 2023, with 45 of these being managed through the Early Resolution pathway of Putting Things Right. There was 1 re-opened concern.
There have been no concerns raised in the time period that relate to breach of duty, none have been transferred over to redress and VCChas received no referrals from the Ombudsman.

Themes for this time period can be summarised as:
•   Challenges with appointments – both Outpatient and SACT bookings
•   Communication issues due to poor telephone contact (calls not being answered or returned) which also account for the access to service concerns
•   Medical staff communication

Improvements and learning identified:

• Task and finish group to identify issues with the telephony system and communication with patients regarding appointments

• Review of outpatient clinic structure - clinic start and end times and face to face/virtual contacts

• Meetings with SACT bookings to ensure SOP's are being followed regarding booking rules and communication to patients

• Clinicians continue to undertake reflective practice where communication issues have been raised. This action is owned by the medical directorate and communication issues continue to be a theme from previous reporting cycles

• The preparation of timely SACT treatments is under review by the Pharmacy Department to avoid delays in patient waiting on the day of treatment

5.1.1 Claims

April – September 2023

- 2 new claims received.
- 4 Clinical Negligence Claims and 1 personal injury claim remain open.
- No claims closed.

Personal Injury Total 1 Velindre Cancer Centre		Clinical Negligence Total 4 Velindre Cancer Centre	
Defective Equipment	1	Missed diagnosis / failure to diagnose	2
		Failure to assess	1
		Delay in clinical assessment	1
		Misdiagnosis	1
		Failure to recognise complication of treatment	1

Open Claims from April - September 2023

OPEN CLAIMS FROM APRIL - SEPTEMBER 2023
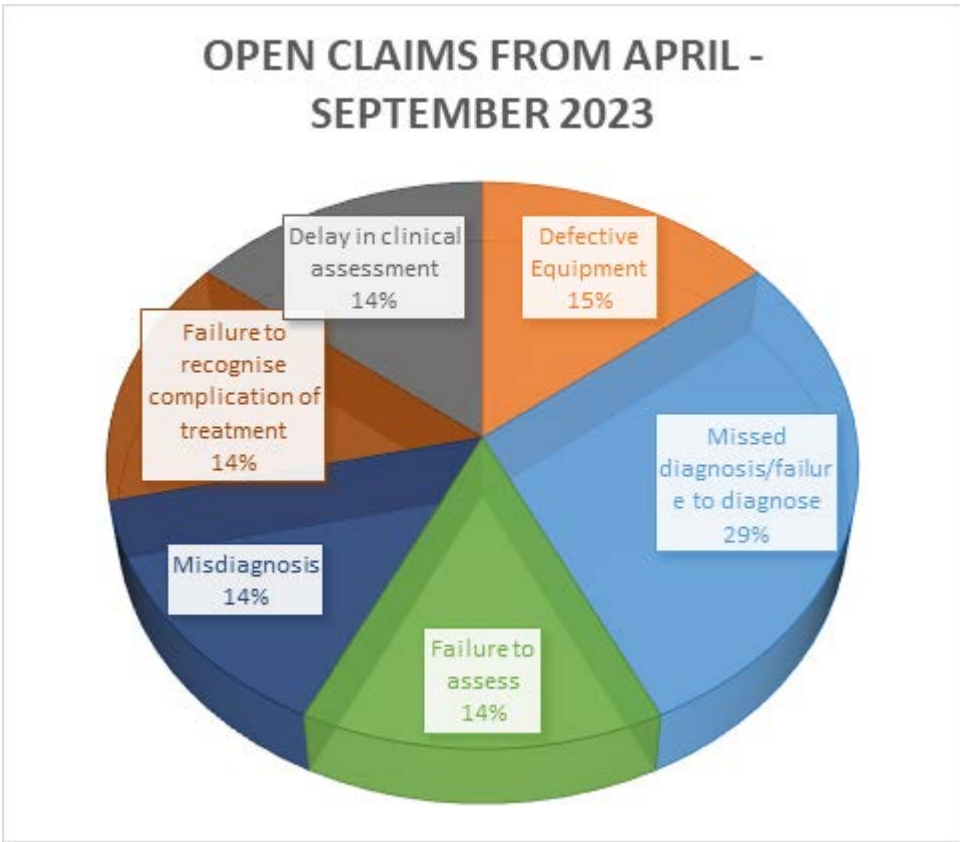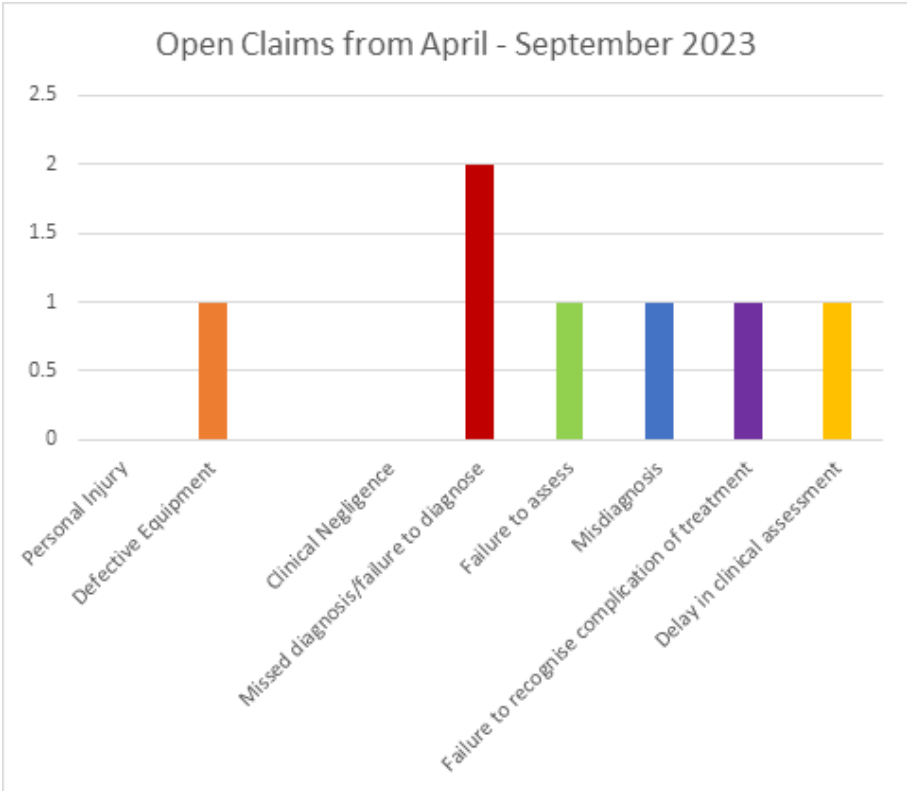
6.0	Efficient Care Descriptor; avoid waste

6.1. Clinical audit Update:

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

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

NATCAN The National Cancer Audit Collaborating Centre was established as a new national centre of excellence in October 2022 with the aim of strengthening NHS cancer services by looking at treatments and patient outcomes across the country.

NATCAN will bring national cancer audits together in one place, enabling us to share best practice and clinical excellence as part of the overall strategy of improving healthcare. Each audit will develop explicit goals aiming to improve cancer outcomes and the experience of patients.
NATCAN will deliver six new cancer audits covering:

- kidney cancer
- non-Hodgkin lymphoma
- ovarian cancer
- pancreatic cancer
- primary and metastatic breast cancer (two separate but closely connected audits)

The results from these audits will be published from 2024 onwards – both annually and quarterly.
The CEU was already the sole provider of national cancer audits in the English and Welsh NHS with audits covering:

- oesophago-gastric cancer
- bowel cancer
- prostate cancer
- breast cancer in older patients
- lung cancer

The clinical audit team have been in contact with the Welsh Cancer Network, to understand the process for the new national audits and how Velindre data will be captured. The data requirements for each new national audit have not been published yet, the WCN will share these once they have been confirmed by NATCAN.

It will be Velindre's responsibility to ensure the data is complete and accurate, there will be an element of validation required.

7.0	**Patient Centred Care** **Descriptor: respectful and responsive to the individuals needs and wishes**

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

Civica is widely used throughout VCC, with response rates over time shown below.
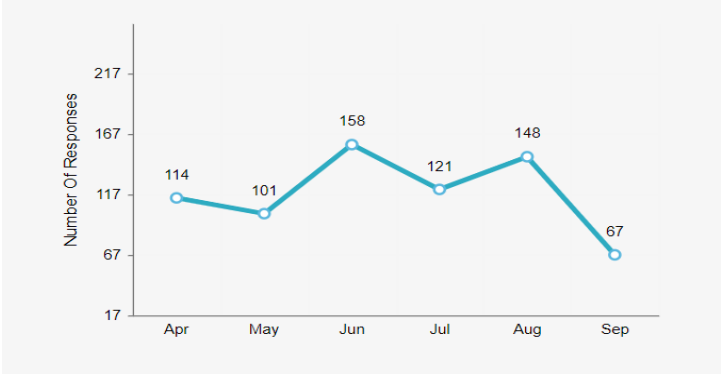
Departments have a 'You said, we did' board to allow patient, visitors and staff to see how each department is utilising the feedback they are receiving. Whilst updating these boards is the departments responsibility, it has recently been noticed that some departments they have not been updated to reflect recent feedback. The Q&S Team are working with Department Leads to ensure these boards are updated monthly, in line with the Civica reporting.

Service	Responses	1 - Overall, how was your experience of our service? VCC - Friends and	2 - Did you feel that you were listened to? Your Velindre Experience	3 - Were you able to speak Welsh to staff if you needed to? Your Velindre Experience	4 - From the time you realised you needed to use the service, was the time you waited: Your Velindre Experience	5 - Did you feel well cared for? Your Velindre Experience	6 - If you asked for assistance did you get it when you needed it? Your Velindre Experience	7 - Did you feel you understood what was happening in your care? Your Velindre Experience	8 - Were things explained to you in a way that you could understand? Your Velindre Experience	9 - Were you involved as much as you wanted to be in decisions about your care? Your Velindre Experience	10 - Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall e Your Velindre Experience	Overall
Catering services	4	100	-	-	-	-	-	-	-	-	-	100
Clinical Psychology	1	100	-	-	-	-	-	-	-	-	-	100
Clinical Trials	58	100	99	93	78	100	100	97	99	98	95	95
Nuclear Medicine	25	100	100	100	73	75	100	100	100	100	70	98
Nursing	140	100	94	94	84	98	97	94	96	94	96	96
Outpatients	143	89	85	93	66	87	87	83	86	83	86	84
Palliative care	5	-	100	100	100	100	100	100	100	100	100	100
Pharmacy	14	100	-	-	-	-	-	-	-	-	-	100
Radiology	74	100	92	92	78	94	99	92	92	93	93	93
Radiotherapy	62	90	89	100	61	91	91	89	90	88	90	88
SACT	177	99	89	89	82	100	100	83	92	92	80	98
Therapies	1	-	100	33	100	-	-	-	-	-	-	78
Welfare rights	1	100	-	-	-	-	-	-	-	-	-	100
Overall		98	91	94	72	92	93	90	91	89	90	91
Benchmarks		85	85	85	85	85	85	85	85	85	85	92

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

Waiting times within Radiotherapy over the reporting period were due to mechanical issues i.e. machine breakdown, which the Department has now resolved. During this time they were actively communicating with patients regarding these issues.

Waiting times in Outpatients – whilst a consistent theme throughout the reporting period – are being addressed by the Department. Managers are reviewing the use of clinical rooms to ensure all are maximised but volume of patient visits and the needs of the service continue to be a challenge in relation to available space.

Question 4: From the time you realised you needed to use the service, was the time you waited:

Create new action

Available Answers	Responses	Score (%)
Shorter than expected	99	36.53%
About right	123	45.39%
A bit too long	32	11.81%
Much too long	17	6.27%
Total	271	100%

Score: 72%

Shorter than expected (36.53%) | A bit too long (11.81%) | Much too long (6.27%)
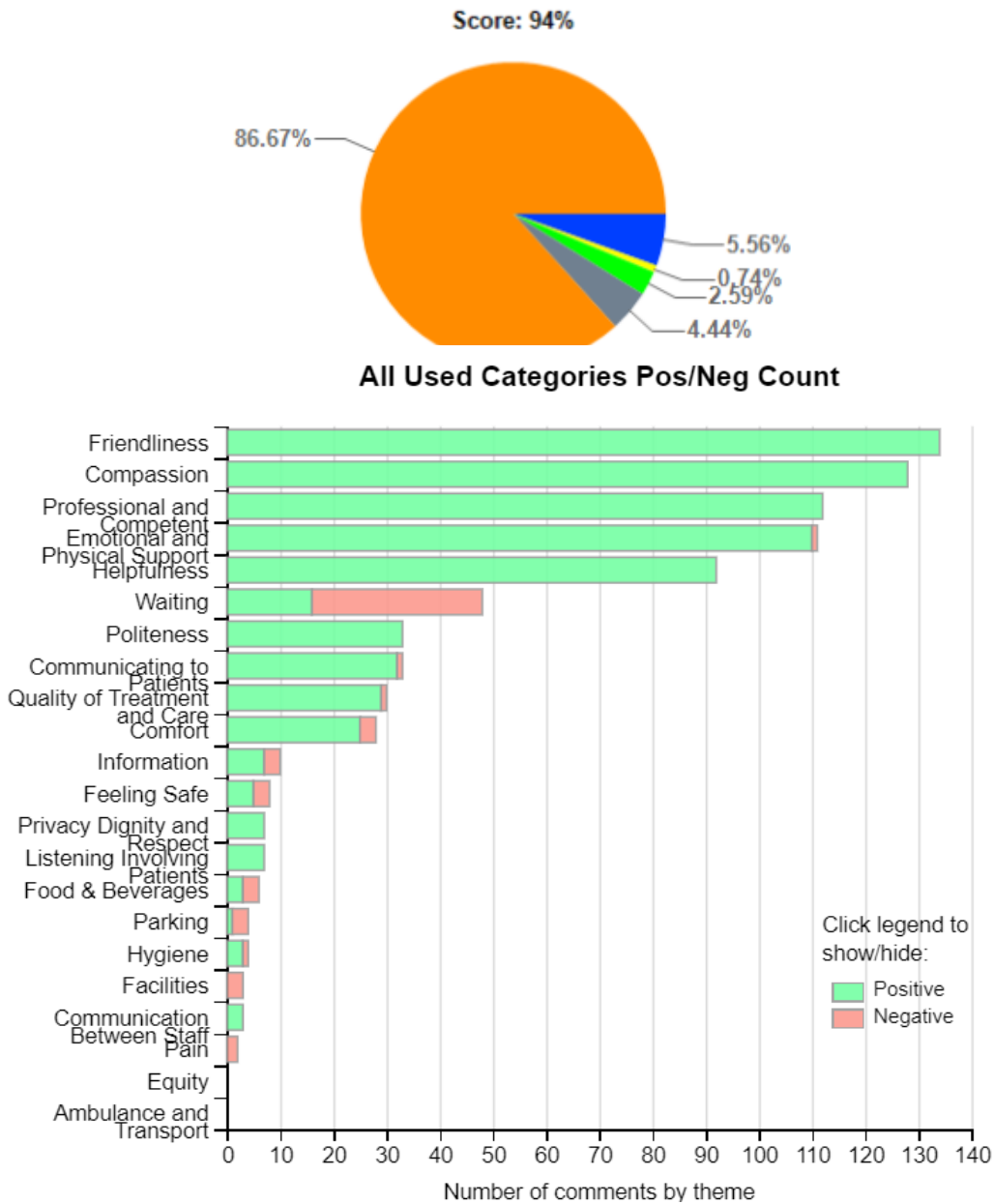About right (45.39%)
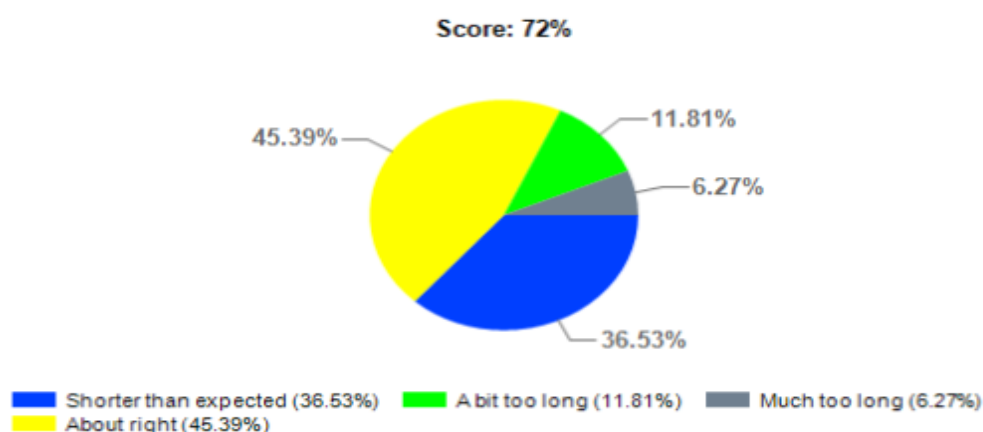
During the reporting period, the scoring of the 'were you able to speak Welsh' question was amended, so that 'not applicable' did not score negatively as a non-compliance.

Question 3: Were you able to speak Welsh to staff if you needed to?

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
Always	15	5.56%
Usually	2	0.74%
Sometimes	7	2.59%
Never	12	4.44%
Not applicable	234	86.67%
Total	270	100%

Score: 94%

86.67%
5.56%
0.74%
2.59%
4.44%

All Used Categories Pos/Neg Count

Click legend to show/hide:
- Positive
- Negative

Number of comments by theme

7.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

HIW Ionising Radiation Regulations Inspection Report Radiotherapy Department
HIW undertook a visit to the Radiotherapy department on 10th and 11th May 2023. Overall feedback was positive with positive comments made regarding the quality of patient experience, the delivery of safe and effective care, and the quality of management and leadership. Recommendations were made and an improvement plan has been produced and timescales are being met. Recommendations include environmental changes, Welsh language, patient information, documentation, and governance assurance. (**appendix A** review and the improvement plan)

External Peer Review of the Intravenous Access Service at Velindre Cancer Centre.

A peer review was commissioned and undertaken by IV Access lead from ABUHB on 27th and 28th June 2023 (**appendix B**).
The review identified the quality, safety and governance procedures were reviewed and considered to be excellent with no current areas of risk. Improvements were identified around the increasing demand on the PICC service and the need for consideration to increase capacity including appointment of Band 4 Assistant Practitioner to support troubleshooting across the site, and to update the insertion method to a more time efficient method, such as ECG tip confirmation. Recommendation was also made regarding developing a process to streamline the bookings of PICC line insertion appointments.

Patient Experiencee Survey?

The results presented in the report are from the third Wales Cancer Patient Experience Survey (WCPES) which was conducted by IQVIA in 2021/2022, on behalf of Macmillan Cancer Support and the Wales Cancer Network (**appendix C**).

The survey results for Velindre Cancer Centre are positive. **92%** of respondents rated their overall care as 7 or more out of 10 (a slight drop from **95%** when the survey was last carried out in 2016), with only **2%** rating their overall care as between 0 and 3 out of 10 (**1%** in 2016). **88%** said they were always treated with dignity and respect while they were in hospital (**89%** in 2016).

Other positive scores in the survey include:
- **93%** of respondents said they were always given enough privacy when they were being examined or treated

- **94%** of respondents said they were given all the information they needed about their operation

- **92%** of respondents said they were given all the information they needed about their test

- **92%** of respondents said hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

However, in other areas, responses were less positive. These include:
- 48% were offered the opportunity to discuss their needs and concerns

- **40%** of respondents said their healthcare team completely discussed with them or gave them information about the impact cancer could have on their day-to-day activities (for example, their work life or education)

- **39%** of respondents said their family or someone else close to them definitely had enough opportunity to talk to a healthcare professional

- **31%** of respondents said that, after leaving hospital, they were definitely given enough care and help from their GP and the GP practice

- **29%** of respondents said they had been offered a written care plan

- **25%** of respondents said that, since their diagnosis, someone had discussed with them whether they would like to take part in cancer research (e.g. clinical trials)

An action plan is being developed to address the areas for improvement and is being managed through VCC QSMG.

NMC Visit to VCC
VCC welcomed NMC council members on site on 26th September 2023. Feedback from the visit was very positive with the council members commenting they were thoroughly impressed with the entire operation, and the
unique collaboration that brings together the expertise, vision and resources of public sector and third sector organisations. The way in which this enhances the patient centred approach and has enabled progress changes in patient diagnosis, care and treatment within the NHS, and importantly the care and experience of patients, carers and families during and following treatment (appendix **D**).

8.0	Timely Care

8.2. SACT and Radiotherapy Prioritisation and Harm Review Process

Both SACT services and Radiation Services as the major services provided by VCC have treatment prioritisation processes in place including escalation processes for urgent treatment requests, managing increased demand where capacity is a challenge. These processes are routinely triggered by both services in the day-to-day management of the services, the processes are;

SACT Prioritisation Process

A daily prioritisation meeting, Monday to Friday, is held as required. Prioritisation of patients is according to their intent and is as follows:
- Emergency
- Neo-adjuvant
- Radical

- Palliative
- Adjuvant
-

Senior clinical advice (SLT Lead or Clinical Director) is sought when advice is required as how to prioritise patients within the same treatment intent.

Radiotherapy Prioritisation Process

Weekly MDT Capacity Meeting
Referral data is discussed at the weekly Radiotherapy capacity meetings with members of the MDT in attendance. This meeting discusses the demand on the service, workforce and the pathway, also highlighting any issues that may affect performance for that coming week.

Breast Referrals
Referrals from the Breast radiotherapy SST are clinically prioritised by the referring clinician. This is highlighted on the eIR(ME)R referral form prior to scheduling of the treatment pathway.

Machine Breakdown
In the event of a Machine Breakdown in radiotherapy the operational process is highlighted in QPWI 4b The Contingency for Patient Treatments in Event of Machine Breakdowns and Pre-Planned Maintenance Days on Linear Accelerators, QPWI 18 Unscheduled Interruptions (Gaps) Policy and QPWI 13 Departmental Emergency Treatment On-Call, Shift and Extended Working Day Policy to minimise interruptions.

Final draft of the harm review due to be signed off at the divisional and trust triumvirate meetings. The objectives of the VCC Clinical Harm Review process are listed below:

- There is a robust mechanism in place to undertake a proportionate review of any harm caused to a patient as a result of non-clinically generated delay to treatment (at any stage).

- There is robust oversight and management of all Harm reviews through the VCC governance structure through to Trust wide level for any case outlined in the introduction where harm has been identified.

- There are robust mechanisms in place to ensure that the reasons behind patient pathway delays are identified, reviewed, and appropriate and effective remedial actions are implemented in a timely manner to reduce risk to future patients also allowing for the opportunity to learn.

- To ensure that where clinical or physiological harm has been identified following a formal Clinical Harm Review, any affected patient / next of kin is informed as per the Duty of Candour process, and that the Putting Things Right processes are instigated.

- To ensure any affected patient has their case reviewed and discussed with a consultant specialist to optimise any future disease management.

- That Velindre Cancer Centre and the Trust is effectively meeting its statutory responsibilities in respect of the Putting Things Right Regulations and Wales Quality & Engagement Act.

- Velindre Cancer Centre and the Trust ensures provision of a service that is fair, accessible and meets the needs of all individuals.

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

8.1.1. Safe Care Collaborative

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

Barriers
- Financial cost of any revised ambulance transport service likely to be significant.
- Radiotherpay physics and planning capacity to support decision making earlier during the day.
- Variation in use of terminology in health board radiology reporting resulting in some lack of clarity with respect to MSCC diagnosis.
- Timely access to health board patient level data (for example, NICE guidance requires that treatment begin within 24-hours of positive diagnosis. Needs to be determined whether this information can be routinely obtained in a timely fashion and is accurate).

Breakthrough
- Project team have identified range of change options that have not previously been considered.
- Regular bi-weekly meetings established for the team.
- Patient pathway mapping commenced – Cardiff and Vale UHB AOS team to cooperate on whole pathway work to be supported by Improvement Cymru.
- Contact with clinical audit to regarding post-radiotherapy mortality data.
- Aligned junior and consultant on-call rotas (for an initial period of six months) to ensure that a clinical oncologist is available to review referrals and prescribe radiotherapy treatment at any given time.

Next Steps
- Finalise action plan with project manager.
- Form working group to undertake cooperative work with Cardiff and Vale UHB AOS team.
- WAST NEPTS to produce script to ensure capture of all necessary information at time of transport booking. Script to be reviewed and requirements to be included in communications package.
- Review and revise process flowchart for management of MSCC patients.
- Review impact of changes to medical on-call rota.

SACT Telephone Helpline

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

Barriers

- Planned annual leave and clinical pressures resulting in less time available and hampered ability to attend national event.
- Obtaining clarity of publishing external CNS contact details.
- Digital team capacity to focus on prioritise telephony system changes.

Breakthroughs

- Formal approval of triage tool and escalation process.
- Several priority elements of STH plan (triage tool, escalation, training) are nearing completion.
- Clarity on SACT Treatment Helpline scope.

Next Steps

- Analyse STH data to identify whether impact from awareness raising.
- Several priority elements of STH plan (triage tool, escalation, training) are nearing completion. Focus will then be on PDSAs to reduce out of scope calls and consider possibility of wider project group to address cross-directorate challenges.

  Terms of Reference for STH Peer Review being finalized and date agreed for reviewer to attend VCC for 2 days in December 2023.

Learning Infographics

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

Velindre Cancer Centre themes from incidents and feedback

Appointments	Staff Attitude / Behaviour	Clinical Services/Assessments

Communications issues (Including Language)	Infection Control	Monitoring and Observations
Access to Services and Resources	Test and Investigation	Patient Care

10.0	Performance

10.1   VCC Performance Summary upto an including September 2023 data.

(**Appendix E**)

11.0	Celebration and Exception

11.1   Celebrations

In celebration of 40 Years of Nursing, Michele Pengelly has teamed up with Velindre Cancer Charity and our communications team to deliver an exciting campaign and charity challenge.

The VCC Paracentesis Team have been awarded a Chief Nursing Officer Excellence Award for their outstanding work.

A Trainee Advanced Practice Gynae-oncology Physiotherapist from Velindre Cancer Centre has been appointed to a key National Cancer Research Institute (NCRI) working group.

Becky Bowey, who works at Velindre Cancer Centre Outpatients Department, has become Velindre University NHS Trust's first Assistant Practitioner, having advanced from being a Healthcare Support Worker to a Trainee Assistant Practitioner. To achieve this, Becky has undertaken a Certificate of Higher Education (CertHE) in Healthcare Nursing Support Worker Education.

Congratulations to Fran Lewis who has been awarded the Research Capacity Building Collaboration Wales (RCBC Wales) First into Research fellowship.

We are delighted to announce that a total of £3 million has been awarded to establish the Advancing Radiotherapy Cymru (ARC) Academy. The Moondance Foundation has generously pledged £1.5 million over five years. Velindre's Charitable Funds Committee has agreed to match this funding, achieving £3 million to establish the ARC Academy.

The Advanced Nurse Practictioner team have been shortlisted for RCN Team of the Year award and will be attending the awards ceremony in Liverpool on 10th November 2023.

12.0	Conclusions

There is evidence that incidents/concerns/compliments continue to be consistently managed appropriately and compliant with the PTR regulations, the VCC team have worked hard to achieve 100% compliance with the national KPIs. Lessons learned and actions are implemented and monitored by Directorate leads and their teams. Improvement has been made in the identification on themes and trends amongst incident, concerns, and patient feedback with the Q&S Team working proactively with directorates to develop improvement plans.
The Duty of Canodur has been enacted during this reporting period and there is evdicen of engagement and compliance with the new regulations across the cancer centre.

Following review the Quality and Safety team have set out the VCC quality priorities for 24/25 these are;
- Compliance with the Duty of Quality & Duty of Candour,
- SACT treatment helpline improvement,
- MSCC treatment pathway,
- improvement in timely incident management,
- work towards organisation culture that "quality is everybody's responsibility", clear improvement plans to be established and owned by departments following concern investigation.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Radiotherapy Department, Velindre Cancer Centre, Velindre University NHS Trust

Inspection date: 10 and 11 May 2023

Publication date: XX XXX 20XX

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose
To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values
We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal
To be a trusted voice which influences and drives improvement in healthcare

Our priorities
- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

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1. What we did

Full details on how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Radiotherapy Department at Velindre Cancer Centre, Velindre University NHS Trust on 10 and 11 May 2023. During our inspection we looked at how the department complied with the Regulations and met the Health and Care Quality Standards.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors, a HIW Healthcare Inspector and a Specialist Radiation Protection Scientist from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. The inspection was led by a HIW Senior Healthcare Inspector.

Before the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 42 questionnaires were completed by patients or their carers and 94 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the Radiotherapy Department at the hospital. They also told us they had been involved as much as they had wanted to be in decisions about their treatment.

We found staff were courteous to patients and they made efforts to protect their privacy and dignity. We also found care and treatment was provided to patients in a way that protected and promoted their rights.

Information available within the department was generally available in English only. However, the Trust had a website where patients with access could find information in both Welsh and English.

This is what we recommend the service can improve
- The Trust is required to provide HIW with details of the action taken to review the area used for Brachytherapy to determine whether further environmental changes can be made to help promote patients' dignity and privacy.

This is what the service did well:
- Patients provided very positive feedback and comments about the service they had received
- We found all staff interacted with patients in a polite and courteous manner
- Generally, the environment and furnishings in the department were well maintained, providing a pleasant environment for patients.

Delivery of Safe and Effective Care

Overall summary:
We found very good compliance with The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017.

We also found suitable arrangements were in place to provide safe and effective care to patients.

This is what we recommend the service can improve:

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- The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint protocols, taking into account relevant guidance
- The employer is required to provide HIW with details of the action taken to better reflect the governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy document
- The employer is required to provide HIW with details of the action taken to show the rationale where a decision is made to delay annual equipment checks.

This is what the service did well:
- The documents provided to HIW as part of the inspection showed a good understanding of the IR(ME)R requirements
- Very good arrangements were described and demonstrated in relation to the management of accidental and unintended medical exposures
- Very good arrangements were described for the optimisation of Computerised Tomography (CT) and Cone Beam Computerised Tomography (CBCT)
- We saw patient choice was promoted around the use of masks and other personal protective equipment (PPE) in relation to COVID-19.

Quality of Management and Leadership

Overall summary:
The Chief Executive of the NHS Trust was the designated employer under IR(ME)R. clear lines of reporting and accountability were described and demonstrated. Interim arrangements were in place for two key management positions.

Staff provided mixed feedback about working for the organisation.

We saw training records in relation to IR(ME)R were complete and comprehensive. However, documentation we reviewed showed that not all the Clinical Oncologists had confirmed they had read the employer's written procedures.

Suitable arrangements were in place for patients and their carers to provide feedback about their experiences. However, feedback from patients showed they did not always know how to make a complaint.

This is what we recommend the service can improve:

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- The Trust is required to provide HIW with details of the action taken to address the less favourable staff comments described in this report
- The Trust is required to provide HIW with details of the action taken to recruit to the Clinical Lead, Professional Lead, Radiotherapy Services Manager and Deputy positions
- The employer is required to provide HIW with details of the action taken to show Clinical Oncologists have read the employer's written procedures
- The Trust is required to provide HIW with details of the action taken to improve staff awareness of the system for seeking patient feedback
- The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.

This is what the service did well:
- The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements where needed
- The staff team was committed to providing a good service and were patient focussed
- There was good staff compliance with mandatory training and training records in relation to IR(ME)R were complete and comprehensive.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

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3. What we found

Quality of Patient Experience

Patient Feedback

Responses received through HIW questionnaires were positive across all areas considered, with all respondents (42/42) rating the service as 'very good' or 'good'.

Patient comments included the following:

> "Staff are welcoming, cheerful and reassuring. Staff are patient and kind. The setting is pleasant and user-friendly."
> "First rate care and support in every aspect. A credit to the NHS."
> "All staff (including the ladies on reception) foster an atmosphere in which patients (often new to treatment or distressed because of their situation) are put at ease and reassured. This encourages patients to speak to each other, offer encouraging advice etc.
> Every act of patience or kindness has a beneficial effect somewhere along the line. Commendable."

We asked what could be done to improve the service. Comments included the following:

> "Where the treatment takes place is very dull not painted nicely like the corridors or toilets etc. The radiotherapy rooms are very yellow and run down in colour which makes the experience a little dull at times."
> "…THE GOWNS. These are ridiculously ill fitting. I have been resigned to wearing a vest top, which is indeed far easier. The majority of them are far too small.."
> "It would be useful to understand in more detail how the treatment works, more detail about side effects and post treatment care. The telephone review process is ok but would have preferred a face-to-face meeting. Delays to treatment are not really explained and this affects pre-treatment preparation."

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Person Centred

Health Promotion

We saw a variety of leaflets were displayed in the main waiting rooms for patients and their carers. These provided written information about the different types of cancer and cancer treatments. They also provided information on the support available.

Information for patients and their carers, including what to expect when they attended the Radiotherapy Department, was also available on the Trust's website. The website also included links to the websites and contact details of other organisations who produce their own information leaflets and who can provide help and support for persons affected by cancer.

Dignified and Respectful Care

During our inspection, we found staff were courteous to patients and they made efforts to protect patients' privacy and dignity.

Sub waiting areas were located near the treatment rooms, which provided a greater level of privacy away from the main waiting room. Individual changing rooms were available, providing privacy when patients were required to change out of their clothes for their treatment. We also saw doors to rooms where treatment was performed were closed when being used.

Generally, the environment helped promote patient privacy and dignity. However, the area used for Brachytherapy presented significant challenges for staff in this regard. Staff used privacy screens and were mindful when scheduling appointments to help mitigate these. **The Trust is required to provide HIW with details of the action taken to review the area used for Brachytherapy to determine whether further environmental changes can be made to help promote patients' dignity and privacy.**

All respondents who completed a HIW patient questionnaire (42/42) told us staff had treated them with dignity and respect. In addition, the majority of respondents who answered the question (39/41) felt measures had been taken to protect their privacy and dignity. The majority of respondents (38/42) also told us they were able to speak to staff without being overheard by other patients.

The majority of staff who answered the question in the HIW questionnaire (82/93) told us patients' privacy and dignity are maintained in the department

We saw there was no designated waiting area in use for children visiting the department. We were told children were not often treated at the department.

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However, when children did receive treatment, we were told arrangements would be made to use a designated treatment room, and there was a paediatric team available to offer appropriate support and play therapy.

Individualised Care
The majority of respondents (39/42) who answered a HIW patient questionnaire told us they had been given information on how to care for themselves following their treatment. All respondents who answered the question (41/41) also told us they had been given written information on who to contact for advice about any after effects following their treatment.

The majority of respondents who completed a HIW patient questionnaire (41/42) told us they had been involved as much as they had wanted to be in decisions about their treatment.

The majority of staff who answered the question in the HIW questionnaire (91/93) told us patients are involved in decisions about their care. The majority of staff who completed a questionnaire (74/94) told us they were satisfied with the quality of care and support they give to patients. However, the remainder (20/94) disagreed with this.

All respondents who completed a HIW patient questionnaire (42/42) told us staff had explained what they were doing, had listened to them and answered their questions.

Timely

Timely Care
Staff told us when unexpected delays were experienced these would be communicated to patients on the day of their appointments. We were told patients would be informed verbally by reception staff. We also saw a large screen monitor in the waiting area was used to inform patients of any delays.

The majority of respondents who completed a HIW patient questionnaire (41/42) told us they thought the wait between referral and their appointment was reasonable. In addition, the majority of respondents (39/42) also told us when at the department, they were told how long they would likely have to wait to be seen.

Staff described suitable arrangements to provide emergency on-call radiotherapy treatments during weekends and public holidays.

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Equitable

Communication and Language

We saw bilingual signage, in both Welsh and English, displayed within the department. There were also symbols displayed to inform patients they may converse with staff in Welsh and we also saw some staff wearing lanyards to show patients they were Welsh speakers.

Information for patients was available on the Trust's website in both Welsh and English. However, written patient information leaflets available in the department were, generally, available in English only. This meant some patients may not have been able to access this information in their preferred language. **The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration the needs of the patient population.**

Posters were displayed advising patients who are or might be pregnant to inform staff prior to them receiving their treatment. This information was provided in multiple languages.

Staff we spoke to told us they could access a translation service, if required, to assist communication with patients whose first language is not English.

All respondents who completed a HIW patient questionnaire told us their preferred language is English.

The majority of staff who completed the question in the HIW questionnaire told us they were not a Welsh speaker (29/86). Under half of the staff who told us they did speak Welsh (3/7) told us they wore a badge or lanyard to show patients they could speak Welsh. Responses in the HIW questionnaire showed patients were not always asked to state their preferred language, with most telling us patients were either asked sometimes (4/7) or not asked (2/7). This meant patients may not have always been able to speak to staff in their preferred language. **The Trust is required to provide HIW with details of the action taken to encourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh and the action taken to consistently ask patients to confirm their preferred language.**

Rights and Equality

We found care and treatment at the department was provided in a way that protected and promoted patients' rights.

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We were told Equality, Diversity and Human Rights training formed part of the Trust's mandatory staff training programme. Data provided to HIW showed good staff compliance with such training.

The majority of respondents who completed the question (34/41) in the HIW patient questionnaire told us they felt they could access the right healthcare at the right time. The remaining respondents either told us they could not (6/41) or preferred not to say (1/41).

All respondents who completed a questionnaire (42/42) told us they had not faced discrimination when accessing the radiotherapy service.

The majority of staff who answered the questions in the questionnaire told us the workplace was supportive of equality and diversity (77/85), that staff have fair and equal access to workplace opportunities (69/84) and had not faced discrimination at work (78/83). However, there were staff who disagreed with these or preferred not to say.

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Delivery of Safe and Effective Care

Compliance with The Ionising Radiation (Medical Exposure) Regulations 2017

Employer's Duties: Establishment of General Procedures, Protocols and Quality Assurance Programmes

Procedures and Protocols
The employer had established written procedures and protocols as required under IR(ME)R 2017. These demonstrated a clear understanding of IR(ME)R.

We recommended consideration be given to the rationalisation of the written procedures and systems used to manage documentation to avoid unnecessary duplication across the documents and to streamline the suite of documents used within the department.

Suitable arrangements were described for the quality assurance of written procedures and protocols used in the department. These arrangements included a process for developing and reviewing written documents, an agreed frequency for review and a system for communicating changes to relevant staff. The employer had suitable written procedures in this regard.

The sample of written procedures and protocols we reviewed demonstrated the above arrangements, and their status was clear. However, we identified two Trust wide documents had passed their review dates. We highlighted this to senior staff, who agreed to check whether these were still needed given the other written procedures in place. This was dealt with before the end of the inspection.

Referral Guidelines
The employer had established referral guidelines and suitable arrangements were described for making these available to individuals entitled as referrers.

However, we felt the range of exposures performed at the department could be better reflected in the joint clinical protocols. We recommended these documents be revised and consideration be given to the guidance set out in the Ionising Radiation (Medical Exposure) Regulations: Implications for clinical practice in radiotherapy, Guidance from the Radiotherapy Board[1].

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[1] https://www.rcr.ac.uk/sites/default/files/guidance-on-irmer-implications-for-clinical-practice-in-radiotherapy.pdf

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The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint protocols, taking into account relevant guidance.

We also recommended reference could be made to the referral guidelines being included in the joint clinical protocols under the section 'Referral' in the overarching document, specific to radiotherapy, describing how the department implements the requirements under IR(ME)R 2017[2].

Diagnostic Reference Levels
Note diagnostic reference levels are not a requirement of radiotherapeutic exposures.

Medical Research
We were told the department participated in research involving medical exposures. The arrangements for this were set out in an overarching document.

The completed self-assessment form described suitable governance arrangements for research trials, the process for managing for research exposures and the measures in place to ensure adherence to dose constraints. However, we felt these could be better reflected in the overarching document.

We recommended the document be revised and consideration be given to the guidance set out in the 'Ionising Radiation (Medical Exposure) Regulations: Implications for clinical practice in radiotherapy, Guidance from the Radiotherapy Board'. **The employer is required to provide HIW with details of the action taken better reflect the governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 in Radiotherapy document.**

The employer may also wish to develop specific written employer's procedures in this regard to supplement the overarching document.

Entitlement
There was a suitable employer's written procedure to identify individuals entitled to act as referrer, practitioner, or operator within a specified scope of practice. This clearly described the task of entitlement was delegated to the Medical Director who in turn delegated authority to departmental managers or service leads.

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[2] Velindre NHS Trust - Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy

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Entitlement was also referenced within the overarching document, specific to radiotherapy.

The entitlement of Clinical Oncologists was well described in the self-assessment form and evidenced at site during inspection. However, we felt this practice could be better reflected in the local employer's procedures. **The employer is required to provide HIW with details of the action taken to better reflect the entitlement of Clinical Oncologists in the local employer's written procedures.**

We saw entitlement was recorded on a matrix document. This clearly set out each individual's entitlement.

Patient Identification
There was a suitable employer's written procedure in place to correctly identify the individual to be exposed to ionising radiation.

The employer's written procedure clearly addressed those situations where more than one operator was involved in the exposure and where the individual may not be able to identify themselves fully.

We reviewed the referral and treatment documentation for two patients. These had evidence of staff completing the identity check in accordance with the employer's procedure.

Staff we spoke with had a clear understanding of the patient identification procedure.

We identified there was also a Trust wide patient identification policy (Green 68), which had passed its review date. We highlighted this to senior staff, who agreed to check whether this policy was still needed given the other written procedure was in place. This was dealt with before the end of the inspection.

Individuals of Childbearing Potential (Pregnancy Enquiries)
There was a suitable employer's written procedure in place for making enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding.

Language used within the written procedure considered the diversity of the gender spectrum in the population. In addition, the written procedure included reference

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to the Inclusive pregnancy status guidelines for ionising radiation: Diagnostic and therapeutic exposures[3].

The employer's written procedure clearly addressed the situation where the individual may not be able to respond to the pregnancy enquiry.

The sample of referral and treatment documentation we reviewed evidenced operators had made enquiries regarding the pregnancy status of individuals in accordance with the employer's written procedure.

Staff we spoke to were able to describe the action they would take to make pregnancy enquires of individuals. This was consistent with the employer's written procedure.

Benefits and Risks
Suitable arrangements were described for providing patients with adequate information on the benefits of having the exposure and the risks associated with the radiation dose. We were told this information was provided to patients during discussions as part of the consent to treatment process.

Written information leaflets were also provided to patients to help support these discussions and a copy of the written consent form was also available for patients.

All respondents who completed a HIW patient questionnaire (42/42) told us they had been given enough information to understand the risks and benefits of their treatment.

Clinical Evaluation
There were suitable employer's written procedures for the evaluation of each exposure performed at the radiotherapy planning, verification, and treatment stages of the patient's care pathway.

We identified there was a Trust wide policy for providing a clinical evaluation of a medical exposure (Green 48), which had passed its review date. We highlighted this to senior staff, who agreed to check whether this policy was still needed given the other written procedures were in place. This was dealt with before the end of the inspection.

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[3] https://www.sor.org/getmedia/1d256f96-40cb-4eeb-b120-90fe27daf7e9/Inclusive-Pregnancy-Status-Guidelines-for-Ionising-Radiation_LLv2

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Non-medical Imaging Exposures
The employer's written procedures clearly stated non-medical imaging exposures were not performed at the department.

Employer's Duties - Clinical Audit
We were told there was a department within Velindre Cancer Centre specialising in clinical audit.

We were provided with examples of clinical audits that had been carried out and we saw a multidisciplinary approach had been used. We identified this as noteworthy practice. A programme for clinical audit was in place.

When asked how the outcomes of the clinical audit have influenced or changed practice, we were provided with a positive example in relation to stereotactic ablative body radiotherapy (SABR) treatment for oligometastatic prostate.

Employer's Duties - Accidental or Unintended exposures
There was a suitable employer's written procedure in place for the reporting, recording, investigating and the analysis of significant accidental or unintended exposures involving radiation. This clearly described individuals' roles and responsibilities and the thresholds for when such incidents were required to be reported. The arrangements for informing the referrer, practitioner and the patient were also well described in the written procedure.

We identified noteworthy practice in relation to the management of accidental and unintended exposures. This extended to the study of risk of accidental or unintended exposures.

The majority of staff who answered the questions in the HIW questionnaire told us their organisation encourages them to report errors, near misses and incidents (86/87), treats staff who are involved in incidents fairly (68/85), takes action to ensure they do not happen again (76/87) and gives feedback to staff about changes made in response to incidents (73/87).

Duties of Practitioner, Operator and Referrer
Staff we spoke with demonstrated a good understanding of their duty holder roles and responsibilities under IR(ME)R 2017. However, documentation we reviewed showed that not all the Clinical Oncologists had confirmed they had read the employer's written procedures. This meant we could not be fully assured this group of staff were aware of the correct employer's written procedures they needed to follow. **The employer is required to provide HIW with details of the action taken to show Clinical Oncologists have read the employer's written procedures relevant to their roles.**

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The employer had suitable written procedures in place for managing referrals to the department. Senior staff also described a suitable process for making referrals to the department. Suitable processes were also described for prioritising and cancelling referrals.

We saw an electronic referral system was in place and this included mandatory fields for completion, which ensured referral documentation was complete before being received by the department.

We reviewed the referral records for two patients and saw these had been completed fully and in accordance with the established referral guidelines. Senior staff described suitable arrangements for conducting IR(ME)R audits and shared three examples demonstrating the audit process.

Justification of Individual Exposures
Suitable arrangements were described for the justification and authorisation of each exposure performed at the radiotherapy planning and re-planning, verification, and treatment stages of the patient's care pathway. There was also a suitable employer's written procedure and protocols in place in relation to justification.

The sample of referral documentation we reviewed had evidence of the exposure having been justified by the practitioner, demonstrated by them signing the form.

Optimisation
A suitable employer's written procedure and protocols were in place in relation to the optimisation of exposures performed for treatment planning, positional verification for radiotherapy treatment and monitoring purposes. These included optimising exposures to children, exposures involving high doses, and to individuals in whom pregnancy cannot be excluded.

We identified noteworthy practice in relation the optimisation of exposures from CT and CBCT scans. The department had applied national dose reference levels to their CT scanning protocols and had developed local dose reference levels for commonly used CBCT scanning protocols.

Suitable arrangements were described to involve a Medical Physics Expert (MPE) in the optimisation of exposures.

Paediatrics
Suitable arrangements were described for the treatment of paediatric patients. We were told specific written protocols were in place for the treatment of children.

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We were told treatment plans would be discussed with the Clinical Oncologist at the treatment planning stage.

Carers or Comforters
The local rules included a statement to reflect carers or comforters are not allowed to remain with patients during any medical exposures. This should be included in the employer's procedures. **The employer is required to provide HIW with details of the action taken to revise the employer's written procedures to show carers or comforters are not allowed to remain with patients during any medical exposure.**

Expert Advice
We confirmed the employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R. Each MPE had a clearly defined scope of practice.

Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in, and provide advice on, medical exposures performed at the department.

Equipment: General Duties of the Employer
The employer had a quality assurance programme in respect of the equipment used in the department. We saw quality assurance procedures included the treatment planning and the operation management systems. We identified this as noteworthy practice.

We reviewed the quality assurance schedule for the equipment, and we saw this was generally up to date. However, we saw the annual checks for two pieces of equipment had not been recorded on the electronic record system. Staff confirmed these checks had been completed but the system had not been updated. In addition, the record did not show the rationale for the decision made to safely delay checks to ensure continuity of the radiotherapy service. **The employer is required to provide HIW with details of the action taken to update the electronic system in a timely manner when equipment checks have been completed and to show the rationale where a decision is made to delay annual equipment checks.**

We confirmed the employer had suitable arrangements in place to improve inadequate or defective equipment. This involved processes for identifying, reporting and escalating equipment faults to senior staff and taking corrective action, including removing equipment from service.

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A suitable process was described for the assessment of patient dose following each exposure performed at the radiotherapy planning, verification, and treatment stages of the patient's care pathway.

An up-to-date equipment inventory was available, and this contained the information required under IR(ME)R 2017.

Safe

Risk Management

Generally, the environment appeared well maintained and in a good state of repair. However, we saw some areas of the floor in corridors was visibly damaged or worn. This may present a trip hazard. **The Trust is required to provide HIW with details of the action taken to repair or replace areas of the floor which are visibly worn and presenting a hazard.**

We did not identify any other obvious hazards to the health and safety of staff working in the department or to patients and other individuals visiting the department.

Most staff who answered the question in the HIW questionnaire (64/93) told us they were content with the efforts made by their organisation to keep them and patients safe.

The department was signposted from the main entrance of the hospital, and we found the signs generally easy to follow. A second designated entrance to the department was also signposted. The department was located on the ground floor making it accessible to patients using both the hospital's main entrance and the department's entrance.

The majority of respondents who completed a questionnaire (39/42) told us they were able to find the department easily. However, some (3/42) told us they were not able to find it easily.

We saw waiting areas were of a suitable size, and sufficient seating was provided for the numbers of patients attending the department. We also saw chairs of various heights, some with armrests, were available. We identified this as noteworthy practice as it meant these may provide a higher level of comfort to patients and also make it easier for patients with mobility impairments to sit down and get up from a seated position more easily.

We saw signage clearly displayed to alert patients and visitors not to enter controlled areas when radiotherapy treatment was being given.

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Infection Prevention and Control (IPC) and Decontamination

All areas of the department we saw were visibly clean and tidy and the equipment we saw was also clean.

Suitable handwashing and drying facilities were available and hand sanitising stations were located throughout the department. Personal protective equipment (PPE) was readily available for staff to use.

At the time of our inspection, we were told general precautions, previously in place to reduce the spread of COVID-19, were no longer mandatory and had been removed. However, we were told face masks were available to both staff and patients who wished to continue wearing them according to their needs and preference. We saw these were readily available, together with hand sanitiser, at the main entrance of the department. We were also told that staff would still be required to take precautions to reduce the spread of COVID-19 and other infections when treating patients with suspected infections or patients susceptible to infections.

The majority of respondents who completed a HIW patient questionnaire (35/42) told us they felt infection prevention and control measures, such as staff wearing masks and staff washing hands, were being followed. The remaining respondents told us either measures were sometimes/partially being followed (6/42) or they were not being followed (1/42). Similar responses were received regarding the cleanliness of the department. The majority of respondents (35/42) felt the department was very clean, with the remainder feeling the department was fairly clean (6/42) or not very clean (1/32).

The majority of staff who completed the questions in the HIW questionnaire told us their organisation implements and effective infection control policy (81/86), there is an effective cleaning schedule in place (73/87), appropriate PPE is supplied and used (85/86) and the environment allows for effective infection control (76/87).

We were told Infection Prevention and Control training formed part of the Trust's mandatory staff training programme. Data provided to HIW showed very good staff compliance with this training.

Safeguarding of Children and Safeguarding Adults

Staff we spoke to were aware of the Trust's safeguarding policies and procedures and where to access these. Staff were also able to describe the actions they would take should they have a safeguarding concern.

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We were told Safeguarding training formed part of the Trust's mandatory staff training programme. Data provided to HIW showed good staff compliance with this training.

The majority of staff who answered the questions in the HIW questionnaire (81/87) told us they would know how to report a concern about unsafe practice and would feel secure in doing so (66/87). However, responses were more mixed when asked whether they felt confident the organisation would address the concerns, with just under half (40/87) telling us they were and the remainder either telling us they were not (27/87) or they didn't know (20/87). **The Trust is required to provide HIW with details of the action taken to assure staff that when they report concerns about unsafe practice, the organisation will address these.**

Effective

Record Keeping
The sample of referral and treatment records we reviewed had a clear layout and had been completed in full.

The records showed evidence of the employer's written procedures being followed by staff, such as those in relation to patient identification checks and confirmation of pregnancy status.

Efficient

Efficient
Senior staff described patient care pathways were kept under continuous review as part of the service improvement and efficiency process.

We were also told work was ongoing to refine the number of planning and treatment vendor systems in use, so as to improve the consistency of approach and efficiency of the service.

At the time of our inspection, work was progressing with a new radiotherapy department as part of the development of cancer services in South East Wales. We were told this provided an opportunity to improve efficiency in delivering the radiotherapy service. Some staff we spoke with also told us how they had been involved in the planning and decision making for the new department.

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Quality of Management and Leadership

Staff Feedback

Responses received through HIW questionnaires were mixed. While over half the staff would recommend their organisation as a place to work, few staff felt there were sufficient staff for them to do their job properly.

The Trust is required to provide HIW with details of the action taken to address the less favourable staff comments described in this report.

Staff comments included the following:

"We do manage well as a team regardless of the time pressures, workload and staff shortages. But each week the stress of work is increasing due to the number of patients, reduced staff and not enough scanners."

"At this point in time staff morale is at an all time low, and many staff are reaching the point of burnout. Staff are under incredible stress, pressure and worry as there are huge capacity issues in conjunction with staffing issues. Staff do not feel supported at this time and are being worked to breaking point in order to meet patient demands. Staff are on a regular basis working overtime to treat patients due to delays throughout the day, causing increased tiredness and stress for staff. This is also having huge impacts on staffs' work/life balance..."

"Staff really care about the service they provide for patients and always try to go above and beyond - this is evidenced in the feedback patients give us verbally about their treatment and care."

"I think leadership/management for our med phys department is very strong. Managers are approachable, easy to communicate with and are fair in decisions they make. I enjoy working here and feel like I'm supported well to do my job. That being said, I do think our department is over-worked and I think this increases staff stress and could cause risks/delays to patient treatment..."

"Staff are made to feel unappreciated. Whenever change is required e.g. extending working days due to capacity, it is suggested staff are involved but ultimately never listened too - management make decisions without caring and there is no empathy or thought to the effect it has on staff..."

"It often feels that the organisation's primary focus is reaching targets and numbers of patients without considering the impact on patient care as pushing capacity is resulting in poor patient experience due to long waiting times and machine breakdowns."

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Leadership

Governance and Leadership

The Chief Executive of the NHS Trust was the designated employer under IR(ME)R. They had overall responsibility for ensuring the regulations are complied with. Where appropriate the employer had delegated tasks to other professionals working in the Trust to implement IR(ME)R.

Senior staff submitted details of the organisational structure. Clear lines of reporting and responsibilities under IR(ME)R were described and demonstrated.

The self-assessment form completed by the department ahead of the inspection was submitted within the agreed timescale and was comprehensive. All staff engaged fully with the inspection process and managers demonstrated a commitment to acting on HIW's inspection findings, making improvements where needed.

The organisational structure included a Clinical Lead and a Professional Lead, however, we were told these positions were vacant at the time of our inspection. In addition, interim arrangements were in place for the Radiotherapy Services Manager and their Deputy. **The Trust is required to provide HIW with details of the action taken to recruit to Clinical Lead, Professional Lead, Radiotherapy Services Manager and Deputy positions.**

Senior staff described the arrangements in place to monitor the quality and safety of services provided in the department and to provide assurance to the Trust as part of the governance and monitoring arrangements.

Over half of the staff who answered the question in the HIW questionnaire (55/93) told us they would recommend their organisation as a good place to work. The remainder of staff told us they would not. Most staff who answered the question (57/93) told us their organisation was supportive, with the remainder (36/93) disagreeing with this.

Responses were mixed regarding the organisation supporting staff to identify and solve problems, with around half of staff who answered the question (47/93) agreeing with this and the reminder disagreeing. Most staff (59/92) who answered the question told us they did not agree their organisation takes swift action to improve with few staff (33/92) agreeing.

The majority of staff who answered the question in the HIW questionnaire (74/93) told us the care of patients is their organisation's top priority, with the reminder disagreeing (19/93) with this.

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When asked about their immediate manager, most staff who answered the question in the HIW questionnaire (61/89) told us their immediate manager could be counted upon to help them with a difficult task in work, with the remainder disagreeing with this. Over half who answered the question (53/89) told us their manager gave them clear feedback about their work. However, the remainder disagreed. Less than half who answered the question (43/89) told us their manager asks for their opinion before making decisions that affect their work, with the remainder (46/89) disagreeing.

When asked about senior managers, over half the staff who answered the question (49/89) felt they were visible. Most staff (63/88) also told us senior managers were committed to patient care. However, few staff (33/88) felt communication between senior management and staff was effective.

Workforce

Skilled and Enabled Workforce
A range of staff worked in or on behalf of the department and included Clinical Oncologists, Clinical Oncology Registrars, Consultant/Advanced Practice Radiographers, Radiographers, MPEs, Clinical Scientists, Dosimetrists and Clinical Technical Officers. The department also provided clinical placements for Radiotherapy and Radiotherapy Physics students.

It was evident the staff team was committed to providing a good service and were patient focussed.

Senior staff reported there were some long term vacancies at the time of the inspection in relation to Radiotherapy and Physics staff, which would need to be recruited to meet recommendations made by relevant professional bodies.

Most staff who answered the question in the HIW questionnaire told us there were not enough staff for them to do their job properly (61/93), with just over half feeling they were able to meet the conflicting demands on their time at work (49/94). While most staff who answered the question in the HIW questionnaire told us their job was not detrimental to their health (56/88), there were some who disagreed (32/88). Similar responses were received regarding being able to achieve a good work life balance and the organisation taking positive action on staff health and wellbeing. The majority of staff were aware of the Occupational Health support available to them (66/88).

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Most staff who answered the questions in the HIW questionnaire told us they had adequate materials, supplies and equipment to do their job (62/94) and they were able to access ICT systems they needed (68/93).

We reviewed the training records in relation to IR(ME)R for three staff. These demonstrated staff had completed suitable training relevant to their duty holder roles as practitioner and operator, and relevant to their specific area of practice. The records showed clear evidence of assessing competence, evidence of entitlement and their scope of practice. We also found there was a suitable system to identify when reviews had taken place to take account of an individual's change in scope of practice or before they used new equipment.

We saw a new approach was used for recording MPE training in relation to Brachytherapy. These clearly set out individuals' scope of practice, and consideration should be given to using this approach for other teams.

We also reviewed data showing staff compliance with the Trust's mandatory training programme. Staff were expected to complete training on a range of topics relevant to their role. The data showed a good level of staff compliance with mandatory training.

The majority of staff who completed a HIW questionnaire told us they felt they had appropriate training to perform their role (74/94). The remainder either answered with 'partially' (18/94) or told us they had not had appropriate training (2/94). When asked what other training they would find useful, staff comments included:

> *"My role specific training has been excellent and equips me appropriately. However, I would like some more quality improvement, project planning and leadership training to allow me to progress further."*
> *"Future training in IRMER forms for role."*
> *"Local training around managing machine delays/patient comfort available."*
> *"Updated imaging problem solving training, training towards service improvement to ensure best quality treatment and techniques for patients."*

Other comments also included:
> *"The new IT changes (DHCR and all tasks within that) would have benefited from better training - we've had to have additional training after their introduction. We also now have Raystation - I have had no training on that at all."*

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"It would be useful to have time offset to undertake training. However, due to staff shortages and huge capacity issues it is currently impossible to be released to undertake any training, CPD or keeping up to date with mandatory training requirements."

"More time for training as a team would be helpful."

The data provided to us also showed the majority of staff had received an appraisal of their work within the last 12 months. The majority of staff who completed a HIW questionnaire (82/94) also told us they had an appraisal of their work.

Culture

People Engagement, Feedback and Learning

We saw posters with a QR code prominently displayed in the department. These allowed patients with suitable mobile devices, such as mobile phones with cameras, to provide feedback or make a complaint. We also saw an electronic tablet was available in the main waiting area for patients to use to provide feedback. There was no information displayed on other organisations patients can contact for help and advice on making a complaint. However, we were told this was available on request.

When asked whether they would know how to complain, 50% of respondents who completed a questionnaire (21/42) told us they would and 50% told us they would not. **The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.**

A 'You Said, We Did' notice board was in the main waiting area. While the intention is for this board to show patients and visitors the feedback received and the action taken by the department in response, we felt information in this regard was limited. **The Trust is required to provide HIW with details of each action taken to improve the information available on how the department has acted on patient feedback received.**

When asked whether patient experience feedback is collected within the department, most staff who answered this question in the HIW questionnaire (68/92) told us it was. The reminder either told us it was not (2/92) or they did not know (22/92). **The Trust is required to provide HIW with details of the action taken to improve staff awareness of the system for seeking patient feedback.**

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When asked whether they receive regular updates on patient feedback, most staff who answered the question told us they did (59/92).

Senior staff were aware of the Duty of Candour and described changes had been made to incident reporting forms to reflect the Duty requirements. We were told engagement sessions for staff had been delivered and training had recently been introduced. We were also told resources for staff were available on the Trust's intranet.

Generally, staff we spoke to were aware of the Duty of Candour and confirmed they had received information on its implementation.

The majority of staff who answered the questions in the HIW questionnaire told us they understood the Duty of Candour (77/81), they understood their role in meeting the associated standards (73/79) and their organisation encouraged them to raise concerns and share this with the patient (72/81). The remainder disagreed.

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4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

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Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Radiotherapy Department, Velindre Cancer Centre

Date of inspection: 10 and 11 May 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate improvement plan required.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

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Appendix C – Improvement plan

Service: Radiotherapy Department, Velindre Cancer Centre

Date of inspection: 10 and 11 May 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The Trust is required to provide HIW with details of the action taken to review the area used for Brachytherapy to determine whether further environmental changes can be made to help promote patients' dignity and privacy.	Standard - Person Centred			
The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration	Standard - Equitable			

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the needs of the patient population.				
The Trust is required to provide HIW with details of the action taken to: • encourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh • to consistently ask patients to confirm their preferred language.	Standard - Equitable			
The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint protocols, taking into account relevant guidance	IR(ME)R - Regulation 6 (5)(a)			
The employer is required to provide HIW with details of the action taken better reflect the	IR(ME)R - Regulation 11 (1)(d)			

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governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy document.				
The employer is required to provide HIW with details of the action taken to better reflect the entitlement of Clinical Oncologists in the local employer's written procedures.	IR(ME)R Regulation 6 (1) (a) and Schedule 2 (1)(b)			
The employer is required to provide HIW with details of the action taken to show Clinical Oncologists have read the employer's written procedures relevant to their roles.	IR(ME)R - Regulation 6 (2)			
The employer is required to provide HIW with details of the action taken to revise the employer's written procedures to show carers or comforters are not allowed to remain with patients during any medical exposure.	IR(ME)R – Regulation 6 (1)(a) Schedule 2 (1)(n)			

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The employer is required to provide HIW with details of the action taken to update the electronic system in a timely manner when equipment checks have been completed and to show the rationale where a decision is made to delay annual equipment checks.	IR(ME)R - Regulation 15 (3)			
The Trust is required to provide HIW with details of the action taken to repair or replace areas of the floor which are visibly worn and presenting a hazard.	Standard - Safe			
The Trust is required to provide HIW with details of the action taken to assure staff that when they report concerns about unsafe practice, the organisation will address these.	Standard - Safe			
The Trust is required to provide HIW with details of the action taken to address the less	Standard - Workforce			

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favourable staff comments described in this report.				
The Trust is required to provide HIW with details of the action taken to recruit to Clinical Lead, Professional Lead, Radiotherapy Services Manager and Deputy positions.	Standard - Leadership			
The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.	Standard - Culture			
The Trust is required to provide HIW with details of the action taken to improve the information available on how the department has acted on patient feedback received.	Standard - Culture			
The Trust is required to provide HIW with details of the action	Standard - Culture			

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taken to improve staff awareness of the system for seeking patient feedback.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role:

Date:

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Appendix C – Improvement plan

Service: Radiotherapy Department, Velindre Cancer Centre

Date of inspection: 10 and 11 May 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The Trust is required to provide HIW with details of the action taken to review the area used for Brachytherapy to determine whether further environmental changes can be made to help promote patients' dignity and privacy.	Standard - Person Centred	Environmental review already completed and determined Swipe access door controls required	Infrastructure and Design Manager	31st October 2023
		Door replacements being installed within 4-6 weeks	Infrastructure and Design Manager	31st October 2023
		Access control permissions to be developed into a Standard Operating Procedure (SOP)	Infrastructure and Design Manager	31st October 2023
		Communication of revised access control permission to	Infrastructure and Design Manager	31st October 2023

		staff in Velindre Cancer Centre		
The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration the needs of the patient population.	Standard - Equitable	Trust Radiotherapy Team are working with Wales Cancer Network (WCN) and the other Wales Radiotherapy centres to review current patient information leaflets in use with the view to reduce duplication, have consistency and to ensure availability in English, Welsh and other core languages aligned to the needs of the patient population Gap analysis of information leaflets currently in use and available is underway	Radiotherapy Service Manager	Meeting arranged for September 2023 with Wales Cancer Network to review patient population requirements. 31st January 2024 revised information to be available in language requirements identified

The Trust is required to provide HIW with details of the action taken to: - encourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh - to consistently ask patients to confirm their preferred language.	Standard - Equitable	Lanyards are not permitted within clinical areas due to infection risks Corporate communications to release periodic update reminders to all staff to wear Iaith gwaith badge if Welsh Speaking and able to converse in Welsh or Welsh learner badge if learning to speak Welsh	Welsh Language Officer / Corporate Communication team	Initial Communications 31st July 2023
		Uniforms with embroidered with Iaith gwaith logo to be sourced and provided to all Welsh speaking staff	Radiotherapy Services Manager	31st January 2024

| | | Baseline audit to be undertaken to assess current level of information gained on language preference, and detailed actions to target specific aspect of patient pathway to follow.

Implement changes based on the audit findings and follow with a review to ensure patients are asked to confirm their preferred language. | Deputy Radiotherapy Service Manager

Radiotherapy Oncology Lead | 31st January 2024 |
|---|---|---|---|---|
| | | Investigate most appropriate information system location to indicate preferred language | Deputy Radiotherapy Service Manager

Lead Radiotherapy Clinical Oncologist

Deputy Head of Radiotherapy Physics | 30th August 2023 |
| **The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint** | IR(ME)R - Regulation 6 (5)(a) | Update all joint Clinical protocols and update format more in keeping with template included in Ionising radiation Medical Exposure) Regulations: | Radiotherapy Clinical Governance Manager

Deputy Head of Radiotherapy Physics | 1st document to be ready for January 2024 document issue |

		Implications for clinical practice in radiotherapy. Guidance from the radiotherapy board. Starting with Joint breast protocol in preparation for treatment on Halcyon then each document to be updated at annual review. Each joint Clinical protocols will be updated on rolling monthly update and complete within one year		
protocols, taking into account relevant guidance				All Joint protocols expected will be updated by 31st July 2024
The employer is required to provide HIW with details of the action taken better reflect the governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy document.	IR(ME)R - Regulation 11 (1)(d)	Update IR(ME)R in RT document to include governance arrangements for research trials	Radiotherapy Clinical Governance Manager	30th November 2023
The employer is required to provide HIW with details of the action taken to better reflect the entitlement of Clinical	IR(ME)R Regulation 6 (1) (a) and	Update IR(ME)R in RT document to include the entitlement of Clinical Oncologists in the local	Radiotherapy Clinical Governance Manager	30th November 2023

Oncologists in the local employer's written procedures.	Schedule 2 (1)(b)	employer's written procedures.		
The employer is required to provide HIW with details of the action taken to show Clinical Oncologists have read the employer's written procedures relevant to their roles.	IR(ME)R - Regulation 6 (2)	SOP to be developed to define process for monitoring, follow up and escalation of any non-compliance with the SOP	Clinical Director / Clinical Oncologist Lead for Radiotherapy	31st October 2023
		IRMER training to be moved to ESR to provide a more reliable and robust method of monitoring compliance	Clinical Director / Clinical Oncologist Lead for Radiotherapy	31st October 2023
The employer is required to provide HIW with details of the action taken to revise the employer's written procedures to show carers or comforters are not allowed to remain with patients during any medical exposure.	IR(ME)R – Regulation 6 (1)(a) Schedule 2 (1)(n)	Update IR(ME)R in RT document by adding a statement to show carers or comforters are not allowed to remain with patients during any medical exposure	Radiotherapy Clinical Governance Manager	30th November 2023
The employer is required to provide HIW with details of the action taken to update the electronic system in a timely	IR(ME)R - Regulation 15 (3)	A simplified process is to be established to ensure engineering equipment tasks are logged within the	Deputy Head of Radiotherapy Physics	31st October 2023

manner when equipment checks have been completed and to show the rationale where a decision is made to delay annual equipment checks.		electronic system in a timely manner. This will include the addition of a simple check box		
		The machine QA procedure is to be updated to include the process to be followed when a decision is made to rearrange scheduled preventative maintenance and QC. If a decision is made to rescheduled a service or Quality Control (QC) review, then the rearranged (QC) or service, will be scheduled for a date as soon as reasonably practicable. This will trigger a concession raised in the Q-Pulse Quality Management System containing the justification for the postponement	Deputy Head of Radiotherapy Physics	31st October 2023

The Trust is required to provide HIW with details of the action taken to repair or replace areas of the floor which are visibly worn and presenting a hazard.	Standard - Safe	Estates to review all flooring for any hazards and make safe	Estates Manager	30th August 2023
The Trust is required to provide HIW with details of the action taken to assure staff that when they report concerns about unsafe practice, the organisation will address these.	Standard - Safe	Set up a reactive focus group to discuss and address staff concerns when they arise. Safety concerns outside of our control will be escalated and timely responses back to staff	Radiotherapy Services Manager Clinical Director Head of Radiotherapy Physics	30th August 2023
		Psychological safety and safe reporting to be included on agendas for all staff meetings	Radiotherapy Services Manager Clinical Director Head of Radiotherapy Physics	30th August 2023
		Trust Safe Care Collaborative leadership priority identified as enhancing psychological safety across the Trust. An element of this is to engender a positive reporting culture	Executive Team	Long term culture change programme commenced in April 2023

The Trust is required to provide HIW with details of the action taken to address the less favourable staff comments described in this report.	Standard - Workforce	All disciplines to review all staff comments on report, consider the different views and identify any associated follow up if not addressed elsewhere in existing work plans	Radiotherapy Services Manager	30th August 23
		Set up an MDT group consisting of representation of all three disciplines to address comments, amend processes and discuss feedback to staff. Produce an action plan for immediate commencement of delivery reflecting differences for different staff groups.	Clinical Director Head of Radiotherapy Physics Radiotherapy Services Manager	30th September 2023
		Address specific actions within own department as appropriate	Clinical Director Head of Radiotherapy Physics Radiotherapy Services Manager	All outcomes from actions to complete 31st December 23

The Trust is required to provide HIW with details of the action taken to recruit to Clinical Lead, Professional Lead, Radiotherapy Services Manager and Deputy positions.	Standard - Leadership	RSM and DRSM posts undergoing job evaluation for JDs and active recruitment. Finalise the new approach to clinical leadership to update current approach and finalise the approach to ensuring robust professional leadership roles are sufficient and aligned appropriately	Head of Radiation Service Director of Cancer Service	30th August 2023 30th October 2023
The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.	Standard - Culture	Work ongoing with Velindre Quality and Safety Team to improve CIVICA access. Discussions ongoing regarding increasing the size/access of the touch screen terminal in RT reception. Potential second screen in pre-treatment area to promote feedback opportunity	Radiotherapy Services Manager	30th October 2023
		Develop and issue updated patient leaflet regarding sharing thoughts, opinions, and concerns	Deputy Radiotherapy Service Manager	1st August 2023

		Make leaflet available in all RT pathway patient contact points	Radiotherapy Clinical Governance Manager	1st August 2023
		Trust wide how to raise a concern poster to be developed and provided to each department	Head of Quality & Safety	31st August 2023
		Review opportunity for poster display across the service for Trust wide how to raise a concern poster and other appropriate organisations, particularly Llais	Radiotherapy Clinical Governance Manager	30th August 2023.
The Trust is required to provide HIW with details of the action taken to improve the information available on how the department has acted on patient feedback received.	Standard - Culture	We have reviewed the 'you said, we did' notice areas. We will be enlarging the area and developing large display boards and reviewing publications in a range of languages following the assessment of population language distribution.	Radiotherapy Services Manager	30th September 2023

The Trust is required to provide HIW with details of the action taken to improve staff awareness of the system for seeking patient feedback.	Standard - Culture	Radiotherapy Clinical Governance Manager to work with Information and Support Radiographer and the radiotherapy department Patient support group, to improve staff awareness of the system. This will be shared with staff through targeted information sharing sessions, covering why it is so important and how we collect patient feedback, and how we respond to it	Radiotherapy Clinical Governance Manager	1st December 2023
		Issue updated patient leaflet regarding sharing thoughts, opinions, and concerns and share with staff via Radiotherapy weekly update how to access and share this information with patients	Radiotherapy Clinical Governance Manager	1st August 2023

		Patient feedback to be discussed at each radiotherapy staff meeting, and shared through departmental meetings and SST leads	Radiotherapy Service Manager Deputy Radiotherapy Service Manager Clinical Director	30th October 2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Nicola Williams**

Job role: **Executive Director of Nursing, AHP's & Medical Scientists**

Date: 14/07/2023

External Peer Review of the Intravenous Access Service at Velindre Cancer Centre.

Date: 27th and 28th June 2023

**Reviewer: Vicky Watkins
Lead IV Access
Practitioner
Aneurin Bevan Health
board**

Introduction

This document outlines the findings and recommendations of the external peer review of the PICC service at Velindre Cancer Centre. The findings described are primarily based upon documentation provided by Velindre Cancer Centre, the site visit which took place on June 27th and 28th together with prior and subsequent communications.

The following abbreviations will be used throughout the document:

PICC – Peripherally Inserted Central Venous Catheter
VCC – Velindre Cancer Centre
USS – Ultrasound Scan
CXR – Chest X-ray
IV – Intravenous
ECG – Electrocardiogram
WTE – Whole Time Equivalent
ABUHB – Aneurin Bevan University Health Board
MRSA – Methicillin Resistant Staphylococcus Aureus
HCSW – Health care support Worker
SOP – Standard Operating Procedure
SACT – Systemic Anti-Cancer Therapy
VAS – Vascular Access Service
VA – Vascular Access

Quality, Safety and Clinical Governance

The quality, safety and governance procedures were reviewed and considered to be excellent with no current areas of risk.
The documentation is comprehensive and appropriate.
The consent process is thorough and documented accordingly.
Patients seem entirely understanding of the process and are aware of what to expect and how to get in contact should things go wrong.
No evidence of ongoing clinical audit was seen at the site visit. The current staffing levels and level of demand mean that CPD and clinical audit is challenging.

Improvement

The primary issue identified is the ongoing, increasing demand putting at risk the timely access to PICCs for the patients and therefore urgent consideration is suggested to increase capacity.
The insertion method is out of date and time consuming. The use of an ultrasound machine and a Chest X-ray to confirm the PICC tip is slow and laborious. There are alternative options to insert PICCs which are considered much more time efficient such as ECG tip confirmation systems (which tell the inserted the tip position in real time using electrodes) or Fluoroscopy (use of live x ray equipment to visualize in real time the placement of the PICCs).

ECG Confirmation system- There are a few products available on the market which each have pros and cons ABUHB has used two ECG systems; Vygon's PILOT tip location system and BD Sherlock 3ECG tip confirmation system. These systems occasionally require a Chest X-ray; however, this is not mandatory practice for every PICC placement making the method more time efficient. (roughly 1 in

10 require a CXR down from 100% using current method).

Policies and procedures

There is an all-encompassing SOP for PICC lines including: referral, booking, placement, and aftercare. This SOP has been seen to be adhered to and is considered safe and appropriate, but improvements could be made. The SOP makes provision for looking after the PICCs in the community with early communication with the district nurses.
Specific infection control policies were not reviewed during this visit, but no concerns were raised regarding this.

Operational Leadership and Effectiveness

The unit is operational Monday to Friday 0900-1700 (constrained primarily due to the operational hours of routine radiography). The service was originally predicted to provide up to 4 PICC placements per day.
Historically the PICC placement clinic was open 3 days a week and has been increased to 5 days a week to manage the rising demand. Despite this expansion, the continuing increase in demand means that additional placements are now performed routinely with 5 PICCs a day being common and 6 not unusual.

There is an out of hours PICC troubleshooting provision at VCC. The ambulatory unit is open 8am-8pm Monday to Friday and 9am – 3pm Sunday. Patients with PICC complications are reviewed. Patients are seen in a prompt manner and a plan is efficiently put in place. If the patient requires diagnostic imaging, for example a doppler scan to exclude thrombosis, this happens without delay.

VCC has a 24/7 treatment helpline available for patients. The triage nurse will direct the patient to the most appropriate centre depending on the concern. This pathway was observed to work extremely well during the visit, which is excellent and a credit to you.

The VAS is nurse lead and held within the governance structure of the Integrated Care operational division, alongside ambulatory, first floor inpatient ward and theatres. The booking office is under managed under the division of SACT and Medicines Management.

PICC lines are inserted by 2.6 WTE Band 7 nurses, Monday - Friday. Band 3 and Band 4 staff can perform care and maintenance on PICCs and have been trained to flush the lines using a pre-filled posi-flush 0.9% 10mls. This practice appears to have been disseminated through the entire Cancer Centre with staff observed to be competent and comfortable with delivering care for patients with PICC in situ – this is to be commended. This practice helps to free up the VAS nurses to review more complex patient concerns and is entirely appropriate.

Staff groups within VCC rely on the VAS for simple troubleshooting and cannulations, it is suggested that you explore the option of having practitioners of a lower banding available to support simple troubleshooting to maximise the band 7 PICC placers usefulness. This is a model which has been employed elsewhere locally with great success.

The VAS are highly specialised oncology nurses with expert knowledge and were observed to work exceptionally well together. The structure of the working day comprises of one nurse inserting the PICCs and the other nurse 'holding the pager' and responsible for all troubleshooting queries,

ranging from giving advice over the telephone, arranging for patients to attend the ambulatory care unit for treatment or assisting in outpatients. The quantity and complexity of the phone calls vastly range. From my observations, the addition of an experienced support worker as described above would benefit this team. The external and internal queries can be filtered and delegated to the most appropriate member of the team. This would enable the other band 7 member of staff to either instate an additional PICC placement list or have the appropriate time to problem solve the complex issues.

The aftercare support for the patient is very responsive. There is an ambulatory care unit available for the vascular access team to utilize when necessary. However, I am unsure if this space is protected for their patients or only if capacity allows it.

Representation of the service within the wider VCC management structure

The VAS is managed by a different division of the booking department (which books the PICCs). Patients are booked into the next available PICC appointment by following the PICC service template. The booking system is overly complex and is reliant on staff to consistently monitor templates on 5 units; including VCC, Prince Charles and Neville Hall hospital (this monitoring is to try to ensure that treatment is not delayed due to lack of a PICC).

Patients will attend clinic to be consulted and reviewed by the oncology consultant. A decision is made at this point whether the patient will require a PICC depending on their treatment plan. The patient will be consented informally for this procedure at this stage. The referral for a PICC is made at this stage of the process, whereby a note is made in the clinic note stating any additional requirements for the patient needed. Treatment may be delayed if the next available appointment for a PICC insertion is later than the specified target for that treatment. 4 PICC appointments are scheduled for each day. The booking office will highlight if the patients treatment may be delayed due to the PICC. The VAS will accommodate urgent patients on an individual basis as previously described.

The booking team reschedule and adjust patient's appointments for a variety of reasons; these may include patient unwell, poor response to treatment or social reasons. This pathway involves a lot of systems to manage. The booking team consists of 8 clerks managing these systems. Staff are designated at the beginning of the week to their role and responsibilities. Clerks will appoint a patient according to their geographical location. Bed spaces for the chemotherapy units are 'blocked' for urgent patients, this enables patients on the emergency pathway to be allocated this space.

Lines of responsibility internally, between staff, and other departments and management.

The VAS are very responsive to trouble shooting of patients with any IV access concerns. The team will troubleshoot cannulations, PICCs, Hickman's and Ports. All band 3 and band 4 support workers have been competently trained to provide care and maintenance of PICCs and flush the lines using a pre-filled posi-flush Sodium Chloride x10mls.

Inpatient, outpatient, ambulatory care, treatment helpline will contact the team to assist with any vascular access concerns. The volume of queries is of a variable quantity and cannot be predicted. At the moment, they are not filtered according to complexity and a band 7 member of the team will respond to each query no matter how straightforward. The utilization of a band 4 member of the

team would be valuable in this circumstance.

Planning

Referrals are made by the oncology consultant in clinic following an appointment with the patient. The treatment plan has been discussed and consent has been given. If the treatment requires a PICC, this is stated in the referral form. In clinic routine bloods are taken and, ideally, an MRSA swab is performed.
If the submission of the referral letter is delayed, the window of opportunity for the PICC to be inserted is greatly reduced.

The target for commencing treatment (which can require a PICC) ranges from 2 days to 21 days. MRSA swabs are required for all patients; however, this decision is overridden for the emergency 2-day programme. If an MRSA swab has not been taken when the patient is in clinic, then the booking department will arrange this. The PICC insertion is dependent on the MRSA result and will take 2 days to process. This process can delay the insertion of a PICC and lead delays to the patient's treatment. Locally, other units do not routinely MRSA swab pre PICC placement, review of this should be considered as it could lead to significant efficiency gains.

Capacity and demand

There is capacity for 104 patients each day to receive chemotherapy on 5 different hospital sites. There are 4 scheduled appointments available for PICC insertions Monday – Friday. Each patient given a 2-hour slot. Demand has increased by 15% from 2021/2 to –2022/3. A waiting list for PICCs is generated when the next available appointment is after the treatment date. The VAS will try to accommodate emergency patients and increase the room capacity to 5 and occasionally 6.
The team comprises of 2.6 band 7 oncology nurses. 1 nurse will be designated PICC placer and insert the PICCs with the support of a HCSW (supplied from another area). The HCSW will input data onto the relevant audits, refer the patient to the district nurse and support the nurse if necessary.
The other nurse will be responsible for all problem solving of PICCs, cannulations, ports and Hickman lines from the community, outpatients, inpatients, and referrals from the chemotherapy treatment line.

Determine optimum service delivery model

It is considered that there are multiple service delivery improvement opportunities. As previously discussed, a band 4 in the team could help with basic troubleshooting and therefore largely free up a band 7 who would be a competent PICC placed to place more lines.
The placement of PICCs could be sped up enormously by using either fluoroscopy or an ECG PICC tip locator device which obviates the need to CXR (the process of which eats a lot of time). It is anticipated that with no other changes – changing to an ECG tip location system rather than routine use of CXR would comfortably double throughput to up to 8 PICCs per day per PICC placer.

Service Delivery

Facilities and equipment

PICC insertions are performed in a designated clinic room with the necessary equipment for placement using this out-of-date method. There is adequate access to an ultrasound machine of appropriate quality. A Chest X-ray is required to confirm the PICC tip before the patient can be discharged. The X-Ray room is next door to the PICC clinic; however, these patients do not take priority and may have to wait to be seen if the radiographers have existing patients to attend to (but even if patients proceed straight to CXR this is time consuming due to the transfers).

If the PICC requires adjusting following a Chest X-ray, they will be seen in the PICC clinic room (then potentially require another CXR).

Patients that are referred into VCC with vascular access concerns have no dedicated space to review patients. These patients may be in the department for several hours depending on the issue. Sometimes this uses up a lot of staff time trying to find an appropriate space to trouble shoot that patients PICC.

Staffing and skill mix – top of license working

From my observations, I think an additional band 4 member of the team will be invaluable. This person would have the ability to filter through the queries and attend to the simple concerns patients and staff on other wards may have. This practice would free up the band 7 nurse to carry out an additional list; physical space pending or spend more appropriate time troubleshooting more difficult problems.

Compliance with guidelines and procedures

The vascular access team are observed to adhere to all guidelines and procedures.

Service workforce, sustainability and development

Following my visit to VCC I think there are few areas that would benefit from development.

The referral pathway – Bookings Team- The bookings team have a large volume of patients to accommodate each day and PICC patients are only a very small proportion of these. The booking system appears incredibly complex with staff having to use multiple screens and windows to complete bookings. Due to the complexity within the system, booking errors are likely to occur as the system is reliant on the booking team filtering through several processes to accommodate patients and their treatments. There have been PICC breaches reported in recent months which I feel are possibly linked to the complex bookings system described above which is potentially causing delays to referrals that are awaiting action and therefore impacting on service capacity and patient experience.

The acquisition of an ECG tip confirmation system will provide the ability to increase capacity (up to double per PICC placer) and reduce the requirement for a Chest X-ray; however, it will not eradicate this requirement for a small cohort of patients (estimated approx. 1 in 10). By using this method, the

VAS would also have the option to increase their operational time as they would not have to mirror the radiographer's working hours.

An additional working space equipped to insert PICCs could double the capacity. By recruiting a band 4 to be the point of contact, this would enable the other band 7 nurse to insert PICCS at least some of the time.

The role of an VA nurse is not only to insert PICCs but to carry out service development, research, CPD, extravasation management and networking. The current staff model does not allow for mandatory CPD, service innovation and supervision.

It is anticipated the service has insufficient capacity to cope with the increase in predicted demand. There is no resilience within the team to cover annual leave, sickness and study leave. The current whole time equivalent establishment does not include the required 26.9% uplift as mandated by the Nurse Staffing Levels (Wales) Act 2016.

Current establishment WTE calculation

Based on a five-day working model Monday to Friday.

FF Ward	Nurses on duty	shift length	days per week	WTE	Headroom	Total
BAND 7 IV Access Nurse PICC Clinic	1	10.5	5	1.4	0.4	1.78
BAND 7 IV Access Nurse Pager Cover	1	10.5	5	1.4	0.4	1.78
RGN Sub-total						**3.55**
Band 3 HCSW PICC Clinic	1	10.5	5	1.4	0.4	1.78
HCSW Sub-total						**1.78**
Nursing Total						**5.33**

Current funded Band 7 IV access nursing posts= 2.6 WTE

Required Band 7 IV access nursing posts= 3.55 WTE

Current Band 7 Deficit = 0.95 WTE

Band 3 HCSW= 1.78 WTE (supplied from FF ward)

Recruitment and retention of staff

The VAS is welcoming and highly specialised in their roles, with a supportive and encouraging management team. The team is invaluable to all the services that require iv access, and a large part of the patients journey through their treatment during this difficult time. There is an ongoing increase in requirements for PICCs and this service is seen as crucial to the running of Velindre cancer center in delivering modern care. Morale would be improved if the VAS felt they had more control over bookings as well as more capacity in order to provide a more timely service.

Future of the service

A new treatment has recently been developed specifically for breast cancer. It has been

recommended for these cohorts of patients to have PICCs at the commencement of treatment. It is predicted this will increase the demand by 200 patients per annum.

Treatments will continue to develop and require reliable IV access. Demand does not appear to decrease, only increase exponentially. Resilience in the system and capacity will promote the future of the service.

Financial constraints

It is accepted that the recommendations within this document require increased revenue costs as well as capital outlay, which in the current financial environment is challenging. However, PICCs are seen to be core to the delivery of current a future oncological treatment and timely placement is essential.

Following this review the Integrated Care Directorate will develop and action plan to monitor progress to improve the current IV Access Service.

Velindre Cancer Centre

Wales Cancer Patient Experience Survey 2021/22

Cancer Centre Report

Contents

1. Executive Summary

The results presented in this report are from the third Wales Cancer Patient Experience Survey (WCPES) which was conducted by IQVIA in 2021/2022, on behalf of Macmillan Cancer Support and the Wales Cancer Network.

The WCPES is designed to measure and understand patient experiences of cancer care and treatment in Wales to help drive improvement both nationally and locally. The findings of the national report, supported by a data dashboard, as well as accompanying Local Health Board and Trust reports, will help us to celebrate what is working well, but also inform further improvements in cancer care by highlighting areas of importance, raised by people living with cancer across Wales. Please note when you read the report you will see that some of the percentages don't total to 100%, this is because of the rounding process used to analyse the data. Please see section in Chapter 7 titled 'Other Reporting Conventions' for more detail.

The COVID-19 pandemic brought unprecedented changes to the delivery of clinical services as a means of reducing the spread of the virus which impacted on the experience of care. As this iteration of the WCPES includes the experiences of those who received treatment from 1st January to 31st December 2020, the additional impact on services and delivery during the COVID-19 pandemic is included. Fewer patients came into hospitals and GP Practices for face-to-face appointments, many consultations were undertaken virtually, and those who attended face-to-face appointments for investigations and treatments, were often asked to do so alone. Whilst this was done in order to comply with national guidance around infection prevention and control, this will have affected experiences.

The impact of the pandemic varied across Health Boards and Velindre at different times depending on the numbers of COVID cases, services, and workforce capacity. As primary care (e.g. access to GP and pharmacy), community services (e.g. health and social care), secondary care (e.g. hospitals and specialist services), and the third sector (e.g. charity support) were all disrupted, significant adaptations to how these services were accessed and delivered were made. This in turn may have affected the sharing of practical, supportive, and holistic information across the cancer pathway, from information being given in person, to needing to rely on postal/ remote/digital approaches.

It is important to recognise the background context of the pandemic when interpreting the report as a means of fully appreciating the circumstances in which patients were reporting their experiences. This report has been produced to accurately reflect what people who experienced cancer care during this time have shared with us. Whilst it does not judge provision of care in any way or indeed rationalise or interpret these responses, reflecting on some of the comments people have shared around the impact of COVID-19, makes for sobering reading in a way that must support continuous learning and improvement. The quantitative and qualitative feedback are considered as being of equal importance and is designed to be read as two parts of one report.

We are hugely grateful to the thousands of people living with cancer who took part in the survey for providing such detailed feedback on their experiences of diagnosis, treatment, and care and we commit to improving experiences in the future.

Headline results

The survey results for Velindre Cancer Centre are positive. **92%** of respondents rated their overall care as 7 or more out of 10 (a slight drop from **95%** when the survey was last carried out in 2016), with only **2%** rating their overall care as between 0 and 3 out of 10 (**1%** in 2016). **88%** said they were always treated with dignity and respect while they were in hospital (**89%** in 2016).

Other positive scores in the survey include:

- **93%** of respondents said they were always given enough privacy when they were being examined or treated

- **94%** of respondents said they were given all the information they needed about their operation

- **92%** of respondents said they were given all the information they needed about their test

- **92%** of respondents said hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

However, in other areas, responses were less positive. These include:

- **48%** were offered the opportunity to discuss their needs and concerns

- **40%** of respondents said their healthcare team completely discussed with them or gave them information about the impact cancer could have on their day-to-day activities (for example, their work life or education)

- **39%** of respondents said their family or someone else close to them definitely had enough opportunity to talk to a healthcare professional

- **31%** of respondents said that, after leaving hospital, they were definitely given enough care and help from their GP and the GP practice

- **29%** of respondents said they had been offered a written care plan

- **25%** of respondents said that, since their diagnosis, someone had discussed with them whether they would like to take part in cancer research (e.g. clinical trials)

Key Workers, Clinical Nurse Specialists and other health professionals

We know from previous iterations of this survey that having access to a Key Worker and a Clinical Nurse Specialist (CNS), is associated with better patient experience across the entire care pathway. In Wales, everyone with a cancer diagnosis should have a named Key Worker and the opportunity to have a supported conversation about meeting their needs.[1]

92% of respondents said they were given the name and contact details of their Key Worker. **66%** of these respondents said that it was easy to contact them. **84%** said that, when they had questions to ask, they got answers they could understand all or most of the time. **77%** said their Key Worker provided them with all the information they needed to make informed decisions about their treatment.

In this survey, **91%** of respondents said their care included access to a CNS, (**81%** reported that their CNS was also their Key Worker, **10%** said their CNS was not their Key Worker). **64%** of the respondents who had access said it was easy to contact them. **85%** said that, when they had questions to ask, they got answers they could understand all or most of the time. **76%** said their CNS provided them with all the information they needed to make informed decisions about their treatment.

75% of respondents said that their care included access to another health professional, such as a physiotherapist, dietitian, speech and language therapist, occupational therapist or lymphoedema specialist. **59%** of respondents who had contacted their other health professional said that it was easy to do so. **77%** said that, when they had questions to ask, they got answers they could understand all or most of the time. **73%** said their other healthcare professional provided them with all the information they needed to make informed decisions about their treatment.

Time to first seeing a GP or other doctor

61% of respondents reported that it was less than 3 months from the first time they thought something might be wrong with them until they first saw a GP or other doctor. This is an increase on the 2016 score of **54%**.

Welsh language

'*The Welsh Government's strategic framework for the Welsh Language in health and social care aims to support Welsh speakers to receive services in their first language.*' [2] and is in the context of the Welsh language strategy 'Cymraeg 2050' [3] which sets out Welsh Government's vision for reaching a million speakers by 2050.

Within the survey, people living with cancer were asked if they were able to speak in Welsh to staff if they needed to. 239 of respondents who answered this question (**14%**) indicated that they needed to speak to staff in Welsh; of these, **24%** agreed 'Yes, completely' that they were able to do so.

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[1] Key workers for cancer patients (WHC/2014/001) (Welsh Government 2014)
[2] More Than Just Words Five Year Plan 2022-2027 (Welsh Government 2022)
[3] Cymraeg 2050: A million Welsh speakers (gov.wales) (Welsh Government 2017)

Comparisons with 2016

31 questions in the survey are broadly comparable with 2016 (see section 5). Of these 27 scores have worsened and 4 have improved.

The 3 largest improvements were:

- **91.3%** of respondents in 2021/22 reported their care included access to a CNS – **86.2%** in 2016 (**+5.1%**)

- **83.6%** of respondents in 2021/22 reported that before they were told they needed to go to hospital about cancer, they saw their GP (family doctor) 1 or 2 times about the health problem caused by cancer – **80.3%** in 2016 (**+3.3%**)

- **87.9%** of respondents in 2021/22 reported they were always given enough privacy when discussing their condition or treatment – **86.4%** in 2016 (**+1.5%**)

The 3 largest declines related to care after leaving hospital/support at home:

- **31.3%** of respondents in 2021/22 reported that after leaving hospital, they were definitely given enough care and help from their GP and the GP practice – **53.6%** in 2016 (**-22.3%**)

- **46.9%** of respondents in 2021/22 reported that they were definitely offered practical advice and support in dealing with the side effects of their treatment at home – **61.4%** in 2016 (**-14.5%**)

- **64.8%** of respondents in 2021/22 reported that since their diagnosis, the different professionals treating and caring for them always worked well together to give the best possible care – **73.7%** in 2016 (**-8.9%**)

2. Introduction

The Wales Cancer Patient Experience Survey 2021/22 is the third iteration of the survey, first undertaken in 2013. This survey has been designed to measure and understand patient experience of cancer care and treatment in Wales to help drive improvement both locally and nationally. The findings of the survey will help celebrate what is working well and inform ongoing improvements in cancer care, by highlighting areas of importance, raised by people living with cancer across Wales, and their associated findings.

We express our gratitude to the thousands of people living with cancer who took part in the survey for providing such detailed feedback on their experiences of cancer diagnosis, treatment, and care. We also extend our thanks to those who supported the development of the survey, attended the engagement sessions, and those who gave up their time to help test the survey.

Cancer care in Wales is underpinned by high-quality person-centred care; this can mean having a good conversation about their concerns, understanding if they need signposting to financial advice or counselling and making sure there's a named point of contact throughout their care.

Person-centred care has been a long-established component of cancer care in Wales, initially set out in public policy under the Cancer Delivery Plan (2011-2016)[4], Cancer Delivery Plan (2016-2020)[5] and most recently in 2021 through the Cancer Quality Statement[6]. Our approach to person-centred care is evidence-based and embedded in the National Optimal Pathways. As part of the Single Cancer Pathway, the National Optimal Pathways provide the standards for health boards and trusts to develop consistent and embedded approaches to delivering person-centred care across Wales[7]. The National Optimal Pathways set out the need for a Key Worker and Holistic Needs Assessment to take place as a standard part of a person's cancer care and to ensure their wider needs are met.

This iteration of the survey includes the experiences of those who received treatment during the COVID-19 pandemic (1st Jan 2020 - 31st Dec 2020) and will therefore reflect experiences of the changes to services and delivery during this time. The survey was commissioned and managed by Macmillan Cancer Support and the Wales Cancer Network. The survey provider IQVIA are responsible for the designing, dissemination, implementation, analysis, and interpretation.

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[4] https://www.iccp-portal.org/system/files/plans/120613cancerplanen.pdf
[5] http://www.walescanet.wales.nhs.uk/sitesplus/documents/1113/161114cancerplanen.pdf
[6] https://gov.wales/quality-statement-cancer-html
[7] https://gov.wales/national-optimal-pathways-cancer-whc2022021

3. Methodology

3.1 Sample Process

All 7 Health Boards and a tertiary cancer centre (Velindre Cancer Centre, part of Velindre University NHS Trust) participated in the survey. The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged after an inpatient episode or day case attendance for cancer-related treatment between 1 January and 31 December 2020.

The fieldwork for the survey was undertaken between 23 October 2021 and 13 February 2022.

3.2 Questionnaire distribution

As in 2016, the survey used a mixed-mode methodology. Questionnaires were sent by post in English and Welsh, but also included an option to complete online, also in English or Welsh. 21 days after the initial mail out, a reminder letter was sent to those who had not responded. A further, final, reminder was sent after another 21 days to non-responders, this included another copy of the questionnaire. A Freephone helpline was available to respondents to ask questions about the survey, to enable them to complete their questionnaires over the phone, and to provide access to a translation and interpreting facility for those whose first language was not English or Welsh.

3.3 Assignment of respondents to a Health Board / Velindre

In 2016, individual Health Board scores were produced by assigning people to their Health Board of residence, regardless of where they were treated. Feedback confirmed that this was the preferred approach for interpreting the results again in 2021/22. The exception to this is Velindre Cancer Centre because it is a tertiary cancer centre treating people from multiple health boards.

The reporting for Velindre Cancer Centre is based on patients discharged most recently from the cancer centre – as in the 2013 and 2016 surveys. Therefore, Velindre Cancer Centre is treated separately in this report and is not compared to the 7 Health Boards in Wales. For this reason, as well as the fact that it is a specialist cancer centre within a Trust, Velindre Cancer Centre is treated separately in this report.

Approval of this approach for the 2021/22 was agreed by the steering group that oversaw the programme.

As the patients in this report are assigned by discharge rather than by residence, it is not appropriate to compare Velindre Cancer Centre's performance to the Health Boards in Wales. In addition, the respondents in Velindre Cancer Centre's report will also be included (duplicated) in the Health Board reports where they are assigned by residence, making comparisons inadvisable.

This report gives an insight into the cancer experience of respondents who were discharged from Velindre Cancer Centre.

4. Response rates

The sample size for Velindre Cancer Centre was **3,109** cancer patients.

Of these **214** were removed as they were ineligible. Ineligible patients were those who had died between the sample being finalised and receiving any of the survey letters (**189**), had moved address (**22**) or had informed the helpline they were ineligible for another reason (**3**).

The eligible sample size was therefore calculated as **2,895** patients. A total of **1,793** questionnaires were returned completed, giving an overall response rate of **61.9%**.

Completed questionnaires were received by post from **1,457** respondents (**81.3%** of responses); and **316** (**17.6%**) chose to complete their questionnaires on-line. **20** respondents called IQVIA's Freephone helpline to give their responses over the telephone.

As in previous years, because of the very large sample, high response rate, and high completion levels for each question, the data is highly robust from a statistical point of view.

More information on statistical tests undertaken can be found in the Technical Document at https://wcpes.co.uk/library

Response rates

Post

81.3%

Online

17.6%

Telephone

1.1%

Translation

0%

Wales Cancer Patient Experience Survey 2021/22

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The tables below show the percentage and responses by tumour group, sex, age, ethnicity, and sexuality.

Tumour Group	Number of respondents	Percentage of total respondents
Breast	513	28.6%
Other cancers[8]	406	22.6%
Prostate	267	14.9%
Colorectal / lower gastrointestinal	153	8.5%
Lung	103	5.7%
Gynaecological	102	5.7%
Head and neck	84	4.7%
Urological (excluding prostate)	61	3.4%
Upper gastrointestinal	46	2.6%
Haematological	22	1.2%
Skin	14	<1%
Brain / central nervous system (CNS)	11	<1%
Sarcoma	11	<1%

Sex of respondents	Number of respondents	Percentage of total respondents
Female	1067	59.5%
Male	726	40.5%

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[8] The list of codes that make up the Other cancers category are detailed in Appendix 2.

Age of respondents	Number of respondents	Percentage of total respondents
16-24	6	<1%
25-34	10	<1%
35-44	70	3.9%
45-54	182	10.2%
55-64	429	23.9%
65-74	617	34.4%
75-84	420	23.4%
85+	59	3.3%

It is important to acknowledge the small number of responses received from Asian, Asian British, Black, Black British, Caribbean, Mixed or multiple ethnic, and other ethnic groups.

Equality and diversity statistics in Wales report that 94% of the general population in Wales describe themselves as White[9], and this mirrors the proportion of responses to the survey.

While it appears the ethnicity of people responding to the survey is broadly representative of the general population of Wales, it means there is less data available on the experiences of Asian, Asian British, Black, Black British, Caribbean, Mixed or multiple ethnic, and other ethnic groups.

Ethnicity of respondents	Number of respondents	Percentage of total respondents
Asian background	14	<1%
Black / African / Caribbean background	2	<1%
Mixed / multiple ethnic background	13	<1%
Other ethnic group	1	<1%
White background	1669	93.1%
Not available	94	5.2%

Sexual orientation of respondents [10]	Number of respondents	Percentage of total respondents
Heterosexual	1624	90.6%
Bisexual	6	<1%
Gay or lesbian	12	<1%
Other sexuality	6	<1%

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[9] https://gov.wales/equality-and-diversity-statistics-2017-2019#:~:text=94.8%25%20of%20the%20population%20of,or%20'Other%20ethnic%20group

[10] *<1% of respondents said that they didn't know or were not sure, 1.7% of respondents said they preferred not to answer this question, and a further 6.2% of all respondents to the survey did not answer the question at all.

5. Comparisons with previous years

Following a comprehensive review with stakeholders, and testing the questions with people living with cancer, the questionnaire has been extensively revised since the 2016 survey.

- 16 new questions

- 19 questions removed

- 25 questions edited

- 2 pairs of questions combined

31 questions have been deemed as broadly comparable to previous iterations of the survey, however due to the significant overhaul to the questionnaire, time since the previous iterations, and changes to service during the COVID-19 pandemic, caution must be taken when making **any** comparisons.

Where questions are the same as previous iterations or have been edited but the meaning remains the same, the results for the related question in 2013 and 2016 are shown to add context to the 2021/22 results.

For each question with comparable data from previous iterations of the survey, there is a note indicating if it is:

a) Directly comparable

b) Comparable with changes – see appendix 1

The 2016 version of the questionnaire and full record of changes is available at https://wcpes.co.uk/library

6. This report, and subsequent publications

This report sets out a summary of the results of the survey for Velindre Cancer Centre. Velindre Cancer Centre is part of Velindre University NHS Trust.

Velindre Cancer Centre delivers specialist cancer services for South East Wales, within the cancer centre and in outreach clinics in some Health Boards. Velindre Cancer Centre treat patients with including chemotherapy, immunotherapy and other Systemic Anti-Cancer Treatments (SACT), radiotherapy and related treatments.

The majority of patients completing the CPES from Velindre Cancer Centre, would have had part of their care delivered by their Health Board of residence. E.g. diagnostics and surgery.

The chart below shows how many respondents from each Health Board (of residence) were discharged from Velindre.

Velindre Discharges by Health Board of Residence

- Betsi Cadwaladr: 1,394 / 1
- Hywel Dda: 901 / 24
- Swansea Bay: 760 / 13
- Cardiff and Vale: 390 / 545
- Cwm Taf Morgannwg: 373 / 522
- Aneurin Bevan: 577 / 656
- Powys: 71 / 32

■ Discharged from non-Velindre site   ■ Discharged from Velindre
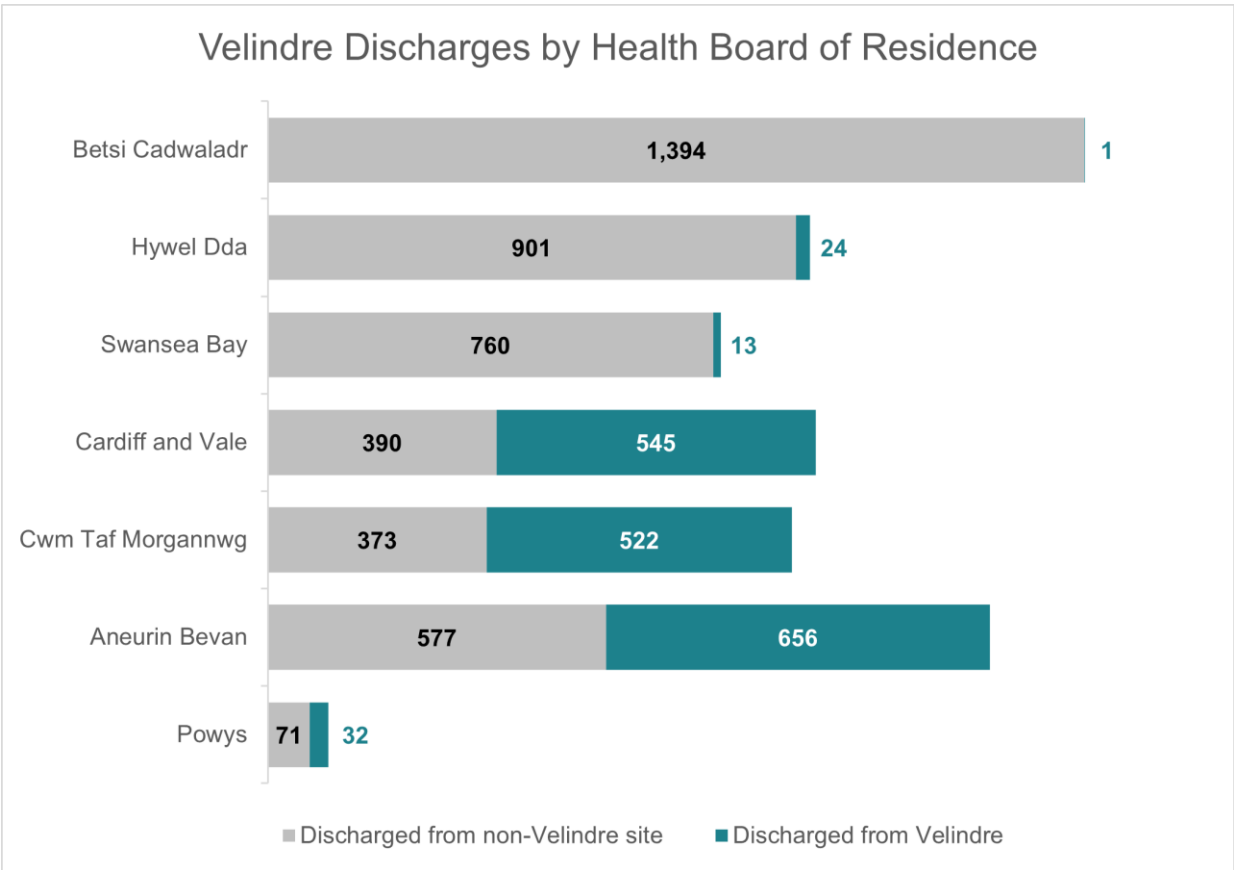
Note: When interpreting Velindre Cancer Centre's results, the reported experience will reflect the whole patient pathway which may span multiple Health Boards/Trust.

Additional analysis is available in the national quantitative report, individual reports for each participating Health Board, and the national qualitative report.

This report is accompanied by an online reporting platform, which displays data tables and enables breakdowns by key variables. The online reporting platform can be found at https://wcpes.co.uk

The following guidance and survey materials have also been made available alongside the published results:

- Sampling guidance (detailed instructions provided to DHCW on who should be included in the sample)

- A copy of the 2021/22 questionnaire

- Technical documentation (detailed outline of processes undertaken for statistical analysis, record of comparability and record of scoring)

All of these documents are available at: https://wcpes.co.uk/library

7. Understanding the results

The 2021/22 questionnaire contained 89 individual questions. 8 questions related to respondent demographics and 81 asked about the cancer journey.

Within the 81 questions, 23 were 'informational', or routing questions, for example Q07 *(In the last 12 months have you had diagnostic test(s) for cancer such as an endoscopy, biopsy, mammogram, or scan at one of the hospitals named in the covering letter?)*, and 58 questions related to patient experience in a way that can be evaluated.

This report contains charts for each of the 58 evaluative questions, plus 2 informational questions that were deemed to contain important data. For this reason, not every question in the survey has been charted.

Unadjusted raw data. It should be noted that all data used in this report is unadjusted/raw and illustrates exactly how people living with cancer have responded to the survey.

Scoring

For each evaluative patient experience question in the survey, the individual responses are converted into scores on a scale from 0% to 100%. To calculate these scores, each individual answer option to a scored question has been identified as either positive, negative, or neutral. The percentage score is calculated using the positive total as the numerator, and the total of positive and negative responses as the denominator. Neutral scores (e.g. "Don't know / can't remember") are excluded from the scoring calculation (i.e. not included in either the numerator or denominator). A score of 100% represents the best possible response and a score of 0% the worst possible response. The higher the score, the better the result.

Question 61 asks respondents to rate their overall care on a scale of 0 to 10. Scores have been given as the average on this scale.

Full details of the scoring methodology are in included in the technical document available at https://wcpes.co.uk/library

Evaluative patient experience questions

The 58 evaluative patient experience questions have been charted in 3 ways:

1. Compositional Chart. The Compositional Chart shows the range of responses to the question. These charts exclude any non-specific responses such as don't know / can't remember.

Example of a Compositional Chart - Question 4: "Before you were told you needed to go to hospital about cancer, how many times did you see your GP (family doctor) about the health problem caused by cancer?"

Responses for Velindre

I saw my GP once	774	63%
I saw my GP twice	248	20%
I saw my GP 3 or 4 times	136	11%
I saw my GP 5 or more times	65	5%

Results above based on 1,223 responses. Those answering, "I went straight to hospital following a cancer screening appointment" (235), "I went straight to hospital via Accident & Emergency" (77), "Other" (127), "Don't know / can't remember" (61) excluded from base size/percentage calculation. 1,723 responses in total.
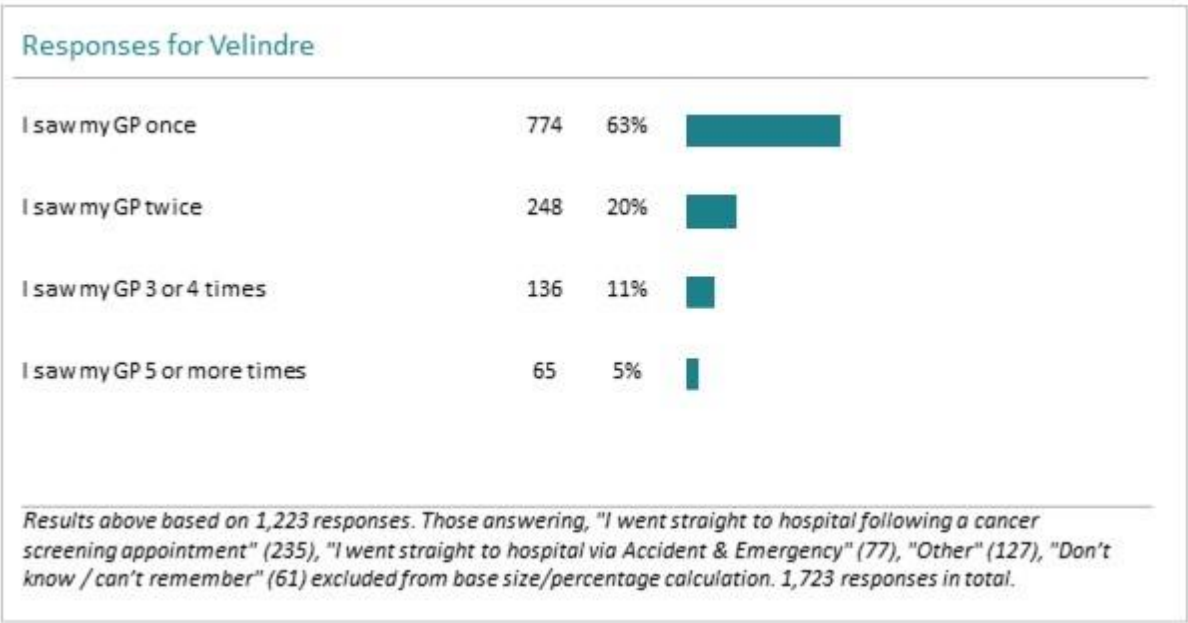
2. Scored Chart. These charts illustrate the scored result for each question using unadjusted raw data.

Example of a Scored Chart - Question 4: "Before you were told you needed to go to hospital about cancer, how many times did you see your GP (family doctor) about the health problem caused by cancer?"

Velindre Question Level Score

84% of respondents saw their GP once or twice before they were told they needed to go to hospital about cancer
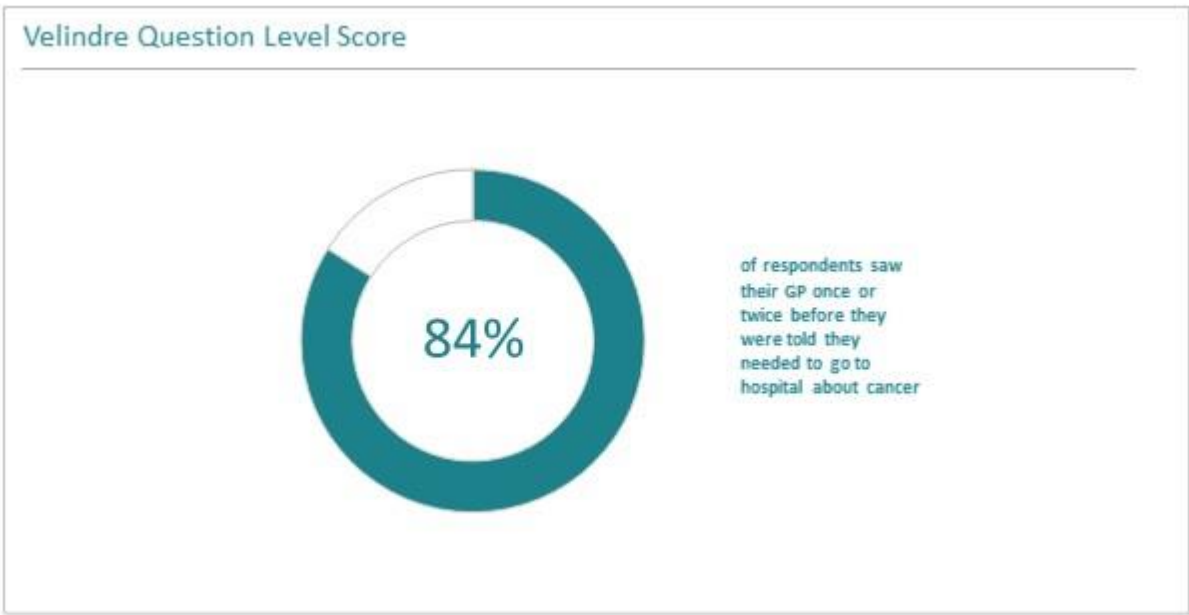
3. Longitudinal Chart. The Longitudinal Chart uses unadjusted raw data. Where a scored question is comparable to previous iterations of the survey, it has a longitudinal chart showing the 2013 and /or 2016 scores. Where there is no column for 2013, this is because there is no comparable data.

Example of a Longitudinal Chart - Question 4: "Before you were told you needed to go to hospital about cancer, how many times did you see your GP (family doctor) about the health problem caused by cancer?"
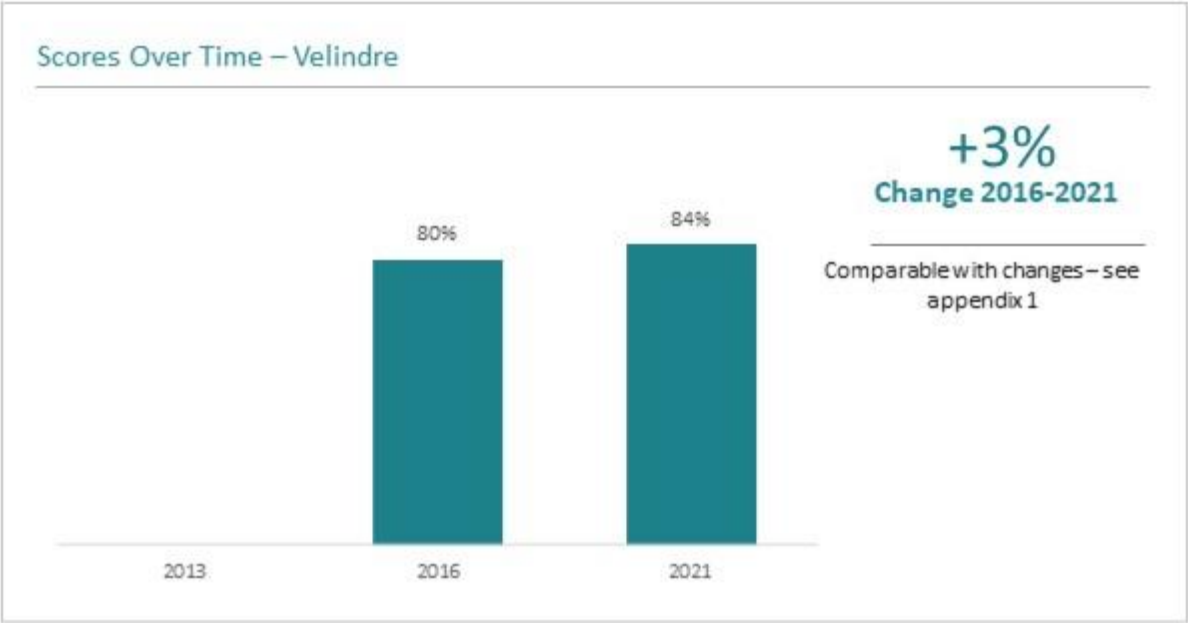
Informational (non-evaluative) questions

Despite not being assigned a score, 2 of the informational questions (Q02 and Q13) were deemed to contain important data.

The results for these informational non-evaluative questions are illustrated using Compositional Charts and Longitudinal Charts.

Example of a Compositional Chart for informational questions - Question 2: "How long was it from the time you first thought something might be wrong with you until you first saw a GP or other doctor?"

Example of a Longitudinal Chart for informational questions - Question 2: "How long was it from the time you first thought something might be wrong with you until you first saw a GP or other doctor?"

Responses for Velindre

Less than 3 months: 54% (2016), 61% (2021)
3-6 months: 11% (2016), 10% (2021)
6-12 months: 5% (2016), 4% (2021)
More than 12 months: 3% (2016), 3% (2021)
[did not think something was wrong until told]: 26% (2016), 20% (2021)
Don't know / can't remember: 1% (2016), 2% (2021)

Results above based on 1,737 responses.
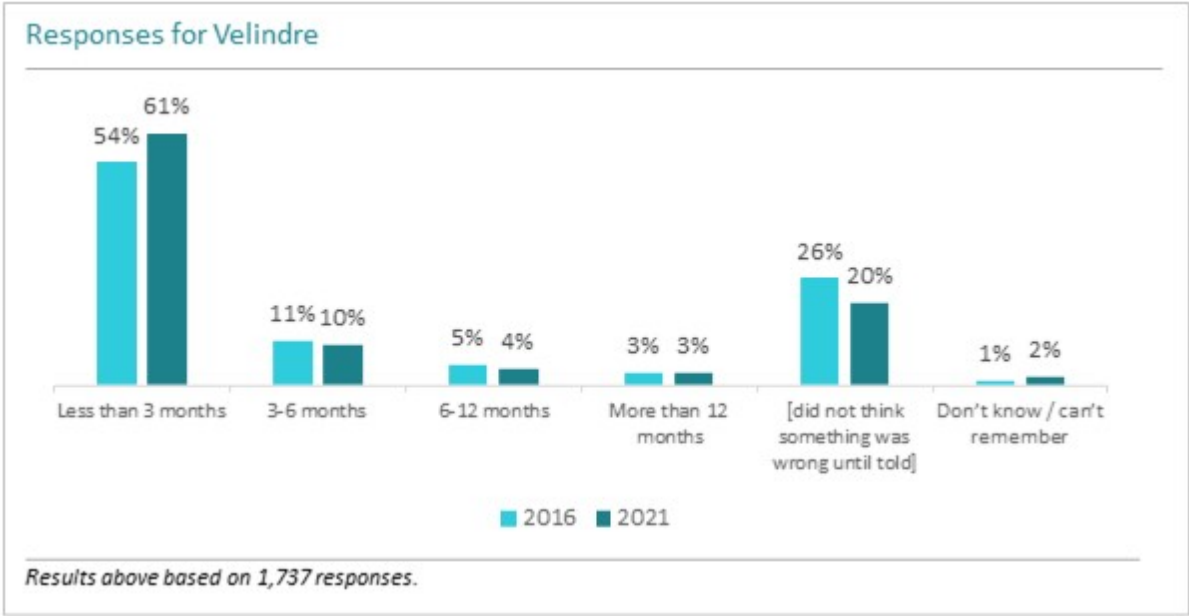
Other reporting conventions

Unanswered questions. The percentages are calculated after excluding those respondents that did not answer that particular question ('Missing').

Rounding. All percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a question on a Compositional Chart may not total 100% because of this rounding. The rounding may also affect the appearance of the change over time shown in the Longitudinal Charts.

Not applicable and non-specific responses. Some questions have been recalculated to exclude responses where the question was not applicable to the respondent's circumstances, or they felt unable to give a definite answer. For example, on questions such as Q12 - " *When you were told you had cancer, were you given written information about the type of cancer you had?"* those saying *"I did not need written information"* or *"Don't know / can't remember"* are excluded from base size/percentage calculation. Where the total number of responses and base size are different, both figures are included under the charts.

Further information

Full details on the scoring is included in the Technical Document for this survey, which is published separately at https://wcpes.co.uk/library

8. Survey results

This section contains charts for each of the 58 evaluative questions, plus 2 informational questions that were deemed to contain important data. For this reason, not every question in the survey has been charted.

8.1 Before your diagnosis

Question 2: "How long was it from the time you first thought something might be wrong with you until you first saw a GP or other doctor?"

Responses for Velindre

Response	Velindre	HB Average
Less than 3 months	61%	59%
3-6 months	10%	11%
6-12 months	4%	4%
More than 12 months	3%	4%
[did not think something was wrong until told]	20%	20%
Don't know / can't remember	2%	2%

Results above based on 1,737 responses.

Responses for Velindre

Response	2016	2021
Less than 3 months	54%	61%
3-6 months	11%	10%
6-12 months	5%	4%
More than 12 months	3%	3%
[did not think something was wrong until told]	26%	20%
Don't know / can't remember	1%	2%

Results above based on 1,737 responses.
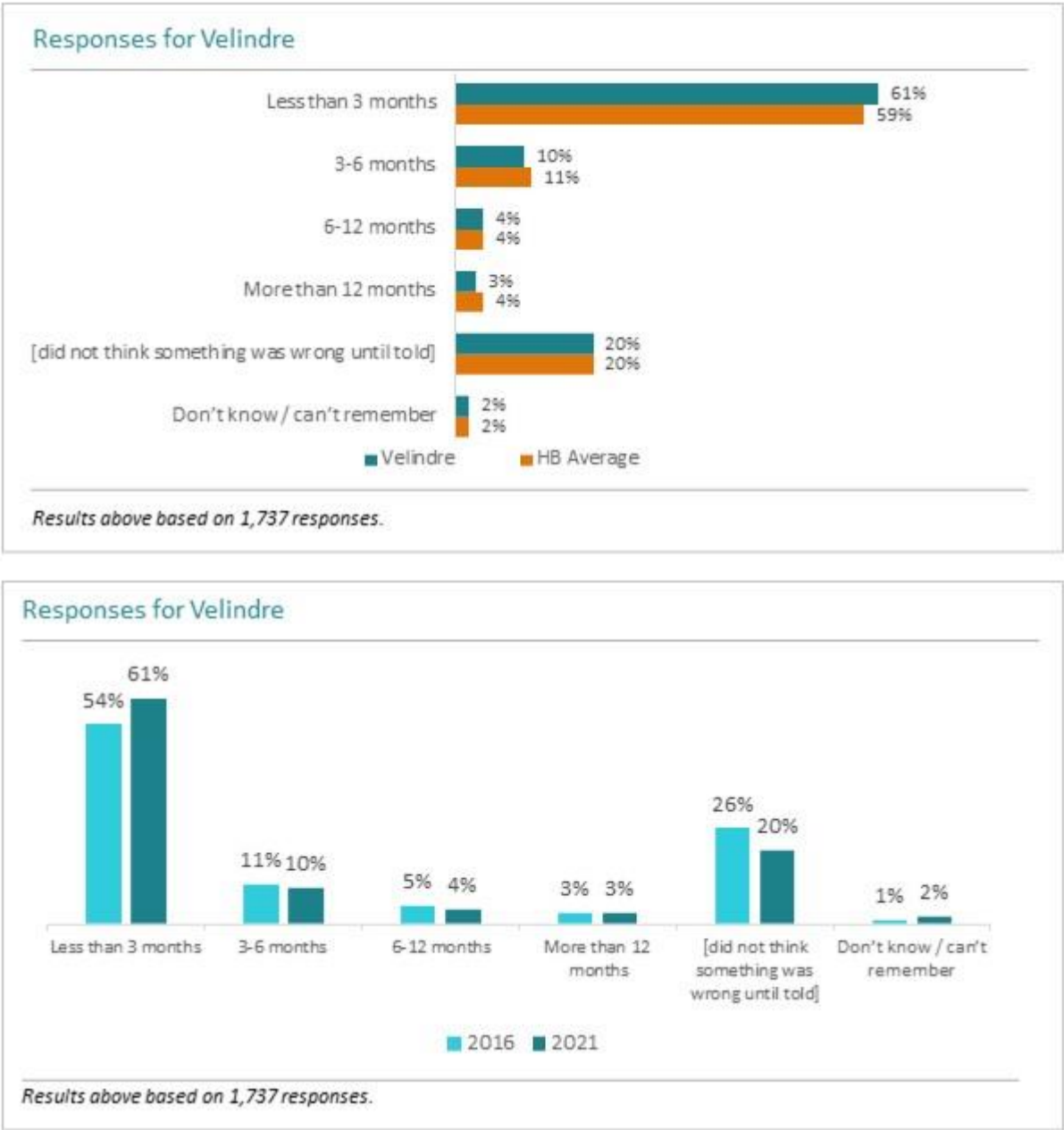
Question 3: "Did you understand the explanation of what was wrong with you?"

Responses for Velindre

Yes, I completely understood it	1,400	80%	
Yes, I understood some of it	290	17%	
No, I did not understand it	58	3%	

Results above based on 1,748 responses. Those answering, "Don't know / can't remember" (10) excluded from base size/percentage calculation. 1,758 responses in total.

Velindre Question Level Score

80%

of respondents completely understood the explanation of what was wrong with them

Question 4: "Before you were told you needed to go to hospital about cancer, how many times did you see your GP (family doctor) about the health problem caused by cancer?"

Responses for Velindre

I saw my GP once	774	63%	
I saw my GP twice	248	20%	
I saw my GP 3 or 4 times	136	11%	
I saw my GP 5 or more times	65	5%	

Results above based on 1,223 responses. Those answering, "I went straight to hospital following a cancer screening appointment" (235), "I went straight to hospital via Accident & Emergency" (77), "Other" (127), "Don't know / can't remember" (61) excluded from base size/percentage calculation. 1,723 responses in total.

Velindre Question Level Score

84%

of respondents saw their GP once or twice before they were told they needed to go to hospital about cancer

Scores Over Time – Velindre

+3%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	80%	84%

Question 6: " How do you feel about the length of time you had to wait before your first appointment with a healthcare professional in a hospital?"

Responses for Velindre

I was seen as soon as I thought was necessary	1,479	84%	
I should have been seen a bit sooner	180	10%	
I should have been seen a lot sooner	102	6%	

Results above based on 1,761 responses.

Velindre Question Level Score

84%

of respondents felt they were seen as soon as they thought was necessary for their first appointment with a healthcare professional in a hospital
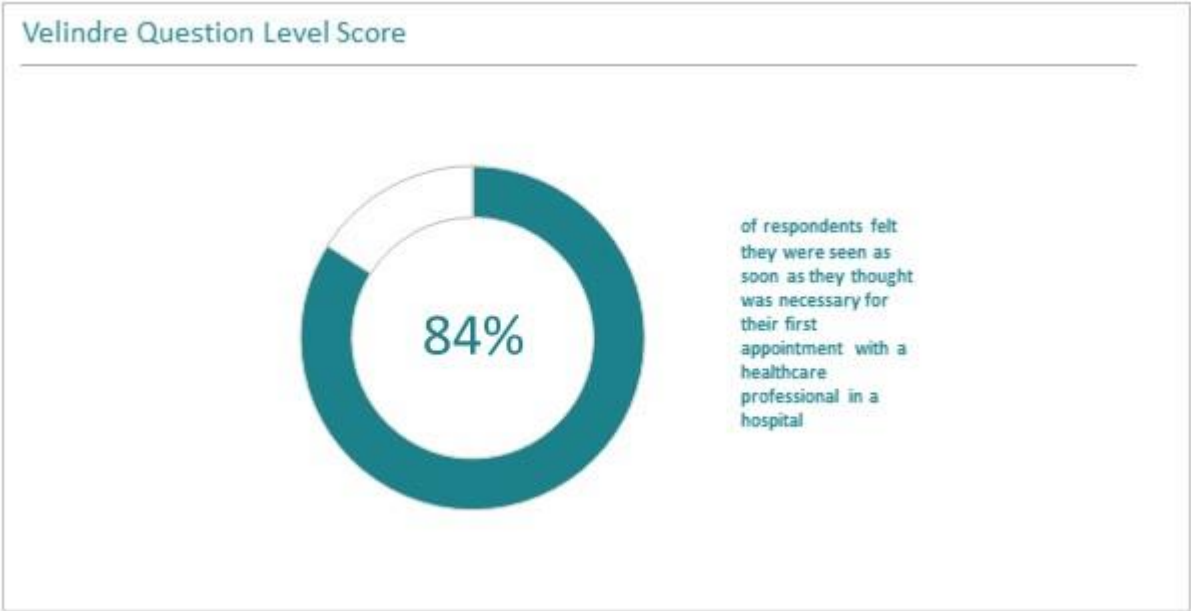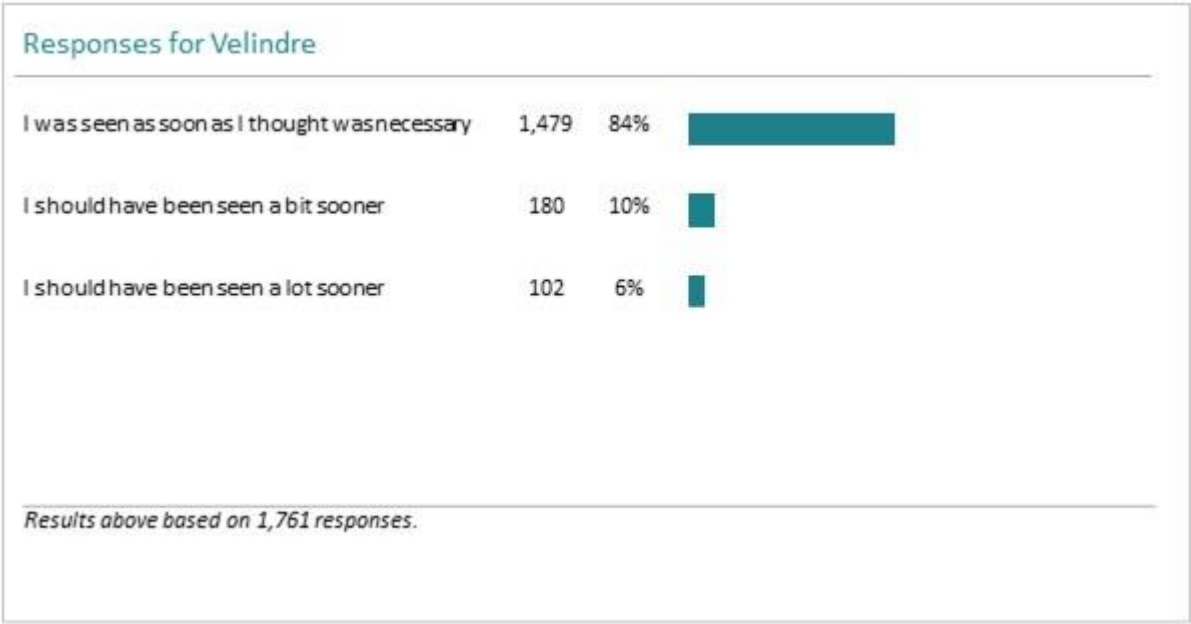
Question 8: "Beforehand, did you have all the information you needed about your test?"

Responses for Velindre

Yes	1,230	92%	
No, I would have liked more information	73	5%	
No, I did not need any information	32	2%	

Results above based on 1,335 responses. Those answering, "Don't know / can't remember" (21) excluded from base size/percentage calculation. 1,356 responses in total.

Velindre Question Level Score

92% of respondents had all the information they needed about their test

Question 9: "Were the results of the test(s) explained in a way you could understand?

Responses for Velindre

Yes, completely	1,052	78%	
Yes, to some extent	271	20%	
No, I did not understand the explanation	9	1%	
No, but I would have liked an explanation	12	1%	

Results above based on 1,344 responses. Those answering, "I did not need an explanation" (6), "Don't know / can't remember" (6) excluded from base size/percentage calculation. 1,356 responses in total.

Velindre Question Level Score

78%

of respondents said their test results were explained in a way they could completely understand

Scores Over Time – Velindre

-5%
Change 2016-2021

Directly comparable

83% (2016)
78% (2021)

2013   2016   2021

8.2 Finding out you had cancer

Question 10: "How do you feel about the way you were told you had cancer?"

Responses for Velindre

It was done sensitively	1,465	83%	
It should have been done a bit more sensitively	189	11%	
It should have been done a lot more sensitively	106	6%	

Results above based on 1,760 responses.

Velindre Question Level Score

83% of respondents felt they were told sensitively that they had cancer

Scores Over Time – Velindre

85% 2013
84% 2016
83% 2021

0%
Change 2016-2021
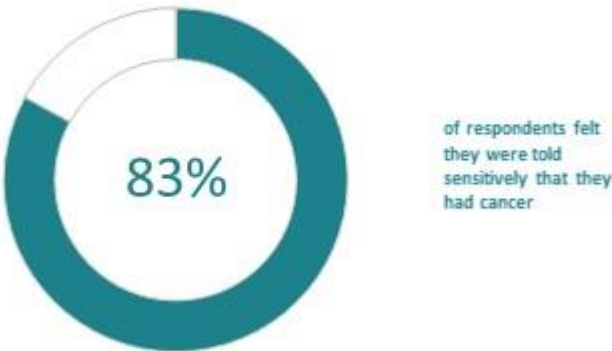
Directly comparable
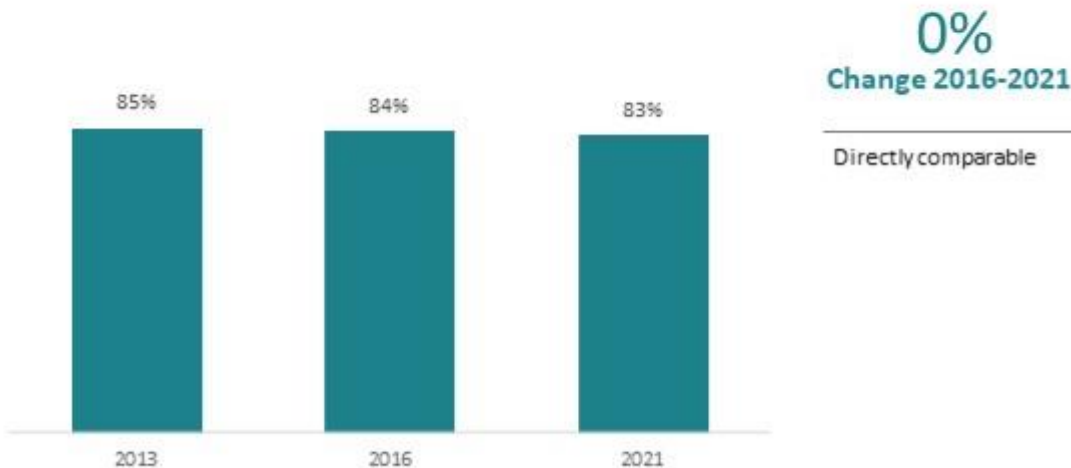
Question 11: "Did you understand the explanation of what was wrong with you?"

Responses for Velindre

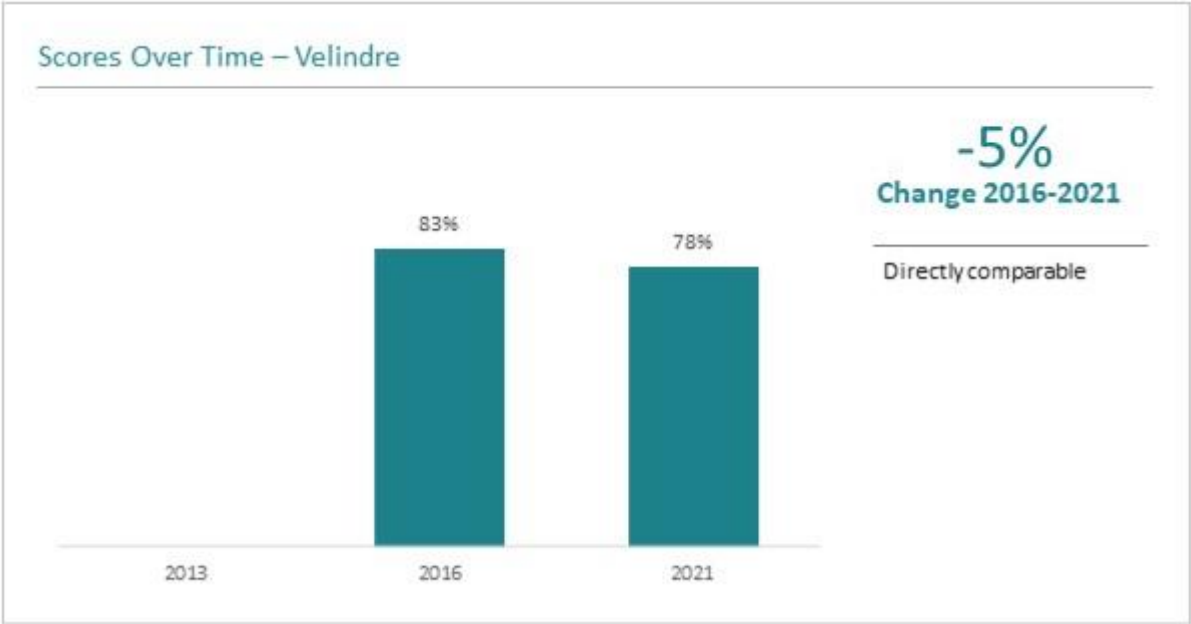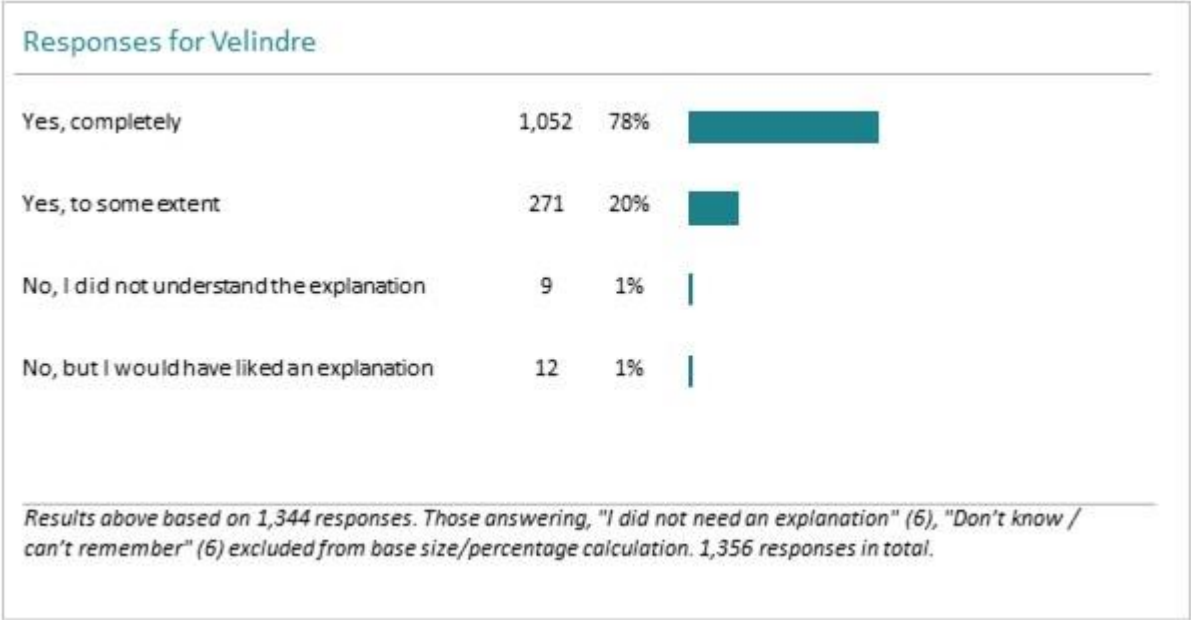|			
Yes, I completely understood it	1,378	78%	
Yes, I understood some of it	378	21%	
No, I did not understand it	19	1%	

Results above based on 1,775 responses. Those answering, "Don't know / can't remember" (4) excluded from base size/percentage calculation. 1,779 responses in total.

Velindre Question Level Score
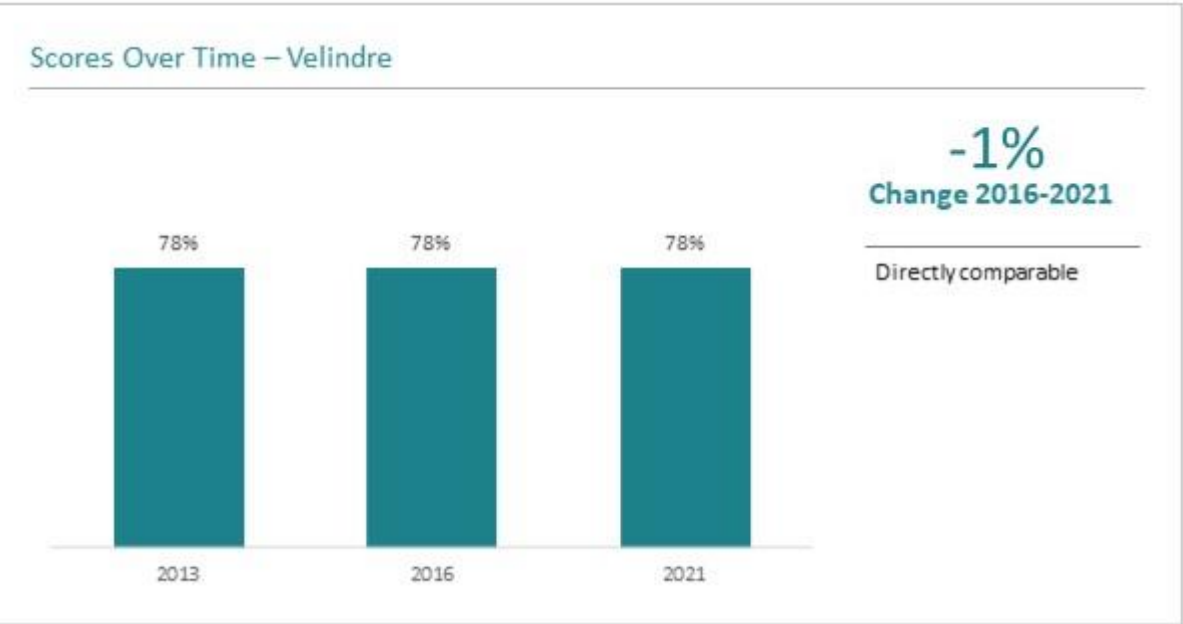
78% of respondents completely understood the explanation of what was wrong with them

Scores Over Time – Velindre

-1%
Change 2016-2021

Directly comparable

2013	2016	2021
78%	78%	78%

Question 12: "When you were told you had cancer, were you given written information about the type of cancer you had?"

Responses for Velindre

Yes, and it was easy to understand	948	63%
Yes, but it was difficult to understand	122	8%
[No, not given written info. re. cancer type]	431	29%

Results above based on 1,501 responses. Those answering, "I did not need written information" (146), "Don't know / can't remember" (112) excluded from base size/percentage calculation. 1,759 responses in total.

Velindre Question Level Score

63% of respondents were given written information about their cancer which was easy to understand

Scores Over Time – Velindre

-1%
Change 2016-2021

Directly comparable

2013	2016	2021
65%	64%	63%

Question 13: "Were you given any of the following information before treatment?"

Responses for Velindre

	Velindre	HB Average
Physical activity and exercise	23%	23%
Nutrition and diet	24%	24%
Psychological support	23%	20%
None of the above	36%	37%
Don't know / can't remember	15%	13%
Not applicable - didn't have time	9%	10%

■ Velindre   ■ HB Average

Results above based on 1,793 responses.
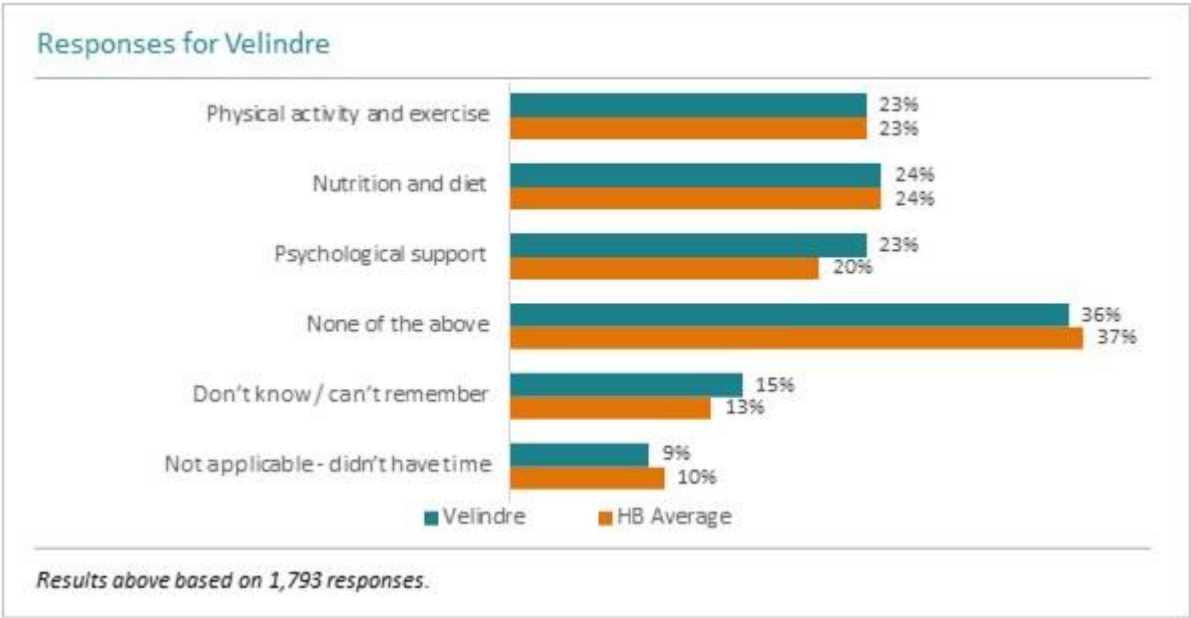
Question 14: "When you were first told that you had cancer, had you been told you could bring a family member or friend with you?"

Responses for Velindre

Yes	1,130	67%	
No	482	29%	
I was told by phone or letter	66	4%	

Results above based on 1,678 responses. Those answering, "Don't know / can't remember" (77) excluded from base size/percentage calculation. 1,755 responses in total.

Velindre Question Level Score

67%

of respondents were told they could bring a family member or friend to their diagnosis
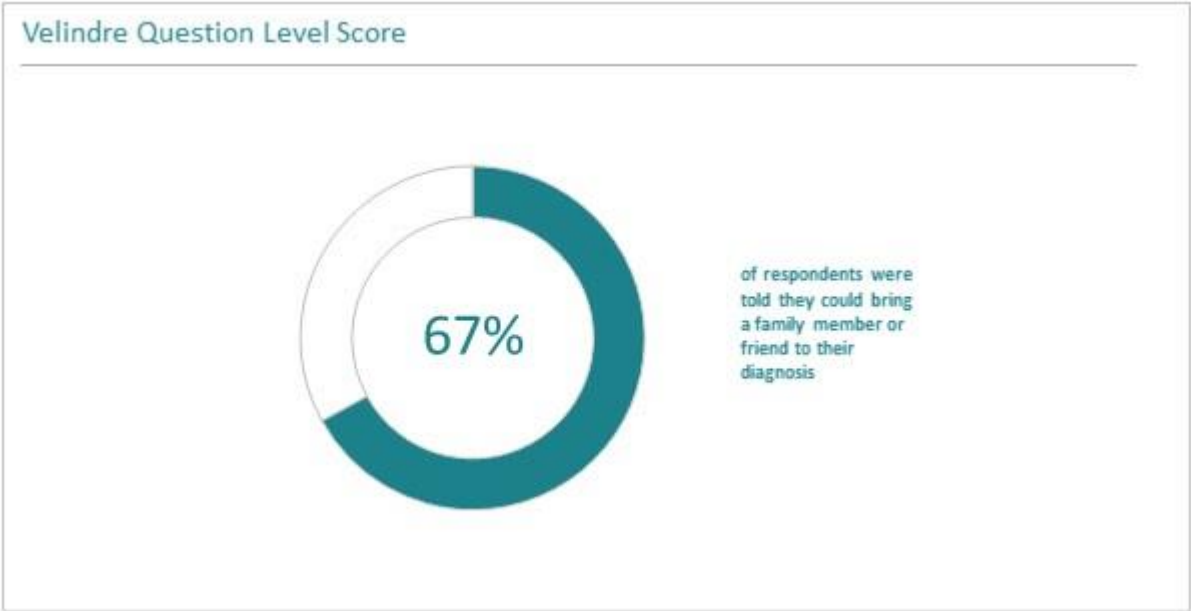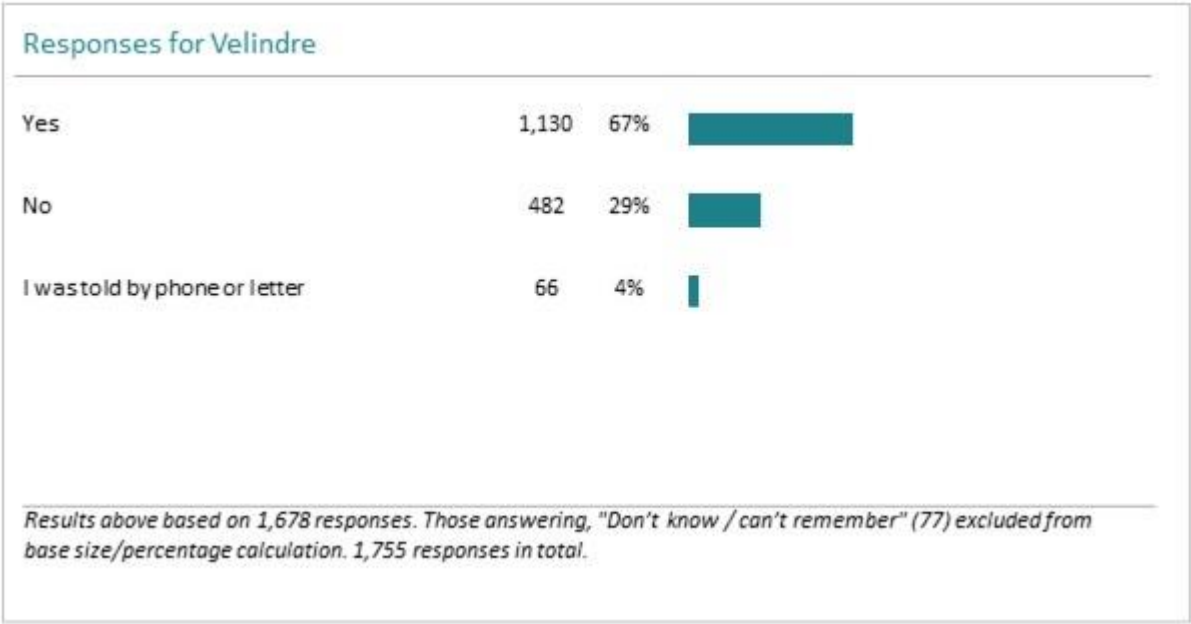
8.3   Deciding the best treatment and / or care for you

Question 15: "Before your cancer treatment started, were your treatment options discussed with you?"

Responses for Velindre

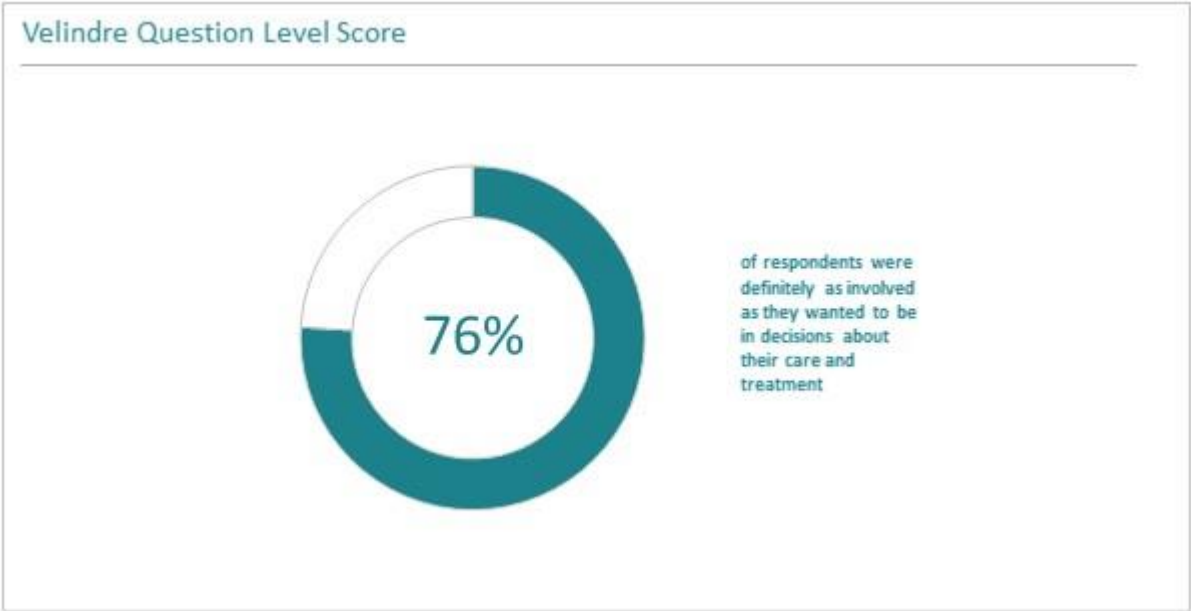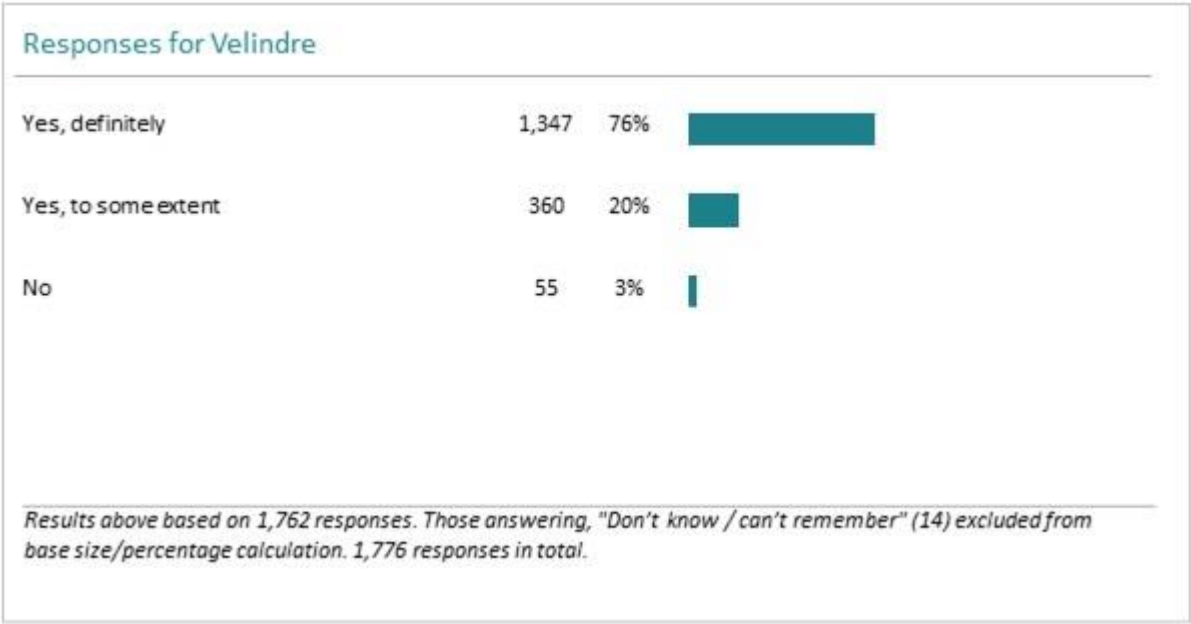|			
Yes, completely	1,254	81%	
Yes, to some extent	262	17%	
No	35	2%	

Results above based on 1,551 responses. Those answering, "There was only one type of treatment that was suitable for me" (195), "Don't know / can't remember" (13) excluded from base size/percentage calculation. 1,759 responses in total.
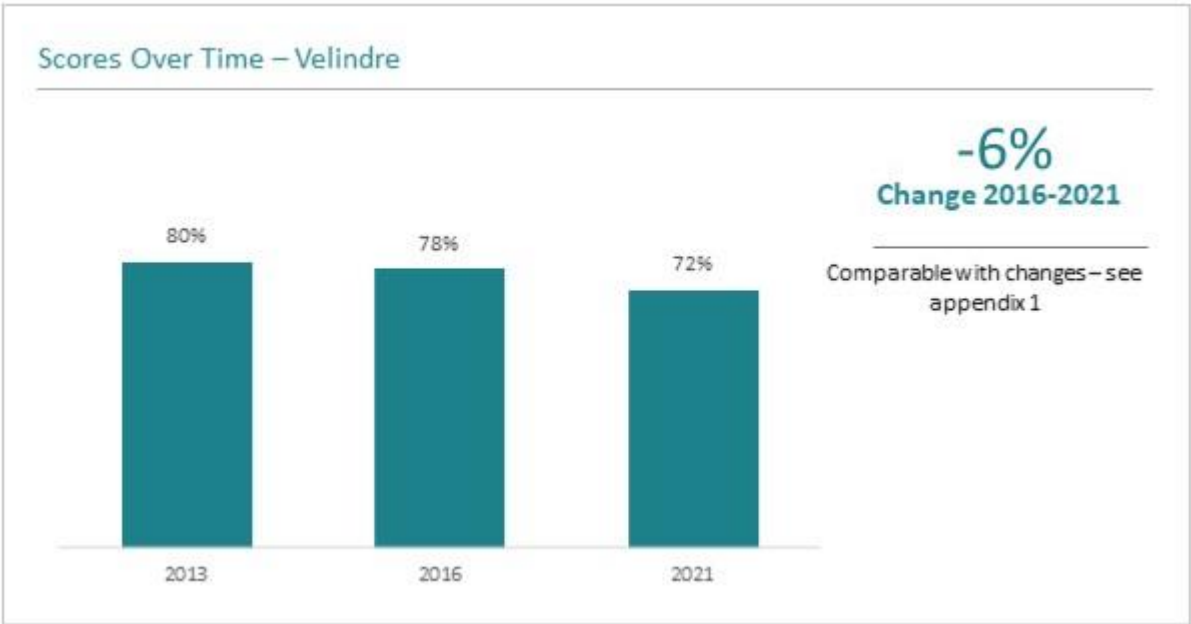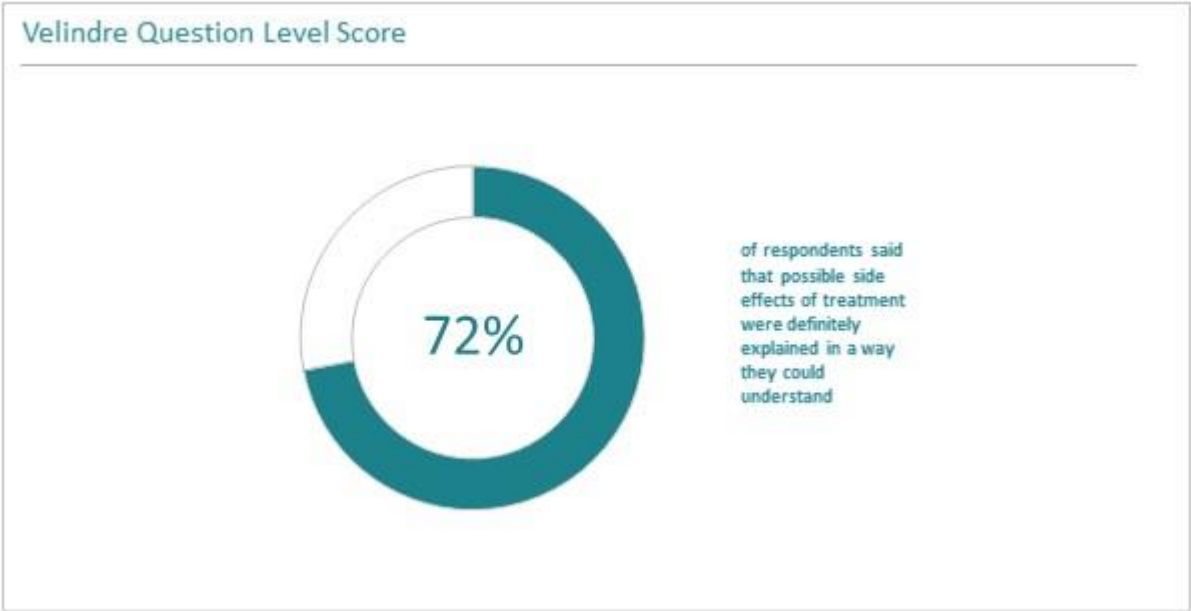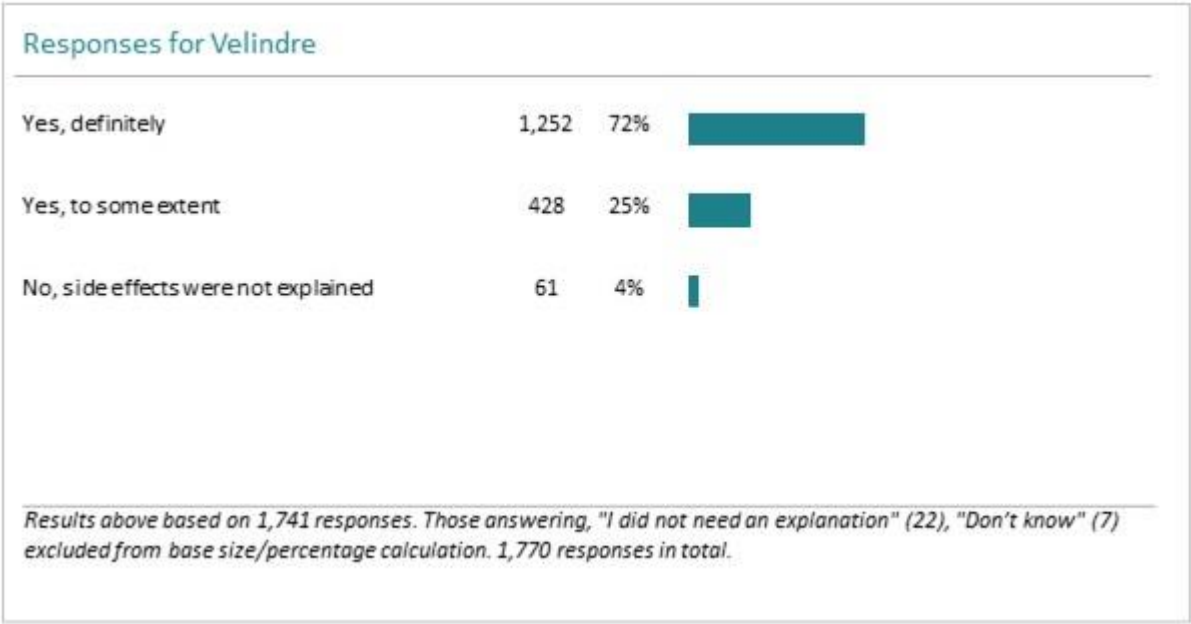
Velindre Question Level Score

81% of respondents felt their treatment options were completely discussed with them

Question 16: "Were you involved as much as you wanted to be in decisions about your care and treatment?"

Responses for Velindre

Yes, definitely	1,347	76%	
Yes, to some extent	360	20%	
No	55	3%	

Results above based on 1,762 responses. Those answering, "Don't know / can't remember" (14) excluded from base size/percentage calculation. 1,776 responses in total.

Velindre Question Level Score

76% of respondents were definitely as involved as they wanted to be in decisions about their care and treatment

Question 17: "Were the possible side effects of treatment(s) explained in a way you could understand?"

Responses for Velindre

Yes, definitely	1,252	72%	
Yes, to some extent	428	25%	
No, side effects were not explained	61	4%	

Results above based on 1,741 responses. Those answering, "I did not need an explanation" (22), "Don't know" (7) excluded from base size/percentage calculation. 1,770 responses in total.

Velindre Question Level Score

72% of respondents said that possible side effects of treatment were definitely explained in a way they could understand

Scores Over Time – Velindre

-6%
Change 2016-2021

Comparable with changes – see appendix 1
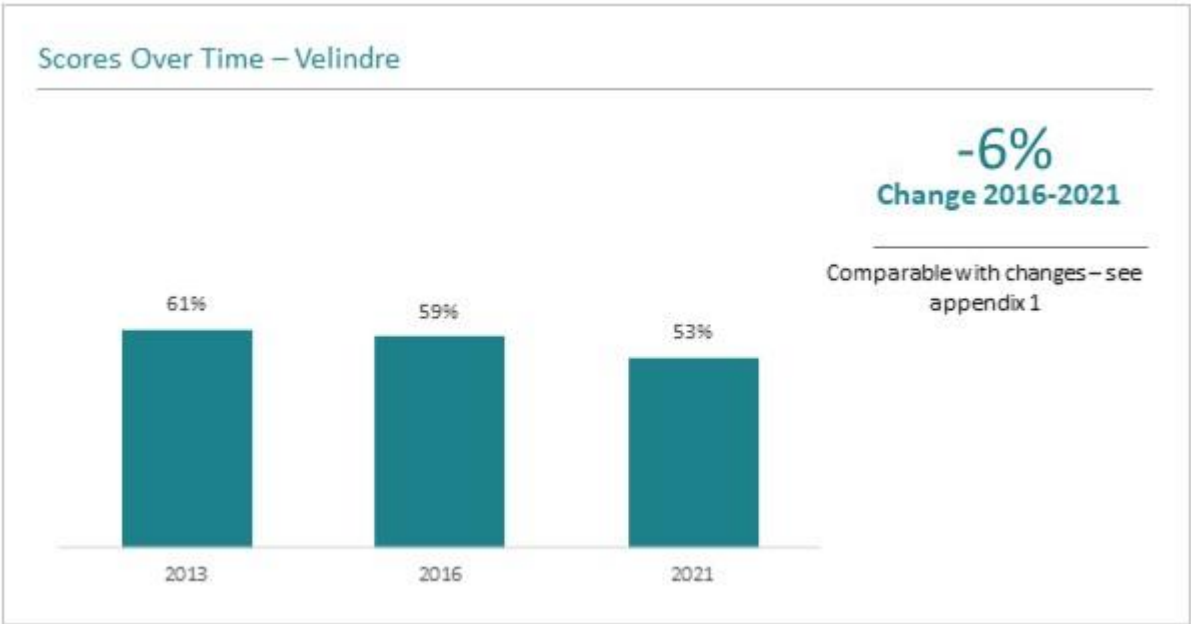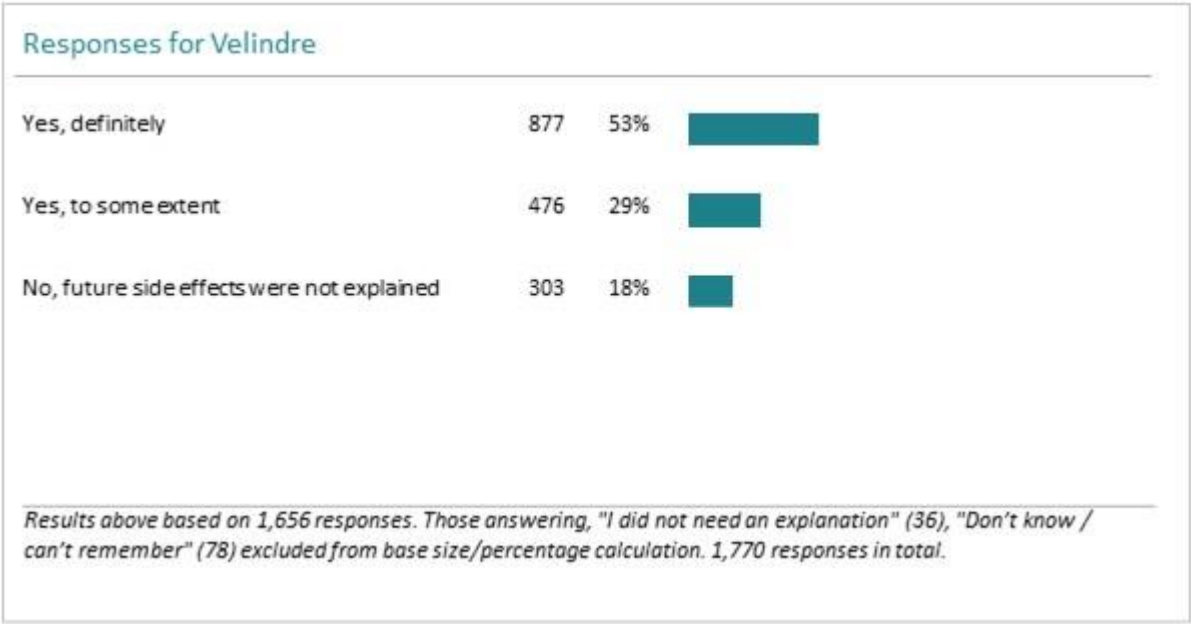
- 2013: 80%
- 2016: 78%
- 2021: 72%

Question 18: "Were you offered practical advice and support in dealing with the side effects of your treatment(s)?"

Responses for Velindre

Yes, definitely	1,068	62%	
Yes, to some extent	523	30%	
[No, not offered practical advice/support]	126	7%	

Results above based on 1,717 responses. Those answering, "Don't know / can't remember" (53) excluded from base size/percentage calculation. 1,770 responses in total.

Velindre Question Level Score

62% of respondents said that they were definitely offered practical advice and support to deal with side effects
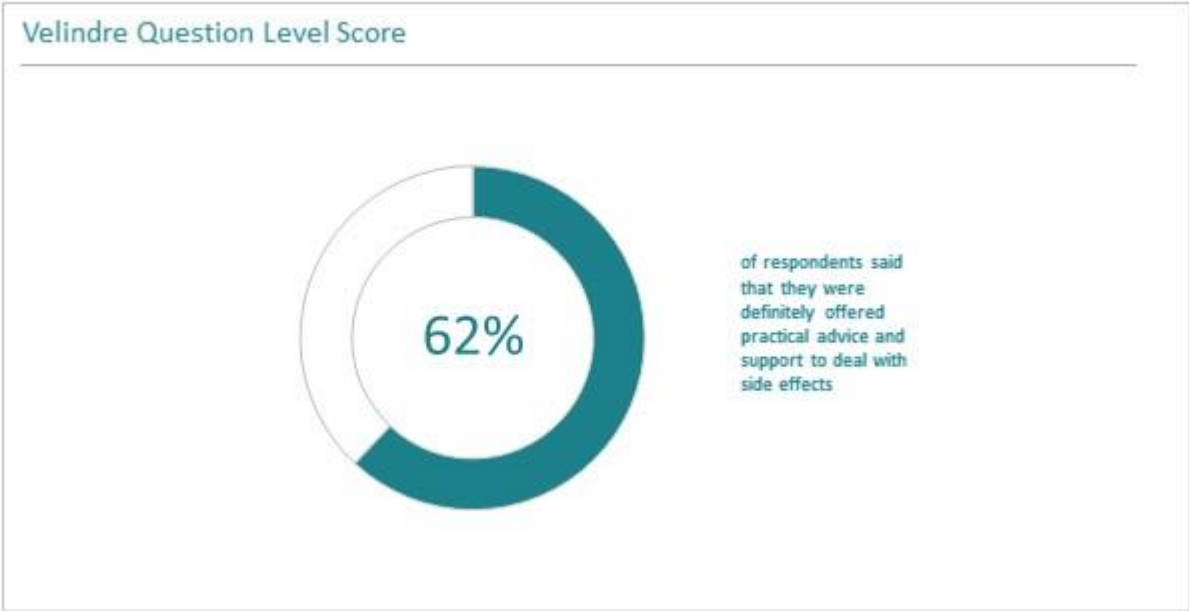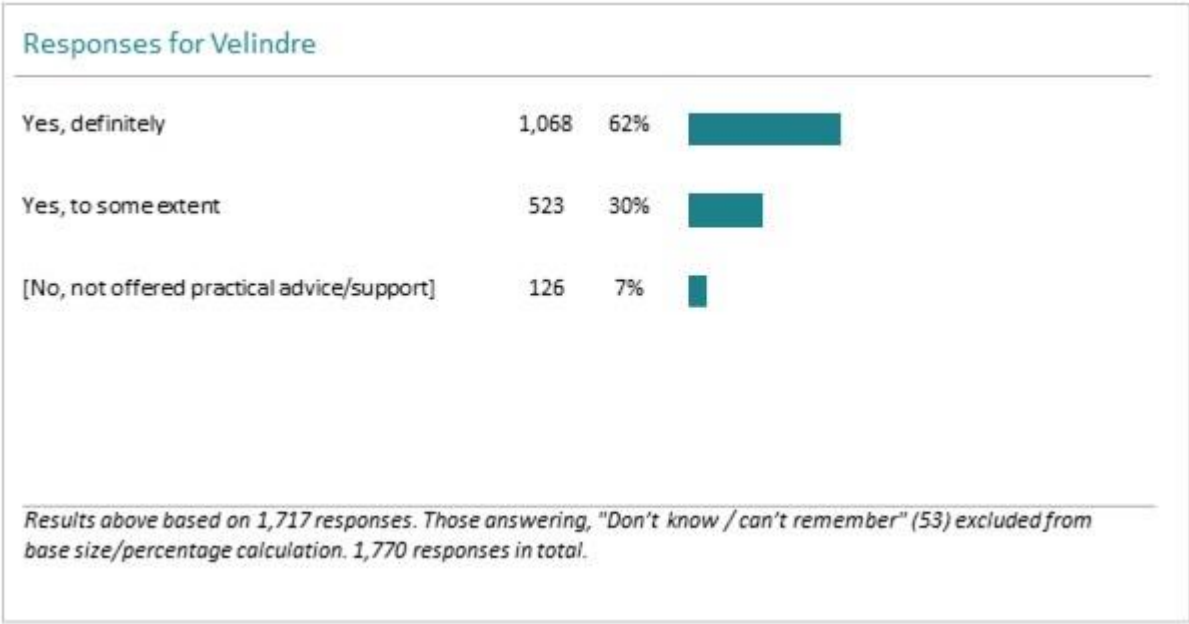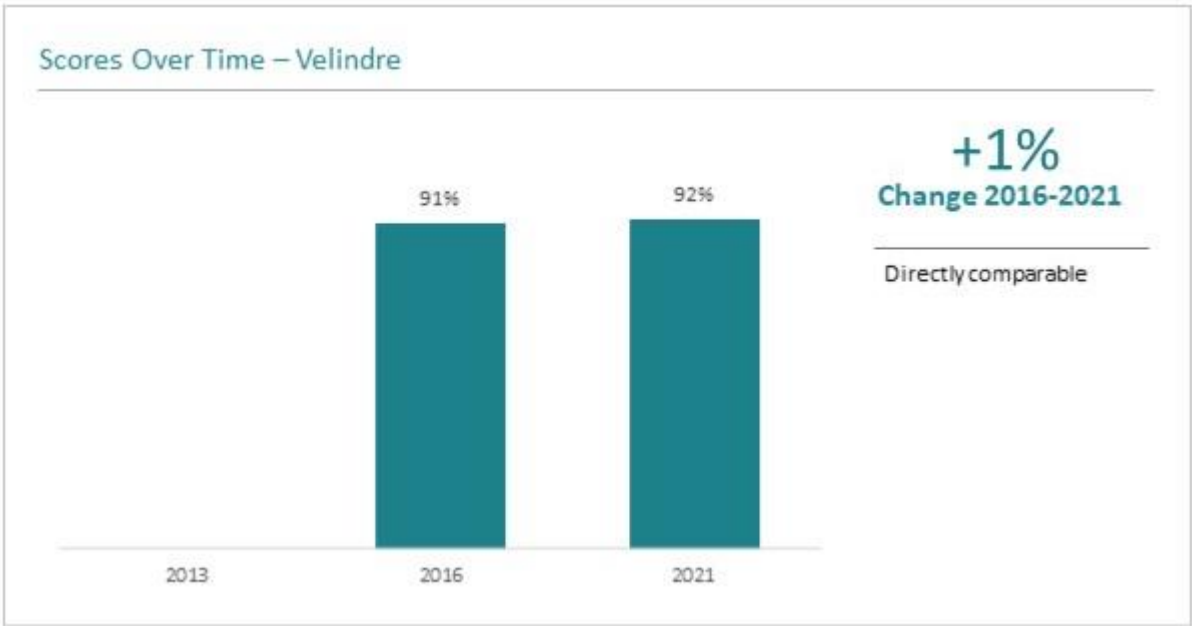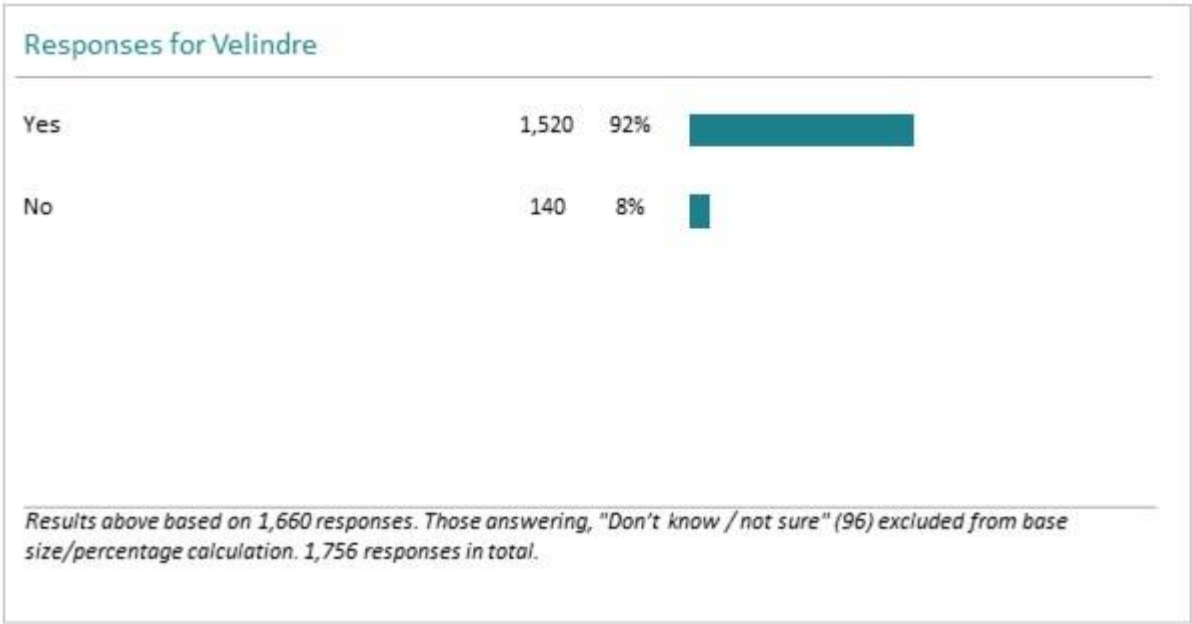
Question 19: "Before you started your treatment, were you also told about any side effects of the treatment that could affect you in the future rather than straight away?"
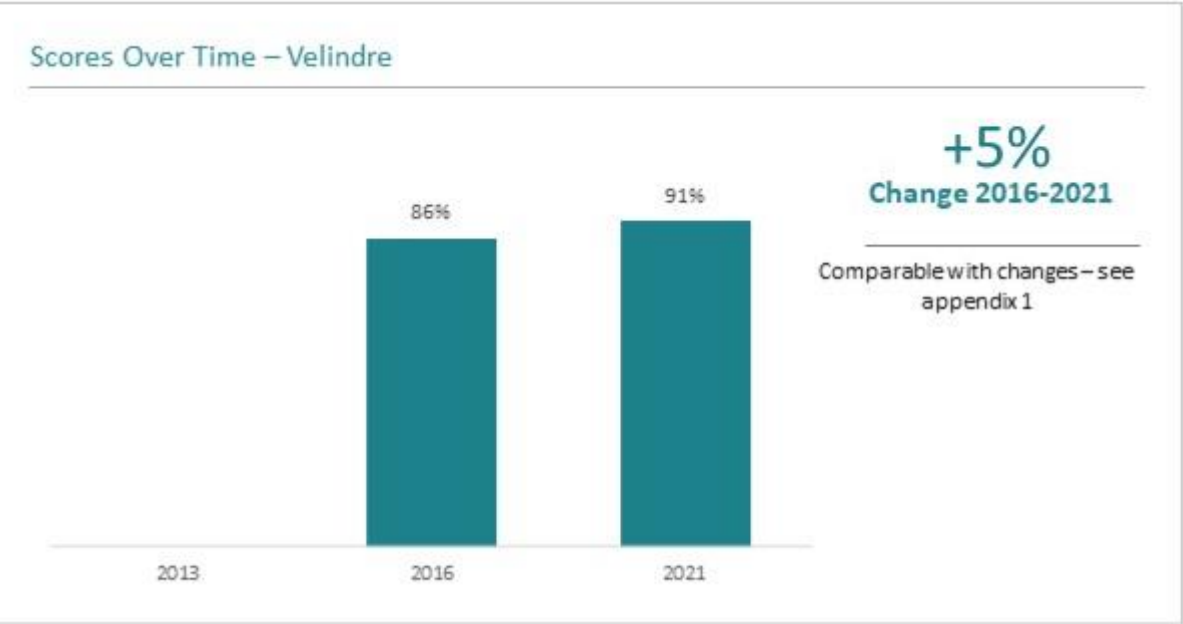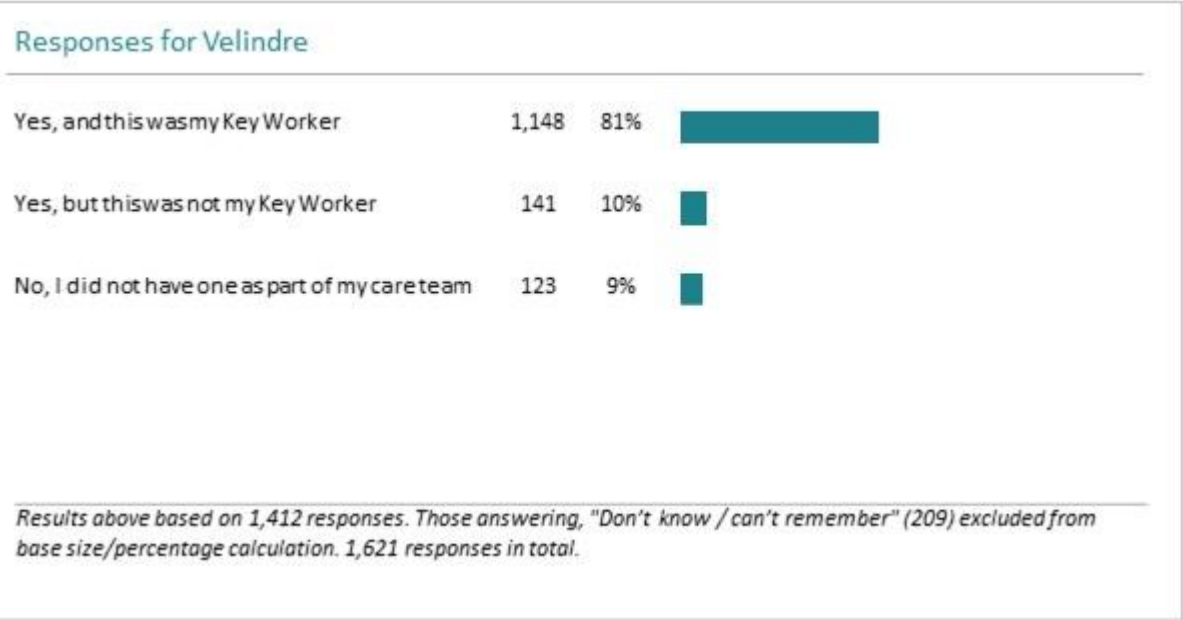
Responses for Velindre
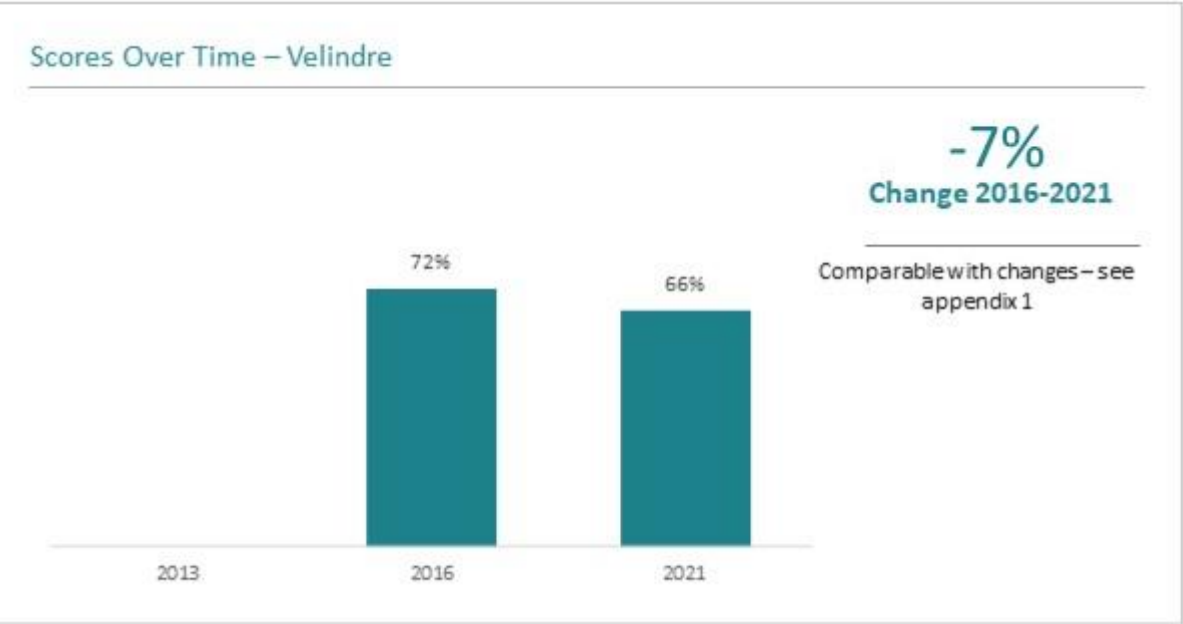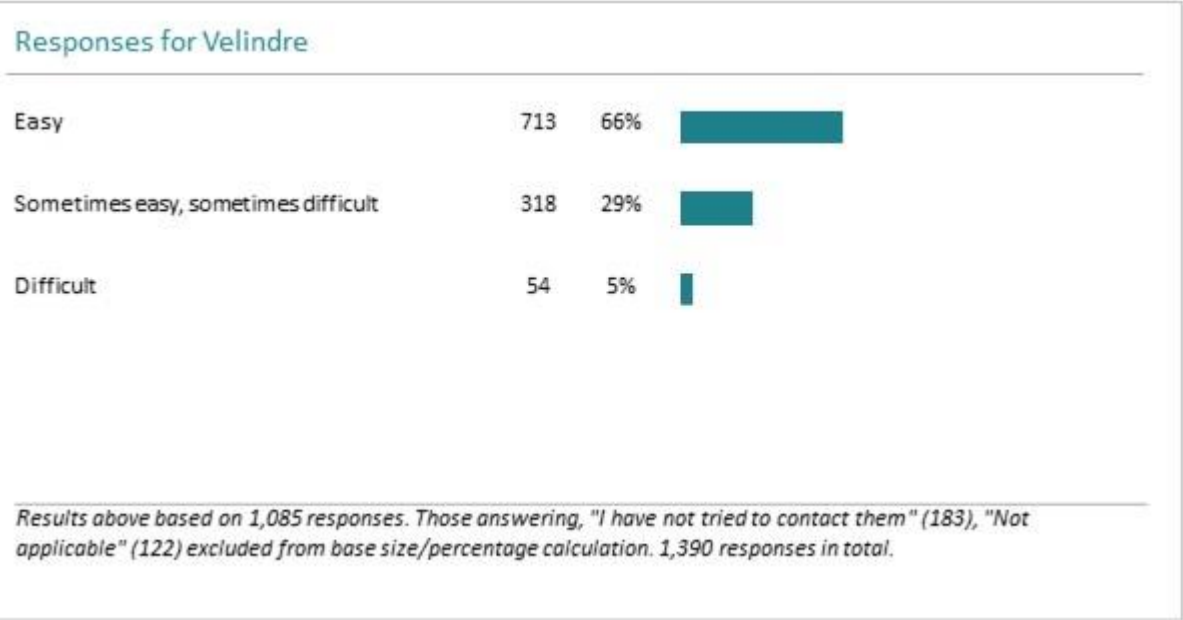
Yes, definitely	877	53%	
Yes, to some extent	476	29%	
No, future side effects were not explained	303	18%	

Results above based on 1,656 responses. Those answering, "I did not need an explanation" (36), "Don't know / can't remember" (78) excluded from base size/percentage calculation. 1,770 responses in total.

Velindre Question Level Score

53% of respondents were definitely told about side effects of treatment that could affect them in the future

Scores Over Time – Velindre

-6%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
61%	59%	53%

8.4 Healthcare professionals

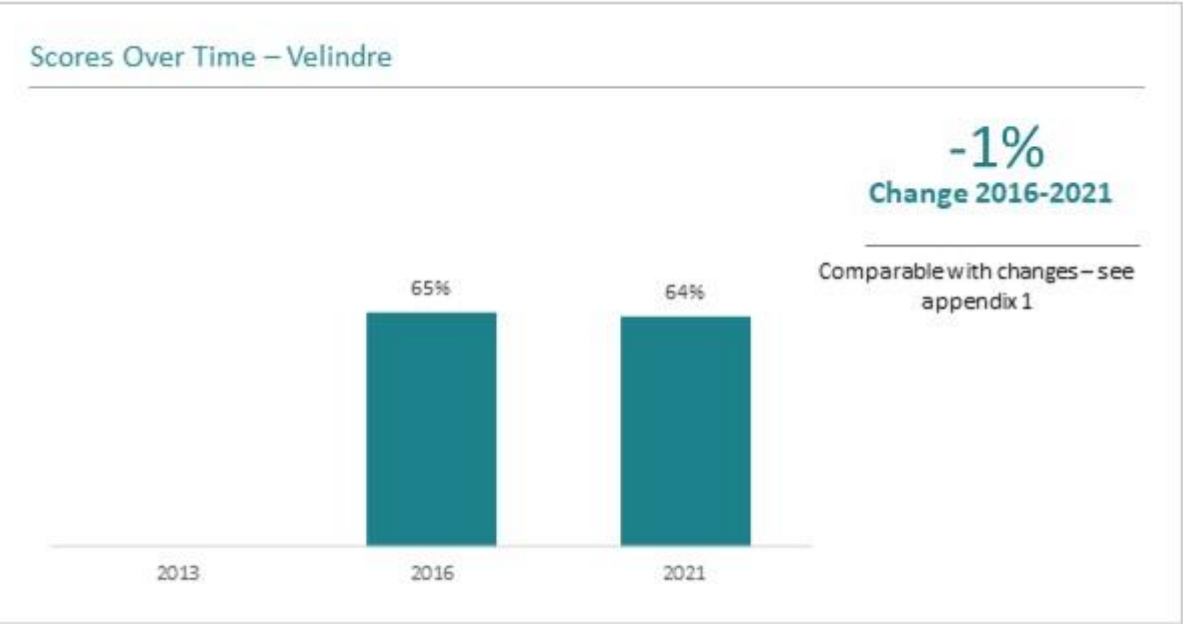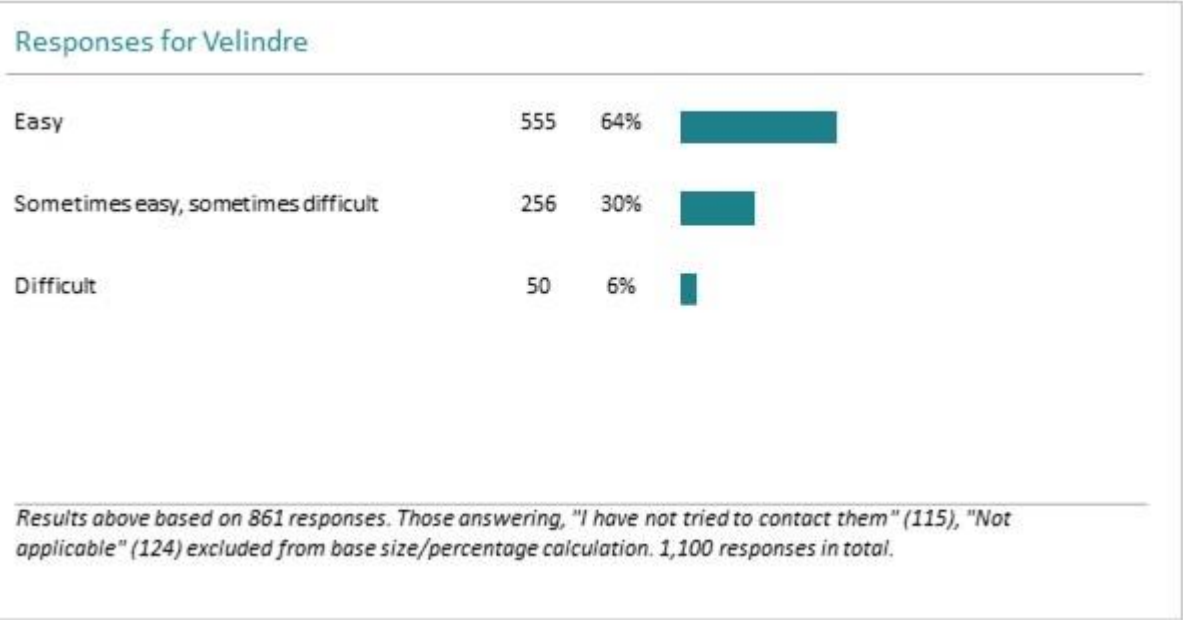**Question 20: "Were you given the name and contact details of your Key Worker?"**

Responses for Velindre

Yes	1,520	92%	
No	140	8%	

Results above based on 1,660 responses. Those answering, "Don't know / not sure" (96) excluded from base size/percentage calculation. 1,756 responses in total.

Velindre Question Level Score

92% of respondents were given name and contact details of a key worker

Scores Over Time – Velindre

91% 2016
92% 2021

+1%
Change 2016-2021

Directly comparable

2013   2016   2021

Question 21a: "Did your care include access to... A CNS?"

Responses for Velindre

Yes, and this was my Key Worker	1,148	81%	
Yes, but this was not my Key Worker	141	10%	
No, I did not have one as part of my care team	123	9%	

Results above based on 1,412 responses. Those answering, "Don't know / can't remember" (209) excluded from base size/percentage calculation. 1,621 responses in total.

Velindre Question Level Score

91% of respondents had access to a CNS

Scores Over Time – Velindre

2013	2016	2021
	86%	91%

+5%
Change 2016-2021

Comparable with changes – see appendix 1

Question 22a: "How easy was it for you to contact your... Key Worker?"

Responses for Velindre

Easy	713	66%	
Sometimes easy, sometimes difficult	318	29%	
Difficult	54	5%	

Results above based on 1,085 responses. Those answering, "I have not tried to contact them" (183), "Not applicable" (122) excluded from base size/percentage calculation. 1,390 responses in total.

Velindre Question Level Score

66%

of respondents said it was easy to contact their key worker

Scores Over Time – Velindre

-7%
Change 2016-2021

Comparable with changes – see appendix 1

2013   2016 72%   2021 66%

Question 22b: "How easy was it for you to contact your... CNS?"

Responses for Velindre

Easy	555	64%	
Sometimes easy, sometimes difficult	256	30%	
Difficult	50	6%	

Results above based on 861 responses. Those answering, "I have not tried to contact them" (115), "Not applicable" (124) excluded from base size/percentage calculation. 1,100 responses in total.

Velindre Question Level Score

64%

of respondents said it was easy to contact their CNS

Scores Over Time – Velindre

-1%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	65%	64%

Question 22c: "How easy was it for you to contact your... Other health professional?"

Responses for Velindre

Easy	326	59%	
Sometimes easy, sometimes difficult	180	33%	
Difficult	43	8%	

Results above based on 549 responses. Those answering, "I have not tried to contact them" (128), "Not applicable" (175) excluded from base size/percentage calculation. 852 responses in total.

Velindre Question Level Score

59%

of respondents said it was easy to contact their other health professional

Question 23a: "When you had questions to ask, how often did you get answers you can understand from your... Key Worker?"

Responses for Velindre

All or most of the time	866	84%	
Some of the time	133	13%	
Rarely or never	34	3%	

Results above based on 1,033 responses. Those answering, "I did not ask any questions" (110), "Not applicable" (151) excluded from base size/percentage calculation. 1,294 responses in total.

Velindre Question Level Score

84% of respondents were able to get answers they could understand from their key worker all or most of the time

Question 23b: "When you had questions to ask, how often did you get answers you can understand from your... CNS?"

Responses for Velindre

All or most of the time	772	85%	
Some of the time	109	12%	
Rarely or never	26	3%	

Results above based on 907 responses. Those answering, "I did not ask any questions" (82), "Not applicable" (144) excluded from base size/percentage calculation. 1,133 responses in total.

Velindre Question Level Score

85%

of respondents were able to get answers from their CNS all or most of the time

Scores Over Time – Velindre

90% (2016)
85% (2021)

-5%
Change 2016-2021

Comparable with changes – see appendix 1

2013   2016   2021

Question 23c: "When you had questions to ask, how often did you get answers you can understand from your... Other health professional?"

Responses for Velindre

All or most of the time	501	77%	
Some of the time	135	21%	
Rarely or never	17	3%	

Results above based on 653 responses. Those answering, "I did not ask any questions" (62), "Not applicable" (190) excluded from base size/percentage calculation. 905 responses in total.

Velindre Question Level Score

77%

of respondents were able to get answers from other health professionals all or most of the time

Question 24a: "Did they provide you with the information you needed to make informed decisions about your treatment? Key Worker"

Responses for Velindre

Yes, completely	802	77%	
Yes, to some extent	191	18%	
No	50	5%	

Results above based on 1,043 responses. Those answering, "Don't know / can't remember" (46), "Not applicable" (184) excluded from base size/percentage calculation. 1,273 responses in total.

Velindre Question Level Score

77%

of respondents agreed completely that their key worker provided them with the information they needed to make informed decisions about their treatment

Question 24b: "Did they provide you with the information you needed to make informed decisions about your treatment? CNS"

Responses for Velindre

Yes, completely	701	76%	
Yes, to some extent	181	20%	
No	43	5%	

Results above based on 925 responses. Those answering, "Don't know / can't remember" (35), "Not applicable" (164) excluded from base size/percentage calculation. 1,124 responses in total.

Velindre Question Level Score

76%

of respondents agreed completely that their CNS provided them with the information they needed to make informed decisions about their treatment

Scores Over Time – Velindre

-5%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	80%	76%

Question 24c: "Did they provide you with the information you needed to make informed decisions about your treatment? Other health professional"

Responses for Velindre

Yes, completely	483	73%	
Yes, to some extent	139	21%	
No	39	6%	

Results above based on 661 responses. Those answering, "Don't know / can't remember" (38), "Not applicable" (196) excluded from base size/percentage calculation. 895 responses in total.

Velindre Question Level Score

73%

of respondents agreed completely that other health professionals provided them with the information they needed to make informed decisions about their treatment

Question 25: "Were you offered the opportunity to discuss your needs and concerns?"[11]

Responses for Velindre

Yes - using a Holistic Needs Assessment	159	14%	
Yes - using a PROM assessment	56	5%	
[Yes, asked to complete HNA & PROM]	20	2%	
[Yes, offered discussion but unsure of format]	309	27%	
No	600	52%	

Results above based on 1,144 responses. Those answering, "Don't know / can't remember" (551) excluded from base size/percentage calculation. 1,695 responses in total.

Velindre Question Level Score

48% of respondents were offered an opportunity to discuss their needs and concerns

---

[11] A HNA is a Holistic Needs Assessment. Patient-Reported Outcome Measures (PROMs) are questionnaires that have been designed and tested with patients and clinicians for either specific diseases or for general health or quality of life.

Question 26: "Have you been offered a written care plan?"

Responses for Velindre

Yes	386	29%	
No	957	71%	

Results above based on 1,343 responses. Those answering, "I do not know / understand what a care plan is" (123), "Don't know / can't remember" (270) excluded from base size/percentage calculation. 1,736 responses in total.

Velindre Question Level Score

29% of respondents were offered a written care plan
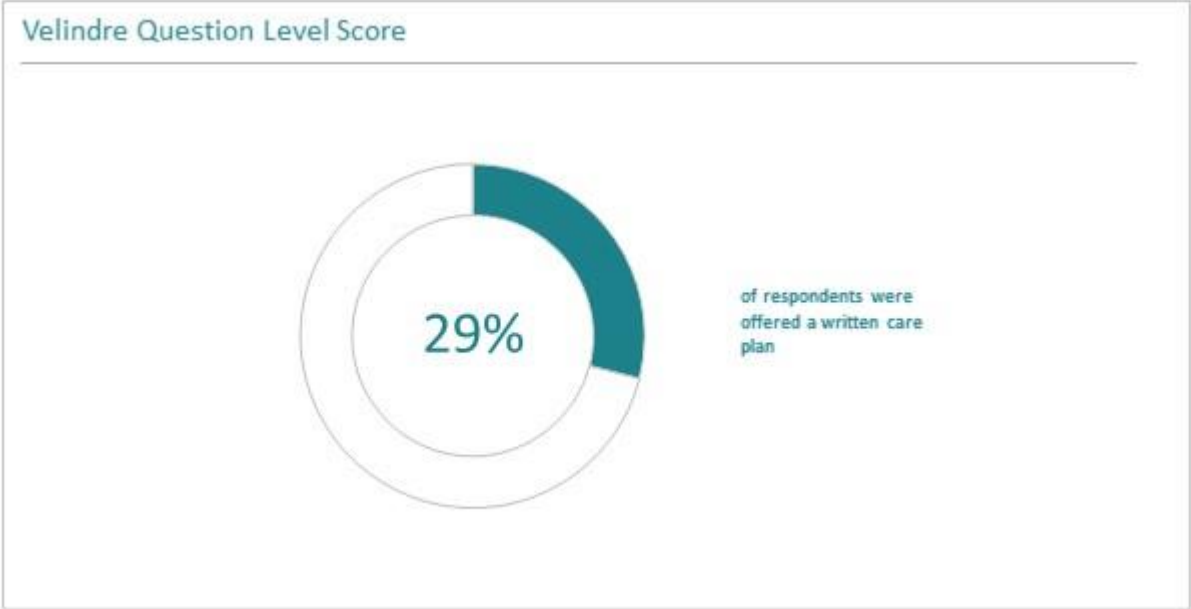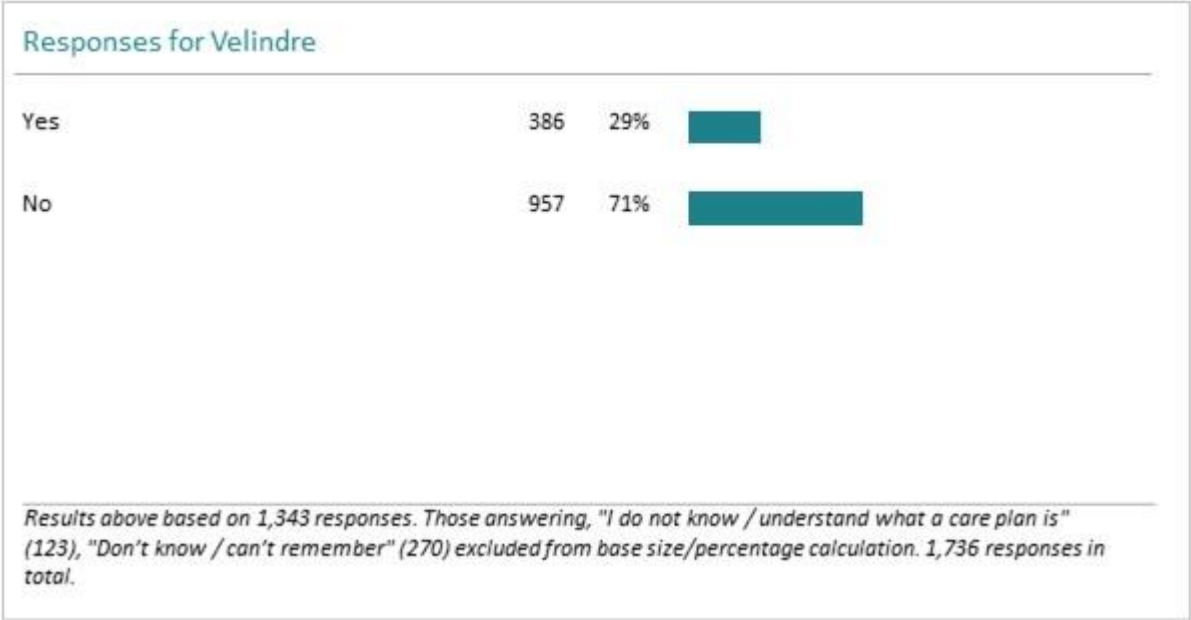
8.5 Support for people living with cancer

Question 27: "How much information about support or self-help groups did your healthcare team give you?"

Responses for Velindre

Not enough	224	14%	
The right amount	1,033	66%	
Too much	23	1%	
I was not given any information	285	18%	

Results above based on 1,565 responses. Those answering, "Don't know / can't remember" (188) excluded from base size/percentage calculation. 1,753 responses in total.

Velindre Question Level Score

66% of respondents said they were given the right amount of information about support/self help groups

Wales Cancer Patient Experience Survey 2021/22

Question 28: "During your care, were you told about voluntary or charity support?"

Responses for Velindre

Yes	972	64%
No	544	36%

Results above based on 1,516 responses. Those answering, "Don't know / can't remember" (246) excluded from base size/percentage calculation. 1,762 responses in total.

Velindre Question Level Score

64% of respondents were told about voluntary/charity support during their care

Scores Over Time – Velindre

-6%
Change 2016-2021

Directly comparable

2013	2016	2021
	70%	64%

Question 29: "Did your healthcare team discuss with you or give you information about the impact cancer could have on your day-to-day activities (for example, work life or education)?"

Responses for Velindre

Yes, completely	642	40%	
Yes, to some extent	580	36%	
No	402	25%	

Results above based on 1,624 responses. Those answering, "Don't know / can't remember" (131) excluded from base size/percentage calculation. 1,755 responses in total.

Velindre Question Level Score

40%

of respondents agreed completely that they had a discussion, or were given information about the impact cancer could have on their day to day activities

Question 30: "Did your healthcare team give you information about how to get financial help or any benefits you might be entitled to?"

Responses for Velindre

Yes	628	60%	
Yes, but I would have liked more information	122	12%	
No, but I would have liked information	302	29%	

Results above based on 1,052 responses. Those answering, "It was not necessary" (614), "Don't know / can't remember" (86) excluded from base size/percentage calculation. 1,752 responses in total.

Velindre Question Level Score

60% of respondents said they were given enough information on how to get financial support or any benefits they were entitled to

8.6 Operations

Question 32: "Beforehand, did you have all the information you needed about your operation?"

Responses for Velindre

Yes	352	94%
No, I would have liked more information	23	6%

Results above based on 375 responses. Those answering, "Don't know / can't remember" (3) excluded from base size/percentage calculation. 378 responses in total.

Velindre Question Level Score

94%

of respondents said they were given all the information they needed before their operation

Question 33: "After the operation, did a member of staff explain how it had gone in a way you could understand?"

Responses for Velindre

|			
Yes, completely	271	74%	
Yes, to some extent	78	21%	
No, but I would have liked an explanation	19	5%	

Results above based on 368 responses. Those answering, "I did not need an explanation" (5) excluded from base size/percentage calculation. 373 responses in total.
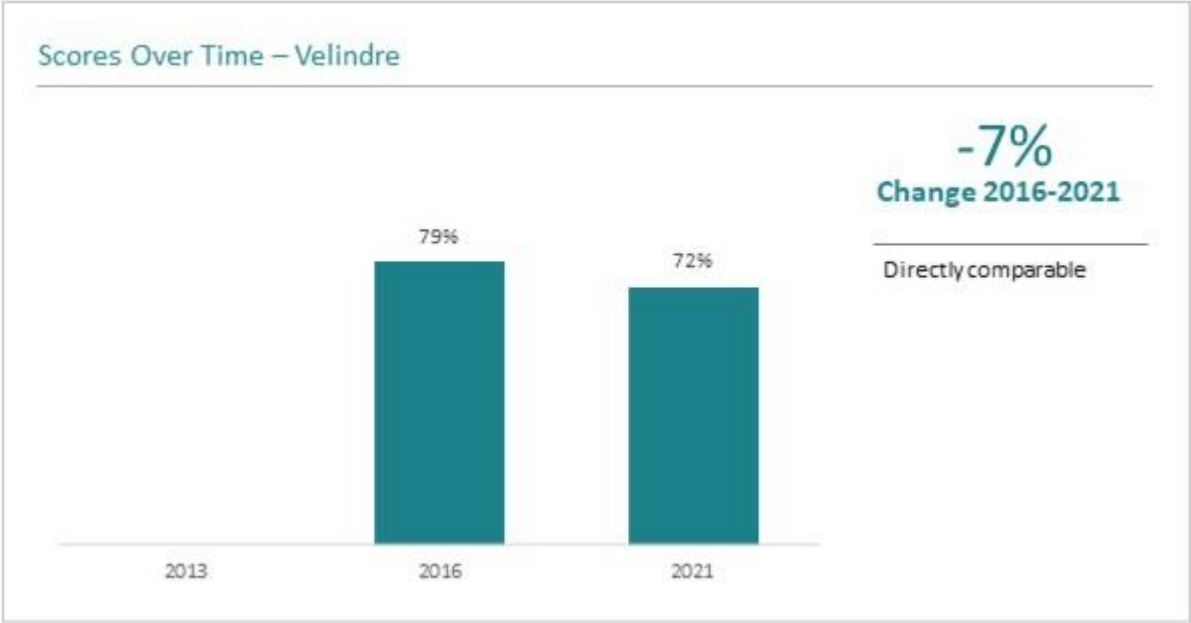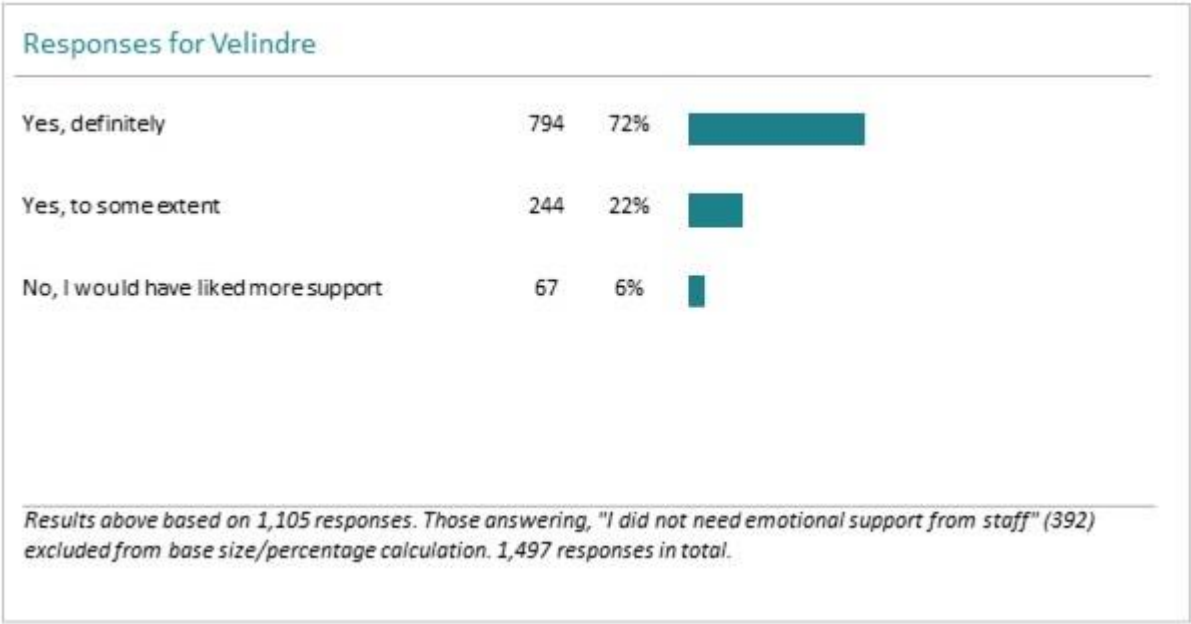
Velindre Question Level Score

74% of respondents said a member of staff explained how the operation had gone in a way they could completely understand

Scores Over Time – Velindre

-5%
Change 2016-2021

Directly comparable

2013	2016	2021
	78%	74%

8.7 Hospital care as an inpatient

Question 35: "Overall, while you were in hospital, were you treated with dignity and respect?"

Responses for Velindre

Yes, always	365	88%	
Yes, sometimes	40	10%	
No	8	2%	

Results above based on 413 responses.

Velindre Question Level Score

88% of respondents said that they were always treated with dignity and respect in hospital

Scores Over Time – Velindre

89% (2016) 88% (2021)

-1%
Change 2016-2021

Directly comparable

2013   2016   2021
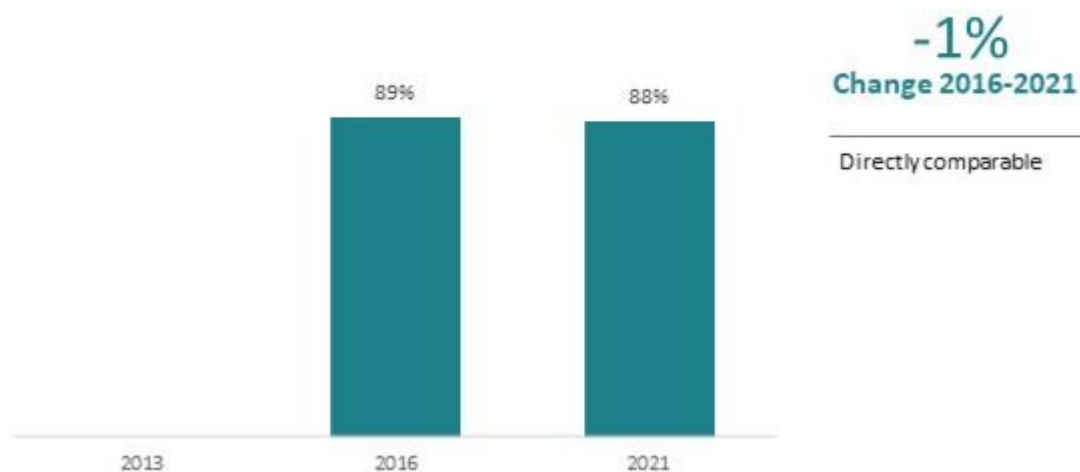
Question 36: "Were you able to discuss any worries or fears with staff during your hospital visit?"

Responses for Velindre

As much as I wanted	238	63%	
Most of the time	65	17%	
Some of the time	44	12%	
Not at all, but would have liked to	30	8%	

Results above based on 377 responses. Those answering, "I did not have any worries or fears" (33) excluded from base size/percentage calculation. 410 responses in total.

Velindre Question Level Score

63% of respondents were able to discuss any worries or fears they had, as much as they wanted with staff

Scores Over Time – Velindre

-6%
Change 2016-2021

Directly comparable

2013	2016	2021
	69%	63%

Question 37: "Did your family or someone else close to you have enough opportunity to talk to a healthcare professional?"

Responses for Velindre

Yes, definitely	134	39%	
Yes, to some extent	94	27%	
No	120	34%	

Results above based on 348 responses. Those answering, "No family or friends were involved" (53), "My family did not want to talk to a healthcare professional" (10) excluded from base size/percentage calculation. 411 responses in total.

Velindre Question Level Score

39%

of respondents said that a family member or someone else close to them definitely had enough opportunity to talk to a healthcare professional

Scores Over Time – Velindre

n/a
Change 2016-2021

Not comparable

39%

2013	2016	2021

Question 38: "Did you have confidence and trust in the healthcare professionals treating you?"

Responses for Velindre

Yes, in all of them	341	82%	
Yes, in some of them	71	17%	
No, in none of them	5	1%	

Results above based on 417 responses.

Velindre Question Level Score

82%

of respondents had confidence and trust in all of the healthcare professionals involved in their care
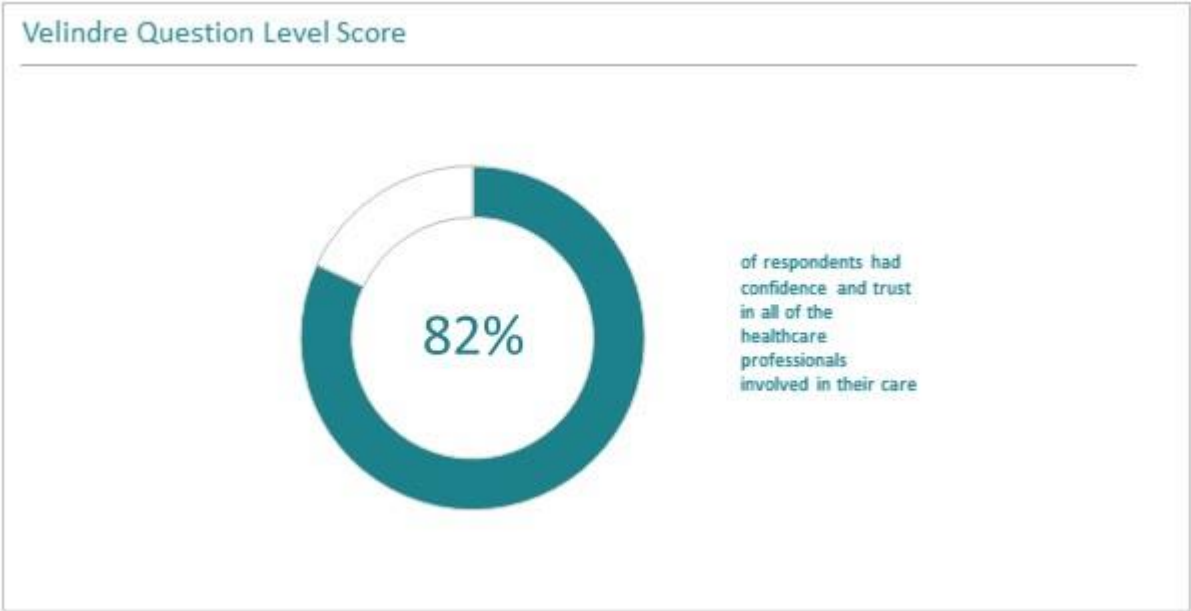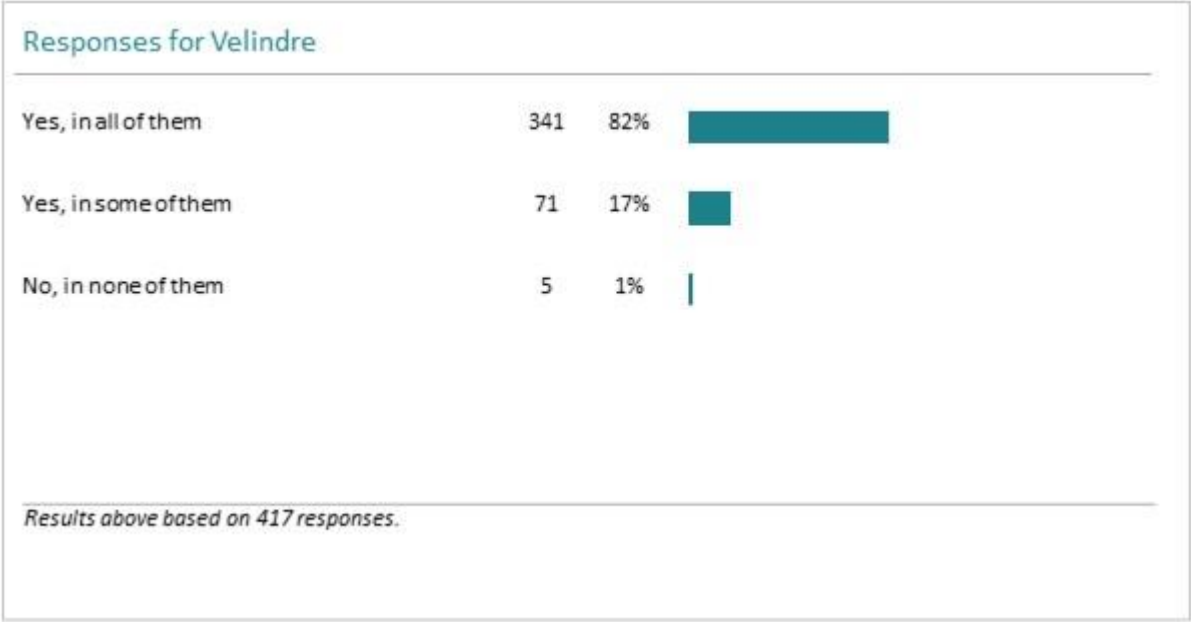
Question 39: "Were you given enough privacy when discussing your condition or treatment?"

Responses for Velindre

Yes, always	364	88%	
Yes, sometimes	38	9%	
No	12	3%	

Results above based on 414 responses.

Velindre Question Level Score

88%

of respondents said they were always given enough privacy when discussing their condition or treatment

Scores Over Time – Velindre

86% (2016)

88% (2021)

+1%
Change 2016-2021

Directly comparable

2013   2016   2021
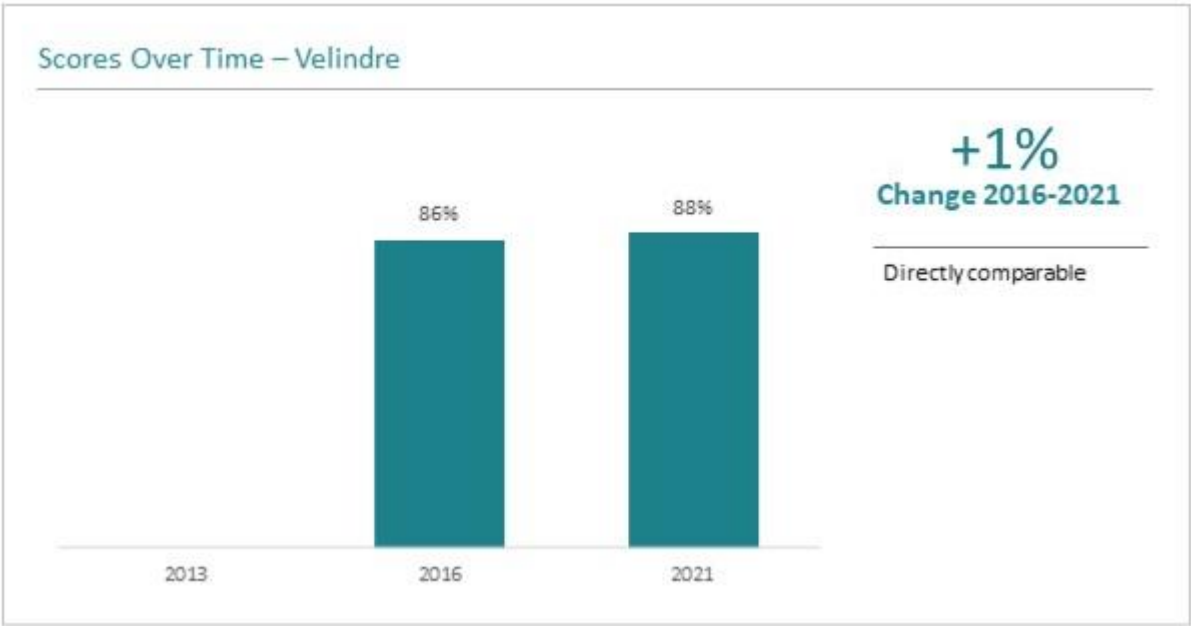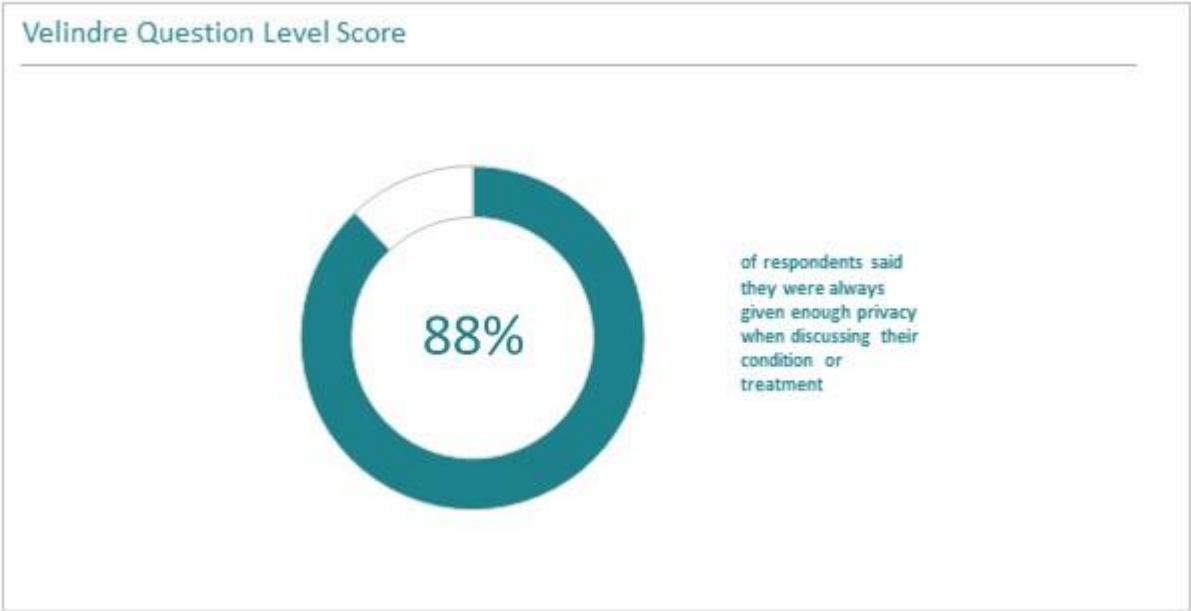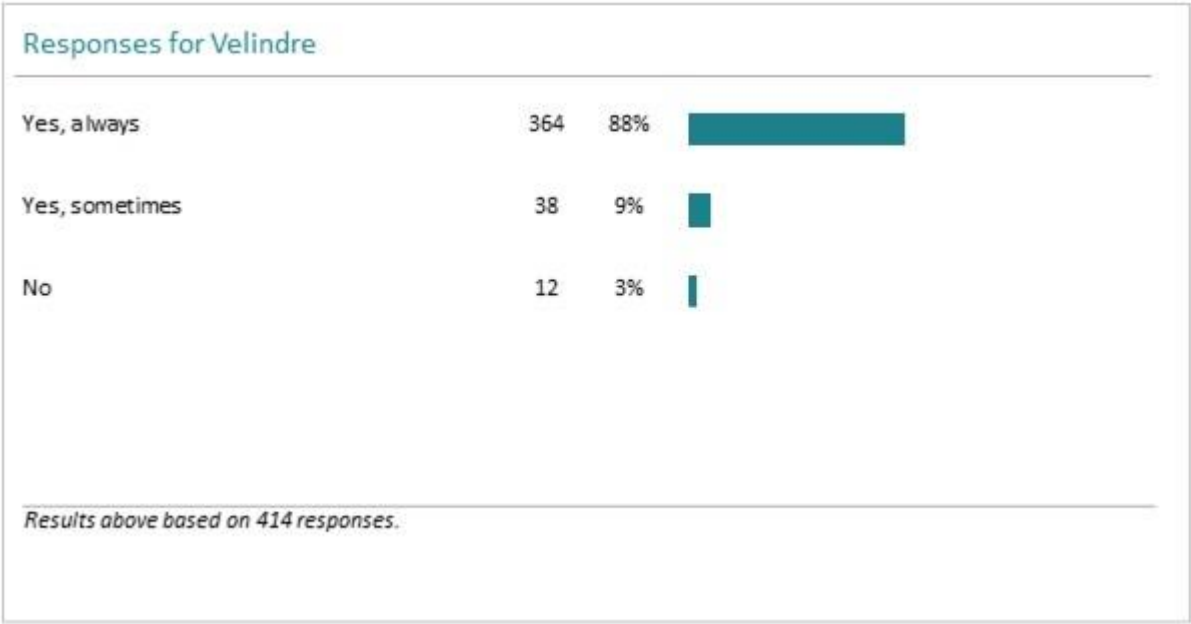
Question 40: "Were you given enough privacy when being examined or treated?"

Responses for Velindre

Yes, always	389	93%
Yes, sometimes	27	6%
No	2	0%

Results above based on 418 responses.

Velindre Question Level Score

93%

of respondents said they were always given enough privacy when being examined or treated

Scores Over Time – Velindre

96% — 2016
93% — 2021

-3%
Change 2016-2021

Directly comparable

2013 2016 2021
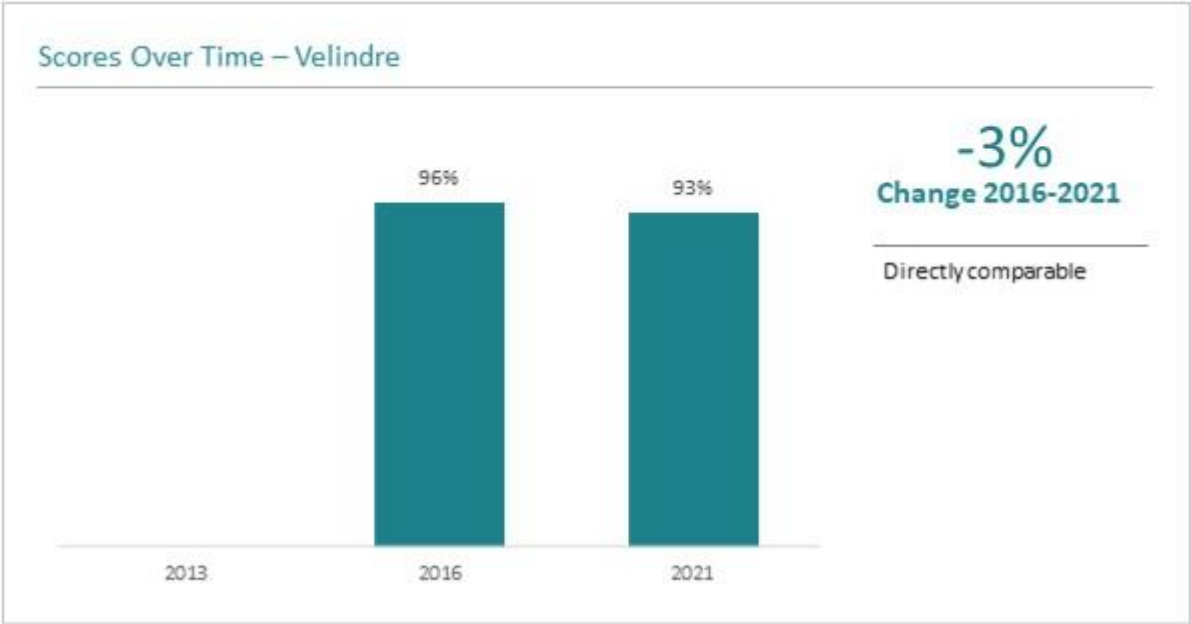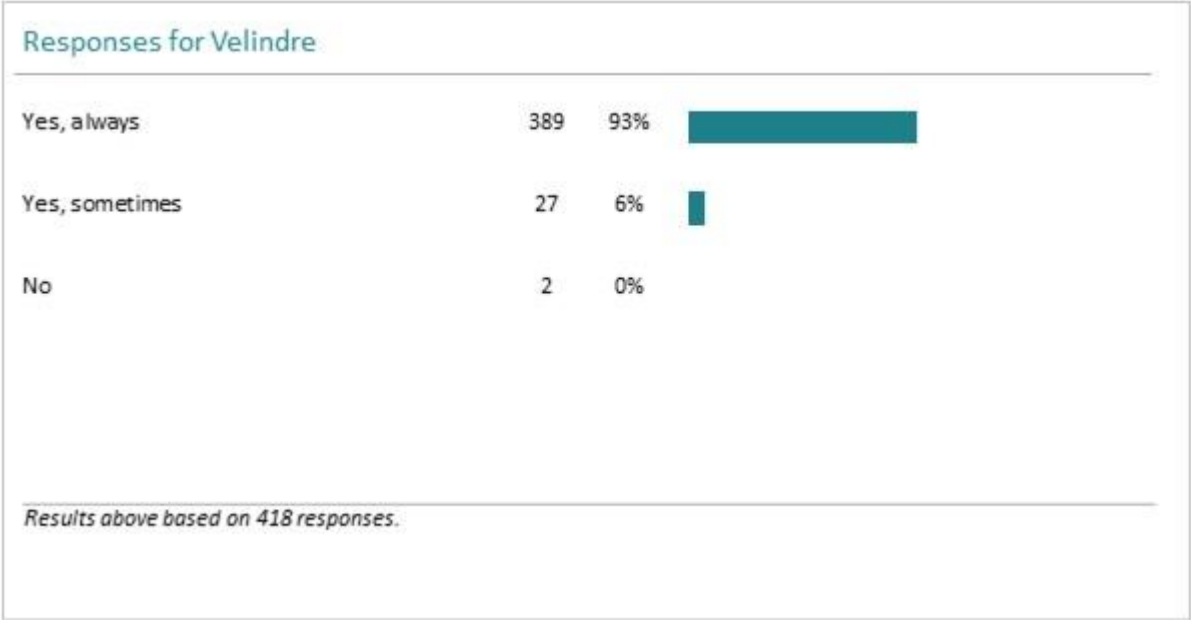
Question 41: "Do you think the hospital staff did everything they could to help control your pain?"

Responses for Velindre

All of the time	319	85%	
Some of the time	54	14%	
Not at all	4	1%	

Results above based on 377 responses. Those answering, "I did not have any pain" (36) excluded from base size/percentage calculation. 413 responses in total.

Velindre Question Level Score

85%

of respondents said that hospital staff did everything they could to control their pain all of the time

Scores Over Time – Velindre

-4%
Change 2016-2021

Directly comparable

2013	2016	2021
	89%	85%

Question 42: "Were you given clear written information about what you should or should not do after leaving hospital?"

Responses for Velindre

Yes	278	78%	
No	77	22%	

Results above based on 355 responses. Those answering, "I did not need written information" (49), "Don't know / can't remember" (13) excluded from base size/percentage calculation. 417 responses in total.

Velindre Question Level Score

78%

of respondents were given clear written information about what to do or not do after leaving hospital

Scores Over Time – Velindre

86%   78%

-7%
Change 2016-2021

Comparable with changes – see appendix 1

2013   2016   2021

Question 43: "Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?"

Responses for Velindre

|			
Yes	365	92%	
No	32	8%	

Results above based on 397 responses. Those answering, "Don't know / can't remember" (23) excluded from base size/percentage calculation. 420 responses in total.

Velindre Question Level Score

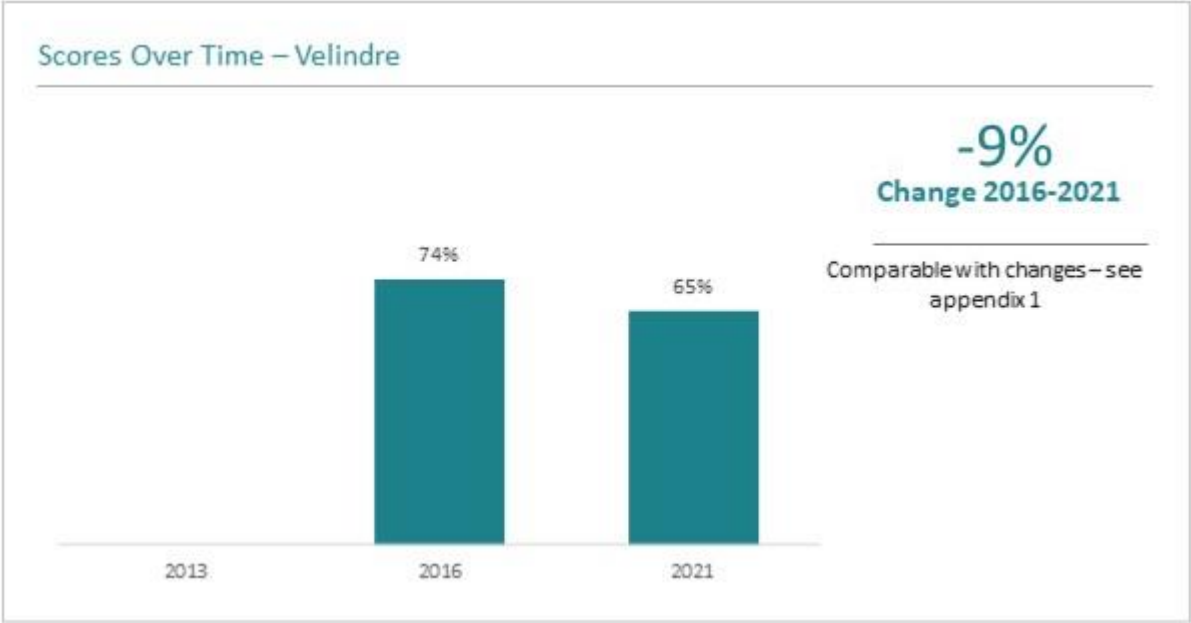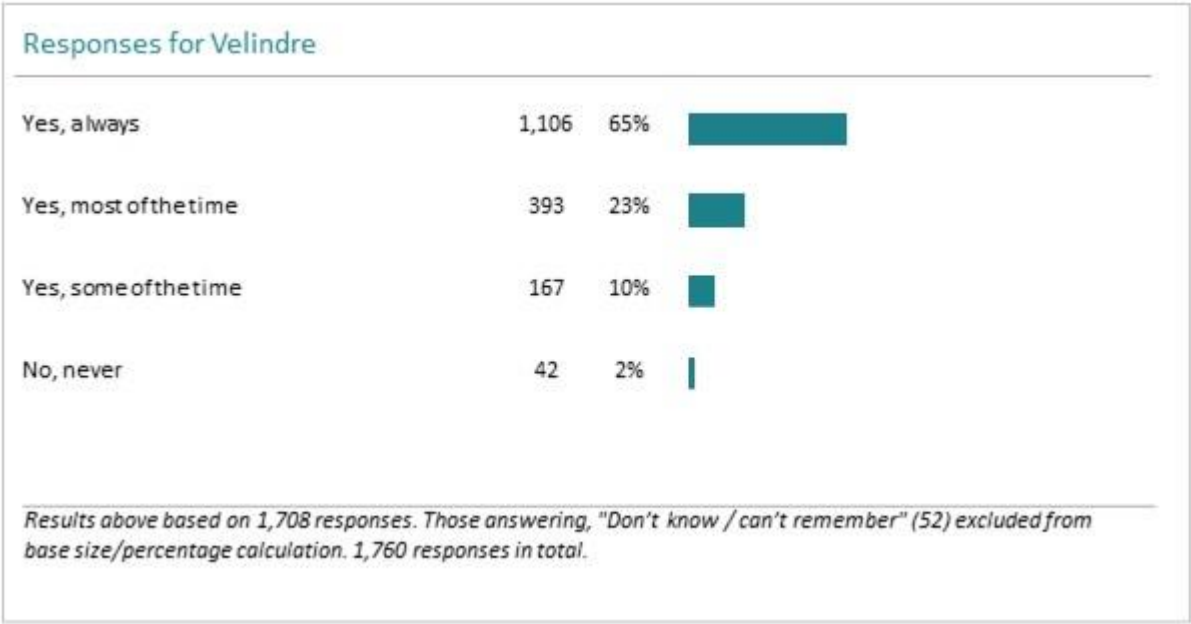**92%** of respondents were told by hospital staff who to contact if worried after leaving hospital

Scores Over Time – Velindre

95% (2016)
92% (2021)

-3%
Change 2016-2021

Directly comparable

2013   2016   2021

8.8 Outpatients / day case appointments

Question 45: "While you were being treated as an outpatient or day case, did hospital staff do everything they could to help control your pain?"

Responses for Velindre

Yes, definitely	630	84%	
Yes, to some extent	106	14%	
No, they could have done more	17	2%	

Results above based on 753 responses. Those answering, "I did not have any pain" (741) excluded from base size/percentage calculation. 1,494 responses in total.

Velindre Question Level Score

84%

of respondents said that hospital staff definitely did everything they could to control their pain while they were being treated as an outpatient or day case

Scores Over Time – Velindre

88% (2016)   84% (2021)

-4%
Change 2016-2021

Directly comparable

2013   2016   2021
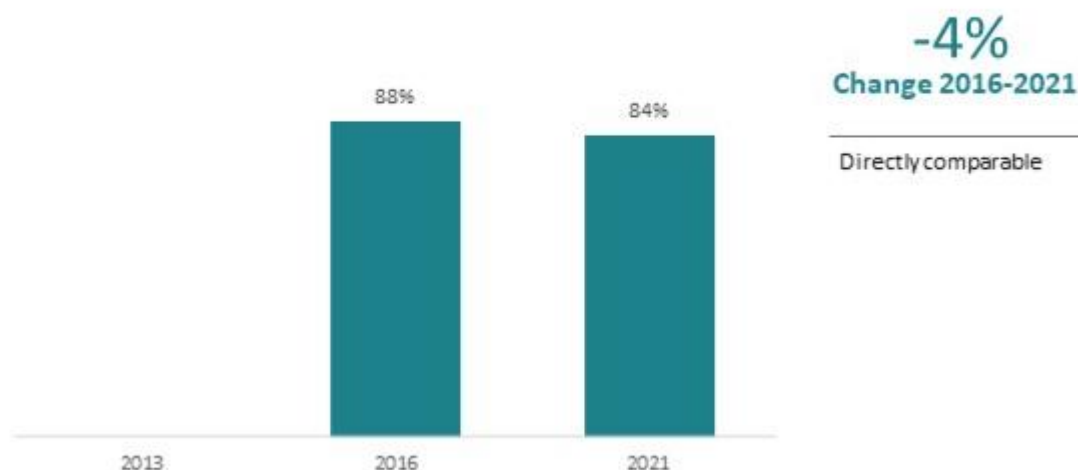
Question 46: "While you were being treated as an outpatient or day case, were you given enough emotional support from hospital staff?"

Responses for Velindre

Yes, definitely	794	72%	
Yes, to some extent	244	22%	
No, I would have liked more support	67	6%	

Results above based on 1,105 responses. Those answering, "I did not need emotional support from staff" (392) excluded from base size/percentage calculation. 1,497 responses in total.

Velindre Question Level Score

72%

of respondents said that hospital staff definitely gave them enough emotional support while being treated as an outpatient or day case

Scores Over Time – Velindre

-7%
Change 2016-2021

Directly comparable

79% — 2016
72% — 2021

2013   2016   2021

8.9 Radiotherapy / chemotherapy

Question 48: "Beforehand, did you have all of the information you needed about your radiotherapy treatment?"

Responses for Velindre

Yes, completely	1,071	82%	
Yes, to some extent	210	16%	
No	29	2%	

Results above based on 1,310 responses. Those answering, "I did not need any information" (6) excluded from base size/percentage calculation. 1,316 responses in total.

Velindre Question Level Score

82%

of respondents completely agreed that they had all the information they needed before they started their radiotherapy treatment

Question 50: "Beforehand, did you have all of the information you needed about your chemotherapy treatment?"

Responses for Velindre

Yes, completely	769	78%	
Yes, to some extent	199	20%	
No	22	2%	

Results above based on 990 responses. Those answering, "I did not need any information" (8) excluded from base size/percentage calculation. 998 responses in total.

Velindre Question Level Score

78%

of respondents completely agreed that they had all the information they needed before they started their chemotherapy treatment

8.10 Arranging home support

Question 51: "Did healthcare professionals give your family or someone close to you all the information they needed to help care for you at home?"

Responses for Velindre

Yes, definitely	633	44%	
Yes, to some extent	370	26%	
No	425	30%	

Results above based on 1,428 responses. Those answering, "No family or friends were involved" (256), "My family did not want to talk to a healthcare professional" (38) excluded from base size/percentage calculation. 1,722 responses in total.

Velindre Question Level Score

44%

of respondents said that their family member or someone close to them were definitely given enough information about helping to care for them at home

Question 52: "Were you given information about how to manage your health and wellbeing after your treatment ends?)"

Responses for Velindre

Yes, definitely	633	45%	
Yes, to some extent	395	28%	
No	368	26%	

Results above based on 1,396 responses. Those answering, "Don't know / can't remember" (127), "Not applicable" (221) excluded from base size/percentage calculation. 1,744 responses in total.

Velindre Question Level Score

45%

of respondents said that they were definitely given enough information about how to manage health and wellbeing after their treatment ends

Question 53: "Were you offered practical advice and support in dealing with the side effects of your treatment(s) at home (such as physical activity advice, how to manage diet and fatigue)?"

Responses for Velindre

Yes, definitely	765	47%	
Yes, to some extent	585	36%	
[No, not offered practical advice/support]	282	17%	

Results above based on 1,632 responses. Those answering, "Don't know / can't remember" (108) excluded from base size/percentage calculation. 1,740 responses in total.

Velindre Question Level Score

47%

of respondents said they were definitely offered enough practical advice and support in dealing with the side effects of their treatment at home

Scores Over Time – Velindre

-15%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	61%	47%

Question 54: "After leaving hospital, were you given enough care and help from health or social services (for example, district nurses, home helps or physiotherapists)?"

Responses for Velindre

Yes, definitely	539	52%	
Yes, to some extent	277	27%	
No	229	22%	

Results above based on 1,045 responses. Those answering, "I did not need help" (666), "Don't know / can't remember" (12) excluded from base size/percentage calculation. 1,723 responses in total.

Velindre Question Level Score

52%

of respondents said they were definitely given enough care and help from health or social services after leaving hospital

Scores Over Time – Velindre

-8%
Change 2016-2021

Directly comparable

2013	2016	2021
	60%	52%

8.11 Care from your General Practice

Question 55: "After leaving hospital, were you given enough care and help from your GP and the GP practice?"

Responses for Velindre

Yes, definitely	373	31%
Yes, to some extent	320	27%
No	498	42%

Results above based on 1,191 responses. Those answering, "I did not need help" (527), "Don't know / can't remember" (14) excluded from base size/percentage calculation. 1,732 responses in total.

Velindre Question Level Score

31% of respondents said they were definitely given enough care and help from their GP and GP practice after leaving hospital

Scores Over Time – Velindre

-22%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	54%	31%
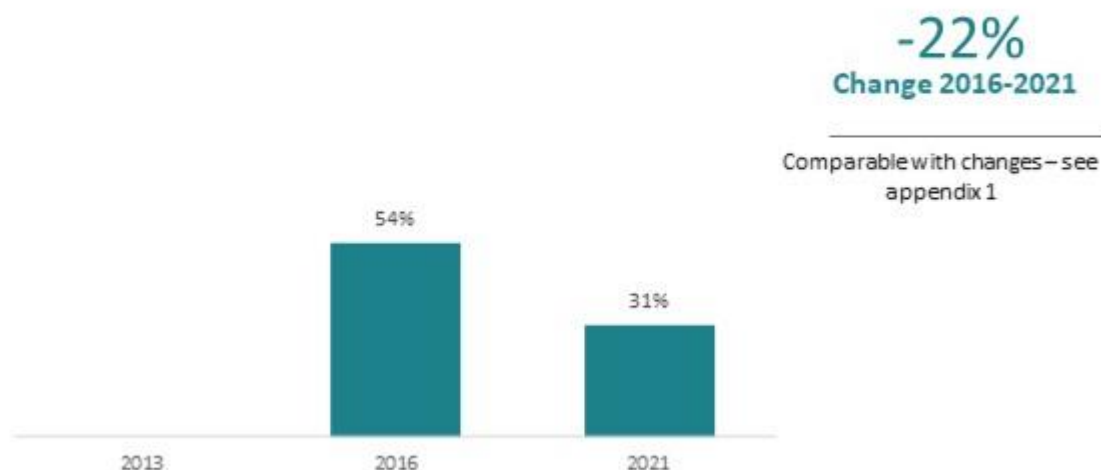
Question 56: "As far as you know, did your GP practice have all the information they needed about your care after leaving hospital?"

Responses for Velindre

Yes	878	86%	
No	142	14%	

Results above based on 1,020 responses. Those answering, "Don't know / can't remember" (718) excluded from base size/percentage calculation. 1,738 responses in total.

Velindre Question Level Score

86%

of respondents said that as far as they know, their GP had all the information they needed about their care after they left hospital
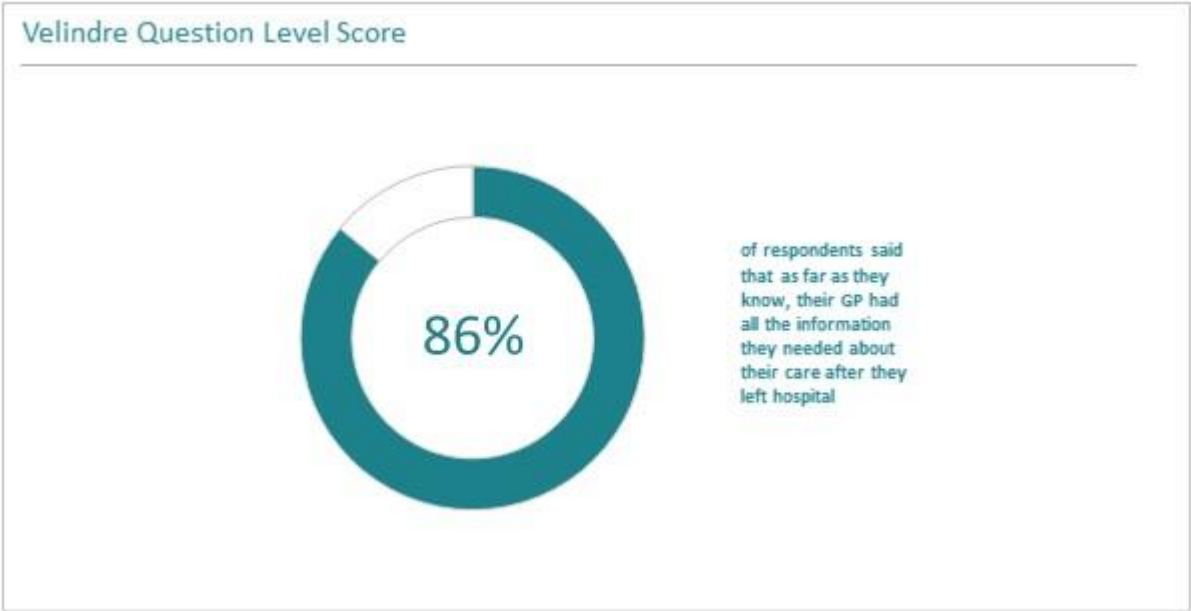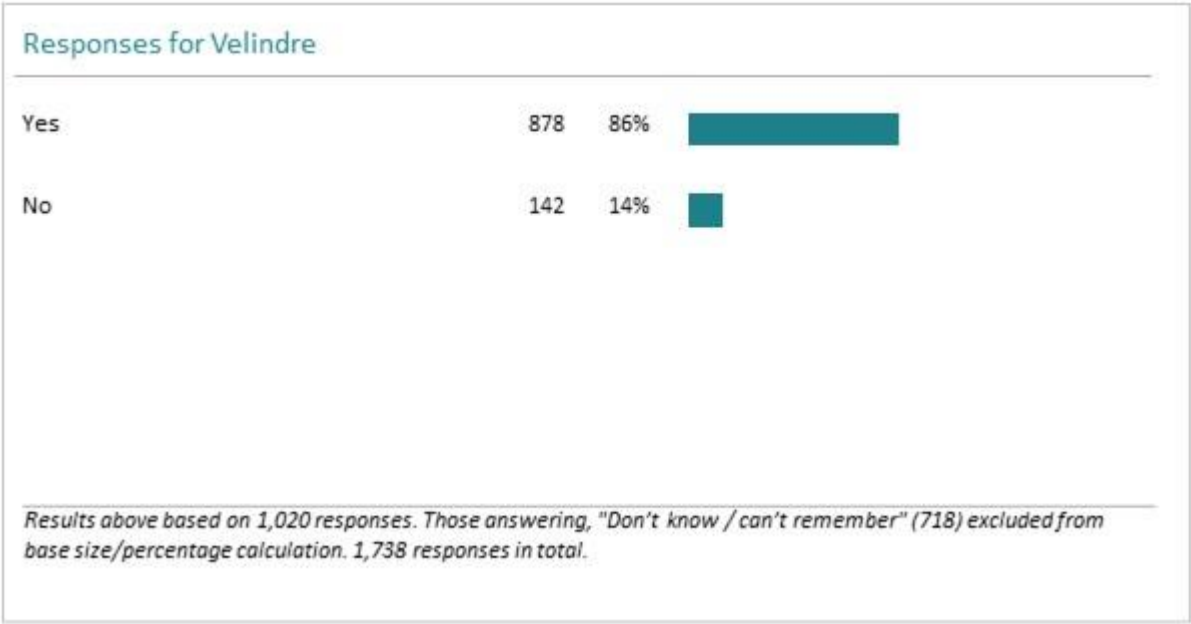
8.12   Your overall NHS care

Question 57: "Since your diagnosis, has anyone discussed with you whether you would like to take part in cancer research (e.g. clinical trials)?"

Responses for Velindre

Yes	413	25%	
No	1,251	75%	

Results above based on 1,664 responses. Those answering, "Don't know / can't remember" (103) excluded from base size/percentage calculation. 1,767 responses in total.

Velindre Question Level Score

25%

of respondents said they have had a discussion about taking part in cancer research

Scores Over Time – Velindre

-5%
Change 2016-2021

Directly comparable

2013	2016	2021
	30%	25%
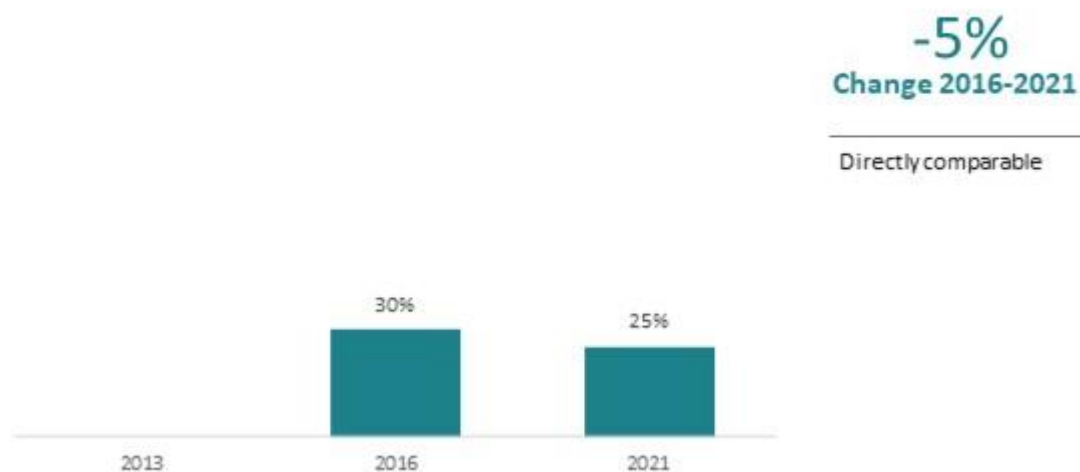
Question 58: "Since your diagnosis, have the different professionals treating and caring for you worked well together to give you the best possible care?"

Responses for Velindre

Yes, always	1,106	65%	
Yes, most of the time	393	23%	
Yes, some of the time	167	10%	
No, never	42	2%	

Results above based on 1,708 responses. Those answering, "Don't know / can't remember" (52) excluded from base size/percentage calculation. 1,760 responses in total.

Velindre Question Level Score

65% of respondents said the different professionals treating and caring for them have worked well together all of the time

Scores Over Time – Velindre

-9%
Change 2016-2021

Comparable with changes – see appendix 1

2013	2016	2021
	74%	65%

Question 59: "Overall, how would you rate the administration of your care (getting letters at the right time, doctors having the right notes/tests results, etc.)?"

Responses for Velindre

Very good	1,086	62%	
Good	475	27%	
Neither good nor bad	140	8%	
Quite bad	39	2%	
Very bad	12	1%	

Results above based on 1,752 responses. Those answering, "Don't know / can't remember" (15) excluded from base size/percentage calculation. 1,767 responses in total.

Velindre Question Level Score

89% of respondents rated the overall administration of their care as good or very good

Scores Over Time – Velindre

93% (2016)   89% (2021)

-4%
Change 2016-2021

Directly comparable

2013   2016   2021

Question 60: "Were you able to speak in Welsh to staff if you needed to?"

Responses for Velindre

Yes, completely	57	24%	
Yes, to some extent	29	12%	
No	153	64%	

Results above based on 239 responses. Those answering, "Don't know / can't remember" (30), "Not applicable to me" (1477) excluded from base size/percentage calculation. 1,746 responses in total.

Velindre Question Level Score

24%

of respondents completely agreed that they were able to speak in Welsh if they needed to

Question 61: "Overall, how would you rate your care? 0 is I had a very poor experience and 10 is I had a very good experience"[12]

Responses for Velindre

0	2	0%	
1	7	0%	
2	4	0%	
3	13	1%	
4	23	1%	
5	40	2%	
6	50	3%	
7	116	7%	
8	277	16%	
9	347	21%	
10	804	48%	

8.82
overall rating of care

Results above based on 1,683 responses. Those answering, "No answer" (12) excluded from base size/percentage calculation. 1,695 responses in total.

Responses for Velindre

8.82

Overall rating of care

Scores Over Time – Velindre

9.01 (2016)   8.82 (2021)

-0.19
Change 2016-2021

Directly comparable

2013   2016   2021

---

[12] Question 61 asks respondents to rate their overall care on a scale of 0 to 10. Scores are the average of this scale.

Appendix 1

Where questions are not directly comparable with previous iterations of the survey but the question meaning remains the same, questions are marked as 'comparable with changes'. These changes are outlined below. Full record of changes is available at https://wcpes.co.uk/library

Q04	Comparable - but additional response option added 'Other'
Q17	Comparable - but response option changed from 'Not sure/can't remember' to 'Don't know/can't remember'
Q19	Comparable - but response option changed from 'Not sure/can't remember' to 'Don't know/can't remember'
Q21a	Comparable - but question changed from 'Did your care include access to a **Clinical Nurse Specialist** ' to 'Did your care include access to a **CNS**'; change to the response options from 'No I did not have a clinical nurse specialist as part of my care team' to 'No I did not have one as part of my team' and 'Don't know/not sure' to 'Don't know/can't remember'
Q22a	Comparable - but question changed from 'How easy **is it** for you to contact your Key Worker' to 'How easy **was it** to contact your Key Worker'; change to the response options from 'I have not tried to contact her/him' to 'I have not tried to contact them' and additional response of 'Not applicable'
Q22b	Comparable- but question changed from 'How easy **is it** for you to contact your clinical nurse specialist' to 'How easy **was it** to contact your CNS'; change to response options from 'I have not tried to contact her/him' to 'I have not tried to contact them' and additional response of 'Not applicable'
Q23b	Comparable - but question text changed from 'When you **have** important questions to ask your Clinical Nurse Specialist, how often **do** you get answers you can understand?' to 'When you **had** questions to ask, how often **did** you get answers you can understand from your... CNS'; response option changed from 'I do not ask any questions' to 'I did not ask any questions' and additional response 'Not applicable'.
Q24b	Comparable - but question text changed from 'Did your **Clinical Nurse Specialist** provide you with the information you needed to make informed decisions about your **treatment and care**?' to 'Did **they** provide you with the information you needed to make informed decisions about your **treatment**? CNS' and additional response: 'Not applicable'
Q42	Comparable - but response option changed from 'Can't remember' to 'Don't know/Can't remember'
Q53	Comparable - but response option changed from 'Not sure / can't remember' to 'Don't know/can't remember'
Q55	Comparable - but question text changed from 'After leaving hospital, were you given enough care and help from your GP and the **GP surgery**?' to 'After leaving hospital, were you given enough care and help from your GP and the **GP practice**?'
Q58	Comparable - but response option changed from 'Don't know' to 'Don't know/can't remember'

Appendix 2

The Other cancer category is comprised of codes below. This has been used throughout the reporting of the 2021 results and is consistent with the last survey in 2016, as well as the most recently published CPES in both England and Northern Ireland.

Secondary

C77	Secondary and unspecified malignant neoplasm of lymph nodes (C77), of respiratory and digestive organs (C78) and of other and unspecified sites (C79)
C78	
C79	

Any other

C00	Malignant neoplasm of lip
C05	Malignant neoplasm of palate
C11	Malignant neoplasm of oropharynx
C12	Malignant neoplasm of pyriform sinus
C13	Malignant neoplasm of hypopharynx
C14	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx
C24	Malignant neoplasm of other and unspecified parts of biliary tract
C26	Malignant neoplasm of other and ill-defined digestive organs
C30	Malignant neoplasm of nasal cavity and middle ear
C31	Malignant neoplasm of accessory sinuses
C37	Malignant neoplasm of thymus
C38	Malignant neoplasm of heart, mediastinum and pleura
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs
C47	Malignant neoplasm of peripheral nerves and autonomic nervous system
C57	Malignant neoplasm of other and unspecified female genital organs
C58	Malignant neoplasm of placenta
C63	Malignant neoplasm of other and unspecified male genital organs
C68	Malignant neoplasm of other and unspecified urinary organs
C69	Malignant neoplasm of eye and adnexa
C70	Malignant neoplasm of meninges
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
C74	Malignant neoplasm of adrenal gland
C75	Malignant neoplasm of other endocrine glands and related structures
C76	Malignant neoplasm of other and ill-defined sites
C80	Malignant neoplasm, without specification of site
C86	Other specified types of T/NK-cell lymphoma
C88	Malignant immunoproliferative diseases
C96	Other and unspecified malignant neoplasms of lymphoid, haematopoietic and related tissue
C97	Malignant neoplasms of independent (primary) multiple sites

Acknowledgments

This report would not have been possible without the thousands of responses from people living with cancer in Wales, we are indebted to the time they gave us to deliver this report.

Sue Tranka
Prif Swyddog Nyrsio
Chief Nursing Officer
Cyfarwyddwr Nyrsio GIG Cymru
Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

Nicola Williams, Director of Nursing, AHP's & Medical Scientists,
Velindre NHS Trust
Nicola.Williams13@wales.nhs.uk

02 October 2023

Dear Nicola,

I wanted to take the time to extend my thanks to you and your team at Velindre and also the staff at the City Hospice and Maggie's Centre for welcoming the NMC council members on their visit of 26 September. I'm aware that your entire workforce continues to work under great pressure, so Andrew, David, Sam and all their NMC members were truly grateful for the time that your staff took to host their visit which they found incredibly valuable.

Richard and the Council members were thoroughly impressed with the entire operation, and the unique collaboration that brings together the expertise, vision and resources of public sector and third sector organisations. The way in which this enhances the patient centred approach and has enabled` progress changes in patient diagnosis, care and treatment within the NHS, and importantly the care and experience of patients, carers and families during and following treatment

Please pass on my thanks and that of the NMC to Viv, Matthew and everyone who was involved on the day from the City Hospice, Maggie's and Marie Curie.

Yours sincerely,

CHIEF NURSING OFFICER
NURSE DIRECTOR NHS WALES
PRIF SWYDDOG NYRSIO
CYFARWYDDWR NYRSIO GIG CYMRU

BUDDSODDWR MEWN POBL
INVESTOR IN PEOPLE

Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ
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Quality Safety and Performance Committee

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

Date of meeting	16/11/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

Prepared by	Peter Gorin, Head of Strategic Planning and Performance Rachel Hennessy, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD TO SEPTEMBER 2023/24** 1.1 This paper reports on the performance of our Trust for the month of September 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance. 1.2 The overview, in Section 2, draws attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas 1.3 The Performance Management Framework (PMF) Scorecards, in Section 3, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. 1.4 Each KPI is supported by data, in Appendices 1 to 3, that explain the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. 1.5 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings. 1.6 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

RECOMMENDATION / ACTIONS	**The Quality Safety and Performance Committee is asked to:** • **The QSP Committee is asked to NOTE the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3.** • **The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**11 October 2023**
VCS SLT / Performance Review	**18 October 2023**
Executive Management Board – Run	**30 October 2023**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings and EMB and is presented to the QSP Committee for information and noting.**	

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

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

ACRONYMS	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**
EMB	**Executive Management Board**

SLT	**Senior Leadership Team**
PMF	**Performance Management Framework**
QSF	**Quality Safety Framework**
KPI	**Key Performance Indicators**
SPC	**Statistical Process Control Charts**

2. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR SEPTEMBER 2023

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

2.1 Cancer Centre Services Overview

The reported improvement in radiotherapy performance observed in August was sustained in September. Compliance with the 21-day time-to-treatment target for scheduled radiotherapy treatment increased again from 81% in August to 88%. Further, compliance with the 7-day time-to-treatment target for urgent symptom control increased in September to 84% from 73% in the previous month. The sustained improvement in performance remains encouraging and can be attributed, in part, to detailed work to rationalise and shorten treatment pathways which has been undertaken throughout 2023 and targeted training delivered to clinical teams. Additionally, a new radiotherapy workflow system trialled in May 2023 has now been rolled out to all treatment sites. This new system has supported the delivery of marked efficiencies.

Maintaining radiotherapy treatment capacity continues to present challenges. It should be noted that the number of patients referred for radiotherapy treatment and those actually beginning treatment in September were lower than anticipated based on historical patterns of demand. Depressed demand for radiotherapy treatment was likely a contributing factor in the improved performance reported in August and September. Due to factors such the fragility of the fleet of linear accelerators, instances of downtime and lost capacity are being experienced. In these instances, extensions to the working day and week have been implemented to manage the capacity.

Compliance with the 21-day time-to-treatment target for new patients referred for treatment with SACT decreased marginally in September to 90% from 92% in the previous reporting period. Nursing and pharmacy workforce capacity remain significant challenges and a recruitment and resource plan intended to address these issues in a sustainable manner is in development.

Performance targets were met in September in the case of patient falls and pressure ulcers. There were two reported instances of non-compliance with the timely administration of the NEWS bundle, but no harm was reported to either of the patients. Two Healthcare Acquired Infections (HAI) were reported in September. Both instances will be the subject of a multi-disciplinary review facilitated by the Infection Prevention and Control team which will identify learning and inform any subsequent response. There were no instances of potentially avoidable Hospital Acquired Thrombosis (HAT) reported in September.

There were three Delayed Transfers of Care (DToC) in September. One patient's transfer to another local hospital site was delayed due to bed capacity challenges. Such challenges are being experienced across the wider healthcare system and impacts the ability of Velindre Cancer Centre to discharge patients without delay. A second patient required a nursing home placement and a third required a packaged of care to be developed prior to discharge. Velindre Cancer Centre nurse leads are active members of the all-Wales Pathways of Care Delays (PoCD) national group which is considering delayed discharges.

Discussions continue to take place with health board and community teams to realise improvements. The PoCD national group have scheduled visits at Velindre Cancer Centre to provide additional training on the Six Goals of Emergency Care to provide further support in facilitating patient discharge.

There were some instances of delayed access to Therapies services reported in September. Workforce capacity remains a challenge in the case of certain Therapy modalities, notably, dietetics and physiotherapy, which is reflective of the national position. Locum staff have been recruited in dietetics.

The data quality issues related to the implementation of the DH&CR continues to cause significant administrative challenges across Velindre Cancer Centre. The Medical Records team continue to make significant progress against the backlog of unprocessed outcomes through the support of additional resource.

To mitigate the data quality issues that have been experienced, a revised staff training plan, which meets the needs of individual users and groups in relation to their specific role, has been developed by the IT Applications Support Team and Operational Services.

2.2   Welsh Blood Service Overview

WBS have continued to perform well during September and all clinical demand was met, however, there was a Blue Alert for O negative for the period 20th September 2023 – 4th October 2023. Provision of red cells to hospitals was maintained and no mutual aid was required as a result of this.

Quality incident investigations closed within 30 days remains well above target (90%) at 95%. There was one reportable event submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in September.

- This event has arisen from the lookback exercise undertaken as a Corrective and Preventive Action (CAPA) for SABRE 106 Malaria residency risk incorrectly assessed. Root Cause Analysis investigation is complete, and the report is being written up (target date for confirmatory report submission to MHRA is 21/10/23). Any remedial actions / lessons learnt will be implemented.

Donor satisfaction met the 95% target in September. 6,896 donors were registered at donation clinics with no formal concerns and 2 informal concerns raised (0.03%).

Reference Serology performance is slightly below target (80%) at 70% for September. Training and development of junior members of staff will be completed between September 2023 and April 2024 and performance levels are expected to improve during this period. There was excellent performance during Quarter 2 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 100% in September, performance averaged 99% for the quarter, meeting target and showing continued performance improvement in July, August & September.

The quarterly performance for Deceased Donor Typing / Cross Matching performance did not meet target. This target measures turnaround times of less than four hours and Quarter 2 performance was below target at 70%. This was attributed to delays in notification times by NHSBT Specialist Nurses and new staff joining the on-call rota. Work is now underway with NHSBT Specialist Nurses to ensure earlier notice for samples.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage just missed target in September (11% against a target of 10%). This is attributed to the significant weekly variance in platelet demand experienced in September. Work is underway to develop a Platelet Strategy to address issues being experienced.

Collection productivity performance reduced slightly in September and failed to meet target. Contributory factors influencing performance include reduced clinic donation slots due to sickness absence limiting donation capacity particularly in north Wales and the number of donors attending collection sessions in September who were unable to provide a completed donation.

At 1,262, the number of new donors did not meet the quarterly target of 2,750 in September. The requirement to intensify appointment management by donor blood type throughout a prolonged need for additional O Positive and O Negative blood in September, as well as one short-term blue alert, inhibited the recruitment of new donors. In addition, campaigns to optimise appointment uptake left fewer appointments for new donors, due to their unknown blood type status. At 90%, appointment uptake from existing donors was on target for the quarter. However, this success provides less opportunities for non-donors to book their first donation.

The total number of collections in September was 5 (all Peripheral Blood Stem Cell collections). The total cell provision for the service was 8 (5 collected and 3 imported for a Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures.

2.3   Workforce and Wellbeing

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

Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.75% to September 2023 which is still above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%.

Trust wide PADRs this month remains at 74% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 87% and has been consecutively on target for the whole year to September 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES).

2.4   Nursing and Quality

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

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

2.5   Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (95%) and 'Your Velindre experience?' (63%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% that continues to meet the target.

2.6   Digital Services

Performance largely stable – no significant change in performance since August 2023.

Following a number of incidents in August 2023, the rolling 12-month position for the number of significant IT business continuity incidents has stabilised in September. Improved performance through early/mid-2023 should start to be reflected in reported 12-month performance towards end of 2023/24 financial year. Work ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. This work will continue through 2023/24 and beyond.

Resolution timescales for service requests and incidents was unchanged in September 2023. Both remain under the 85% target for both indicators. Both 1st and 2nd line IT support teams are now fully established. Coupled with a new service improvement plan for the Digital Service Desk and 2nd line support teams, it is anticipated that improvements in performance will be observed through Q3/Q4 2023/24, with the aim of achieving target from the start of the 2024/25 financial year.

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

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role – this role was due to be filled in September 2023, but the candidate withdrew. Interviews for a replacement are scheduled for late-September 2023.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

2.7 Estates Infrastructure and Sustainability

The period through to September has seen consolidation of levels of compliance for PPM and reactive tasks which are currently listed as green. The technical issue with CAFM has been resolved and figures have been updated accordingly. This is expected to be resolved shortly and the PMF will be updated accordingly. Recruitment has seen appointment of a maintenance technician post with further vacancies re-advertised. Two H&S posts are progressing through the recruitment process Head of H&S out to advert and the H&S Technician currently with translation.

Energy management is intrinsically linked to Estates resourcing and will be improved with recruitment in the Estates Department, and implementation of the decarbonisation plan. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data. This month has seen similar issues and data will be uploaded once available.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation.

Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward, minor improvements are witnessed month on month.

Divisions have reinvigorated H&S meeting which will support improvement of training, by approaching issues at operational level, working with trainers and departments to tailor a package that meets departmental requirements, this is underpinned by support from SLT.

Patient manual handling figures for WBS have increased to acceptable levels as the training provision is captured in the reporting figures.

2.8   Finance

The overall position against the profiled revenue budget to the end of September 2023 is an underspend of £0.007m and is currently expecting to achieve an outturn forecast of Breakeven.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **22.833m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to August '23 of £8.683m and is forecasting to remain within the CEL of £24.416m. A risk to delivery of the Capital programme exists where Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close, however this risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.7m.

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month , and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

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

The expected underlying surplus to be carried into 2024-25 has reduced in year from £0.391m to £0.086m as underlying recurrent cost pressures are now forecast to exceed recurrent savings schemes.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organizations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust considered options at the extraordinary Board meeting on the 09th of August and have submitted several financial improvement options to WG on the 11th of August to support the NHS Wales Deficit.

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

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

3.2   **Navigating our PMF Performance Report**
Each QSF domain in the PMF scorecards is populated with a range of KPIs for VCC and WBS services plus a range of KPIs for Support Services functions. Performance is assessed as either 'within standard' ✓ or 'outside standard' ✗ against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' ⬆ or 'stable' ➔ or fluctuating ⬆⬇ or 'declining' ⬇ The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.
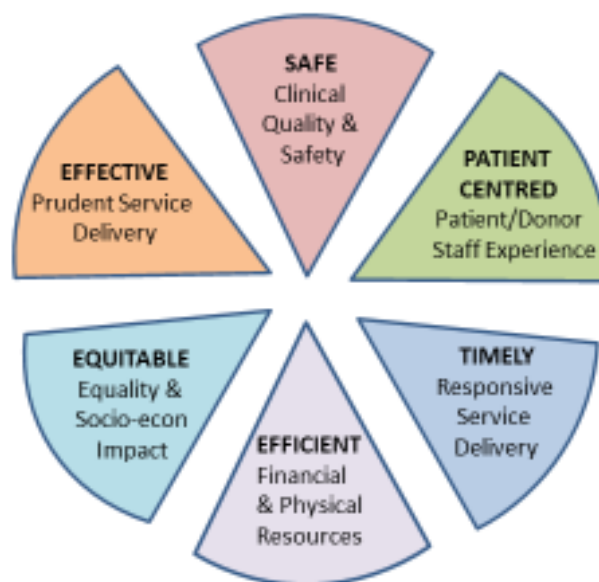
Quality Safety & Performance (QSP) Committee Scorecard as at September (Month 06) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	87%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99.6%	✓	→	KPV.08
	Number of National VCS Serious Untoward Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	14	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	99.9 C/m3	85.3 C/m3	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	1	0	3	✗	⬇	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	95%	✗	⬇	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	⬆	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	121%	✓	⬆	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	11%	✗	⬆	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	5	✗	⬇	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.75%	✗	⬇	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	⬆⬇	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	95%	✓	➡	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	95%	✓	⬆	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	➡	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A	✓	➡	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	23% 88%	✗	➡	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	8% 84%	✗	➡	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	100%	85% 95%	✓	⬆	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	87% 91%	✘	➔	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	90%	✘	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	96%	✓	➔	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	99%	✓	↑	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.007m)	✓	➔	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	N/A	£11.326m	£11.326m	✓	➔	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.50m	£0.117m	✘	↓	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.767m	£0.685m	✘	↓	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	➔	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	➔	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✘   Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓

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4. IMPACT ASSESSMENT

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

If yes - please select all relevant goals:
• Outstanding for quality, safety and experience   ☒
• An internationally renowned provider of exceptional clinical services ☐
  that always meet, and routinely exceed expectations
• A beacon for research, development and innovation in our stated ☐
  areas of priority
• An established 'University' Trust which provides highly valued ☐
  knowledge for learning for all.
• A sustainable organisation that plays its part in creating a better future ☐
  for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text

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

5. RISKS

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Number of VCC Inpatient Falls per month															

Target: 0 Avoidable — SLT Lead: Head of Nursing

Current Performance against Target or Standard — **Performance**

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul2 3	Aug 23	Sep 23
Actual Number	2	1	3	4	4	5	2	0	4	2	0	3	5	5	3
Avoidable Falls	2	0	1	2	2	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

No avoidable falls in September 2023.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

SPC Chart Inpatient Falls per month Target NIL (avoidable)

SPC Chart Analysis

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

Number of VCC Acquired Pressure Ulcers per month (Inpatients)

| **Target: 0 Avoidable** | **SLT Lead: Head of Nursing** |

Current Performance against Target or Standard

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual Number	0	0	4	1	1	1	0	0	1	0	0	0	2	2	3
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

SPC Chart Acquired Pressure Ulcers per month Target NIL

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

Statutory and Mandatory (S and M) Training Compliance															
Target: 85%												**SLT Lead: WOD Business Partner**			

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:
- Compliance target is being met

SPC Chart Statutory & Mandatory Training Target 85%

SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 86% against the 85% target, with the target being met for the last year.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.
Having well trained and developed workforce will ensure the safe and quality delivery of services across the Trust.

Risks to future performance

Set out risks which could affect future performance
- Future predicated wave of COVID and Flu may affect staffing levels and ability to release staff to undertake training.

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

Target: NIL	SLT Lead: Clinical Director
Current Performance against Target or Standard	**Performance**

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

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

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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

Incidence of Healthcare Acquired Infections for the period February 2022 to April 2023

VCC

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
C.diff	0	0	0	0	0	1	1	0	0	0	0	0	2	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
E.coli	1	0	0	0	0	1	3	1	0	1	0	0	1	0	1
Klebsiella	0	0	0	0	0	0	1	0	0	1	0	1	1	0	1
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	0	0	0	0	0	1	4	1	0	1	1	0	0	0	0

Performance

Assessment of current performance, set out key points:
- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale: To be completed within 2 weeks of positive result	Lead: IPCT
• Reviewing individual cases using an MDT approach to identify any lessons to be learnt and training.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department

| Target: 100% | | | | | | | | | | | | | | | | SLT Lead: Clinical Director |

Current Performance against Target or Standard

Performance

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
VCS Hand Hygiene												100%	100%	99%	99.6%
WBS Hand Hygiene												100%	99.2%	99%	
Trust Hand Hygiene												100%	100%	99%	
IPC Validation												100%	100%	100%	99.4%
Target I00%	0	0	0	0	0	0	0	0	0	0	0	100%	100%	100%	100%

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by Department based on 20 weekly hand hygiene observations over the month

Plus Infection Prevention Control Team Validation Audits % compliance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: IPC
• Weekly validation audit by IPCT		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

Number of National VCS Serious Untoward Incidents(SUIs) recorded with Welsh Government in a calendar month	
Target: NIL	**SLT Lead:**
Current Performance against Target or Standard	**Performance**

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Actual															
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[SUI data to be input]

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

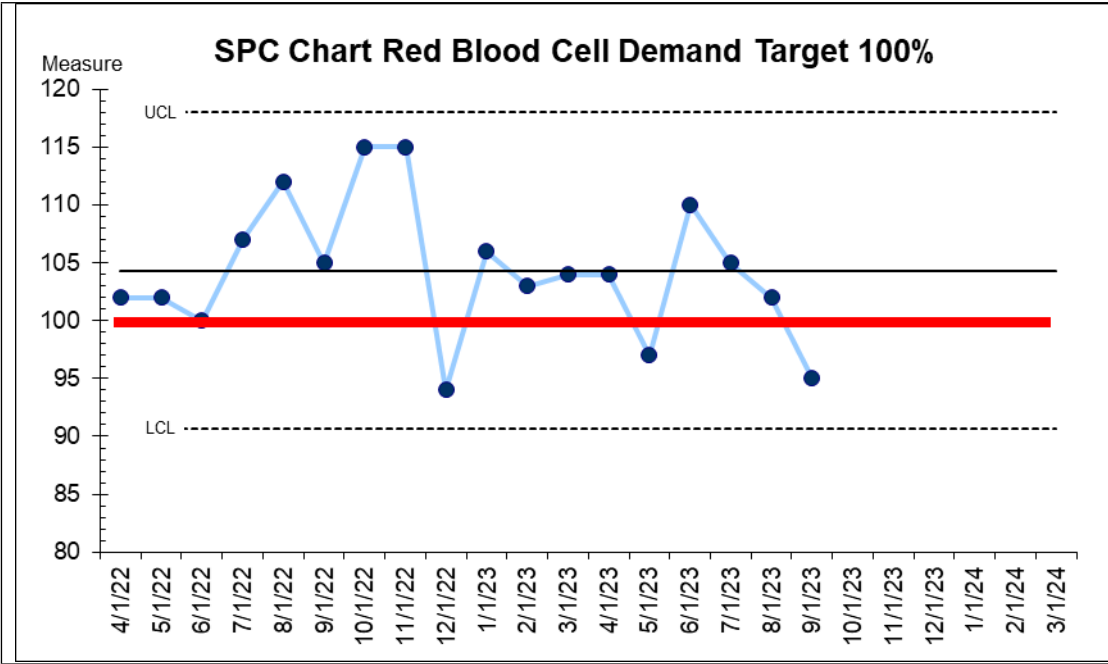**Service Improvement Actions – tactical (12 months +)**

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

Expected Performance gain – longer-term

Risks to future performance

Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month															
Target: NIL															

SLT Lead: Peter Richardson

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:
There was one event submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in August:

- SABRE 110 - *Malaria positive donor archive sample*
  This event has arisen from the lookback exercise undertaken as Corrective and Preventive Action (CAPA) for SABRE 106 *Malaria residency risk incorrectly assessed.*
  Status: A Root Cause Analysis (RCA) investigation is complete, and the report being written up. A target date for the confirmatory report submission to MHRA is 21/10/23. Any remedial actions / lessons learnt will be implemented.

Incidents Reported to Regulator/Licensing

(chart: Jan-23: 0, Feb-23: 2, Mar-23: 0, Apr-23: 0, May-23: 2, Jun-23: 0, Jul-23: 1, Aug-23: 2, Sep-23: 1, Oct-23: -, Nov-23: -, Dec-23: -)

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
The completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub	Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.	Peter Richardson

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Actions have been/will be introduced as outcome of root cause analysis of these incidents is known.		

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

KPI Indicator H&S.55

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

Target: 0	SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
VCC	8	4	4	2	7	9	5	2	9	4	3	4	6	9	6
WBS	6	12	3	8	11	2	3	3	6	2	10	1	9	6	8
Corporate	0	2	0	0	0	0	0	0	0	2	0	1	0	2	0

Service Improvement Actions – Immediate (0 to 3 months)

Actions All incidents investigated. H&S incident investigation training complete	Timescale Q4 2022/23.

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

Service Improvement Actions – tactical (12 months +)

Actions: As above	Timescale:

Expected Performance gain

Risks to future performance
 Incomplete incident investigation – ongoing monitoring

Total Number of Incidents by Division

Legend: VCC, WBS, Corporate/TCS/RD&A

PMF Performance Report September 2023

KPI Indicator EST.06

% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline															

Target: -16% by 2025 — **SLT Lead: Asst. Director of Estates**

Current Performance against Target or Standard — **Performance**

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr23	May 23	Jun 23	July 23	Aug 23	Sept 23
Actual Number	103.01	95.85	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33		
Target (-3% from previous year emissions)	110.6551	104.4917	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858		

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

Performance

Assessment of current performance, set out key points:
- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- VCC Gas data for June / July is currently under review, therefore the carbon figure for June & July may be updated in due course.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale: XX/XX/XX XX/XX/XX	Lead: AN Other AN Other
• Deacrbonisation Action Plan • Site Based Sustainability Implementation Plan		

Expected Performance gain – immediate
Ongoing communication and engagement with staff to reduce consumption.
Amendments to the BMS across all sites for better controls.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: XX/XX/XX XX/XX/XX	Lead: AN Other AN Other
• Continuing monitoring • Improvement to monitoring energy through the BMS		

Expected Performance gain – longer-term
Reduced carbon footprint
Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

Set out risks which could affect future performance
-

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EFFECTIVENESS

KPI Indicator KPV.05

Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD).																
Target: NIL														**SLT Lead: Head of Nursing**		
Current Performance against Target or Standard														**Performance**		

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:
There were 3 pathways of care delays reported in September 2023.
There was 1 repatriation delay reported in September 2023.
Patient 1: Awaiting repatriation to local hospital with a delay of 1 day.
There were 2 pathways of care delays reported in September 2023.
Patient 1: Awaiting Nursing Home Placement for discharge referred on 11/09/2023 causing a delay of 36 days.

Patient 2: Awaiting Package of Care for discharge referred on 10/10/2023 causing a delay of 7 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer. Pathways of Care NHS Executive team leads have visited VCC and provided additional training on the Six Goals of Emergency Care to further support and facilitate patient discharge.		Matthew Walters Operational Senior Nurse Matthew Walters Operational Senior Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Delayed transfers of Care (DToCs) Target NIL

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

PMF Performance Report September 2023

	% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE																
Target: 100%																**SLT Lead: Jayne Davey / Tracey Rees**	

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Actual %	107	112	105	115	115	94	106	103	104	104	97	110	105	102	95
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

% Red Cell Demand Met

Performance

Blood collection in September was lower than demand. The average weekly demand in September was slightly higher than August at 1405 units per week in September compared to 1381 in August. **NOTE:** All hospital demand was met, but the service issued a Blue alert to hospitals for Group O negative red cells for 14 days in September. No mutual aid was required.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** Daily
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.	**Lead:** Jayne Davey / Tracey Rees

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:** N/A
N/A	**Lead:** Jayne Davey / Tracey Rees

Expected Performance gain – longer-term   N/A

Risks to future performance

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

SPC Chart Red Blood Cell Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 104% consistently exceeding the 100% target.

Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags	
Target: Maximum Wastage 1%	**SLT Lead: Tracey Rees**
Current Performance against Target or Standard	**Performance**

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	0.01	0.03	0.35	0.01	0.33	0.36	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

Assessment of current performance, set out key points:
Performance of this metric has met target.

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

Balanced stocks for each blood group are managed through the daily Resilience meetings where priorities are set as needed. This supports the recovery of specific blood groups when they are at lower level but also minimises excess collections to minimise wastage.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Daily monitoring of age of stock as part of the resilience meetings.	Daily (BAU)	Tracey Rees

Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
N/A		

Expected Performance gain – longer-term.
N/A

Risks to future performance

High stock levels lead to a risk of increased time expiry.

SPC Chart Time Expired Red Blood Cells Target 1%
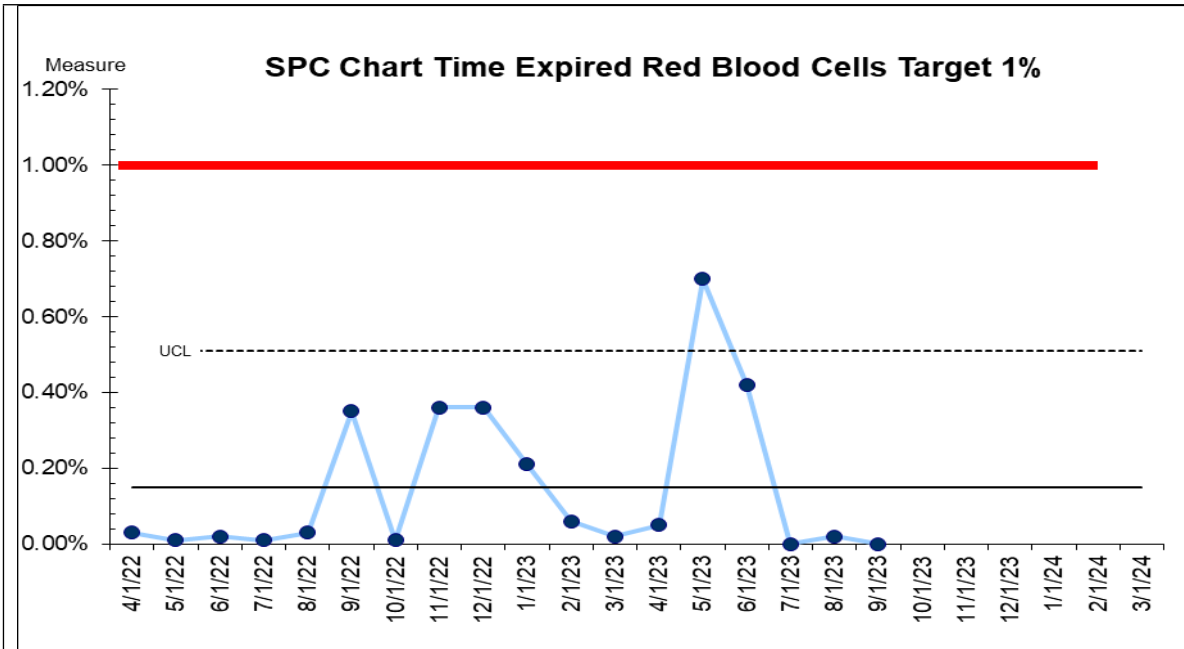
SPC Chart Analysis

The SPC chart shows common cause variation over the last 6-month period, with one 'special cause variation' in the month of May. However, the average performance of 0.15% remains well within the maximum 1%

Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%		SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23
Actual %	145	164	132	126	139	145	141	168	133	127	117	114	120	125	121
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

% Platelets Demand Met

NB: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.

Performance

Assessment of current performance, set out key points:
All clinical demand for platelets was met representing a continued strong performance against this metric in September.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days. Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.	**Lead:** Tracey Rees Daily - BAU **Timescale:** Ongoing – Business As Usual

Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
A focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under Laboratory Modernisation work. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included.	Dec 2023 **Lead:** Tracey Rees

Expected Performance gain – longer-term.
Optimised clinic collection plan for Apheresis and a forecasting tool to inform decisions around pooled platelet manufacture.

Risks to future performance
Fluctuations in platelet demand.
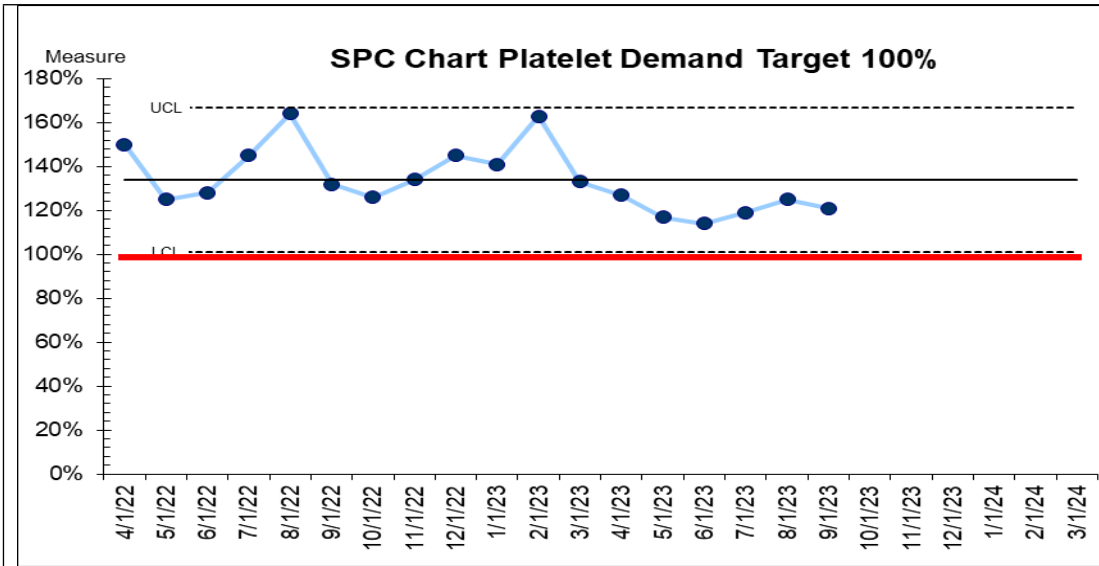
SPC Chart Platelet Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 138% consistently exceeding the 100% target.

Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured															
Target: Maximum Wastage 10%									**SLT Lead: Tracey Rees**						
Current Performance against Target or Standard									**Performance**						

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	19	30	25	14	15	27	23	25	20	10	8	9	12	12	11
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Performance

Assessment of current performance, set out key points:
At 11% performance was just above target for September with 87 units time expired, improving slightly on the performance for August.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve — **Lead:** Tracey Rees
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings.
b. Pooled platelet reductions have been implemented and are being reviewed as a measured approach to the declining demand trend.
c. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme.
d. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.

Timescale: Daily (BAU)

Timelines to be confirmed as part of WBS Futures

Expected Performance gain – immediate.
Controlled platelet production leading to reduced wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve
Reviewing the clinic collection plan for Apheresis to ensure the clinic times are optimised to reflect changes to 7-day platelet expiry.
Embedding the demand planning tools for platelets into routine practice.

Timescale: Qtr 3&4 onwards

Lead: Jayne Davey/Tracey Rees

Time Expired Platelets chart: Jan-23 23.00%, Feb-23 26.00%, Mar-23 20.00%, Apr-23 10.00%, May-23 7.72%, Jun-23 9.00%, Jul-23 12.00%, Aug-23 12.00%, Sep-23 11.00%

NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before platelets are available for issue. This means in shortage there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

	Expected Performance gain – longer-term.
	Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.
	Risks to future performance
	Set out risks which could affect future performance.
	Unexpected increases in clinical need - noting unexpected spike in demand may require imports.
	Future Bank holidays.
	SPC Chart Analysis
	The SPC chart shows fluctuating special cause variation over 4 of the last 6- month period, with the beginnings of a favourable trend over the last four months. The average performance of 18% remains above the maximum wastage limit of 10%. Signifiicantly improved and sustained performance noted.

Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum															SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Cumulative Actual	8	12	14	14	15	19	23	26	32	3	6	12	18	21	26
Cumulative Target p/a	28	35	42	49	56	63	70	77	84	7	14	20	27	34	40

Stem Cell Collections (chart)

Legend: Stem Cell Collection in Wales; Stem Cell Projected Forecast FinYear 23/24

Bar values: Apr-23: 3; May-23: 6; Jun-23: 12; Jul-23: 18; Aug-23: 21; Sep-23: 26

Forecast line values: 7, 14, 20, 27, 34, 40, 47, 54, 60, 67, 73, 80

Performance

The total cell provision for the service in September was 8 with 5 collections (Peripheral Blood Stem Cell) and 3 imported for a Welsh patient.

The Service continues to experience a cancellation rate of approx. 30%-40% compared to 15%-20% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80).

NB: The Projected Forecast detail does not include stem cells collection sourced globally for patients in Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. This will form part of the WBS futures programme. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	**Timescale:** Q3 **Lead:** Tracey Rees

Expected Performance gain - immediate.

	As above
	Service Improvement Actions – tactical (12 months +)

	Implementation of the five-year strategy.	**Timescale:** 2024/25 **Lead:** Tracey Rees
	Expected Performance gain – longer-term. Improved recruitment of new donors to the Register which over time will increase the number of collections	
	Risks to future performance	
	Set out risks which could affect future performance. Identified risks are being managed.	

Staff Sickness levels against Target															
Target: National 3.54% Local Stretch Target 4.70%														**SLT Lead: WOD Director**	
Current Performance against Target or Standard														**Performance**	

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23
Actual %	6.53	6.50	6.36	6.30	6.19	6.19	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Assessment of current performance, set out key points:
There is a slight decline in sickness following the winter months and as the People and Relationship Team continue to support managers in the application of the sickness policy. Corporate Services has significantly reduced their rolling 12 months from 5.37 to 2.85 in the year to date.

Short-term absence remains relatively low across the Trust.

Focused management on resolving long-term absence has seen in month figured reduce from 4.97% to 2.91% in the past 6 months. This continued reduction should see the overall rolling target reduce also.

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

SPC Staff Sicknesss National Target 3.54% Local 4.7%

SPC Chart Analysis
The SPC chart shows an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients (Closed) Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken	01/09/2023 01/08/2023	Head of Workforce Head of Workforce

Expected Performance gain - immediate
Regular monitoring against the application of the policy will ensure our staff are supported and encouraged to improve their health and areas where there are concerns are provided with immediate interventions to improve practice.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture	30/04/2024	Head of OD

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	• Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

Performance and Development Reviews (PADR) % Compliance														
Target: 85%														

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %	69	70	71	75	76	77	77	74	73	73	72	73	74	74	74
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:
As anticipated, there was short-term growth in PADR activity during the early implementation of the new Pay Progression Policy in Autumn 2022 however this remains significantly below the Welsh Government target. Transforming Cancer Services remains the biggest cause for concern reporting 8 months consecutively below 50%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Support TCS with improvement plan	01/09/2023	Senior BP Head of Workforce
Continue to monitor for hotspot areas of concern and provide interventions for improvement.	01/09/2023	

Expected Performance gain - immediate
With targeted interventions in hotspot areas that are continually preforming significantly below the expectations this should see a growth in the overall compliance within the Trust.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Ongoing Monthly	Business Partners alongside SMT/SLT

Expected Performance gain – longer-term
As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance
- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

SPC Chart Analysis
The SPC chart shows a stabilising trend over the last 7 months. However, averaging 72%, consistently falling short of the 85% target.

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

% of Patients that Rate Experience at Velindre at 9/10 or above															
Target: 85%								SLT Lead: Head of Nursing							

Current Performance against Target or Standard															
VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Would you recommend us? %		89	89	88	nda	nda	93	96	95	95	98	96	97	97	95
Your Velindre Experience? %					nda	nda	84	86	82	82	68	71	91	94	63
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:
There are two surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience'.
The 'Would you recommend us?' survey uses categories such as Very good, good etc

Question 1: Overall, how was your experience of our service?

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	33	86.84%
Good	3	7.89%
Neither good nor poor	0	0.00%
Poor	1	2.63%
Very poor	1	2.63%
Don't know	0	0.00%
Total	38	100%

The Your Velindre experience survey uses 0-10 in the question about rating VCC

Question 10: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Create new action

Available Answers	Responses	Score (%)
10	4	50.00%
9	1	12.50%
8	3	37.50%
7	0	0.00%
6	0	0.00%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0	0	0.00%
Total	8	100%

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report	Ongoing	Head of Nursing/SLT SLT/Directorate Managers
Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	
Directorates to develop plans to increase response rate. Q+S team to work with each directorate to provide further analysis on responses	Ongoing	SLT/Directorate Managers Q+S manager
CIVICA working group established with attendees from each directorate		
Q+S team to review the difference in positive percentages for both surveys		
Expected Performance gain – immediate		
A new Patient Experience and Concerns manager has been in post since June 2023 who is engaging with staff across teams to encourage patient feedback and the recording of compliments.		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback.	December 2023	Head of Patient Engagement
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		
• insert text		

% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%	**SLT Lead: Jayne Davey**

Current Performance against Target or Standard	**Performance**

Assessment of current performance, set out key points:

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	96	97	97	96	96	95	97	97	95	97	97	97	97	96	94.9
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

At 94.9%, is 0.1% off target for donor satisfaction in September. In total there were 1,092 respondents to the donor survey, 220 from North Wales (scoring satisfaction at 97.6%), and 976 from South or West Wales (scoring satisfaction at 94.2%).

Donor Satisfactions

Legend: ■ Scored 5_6 out of 6 SW   ■ Scored 5_6 out of 6 NW

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Findings are reported at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the report.	Business as usual, reviewed monthly	Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Following analysis of the donor satisfaction survey from the Service Improvement team there are nine metrics statistically linked to the donor satisfaction score. These metrics are now being explored to evaluate if improvements can be made in these areas	**Q4 2023/24**	Andrew Harris

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

N/A

Number VCC formal complaints received under Putting Things Right within 30 days														
Target: 85%														

	SLT Lead: Head of Nursing
Current Performance against Target or Standard	**Performance**

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:
- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate
New Patient Experience and Concerns manager in post since June 2023 promoting instant access to deal with early resolutions or PTR concerns.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale	
Target: 100%	**SLT Lead: Edwin Massey**
Current Performance against Target or Standard	**Performance**

WBS	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Performance

Assessment of current performance, set out key points:
There were no formal concerns raised or due for closure in September 2023.

NB: In September 2023, an enquiry was received by a Welsh Government Minister regarding a concern raised by a constituent relating to the environmental impact associated with a proposed change at the WBS. A response was issued to the Minister by VUNHST on 03/10/23.

% Responses to Concerns within 30 Working Days

100% 100%

| 100% |
| 80% |
| 60% |
| 40% |
| 20% |
| 0% |

N/a N/a N/a N/a N/a N/a N/a

Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

NB:
Performance against target only shown the month when a formal concern has been raised.
Under Putting Things Right (PTR) guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
– Continue to monitor this measure against the '30 working day' target compliance. – Continued emphasis of concerns reporting timescale to all staff involved in concerns management reporting. – Work closer with relevant departments to ensure proactive and thorough investigations and learning outcomes. – Adherence to Duty of Candour requirements.	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Continue to monitor and have oversight of concerns management in line with PTR.	Ongoing **Lead:** Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

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TIMELINESS

KPI Indicator KPV.14

Scheduled Elective Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	
Target: 80% within 14 Days and 100% within 21 Days (COSC)	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Current Performance against Target or Standard:

Scheduled Elective RT COSC within 14 & 21 days

12% of RT patients (Sept) (25) breached the 100% referral to treatment within 21 days target

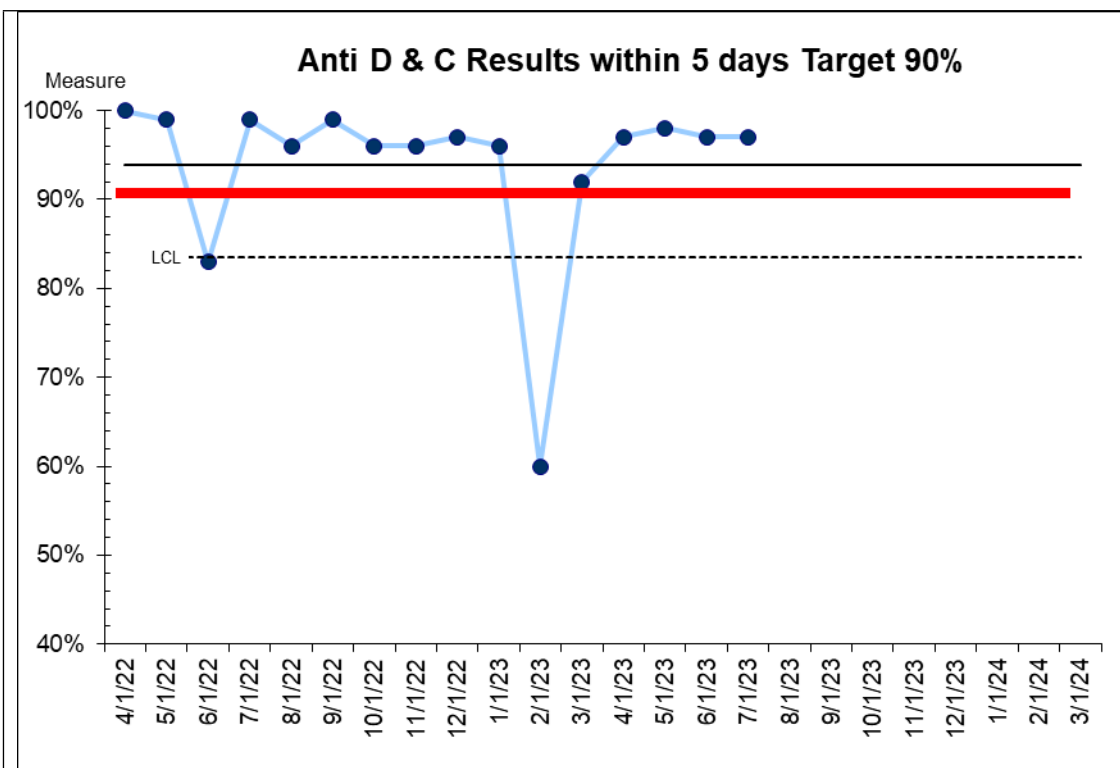81% of RT patients (Sept) (45 + 130 =175) met the 100% referral to treatment within 21 days target

Only 23% of RT patients (Sept) (45) met the 80% referral to treatment within 14 days target

Legend: Patients <14 days | Patients <21 days | Patients >21 days

SPC Chart Analysis
The SPC chart analysis is not possible until well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance:

Assessment of current performance, set out key points:
Ongoing challenges post DHCR in establishing a fully validated position. Validation resources currently insufficient to address range of issues identified.

Number of referrals	200	
treated within 14 days of referral (80% target)	45	23%
treated within 21 days of referral (100% target)	175	88%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		Lead:
Retraining for clinical teams to ensure categorising of the referrals is correct.	Ongoing	Helen Payne/Tom Rackley
Additional validation resources to be provided.	Ongoing Complete	Helen Payne Kathy Ikin
Care Path implemented and streamlining booking processes		

Expected Performance gain – immediate
Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: October 2023	Lead: Tom Rackley
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.		

Expected Performance gain – longer-term
Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance
Linac replacement programme which has commenced

Sickness absence levels in radiotherapy workforce

PMF Performance Report September 2023

Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	
Target: 80% within 2 Days and 100% within 7 days (COSC)	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Current Performance against Target or Standard

Scheduled Urgent RT COSC within 2 & 7 days

16% of RT patients (Sept) (8) breached the 100% referral to treatment

73% of RT patients (Sept) (4 + 37 = 41) met the 100% referral to treatment within 7 days target

Only 8% of RT patients (Sept) (4) met the 80% referral to treatment within 2 days target

■ Patients <2 days ■ Patients <7 days ■ Patients >7 days

SPC Chart Analysis

The SPC chart analysis is not possible until we have well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals		49
treated within 2 days of referral (80% target)	4	8%
treated within 7 days of referral (100% target)	41	84%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve ● Implementation of revised Urgent Symptom Control definition	Helen Payne/ Thomas Rackley	November 2023

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
●

Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Current Performance against Target or Standard

Emergency RT COSC within 1 day

0% (0) RT patient treated over 48 hours

100% of RT patients (Sept) (20) met the 100% referral to treatment within 1 day target

SPC Chart Analysis
The SPC chart analysis is not possible until we well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:
Target Achieved

Number of referrals		20
85% treated within 24 hours of referral	17	85%
95% treated within 48hours of referral	19	95%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
• As scheduled above.	

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment

Assessment of current performance, set out key points:
Issues as Scheduled elective patients above

Number of referrals		55
treated within 7 days of referral (80% target)	48	87%
treated within 14 days of referral (100% target)	50	91%

Elective Delay RT Treated COSC within 7 Days and 14 days

9% of RT patients (Sept) (5) breached the 100% Elective Delay within 14 days target

91% of RT patients (Sept) (48 + 2 = 50) met the 100% Elective Delay within 14 days target

87% of RT patients (Sept) (48) met the 80% Elective Delay within 7 days target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve
- As scheduled above.

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve
-

Expected Performance gain – longer-term

SPC Chart Analysis
The SPC chart analysis is not possible until we well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Risks to future performance

Set out risks which could affect future performance
-

Non-Emergency SACT Patients Treated Within 21-Days

| Target: 98% | | | | | | | | | | | | | | | | SLT Lead: Head of Medicines Management and SACT |

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

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23
Actual %	66	77	89	96	98	96	97	98	98	93	90	90	94	92	90
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days				14	6	12	9	9	8	26	40	40	25	32	35
Within 21 days				341	354	322	336	388	409	343	354	378	370	380	323

The number of patients scheduled to begin non-emergency SACT treatment in Sept 2023 was 358.

Parenteral Attendances (excludes patients on single agent oral SACT regimens)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,220	2,545	2,622	2,483	2,679	2,453						

Performance

Of 358 non-emergency new patients started patients started, 35 patients waited over 21 days = performance of 90%. Target Not Achieved

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	34	0	1	0

1 patient who waited > 28 days due to incorrectly being allocated to clinical trials by the prescriber.

SACT data lead in process of validating BI report which will enable such patients to be identified earlier by the bookings team

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve Continue to progress SACT nurse and booking review recommendations.	Timescale: March 2024	Lead Barbara Wilson
Validation of BI tool to identify incorrectly allocated patients	15/11/23	EH

Expected Performance gain – immediate
Reduction of breaches/lengths of wait due to systems/ human error

Service Improvement Actions – tactical (12 months +)

SPC Chart Non Emergency SACT within 21 days Target 98%

Actions: what we are doing to improve

- Re-determine the impact of continued growth in demand across SACT teams

- Implement additional staff resources/ recruitment plan to meet revised forecasts across all staffing groups

- Nursing: international nurse recruitment and perceptorship recruitment

   Pharmacy (as pharmacy capacity review recommendations, see below)

   Booking: 0.5WTE identified through DHCR work, funding continues to be explored

- Engage with HB partner to deliver on VCC strategy to deliver care closer to home

Progress pharmacy capacity review: submitted to BPG and SLT Oct 2023.

Timescale:

01/04/24

Lead:

BW

BT

RM Outreach board

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Staff recruitment and retention: nursing and pharmacy. Availability of suitably skilled workforce
- Financial ability to recruit ahead of increased demand, in order for training
- Timescales for on-boarding of HB partner outreach locations and available VCC accommodation capacity
- Overall capacity of aseptic services across SE Wales

SPC Chart Analysis

The SPC chart shows an improvement trend, followed by stable performance close to the 98% target.

Emergency SACT Patients Treated Within 5 Days														
Target: 100%														

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

VCC	Jul 22	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual %	100	100	100	100	100	83	100	75	100	100	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0
Within 5 days			0	5	6	5	8	3		5	0	12	10	5	8

SPC Chart Analysis
The SPC chart shows a fluctuating process starting to stabilize with average 97 % against the 100% target, however note small numbers involved.

Performance

8 patients referred for emergency SACT treatment were scheduled to begin treatment in Sept 2023. All waits were in line with clinical decision and thus were treated in target = 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Continue to balance demand and ring fencing with capacity.	**Continuous**	BT
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
		Lead:
Expected Performance gain – longer-term		

Risks to future performance		
Set out risks which could affect future performance •		

SPC Chart Emergenct SACT within 5 days Target 100%

KPI Indicator KPI.18

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Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample															

Target: 90% — **SLT Lead: Tracey Rees**

Current Performance against Target or Standard — **Performance**

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	96	97	97	98	96	87	97	96	96	96	95	98	97	96	96
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Assessment of current performance, set out key points:
At 96% the turnaround time performance for routine Antenatal tests continued to exceed target in September 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Ongoing	Tracey Rees

Expected Performance gain - immediate.
Business as usual, reviewed daily.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance

Antenatal Turnaround Times

Chart showing monthly values: Jan-23 97%, Feb-23 96%, Mar-23 96%, Apr-23 96%, May-23 95%, Jun-23 98%, Jul-23 97%, Aug-23 96%, Sep-23 96%. Target line at 90%. Y-axis 0% to 100%. X-axis Jan-23 to Dec-23.

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SPC Chart Antenatal Turnround Time 3 days Target 90%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December due to an IT incident The average performance of nearly 96% exceeds the 90% target.

% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days														

Target: 90% per quarter	SLT Lead: Tracey Rees

Current Performance against Target or Standard	Performance

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	99	96	99	99	96	97	96	60	92	97	98	97	98	99	100
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Performance

Excellent performance during Quarter 2, met the target and continued to improve.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	Timescale:	Lead:

Expected Performance gain - immediate.

Anti D & -c Quantitation

120%

100%

84%   97%   99%

90%

80%

60%

40%

20%

0%   0%

	Qtr 4	Qtr 1	Qtr 2	Qtr 3
	Mar-23	Jun-23	Sep-23	Dec-23

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

Anti D & C Results within 5 days Target 90%

SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four. However, the average performance of 94% exceeds the 90% target overall.

EFFICIENT

Financial Balance – Revenue Position												
Target: Net Zero Trajectory												

SLT Lead: Director of Finance

Current Performance against Target or Standard													
Trust Position (core)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4	2	4	5	7						
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at September23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(21.191)	(21.190)	0.001	(40.123)	(40.123)	0.000
RD&I	(0.538)	(0.538)	(0.000)	0.091	0.091	0.000
WBS	(11.065)	(11.066)	(0.000)	(21.532)	(21.532)	0.000
Sub-Total Divisions	**(32.795)**	**(32.794)**	**0.000**	**(61.564)**	**(61.564)**	**0.000**
Corporate Services Directorates	**(6.639)**	**(6.615)**	**0.024**	**(12.956)**	**(12.956)**	**0.000**
Delegated Budget Position	**(39.433)**	**(39.409)**	**0.025**	**(74.520)**	**(74.520)**	**0.000**
TCS	(0.386)	(0.404)	0.018	(0.744)	(0.744)	0.000
Health Technology Wales	(0.071)	(0.071)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	39.891	39.891	0.000	75.381	75.381	0.000
Trust Position	**(0.000)**	**0.007**	**0.007**	**0.000**	**0.000**	**0.000**

In response to the letter received from Judith Paget the Trust considered options at the extraordinary Board meeting on the 09th August and submitted the following financial improvement options to WG on the 11th August.

Performance

The overall position against the profiled revenue budget to the end of September 2023 is an underspend of £0.00m and is currently expecting to achieve an outturn forecast of Breakeven.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organisations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve Actions addressed through Divisional Action Plans	**Timescale:**	**Lead:** M Bunce
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:**	**Lead:**
Expected Performance gain – longer-term		

Risks to future performance
Set out risks which could affect future performance   • Further Non Delivery of recurrent savings plans

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	1.991	

Financial Balance – Capital Expenditure Position														
Target: Expenditure in line with Capital Forecast												**SLT Lead: Finance Director**		
Current Performance against Target or Standard												**Performance**		

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual(Cum)	27.8	1.389m	1.637m	5.646m	10.333m	8.683m	11.326m						
Target £24.416m CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m						

Capital Position as at September 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.508	0.000	3.388	10.896	0.000
nVCC - Project costs	0.000	1.573	0.000	(1.573)	2.856	(2.856)
nVCC - Advanced Works	3.800	0.000	0.000	3.800	3.800	0.000
Integrated Radiotherapy Solutions (IRS)	7.826	2.137	0.000	5.689	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.833	11.218	0.000	11.615	25.689	(2.856)
Discretionary Capital	1.683	0.108	0.000	1.575	1.683	0.000
Total	24.516	11.326	0.000	13.190	27.372	(2.856)

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

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

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2022/23 was agreed at the Capital Planning Group on the 11th of July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m has been ring fenced to support the nVCC enabling works and project costs with expectation that this funding will be reimbursed from additional funding requested from WG for the nVCC enabling works.

 Performance to date

The actual expenditure to September 2023 on the All-Wales Capital Programme schemes was £11.218m, this is broken down between spend on the nVCC enabling works £7.508, nVCC Project Costs £1.573m, and the IRS £2.137m.

Spend to date on Discretionary Capital is currently £0.108m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a

	request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.
	All other schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.
	The CEL will be fixed by WG at the end of October, after this point the Trust is expected to internally manage any slippage on the Capital programme.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£2.m for project support costs.		

Usage of Overtime Bank and Agency Staff within Budget													
Target: Spending within budget												**SLT Lead: Finance Director**	
Current Performance against Target or Standard												**Performance**	

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.323	88	77	86	75	109	117						
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0

Performance

The spend on agency for Sept'23 was **£0.117m,** which gives a cumulative year to date spend of £0.552m and a current forecast outturn spend of circa **£0.940m** (£1.323m 2022/23).

Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: Matthew Bunce
• Actions addressed via Divisional action plans		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
  •

Cost Improvement Programme delivery against plan													
Target: Savings in line with Forecast CIP													

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	0.132m	0.137m	0.137m						
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

Cummulative monthly savings achieved compared to target

Legend: ■ Cumulative Achieved Savings ■ Cumulative Target Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

There is a small year to date underachievement against the planned savings target with the commencement of two schemes expected later in the year.

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

| Target: 95% | | | | | | | | | | | | | | SLT Lead: Finance Director |

Current Performance against Target or Standard

Performance

	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98	96	98						
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 6, and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: 31/03/2024	Lead: M Bunce
Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.		

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

EQUITABLE

% Workforce declared Welsh Speakers in Trust at Level 1	

Target: TBA%	SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard	Performance

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %															
Target TBA%															

Assessment of current performance, set out key points:
- insert text
-

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624
Welsh speakers 116 headcount (4%)

SPC Chart Analysis
The SPC chart shows

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
- insert text

Diversity of Workforce (Gender) % of Women in Senior Leadership positions															
Target: TBA%															

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624

Male 405 (25%)

Female 1219 (75%)

Senior positions (Band 8 +)

Male 94 (37%)

Female 159 (63%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:
- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Diversity of Workforce % Black, Asian and Minority Ethnic people applying Wales version of Workforce Race Equality Standard (WRES)															

Target: TBA%   **SLT Lead: Director of Workforce and OD**

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %															
Target TBA%															

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES)

Total VUNHST headcount 1624

White 1424 (88%)

Black, Asian and Minority Ethnic people 200 (12%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:
- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Diversity of Workforce – People with a Disability																
Target: TBA%															**SLT Lead: Director of Workforce and OD**	
Current Performance against Target or Standard															**Performance**	

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %															
Target TBA%															

Performance

Assessment of current performance, set out key points:
- insert text
-

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624
People with a Disability 70 (4%)

SPC Chart Analysis
The SPC chart shows

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Quality, Safety and Performance Committee

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (QUARTER 2)

Date of meeting	16/11/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

Prepared by	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2023/24** 1.1 This report provides an update (position as of 25th October 2023) of progress against the actions (July – September 2023) which were included within the IMTP for 2023/24 as at Quarter 2. 1.2 These updates are provided in the form of the monitoring templates for WBS and VCS (See Appendix 1 and Appendix 2). 1.3 Good progress has been made again against IMTP actions as at Quarter 2.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to: • **The QSP is asked to NOTE the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 2 for both the Velindre Cancer Service and the Welsh Blood Service.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	**19 October 2023**
VCS SLT / Performance Review	**20 October 2023**
Executive Management Board Run	**30 October 2023**
Summary and outcome of previous governance discussions: **The report has been considered and endorsed at the VCS and WBS Performance Review and EMB Run meetings and is presented to the QSP Committee for information and noting.**	

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

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.**

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2023/24-2025/26 was submitted to the Welsh Government on 31st March 2023. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 2 (July to September 2023), has given the time for a detailed assessment of progress against IMTP actions and has been prepared for the QSP Committee, meeting to be held on 16th November 2023.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q2 for WBS and for VCS.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2023/24 Actions	Velindre Cancer Services IMTP 2023/24 Actions
BLUE	Action successfully completed with benefits being realized		
GREEN	Satisfactory progress being made against action in line with agreed timescale	8 Q actions	9 Q actions
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	7 Q actions	11 Q actions
AMBER	Delays in implementation / action paused due to external issues beyond our control		2 Q actions
RED	Challenges causing problems requiring recovery actions to be identified		
Total IMTP 2023/23 Quarterly Actions		**15 Q actions**	**22 Q actions**

3.3 WBS are making satisfactory progress, categorised as '*green or yellow*', against all 15 of their actions as at Q2.

3.4   VCS are making satisfactory progress, categorised as '*green or yellow*', against 20 of their 22 actions.

3.5   However, two actions that remain assessed as 'amber'. This is defined as *'Delays in implementation / action paused due to external issues beyond our control'*. These two actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.24)
- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025) (pg. 32)

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organization that plays its part in creating a better future for people across the globe	⊠ ⊠ ⊠ ⊠ ⊠	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.	
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐	

	Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarized here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:** *For more information:* https://www.gov.wales/socio-economic-duty-overview | Not required |
| | Click or tap here to enter text |

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text

Type of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text

Scale of Change Please detail the value of revenue and/or capital impact: |

	Click or tap here to enter text
	Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/* *SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2032 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2025/26.	• Personalised donor experience • Wider communication choice for donors • Increased donor retention • Improved information (for sharing/decision-making) • Increased levels of efficiency/ productivity	Prepare donor data recovery map for incorrect donor details.	Begin implementation of donor data recovery plan.	Finalise implementation of donor data recovery plan. Re-platform appointment system portal for booking blood donations.	Scope requirements of integrated communication platform.	**Donor Data Recovery Plan** - introduced new semi-automated process where donors who are unsuccessfully sent an SMS receive an email requesting they update mobile details. Appointment system portal concept has been successfully piloted, implementation will continue into Q3. Donor Contact Centre integrated communication platform procurement underway. Work progressing to establish a donor forum.	
	Develop and implement strategy for sustained growth and retention of the	• Increased stem cell donor panel • Increase in stem cells supply	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved.	Launch and implement strategy.	Post implementation review.	Development of strategy has commenced and is now being taken forward as part of the WBS Futures initiative.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
	stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2023/24.	• Improved resilience in stem cell supplies • Improved clinical outcomes in Wales/globally • Increased income levels		Develop implementation plan.			Timelines have been reappraised as part of the WBS Futures initiative.	
SP2: To provide a world class donor experience **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement our new donor strategy by 2025/26.	• Right size/shape donor panel • Increased resilience for supply of blood/products across Wales • Improved levels of efficiency/productivity Reduced importation and costs • Increased brand awareness and reach	Sign off strategy.	Review existing systems and processes in line with strategy.	Identify opportunities for further improvement.	Commence implementation. Review and Identify opportunities. Review current establishment.	Final draft strategy developed, awaiting sign off prior to initiating a review of systems and processes.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	Progress Rating
		• Wider population/donor education • Development of rich data to improved insights and focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales (Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively • Reduced length of stay post-surgery • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes • Reduction in clinical complications associated with receiving blood products.	Advertise and recruit Anaemia Team Review baseline Digital Health Care Wales (DHCW) data.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Implement relevant plan as agreed. Recruit Health Board nurses to manage Anaemia clinics.	Preoperative anaemia standards have been agreed by all NHS Wales preoperative services & agreed implementation of the All-Wales pathway across Health Boards for all surgical specialties. Pre-op anaemia reports have been benchmarked against standards, resulting in recommendations to optimise services. Bilingual preoperative anaemia toolkit resources have been	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
		• Compliance with the NICE guidance. • Improved efficiency • Cost efficiencies.					created and are hosted on BHNOG website. Patient Blood Management (PBM) training is now included for all 'Foundation' doctors across Wales. Work is ongoing with DHCW to create live data dashboard for the initial data set.	
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2024/25.	• Increased /Sustainable collection model • Improved access for service users • Improved collection efficiency • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow	Continue reintroduction of Mobile Donation Collections.	Introduce 'tours' to remote areas of North West Wales.	Establish project group to progress identified fixed site options.	Continue to progress fixed site model.	'Tours' for North Wales are still being scoped to better understand capacity return/viability. Powys 'tours' have been adjusted to increase capacity by approx.400 appointments. There has been an increase in the number of mobile donation clinics in Q2 creating approx. 600 extra appointments.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
		Donor Registry						
	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Continue phased implementation of OCP (2019) outcomes. Complete new job descriptions.	Continue phased implementation of OCP (2019) outcomes. Complete review of existing service model.	Complete implementation of OCP (2019) outcomes. Develop workforce plan. Provide and promote leadership learning opportunities.	Prepare OCP 2 process in relation to clinically led service model. Complete OCP 2 consultation. Implement new clinically led collection team model.	The OCP implementation is completed in North and West Wales. A phased implementation in South Wales is due to begin in January 2024. Preliminary work has been initiated in respect of the new clinically led collection team model. This work is being taken forward as part of the WBS Future initiative.	
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of	Planning tool developed and in routine use. Review the clinic collection plan for Apheresis to ensure the clinic times are	Clinical and Scientific roadmap established to predict future trends e.g., cold platelets. Begin development	Continue development of the platelet strategy.	The Platelet Strategy Group (established as part of WBS Futures initiative) will meet in October and will align work around the development of the planning tool and the review of the clinic collection plan for Apheresis.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

| Strategic Priorities 2023/24 | Objectives | Expected Benefits | Key Specific Quarterly Actions for 2023/24 | | | | | Progress Rating |
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	
		• Reduce wastage.	platelet planning tool.	optimised.	of platelet strategy.			
	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Improved availability of information • Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Procurement has been delayed, due to WG query regarding alternative funding routes, but expected to commence by October 2023.	
	Procure new Blood Establishment Computer System (BECS) contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	Commence Supplier engagement for new BECS contract.	Supplier Engagement.	Contract award.	Confirm supplier & commence implementation	Post-engagement days & supplier engagement is ongoing. User Requirements Specification in development, and discussions are being held across the WBS Senior Leadership Team and Executive Team to consider options regarding the shape and	

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
							structure of procurement process. The funding position is currently unconfirmed.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO recommendations.	Implemented testing strategy in 2022/23. Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	The project is running to plan, in compliance with SaBTO recommendations and the approach agreed by the 4 UK nations. Data is being collated as our contribution to the planned SaBTO review. SaBTO have not confirmed a report date for this review as yet.	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more	• Maintain compliance with regulatory standards • Improved quality • Improved safety	Complete reconfiguration of the Regulatory Assurance and Governance Group to create	Validation and deployment of eQMS. Review document hierarchy structure.	6 month review of Quality Hub delivery. Implementation of eQMS.	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and	An initial review of the electronic signatures pilot is underway. The eQMS procurement is behind schedule. Currently awaiting Trust Board approval before the contract is awarded.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	efficient and effective management of regulatory compliance and maximises digital technology by 2023/24.	• Improved donor experience.	the Divisional Quality Hub. Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and update processes	Adapt change management process to support Continuous Improvement culture.	Review amended Change Management process	functionality.	The Document Hierarchy work will be paused until the eQMS procurement is complete. Initial change management process changes are in place, and a Continuous Improvement approach is underway.	
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free foetal DNA testing.	On track to award tender in October 2023. The 'Go live' date has been agreed by Programme Board as 13th May 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved patient experience • Reduction in avoidable waste/costs						(yellow)
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secure the supply chain for Immunoglobulins in Wales • Reduces need for importation • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate / renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme (subject to WG policy decision).	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and recovered plasma.	Diagnostic Plasma contract prices have been renegotiated, and the Plasma Project Brief has been written. WBS is awaiting notification of WG position on funding. The National Fractionation contract has been awarded, with commercial details received and a benefits scenario model developed. A High-level costing model for apheresis has been prepared. The Business Case for investment in	(green)

IMTP Strategic Priorities Welsh Blood Services for 2023/24

| Strategic Priorities 2023/24 | Objectives | Expected Benefits | Key Specific Quarterly Actions for 2023/24 | | | | | Progress Rating |
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	
							Leucodepletion kits has been submitted.	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model	• Improved donor satisfaction • Improved staff well-being • Increased service resilience • Reduction in energy consumption and utilisation • Reduction in carbon emissions • Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Refresh of Programme Business Case (PBC). Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Decision to integrate phase 1 (sustainability elements) & phase 2 (laboratory space utilisation) into one OBC. Awaiting updated programme and associated costs from Supply Chain Partner.	
SP7 Develop great people and a great place to work	Develop a sustainable workforce model which provides leadership,	• Enhanced workforce capacity & capability to meet need.	Consult on new Senior Leadership Team (SLT) workforce model	Permanently recruit to remaining SLT roles where there are	Permanently recruit to remaining SLT roles where there are	Review of newly implemented SLT workforce model.	Senior Leadership Team (SLT) Recruitment is progressing. All SLT posts are aimed to be appointed to by	

IMTP Strategic Priorities Welsh Blood Services for 2023/24							
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)	resilience and succession planning by 2025/26.	• Enhanced Leadership capacity & capability • Improved staff satisfaction • Improved staff well-being • Improved service quality, safety and donor satisfaction.	and recruit to roles where there are substantive job holders.	currently only seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	currently only seconded post holders. Plan and deliver training / team development sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	Phased implementation of new Clinical Services workforce model. Phased implementation of new Laboratory Services workforce model.	31.12.23, with the potential for start dates early in 2024 where external appointments are made. The Clinical Services delivery model scoping has concluded, and a new model has been recommended. The WBS SLT & Workforce Business Manager are evaluating recommendations. The Laboratory Services Modernisation Programme has been initiated as part of the WBS Futures initiative.	(green)

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24					Progress Rating
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q2	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction	Complete recruitment to any additional posts identified in workforce plan. Review SLAs. Review operational model	Undertake staff training. Deploy communications plan. Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25 Installation of 2 standard linear accelerators and a CT Sim at the centre.	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan .	• Working group established in conjunction with ABUHB to design service specification and SLA.	(yellow)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care	Clinical commissioning of first replacement linear accelerator at the existing VCS	Realise initial pathway improvements. Initiate digital implementation and develop	Decommissioning and removal of second linear accelerator. Bunker refurbishment commenced in	Installation and commissioning of second replacement linear accelerator at VCS	• All aspects of phase 1 (year 1) delivered on-time and on-budget.	(green)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	First patient treatment (June 2023)	benefits realisation plan.	advance of installation of second replacement linear accelerator.		• Planning for phase 1 (year 2) in development.	
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy services by Q1 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Brachy therapy service improvement group. Identify actions requiring divisional/Trust support.	Optional appraisal to be completed to identify and agree service model required to address capacity gap.	Business case to be completed (if required) to address additional resource requirement.	Continue to implement local actions.	• Work on the peer review action plan has been paused during summer months following the resignation of a Brachytherapy MPE. Now	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Improved productivity and efficiency levels • Improved patient satisfaction	Gather and review baseline data set for theatre utilisation and determine capacity gap Work with Cardiff and Vale University Health Board to review anaesthetic provision and associated SLA	Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		single handed MPE focused activity on Clinical Commissioning and training additional MPE to maintain operational service. • Action plan to be reviewed in October, when MPE capacity should be improved subject to training and competence assessment of clinical scientist in training.	(yellow)
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP -**	• Improved diagnostics information	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support	Development of a local implementation plan to support	• Local deployment order approved by Executive	(green)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
	Radiology Informatics System Procurement.	• Better information sharing and enhanced clinical decision-making • Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction			National implementation	National implementation	• Management Board and to be considered by the Trust Board (September 2023). • Full implementation plan to be developed. Work to commence in September 2023.	
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre**	• Improved patient outcomes • Improved quality of care		Complete phase 2 of SDEC programme			**Ambulatory Care-:** • Established Internet page for ACU/PSU patients	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
	Cancer Services by Q4 2024/25	• Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Reduction in avoidable admissions • Improved patient satisfaction		Develop business case to secure ongoing funding			• Review of nursing resources and potential requirement for extra staff • Recruitment of ACU Ward Manager to manage SDEC Ambulatory service **IO Service-:** • Audit of IO toxicity clinics to capture complexity of calls, referrals, prescription • Specialist Consultant SLAs for Lung, Gastro & Neuro • Review of job title and role of IO MDT Coordinator and workload	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Quality Management System (Hub) within Velindre Cancer Services by Q2 2023/24**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Task and Finish group. Agree scope of Quality Management System.	Identify resource within VCS to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	• Work to describe governance structure advanced (to conclude September 2023).	(yellow)
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist Review by Q3 2023/24**	• Improved patient outcomes • Improved quality of care • Improved patient safety • Improved patient • Satisfaction • Reduction in avoidable admissions	Identify possible funding requirements and develop business case to support change of service model / finance	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts Completion of review	Review and evaluate impact of implementation	• Capacity and demand review at a tumor site by tumor site level progressing and due to conclude in September 2023. • CNS competency	(green)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
							• framework complete. • Job descriptions for band 6 and 7 CNS roles revised and redrafted.	🟩
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Progress Pilot 3 - BOPA Centralised (Separated) Clinical Verification Process	Clinical and technical elements of Clinical Verification separated Undertake local compounding of materials	Define local financial impact of model. Further review / Development of SACT processes to ensure service sustainability	Confirm Pay Tech Service resource that must remain @nVCC	• Continued engagement with national teams. Local work progressing and initial round of Pilot 3 complete (further rounds now to be progressed) however, National TrAMS Service Model is not yet defined to enable significant change of	🟧

GIG
CYMRU
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WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
							practices to be implemented locally. For this reason, work around local compounding of materials has been rescheduled for 24/25	
Trust Strategic Goals 1, 2 and 5	**Expansion of VAPP services by Q4 2023/24**	• Provision of care at home/close to home • Reduced patient needs to travel • Increased patient experience / satisfaction		Develop service model for expansion of service (to include opportunities for service transformation).	Develop workforce plan. Develop financial plan and supporting business case.	Realise service expansion subject to any resource requirement being secured. Evaluation of service change.	• Data collected. in early stages of analysis to determine unmet demand.	
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with**	• Improved quality • Improved patient safety • Improved information (access to and sharing of)	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier	Develop local procurement specification Identify resource required for implementation	Recruit VCS system implementation team	Recruit to VCS System Implementatio n Team (if staff additional to Pre-implementatio n Team required)	• System specification at local approval stage. • Engagement with health board partners	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
	national timeframes	• Improved levels of efficiency and productivity • Reduction in carbon emissions	Map business processes and consider the effects ePMA will have on ways of working	team Develop business case to support recruitment of implementation team Develop project plan for implementation			focused on identifying potential collaboration opportunities.	
Trust Strategic Goals 1, 2, 4 and 5	Implementation of SACT improvement programme by Q1 2024/25	• Improved quality • Improved patient safety • Reduced waiting times • Improved levels of efficiency and productivity • Reduced costs • Improved patient experience	Commence implementation of changes in response to findings of capacity reviews in nursing, treatment booking and pharmacy Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs.	Implementation of findings from capacity reviews in nursing and booking NHH interim service model in place Best practice service model in place ready to transition to nVCC	Progress continues: • Nursing - 8/17 recommendations completed / closed • Bookings - 4/6 recommendations completed / closed • Pharmacy - 2/7 recommendations completed / closed	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
Trust Strategic Goals 1 and 2	Enhance the Velindre Cancer Services SACT telephone helpline to provide 24hr advice, triage service and achieve required standards by Q3 2023/24	• Improved quality • Improved patient safety • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish working group as part of the Safe Care Collaborative Technical capability to record all telephone calls is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.	Develop guidelines for audit. Conduct audit process	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage line is achieving agreed VCS standards in accordance with the VCS Generic Patient Enquiry implementation action plan	• Triage tool updated and launched. • UKONS tool digitalised and launched.	
Trust Strategic Goals 1, 2 and 4	Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere	• Project management resource in post. Work plan identifies initial focus on Cwm Taf Morgannwg UHB / Velindre lower GI pathway.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	2024/25	• Reduced waiting times • Improved patient experience	focus on supporting improved system-wide Suspected Cancer Pathway compliance. Improving compliance against new radiotherapy time-to-treatment (previously COSC) targets and improved flow and performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to map sessions and agree key processes and treatment	with Improvement Cymru and Toyota to address area for improvement Establish project teams to take forward Safe care Collaborative project and ensure clear scope of work Develop and Implement new service and delivery model for Attend Anywhere.	of pathway improvements where possible Review ways of working and identify opportunities for workforce reconfiguration Continued engagement in Safe Care Collaborative programme, including review of existing pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere	Continued engagement in Safe Care Collaborative Programme Identify new ways of working and opportunities for workforce reconfiguration	• Work to define new radiotherapy pathway performance indicators undertaken. • Safe Care Collaborative project teams established. Continued engagement with national programme. Baseline data trawls and process mapping undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			specific pathways for focus Identify service improvements / opportunities for change aligned to best practice / national standards Gather and review baseline data sets Establish Task and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries					

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
			Initiate service improvement projects in conjunction with the Safe Care Collaborative within MSSC pathway and SACT telephone helpline Review lessons learned/benefits from previous Attend Anywhere pilot, identify tumour site group to initiate work, secure approval to proceed Establish project group					

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
Trust Strategic Goals 1, 2 and 5	Digitisation of Medical Records programme by Q4 2024/25	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal Explore off-site storage options as part of a phased transition	Develop supporting business case(s) Initiate phased delivery of the Project	• Project group yet to be established.	
Trust Strategic Goals 1, 2, 3, 4 and 5	Implementation of national prehabilitation to rehabilitation deliverables by 2025/26	• Improved quality • Improved patient safety • Reduction in cancelled treatments • Improved patient health and well-being • Improved clinical outcomes	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define	Establish task and finish group to develop prehabilitation website for VCS patients	Introduce prehabilitation (self-management) website for VCS patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	• Project management support assigned to project. • Project board established. • Working group set up and Terms of Reference and Project	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
		• Improved patient experience	timelines Review funding streams and commissioning models to facilitate prehabilitation service development.				Initiation Document developed and approved. RAID and project benefits logs established.	■
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025)**	• Improved quality • Improved patient safety • Improved patient dignity and experience • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Reduction in carbon emissions	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works Continued engagement between nVCC project team and VCS.	Achieve financial close Ground clearance works Continued engagement between nVCC project team and VCS.	Commence nVCC construction Continued engagement between nVCC project team and VCS.	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCS to the nVCC Finalise clinical models to be implemented to support nVCC.	• Full Business Case remains under development and awaits Welsh Government approval.	■

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Reduced staff sickness						
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025/26**	• Increase care close to home • Improved access • Improved equity • Improved patient experience • Reduction in carbon emissions	Project board re-established in conjunction with HBs	Service model developed and agreed in partnership with ABUHB Development of service model in partnership with CTMUHB	Identify and agree additional workforce requirements and funding streams Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB Ongoing discussions with CTMUHB to determine model and next steps.	Service model developed and agreed with both CTMUHB and C&VUHB	• Strategic planning assumptions and baseline data reviewed. • Internal project board to re-start (end of September 2023).	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes • Reduction in avoidable admissions • Improved patient experience • Reduction in carbon footprint	Establish an acute care programme board Agree scope and develop a statement of intent	Undertake review of service model at VCS and identification of required next steps	Develop communication strategy Develop AOS framework for VCS and service model	Undertake engagement on service model for nVCC	• Regional activity temporarily paused pending recruitment of new operational manager. • Velindre specific acute oncology project progressing with particular focus on pathways, processes and transport issues.	
Trust Strategic Goals 1, 2 and 4	**Implementation of national programme for palliative care and end of life in line with national timeframes**	• Improved quality of care • Reduction in avoidable admissions • Improved patient experience	Review baseline data and outcome from pilot work to date. Identify scope of palliative	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service	Develop business case to support palliative radiotherapy model if required	• Palliative radiotherapy workshop scheduled (for November 2023) to consider options for	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q2	Progress Rating
			Q1	Q2	Q3	Q4		
			radiotherapy within VCS and as part of a regional model.	redesign and develop associated workforce plan Identify possible funding options	Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan		resourcing clinic sustainably. • CIVICA-based palliative patient experience launched facilitating the collection of experience and outcome data.	
Trust Strategic Goals 1, 2, and 4	**Implementation of new services / delivery models by 2025/26.**	• Improved quality • Improved patient safety • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners	• Working group established to plan introduction of IMN and other breast cancer treatments. Group will identify any resource implications which will inform the development of	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24							
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Enhanced organisational reputation for quality of service	developments Establish working group to develop service model to support delivery of internal mammary lymph node (IMN) radiotherapy for eligible patients with breast cancer Continue to engage with WHSSC service appraisal process in relation to proposed PRRT service Develop service model to support implementation of PRRT service for eligible patients with	where appropriate commence business case developments for agreed treatments in phased approach according to priority and timetable agreed Identify additional resource required to implement IMN and develop business case if required for consideration by commissioners. Develop service models to support delivery of extreme hypofractionated radiotherapy for eligible patients	Develop strategy and service model to support adoption of motion management	Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional resource required to support the expansion of the SRS service and develop business case, if required	a business case to support introduction of new techniques. • Hyperarc phantoms procured to support testing of SRS treatment solutions.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients with prostate cancer. Develop business case for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery	with prostate cancer if required Identify additional resource required to implement extreme hypofractionated radiotherapy for eligible patients with prostate cancer and develop business case for consideration by commissioners Develop business case to support implementation of PRRT service to WHSSC and funding stream for additional revenue resource if				

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			of new indications for Stereotactic Ablative Radiotherapy (SABR)	required Train Medical Physics Expert to support implementation of PRRT service				
Trust Strategic Goals 1, 2 and 5	**Implement DHCR phase 2 by 2024/25**		Review learning from phase 1 to support implementation of further phases continue implementation of training plan Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• Phase 1 closure report and benefits realisation review developed. Lessons learned exercise undertaken. • Revised programme governance structure to be implemented from September 2023.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			VCS agreed scope and prioritisation of phase 1b (VCS specific) agree scope and prioritisation of phase 2					(yellow)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation by Q4 2024/25**	• Creation and sharing of knowledge across Wales/wider to improved cancer care • Development of network of partners to tackle key issues • Creation of knowledge economy and innovation across Wales	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway	Workshop to be held to scope CfCL and ways of working	Review potential projects aligned to CfCL, e.g. school for oncology, ARC, etc.	Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community	• The CCfLI, Velindre Oncology Academy and ARC Academy collaborative scoping work has been completed to inform the workshop. • CCfLI collaborative workshop has been scheduled and	(green)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q2**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Physical space to support innovation and development working across the region/Wales/wider	delivery between and with primary and community care and Velindre			care and Velindre	next steps to be agreed.	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023 / 24 – 2025 / 26 had been approved. Following the approval of the IMTP the Trust received an accountability conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive. The key accountability conditions are summarised in section1 (*situation*). A stated requirement within the accountability conditions letter was for the Trust to report Progress against

	the conditions on a quarterly basis from quarter 3 (2023/24).

RECOMMENDATION / ACTIONS	The Quality safety and Performance Committee is asked to: • Note the Welsh Government accountabilities conditions • Approve the approach for reporting against the Welsh Government conditions

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	**30/10/23**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board.	

7 LEVELS OF ASSURANCE – NOT APPLICABLE

APPENDICES	
1	Velindre University NHS Trust IMTP Accountability Conditions Letter from the Welsh Government

1.   SITUATION

1.1   The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023 / 24 – 2025 / 26 had been approved.

1.2   Following the approval of the IMTP the Trust received an accountability conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive. The key accountabilities are listed below with the Trust accountable officer(s) for each condition also identified:

- Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risk (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible (Executive Director of Finance)

2. BACKGROUND

2.1 Within the Welsh Government Accountability Conditions letter it was stated that there was an expectation that:

"*The Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year*".

3. ASSESSMENT

3.1 To ensure robust delivery of the IMTP for 2024 / 25 – 2026 / 27 and to discharge the Welsh Government IMTP accountability conditions it is recommended, from November 2023, that a quarterly progress report is submitted to:

- The Executive Management Board (Run)
- The Quality, Safety and Performance Committee
- The Velindre University NHS Trust Board

Note: we currently report progress against the actions included within the Trust IMTP on a quarterly basis. This proposal is specific to the four Welsh Government accountability conditions.

4. SUMMARY OF MATTERS FOR CONSIDERATION

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

- Note the Welsh Government accountabilities conditions
- Approve the approach for reporting against the Welsh Government conditions

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☐ ☐ ☐ ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Not applicable	
	Not Applicable	
	The purpose of this paper is to outline the approach for reporting against the Welsh Government IMTP accountability conditions.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required	

For more information: https://www.gov.wales/socio-economic-duty-overview	There are no socio-economic impacts linked directly to the approach outlined within the paper or attached appendices.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A - There are no Trust Well-Being goal implications or impact linked directly to the approach outlined within the paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	The purpose of this paper is to initiate a discussion in relation reporting requirements against the Trust IMTP accountability conditions. However, there will be a requirement to undertake an IMTP Equality Impact Assessment I support of the development of the Trust IMTP for 2024/25 – 2026/27.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Integrated Quality and Safety Group Highlight Report

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance.
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	This paper provides the Quality, Safety and Performance Committee with an overview of key deliberations and outcomes of the Trust Integrated Quality & Safety Group meeting held on 18th October 2023. In summary: • The Executive Management board have agreed the initial phase one additional quality metrics to be developed a fully timed implementation plan is being developed by the business intelligence team. • The Quality & Safety Tracker has moved over to the Amat (electronic audit) system with the aim of providing enhanced governance and streamlined reporting moving forward. There is insufficient

	assurance to date in relation to the robustness of the reporting through the system, action is being led through the corporate quality and safety team to ensure all action owners can use the system and update the actions on a regular basis as well as work being undertaken with Amat to build effective assurance reports.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee are asked to NOTE the discussions held at the Integrated Quality & Safety Group in particular the: • The Integrated Quality & Safety Group Workplan • Safe Care Collaborative Governance Structure • The approach to development of Quality and Safety Action tracker • The approach for revision of Information Governance Policies.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	30th October 2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Executive Management Board accepted the progress made with the implementation of the AMaT system to support the Quality and Safety Tracker.

Positive feedback was provided regarding the developed Safe Care Collaborative Structure.

The Executive Management Board endorsed:
• The approach to development of the Quality and Safety Action Tracker
• Integrated Quality and Safety Workplan
• Safe Care Collaborative Governance Structure
• The approach for revision of Information Governance Policies.

7 LEVELS OF ASSURANCE
For Noting

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

APPENDICES	
Appendix 1	Safe Care Collaborative Governance Structure
Appendix 2	September 2023 Quality and Safety Tracker Report
Appendix 3	Integrated Quality and Safety Group Workplan.

1. BACKGROUND

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

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

2. ASSESSMENT

Meeting Key Outcomes/ Deliberations of the Integrated Quality and Safety Group meetings held on 18th October 2023 were:

2.1 Trust Quality Dashboard

A phased approach to the Quality dashboard development and implementation has been proposed and agreed at Integrated Quality and Safety Group:

- Baseline: Existing quality and safety metrics that are currently reported via the Trust Performance Management Framework (PMF).

- Phase 1: New quality and safety metrics that are to be added into the PMF and require further development.

- Phase 2: Service level quality metrics that are required to inform service delivery but are not required for board assurance or PMF reporting.

Metrics have been developed and endorsed by the Integrated Quality and Safety Group, approved by Executive Management Board and passed to the Performance Management Framework Group for implementation.

To further progress this programme of work a detailed project plan is being developed that will include key delivery milestones and timelines for presentation at the next Group on the 21st November 2023.

2.2   Quality and Safety Tracker

The Corporate Quality and Safety team are responsible for the development, improvement and management of the Quality and Safety tracker, with the Integrated Quality & Safety Group being responsible for the oversight, monitoring and assurance to the Executive Management Board. Over the past few months it has become evident that there are numerous action trackers in existence across the Trust and, although improvements have been progressed, the ability to provide oversight and assurance has been challenging. To overcome this, an overarching Quality and Safety Regulatory action tracker has been developed upon the AMaT (digital audit system) in line with the agreed prioritised approach:

- **Priority 1 - complete**
  Define the Quality & Safety Regulatory Tracker function across Velindre University NHS Trust

  The areas for inclusion in the tracker were previously approved by the Committee and are now all included within the tracker.

- **Priority 2 - complete**
  Produce an annual Quality & Safety Regulatory Compliance Assurance plan, with objectives, priorities and inspections/audits planned for 2023/24

  During this period, divisions have been asked to provide details of anticipated inspections and audits for the financial year 2023/24, to date details of several anticipated audits and inspections have been provided. However, it is anticipated that further audits and inspections will be identified on a continual basis.

- **Priority 3 - ongoing**
  Further develop the Quality & Safety tracker and prepare options for the automation of the Trust Quality & Safety Improvement Tracker (using an automated electronic quality management system such as Q Pulse AMaT)

The Integrated Quality and Safety Group, Executive Management Board and Quality, Safety and Performance Committee agreed to move the Quality & Safety Tracker onto the inspection module of the AMaT Quality Management system. Very rapidly, all existing inspections, recommendations and actions that were housed on the excel spreadsheet have been updated and transferred onto the AMaT system in addition, all recommendations and actions identified within National Reportable Incidents investigations have also been included – achieved by the 16th October 2023 (An overview of the system can be provided via Zoe Gibson, Interim Head of Quality & Safety if required).

Currently within the AMaT inspection module there are **16** inspections, **104** recommendations and **135** actions open upon the system, **85** actions are reported as overdue, **44** in progress and **6** awaiting approval. **58** overdue incidents relate to Radiotherapy/ Brachytherapy recommendations, **1** overdue action relating to CHC Outpatient Inspection, **1** overdue action relating to First Floor HIW inspection and **4** overdue actions relating to Patient and Donor Experience recommendations. This does not necessarily mean that all 85 actions are overdue, rather, for some responsible officers may not have updated the action status. To address this the Corporate Quality and Safety team are working in partnership with departmental leads to ensure relevant actions are allocated to appropriate leads, that action due dates set are correct and that relevant actions are being progressed. This further review will be completed prior to the published in the next report.

From undertaking this review it has become evident that the allocation of responsible individuals for each action is key to assisting in appropriate updates being provided and action completion dates being set and achieved. Continued review of action leads and action delivery dates will continue to be a focus within meetings held in November 2023.

The Head of Quality and Safety is currently working collaboratively with AMaT and service leads to develop a range of bespoke monthly reports that will facilitate effective service level to Committee assurance and exception reporting. AMaT have estimated at least a 9-week delivery period.

Current tracker is attached in *appendix 1*.

2.3 Smart 2023/24 Quality Improvement Goals - Safe Care Collaborative (SCC)

The safe care collaborative projects continue to progress. All projects continue to report monthly progress through the Trust Safe Care Collaborative Group and Improvement Cymru reporting cycles, with all monthly reports now containing both project progression and 7 levels of assurance scores.

2.3.1 Donor Adverse Event (DAER) Reporting Project

Aim: *To achieve 100% follow-up for donors who have suffered an adverse event by the next working day and achieve 98% DAER donor experience scores consistently for a 12-month period and reduce inappropriate donor attendance at A&E and primary care services* – Initial improvement cycles relating to donor information provision, rationalisation of Standard Operating Procedures and revision of Donor Adverse Events Record reports have been finalised and will be piloted during October 2023 in North and South Wales.

- *Project Progression Score **2.0** (*Team actively engaged in development, research, discussion but no changes have been tested)
- *7 levels of assurance score **3.0***

2.3.2 Haemochromatosis Project

Aim: *To Enable Cwm Taf Morgannwg UHB to identify eligible Genetic Haemochromatosis patients for referral to the Welsh Blood Service for regular venesection by April 2024* - The project is progressing well with data capture and stakeholder involvement in partnership with Haemochromatosis UK nearing completion. A patient information database to support the project has been developed with data entry nearing completion and patient information being issued to patients within the pilot site area (Cwm Taf Morgannwg UHB). During this period, Haemochromatosis UK have also issued a survey on behalf of the project to both identify any current barriers that Genetic Hemochromatosis (GH) patients face whilst donating, and to raise the profile of the WBS GH service.

- *Project Progression Score **3.0** (*Initial test cycles have been completed and implementation begun for several components. Evidence of moderate improvement in process measures).
- *7 Levels of assurance Score: **4.0***

2.3.3 SACT Treatment Helpline

Aim: To ensure that the VCC SACT Treatment Helpline provides safe, reliable, and effective care for 100% of unwell patients where there is a high probability that SACT treatment is the cause - The project has progressed during this period, with several interventions undertaken in relation to escalation pathways, patient triage and SACT Helpline scope with initial Plan Do Study Act (PDSA) commencing. A SACT Treatment helpline Peer Review has been commissioned and will be undertaken in December 2023.

- *Project Progression score **2.5** (Components of the model being tested but no improvement in measures. Data on key measures are reported).*
- *7 levels of assurance score **3.0***

2.3.4 Malignant Spinal Cord Compression Pathway

Aim: By March 2024 85% of patients diagnosed with Metastatic Cord Compression (MSCC) to begin treatment with radiotherapy within 24-hours of positive diagnosis - Work has progressed on the initial PDSA cycle focusing upon a review of on-call skill to ensure availability of clinical oncologist both in and out of hours. Work also continues in collaboration with WAST and CVUHB to improve MSCC transfer pathways and associated transport provision.
- *Project Progression score reported **2.0** (Team actively engaged in development, research, discussion but no changes have been tested).*
- *7 Levels of assurance score **2.0***

2.3.5 Leadership Project

Aim: To enable Senior Leaders to create the conditions and learning systems by April 2024 that supports and enables a culture of psychological safety, to deliver required outcomes for the delivery of Safe, Effective and Reliable care - The leadership workstream is gathering momentum with project approach and direction being agreed. Work has commenced to develop a staff survey tool to measure current levels of psychological safety across the organisation to enable development of relevant PDSA cycles. This project will also closely align with the Speaking Up Safely Framework going forward.
- *Project progression score **2.0** (Team actively engaged in development, research, discussion but no changes have been tested).*
- *7 Levels of assurance score **2.0**.*

2.3.6 *Safe Care Collaborative Governance Structure*

To ensure the delivery of required improvements in an effective and timely manner, to ensure that improvements, learning and best practice are shared across the organisation and to ensure the project teams receive the required support to realise the required improvements it is imperative that robust leadership, communication and governance processes are in place. To achieve this a Safe Care Collaborative Governance Structure has been developed and agreed at the Integrated Quality & Safety Group (attached in *Appendix 2*).

2.4 Datix Operational Group Update

2.4.1 *Global performance Issues with Datix Cymru*

There have been significant ongoing system performance issues and challenges over the last month relating to the national Datix Cymru system. Investigations have been undertaken by RL Datix and the Once for Wales Central Team to determine the root cause and possible mitigations. To address this server changes have been made. Following the successful server move there was an improvement noted in system responsiveness which will continue to be monitored by RL Datix.

2.4.2 **Risk Enterprise Module Update**

There continues to be anxiety from organisations across Wales regarding moving to Datix Cymru Risk Enterprise Module, as the system does not meet all requirements and has fundamental flaws regarding key areas. Work is currently being undertaken by RL Datix and the Risk workstream to resolve these issues. Timescales and contact obligations of system implementation are currently unknown but are expected to be announced at the next Once for Wales Programme Board meeting.

It has been highlighted that there is an alignment issue between risk management process and Board/Committee expectations and how this will be translated into the new system. This has been escalated to the Director of Corporate Governance via the Risk workstream.

2.5   **Welsh Blood Service Externally Reportable Event SABRE 110**

One adverse incident was reported to Medicine & Healthcare products Regulatory Agency via the SABRE portal during September 2023 which relates to a positive donor archive sample that was incorrectly identified within a recent lookback exercise

undertaken as CAPA for SABRE 106 Malaria residency risk. Following this incident an Root Cause Analysis investigation has been completed and the incident report is currently being compiled. Initial investigations have identified that the individual sample, although tested positive for malarial DNA, has not tested positive for active malaria infection, therefore no recipient risk has been identified.

2.6 Intracranial Haemorrhage in Blood Donation

The WBS Medical Director has identified a publication in the Journal of the American Medical Association (JAMA) suggesting an association between the occurrence of spontaneous recurrent intracranial haemorrhages (ICHs) in blood donors and the occurrence of an ICH in recipients of their blood: https://jamanetwork.com/journals/jama/article-abstract/2809417

The paper provides a hypothesis that if there was a genuine link, a reason could be due to cerebral amyloid angiopathy (CAA) occurring in both donor and recipient. This is the only study suggesting such a link, and CAA as a cause is purely a hypothesis if there was a link.

Disorders associated with CAA are a contraindication to donation in the UK with such donors being deferred, so it is considered even if an association becomes clearer with further publications, it is unlikely to have significant impact on transfusion practice other than to reinforce the need for prudent use of blood components driven by evidence that the benefit outweighs known risks.

2.7 Information Governance (IG) Policies In Need of Review

During recent months an All Wales working group was established to renew and publish agree All Wales Information Governance Policies. To date the working group consisting of IG leads across Wales have been unable to identify an agreed National Policy approach. Due to this situation and existing Trust IG policies review dates being exceeded, the Trust IG lead is prioritising the update of IG policies.

2.8 Integrated Quality and Safety Workplan

To prioritise workload and ensure roles and responsibilities of the Integrated Quality and Safety Group are discharged and requirements of the Duties of Quality and Candour are delivered the Integrated Quality & Safety Group have developed a work plan for 2023/24. Each item upon the workplan has been prioritised, triangulated with request origin and aligned with the 7 levels of assurance (attached in *Appendix 3*).

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* [STRATEGIC RISK DESCRIPTIONS](#)	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	Provides Quality, Safety and Performance Committee details of discussions and decisions made at an integrated divisional level which impact upon all domains of quality.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required	
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approach change with a direct impact upon Socio Economic Duty.	

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

6.   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	1. *Delays in the development of the quality and safety dashboard, prevent consistent and Accutane report of quality data.* 2. *There are risks associated with the current lack of assurance related to the quality and safety tracker.*
WHAT IS THE CURRENT RISK SCORE	For inclusion on the risk register and assessment of risk.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions if implemented fully should reduce the risks
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Low Risk
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

Appendix 1

Governance and Reporting Structure for the Safe Care Collaborative Group (SCCG)

The Safe Care Collaborative aims to bring together health boards and trusts across Wales to accelerate improvement projects that will improve patient safety throughout the NHS in Wales.

The SCCG has been established as part of the wider National Safe Care Partnership Programme led by Improvement Cymru. The Safe Care Collaborative creates a learning system where organisations test and measure practice innovations and share their experiences to accelerate learning and widespread implementation of best practices for safe care.

The Safe Care Collaborative consists of 4 main workstreams:

1. Leadership for Patient Safety Improvement
2. Safe and effective Community Care
3. Safe and effective Ambulatory Care
4. Safe and effective Acute Care

VUNHST is an active participant of the Safe Care Collaborative with 5 projects being undertaken, with each project team consisting of a project lead, required team members and Improvement Cymru Improvement Coaches. To support project delivery and progression each team also has a Senior Leadership and Executive Lead.

Leadership Project
To enable Senior Leaders to create the conditions and learning systems by April 2024 that support and enable a culture of psychological safety, to deliver required outcomes for the delivery of Safe, Effective & Reliable care.

Donor Adverse Event Reporting Project, Welsh Blood Service
Aim: To achieve 100% follow-up for donors who have suffered an adverse event by the next working day and achieve 98% DAER donor experience scores consistently for a 12-month period and reduce inappropriate donor attendance at A&E and primary care services.

Haemochromatosis Project

Aim: To Enable Cwm Taf Morgannwg UHB to identify eligible Genetic Haemochromatosis patients for referral to the Welsh Blood Service for regular venesection by April 2024.

SACT Treatment Helpline

Aim: To ensure that the VCC SACT Treatment Helpline provides safe, reliable, and effective care for 100% of unwell patients where there is a high probability that SACT treatment is the cause.

Malignant Spinal Cord Compression Pathway

Aim: By March 2024 85 % of patients diagnosed with MSCC to begin treatment with radiotherapy within 24-hours of positive diagnosis.

Governance Structure

To ensure the delivery of required improvements in an effective and timely manner, to ensure that improvements, learning and best practice are shared across the organisation and to ensure the project teams receive the required support to realise the required improvements it is imperative that robust leadership, communication and governance processes are in place. To achieve this the following reporting and governance structure has been developed:
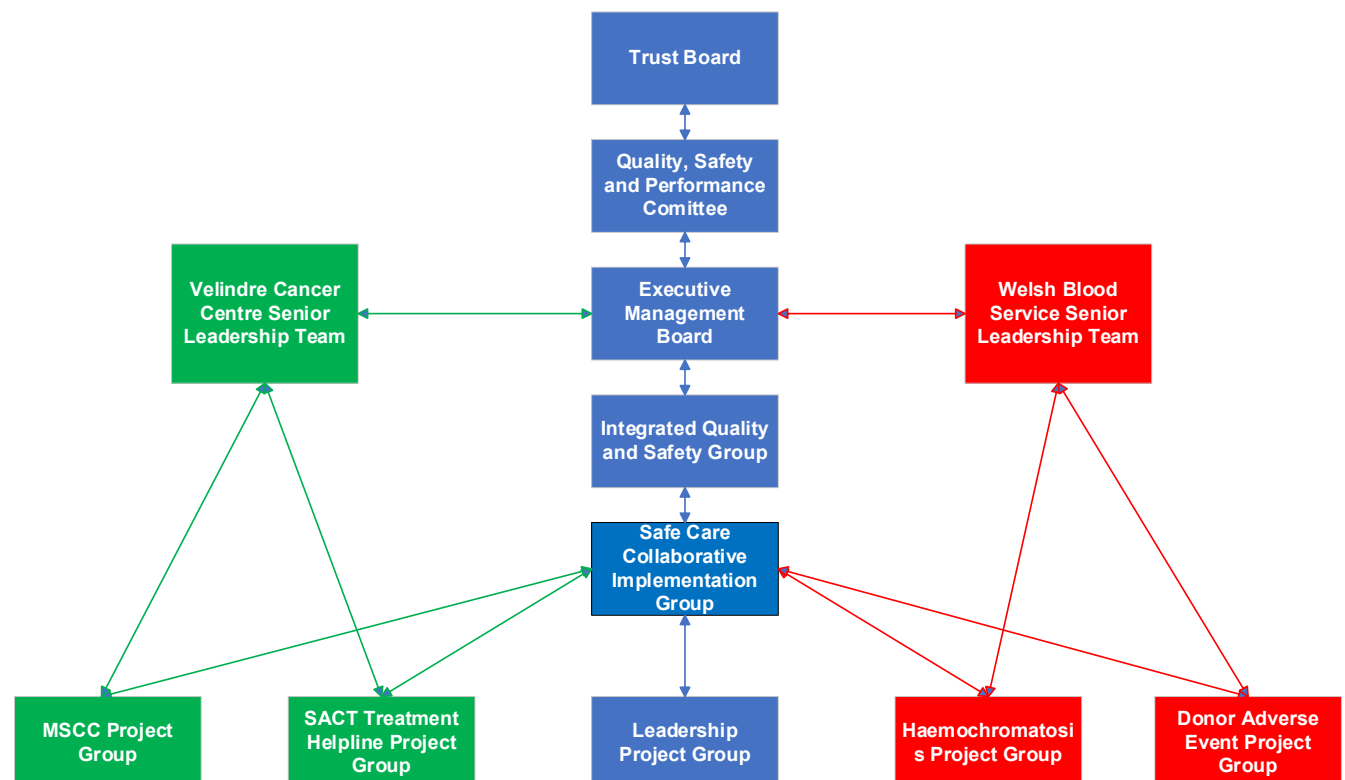
Reporting Requirements

To ensure the accurate and timely reporting of progression all project teams are required to submit a written progress report to the Safe Care Collaborative Implementation group which is then shared both internally through the SCC governance structure and externally with Improvement Cymru utilising the national progress report template:

GWELLIANT IMPROVEMENT CYMRU CYMRU — GIG NHS

Project Level Score:

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

Progress – Monthly Update Report Template

Notes for completing the report:
1. Make the report clear and easy to read. Keep it brief and to the point.
2. Start a new template each time – do not just add more to the previous one. What is included will depend on what stage of the project you are at.
3. Assess your project stage based on the below scale.

Assessment / Description	
1.0 Forming a team	Team has been formed, target population identified, aim determined, and baseline measurement begun.
1.5 Planning for the project has begun	Team is meeting, discussion is occurring, Plans for the project have been made.
2.0 Activity, but no changes	Team actively engaged in development, research, discussion but no changes have been tested.
2.5 Changes tested, but no improvement	Components of the model being tested but no improvement in measures. Data on key measures are reported.
3.0 Modest improvement	Initial test cycles have been completed and implementation begun for several components. Evidence of moderate improvement in

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	process measures.
3.5 Improvement	Some improvement in outcome measures, process measures continuing to improve, PDSA test cycles on all components of the Change Package, changes implemented for many components of the Change Package.
4.0 Significant improvement	Most components of the Change Package are implemented for the population of focus. Evidence of sustained improvement in outcome measures, halfway toward accomplishing all of the goals. Plans for spread and scale improvement are in place.
4.5 Sustained improvement	Sustained improvement in most outcomes' measures, 75% of goals achieved, spread to a larger population.
5.0 Outstanding sustained results	All components of the Change Package implemented, all goals of the aim have been accomplished, outcome measures at national benchmark levels, and spread to another facility is underway.

Team name: **MSCC** Date: 30/08/23

Project title	Project score
What is the aim?	
Activity this month	
Changes – PDSA's	

Tested - PDSA:

N/A at this stage

Implemented:

N/A at this stage

What did you learn from your PDSA's?

N/A at this stage

Data: include data that you have been collecting (Run charts)

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Barriers / Breakthroughs

Next steps – actions for next month

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Appendix 2

Quality & Safety Regulatory Action Tracker

Update for IQSP October 2023

Introduction

VUNHST has recently introduced the AMaT audit tool, for the monitoring of recommendations and actions emerging from audits and inspections. AMaT has replaced previous Excel-based service-level trackers.

All recommendations and actions have now been added to AMaT by the corporate Quality & Safety Team. Work is underway to ensure all actions are aligned to correct leads. Meetings are being scheduled with those staff members, in order to demonstrate AMaT and support engagement with the tool.

Number of inspections	15
Total recommendations	105
Total actions required	156

Actions by approval status
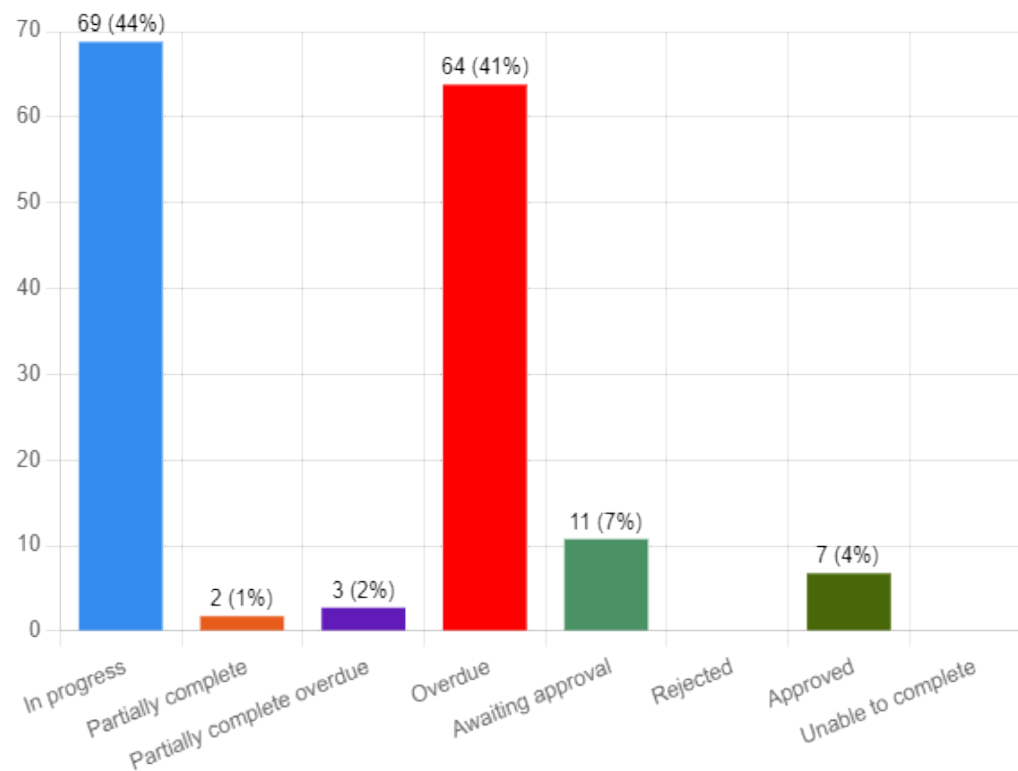
VNUNHST Inspections

The table shows recommendations and actions by approval status, per inspection.

Title	Date of Inspection	Recommendations	Actions total	In prog.	Part. complete	Overdue	Complete (AA)	Complete
Brachytherapy Audit	02/02/23	46	46	1	0	44	0	1
Brachytherapy NRI steps 1-6	10/09/23	5	5	5	0	0	0	0
CHC visit to VCC Outpatients Department 8th February 2023	08/02/23	1	1	0	0	0	1	0
HIW Radiotherapy Department, Velindre Cancer Centre Inspection 10th & 11th May 2023	10/05/23	16	31	17	2	4	5	3
HIW Visit to VCC First Floor Ward 12th & 12th July 2022	12/07/22	1	1	0	0	1	0	0
Loss to follow up NRI steps 1-9	10/09/23	6	6	6	0	0	0	0
NRI 13221 VCC steps 1-7	24/08/23	6	6	6	0	0	0	0
Patient & Donor Experience	05/01/23	4	4	0	0	4	0	0
SACT NRI steps 1-7	11/09/23	7	7	7	0	0	0	0
SACT Treatment Helpline Incidents	01/01/23	1	28	15	0	10	0	3
Urology NRI Recommendation steps 1-12	11/09/23	7	7	6	0	0	1	0
VCC Clinical Audit Action Plan	12/07/23	1	2	2	0	0	0	0
VCC Clinical Audit Tracker	26/09/23	2	9	2	0	3	4	0
WRP concerns Assessment	17/03/23	1	1	1	0	0	0	0
WRP Validation	22/02/23	1	2	1	0	1	0	0
Total		**105**	**156**	**69**	**2**	**67**	**11**	**7**

Appendix 3: VELINDRE UNIVERSITY NHS TRUST INTEGRATED QUALITY AND SAFETY GROUP WORK PLAN 2023/24
(Devised 15/09/2023)

7 Levels of Assurance

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

Ref Number	Action	Date Added to Workplan	Source of Action	How Success Will Be Determined	7 Levels of Assurance	Planned date for completion		Lead
1	**To develop, implement and oversee a single Trust wide Quality and Safety Action Tracker.**	26th September 2023	Executive Management Request.	Secure AMaT system access and superuser training.	3	Superuser/ administrator training completed 18th September 2023	18th September 2023	Corporate Head of Quality and Safety
				Develop and deliver training for operational leads	2	Training commenced in one-to-one sessions with operational action leads	9th October 2023	Corporate Quality and Safety Managers
				Enter all existing actions within AMaT system	4	Complete	1st October 2023	Corporate Quality and Safety Managers
				Develop monthly tracker report format for delivery at IQSG, EMB and QSP	4	Draft Reports developed	1st October 2023	Corporate Head of Quality and Safety
				Develop robust roles, responsibilities and processes to support tracker management, oversight and reporting.	2	Paper to be presented at IQSG for agreement 26/9/2023	31st October 2023	Corporate Head of Quality and Safety/ Operational Service Leads

1

2	**Development of Always on Reporting Legacy actions transferred from Duty of Quality and Duty of Candour Implementation Group**	26th September 2023	Duty of Candour implementation Group	Develop and publish initial experience reporting measures	6	Complete and implemented in practice	complete	Corporate Head of Quality and Safety
				Develop and expand suite of measures	6	Wall of thanks has been launched (September 2023). The responsibility for development has been transferred to corporate governance team for management going forward.	complete	Deputy Head of Quality and Safety
3	**Duty of Candour Training All relevant staff to understand and apply Duty of Candour. Staff who are involved in performing or exercising functions in connection with the Duty of Candour procedures must undergo appropriate training. Training must be tailored to reflect banding, status and seniority of staff, consisting of basic training for lower graded staff, to more in-depth training for senior members of staff.**	26th September 2023	Duty of Candour implementation Group	Development of a clear training plan to be developed and delivered to relevant staff. To include: • Requirements and legal responsibilities of Duty of Candour • Understanding the legal framework and levels of harm • Understanding terminology and meaning of when duty of Candour is triggered • Investigating or managing notifiable adverse outcomes • General Data Protection Rules (GDPR) principles • Systems recording (please see above separate Datix training requirements) • Apologising and saying sorry.	3	Online Training has been launched. Compliance currently low	Complete.	Deputy Director of Nursing, Quality and Patient Experience/ IQSG WOD Lead

2

4	**Communication and written outcomes to address the effects of harm and the physical consequences for service users, their families, carers and advocates once the Duty of Candour is triggered.**	26th September 2023	Duty of Quality/ Candour Implementation Group	Trust Duty of Candour procedures to be developed and aligned with regulatory requirements to cover all operational requirements. To support this Trust tool kit to be provided	2	National Duty of Candour procedures have been implemented. Trust Toolkit is under development.	30th November 2023.	Deputy Head of Quality and Safety
5.	**Process for Trust website monthly 'Always On' of key quality & experience measures and annual reporting to be determined and implemented (including assessment of the extent of improvements in outcomes).**	26th September 2023	Duty of Quality and Candour Implementation	Always on reporting mechanism in place	6	Always on mechanism was developed and launched in August 2023. Compliment 'Wall of thanks' web page developed and due to go live September 2023. Action closed, responsibility for always on report developments has been given to xxx following discussions at EMB.	1st August 2023	Corporate Head of Quality and Safety
6.	**Trust to develop a quality management system, with appropriate focus on quality control, quality planning, quality improvement and quality assurance, with the aim of achieving a learning and improving environment; and creating a culture of quality**	26th September 2023	Requirement of the Duty of Quality	Develop and agree system and implementation plan Full system implementation	2	Initial approach document has been drafted and presented to EMB	30th March 2024	Executive Team (collective)

3

No.	Description	Date	Requirement	Action	RAG	Comment	Target	Lead
7.	**Trust wide Duty of Quality Training to be rolled out to all responsible officers**	26th September 2023	Requirement of Duty of Quality	Delivery of required training	**1**	Update National Training Package outstanding (September 2023).	January 2024	IQSG WOD Lead
8.	**The Trust needs a systematic approach to managing quality that includes building improvement capability to ensure teams at each level of the Trust have the general and specialist improvement skills needed.**	26th September 2023	Requirement of the Duty of Quality	Development of a suite of Quality and safety measures service level to Board through:				
				Identifying existing measures across the service	**6**	This aspect is complete and actions prioritised.	Complete	Corporate Head of Quality and Safety/ Head of Information
				Reviewing and agreeing measures for inclusion	**6**	Initial workshop held and suite of measures and suggested approach developed for presentation at IQSG	26th September 2023	Head of Information
				Developing and Implementing dashboard	**2**	Priority areas identified and phased approach to be undertaken	All measures by 30th March 2024.	Head of Information
9.	**The Trust needs to ensure that initiatives to improve quality are consistent with the Trust's overall strategy and mission and barriers are identified and unlocked.**	26th September 2023	Requirement of the Duty of Quality	The Trust should ensure that learning from success and weaker areas continue to shape the improvements in quality that are required.	**2**	WBS 5 Minute improvement initiative Safe Care Collaborative Projects	Ongoing Focus throughout 2023/24	All Group Members
10.	**Quality and Safety team to review and update a plan during Q1 2022-23 to introduce the new health and care quality standards.**	26th September 2023	National Requirement to implement Health and Care Quality Standards.	Introduction of new health and care quality standards and associated processes	**0**	Workshop plan to scope and develop approach.	December 2023	Deputy Director of Nursing
11.	**Culture Survey Tool is Operationalised**	26th September 2023		Survey staff across the organisation	**1**	This is to be undertaken as part of leadership safe care collaborative	31st December 2023	SCC Leadership Workstream Lead

4

12.	**Oversight of Development of Mortality reports that align with national requirements and maximise organisational assurance**	26th September 2023	National Requirement	Robust Reporting in place and received by IQSG	1	Work commenced, working group established and met to agree reporting requirements going forward led by VCS Quality and Safety Manager.	30th November 2023	VCS Quality and Safety Manager/ Head of Nursing and Quality
13.	**Develop and implement Integrated Quality and Safety Group Reporting mechanisms**	26th September 2023	Requirement of Duty of Quality	Agreement of key measures and standardised reporting approach for all departments/ divisions	6	Work commenced, key reporting measures drafted and being progressed and refined through key stakeholder events	18th October 2023	Divisional Quality and Safety Leads/ Corporate Head of Quality and Safety
14.	**Revise, update and agree:** **Handling of Concerns** **National Reportable Incidents** **Claims** **Policies.**	26th September 2023	Core requirement for compliance with Putting Things Right Regulations	All relevant policies and procedures are reviewed and published in line with required timescales.	6	Concerns and National Reportable Incident Management and Reporting Policy have been agreed at August IQSG and Claims policy has been reviewed and upon September agenda for IQSG	26th September 2023	Corporate Head of Quality and Safety/ Corporate Claims Manager
15.	**Utilise National Digital Story Telling Boards to assist in patient and donor feedback provision**	26th September 2023	All Wales Resource	Digital Story Telling Boards and associated resources introduced as a feedback mechanism.	0	National tool developed	30th March 2024	Deputy Head of Quality and Safety.

5

16.	**Develop and Implement a robust process for management and oversight of NICE guidance utilising AMAT system.**	26th September 2023	Core Quality and Safety Requirement	Robust system embedded into practice	0	Will be commenced once Quality and Safety Tracker is implemented.	1st February 2024	Clinical Audit Lead/ Head of Quality and Safety

6

Quality Safety and Performance Committee	

TRUST QUALITY & SAFETY FRAMEWORK & QUALITY PRIORITIES UPDATE	

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	14 out of the 26 (54%) of the quality framework implementation actions have been delivered. 2 (8%) will meet agreed timescales, 10 (38%) have had revised timescales due to delivery capacity issues as unable to recruit into implementation post and gaps within the Trust Corporate Quality & Safety team for extended periods. The team is now fully resourced. The key exception is in relation to the development of the quality and harm measures which requires dedicated Business Intelligence support and to date there is no trajectory for completion of this work. This has helped the Trust in meeting its duty of quality responsibilities.

RECOMMENDATION / ACTIONS	To **DISCUSS** and **NOTE** the status of the Quality Framework Implementation, the plans to have a peer review undertaken by Hywel Dda University Health Board followed by a refresh of the framework and the plans to develop the 2024/2025 Quality priorities.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	30/10/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Noted	

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

APPENDICES	
Appendix 1	Quality Framework Implementation Plan

1.   SITUATION

This paper is to provide the Quality Safety and Performance Committee with an update on the implementation of the Trust's Quality & Safety Framework and plans to determine the 2023/24 Quality Priorities.

2.   BACKGROUND

The Trust Board approved the Quality & Safety Framework in July 2022. An implementation plan was developed. The Quality Framework is due to be refreshed before the end of 2023/24 to reflect the requirements of the Duty of Quality. A peer review from Hywel Dda University Health Board has been requested in advance of the refresh being undertaken.

Although funding was approved for a secondment position to support the implementation of the Framework, despite several attempts the Trust failed to recruit anyone into this position.

The 2022/2023 Quality Improvement Goals were:

- **SACT Treatment Helpline:** To ensure that the VCC SACT Treatment Helpline provides safe, reliable, and effective care for 100% of unwell patients where there is a high probability that SACT treatment is the cause.

- **Donor Adverse Event Reporting (DAER) Project:** To achieve 100% follow-up for donors who have suffered an adverse event by the next working day and achieve 98% DAER donor experience scores consistently for a 12-month period and reduce inappropriate donor attendance at A&E and primary care services.

- **Haemochromatosis Project:** To Enable Cwm Taf Morgannwg UHB to identify eligible Genetic Haemochromatosis patients for referral to the Welsh Blood Service for regular venesection by April 2024.

- **Malignant Spinal Cord Compression Pathway:** By March 2024 85% of patients diagnosed with MSCC to begin treatment with radiotherapy within 24-hours of positive diagnosis.

- **Leadership Project:** To enable Senior Leaders to create the conditions and learning systems by April 2024 that support and enable a culture of psychological safety, to deliver required outcomes for the delivery of Safe, Effective & Reliable care.

3. QUALITY & SAFETY FRAMEWORK DELIVERY STATUS

It was recognised that implementing the Trust's Quality Framework would take time as although considerable work had been undertaken significant development was still required. In April 2023 the Duty of Quality was enacted which has placed additional quality responsibilities onto the Trust.

The Implementation plan is attached in appendix 1. In summary out of 26 actions:

- 14 (54%) have been delivered
- 2 (8%) will meet agreed timescales
- 10 (38%) have revised timescales as have not been able to be delivered due to capacity issues. This is due to business intelligence and quality and safety team capacity. The quality and safety team is now fully established (although implementation lead could not be appointed to) but a trajectory timeframe is awaited for completion of the work on harm and quality metrics

In addition to this the Trust has also been delivering on the Duty of Quality and Duty of Candour Implementation Plan.

4. 2024/2025 QUALITY IMPROVEMENT PRIORITIES

Discussions have commenced in relation to what the Trust's 2024/2025 Quality Improvement priorities will be. The five priorities are currently being progressed through the Safe Care Collaborative Group. It is proposed that at least three of the 2023/2024 priorities will need to continue to be progressed through 2024/2025:

- Leadership
- SACT Treatment Helpline
- Malignant Spinal Cord Compression Pathway

It is anticipated that the two WBS priorities may be completed by the end of March 2024. This is currently being reviewed.

WBS and VCS Senior Leadership Teams are currently considering any other quality improvement priorities for next year. Administrative processes are an emerging quality feature at VCS resulting in concerns, incidents and moderate patient harm incidences including referral and booking processes. These are therefore being considered.

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	The Quality Framework is an enabler for the delivery of the 6 domains of quality and the 6 enablers	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	
	Update report	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are significant financial implications on the Trust if this framework is not implemented as it will increase the likelihood of patient harm which has associated costs
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	Update report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	The Duty of Quality is a legislative requirements

Quality and Safety Framework Implementation Plan

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	December 2023 required	Status October 2023
Dedicated implementation support available to support establishment of Quality Hubs and work with services and teams to determine what good looks like and required measures – Trust meeting Duty of Quality requirements	Recruitment of agreed / resourced one year framework implementation lead	Executive Director Nursing, AHP & Health Science	Recruitment completed by 30th August 2022 Revised date Dec 2022	75% of clinical teams agreed 'what good looks like', agreed metrics to assess status	Despite four attempts to recruit into support role this was not possible. Mapping work now completed through IQ&SG – Quality Metrics determined (3 phases) and BI implementation time frame required.
Staff across the Trust aware of the framework and what this means for them and their teams	Quality Framework in action animated video to be produced aimed at teams and departments	Executive Director Nursing, AHP& Health Science	30th September 2022 Revised date Dec 22	Fully completed	Action revised: Video not developed as could not be supported, rather an infographic easy read document produced and made available on intranet. A number of quality engagement sessions held during 2023
	Quality Framework roadshows to be held within clinical areas and pre-arranged team meetings	Executive Director Nursing, AHP & Health Science	Completed by 30th September 2022 Revised date Dec 22	Fully completed	A number of roadshows held – some delayed due to operational demands

Quality, Safety, outcome and experience measures routinely monitored and used to inform decision making, prioritisation and improvements	Service level to Board quality, outcome & experience measures identified and captured across all services as part of routine monitoring arrangements	Divisional Quality Leads, Head of Quality & Safety & Quality & Safety Implementation Manager	December 2023	100% of clinical teams agreed 'what good looks like', agreed metrics to assess status	Aligned with no 1 above
	Quality & Safety Governance Group to be established	Deputy Director Nursing, AHP & Health Science, Head of Quality & Safety	30th September 2022	Fully embedded in how organisation functions	Integrated Quality & Safety Group established since 19/10/2022
Corporate & Divisional Quality Hubs fully operationalised, undertaking triangulated analysis and supporting the creation of the required quality & safety culture	Quality Hub Lead role specification to be developed	Deputy Director of Nursing, Quality & Patient Experience	31st July 2022	Fully completed	Included as part of Health of Quality, Safety & Assurance Job Description
	Quality Hub Leads to be identified / appointed	Divisional Directors & Director of Nursing, AHP & Health Science	30th August 2022 Revised date Dec 22	Fully completed	WBS & Corporate Hub Lead identified – Hub Lead not appointed at VCS as yet – being covered in interim by Head of nursing
	Corporate & Divisional Quality Hubs to be fully operational	Divisional Directors & Deputy Director of Nursing, Quality & Patient Experience	30th September 2022 Revised date Dec 22	Quality Hubs fully embedded in how organisation functions	All Hubs established

Quality and Quality Improvement is embedded at the centre of all decisions made across the Trust	Trust Quality Management System to be designed and implemented with support from Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & Director Corporate Governance	30th September 2022 Revised date March 2024	QMS will be partially drafted	Quality Management system under development – considerable amount of engagement undertaken
	The Trust will undertake a review of its quality improvement infrastructure and mechanisms supported by Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & COO	March 2023	Fully completed	Undertaken through Safe Care Collaborative work
	2022/23 Quality Improvement Goals met	Executive Directors	March 2023	Fully completed	Ongoing annual cycle of agreeing quality priorities now in place – although some priorities will by their nature be long term
	2023/2024 Trust Quality Improvement Goals agreed	Executive Directors	31st March 2023	Priorities on trajectory for delivery	Ongoing annual cycle of agreeing quality priorities now in place – although some priorities will by their nature be long term
Trust Safety Monitoring Framework developed and in place	IHI Foundation safety & improvement assessment to be undertaken and any further improvement actions quantified	Director of Nursing, AHP & Health Science, Medical Director & COO	30th July 2022 Revised date Dec 22	Fully completed	Completed through safe care collaborative work

	Trust Safety Advisors to undertake staff safety survey and repeat annually	Trust Safety Advisers	Initial by 30th September 2022 Revised date Dec 22	Two staff surveys completed and analysed to assess culture changes	Being led though safe care collaborative – outcome led to psychological safety leadership priority
	Trust Safety Monitoring Framework to be established and implemented across both divisions	Trust Safety Advisers	30th March 2023	Fully operational	Delayed due to delay in completing quality metric work
	Harm to be defined across all services both potential and actual and harm reduction goals determined	Trust Safety Advisers	July 2023 Revised December 2023	Defined across all clinical services	To be progressed through Integrated Quality & Safety Group
	A programme of SLT and Board Safety Walkabouts to be implemented	Director or Corporate Governance & Divisional Directors	December 2022 Revised date March 2024	Fully established as part of how Trust & Divisions operate	15 step visits started – full board roll out plan under development. Included in Governance, Assurance and Risk programme
	A Trust wide Quality & Safety learning portal to be developed for cross-sector sharing of good practice and include Welsh Government.	Deputy Director Nursing, Quality & Patient Experience & Chief Digital Officer	March 2023 Revised March 2024	Plan in place	Being progressed now that full Q&S Team in post
	Senior Trust Officers & Board Members all trained in strategic safety and improvement	Director of Corporate Governance	December 2022 Revised Date April 2024	Members received training	Some board levels quality sessions undertaken including Duty of Quality, Duty of Candour further sessions planned before March 2024

Well-developed Quality & Safety assurance mechanisms in place	Trust Board level Assurance infrastructure and reporting requirements to be clearly defined	Director of Corporate Governance	31st October 2022 Revised date Dec 22	Fully Completed	Board paper template revised to reflect 6 domains of quality and 7 levels of assurance fully implemented
	Trust assurance and performance frameworks aligned with 6 domains of Quality	Director of Corporate Governance & Director of Strategic Transformation, Planning & Digital	31st December 2022	Fully Completed	As above
	Trust meeting Structure to be reviewed to ensure transparency of reporting and removal of any Duplication post implementation of the Quality & Safety Governance Group	Executive Directors Divisional Directors	March 2023	Fully completed	Undertaken via Integrated Quality & Safety Group – ongoing review will be required. Some groups closed down
Clinical Leaders setting Trust clinical quality priorities for future IMTPs	Clinical & Scientific Strategic Board Established	Medical Director, Director of Nursing, AHP & Health Science	30th September 2022 30th November 2023	Fully completed	Clinical & Scientific lead appointed on 6-month secondment. Inaugural meeting planned for 21/11/23
	Trust wide Clinical & Scientific Strategy developed	Medical Director, Director of Nursing, AHP & Health Science	March 2023 Revised date draft by 30th March 2024	Fully completed	Strategy development commenced. Engagement sessions underway

Robust and clearly defined clinical effectiveness arrangements across whole organisation	A formal review of Clinical effectiveness and clinical audit infrastructure to be undertaken	Head of Quality & Safety	June 2023 Revised date March 2024	Fully Completed	Clinical Audit now embedded as part of IQ&S working
Values based healthcare principles embedded across organisation	The Trust has identified a number of values based healthcare priorities for 2022/24 – these will be implemented through a project management approach.	Finance Director	December 2023	VBHC priorities determined	Successful VBHC Bid, head of VBHC appointed and steering group established External delivery support also commissioned

RAG	Meaning
	Delivered
	On track to be delivered by required timescale
	Delivery delayed – will be completed by December 2023
	Delivery significantly delayed – at risk of non delivery

Review: October 2023

QUALITY, SAFETY & PERFORMANCE COMMITTEE

2023-24 Quarter 2 Quality & Safety Report
(Including Welsh Risk Pool Assessment)

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Trust Corporate Quality, Safety and Assurance Team
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

EXECUTIVE SUMMARY	The Velindre University NHS Trust Quarter 2, Quality & Safety 2023-2024 report covers the period 1st July 2023 to 30th September 2023 and describes the key outcomes, trends and themes in respect of: Complaints; Redress; Claims; Duty of Candour; Safety Alerts; Infection Prevention & Control; and Safeguarding.

Quarter 2 at a glance

99% Donor Experience Score	**98%** Patient Experience Score	**77** Compliments	**1** Ombudsman Concern	**2** New Claims Confirmed
3 Duty of Candour Incidents	**0** Never Events	**2** National Reportable Incident	**1** Patient Safety Alert	**0** External Assurance Reviews

Numbers of Concerns Raised	Managed as Early Resolution	Managed as Putting Things Right	Compliance with PTR 30 working day response timescales
55	**34**	**21**	**92.31%**

The report includes reporting data for the quarter and also, to provide appropriate contextualisation, two-year comparison data. Report highlights include:

- **55** concerns were received. **34** were managed successfully as an early resolution (verbally resolved within 48 hours). **21** were managed as formal complaints under Putting Things Right regulations. Of the **21** formal concerns, **20** were investigated and closed to the complainant's satisfaction within 30 working days, **1** concern remained open after 30 days.

- **2** Duty of Candour incidents were reported in Quarter 2, with a further incident reported in Quarter 1 being assessed as meeting the threshold for Duty of Candour. All incidents managed in line with the Duty of Candour procedures.

- There were **2** incidents reportable to Health Inspectorate Wales as IR(ME)R breaches.

- **591** incidents were reported across the Trust: **3** relating to Corporate Services, **502** Velindre Cancer Service and **86** within the Welsh Blood Service. **589** incidents after the initial management review were graded as no or low harm, **2** incidents remained graded as moderate harm.

- **56** safety alerts were received: **33** pharmaceutical alerts, **1** patient safety alert; **3** medical device alerts; **14** estates alerts; **5** Welsh Health Circulars.

The triangulation of data this quarter has identified a theme of increasing concerns and incidents relating to administrative processes at Velindre Cancer Service which is resulting in a poor experience and harm to some patients. The areas identified where wholescale changes are required relate to:

- Referral processes – there needs to be a single electronic referral mechanism into VCS,
- Clinical letter approval processes – need to ensure that patients' GPs and patients receive a letter following an appointment within a reasonable timescale (30 days is proposed), and
- Booking and appointment processes – a central automated booking process is required.

A Welsh Risk Pool audit was undertaken in March 2023 and reported during the quarter. The audit was in relation to compliance with the operationalisation of the Putting Things Right procedures and covered current policies, procedures, and practice. There were 8 proposed recommendations for improvement.

Velindre NHS Trust		
Management of Concerns (Incidents)	LIMITED ASSURANCE	
Management of Concerns (Complaints & Enquiries)	REASONABLE ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

RECOMMENDATION / ACTIONS	To **DISCUSS** and **NOTE** the quarter 2 Quality & Safety report and its findings, in particular the emerging trends relating to administrative processes at VCS.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date

Integrated Quality & Safety Group	18/10/2023
Executive Management Board	30/10/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Integrated Quality & Safety Group: Recognised the importance of including and addressing learning and themes in future reports and further work being undertaken to strengthen this reporting.

Executive Management Board: The report was discussed, and positive feedback regarding revised approach provided. Through discussions, it was agreed that further detail would be added to gram negative bacteraemia data have since been addressed.

Discussions were held regarding the robustness of current Safety Alert processes within the Trust and opportunities for improvement Executive Management Board requested a process review be undertaken by the Integrated Quality & Safety Group.

7 LEVELS OF ASSURANCE

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

APPENDICES

1	Quarter 2 Quality and Safety Report
2	Welsh Risk Pool Assessment Improvement plan

1. **SITUATION**

The Quality & Safety agenda across the Trust has been developing and refining over the past 4 years. The Integrated Quality & Safety Group continues to mature in respect of oversight and reporting as demonstrated within this report, and although it is recognised further work is required to optimise quality and safety approaches, several developments have been realised during Quarter 2 e.g. implementation of Always On reporting, capture of compliments, development of 'the wall of thanks' and continued collaborative efforts to ensuring robust learning and improvement.

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below

If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated	☐

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximized and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The report contains details of legal claims against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided, all of which has the potential for adverse financial consequences. **Type of Funding:** **Revenue** Financial impact of the Trust claims is outlined in the Claims Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com /sites/VEL_Intranet/SitePages/E.asp x*	Not required - please outline why this is not required
	A quarterly outcome report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In addition to litigated claims, the Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated and appropriate Redress remedies offered. When both a breach of duty and harm and/or loss have been identified, amounting to a qualifying liability, the Trust is required to make a suitable financial offer within the PTR threshold (i.e. up to the maximum limit of £25,000). Concerns (consisting of complaints, incidents and claims), have legal and financial implications, as outlined above.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
	The theme of increasing concerns and incidents relating to administrative processes at Velindre Cancer Service which is resulting in a poor experience and harm to some patients.

Quarter 2 Trust Quality and Safety Report

1ST July 2023 – 30TH September 2023

CONTENTS

1. EXECUTIVE SUMMARY

Quarter 2 at a glance

99% Donor Experience Score	98% Patient Experience Score	77 Compliments	1 Ombudsman Concern	2 New Claims Confirmed
3 Duty of Candour Incidents	0 Never Events	2 National Reportable Incident	1 Patient Safety Alert	0 External Assurance Reviews

Numbers of Concerns Raised	Managed as Early Resolution	Managed as Putting Things Right	Compliance with PTR 30 working day response timescales
55	34	21	92.31%

2. INTRODUCTION

The Trust 2023/2024 Quality and Safety Quarter 2 report aims to provide an overview and analysis of Quality and Safety activity and performance during 1st July 2023- 30th September 2023 to provide assurance that the Trust is both fulfilling its legislative requirements in line with the Health and Social Care (Quality and Engagement) (Wales) Act, and maintains a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person Centred Care.

3. QUARTER 2 QUALITY AND SAFETY INDICATORS OVERVIEW

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

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023-2024					
	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
Compliments	*0*	*51*	*26*	*63*	*77*
CONCERNS					
Early Resolution					
(resolved within 48 hours)	*20*	*24*	*24*	*45*	*34*
Trust Putting Things Right (PTR) (Formal)					
Number Received (Trust wide)	*12*	*9*	*11*	*11*	*21*
% Acknowledged within 48 hours	100%	100%	100%	100%	100%
% PTR closed within 30 days	8% (1)	44% (4)	100% (11)	100%	95 % (20)
%PTR closed after 30 days	0%	55% (5)	0%	0%	5% (1)
Welsh language concerns	0	0	1	0	0
Total number of Concerns	32	33	35	56	55
OMBUDSMAN					
New	3	0	1	0	0
Open	6	3	3	4	4
Closed	0	3	1	0	0
REDRESS					
New	0	1	2	1	1
Open	4	3	4	5	5
Closed	0	1	0	0	1
CLAIMS					
New	0	0	1	0	2
Open	7	6	5	5	5
Closed	1	1	2	0	0
INQUESTS					
New relating to Trust	1	1	0	1	4
open	4	5	5	4	3
Closed	0	1	1	0	2
INCIDENTS REPORTED					
Corporate	7	2	2	3	3
VCS	444	385	501	473	502

WBS	73	67	74	89	86
National Reportable Incidents	1	3	2	0	2
IR(ME)R reported incidents	4	5	7	4	2
Total opened during quarter	**529**	**462**	**586**	**569**	**595**
SAFETY ALERTS RECEIVED					
Pharmaceutical alerts	25	31	37	33	45
Patient safety alert	0	2	1	1	1
Patient Safety Notice	1	2	1	0	0
Medical Device	2	0	3	3	3
Estates and facilities	0	3	14	14	7
Field Safety Notice	0	0	0	0	2
Welsh Health Circulars	1	7	3	5	4
Total received during quarter	**29**	**45**	**59**	**56**	**62**
SAFEGUARDING					
Adult reports	2	4	2	5	4
Child reports	1	1	1	1	0
Allegations of Abuse involving Trust treatment or Services at VCS	0	0	0	0	0
MARRAC Referrals	1	0	1	0	0
Concerns about Trust Practitioners	0	2	0	3	1
Deprivation of Liberty Safeguards	1	7	1	2	3
HEALTHCARE ASSOCIATED INFECTIONS					
Clostridioides *difficile*	0	1	1	0	0
Gram Negative Bacteraemia	1	2	4	3	5
Staphylococcus Bacteraemia (including Meticillin Resistant)	0	1	1	0	0

4. QUARTER 2 TRUST CONCERNS, EXPERIENCE AND FEEDBACK.

4.1 Concerns Summary

Trust

Number of Concerns 55	Early Resolution 34	Putting Things Right 21	Reopened 0	Compliments 77

During quarter 2 there was an increase in concerns raised compared with previous quarters. The increase was relating to Velindre Cancer Service with a significant increase in putting things right concerns. This is explored later in section 4.2.

Concern management performance compliance remains high, with all concerns being acknowledged within 48 hours, and **95% (20)** of PTR concerns being investigated and closed within 30 working days.

Q2 - Concerns Received by Theme and Division

Legend:
- Access (to Services)
- Appointments
- Attitude and Behaviour
- Clinical Treatment/Assessment
- Communication Issues (including Language)
- Confidentiality
- Infection Control
- Medication
- Other
- Patient Care
- Test and Investigation Results

Velindre Cancer Centre: 2, 16, 2, 7, 7, 1, 1, 2, 0, 2, 1
Welsh Blood Service: 0, 5, 3, 2, 3, 0, 0, 0, 1, 0, 0

Trustwide Concerns Received over 2 year period.

Legend:
- Managed through PTR
- Early Resolution

Quarter	Managed through PTR	Early Resolution
21/22 Q2	12	40
21/22 Q3	12	31
21/22 Q4	6	38
22/23 Q1	13	40
22/23 Q2	9	19
22/23 Q3	10	23
22/23 Q4	10	26
23/24 Q1	8	44
23/24 Q2	21	34

Trustwide Concerns received over 2 year period by Theme
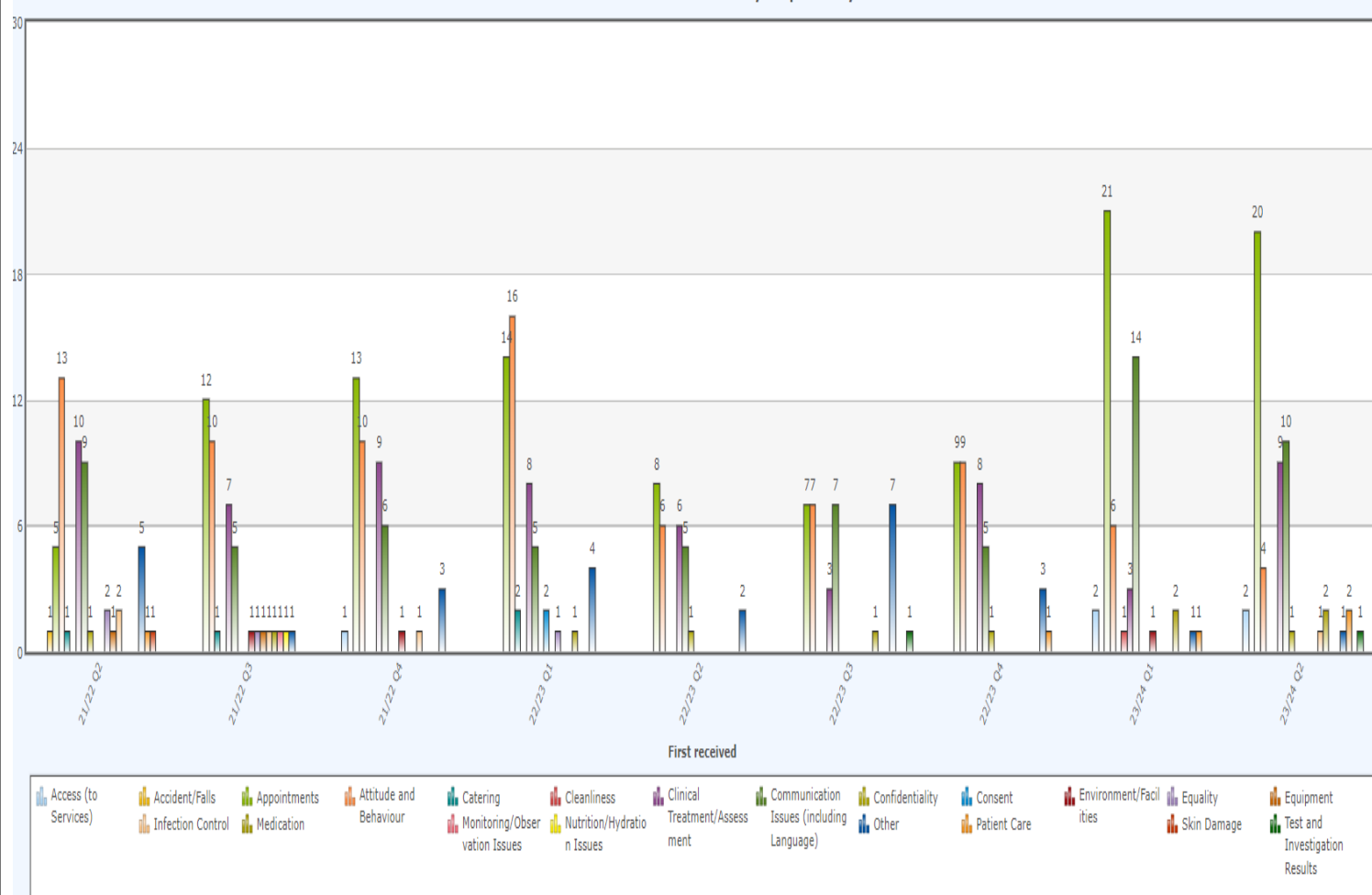
4.2 Velindre Cancer Service Concerns Summary

Total Number of Concerns	Early Resolution	Putting Things Right	Reopened
42	20	21	1

Compliments	Patient Experience Score
77	92%

4.2.1 Velindre Cancer Centre Concerns Themes and Learning

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

- Patients encountering difficulties when contacting departments, particularly medical secretaries.

- Suboptimal communication regarding appointment dates, locations, and times.

These themes and trends have been shared with the division as learning and improvement opportunities with several service reviews being undertaken to address.

4.3 Welsh Blood Service Concerns Summary

Total Number of Concerns	Early Resolution	P.T.R	Reopened
14	**14**	**0**	**0**

Total Number CIVICA Surveys Completed	Donor Experience Scores
2370	**100%**
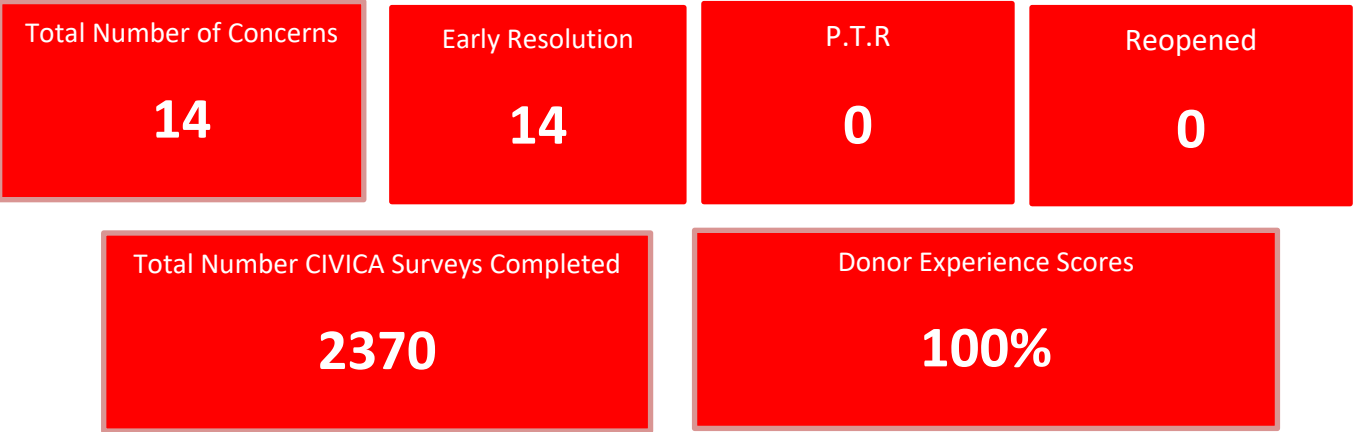
4.3.1 Welsh Blood Service Concerns Themes and Learning

All concerns received during quarter 2 were managed to the complainant's satisfaction through 48 hours early resolution. Top concern themes and opportunities for improvement this quarter were identified and relate to **appointment & communication** issues, this has been shared at a divisional level for consideration and address.

4.4 Patient and Donor Experience Feedback Mechanisms

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

Welsh Blood Service

In Q2 it was noted that there were less collection team survey's being completed predominantly across the South Wales Collection teams, knowing this I set about digging a little deeper into the reasons why this was happening.

It came to light that the WBS Mobile Donor Units (MDU's) were starting to be re-introduced across South Wales following the Covid-19 pandemic and the Donation Clinic was being utilised for whole blood donations meaning that these area's did not have their own CIVICA IPads or QR codes readily available.

On knowing the above information and working in collaboration with the collection team manager new iPads and individual QR codes were sourced for these area's.

You Said	We Did
Just needed a sign by the front door to help to find the venue.	On going Service Improvement Project (SIP) to develop and introduce new signage across all collection teams
There are apps for everything these days but not to give blood. How hard can it be to have a simple app designed to hold our blood card number and the ability to book an appointment. Catch up to the rest of the world	Communications team working in collaboration with IT department are looking at a solution to this theme.
There has been theme of suggestions since the introduction of CIVICA. North Wales donor would like to see the re-introduction of the appointment booking system on session.	The appointment system was removed from session so the WBS can manage donor attendance in line with operational/service requirements. Collection staff reminded to engage with donor who query the appointment system on session and sign post them to RN if needed.
More fans due to extreme heat. (Operational Managers made aware of feedback)	Each collection team has been provided with new Dyson fans that can be used in cold and hot environments as required.

Welsh Blood Service Wall of Thanks

East B

"Overall, it was a smooth operation and staff were pleasant and professional. Thank you for what you do."

Wrexham

"I always find the staff so friendly [in the] Wrexham team. Keep up the good work."

East C

"Lovely atmosphere. Thank you for all taking such good care of us and for doing a fab job!"

Bangor

"All the staff were friendly and approachable. Thank you."

East A

"The service is always so great, and it is a pleasure to support."

West

"All the staff were friendly and kind. They made the donation process easy. It makes me want to keep donating."

Platelets

"All the nursing staff are superb. I like the fact that they are all familiar and treat me like a friend instead of just a patient."

Welsh Blood Service 'Always On Reporting'
The always on reporting percentages represent a percentage of 2370 donor responses. The learning from feedback is then shared within WBS to the Head of Collections and Collections Teams and via the Integrated Quality and Safety Hub.
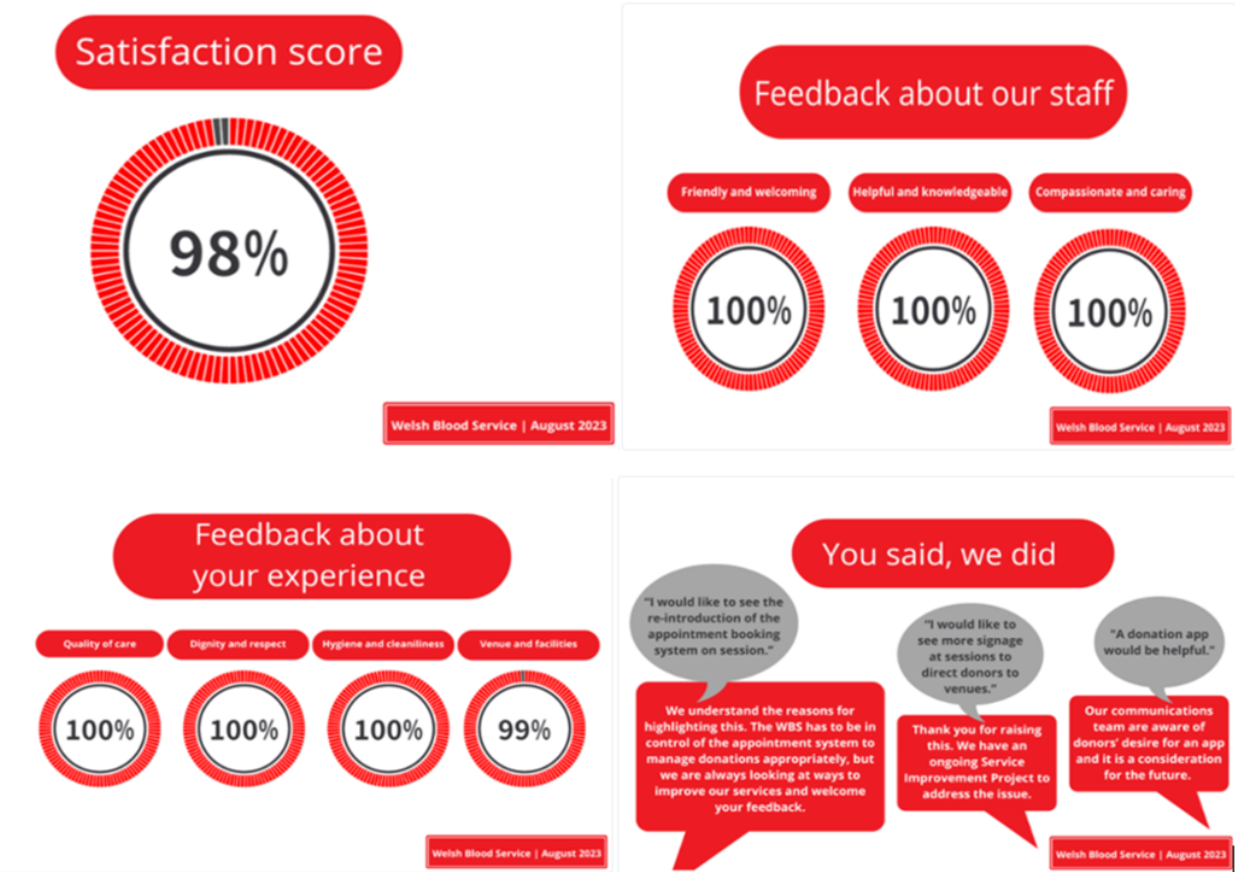
Welsh Blood Service Civica Heatmap

Location	Responses	6 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	7 - Based on today's visit did you find staff welcoming & friendly?	8 - Based on today's visit did you find staff helpful & knowledgeable?	9 - Based on today's visit did you find staff professional, compassionate & caring?	10 - Based on today's visit do you feel you were treated with dignity & respect?	11 - Based on today's visit were you provided with enough information about the donation process?	12 - Based on today's visit did you receive adequate emotional & physical support?	13 - Based on today's visit did you find a good standard of hygiene & cleanliness?	14 - Based on today's visit did you feel safe?	15 - Based on today's visit do you feel you were offered quality of care?	16 - Based on today's visit are you satisfied with the venue & facilities?	17 - Based on today's visit were you satisfied with the snacks and beverages available to you?	Overall
		Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	
Bangor Team	143	100	100	100	99	100	100	100	100	100	100	100	100	100
Donation Clinic (TG)	12	88	100	100	100	100	100	100	100	92	100	92	100	97
East A	159	96	100	100	100	100	99	100	100	100	100	99	100	99
East B	513	97	100	100	100	100	100	99	100	100	99	99	99	99
East C	261	98	100	100	100	100	100	100	100	100	100	100	99	100
West Team	856	98	100	100	100	100	100	100	100	100	100	99	100	100
Wrexham Team	409	98	100	100	100	100	100	100	100	100	99	100	99	100
Overall		98	100	100	100	100	100	100	100	100	100	99	99	100
Benchmarks		95	95	95	95	95	95	95	95	95	95	95	95	

Velindre Cancer Service Always on Reporting

333 responses were received during Quarter 2. The patient feedback data gets shared monthly with all the Departments who have participants and is also included in the Quality safety management Group reports. Furthermore, the data will be included in the new Directorate reports that are being sent out on a bi-monthly basis.

Velindre Cancer Service Wall of Thanks

"Thank you for the warm hug that welcomes as we walk through the doors. The kindness and understanding helps us all. Thank you again."

"Michele is a wonder woman! She made me feel that little bit at ease and was incredible with my family when I was having treatment. I think my experience would have been so much harder without her."

"Thank you for everything. Your care and kindness means so much."

"Well done, Mererid. It was clear to see years ago that you would always be at the forefront of research in H&N cancer treatment"

"Thank you so much for all your help the last few weeks whilst I have been having my radiotherapy and for your kindness throughout this time."

4.5 CIVICA HEATMAPS

Throughout this period both the Velindre Cancer Service and Welsh Blood Service have continued to utilise the CIVICA experience system to support data collection of patient and donor feedback, required to enable the identification of areas of good practice, opportunities for service improvement and to identify any recurrent themes associated with each service.

Velindre Cancer Service CIVICA HEATMAP

Service	Responses	1 - Overall, how was your experience of our service?	2 - Did you feel that you were listened to?	3 - Were you able to speak Welsh to staff if you needed to?	4 - From the time you realised you needed to use the service, was the time you waited:	5 - Did you feel well cared for?	6 - If you asked for assistance did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall e	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Catering services	1	100	-	-	-	-	-	-	-	-	-	100
Clinical Trials	35	100	99	92	81	100	100	97	99	98	95	96
Nuclear Medicine	20	100	100	100	73	75	100	100	100	100	70	97
Nursing	64	100	90	94	83	97	97	95	95	91	94	95
Outpatients	46	82	89	89	59	88	90	83	86	79	87	83
Palliative care	1	-	100	100	100	100	100	100	100	100	100	100
Pharmacy	7	100	-	-	-	-	-	-	-	-	-	100
Radiology	41	100	98	87	80	98	97	98	97	97	95	95
Radiotherapy	35	93	95	100	61	93	88	93	91	91	96	90
SACT	81	99	-	-	-	-	-	-	-	-	-	99
Therapies	1	-	100	33	100	-	-	-	-	-	-	78
Welfare rights	1	100	-	-	-	-	-	-	-	-	-	100
Overall		98	94	92	72	94	95	92	93	90	93	92
Benchmarks		85	85	85	85	85	85	85	85	85	85	92

4.6 COMPLIMENTS

Velindre Cancer Service are now utilising the Datix Cymru system as a compliment repository to record and respond to written compliments. **77** compliments were recorded within this period. To support this implementation a range of staff communications have been issued and training user guides developed by the corporate Quality and Safety Team. Welsh Blood Service are exploring how the same process can be implemented within this Division.

Of the 77 compliments received in writing, 16 of these were themed where appropriate as above within the compliment subjects in the Datix system.

Q2 - Written Compliments by Theme
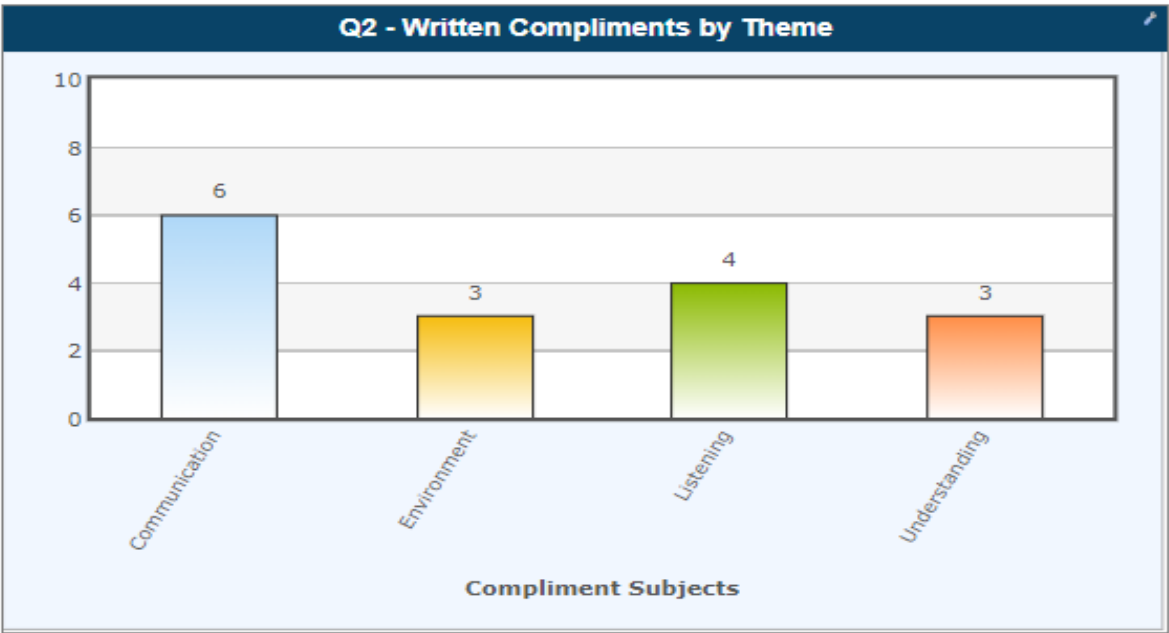
5.0 PUBLIC SERVICE OMBUDSMAN OF WALES (PSOW)

No new Ombudsman cases were opened and no existing cases were closed. 4 Ombudsman cases remain open.

5.1 Themes and learning- Themes demonstrated during this period relate to suboptimal communication, delay or failure to diagnosis and/or treat, and delays in referrals and/or follow-ups with all findings and learning opportunities being shared with the relevant divisions.

During the quarter:

Public Service Ombudsman Themes for Q2 2023 -2024

Total number of Ombudsman cases opened between 2021-2023
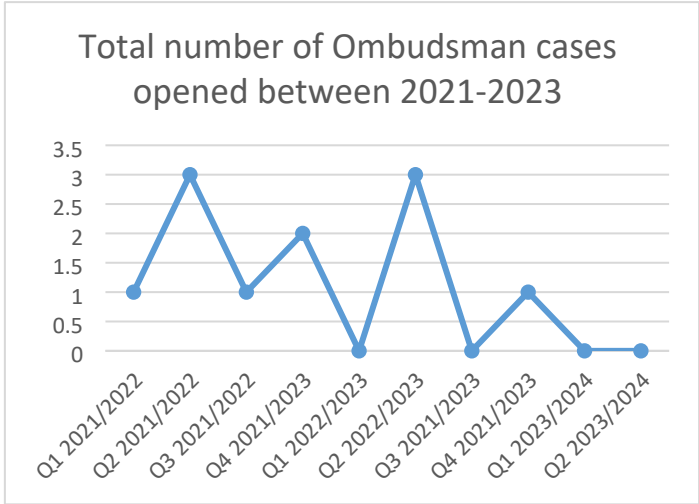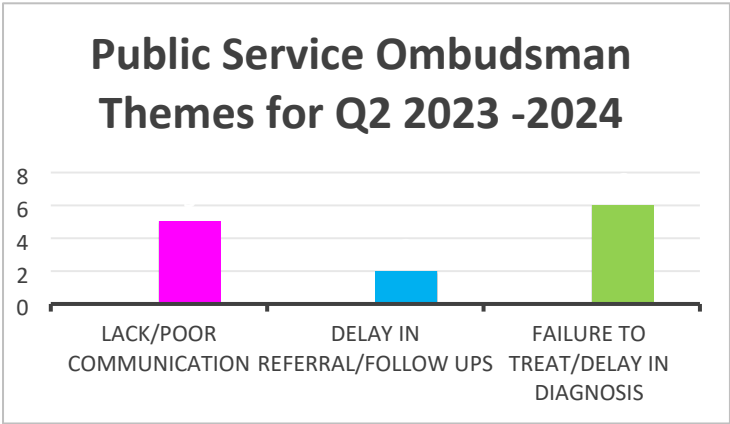
Percentage of PSOW Themes for Q2 2023 - 2024
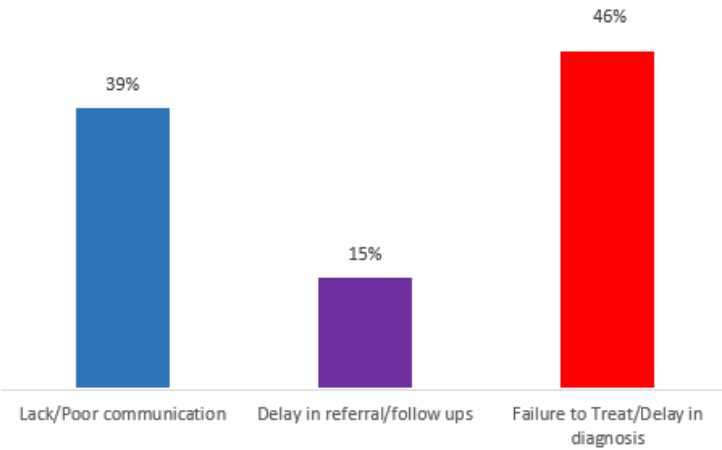
Please note that in some instances, the figures for themes comprise of more than one theme per complaint.

5.2 Assurance: The Ombudsman did not uphold the concerns raised against the Trust. While no recommendations have been made, PSOW investigation reports have been shared as a learning opportunity as demonstrated through the following examples:

Case Summary	Main Learning Points
Family member raised concerns with regard to a delay in commencing lung cancer treatment. **Draft Investigation Report issued by PSOW in Quarter 1** **Trust response provided in Quarter 2** **Awaiting Final Investigation Report**	Concerns were raised in relation to both Velindre Cancer Service and Cwm Taf Morgannwg University Health Board. The PSOW found that the clinician had taken the patient's wishes into account when agreeing to delay treatment. . The final report is awaited, draft report outlined that the concerns were not upheld against the Trust, although concerns against Cwm Taf Morgannwg UHB were partially upheld. **Learning to date:**

	1. **Reinforces** the value of proactive engagement and communication with service users. 2. **Highlights** the importance of continually maintaining good clinical practice by taking into account the wishes and needs of service users 3. **Empowers** service users to make informed choices with regard to their health journey 4. **Demonstrates** the importance of maintaining good clinical record keeping, including discussions held, rationale and decision-making process.
Family member raised concerns in relation to lack of communication and decision-making. **Draft Investigation Report issued by PSOW Quarter 1** **Final investigation Response issued Quarter 2**	The PSOW issued its final investigation report in relation to concerns raised against Cwm Taf Morgannwg Health Board. The Trust was not subject to the investigation but was required to provide comment. **Conclusion:** The Public Service Ombudsman of Wales issued a section 27 report, which meant that (a) the Ombudsman concluded that no person has sustained, or is likely to sustain, injustice or hardship in consequence of the matter investigated, and (b) the Ombudsman is satisfied that the public interest does not require sections 23 to 26 to apply. The Ombudsman did not uphold the concerns raised against Velindre Cancer Service but has upheld the concerns against Cwm Taf Morgannwg University Health Board in relation to the poor standard of record keeping and the standard of trauma and orthopaedic involvement. **Learning:-** 1. **Highlights** the importance of clear communication between services and NHS organisations 2. **Illustrates** regular communication, as evidenced within the medical records 3. **Supports** decision-making and rationale for non-treatment/treatment, recorded within the medical records.

6.REDRESS

During Quarter 2:-
- 1 new Redress cases was opened.
- 1 Redress case was concluded and closed.
- At the end of the quarter 5 Redress cases remained open.
- 3 Learning from Events Reports were submitted to the Welsh Risk Pool and approved following scrutiny of learning.
- 1 Case Management Report was submitted and approved by the Welsh Risk Pool seeking reimbursement for the costs incurred to commission an independent expert to provide a report on causation and condition with a view to determining a qualifying liability (i.e. breach of duty and harm).

Redress Comparison from Q1 2022/2023 to Q2 2023/2024 Comprising of New, Open and Closed cases

	Q1 2022/23	Q2 2022 /2023	Q3 2022 /2023	Q4 2022 /2023	Q1 2023 /2024	Q2 2023 /204
New	1	0	1	2	1	1
Open	3	4	3	4	5	5
Closed	0	0	1	0	0	1

Percentage of Redress Themes for Q2 2023/2024

- Failure to appropriately consent — 15%
- Wrong diagnosis & disclosure of information — 14%
- Failure to appropriately treat/assess — 57%
- Delay in treatment — 14%

6.2 Summary of the learning actions.	

Case Summary	Main Learning Points
Service user wrongly informed of cancer diagnosis following inaccurate data disclosure. **Division: Velindre Cancer Service**	There has been a drive to implement new digital systems and functionality to enhance patient care and safety across NHS organisations and improve the data collated. Measures have been introduced by the Trust to undertake quality checks before information is released to NHS health bodies. This has included devising a work plan, implementing new digital data fields, introducing a system flow chart, providing Information Governance training, and reminding staff of the importance of confidentiality and data sharing. In addition to this, a recruitment drive is underway to increase staff/capacity and resource. **Status: Learning from Events Report: Approved**

Failure to recognise and treat arterial bleed following donor donation. **Division: Welsh Blood Service**	Staff have been reminded of the importance of identifying when to suspect an arterial bleed. Training has been implemented to improve skills and knowledge. Relevant standard operating procedures have been revised. The donor donation training package has been updated to include the key criteria for identifying an arterial bleed. The importance of recording accurate clinical information has been reiterated. **Status: Learning from Events Report: Approved**
Failure to undertake appropriate UKONS triage assessment and escalate for medical review, following contact with the SACT Helpline. **Division: Velindre Cancer Centre**	It has been identified that on rare occasions, a small proportion of call-handlers for the Systemic Anti-Cancer Treatment (SACT) Helpline have experienced difficulties in recognising the severity of patient symptoms and utilising the UKONS Triage Tool appropriately. Although key learning has been put into place in recent years to address issues, the Trust recognises that more work is required to minimise risk. As part of the learning evidence submitted to the Welsh Risk Pool, the directorate responsible for the helpline has been tasked with undertaking a comprehensive review of its function and staffing capacity, with a view to making substantial improvements. These improvements include the provision of enhanced telephone training and the implementation of an improved infrastructure, including a refined staffing model/structure that is designed to improve the efficacy and functionality of the SACT Treatment Helpline. In addition to this, the learning actions undertaken will include the recording of calls, regular auditing of triage calls and a defined escalation process, thereby minimising the risk of recurring incidents in the future. **Status: Learning from Events Report: Approved**
Incorrect radiotherapy treatment administered, resulting in a potentially reduced dose of radiotherapy. **Division: Velindre Cancer Service.**	While no qualifying liability was proven in this case, the Trust, nonetheless, undertook a number of learning actions from recommendations identified in the Serious Incident Report: • The pathway to prescribe and justify the dose and fractionation for vaginal vault brachytherapy has been changed. The treatment must be justified by a practitioner licence holder before the exposure is delivered by an operator. • A refreshed formal medical induction programme has been introduced, and all new consultant staff have arranged meetings with Heads of Department including Radiotherapy, Medical Physics, Radiology and Nuclear Medicine. • All new junior medical staff receive induction training from relevant departments including Radiotherapy, Radiation Protection etc. This incorporates a formal 3-month period at the start of a consultant appointment (locum and substantive) for the doctor to meet with a senior colleague mentor to go through new cases and treatment plans for discussion. • Medical business team will now review and report against training compliance.

- All Tumour Site leads will now ensure compliance with Peer Review of radiotherapy outlining as recommended by the Royal College of Radiologists.
- Following the HIW inspection in 2019 an action plan is in place to ensure training is delivered and recorded accurately, and is accessible to relevant departmental leads. This includes the use of a radiotherapy passport for trainees.

Further learning actions and monitoring will include:

- Review of intranet documentation with a view to updating protocols.
- Training needs analysis for staff prescribing brachytherapy

Following the outcome of the investigation into causation, a final response was issued to the Claimant on the basis of the expert reports received, which did not find a qualifying liability. The Trust submitted a Case Management Report, together with financial information, seeking reimbursement of the costs incurred to commission a joint independent expert report. The sum of £10,724.20 was approved by the Welsh Risk Pool for reimbursement and is due to be received in October 2023.

Status: Case Management Report – Approval of reimbursement

7. CLAIMS

7.1 During Quarter 2:-
- 2 new claims were opened
- At the end of the quarter 5 remained under investigation
- No claims were closed
- 1 Learning from Events Reports was submitted to the Welsh Risk Pool for scrutiny of learning.

Outcome of Learning from Events Report: Amber Deferred pending further learning evidence.

Combined Clinical Negligence & Personal Injury Themes Q1 2021 - Q2 2023
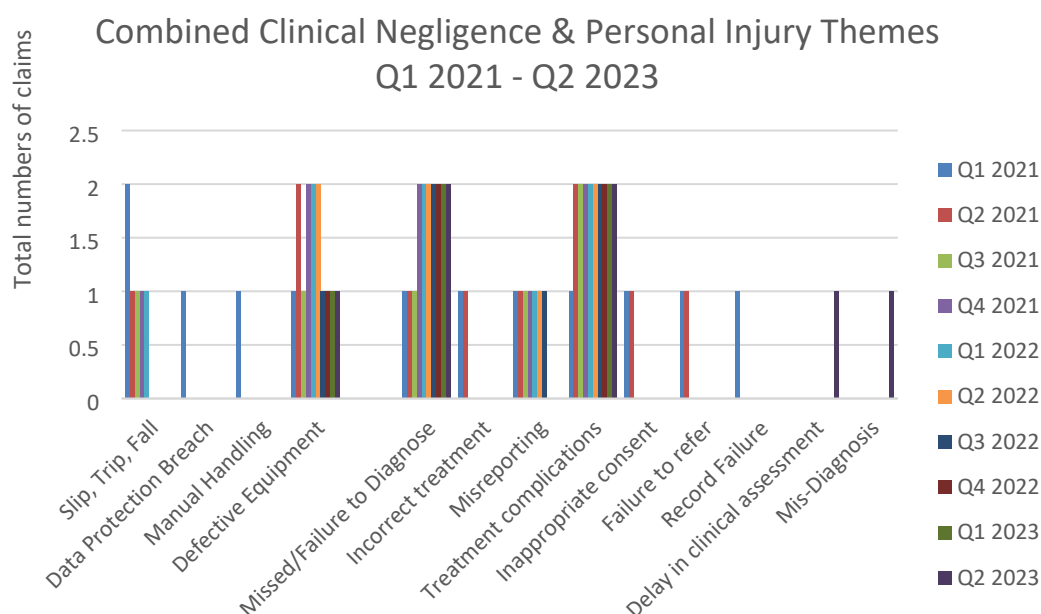
Personal Injury Themes Comparison Q1 2021 - Q2 2023

	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023
Slip, Trip, Fall	2	1	1	1	1	0	0	0	0	0
Data Protection Breach	1	0	0	0	0	0	0	0	0	0
Manual Handling	1	0	0	0	0	0	0	0	0	0
Defective Equipment	1	2	1	2	2	2	1	1	1	1
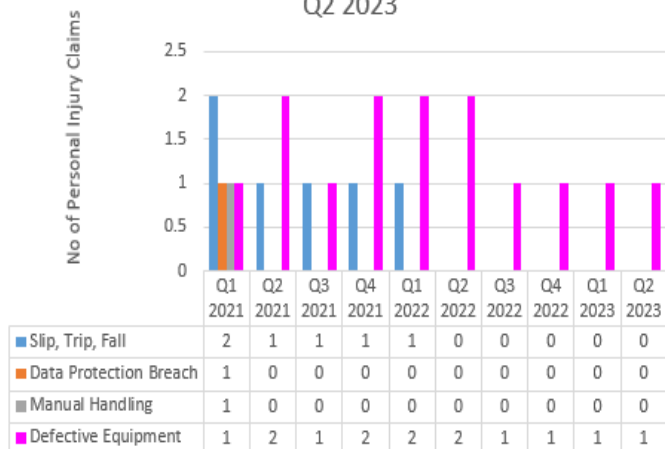
Clinical Negligence Themes Comparison Themes Q1 2021 - Q2 2023

	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023
Missed/Failure to Diagnose	1	1	1	2	2	2	2	2	2	2
Incorrect treatment	1	1	0	0	0	0	0	0	0	0
Misreporting	1	1	1	1	1	1	1	0	0	0
Treatment complications	1	2	2	2	2	2	2	2	2	2
Inappropriate consent	1	1	0	0	0	0	0	0	0	0
Failure to refer	1	1	0	0	0	0	0	0	0	0
Record Failure	1	0	0	0	0	0	0	0	0	0
Delay in clinical assessment	0	0	0	0	0	0	0	0	0	1
Mis-Diagnosis	0	0	0	0	0	0	0	0	0	1

Percentage of Clinical Negligence Themes Q1 2021 - Q2 2023
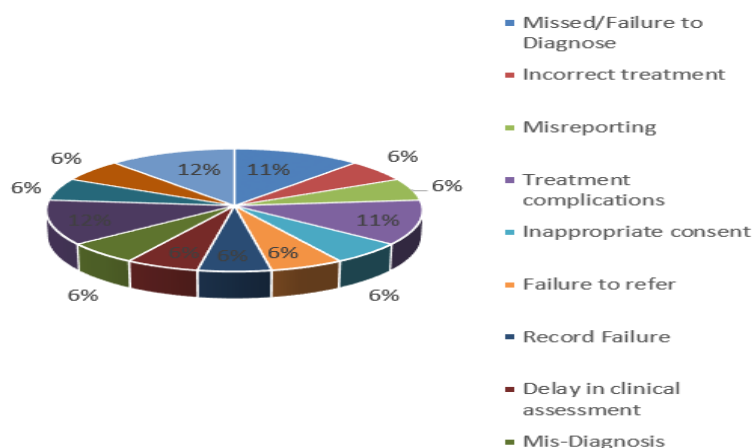
Percentage of Personal Injury Themes Q1 2021 - Q2 2023
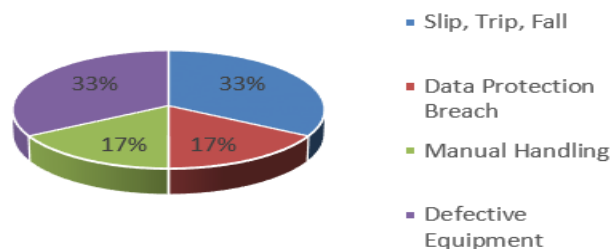
Although no strategy can predict how many claims the Trust will receive over a period of time, the comparison of data from Quarter 1 2021 to Quarter 2 2023, remains stable. Personal injury claims have seen a reduction compared to previous years while Clinical Negligence claims rose during Quarter 2.

7.2 Financial Liability: The Trust will be required to pay the first £25,000 of a claim. It is estimated that the Trust's financial liability to settle cases up to £25,000 is £119,244. For any claims exceeding £25,000, the Welsh Risk Pool will reimburse the Trust the remaining amount, subject to approvals of learning and satisfactory case management evidence. The Trust's overall estimated financial liability for Quarter 2 is in the region of £846,576.23.

7.3 Legal Updates:
The following changes have been made to the Welsh Risk Pool procedures and policies as outlined below:-

1. The Trust must ensure that governance processes are updated to comply with the revised Welsh Risk Pool Procedures which became effective from the 1st September 2023. The main changes are:-
   a) Timescales to submit Learning from Events Reports. Each organisation now has four calendar months to submit the Learning from Events Report and eight calendar months from the due date for submission to ensure the case is approved by the panel.
   b) The re-introduction of financial penalties for failing to meet the Welsh Risk Pool criteria concerning Learning from Events Reports and Case Management Records.
2. The Welsh Risk Pool All-Wales Policy on Indemnity and Insurance and Scoping document sets out the financial responsibilities for the Trust's losses and special payments. The revised documents outline the circumstances when NHS indemnity can be applied by a Welsh NHS health body and provide clarity on recourse to the pooling arrangements in place. The Policy now contains an addendum which specifically allows personal accident cover to be purchased where a health body considers it relevant to do so.
3. A revised draft Claims Policy was approved at the Integrated Quality and Safety Group on the 26th September 2023 and takes account of the revised changes, as outlined above.

8. INQUESTS

8.1 During Quarter 2, the Trust has seen a rise in the number of inquests involving Trust personnel.
- 4 new inquests were opened
- 2 inquests were closed
- At the end of the quarter 5 inquests remained open
- No inquest hearings were held during the reporting period
- No HM Coroner Regulation 28 Prevention of Deaths Report was issued during the reporting period.

Comparison of Inquests from 1st April 2021 - 30th September 2023

8.2 Summary of Learning.

New Inquest Case Summary	Progress of Inquest case during Q2
A patient suffered sudden onset of hypoxia following a blood transfusion. Despite resuscitation, the patient was unable to be revived and passed away.	• Disclosure of Witness Statements to HM Coroner from Welsh Blood Service and Velindre Cancer Services. • No issues have been flagged concerning the Trust's care and treatment. • Copy medical records have been requested • The inquest hearing is awaited

Following a diagnosis of Ewing's-like sarcoma, the patient commenced treatment. However, despite treatment, the patient continued to deteriorate and passed away.	• Disclosure of clinician Witness statement to HM Coroner • No issues have been flagged concerning the Trust's care and treatment. • The inquest hearing is awaited
Following commencement of immunotherapy for epithelioid mesothelioma, the patient continued to decline and passed away.	• Disclosure of clinician Witness statement to HM Coroner • No issues have been flagged concerning the Trust's care and treatment. • The inquest hearing is awaited
Despite treatment commencing for pelvic and para-aortic lymphadenopathy and multiple bony metastases, the patient continued to deteriorate and subsequently passed away.	• Disclosure of clinician Witness statement to HM Coroner • No issues have been flagged concerning the Trust's care and treatment. • The inquest hearing is awaited

Inquests comparison from 1st April 2021 - 30th September 2023

	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023
New	0	0	0	3	1	1	1	0	1	4
Closed	0	0	0	0	0	0	1	1	0	2
Open	1	1	1	1	4	4	5	5	4	3

Percentage of new inquests received from Q1 2021 - Q2 2023
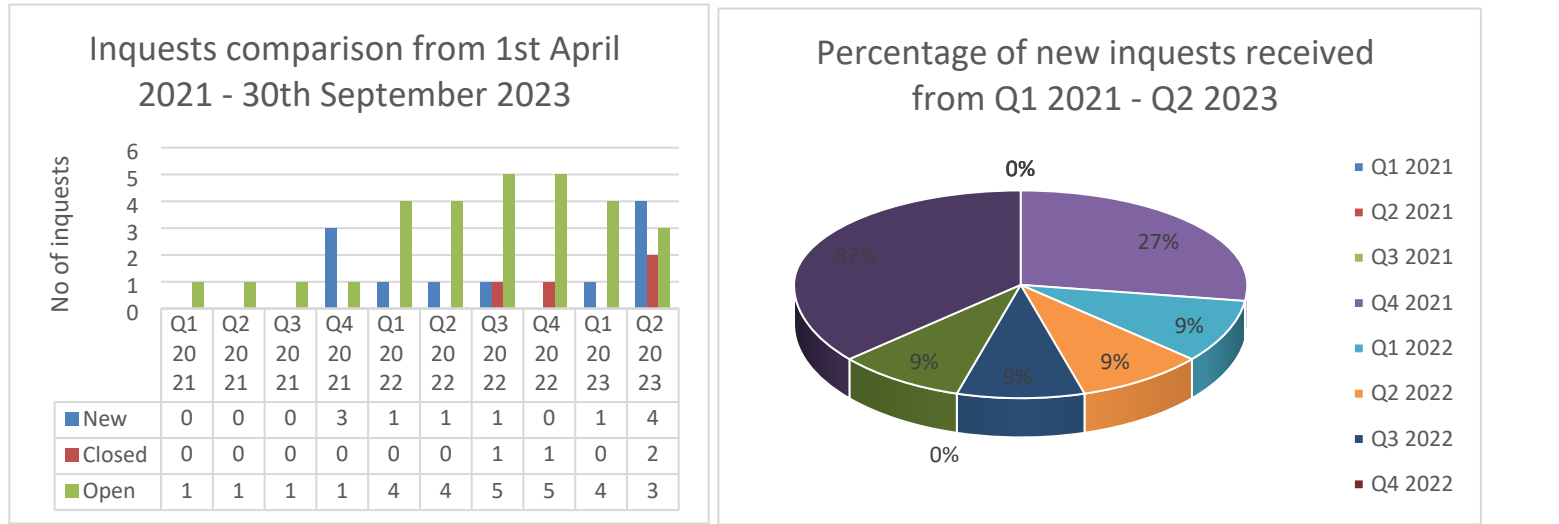
8.3 Assurance and Learning

While HM Coroner did not identify any issues for the Trust to address following the outcome of the below inquest hearings, the Trust, nonetheless, considers if there is any learning that might be applicable to the circumstances surrounding a death and, if so, will address any improvements needed to enhance patient safety. Each inquest case represents an opportunity to review the care provided, with the aim of improving the quality of care delivered.

Case Summary	Coroner's Conclusion	Main Learning Points
Following the patient's death, the Coroner sought a statement from Velindre Cancer Services as to whether the patient's	Natural Causes	1. On review, it was found that the treating clinician had flagged the deranged blood results to the primary care clinician for actioning. No further action appeared to have been undertaken by primary care to address the patient's anaemia.

anaemia should have been treated sooner and, if so, if the failure to have treated the patient's anaemia resulted in the patient's early demise.		2. Reflective practice was undertaken by the treating clinician to consider whether anything more could or should have been done to have treated the patient's anaemia. 3. Clinical overview found that a full up-to-date haemoglobin/blood count was not warranted to proceed with palliative treatment, unless the patient reported symptoms which required further blood investigations.
Patient collapsed following a PEG insertion. Investigations identified the PEG site was infected and treatment commenced. Despite treatment the patient continued to deteriorate and passed away.	Regulation 28 issued to Cardiff and Vale and Abbotts Care to develop a one page leaflet on symptoms/signs of sepsis.	To enhance communication across key organisations there has been the need to improve the responsibility for assessing and treating PEG infections with a view to preventing sepsis. A multi-disciplinary task and finish group was established by the Head and Neck and Altered Airways Advance Nurse Practitioner. The following updated actions are in progress:- 1. **Circulation** of Enteral Tube Policy to the Task and Finish Group. 2. **Discontinuance** of JeJ tube removal guidelines and BRG guidelines. These interventions will now remain the responsibility of the local health boards. 3. **Update** of Displaced Gastronomy Guidelines to reflect inpatient Gastrostomy displacement 4. **Pathway** to manage displacement that has occurred on site during an outpatient attendance 5. **Development** of risk assessment tool for Ng tube insertions. The tool will consider contraindications and risks associated with Ng insertion and the suggested pathway for escalation regarding any contraindications or risks being identified. 6. **Clear labelling** - Dietetic teams have in place clearly labelled stock within storage areas. 7. **Discharge Checklist** document displays information on whether the patient requires Abbott or Nutricia equipment in order to mitigate the risk of incorrect equipment being supplied 8. **Data collection** for all enteral tube interventions performed on the Ambulatory unit is currently being captured and grouped into health boards to

		identify if there is a common theme for intervention requests 9. **Training** - NEWS Cymru Training has been fully rolled out. NEWS Cymru Chart has been sent for printing to prepare for full implementation.

9 INCIDENTS

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

9.1 Quarter 2 Trust Incident Summary

Incidents reported	Corporate Services	Velindre Cancer Service	Welsh Blood Service
591	3	502	86

No/ Low Harm	Moderate Harm	Severe Harm
589	2	0
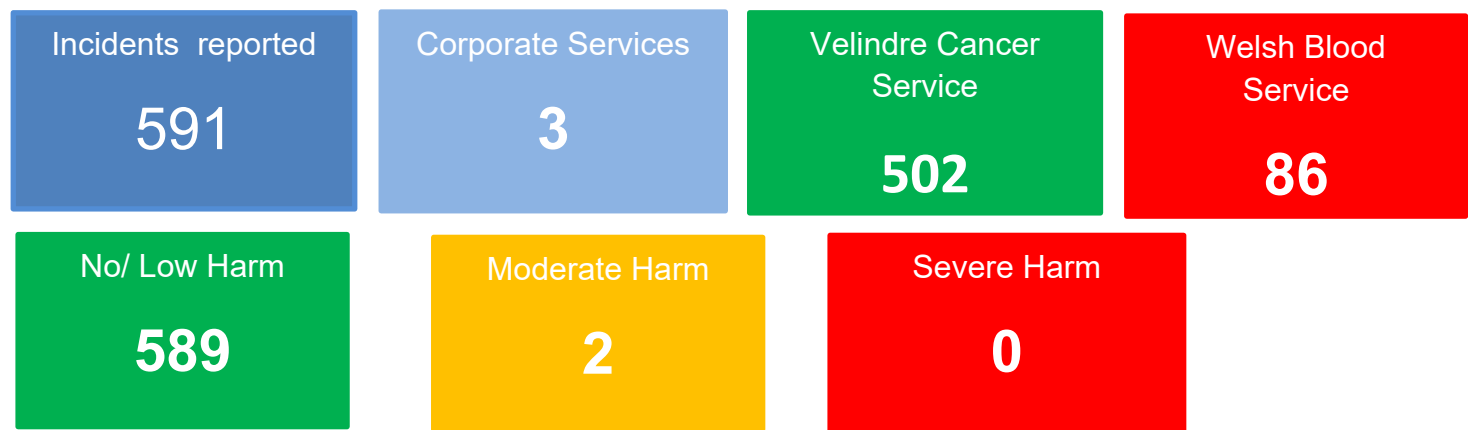
Increased numbers of incidents have been reported during this period which continues to support a robust reporting culture, is considered, to be as a result of both a positive and open reporting culture. In addition, during this period 10 incidents were reported in response to a national request to retrospectively report all patients who acquired COVID 19 infection whilst in hospital during the pandemic period.

Incidents reported 01/07/2021-30/09/2023 by Division/Quarter

	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Corporate Services	2	5	2	6	7	3	1	3	3
Velindre Cancer Centre	396	362	402	384	445	390	483	465	504
Welsh Blood Service	110	102	95	81	73	70	71	99	86
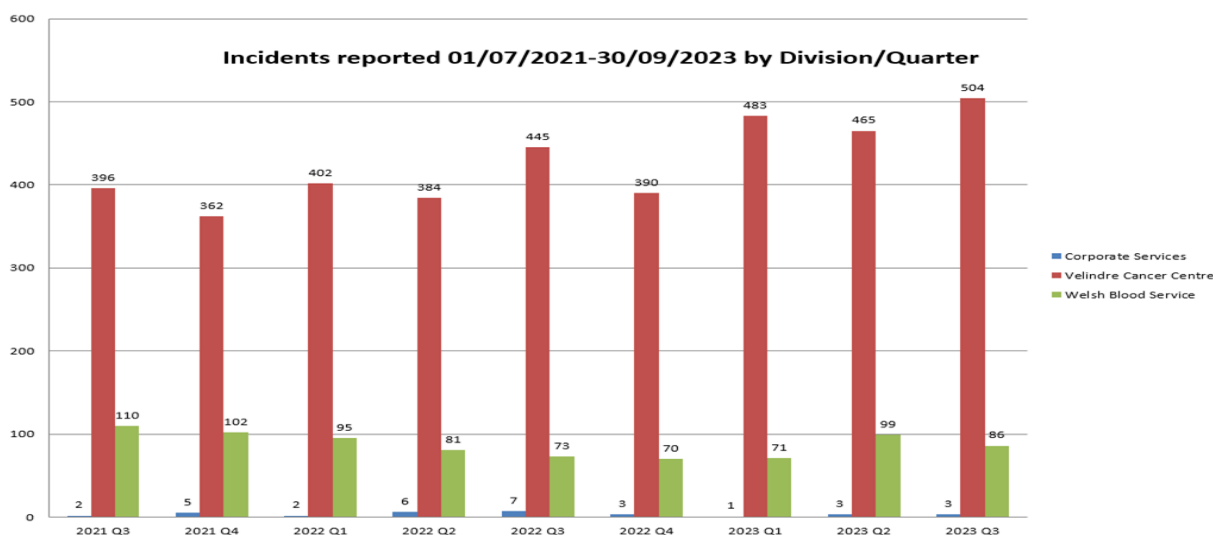
During Q2, there has been a significant improvement in incident closure rates, with 633 incidents in total being closed within this period as a result of collaborative efforts from corporate and divisional teams.

350 incidents remain open over the 30 day KPI for investigation and closure, 194 of these are legacy incidents reported prior to Quarter 2. The remaining 156 incidents were reported during the quarter. To further improve this, an opportunity has been identified within both divisions:

- Velindre Cancer Service will review their radiotherapy event report processes, that are required to be captured, but do not meet the criteria of an incident, nor the 30 day timescale. This improvement opportunity will be undertaken by corporate and divisional quality leads in collaboration with the National Datix team during Quarter 3.
- Welsh Blood Service will review their current processes relating to the reporting and management of health and safety incidents.

Quarter 2 Trust wide Incident reporting trends
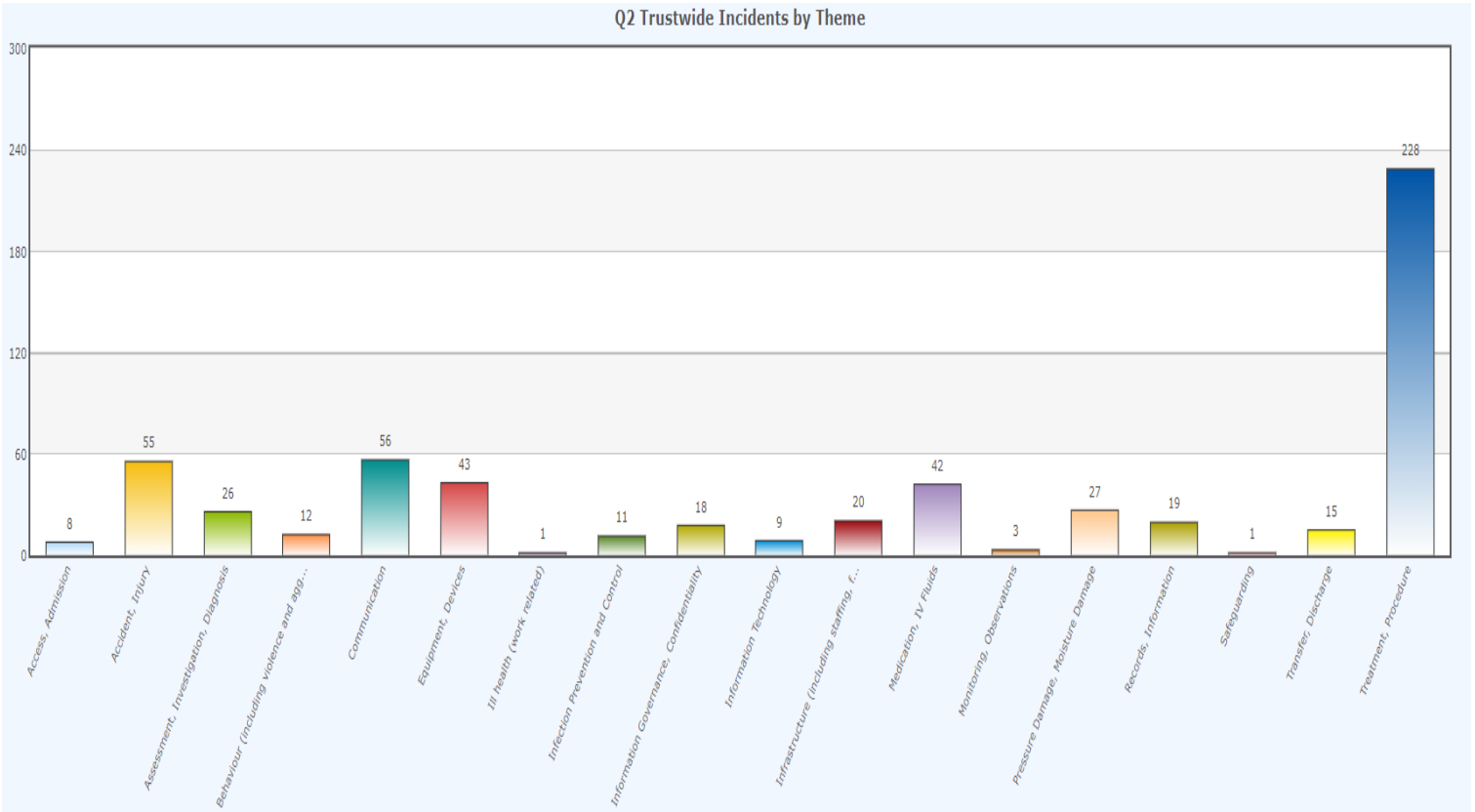
During Quarter 2, Radiotherapy has recorded the highest number of incidents, the Trust are aware that a number of these incidents are a repeated trend and are in relation to:

- A known international manufacturer fault with the radiotherapy system that at this time cannot be resolved, but methods of mitigation are being considered.
- Capture of radiotherapy event reports that do not meet the criteria of an incident, which will be reviewed within Quarter 3.

9.2 Incident Themes and Learning Opportunities.

During the quarter several themes in incident reporting have been identified within Velindre Cancer Service and a trend within the Welsh Blood Service:

Velindre Cancer Service

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

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

Welsh Blood Service

No incidents trends regarding new incidents have been identified in the reporting period, however a trend relating to delayed incident closure is evident with regards Health and Safety incidents, and a project group has been formed to review processes and implement improvement initiatives.

9.3 EXTERNALLY REPORTED INCIDENTS

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

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

During this period **2** incidents have been reported and are currently being investigated. One incident related to Pre-treatment Chemotherapy simulation and the other related to External beam radiotherapy (Image guided radiotherapy). No harm occurred in both incidents.

9.3.2 NATIONAL REPORTABLE INCIDENTS (NRI).

A safety incident should be nationally reported if it is assessed or suspected an action or inaction in the course of treatment has or could have caused or contributed to their severe harm or death. This is now referred to as a nationally reportable incident. During the quarter there were two NRIs both related to Velindre Cancer Service.

Both incidents were reported and managed in line with the All Wales Incident and Reporting Management Policy (2023) and investigations commissioned.

Nationally Reportable Incidents by Theme (2year period)
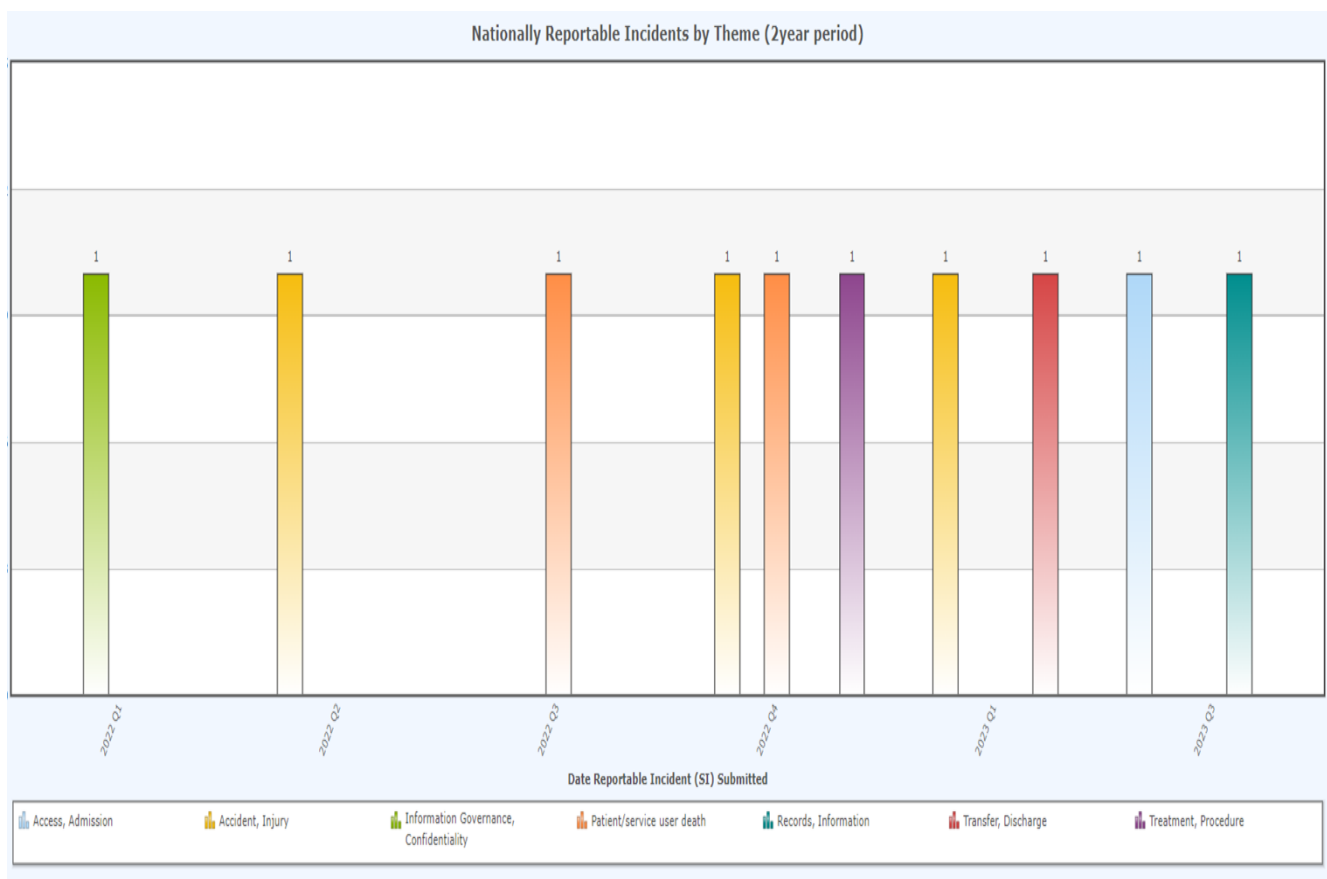
NRI 1: Access and admission, A missed referral for chemotherapy which triggered both NRI and Duty of Candour procedures.

Immediate Make Safe actions:

- Urgent chemotherapy being arranged for the patient to reduce any further delay for treatment.
- Review of the medical secretaries' emails to ensure no other outstanding referrals.
- A referral form for health boards to complete when referring a patient to VCC and correspondence to MDTs re referral pathways into Velindre has been devised.
- A further improvement project to implement a single electronic referral system is to be developed.

NRI 2: High number of digital clinical letter communications within the DMS system not issued within 30 days due to delay in clinical authorisation. (NRI Report made due to significant amounts of patients affected).

Immediate Make Safe actions:

- Immediate harm review of all outstanding letters for issue is being undertaken.
- Communications issued for all outstanding letters to be reviewed and authorised urgently by clinicians.

- Daily oversight of system by Senior Managers to ensure all letters are authorised and issued within 30 days.
- Consistent approaches to letter generation and authorisation to be developed and practice of issuing letters without clinical authorisation to be stopped immediately.

Both these related to administrative processes which are impacting on patients adversely and has / has the potential to cause harm.

Welsh Blood Service Externally Reportable Events

One adverse incident was reported to MHRA via the SABRE portal:

- **SABRE 110 -** *Malaria positive donor archive sample*
  This event has arisen from the lookback exercise undertaken as CAPA for SABRE 106 *Malaria residency risk incorrectly.*

  Status: RCA investigation complete, report being written up. Within target date for confirmatory report submission to MHRA (21/10/23)

- Submission of the confirmatory report for **SABRE 109** (reported August 2023) is overdue. MHRA have been made aware (via a footnote in the SABRE report) and have not raised any issues.

  Event: *Supplementary questions in the self-assessment health history are not appearing under the relevant primary question*
  Reason overdue: complexity of the investigation.

  Status: RCA report in draft, with some details around bug reports and risk assessment requiring further clarification.

10. DUTY OF CANDOUR

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

During the quarter, **2** Duty of Candour incidents reported**,** with a further incident reported in Quarter 1 being assessed as meeting the thresholds for Duty of Candour during Quarter 2 (21st July 2023). As a result, the Trust recorded 3 Duty of Candour cases during quarter 2 – outlined below. All incidents are being managed in line with the Duty of Candour procedures.

Duty of Candour triggered - 21st July 2023

Patient receiving palliative chemo and immunotherapy called helpline with diarrhoea. Helpline consulted on day 1 and advised to manage with loperamide and although diarrhoea improved symptoms did persist and as profound deterioration in overall condition noted during telephone calls. Admission should have been advised earlier. Resulted in a 999 call, emergency admission and ITU admission with severe immunotherapy induced colitis.

Duty of Candour triggered - 25th August 2023

Patient referred to Velindre Cancer Service following colorectal surgery, standard process via ABUHB colorectal nurse to VCC secretary, normal process would be for an appointment to be made. However, ABUHB nurses flagged that no appointment had been made at VCC, subsequently made for next clinic. Patient had telephone appointment, at this point was over 3/12 since primary surgery and complicated by a new cancer. May impact on prognosis and additional complication of concurrent cancer.

Duty of Candour triggered - 29th September 2023

Acute Kidney Injury (AKI), failure to act on earlier blood test. Neoadjuvant chemo/immunotherapy for cancer. Weekly phase requiring weekly blood tests for chemo. Clinic every 3 weeks in Royal Gwent outpatients. Blood tests on same day as clinic and then subsequent weeks day prior to doses of chemo. Patient unwell on clinic review, blood tests reviewed by clinician in afternoon (patient no longer present), severe AKI noted. On review, AKI had been present on blood tests taken a week prior. Chemotherapy had been omitted following blood tests due to anaemia and had been treated with blood transfusion.

To ensure timely initial assessment of moderate incidents the corporate and divisional quality and safety teams have developed and introduced a process to review all incidents graded as moderate harm within 48 hours of report to determine whether duty of candour procedures need to be evoked. This revised approach has been positively evaluated to date and has demonstrated an improvement in compliance.

During the quarter **2, 1** Patient/ Service User incidents at VCS were reported with a harm grading of 'moderate'. However, following the completion of initial harm assessments,19 were identified as not meeting the definitions of moderate harm and the incidents were regraded accordingly. There were no moderate harm incidents reported elsewhere across the Trust.

To further improve reporter harm assessments a number of Datix User Masterclasses accessible to staff across the Trust will be delivered, and a request has been made to the Datix Cymru team to add clear harm definitions that align with the Duty of Candour definitions within the Datix Cymru incident

system, this request was welcomed and accepted as a system enhancement that will be beneficial for users across Wales.

11.SAFETY ALERTS

During the quarter the Trust received **56** safety alerts that consisted of: **1** patient safety alert; **3** medical device alerts; **14** estates alerts; **5** Welsh Health Circulars; and **33** pharmaceutical alerts. All were reviewed by the Quality and Safety team on receipt and the detail of each alert was circulated via the Datix system. Following review, only **16** of the **56** alerts were deemed applicable to Trust, **14** were pharmaceutical alerts, **1** Welsh Health Circular and **1** Patient Safety alert. All alerts were reviewed and Trust compliance recorded.

11.1 PATIENT SAFETY ALERT PSA008: Nasogastric (NG) tube misplacement: continuing risk of death and severe harm, and requested the following actions be completed:
- Training on the use of the Aspirate pH strips to be introduced from 1st April 23.
- Competency Assessment to be completed by nursing staff inserting NG tubes.
- Introduction of a formal consent process for NG tube insertion.
- Requirement to undertake risk assessments to prior to the insertion of any NG tube.

The Trust's Chief Pharmacist has provided assurance that the required risk assessment has been completed and actions are being progressed to ensure the Trust will be fully compliant with the alert. The NHS Executive were informed of the Trust's compliant status on the 29th September 2023.

12. SAFEGUARDING AND PUBLIC PROTECTION

12.1 Safeguarding Referrals

During the quarter 3 duties to reports (allegations of abuse of an adult or child at risk) were raised to the local authority in line with the Wales Safeguarding procedures following disclosures or allegations of abuse. None of these allegations related to care within the Trust and related to:

- 1 allegation of donor self-neglect/harm,
- 2 allegations of emotional abuse raised by Velindre staff following concerns disclosed by patients.
- 1 allegation of a patient experiencing potential financial abuse.

All Safeguarding reports have been managed through the Safeguarding module in the Once for Wales Datix system to ensure that sensitive information is stored securely.

12.2 Deprivation of Liberty Safeguards (DoLS)

- 3 applications for DoLS were made for patients unable to consent to their care arrangements during The quarter.

Throughout the reporting period, Safeguarding supervision and support has been accessed across the Trust, with domestic abuse disclosures being the predominant theme for individuals to seek safeguarding supervision.

12.3 Professional Concerns

- 1 professional concern report was made during this period which is being managed through the section 5 process supported by police and the local authority:

12.4 Safeguarding Challenges and Opportunities

• There has been a vacancy for the Head of Safeguarding post between 1st of July 2023 and 15th October 2023. The Interim Deputy director of Nursing is providing safeguarding supervision and advice pending the recruitment of the new head of Safeguarding and Vulnerable Groups. The new Head of Safeguarding & Vulnerable Adults commenced post on the 2nd October 2023.

• Improving Safeguarding training compliance remains a priority. A Clinical Educator for the Mental Capacity Act has been appointed to deliver training across the Trust.

Types of Report

DoLs Applications
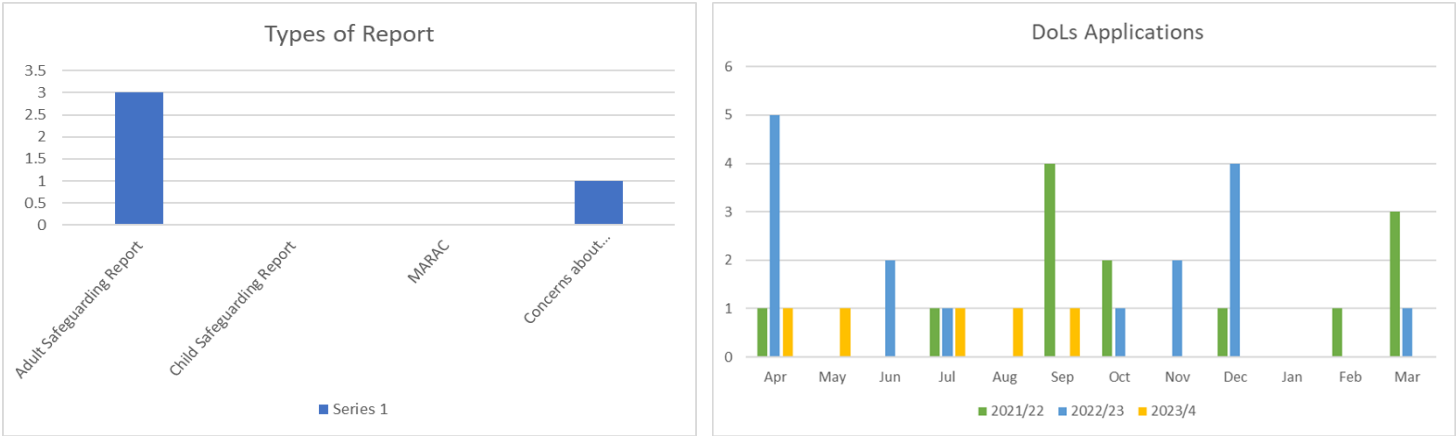
13. INFECTION PREVENTION & CONTROL

Healthcare Associate Performance Summary

		HCAI Review Quarter 2 – July to September 2024					
Month	C. difficile	Bacteraemia cases					
		MRSA	MSSA	E. coli	P. aeruginosa	Klebsiella species	
	2022-23 total no. of cases = 2	2022-23 total no. of cases = 0	2022-23 total no. of cases = 2	2022-23 total no. of cases = 6	2022-23 total no. of cases = 0	2022-23 total no. of cases = 1	
Q1	1	ZERO	ZERO	2	ZERO	2	
Jul-2023	ZERO	1	ZERO	1	ZERO	2	
Aug-2023	ZERO	ZERO	ZERO	ZERO	ZERO	1	
Sep-2023	ZERO	ZERO	ZERO	1	ZERO	ZERO	

Clostridioidies *difficile* - The IPCT have previously reported 3 cases to date however Public Health Wales (PHW) has established a discrepancy of healthcare-associated infection cases recorded on the PHW tableau/dashboard. Clostridium difficile toxin-negative results are not included in the tableau which brings the cases to date 2023-24 to 1. There were two cases of E.coli and three Klebsiella bacteraemia's during the reporting period. There was no Klebsiella sp. bacteraemia in September, however, there have been 5 cases of Klebsiellas sp. Bacteraemia in Q1 and 2 of 2023/23 compared to 1 case in 2022/23 which reflects the national increasing trend. Although each bacteraemia had an individual RCA completed at the time of the result, the wider IPC team are reviewing the cases to ascertain any commonalities. Also, as part of this work isolates from the positive samples are being sent for genotyping.

Route cause analysis investigations have been completed for all cases and identified that although multiple causative risk factors were found, the gram-negative bacteria had the opportunity to translocate and cause infection due to extensive disease. There was no evidence of transmission of infection or poor clinical practices or environmental hygiene standards.

14.0 WELSH RISK POOL ASSESSMENT

Following the Welsh Risk Pool audit in March 2023, the Welsh Risk Pool issued their report during the quarter. The assessment provides Substantial Assurance in three of the six areas for assessment and highlighted that the processes for managing Putting Things Right within the Trust was generally considered to be appropriate. It is envisaged that increased assurance will be achieved over time. 8 recommendations have been made in the report. These recommendations are intended to enhance the processes for concerns management within the Trust. An action plan

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Recommendations

R1 To review process for reviewing incidents, both clinical and non-clinical, to ensure prompt review and investigation.

R2 To establish a process which reviews / validates all incidents upon closure to ensure the management review has been completed as well as all necessary fields.

R3 To review the process for requesting authority on matters to utilise delegated authority options for Claims Managers and Legal & Risk Services where this is considered appropriate.

R04 To utilise the Datix Cymru system fully to log and track disclosure matters to ensure the process is recorded and not person dependant.

R05 To ensure greater use of Datix Cymru functionalities for logging and tracking of finance requests and payments made.

R06 To record LFER and CMR trigger dates on Datix Cymru to monitoring of deadline dates.

R07 To provide training for investigating teams on breach of duty and causation.

R08 VUNHST to share the practice of sending closure letters in matters with colleagues at the Complaints Handling Safety & Learning Network.

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has been devised to address the recommendations with several actions already being completed the action plan is attached in *appendix 1.* .

15. CONCLUSION

The triangulation of data this quarter has identified a theme of increasing concerns and incidents relating to administrative processes at Velindre Cancer Service which is resulting in a poor experience and harm to some patients. The areas identified which very clear fundamental reviews are required relate to:

- Referral processes – there needs to be a single electronic referral mechanism into VCS
- Clinical letter approval processes – need to ensure that patients GP's and patients receive a letter following an appointment within a reasonable timescale (30 days is proposed)
- Booking and appointment processes – a central automated booking process is required.

16. PRIORITIES FOR QUARTER 3, 2023-24

- Commence with pace route and branch reviews of the here administrative processes relating to VCS outlined above.
- Divisions to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, to successfully investigate and close any outstanding incidents.
- To strengthen investigations and to effectively capture and address learning identified from concerns, incidents and patient/ donor feedback during Quarter 3 2023-24.
- To develop the Trust Quality and Safety report to capture Quality and Safety Tracker Actions and wider aspects of Quality and Safety activity.
- To further develop collaborative working opportunities to optimise quality and safety outcomes and support learning and continuous improvement.
- Completion of SACT Treatment Helpline Peer Review.

APPENDICES

Appendix 1

Draft WRP Action Plan

VUNHST WRP Concerns Assessment Action Plan October 2023

Background

The Welsh Risk Pool (WRP) undertook a Concerns Assessment audit During March 2023. The aim of the assessment was to provide relevant feedback to VUNHST to both support the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures, and practice. Following the assessment, the WRP have provided an assurance report and 8 proposed recommendations for address.

Assurance Summary

Velindre NHS Trust		
Management of Concerns (Incidents)	LIMITED ASSURANCE	
Management of Concerns (Complaints & Enquiries)	REASONABLE ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	

Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

Recommendations

R01 VUNHST to review the process for reviewing incidents, both clinical and non-clinical, to ensure prompt review and investigation.

R02 VUNHST to establish a process which reviews / validates all incidents upon closure to ensure the management review has been completed as well as all necessary fields.

R03 VUNHST to review the process for requesting authority on matters to utilise delegated authority options for Claims Managers and Legal & Risk Services where this is considered appropriate.

R04 VUNHST to utilise the Datix Cymru system fully to log and track disclosure matters to ensure the process is recorded and not person dependant.

R05 VUNHST to ensure greater use of Datix Cymru functionalities for logging and tracking of finance requests and payments made.

R06   VUNHST to record LFER and CMR trigger dates on Datix Cymru to monitoring of deadline dates.

R07   VUNHST to provide training for investigating teams on breach of duty and causation.

R08   VUNHST to share the practice of sending closure letters in matters with colleagues at the Complaints Handling Safety & Learning Network.

Recommendation	Action & progress	Monitoring and Evaluation	Responsible Person	Deadline for Completion
R01 VUNHST to review the process for reviewing incidents, both clinical and non-clinical, to ensure prompt review and investigation.	**R1.1** An All-Wales audit plan for Datix Cymru has been scoped and developed by the OFW CMS Team. This was commenced April 2023 and will be undertaken as a quarterly audit.	Bi-monthly audits will be undertaken by the Trust Corporate Quality & Safety Team and reported through IQSG.	Quality Safety Manager and Head of Quality & Assurance.	**1/10/23**
	R1.2 The audit programme aims to provide assurances within each Divisions that: • the highest risk fields in Datix Cymru are being checked and coded accurately and; • action is being taken to address the findings to improve the quality of the data.	Divisional Monitoring/ Audit processes. Incident compliance reported monthly through Divisional Quality Hubs, Senior Leadership Teams and Trust Integrated Quality Group.	Divisional Quality Leads Corporate Quality and Safety Managers	
	R1.3 Bi-Monthly audits to be undertaken by Corporate Quality and Safety Team	Audit findings to be reported through divisional and Trust quality groups.	Corporate Quality and Safety Managers	
	R1.4 VCS to investigate adding incidents over 30 days as a PMF Measure.		VCS Quality and Safety Manager	

			Corporate Quality and Safety Managers	
	1.3 Monthly Divisional Quality reports to encompass: 1. Numbers of incidents open over 30 days. 2. Numbers of incidents that remain open and overdue. 3. Liaise with Once for Wales team to discuss radiotherapy incident management due to 90 day as opposed to 30 day timescale. 1.4 VCS to implement incident lead review meetings 1.7 Corporate Quality and Safety Team to develop toolkit resources and Datix masterclasses to support use of the Datix systems within divisions. 1.8 Development of escalation processes to address overdue incidents.		VCS Datix Lead Corporate Quality and Safety Manager VCS Quality & Safety Manager	

R02 VUNHST to establish a process which reviews / validates all incidents upon closure to ensure the management review has been completed as well as all necessary fields.	2.1 Ensure that management review is completed. 2.2 Monthly Datix masterclasses commence October and will reinforce compliance with the incident policy and Datix user guides. 2.3 Incidents not closed within 30 days will be reported through Divisional Quality Hubs, SLT and Integrated Quality and Safety Group for action and assurance. 2.4 Introduction of National Incident Management and Reporting Policy. 2.5 Development of Incident management and investigation toolkit. 2.4 Implement Scrutiny process for incidents graded	Compliance audit findings to be reported through divisional and Trust quality groups. Oversight and assurance through monthly Divisional IQSG reports.	Corporate Quality Safety Manager Corporate Quality and Safety Manager Quality & Safety Officer VCS Corporate Deputy Head of Quality and Safety/ Divisional Quality Managers	**1/11/23**

			Corporate Quality & Safety Assurance Manager/ VCS Datix Lead. Corporate Head of Quality/ VCS Quality Lead.	**30/11/2023**
	2.5 Development of Dashboards on Datix for VCS to support management of incidents and management review. **2.6** Review process for managing radiotherapy incidents and reporting to align with 90-day closure requirement).			
R03 VUNHST to review the process for requesting authority on matters to utilise delegated authority options for Claims Managers and Legal & Risk Services where this is considered appropriate.	**3.1** To review current requesting authority and delegation arrangements. **3.2** Develop a revised claims procedure.	This document will be approved at the Trust Integrated Quality and Safety Group.	Claims Manager	**28/02/24**
R04 VUNHST to utilise the Datix Cymru system fully to log and track disclosure matters to	**4.1** Review/audit undertaken to check that disclosure matters, where potential claims are	Meeting arranged with WRP Safety Learning Advisor	Claims Manager/Quality and Safety Assurance Manager	**11/10/23**

ensure the process is recorded and not person dependant.	indicated, have been appropriately captured on Datix Cymru.	Where there is no potential claim against the Trust, a separate spreadsheet exists which capture SARs. These are dealt with separately by the health records department. Where there are potential claims, these are captured in Datix Cymru module. Bi-monthly review/audit to be undertaken of Claims Module		
R05 VUNHST to ensure greater use of Datix Cymru functionalities for logging and tracking of finance requests and payments made.	**5.1** Review/audit undertaken to check functionality for logging and tracking of finances requests and payments made are captured. **5.2** Claims module audit to be completed biannually and included in the Datix Operational Group agenda * A separate Laspar finance spreadsheet is being used to assist internal discussions	Audit has identified that the Datix Cymru system is being utilised to record finances including requests and payments made.	Claims Manager/Quality and Safety Assurance Manager Claims Manager/Quality and Safety Assurance Managers To discuss at Redress Network for clarity	01/10/2023

			17/10/23 – Claims Manager	
	with VUNHST finance team who do not have access to the Datix Claims module and is required to ensure that finances can be cross referenced and checked against Datix and recorded for the finance team to complete their ledgers and DELL returns etc. There is greater involvement with the claims manager and finance managers to ensure that all payments are accounted for to comply with Audit Wales and that the Claims Manager is required to ensure that Datix Cymru is also aligned to the Laspar spreadsheet.

The tracking of finance requests and payments is also required to be monitored in relation to the Counter Fraud, Bribery and Corruption Policy – a VUNHST Policy which outlines the response plan regarding risk management concerning payments, including financial | | | |

	vulnerability, error, fraud and potential threats and fraud claims. This Policy outlines the Trust's responsibilities regarding risk management concerning payments in addition to the Welsh Risk Pool Procedures and All-Wales Indemnity Policy and Scope document. Work is envisaged to be undertaken to replace LASPAR , this detail has been feedback to OFW Datix team.			**17/10/2023**
R06 VUNHST to record LFER and CMR trigger dates on Datix Cymru to monitoring of deadline dates.	**6.1** To undertake a review from April 2021 to ensure that dates are included on Datix Cymru.	Review completed. Information included on Datix Cymru. It has been identified that a look back exercise of older cases transferred/migrated across from Datix v/12/14 will require cross referencing to ensure that all information is aligned accordingly. Claims module audit to be completed bi annually and	Claims Manager/Quality and Safety Assurance Managers	**31/03/24**

		included in the Datix Operational Group agenda			
R07 VUNHST to provide training for investigating teams on breach of duty and causation.	**7.1** Training requested from Legal and Risk. Key individuals identified across the Trust to attend	To deliver sessions and evaluate feedback.	Claims Manager	**03/01/24**	
R08 VUNHST to share the practice of sending closure letters in matters with colleagues at the Complaints Handling Safety & Learning Network.	8.1 Findings shared with the Complaints Handling Safety & Learning and Hope Network.	Anonymised copy letter sent to Chair to share good practice.	Quality & Safety Manager	**09/10/23**	
R09 VUNHST add minutes from PTR Panel to Datix Cymru to demonstrate rationale of Panel outcome.	**9.1** Findings shared with directorates and Q&S Team. **9.2** Rationale will be provided in progress notes going forward rather than	PTR Panel/ Datix Audit	Corporate Quality and Safety Managers	**16/10/2023**	

	capturing Minutes on Datix Cymru due to sensitivities.			
Findings				
Delays in sending the Regulation 26 letter may be occurring due to the time needed for scrutiny and discussion of the case prior to it entering the Redress process. The Assessors recommend that opportunities for streamlining the processes are taken where this is considered possible.	1 The corporate quality and safety team will complete all Regulation 26 letters. PTR panels are arranged weekly and dates will be factored in to timeframes of incident investigations. 2 To review PTR Panel and how best to streamline • Regulation 26 responses can take longer to issue and can cause delay due to the need to look at learning and provide a comprehensive response and also to ensure that complainants etc have an opportunity		Head of Quality and Safety / Concerns Manager	28/2/24

	to meet with the Trust before the response is issued thereby offering support to the complainant, aligned to the PTR process. Meeting arrangements can be delayed for various reasons e.g. to allow time for the complainant to meet with clinical team to address the findings. • Review current internal process to identify opportunities for streamlining. 3 Handling Concerns Policy has been adopted to enhance a streamlined approach, with the addition of flow charts to assist the process to make it easier to navigate and prevent delay			

Recommended that further training is arranged for the concerns team, supported by the SOP framework, to ensure accurate capture and recording of data and increased consistency within records.	A workshop was held on the 8th of June 2023 with the Q&S team and key members from the Divisions to improve concern processes. Following the session, a SOP has been drafted and requires finalising.	Training Records	Quality, Safety and Assurance Managers / Deputy Head of Quality and Safety	20/10/23

Quality, Safety & Performance Committee

Private Patient Service Improvement Group Highlight Report & Improvement Plan Update

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Gareth Mitchell, Directorate Support Officer, CSMO
PRESENTED BY	Rachel Hennessy, Interim Director Velindre Cancer Service & Nicola Williams, Executive Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP's and Health Science

REPORT PURPOSE	FOR ASSURANCE

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services
BI	Business Intelligence

1. PURPOSE

This paper is to advise the Quality, Safety & Performance Committee of the highlights from the Private Patient Improvement Group held on the 30th October 2023 and the current status in relation to the Private Patient Improvement Plan.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHP and Health Science was asked to provide Executive leadership to the Group and take on the role as Senior Responsible Officer (SRO). The role was accepted on the provision that appropriate delivery support would be allocated as identified by the SRO. Responsibility for operational delivery of the Private Patient Improvement lies with the Velindre Cancer Service Director.

3. PRIVATE PATIENT IMPROVEMENT PLAN

The Private Patient Improvement Plan was reviewed at the meeting. Four actions were closed due to actions since the previous meeting. The current open improvement actions are attached *in appendix 1*. The full improvement plan is available via the VCS Directors office if required.

Overall delivery of the plan has taken longer than anticipated due to operational capacity constraints, the absence of core staff and business intelligence capacity. Key exceptions were discussed in detail and are summarized below.

To date out of 46 recommendations:
- 35 (76%) have been completed
- 11 recommendations remain open (24%). The timescales on all 11 have been delayed.

It is proposed that the timescale of the following action is delayed until April 2025 due to the volume of work needed within pharmacy following the two commissioned pharmacy reviews: '*Undertake a commercial review of the HCaH (healthcare at home) contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.*'

4. HIGHLIGHT REPORT

The following are additional highlights from the meeting:

ALERT / ESCALATE	**Business Intelligence (BI) Support**: There is currently no delivery date for BI support in relation to the KPIs, contract performance and billing processes. Significant discussions have taken place across a number of areas and some work around solutions are being worked through. However, overall BI support issues previously reported and acknowledged remain prevalent, there is no completion date and the group could not be assured regarding the robustness of billing mechanisms without this being addressed.
ADVISE	**Medical Advisory Committee** No further progress had been made in relation to the creation of the VCS Medical Advisory Committee and, as such, a deferred sate has once again been given to the corresponding point within the improvement plan. The Interim Divisional Director is reviewing this with the aim of establishing this as soon as possible.
ASSURE	**Practicing Privileges Policy & Private Patients Policy** Both policies have been developed and consultation commenced. It is anticipated these will be brought to the next meeting to be endorsed. **Patient Leaflet/Welcome Pack** Final touches are being put into the leaflet/welcome pack by liaison colleagues following discussion within the meeting. The pack will now be considered by the patient voice group and Llais.
INFORM	There were no items to inform

Improvement Plan - Private Patient Service

Date Updated: 10/10/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
STRATEGIC BUSINESS MANAGEMENT									
PP19	**IN PROGRESS**	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Links to Strategy. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - existing materials being refreshed based on retention of current service offer. **11/10/2023 Document in draft. to be reviewed by patient engagement/experience and then will need to be translated**	External provider	30/09/2022	31/09/2023		
PP13	proposed close	28.01.22	Ensure rolling programme in place to ensure workforce agreements are reviewed in a timely manner	Cycle of business in place for the service and under development for management group. 17/05/23 - AMS to progress. Update 31/05/2023 - for consideration at Scrunity beginning of June due to issues with scruitny being quorate end of May **11/10/2023 all posts in place. new Business planning Post for Performance and Private Patients agreed. Once appointed service will move from Head of Medical Records and Outpatients**	AMS	30/04/2022	06/09/2023		
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	procured support. All contracts have been shared with them prior to their visit on 5th December 2022. **DO.10/10/23 - Preparatory work prior to negotiation of current insurer contracts is complete. This included reviewing current contract tariffs and services provided compared to invoicing as well as ensuring billing is up**	COB/MB / External Provider	30/09/2022	30/11/2023		
PP18	**IN PROGRESS**	28.01.22	Develop a new process to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.18/04/23 - Finance and LIAISON working together on financial resource mapping **17/05/23 - Work ongoing but may stall without DO.**	External provider	31/05/2022	30/11/2023		
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Finance and LIAISON working together on financial resource mapping 17/05/23 - Work ongoing but may stall without DO. **10/10/23 - Practice policies have been reviewed and updated, these are presently being concluded for discussion with Clinicians, ensuring payment arrangements are reflective of managing the risk equitably. Application of new fees will be concluded following renegotiation of contracts.**	External provider	31/07/2022	30/11/2023		
MEDICAL GOVERNANCE									

| | Improvement Plan - Private Patient Service | | | | | | | | |

Date Updated: 10/10/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
PP8	IN PROGRESS	28.01.22	Establish Clinical Advisory Committee	Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed. update 31/05/2023 - to be reviewed as part of the proposed VCC clinical advisory group. Discussions being led by VCC Director with medical director **update 10/10/2023 - establishment of the Clincal advisory committee is linked to wider restructure of CAG and the development of the clinical and scientific group, alongside the medical staffing strcuture. Discussions are on going and it is anticipated that draft structures and key appoitnments will be agreed by end of September. There will then need to be an implementation phase**	Clinical Director	30/04/2022	01/10/2023		
COMMERCIAL									
PP21	IN PROGRESS	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	21/11/2022 - Refer to narrative in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 17/05/23 - Work ongoing but may be disrupted by BI resource issues. **10/10/23 - work is complete reviewing the current fees and cost of services which has been compared to market intelligence around fees for cancer services in other NHS Private Patient services, leading to the retrospective review income requests to Insurers and anticipated increase recurrent income going forward.**	External provider	31/07/2022	30/11/2023		
PP22	IN PROGRESS	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding	External provider	31/07/2022	31/08/2023		
PP25	IN PROGRESS	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	External provider 17/05/23 - Work ongoing but may be disrupted by BI resource issues. **10/10/23 - this work has not commenced due to prioritising provision of operational management and insurer contract re-negotiation**	External provider	31/07/2022	30/11/2023		
OPERATIONAL									
PP10	OPEN	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. 21/11/2022 - Refer to narrative in PP1. 17/05/23 - Currently interlinked with other points and can't be updated until the policy is in place. 06/09/2023 - discussions have taken place regarding the private patient clinic structure, including payment mechanisms. A session is due to take place within September which will review the pathway in the context of the data requirements. A draft proposal to support the	RH	30/06/2022	31/10/2023		

| | Improvement Plan - Private Patient Service | | | | | | | | |

Date Updated: 10/10/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
PP14	proposed close	28.01.22	Review management structure and reporting arrangements	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Revised operating stuctures under review and being recruited 17/05/23 - Ongoing – see action PPIG48. 06/09/2023 - an engagement process	COB / External Provider	30/04/2022	31/10/2023		
PP15	proposed close	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **17/05/23 - Ongoing – see action PPIG48.** **06/09/2023 -** an angagement process concluded 05/09/2023 on a proposed structure for operational services which includes private patients. the response will be collated over the next few weeks and advice taken from WOD in relation to the next steps. The senior PP manager role will report to the Head of Operational Services and Delivery **11/10/2023 see PP14**	COB / External Provider	30/04/2022	31/10/2023		
PP41	OPEN	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.	No update provided	DO	30/05/2022	31/10/2023		
PP43	IN PROGRESS	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery. **17/05/23 - Issues to be worked up when DO returns** **11/10/2023 Due to current pressures in relation to workforce and the requirement to review and implement two commissioned pharmacy reviews it is proposed that an option appraisal is undertaken once key actions are complete - review to commence April 2025**	RH	31/07/2022	31/10/2023		

Ref No	Service	Source	Issue	Outcomes Required	Suggested SMART Actions	Operational Lead	Executive Lead	Oversight	Evidence of Delivery	Delivery Date	Summary of Progress	RAG	Outstanding management Action
						Strategic Business Management							
PP1	IN PROGRESS	28.01.22	Review and update Private Patient Service Specification	21/11/22 - Draft Policy circulated to Improvement Group members on 12th and 19th November 2022. Awaiting feedback. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan**		Head of Operational Services and Delivery				31/03/2023			
PP16	IN PROGRESS	28.01.22	Develop marketing plan/commercial strategy	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan**		COB/MB / External Provider				31/03/2023			
PP19	IN PROGRESS	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Links to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan**		External provider				31/03/2023			
PP26	IN PROGRESS	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	This will follow the agreement of a Strategy.						31/03/2023			
PP17	IN PROGRESS	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022.		COB/MB / External Provider				30/06/2023			
						Medical Governance							
PP7	IN PROGRESS	28.01.22	Evaluate and review all clinical professionals undertaking private practice, and privilege rights, as well as appropriate indemnity insurance.	Discussions underway with regard to process requriements. 10.10.23 Register in place that details all clinical professionals undertaking private practice. This includes privelege rights and confirmation of indemnity insurance. This is managed by the PP Manager.		Clinical Director				30/09/2022			
PP8	NOT STARTED	28.01.22	Establish Clinical Advisory Committee	Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed.		Clinical Director				31/03/2023			
						Commerical							
PP21	IN PROGRESS	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	21/11/2022 - Refer to narrative in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP22	IN PROGRESS	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan**		External provider				31/03/2023			
PP25	IN PROGRESS	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Cost estimates provided for those that self pay. Work progressing for private patients and insurance companies. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP27	IN PROGRESS	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		Clinical Lead				31/03/2023			
						Operational							

ID	Status	Date	Action	Progress/Narrative		Owner				Due Date			
PP10	OPEN	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. 21/11/2022 - Refer to narrative in PP1. 05.09.23 Workstream has been established for review patient pathways for all SSTs. The Workstream will include a review of the Private Patient pathway. Request for delivery timeline to be amended given the review will cover all SSTs.		EGE/AMS				31/03/2023			
PP14	IN PROGRESS	28.01.22	Review management structure and reporting arrangements	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		COB / External Provider				31/03/2023			
PP15	IN PROGRESS	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		COB / External Provider				31/03/2023			
PP37	OPEN	28.01.22	Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report.	The CANISC Patient Administration System is the primarily solution for this information. Therefore an additional system is not required. Three standard reports have been established Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Report 3 - Radiology attendances, including exam type Patient KPI report (activity and phlebo) established (to be reviewed and signed off) Requirements provided to provide a single report that captures all activity at a patient level (which can be filter, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team. WPAS has now been deployed. There is ongoing work to ensure SOPs etc are aligned to ensure PPs are correctly recorded in the system to support ongoing activity reporting. 22/12/22 - Issues with the change in patient infomation systems are currently being worked through.		WJ		PPMG agreed that current systems appropriate to capture information.		31/03/2023			
PP43	IN PROGRESS	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		PW	31/03/2023						

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

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

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

SUMMARY STATEMENTS OF 7 LEVELS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Transforming Access to Medicines / Clinical Pharmacy Technical Services Update

DATE OF MEETING	23/10/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	GARETH TYRRELL
PRESENTED BY	GARETH TYRRELL
APPROVED BY	Choose an item

EXECUTIVE SUMMARY	The Pharmacy Technical Services continues to provide ready-to-administer products to organisations across NHS Wales under the MHRA "Specials" licence, whilst also maximising the resource utilisation opportunities through the Wholesale Dealer License. The TrAMS programme is currently not operational however progress is reported through the NWSSP Partnership Committee

RECOMMENDATION / ACTIONS	The committee are asked to note the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Managing Director / Director of Pharmacy / Clinical Director	23/10/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS DETAILS WITHIN THIS REPORT HAVE BEEN PRESENTED AT THE NWSSP PHARMACY DIVISION SERVICE BOARD WHERE SERVICE PERFORMANCE AND SAFETY IS PRESENTED. THERE ARE CURRENTLY NO OUTSTANDING GOVERNANCE ISSUES TO REPORT.	

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

APPENDICES	

1.   SITUATION

1.1   The aim of this report is to provide assurance on the current performance of the Pharmacy Division within NHS Wales Shared Services Partnership, and report to the board any matters of exception that increase the risks of service delivery.

2.   BACKGROUND

2.1   The Pharmacy Division provided several Pharmacy Technical Services to partners across NHS Wales under agreed Service Level and Technical agreements. These services are heavily regulated under Medicines and Healthcare products Regulatory Agency (MHRA), Home Office and General Pharmaceutical Council (GPhC) licences. These services include:

- Manufacture and supply of ready-to-administer injectable medicines under an MHRA "Specials" Licence.

- Purchase, storage, and supply of licenced and unlicenced products, including vaccines, under an MHRA Wholesale Dealer Authorisation.

- Purchase, storage, and distribution of controlled drugs under Home Office Licence.

2.2   Staff within NWSSP who are named on the licences are legally responsible for implementing the regulatory requirements under The Human Medicines Regulations 2012.

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2.3   All services adhere to European and UK Good Manufacturing and Distribution

practices as set out within the licences and are subject to risk-based compliance

inspections by the regulator intervals determined by service risk.

2.4   The service is currently deemed "low risk" and has a 24-month inspection

interval.

2.5   Monthly performance reports are presented to the NWSSP Service Board for

governance.

2.6   Products supplied from the NWSSP Pharmacy Division are detailed below

- Potassium Chloride 50mmol in 50mL syringe

- Rituximab 600mg in 250mL 0.9% Sodium Chloride

- Rituximab 700mg in 250mL 0.9% Sodium Chloride

- Rituximab 800mg in 250mL 0.9% Sodium Chloride

- Atezolizumab 1200mg in 250mL 0.9% Sodium Chloride

- Nivolumab 480mg in 100mL 0.9% Sodium Chloride

3.   ASSESSMENT

3.1   NWSSP aim to comply fully with the licencing requirements for MHRA Specials

Manufacturing and Wholesaler Dealing, and the regulatory standards of Good

Manufacturing Practice.

3.2   The service is currently undergoing a full gap analysis and implementation

programme for compliance with the updated Annex 1 – Manufacture of Sterile

Products.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The purpose of this paper is to highlight current exceptions to service adherence of Good Manufacturing and Distribution Practice.

4.1 There are no service deviations or exceptions to report across the Specials and Wholesale Dealer services.

4.2 The service is currently providing decontamination support to both Velindre and Llandough Aseptic units due to high levels on environmental contamination within the facilities. This is provided using ionised hydrogen peroxide decontamination, developed by the NWSSP Medicines Unit.

4.3 NWSSP Pharmacy are currently working with Welsh Government, Cardiff and Vale University Health Board and other key stakeholders to bring forward options from the TrAMS programme covering South East Wales Radiopharmacy in response to the recent closure of CVUHB Radiopharmacy Service following MHRA inspection.

4.4 Ongoing work is being undertaken to fill current service vacancies.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience	☐

• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* STRATEGIC RISK DESCRIPTIONS	02 - Partnership Working / Stakeholder Engagement
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

The implications outlined in this report as exceptions risk the ability of the service to prepare medicines within a times and efficient manner |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:** | Not required |

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For more information: *https://www.gov.wales/socio-economic-duty-overview*	**Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Choose an item
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Duty of Quality NWSSP Update

DATE OF MEETING	16/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	DR RUTH ALCOLADO (NWSSP)
PRESENTED BY	Dr Ruth Alcolado
APPROVED BY	Choose an item

EXECUTIVE SUMMARY	The Duty of Quality came into force in April 2023. This Duty applies to both clinical and non-clinical services provided by the NHS or commissioned by NHS organisations in Wales. The purpose of this paper is to set out the NWSSP response to the legislation.

RECOMMENDATION / ACTIONS	To note the progress made in implementation of the duty of Quality

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	
[Insert Appendix Number]	N/A

1.   SITUATION

The Duty of Quality came into force in April 2023.
The Duty is measured against 12 Health and Care standards which should be taken into account when making decisions regarding delivery of clinical and (for the first time) non-clinical services.
The traditional 6 domains of clinical quality were supplemented with 6 further domains giving the 12 Health and Care standards.

12 Quality Standards:

1) Safe
2) Timely
3) Effective
4) Efficient
5) Person Centred
6) Equitable
7) Leadership
8) Workforce
9) Culture
10) Information
11) Learning/Improvement
12) Whole System

2.   BACKGROUND

Quality comprises the 12 domains and these domains need to be reflected in 4 processes that make up a quality management system:
    Quality Planning
    Quality Control
    Quality improvement
    Quality Assurance

Reporting against the 12 standards was mandated in the form of an annual report and always on reporting.

The mechanism for reporting for NWSSP has been agreed at Partnership committee, and previously presented at this meeting.
There are 3 strands to reporting in NWSSP:
1) Annual report to be provided as agreed as a separate annex to the Velindre Annual Duty of quality report in June 2024 for the period April 2023-March 2024.
2) Always on reporting on NWSSP quality, a monthly update is to be provided on the NWSSP intranet site.

3) Information provided to NHS bodies in Wales in support of their duty of quality where NWSSP provides services for them on behalf of NHS Wales.

3. ASSESSMENT

3.1 Update on progress:

3.1.1 A duty of quality site has been introduced to the NWSSP SharePoint site. The first of the monthly videos that will be produced by each division in turn has been uploaded. The service submissions can be found at https://nhswales365.sharepoint.com/sites/SSP_Intranet/SitePages/Dui.aspx The first video uploaded details how quality runs through the work of the NWSSP procurement division as it procures the full range of equipment, consumables, medicines services and so much more, that enables NHS Wales to provide clinical services to patients.

News flash items will be uploaded each month to showcase quality improvements – this is the NWSSP equivalent of the 'patient story' which should help shine a light on the activities of NWSSP.

3.1.2 The NWSSP implementation group is established.

Leads from each division to ensure we learn lessons across divisions.

Leads are responsible for the production of the monthly updates.

3.1.3 Quality Impact Assessment.

We have agreed a mechanism to ensure that the IMTP undergoes a full QIA process, utilising adapted forms being piloted through NHS Wales.

3.1.4 The group of non-clinical organisations have met with the NHS Executive Duty of Quality implementation team and agreed to share learning as we go through this first year of implementation.

3.1.5 NWSSP has undergone Customer Service Excellence (CSE) Assessment for the first time as a shole organisation. In the past a number of divisions have independently held CSE accreditation, but it was decided that the whole organisation should go through the assessment process. We expect to hear if we have achieved CSE accreditation in the coming few weeks.

3.2 Ongoing Work:

3.2.1 Work is ongoing with Partnership Board to identify areas where we can further support HBs with their reporting on duty of quality in the mainly non-clinical areas where we provide services on their behalf. A duty of quality session will be carried out on 10/11/23 as part of the Autumn SSP Board development workshop. Velindre is represented alongside each HB and trust on the Partnership Board and we are keen to explore with all our partners in Wales how we can support them.

3.2.2 Administrative support for the implementation of the Duty of Quality is being introduced to co-ordinate the work of the NWSSP divisions.

3.2.3 Following the Partnership development session an offer will be made to HBs and Trusts to provide information at an appropriate setting e.g. Board Development Session to further discuss how NWSSP can support individual NHS organisations with their Duty of Quality reporting.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 You are asked to note the progress made against the duty of Quality, particularly the work focussing on non-clinical services as this is an entirely new concept for NHS Wales as a whole.

5. IMPACT ASSESSMENT

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

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

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	Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Choose an item
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	**Choose an item**
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Choose an item
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

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

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NATIONAL POLICY ON PATIENT SAFETY INCIDENT REPORTING AND MANAGEMENT

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

| EXECUTIVE SUMMARY | A new NHS Wales National Policy on Patient Safety Incident Reporting and Management has been published by the NHS Executive and all NHS Bodies are asked to adopt it in full.

The policy has been developed to enable a consistent approach to Patient Safety Incident Reporting and Management across NHS Wales through the identification of clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

The incident reporting and management approach described within this policy concentrates upon both the support and development of a 'just culture' |
|---|---|

	where organisations and staff feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action, and to maximise opportunities for learning and improvement. This policy will directly replace Trust Policy QS01 Incident Reporting and Investigation. To support the implementation of the policy an Incident Reporting and Investigation Toolkit has been developed and will be available when policy is implemented..
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **APPROVE** the implementation of the NHS Wales National Policy on Patient Safety Incident Reporting and Management across Velindre University NHS Trust in replacement of current Trust policy QS01: Incident reporting and investigation. A supportive Trust procedure has been development to outline Trust processes in respect of this. This was approved at Executive Management on the 30th October 2023.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	25th July 2023.
Executive Management Board	31st July 2023.
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Implementation of the policy endorsed for onward approval at both Integrated Quality and Safety Group and Executive Management Board. Trust implementation procedure commissioned.	
7 LEVELS OF ASSURANCE	
Report for Approval	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance *Not required as policy*

APPENDICES	
Appendix 1	NHS Wales National Policy on Patient Safety Incident Reporting Version 2, May 2023.

1.   SITUATION / BACKGROUND

This National Policy has been developed to set out clear expectations for patient safety incident reporting and management across NHS Wales and enable a consistent approach to Patient Safety Incident Reporting and Management.

The policy is aimed at all services directly provided or managed by a Health Board, Trust or Special Health Authority and it supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

The revised approach described within the policy both aligns with the requirements of the Health and Social Care (Quality and Engagement) (Wales) 2020 and concentrates upon the support and development of a 'just culture' where organisations and staff feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action through:

- learning from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients and donors
- identifying and addressing emerging risks by looking for trends, themes and patterns of incident reports
- oversight and assurance particularly where significant harm has occurred in the delivery of healthcare, in line with The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as 'Putting Things Right'.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The NHS Wales National Policy on Patient Safety Incident Reporting is attached in **Appendix 1**.

3.   IMPACT ASSESSMENT

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

3

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	This policy impacts positively on all 6 domains of quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable for this report
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	No impact was identified
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	This policy ensures Trust compliance with legal responsibilities relating to incident reporting and management

4

NHS Wales

National Policy on

Patient Safety Incident Reporting

& Management

Date to be reviewed:	31 March 2024	No of pages:	23
Document author & owner:	NHS Wales Executive		
Contact email:	PatientSafety.Wales@wales.nhs.uk		
Approved by:	Welsh Government		
Approval date:	4 May 2023		
Effective date (live):	11 May 2023		
Version:	v2.0		

Contents

Supporting sections:

1. NHS Wales Never Events list

2. Nationally Reportable Incident (NRI) reporting processes & flow chart

3. Guidance on nationally reporting specific incident types

4. Joint investigation process

5. Guidance on Safety-II principles

6. Commissioned Services flowchart

1. Changes from previous version

- Merged the content of the policy and the guidance document into a single document

- Removed references to "Phase 1" and "Phase 2" of policy implementation. Phase 2 related to the establishment of systems to thematically analyse incident data, this work has been superseded by the plans to undertake thematic analysis at a national level through the use of the Once for Wales Concerns Management system (Datix Cymru)

- Clarification of the scope of applicability of the policy, particularly with regard to independent service providers

- Improved clarity of roles & responsibilities of all organisations involved in policy delivery, alongside use of more inclusive terminology throughout the document

- Improved clarity on the requirements of the initial assessment process following identification of a patient safety incident

- Strengthened references to the use of Datix Cymru for the reporting and management of patient safety incidents, including the use of the in-built Yorkshire Contributory Factors Framework tool

- Clarified the principles for NHS organisations to consider in determining whether an incident should be nationally reported

- Incorporated the NHS Wales Never Events list

- Endorsement of the just culture guide as a supporting tool

- New/strengthened sections on:
  - Duty of Candour, including alignment of harm definitions
  - Joint safety incident investigations
  - Incidents occurring in relation to commissioned services

- Clarification of accountability for completion (closure) of an incident investigation

- Provision of introductory guidance relating to the use of Safety-II thinking into current incident management processes

- Updated guidance and definitions in relation to specific incident types based on feedback throughout 2021/22 including:
  - patient & service user falls to be retrospectively reported where the investigation has determined the fall was avoidable
  - alignment of reporting requirements associated with maternal & perinatal and infant deaths to National Confidential Enquiry (MMBRACE-UK) definitions

- Clarity on the relationship between Nationally Reportable Incident (NRI) reporting and Welsh Government (WG) Early Warning Notifications

2. Introduction

Patient safety incident reporting is changing across Wales. Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. As a nation, our understanding of how to best use intelligence from incident data is continuing to evolve. New conceptual approaches to safety, such as Safety-II, will help us shift the narrative from focusing purely on "what went wrong?" and balance this line of inquiry alongside "what goes right, and how can we learn from that as well?" (see Supporting Section 5 for more information on Safety-II). These new approaches require us to think differently and consider how incident reporting is one component of a whole safe system of care. We must continue to ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, staff and our NHS organisations.

To achieve these ambitions, our national processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The previous version of this policy (in effect from 14 June 2021) aimed to empower organisations to think differently about what should be reported, taking more ownership and accountability for incident reporting and management. Through this updated version of the Policy, the NHS Wales Executive will take these aims further and continue to work collaboratively with NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analysing incident data which is for the NHS, by the NHS.

3. Purpose of this policy

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

While many incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- to **learn** from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients;

- to identify and address **emerging risks** by looking for trends, themes and patterns of incident reports; and

- as a mechanism for oversight and **assurance** particularly where significant harm has occurred in the delivery of healthcare, in line with *The National Health Services*

(Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. This includes triangulation with other data sources (for example, patient experience and complaint data) as well as looking at what goes well the majority of the time, and what we can learn from that (e.g. Safety-II). Throughout 2023 and beyond, the NHS Wales Executive will be working to improve how this triangulation of multiple data sources is undertaken at a national level.

The purpose of this Policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

4. Strategic policy context

The following national programmes and concepts provide context to this Policy:

- **Health and Social Care (Quality and Engagement) (Wales) Act 2020**, which underpin the statutory **Duties of Candour and Quality**:

    - The **Duty of Candour** is intrinsically linked to incident management. The Duty focusses on the need to be open with patients and service users and anyone acting on their behalf when things go wrong, building on the requirements already set out in the Regulations.

    - The **Duty of Quality** has two aims – to improve the quality of services, and to improve outcomes for people in Wales.

- **Quality & Safety Framework: learning and improving**: the overarching national Framework setting out the national ambitions for Wales in relation to quality and safety in the NHS. In particular, this Policy relates to Action 4 – **the development of a new National Incident Reporting Framework focussing on maximising and sharing learning from incidents**.

- **National Clinical Framework: A Learning Health and Care System**: the overarching national Framework setting out the national ambitions for Wales in relation to the development of clinical services across NHS Wales.

- **NHS Wales Executive**: in fulfilment of an objective set down in A Healthier Wales, a number of organisations have brought together under the banner of the NHS Wales Executive from 1 April 2023. National systems for incident reporting will be established, maintained and developed by the NHS Wales Executive.

- **National Quality Management System (NQMS)**: a visionary system for NHS Wales which will ultimately bring together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and assurance.

- [Once for Wales Concerns Management System](#): the national IT system enabling consistent approaches to a range of processes across NHS Wales. In relation to incident reporting and management, this system is also known as **Datix Cymru.**

- **COVID-19 pandemic & the [National Nosocomial COVID-19 Programme (NNCP)](#):** NHS Wales is still recovering from the effects of the COVID-19 pandemic and this must continue to be taken into consideration in relation to patient safety incident reporting and management. Importantly, learning and changes to process which were brought about by the pandemic must be capitalised on, including in particular learning from the NNCP, which will be incorporated into this and future versions of the policy as applicable.

5. Scope of Policy

This Policy applies to **all** services directly provided or managed by a Health Board, Trust or Special Health Authority in NHS Wales.

NHS Wales organisations that contract, agree or arrange for care to be provided by a non-NHS Wales provider (independent provider) on their behalf, retain responsibility for national incident reporting. This is in keeping with position outlined in the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* for Duty of Candour reporting. The requirement to report extends to Primary Care services providing care as part of NHS Wales.

6. References and related documents

- [Health and Social Care (Quality and Engagement) (Wales) Act 2020](#)

- [The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011](#) as amended by [National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023](#)

- [The Duty of Candour Procedure (Wales) Regulations 2023](#)

- [The Duty of Candour Statutory Guidance 2023](#)

- [Putting Things Right guidance document (v3, 2013)](#)

7. Aims and objectives of this policy

- Provide a clear and consistent national approach to incident reporting, management and investigation across NHS Wales.

- Provide clear guidance on what types of incident should be nationally reported, and how this should occur.

8. Responsibilities in relation to this policy

Welsh Government:

- Setting legislation, statutory guidance and government policy.

- Ensuring that intelligence and learning derived from the outputs of this policy are taken into account in setting legislation, statutory guidance and government policy.

- Publishing official statistics based on reported incidents.

NHS Wales Executive:

- Oversee and deliver national policy and processes in relation to reporting, management and investigation of safety incidents.

- Identification of cross-system learning, ensuring that learning is disseminated.

- Ensuring consistency of application of this policy, including provision of assurance mechanisms in relation to incident reporting, management and investigation.

- Provide national analysis on nationally reported incident data.

- Provide advice, guidance and support to organisations in relation to implementation of this policy, including the reporting, management and investigation of safety incidents.

Health Boards, NHS Trusts and Special Health Authorities

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.

- Implementing this policy including endorsement through their Quality & Safety governance framework.

- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.

- Ensuring local systems and processes for incident reporting are in place and embedded.

- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.

- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.

- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

- Ensuring staff are familiar with the requirements of this Policy.

Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations

- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting.

- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.

- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

Once for Wales Concerns Management System programme:

- Responsible for overseeing the development and delivery of relevant Datix Cymru modules to support the implementation of this Policy.

9. Key Definitions

General definitions:

Policy Term	Applicable Definition
Concern	As defined in the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011,* a concern is any complaint, claim or reported patient safety incident
Patient Safety Incident	An unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare Note: the term "patient safety incident" refers to an incident occurring in the course of the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services
Action	Something done intentionally or unintentionally
Inaction	Something **not** done intentionally or unintentionally including as a result of indecision, unnecessary delay, failure to act
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy

Harm definitions

The following definitions align with the definitions set out in the [Duty of Candour Statutory Guidance](#)

No harm	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition

10. Governance & assurance requirements

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- systems and processes to enact this policy in all areas of the organisation;

- all incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;

- integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;

- internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;

- clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;

- mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;

- mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;

- mechanisms for capturing and demonstrating shared learning;

- mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

11. Local incident reporting, management & investigation requirements

11.1. Context

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident and accordingly NHS organisations will need to apply judgment when considering what should be reported, both at a local and a national level.

11.2. Systems and processes

All organisations are required to ensure that they have systems and processes for local incident reporting, management and investigation in line with this Policy. This must include systems and processes to analyse incident data, extract learning and disseminate it throughout the organisation, with relevant actions taken to improve patient and service user safety, outcomes and experience.

Organisations should also have systems in place for monitoring and nationally reporting incidents that occur within services that are provided on their behalf by non-NHS Wales providers.

These processes must include the use of Datix Cymru where available to ensure a consistent national approach to data collection and analysis. These processes should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

- secondary and acute care settings

- primary and community care, including community pharmacy, optometry, dentistry services

- urgent and emergency services including emergency departments & ambulance services

- out of hours' services

- public health services

- relevant IT services

- prisons

- commissioned services, and

- incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the organisation's governance and assurance mechanisms, ensuring clear reporting across the entire organisation for relevant information.

Organisations must ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

11.3. Initial assessment to determine risk management activities and next steps

All patient safety incidents will require an initial assessment in order to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident has occurred or otherwise been identified.

This initial assessment must include:

- review of known information about the incident and consideration of further information to be obtained to inform the next steps;

- assessment of risk and determination of make safe actions in relation to:

    o all patient(s) or service user(s) affected by the incident, and

    o the organisation, or other safety systems, to prevent recurrence in similar circumstances;

- determination of the depth and parameters of an appropriate investigation;

- consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

- consideration and, where required, escalation e.g.:

  o as a Nationally Reported Incident (NRI);

  o through to relevant national frameworks (e.g. multiagency safeguarding processes); and/or

  o through to relevant external bodies;

- any relevant communications handling required;

- next steps in terms of incident management.

The depth of the initial assessment will vary depending on the circumstances of the incident. The initial assessment must be undertaken by someone of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. In some cases, including where the incident requires reporting as an NRI, this may require Executive level oversight.

Depending on the circumstances of the incident, this may be the point at which the organisation considers whether the Duty of Candour has been triggered and if so, who should make the initial "in person" notification – see Section 4 of the Statutory Guidance.

11.4. Use of Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees of Health Boards, Trusts and Special Health Authorities should have access to report directly into their employer's Datix Cymru system.

Primary Care Contractors in NHS Wales are required to report incidents that have occurred within their organisations. More information can be obtained from the Primary Care Wales Incident Reporting - NHS Wales Shared Services Partnership website.

11.5. Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems described in this Policy, which are overseen and managed by the NHS Wales Executive.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes must be followed.

12.National incident reporting requirements

12.1. Context

A subset of patient safety incidents will require national reporting to the NHS Wales Executive. The reporting of patient safety incidents at a national level:

- provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare;

- provides oversight and assurance relating to incidents that cause high levels of service impact, disruption or risk;

- enables the identification of organisational and/or system risks; and

- informs learning and action, including e.g. development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and potential service reforms.

Building on the foundation of the previous version of the Policy, there is a need to move away from prescriptive "trigger list" approaches to determining what incidents require national reporting. This is because of the complexity of healthcare and the incidents that can occur, it would never be possible to determine and list all the types of incidents which should be reported.

Accordingly, NHS organisations must have systems and processes in place to review all incidents on an individual basis and apply judgement to determine what should be reported nationally.

12.2. Nationally Reportable Incidents (NRIs)

As part of the initial assessment process described above, NHS organisations will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable (please see Supporting Section 3 for more guidance on definitions):

- Never Events, as specified within this Policy, even where no harm has occurred. The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy;

- suspected mental health homicides;

- suspected suicide or self-inflicted death

    o in any clinical setting; or

NHS Wales National Policy on Patient Safety Incident Reporting

        o   during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and

- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm** or **death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;

- IT failures;

- data breaches;

- national system failures; and/or

- service disruptions.

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Guidance on the joint investigation process can be found in Supporting Section 4.

12.3. Reporting process

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in Supporting Section 2.

13. Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of *Being open: communicating patient safety incidents with patients and their carers* and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, in order to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- an adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is
  - unintended or unexpected, and
  - more than minimal e.g., moderate, severe or death, and
- the provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the [Health and Social Care (Quality and Engagement) (Wales) Act 2020](#) occur after the date on which Section 3 was brought into force (i.e. 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

14. Patient safety incident investigations

14.1. Legislation

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. In particular,

[Regulation 23](#) outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

14.2. Methodologies

NHS organisations must have systems and processes for determining the appropriate and proportionate investigation to be undertaken in response to each reported safety incident, taking into account considerations such as scale, complexity and type of incident.

Organisations should therefore ensure they have access to a range of suitable investigation approaches/tools to support a proportionate approach across a range of outcomes. It will not be appropriate to conduct in-depth investigations for all incidents, and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.

Methodologies in use by an organisation should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are a number of focussed review tools built into Datix Cymru, which should be used where they are available. This includes safety incidents relating to:

- Falls

- Pressure damage

- Extravasation

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

14.3. Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents.

14.4. Just culture guide

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way.

NHS Wales endorses the use of the NHS England just culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should **not** be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The just culture guide, along with supporting reference materials, can be found on the NHS England website - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

14.5. Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;

- where patients have been moved between organisations, including patient handovers at emergency departments; and

- where services have been commissioned, including relating to social care.

NHS organisations should have systems and processes in place to manage these types of investigations.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Supporting Section 4.

15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services

Whilst the reporting of patient safety incidents at a national level remains the responsibility of the NHS Wales organisations that provided, managed or commissioned the care at the time of the incident, guidance on the investigation of such incidents is provided within the *The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* ("the Regulations"). The Regulations require all 'responsible bodies' to investigate incidents which occur to services users in receipt of NHS funded care.

A responsible body is defined under the Regulations as:

- a Welsh NHS body:
  - o a Health Board;
  - o an NHS Trust managing a hospital or other establishment or facility wholly or mainly in Wales;
  - o a Special Health Authority
- a primary care provider; or
- an independent provider:
  - o a person or body who provides healthcare in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.

When a patient safety incident occurs, Regulation 23 states that "the responsible body must investigate the matters raised in the notification of a concern in the manner which appears to that body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to additional criteria set out in the Regulations". The Regulations also detail what actions responsible bodies must take in terms of *redress[1]*, when harm is deemed to have been 'caused' to a patient or service user through a 'breach in duty of care' to that patient or service user.

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying

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[1] Redress is a range of actions which include an apology, learning lessons, and/or in certain circumstances, financial compensation.

liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:

   - NHS England; or

   - NHS Scotland; or

   - NHS Northern Ireland; and

2. NHS Wales funded healthcare provided by an 'independent provider', either:

   - provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or

   - provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does**, or **may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare

(CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

1. the investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and

2. there is no requirement on the provider to consider a QL as part of the investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

16. Investigation outcomes

16.1. Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience in order to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

NHS organisations should ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation, and include key learning as part of sharing investigation outcomes with the NHS Wales Executive.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

16.2. Completing (closing) an incident investigation

The accountability for completing (closing) an incident investigation sits with the NHS organisation who undertook the investigation.

NHS organisations must ensure there are robust processes in place to ensure the timely completion of incident investigations in line with this policy, which incorporate processes for patient or service user involvement, quality assurance, and Executive sign off.

To allow Boards to be assured that incidents within their organisation have been dealt with appropriately, all NHS organisations must ensure robust processes are in place to inform and assure their Boards that:

- the quality of their investigation processes is of a high standard;

- investigations are being undertaken and completed in a timely manner;

- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and

- appropriate actions are being taken and learning is being shared across the organisation.

16.3. Process for reporting outcomes of an investigation into an NRI

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Supporting Section 2.

16.4. NHS Wales Executive's role in relation to investigation outcomes

The NHS Wales Executive does not "close" incident investigations related to NRIs. As stated above, the completion of an incident investigation is the responsibility and accountability of the NHS organisation who undertook the investigation.

The NHS Wales Executive has an assurance function to ensure that the information shared in relation to the investigation outcomes is of good quality, using a suitable approach, and undertaken in a timely manner. This is to support a patient or service user focussed approach, as patients or service users affected by safety incidents and people acting on their behalf require good quality information to be provided to them in a timely manner. Where gaps in assurance are identified, the NHS Wales Executive will liaise with the relevant NHS organisation to seek further assurance.

In addition to the extraction and utilisation of learning from incidents, data and intelligence from NRIs will be used to inform local and national assurance activities.

17. Future thinking in relation to incident reporting and analysis

As described in the introduction section, new conceptual approaches to safety including resilience in healthcare and Safety-II, will be increasingly considered by the NHS Wales Executive to determine how these new ways of thinking can help support continual improvement and evolution of our safety management systems in healthcare.

Some preliminary guidance on how to incorporate elements of Safety-II thinking into current incident management practices is included in Supporting Section 5.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

18.Getting Help

Please contact PatientSafety.Wales@wales.nhs.uk if help and support in application of this policy is required.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FREEDOM OF INFORMATION / ENVIRONMENTAL INFORMATION REGULATIONS STANDARD OPERATING PROCEDURE

DATE OF MEETING	16/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	Kay Barrow, Corporate Governance Manager Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The Freedom of Information Act Policy provides the overarching framework within which the Trust has the duty to process and respond to Freedom of Information Act and Environmental Information Regulations requests. It sets out the high-level intent of the Trust to comply with the obligations of the Freedom of Information Act 2000 and also recognises the diversity of the respective Divisions and associated organisations under its control.

	The Freedom of Information/Environmental Information Regulations Standard Operating Procedure will assist Velindre University NHS Trust members of Staff responsible for handling Freedom of Information Act and / or Environmental Information Regulations Requests on a day-to-day basis. Following this will ensure compliance with the Freedom of Information Act 2000 and / or Environmental Information Regulations 2004.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **NOTE** the Equality Impact Assessment undertaken for the Freedom of Information Act Policy (attached as **Appendix 1**). • **APPROVE** the revisions to the Freedom of Information Act and Environmental Information Regulations Standard Operating Procedure (attached as **Appendix 2**).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	30/10/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Executive Management Board:
- **NOTED** the Equality Impact Assessment undertaken for the Freedom of Information Act Policy.
- **ENDORSED** the revisions to the Freedom of Information Act and Environmental Information Regulations Standard Operating Procedure for submission to the Quality, Safety and Performance Committee.

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

APPENDICES	
Appendix 1	Equality Impact Assessment for the Freedom of Information Act Policy
Appendix 2	Freedom of Information / Environmental Information Regulations Standard Operating Procedure

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1. **SITUATION**

The Freedom of Information Act Policy sets out the key areas of responsibility and affirms Velindre University NHS Trust's commitment to the underlying principle of the Freedom of Information Act and meeting its obligations under the legislation.

The Trust supports the principles of openness and transparency and welcomes the rights of access to information that the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 provides. The Trust seeks to create a climate of openness and transparency by providing improved access to information about the Trust will facilitate such an environment.

2. **BACKGROUND**

The Freedom of Information Act Policy provides the overarching framework within which the Trust has the duty to process and respond to Freedom of Information Act and Environmental Information Regulations requests. It sets out the high-level intent of the Trust to comply with the obligations of the Freedom of Information Act 2000 and also recognises the diversity of the respective Divisions and associated organisations under its control.

The Freedom of Information/Environmental Information Regulations Standard Operating Procedure will assist Velindre University NHS Trust members of Staff responsible for handling Freedom of Information Act and / or Environmental Information Regulations Requests on a day-to-day basis. Following this will ensure compliance with the Freedom of Information Act 2000 and / or Environmental Information Regulations 2004.

3. **ASSESSMENT**

The Standard Operating Procedure has been updated to ensure a more thorough process for dealing with the operational requirements for responding to Freedom of Information and Environmental Information Regulations requests.

4. **SUMMARY OF MATTERS FOR CONSIDERATION**

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the Equality Impact Assessment undertaken for the Freedom of Information Act Policy (attached as **Appendix 1**).
- **APPROVE** the revisions to the Freedom of Information Act and Environmental Information Regulations Standard Operating Procedure (attached as **Appendix 2**).

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	The impact of the requirement is increased time for all Staff to ensure that they understand the requirements of the legislation and their needs as individual employees of the Trust to ensure that they comply with it. To assist in this, work is underway to reduce the burden as much as possible via the use of e-learning and bringing training to them, so that the impact on operational delivery of their day-to-day tasks is as low as possible whilst still being compliant. For members of staff who have to undertake additional IG specific duties, the Head of Information Governance and DHCW had refreshed the quarterly VUNSHT IG Group to share best practice and updated legislation to ensure compliance with the Act.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Globally Responsible Wales - Consideration of whether an action may make a positive contribution to global well-being.
	This SOP supports the FOI Policy. Whilst not a legislative requirement is best practice and allows the Trust to ensure that it meets the need to protect the rights of the Public to access information so that Transparency and openness in a Public Authority are promoted.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Where a clear and serious breach of the legislation has taken place, the ICO will take direct action on the specific concern raised. If the ICO decide that there has been a serious failure to comply with the law, it has the power to impose financial penalties (fine of up to 20 million euros) and issue enforcement action.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Reputation and Compromise Position: The Trust recognises the importance of inclusivity and accessibility for patients, donors and their families as well as staff so they feel respected and valued and dignity is a priority. Potential discrimination can lead to negative attention and costly in respect to reputational as well as in monetary terms. *Monitoring Arrangements:* The Head of Information Governance keeps a watching brief on information governance related legislation and its impact on Trust activity. Should legislation change then the Policy will be reviewed accordingly.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (include further details below:
	Where a clear and serious breach of the legislation has taken place, the ICO will take direct action on the specific concern raised. If the ICO decide that there has been a serious failure to comply with the law, it will provide advice and instruction to help ensure an organisation gets it right in future. If an organisation is not taking its responsibilities seriously, the ICO may also take enforcement action

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6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Where a clear and serious breach of the legislation has taken place, the ICO will take direct action on the specific concern raised. If the ICO decide that there has been a serious failure to comply with the law, it will provide advice and instruction to help ensure an organisation gets it right in future. If an organisation isn't taking its responsibilities seriously, the ICO may also take enforcement action and it has the power to impose financial penalties (fine of up to 20 million euros) and issue enforcement action.
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The Standard Operating Procedure has been updated to ensure a more thorough process for dealing with the operational requirements for responding to Freedom of Information and Environmental Information Regulations requests.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Ref: IG08a

Managing Freedom of Information Act (FOIA)/ Environmental Information Regulations (EIR) Requests

Standard Operating Procedure (SOP)

Executive Sponsor & Function	Director of Corporate Governance and Chief of Staff
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
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Foreword

This Standard Operating Procedure is sponsored by the Corporate Governance Team and is intended to assist Velindre University NHS Trust members of Staff responsible for handling Freedom of Information Act and / or Environmental Information Regulations Requests on a day-to-day basis. Following this will ensure compliance with the Freedom of Information Act 2000 and / or Environmental Information Regulations 2004.

This Standard Operating Procedure is NOT intended to replace the Freedom of Information Act Policy or its associated Publication Scheme. The Corporate Governance Team is confident that this Standard Operating Procedure will answer the vast majority of queries related to the Freedom of Information Act 2000 and / or Environmental Information Regulations 2004 however, they and the Head of Information Governance (HOIG) remain available to provide advice and guidance should any member of Staff require it.

Definitions

Term	Definition
EIR	Environmental Information Regulations
EMB	Executive Management Board
FCO	Freedom of Information and Compliance Officer
FOIA	Freedom of Information Act
HOIG	Head of Information Governance
HTW	Health Technology Wales
ICO	Information Commissioners Office
NWSSP	NHS Wales Shared Services Partnership
QSPC	Quality, Safety and Performance Committee
SAR	Subject Access Request
SFI	Standing Financial Instructions
SIRO	Senior Information Risk Officer
SOP	Standard Operating Procedure
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service

1. Aim

The aim of this Standard Operating Procedure (SOP) is to provide Velindre University NHS Trust with a process for managing requests for information under the Freedom of Information Act 2000 and / or Environmental Information Regulations 2004.

2. Scope

This SOP applies to all members of the Governance Team who have delegated responsibility to respond to Freedom of Information Act 2000 and / or Environmental Information Regulations 2004 Requests and to any member of Staff responsible for providing information relating to an individual request for information from a member of the Public.

The Freedom of Information Act (FOIA) and Environmental Information Regulations (EIR) - A Summary

3. The Freedom of Information Act

3.1 The Freedom of Information Act 2000 (FOIA) and the associated Environmental Information Regulations (EIR) both provide public access to information held by public authorities. Velindre University NHS Trust (hereafter known as the Trust) is for the purposes of law, subject to the Act.

3.2 The Act contains many features, however, its main features are:

- A general right of access to information held by public authorities.
- That it sets out exemptions from the duty to provide information.
- It places a requirement on public authorities to exercise discretion; they may have to determine not only whether an exemption applies, but also the extent to which it may apply (some exemptions are conditional and depend on where the balance of 'public interests lie').
- It makes arrangements in respect of costs and fees.
- It places a duty on public authorities to adopt publication schemes (mandatory for FOIA and good practice for EIR).
- That public authorities must make arrangements for enforcement and appeal.
- It places a duty on the public authority to provide advice and assistance to people who wish to make, or have made, requests for information; and it outlines codes of practice.

  It should be noted that:
- Any written communication to the Trust, including those sent by electronic means could be a request under FOIA and/or EIR. For the avoidance of doubt, electronic means includes all Public Authority information Systems and where applicable where Public Authority information has been transmitted or received using commercial platforms (e.g., WhatsApp, text messaging and personal e mail accounts).
- In many cases requests may be dealt with in the normal course of business. Nevertheless, it is important for the Trust to ensure that members of Staff receive sufficient training so that they can recognise a request under FOIA/and or EIR. The HOIG will undertake the responsibility for training and awareness

including the provision of information on legislation, codes of practice and guidance.

The Trust has two members of the team who deal with FOIA/EIR one of which is an FOIA / EIR practitioner, they are:

- The HOIG (FOIA / EIR Practitioner)
- The Freedom of Information and Compliance Officer (FCO)

3.3   FOIA and EIR form part of what is known as a triumvirate of related Regulations and Acts of Parliament, the three related pieces of legislation are:

- The Data Protection Act 2018
- The Freedom of Information Act 2000 (FOIA)
- The Environmental Information Regulations 2004 (EIR)

3.4   The Act is wholly retrospective and applies to all information held by the Trust, regardless of its date. It does not oblige the Trust to retain information which is no longer of value.

3.5   Implementation and adherence to the Act is overseen by the Information Commissioner, who can monitor organisational compliance, issue undertakings, serve information and enforcement notices and, if needed, initiate legal proceedings to ensure compliance.

3.6   In terms of the response process to be observed when dealing with information requests the 8 "R's" are a useful reminder which are explained more thoroughly throughout in this SOP:

READ – Read correspondence and decide whether it constitutes a request or not and if the information is actually held, what it relates to and whether or not it needs to be transferred to another Public Authority (e.g. Welsh Government). If so, do NOT delay.

RECORD – Maintenance of a formal system of logging requests and recording all key actions. To provide ASSURANCE in relation to regulatory compliance to the Board. The Trust requires an accurate and complete audit trail for each request, especially if a request for an Internal Review is subsequently received.

RETRIEVE – The Trust must comply with legislation in that it must be able to Retrieve and consider all the relevant information.

REFER TO OTHERS – Where necessary, consult with others both within THE TRUST and also, if necessary, externally. Views will be sought prior to the disclosure of information, which will for Qualified Exemptions under FOIA and Exceptions under EIR necessitate the completion of a Public Interest Test. A Public Interest Test is not required for Absolute Exemptions.

REDACT – As the legislation refers to the release of information rather than documents it may be appropriate to release just some of the information within a document. Any potentially sensitive information not relevant to the request or for disclosure was not authorised should be removed or "redacted" in the copy sent to

the applicant. This will involve analysis of the document line by line prior to its release. It should be noted that redaction activity falls outside the 20-working day response timeframe and that this may delay the response to the requestor. The requestor MUST be informed in writing where such a delay occurs.

REVIEW – Once the response to a request has been prepared by the FCO it will require review and approval by the Director of Corporate Governance and Chief of Staff prior to final release. Under the Review process, the Director of Corporate Governance and Chief of Staff or in their absence the CEO has the authority to refuse to disclose information based on the advice of the FCO in the first instance. If the request is complex and/or sensitive, further advice may be sought from the HOIG, or if required from a solicitor. The process for this procedure is contained within Section 8.12 of this SOP. The use of Exemptions (FOIA) and Exceptions (EIR) will be approved within the Trust at the appropriate level, this is contained within Section 8.14 of this SOP.

REPLY – Once the Director of Corporate Governance and Chief of Staff, or in their absence, the CEO has approved the response, then it may be sent to the requestor. Responses MUST be in writing and comply with the templates which are at the Appendices. The response is to be kept in the appropriate place with Trust systems so that it may be retrieved accurately and speedily thereby complying with FOIA legislation.

RELEASE TO THE PUBLICATION SCHEME – The Quality, Safety and Performance Committee (QSPC) (delegated to the Director of Corporate Governance and Chief of Staff) will consider, based on the advice of the HOIG and after analysing the Public Interest Test, whether the information is likely to be of general public interest. If so, when released the information will be included in the Publication Scheme and/or in a simultaneous release on the the Trust website. This will take place at a suitable period after Publication to permit the opportunity to conduct a review should it be required.

4.   **Types of information subject to FOIA and EIR**

4.1   The main question encountered by the layman is "what constitutes information that is subject to the Act?" The following definition according to the ICO (ICO Definition of Information) is helpful in determining the answer to that question.

4.2   In general terms it covers any recorded information that is held by a Public Authority in England, Wales and Northern Ireland. Information held by Scottish Public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002 and is considered out of scope for this SOP.

4.3   The definition of recorded information is:
- Printed documents, computer files, letters, emails, photographs and sound or video recordings.

4.4   The key point to note is that any request for environmental information must be answered in accordance with the EIR rather than the FOIA. The initial timescales (20 working days) for dealing with EIR information are the same as those for the FOIA. However, further information to enable processing is available in Section 8 of

this SOP. The HOIG is available to provide assistance and guidance to ensure that all requests are identified correctly and dealt with compliantly.

4.5   The question that may be asked, is how to tell if information requested is subject to the FOIA or EIR? Whilst not exhaustive, Section 39 of FOIA indicates generally when a request should be considered under EIR rather than FOIA. Under EIR Regulation 2, Environmental information can be summarised as:

- The state of the elements of the environment, such as air and atmosphere, water, soil, land, landscape and natural sites and the interaction between these elements.
- Factors such as substances, energy, noise, radiation or waste affecting or likely to affect the elements of the environment.
- Measures such as policies legislation, plans, programmes, environmental agreements, and activities affecting or likely to affect or protect elements of the environment.
- Reports on the implementation of environmental legislation.
- Cost benefit and other economic analyses and assumptions within the framework of environmental measures and activities.
- The state of human health and safety, including the combination of the food chain, conditions of human life, cultural sites and built structures as much as they are or may be affected by the state of the elements of the environment.

4.6   The HOIG is available to provide advice and assistance whenever such a request may fall under EIR so that the response can be formed compliantly.

4.7   FOIA and EIR do not give people access to their own personal data (information about themselves) e.g. employment records, credit references etc. If a member of the public wants to see personal information that the Trust holds about them then they are to be advised to make a Subject Access Request (SAR) under the Data Protection Act 2018. Likewise, should an individual request the personal information of a third party, this is a Subject Access Request (SAR) under the Data Protection Act (DPA) 2018 and is to be treated as such. The Medico-Legal Officer, within the Velindre Cancer Centre (VCC) is to be notified of any approaches for information by a third party. The HOIG is to be notified without delay where an individual requests information about themselves which is not of a clinical nature.

4.8   Requests submitted for personal information under the guise of the Act will be responded to under the Data Protection Act 2018 without any further communication to the requestor asking them to make a new request. The initial request response will articulate this fact within the body of the letter and include references and links to the ICO local office to ensure that the requestors rights under the Data Protection Act 2018 are protected.

5.   Application of FOIA and EIR within the Trust

5.1   Within the Trust, FOIA and EIR applies to all areas of business activity, and it is crucial that all members of Staff understand that every activity under the definition of information may require disclosure under FOIA and/or EIR. To assist in this the Governance Team has implemented processes (see Section 8) and templates (See Appendix 1 and 2) so that members of staff are able to respond to requests with confidence.

5.2   The HOIG is available to act as a professional guide as to what should and should not be included in any response to a request from a member of the Public. It will ensure that members of staff are fully supported and that processes required by law are followed compliantly.

6.   Responsibility for administering the FOIA and EIR

6.1   The responsibility for Trust compliance with FOIA and EIR rests with the CEO who may delegate the functional authority to the Director of Corporate Governance and Chief of Staff. The FCO, under the authority of the Director for Corporate Governance and Chief of Staff, is responsible for the day-to-day management of compliance with FOIA 2000 and EIR 2004. In the interests of clarity, it is to be noted that it is everyone's responsibility to comply with legislation.

6.2   The HOIG is responsible for the provision of technical advice and guidance to the Trust in relation to FOIA and EIR legislation.

6.3   The HOIG is also responsible for the provision of advice and training to the Board, QSPC, Executive Management Board (EMB), and all members of Staff. The HOIG will act as the conduit for any contact between the Information Commissioners Office (also known as the UK Supervisory Authority) and the Trust.

6.4   The HOIG is responsible for conducting an independent Internal Review should it be required or if a complaint is received. The aim of the Internal Review is to ascertain whether the original response to the request was carried out in accordance with legislation. This process ensures that the Internal Review can be seen by the ICO as an independent review should the case escalate to the four-tier review process.

6.5   The Director of Corporate Governance and Chief of Staff will present data relating to the routine management of FOIA and EIR requests to the QSPC via EMB in a format required by the Committee on a quarterly basis.

6.6   The HOIG will present data relating to the conduct of Internal Reviews and Complaints made regarding the FOIA / EIR to the QSPC via EMB in a format required by the Committee on a quarterly basis.

6.7   Should a requestor disagree with the results of the Internal Review, then they may take their case to the Information Commissioner. The escalation process in broad terms is:

- Requestor requests an internal review by the Trust.
- Internal Review carried out; requestor requests a further review by the Information Commissioner (ICO).
- ICO carries out a review, requestor appeals against the ICO decision. Refer to 1st Tier Tribunal.
- 1st tier Tribunal sits, requestor appeals against the decision of the 1st Tier Tribunal. Refer to Upper Tier Tribunal
- Upper Tier Tribunal sits, requestor appeals against the decision of the Upper Tier Tribunal. Refer to Court of Appeal.

- Court of Appeal. Court of Appeal decision is highest level with its decision being final.

The process outlined above is intended to illustrate the procedure that is available to the requestor and to highlight the points at which the decisions made operationally may be examined within the levels of appeal in England and Wales.

6.8   Within the Trust, each Divisional Director is responsible for ensuring that their division complies with the FOIA / EIR and that they adhere to the timelines set in law in responding to requests.

The Divisional Directors are:

- Director of Welsh Blood Service
- Interim Director of Cancer Services
- Transforming Cancer Services (TCS) Project Director
- Executive Medical Director (Research, Development & Innovation)
- Director NHS Wales Shared Services Partnership (NWSSP)
- Director Health Technology Wales (HTW)

6.9   Within the Trust, the Executive Directors also have the functional responsibility for ensuring that their business area complies with the FOIA / EIR and that they adhere to the timelines set in law in responding to requests. They are responsible for issuing the FOIA / EIR request to the appropriate individuals and/or other departments, as necessary, and ensuring that the information is provided to the FCO in accordance with this SOP and within the timelines set by law.

The Executive Directors are:

- Executive Director of Nursing, Allied Health Professionals and Health Science
- Executive Director of Organisational Development & Workforce
- Executive Director of Finance
- Executive Medical Director
- Executive Director of Strategic Transformation, Planning, and Digital
- Chief Operating Officer
- Director of Corporate Governance and Chief of Staff

6.10   Within the Divisions, the Divisional Leads have the functional responsibility for ensuring that their division complies with the FOIA / EIR and that they support the Divisional Directors by adhering to the timelines set in law in responding to requests.

The Divisional Leads are:

- VCC – Director of Operations/Operational Management Team
- WBS – Deputy Director/Operational Management Team
- TCS – Administration Team
- NWSSP – NWSSP Information Governance Department
- HTW – Business Support Officer
- RD&I – Head of Research and Development

6.11   Day-to day administration is split in to two areas, which are Operational Responsibility and Review and Complaints Responsibility. These are as follows:

Operational Responsibility:
- Director of Corporate Governance and Chief of Staff
- Freedom of Information and Compliance Officer (FCO)

Review and Complaints Responsibility:
- Executive Director of Finance and Senior Information Risk Owner (SIRO)
- HOIG (Case Reviewer, Provision of technical advice and guidance)

7.   Approval of Responses to FOIA and EIR Requests

7.1   All staff have an important part to play within their own areas by ensuring that any receipt of an FOIA or EIR request is reported to the Director of Corporate Governance and Chief of Staff without delay. It is important for members of staff to understand the statutory time limits that are in force in terms of the need to respond to a requestor within 20 working days under the FOIA / EIR. The HOIG will ensure that an appropriate level of training is delivered to all staff to enable them to execute their duties in this regard.

7.2   The Divisional and Executive Directors are to ensure that if information is held within their area that it is made available for a full response to be considered in accordance with the processes articulated in Section 8 of this SOP. The HOIG is available to provide professional assistance and guidance to the FCO in all steps needed to process an FOIA or EIR request. The HOIG will deliver training updates as required by way of periodic updates or if there are any changes to legislation.

7.3   The Director of Corporate Governance and Chief of Staff has functional authority over the FOIA and EIR process and has delegated authority to approve all responses made by the Trust under the FOIA and EIR.

7.4   All documentation is to be approved by the Director of Corporate Governance and Chief of Staff or in their absence by the CEO. It is not to be delegated to any other members of staff. This process is necessary to ensure that Trust Standing Financial Instruction (SFI's) are adhered to as well as ensuring that there is a clear separation of duties in terms of administering the Trust's responses to requestors under FOIA / EIR and any subsequent Internal Reviews that may in the future be subject to Information Commissioner or Information Tribunal activity.

7.5   Section 8 of this SOP details the processes to be following the event of a request being made to the Trust for the release of information under the FOIA / EIR.

7.6   This SOP must be followed in line with the Trust's [Freedom of Information Act Policy (IG08)](#).

8.   Procedures

Process to follow whilst dealing with FOIA and EIR requests:

8.1. **When is a request a request?**

It should be noted that it is very important to draw a distinction between requests and routine correspondence. Requests for information that can be provided without any question – such as recruitment brochures, leaflets, press releases, any the text of public speeches should be treated as business as usual.

Requests which are not for recorded information, but instead questions such as "please explain your policy on Data Protection" or "please explain your decision to do "y" are not requests for recorded information and therefore should be treated as routine correspondence. The Trust will record each request made.

8.2 **What makes a request a valid request?**

Applications for information to be released under the Act may be made only in a written form and in accordance with the Section 45 - Code of Practice – request handling. FOIA Section 8 expands on this and details what is a valid FOIA request, to meet these criteria a request **must**:

- Be in writing
- State the name of the requestor and a valid address for correspondence (email addresses are valid)
- Describe the information requested
- Be received in legible form
- Be capable of being used for subsequent reference in any response

For requests made under EIR Regulation 5 there are subtle differences to the FOIA, the request is to be as follows:

- May be in writing or as a difference to the FOIA may be via a verbal request.
- State the name of the requestor and a valid address for correspondence (email addresses are valid); as a difference to FOIA a false name may be accepted under EIR
- Describe the information requested
- Be received in legible form
- Be capable of being used for subsequent reference in any response.

The term 'in writing' covers requests submitted by letter and electronic form, including those sent by social media. The request does not have to make direct reference to the Act or be the sole or main theme of the requestor's correspondence. When determining whether a name and/or address is valid, where a requestor's name is an obvious pseudonym or only includes a part of their real name (e.g. joe@123), then the request will only be valid if their real name is visible elsewhere in the body of the request. A partial name or pseudo-anonymised name is not considered a valid request. Should this scenario occur it is good practice to request the full contact name and contact address prior to any refusal of a request due to not meeting the requirements of Section 8.

It is to be noted that a request is also valid when:

- Information cannot be supplied under another legislative access regime or business as usual criteria within 20 working days.

A request is considered not valid when:

- The Trust has been copied into a request or piece of correspondence from an individual to another person or public authority who are not employed by or a part of the Trust.

To provide further guidance for those receiving requests, the following processes are to be followed:

- **WRITTEN** – Written approaches may be made to the Trust by letter, this may take the form of a letter requesting the release of information which may be addressed to the Trust centrally or via a department of the Trust. The FCO is to be informed without delay of such an approach so that it may be logged in the Schedule of Work and Tracker and a response to the request begun. The FCO is to ensure that the requirements set out in section 8 are within the request, if they are not, the person receiving the request is to contact the requestor and request that they re-send their request with the gaps identified in the original request filled.

- **E MAIL** - Approaches may be made to the Trust by e mail, this is not to be treated differently to a request made by letter. It may be addressed to the Trust centrally or via an employee or a department of the Trust. The Director of Corporate Governance and Chief of Staff is to be informed without delay of such an approach so that it may be logged in the schedule of work and Tracker and a response to the request begun. This task may be delegated to the FCO. The FCO is to ensure that the requirements set out in section 8.2 above (FOIA) are within the request, if they are not, the FCO is to contact the requestor and request that they clarify their request with the gaps identified in the original request filled.

Requests can be received via various e mail channels, these include but are not exclusive to:

- FOI inbox for the Trust   FOI.VUNHST@wales.nhs.uk
- Contact Velindre inbox   Contact.Velindre@wales.nhs.uk

Should any member of staff receive what they perceive to be an FOI/EIR request, then they are to forward the request to the Director of Corporate Governance and Chief of Staff without delay. All requests will be logged and given a unique reference number with the prefix CORP/year/next sequential number. Where the request received is made by letter or in any other written form, where possible the request must be scanned and emailed to the Director of Corporate Governance and Chief of Staff. Where it is not possible to send a scanned version of the request (e.g. COVID Pandemic) the Director of Corporate Governance and Chief of Staff is to be informed without delay.

8.3 Acknowledging a Request

Requests received by or forwarded to the Trust must be acknowledged within 2 working days of receipt. Where a request is received by any other means, an acknowledgement that the request has been received must be sent within 5 working

days of receipt, unless a full response to the request can be sent within this timeframe. For clarity, the first working day is the next day after the receipt of the request.

8.4 What to do when a request is unclear

There is a requirement under the FOIA / EIR for requestors to describe what information they want. However, both sets of legislation put a duty on the Trust to provide advice and assistance to people who have made or propose to make a request for information. The key requirement is to establish dialogue with the requestor. If clarification of the request is needed to identify and locate the information, this must be requested promptly and, in any event, no later than 20 working days. It is to be noted that where clarification is sought, the response timeline is paused until clarification is obtained at which point the timeline recommences. It is helpful to explain what information is readily available, or to explore ways in which a request could be made more specific. This is particularly important if the original request would be refused due to excessive cost. In any event all conversations with the requestor are to be recorded in a written format. All written evidence of contact with the requestor is to be maintained within Trust Systems.

8.5 Transferring Requests for Information

The Trust may only transfer a request when it does not hold, or does not substantially hold, the information requested. Holding of information includes the holding of a copy of the record produced or supplied by another person or body but does not extend to holding a record on behalf of another person or body. The Trust may not hold the information requested, and the requestor will be advised as soon as possible in these cases. The Trust may believe that the information requested is held by another public authority. In such cases it will either:

- Inform the requester, and provide contact details of that authority and advise the requestor to contact the relevant authority; or
- Contact the authority on the requestor's behalf and transfer the request.

Should the Trust consider it appropriate to transfer the request, consultation will take place with the other authority to determine if it holds the information and whether the request should be transferred. The request may be transferred to the other authority without further consultation with the requestor where the Trust believes that the requestor would not object to such a transfer. Should the Trust believe that the requestor would object to the transfer, the transfer will only take place with the consent of the requestor. All transfers of requests will take place as soon as practicable, and the requestor will be informed as soon as this has been done.

8.6 Consultation with third parties

The Trust recognises that in some cases the disclosure of information pursuant to a request may affect the legal rights of a third party; for example, where the information is subject to the common law of duty of confidence, or where it constitutes personal data as defined by the UK GDPR. Unless an exemption applies in relation to any particular information, the Trust will be obliged to disclose the information in response to a request. Where disclosure of information cannot be made without the consent of a third party and would constitute an actionable breach

of confidence such that an exemption would apply, the Trust will consult that third party with a view to seeking their consent, unless such consultation is impractical. The Trust will undertake consultation where:

- The views of the third party may assist in determining whether an exemption under the FOIA / EIR applies; or
- The views of the third party may assist in determining where the public interest lies.

The Trust may consider that consultation is not appropriate where the cost or amount of time and/or effort of consulting with the third party would be disproportionate. In such cases, it will consider the most reasonable course of action to ensure that the requirements of the FOIA / EIR are met. Consultation will be unnecessary where:

- The Trust does not intend to disclose the information; or
- The view of the third party can have no effect on the decision as to whether to disclose the requested information.

Where the interests of a number of third parties may be affected by a disclosure and those parties have a representative, the Trust will, if it considers consultation appropriate, consider it sufficient to consult only some of the organisations. If a third party does not respond to consultation, it does not relieve the Trust of its duty to disclose information under the FOIA / EIR, or its duty to reply within the time specified within the FOIA / EIR. In all cases, it is for the Trust, not the third party, to determine whether information should be disclosed. A refusal to consent to disclosure by a third party does not automatically mean information will be withheld.

8.7   **Information provided by other organisations**

If the response to an FOIA / EIR request belongs to or contains a significant amount of information provided by another organisation, the Trust will consider on a case-by-case basis whether to consult with that organisation. The organisation will apply this process when considering whether an exemption may be applicable.

8.8   **Accepting information in confidence from third parties**

The Trust will only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of its functions and it would otherwise not be provided.

8.9   **Employees names and details**

It is acknowledged that, as a public authority, some justification exists for the disclosure of employee names and contact details. The Trust will release the names of Board members, the CEO, and members of the Senior Leadership/Management Team's unless a valid exemption applies. This means that the names and details of Board members, the CEO, and members of the Senior Leadership Team published on the Trust's website will be provided without gaining additional consent. Consent will be sought from all other employees to release their information where it is reasonable in the context of the request to do so. The HOIG will advise the Director of Corporate Governance and Chief of Staff when it is reasonable to seek consent,

in line with UK GDPR and the principle that employees have a reasonable right to privacy at work prior to their decision to release the information. Requests for salary information will be answered, if applicable, by providing remuneration pay scales. Requestors will be referred to the publication scheme if requiring information regarding Board salaries.

8.10 Re-use of Information

The regulations require organisations to publish details of information available for re-use. Information that the Trust publishes as part of its publication scheme can be considered as the list of information available for re-use. Any published document can be re-used without charge, provided that the Trust is quoted as the source and retains copyright. Requests for re-use will be granted or denied by the Director of Corporate Governance and Chief of Staff in consultation with the HOIG. Where it is complex, the expertise may be sub-contracted to qualified legal support (e.g. NWSSP Legal and Risk Solicitors) to ensure that requests are given due consideration in accordance with the FOIA / EIR. Following the completion of a response to a request for information that is not covered by the Publication Scheme, consideration will be made as to whether this information should become part of the Publication Scheme. If a request to re-use information provided by another organisation is received, the Trust will advise requestors, and they will be directed to that organisation.

8.11 What about fees?

Under FOIA there are regulations which state that requests should be processed without any charge unless the cost involved exceeds £450 (NB: it is £600 for central government bodies). Should there be a need to charge fees in excess of £450 then the rate within FOIA is £25 per hour. Consideration should be given to the narrowing of the field in what information is required as it may significantly reduce cost for the requestor whilst achieving the same aim. Every opportunity to provide advice and assistance to the requestor should be undertaken in these circumstances. The Trust may choose to provide information which would exceed the appropriate limit on payment of a fee. There would be no statutory requirement to provide information as there is no obligation on the organisation to comply under section 12 of the Act. If the Trust offers to provide the information for a fee, then a fees notice should be issued to the applicant. A fees notice should be issued as soon as possible or at least within the 20 working day period. A fee cannot be charged where there is a statutory obligation to supply information in a particular format, such as in the Welsh language (Welsh Language Act 1993) or in Braille, large print or on an audio tape to make reasonable adjustments for disabled persons (Equality Act 2010). The cost of supplying information by the preferred means of communication however is chargeable.

There is no set rate for EIR however, it should be noted that a refusal to provide information under EIR as "manifestly unreasonable" (see the section on vexatious requests for further information on manifestly unreasonable requests). If the Trust does not receive payment within three months of issuing a fees notice, the Information Commissioner's Office would consider that the Trust is no longer obliged to respond to the request. It is also helpful to mention this deadline in the fees notice.

8.12   **How to record requests and diarise the response timeline**

Once the FCO receives notification of the request for the release of information under the FOIA / EIR, they are to annotate the tracker with the relevant details of the request and manage the process of the potential release of information under the FOIA / EIR. The Trust has, under the terms of the Act, 20 working days to comply with a lawful request to release information. To enable this to take place, the FCO or another person acting under the authority of the Director of Corporate Governance and Chief of Staff (except for the HOIG) is to:

- Annotate the date of request in the tracker.
- Diarise the **LATEST** date which the response is to be sent to the requestor by and annotate the tracker with the date
- **20** Working Days - Contact the Executive/Divisional Director who is responsible for holding the information and request that they **READ** and **RECORD** the request and prepare the information for release should it be lawful under the FOIA /EIR.
- **19** Working days – **RETRIEVE** the information requested and ascertain against the request, **REFERRING** to others as necessary:
- Does the request under FOIA meet the ability to be released without application of an exemption?
- Is the release only partially permissible and does a partial exemption need to be applied? if so, **REDACT** the information not to be released (see Section 8.13)
- If an exemption is to be applied is it Absolute, or Qualified?
- If Absolute proceed straight to the step below for review of the documentation, no Public Interest Test is required
- If Qualified, then a Public Interest Test is to be applied and conducted by the FCO (support may be sought from the HOIG if required).
- **10** Working Days – FCO to **REVIEW** the request and ensure that the Public Interest Test is fully completed, the review **MUST** analyse the Public Interest Test against the information requested.
- **10** Working Days – Brief the Communications team **AFTER** the SIRO has been briefed so that any press interest that highlight risk to the Trust (potential negative coverage) can be managed positively
- **7** Working Days - where the release of information is **RECOMMENDED** for approval all documentation and a draft covering letter is to be sent to the Director of Corporate Governance and Chief of Staff.
- **7** Working Days – where the release of information is recommended to be **WITHHELD**, all documentation is to be sent to the Director of Corporate Governance and Chief of Staff (See Section 8.14).

At this point the process will diverge, the first process in Section 8.12.1 describes the timeline and activity to be followed when information is to be released. The second process in Section 8.12.2 describes the timeline and process to be followed where information is to be withheld.

8.12.1 **Release of Information**
For the process aligned with the release of information, the following steps are to be followed:

- **7** Working days prior to the response due date, the FCO is to finalise and forward the draft letter to the Director of Corporate Governance and Chief of Staff which supports the release of Information, should it be lawful to do so (the template for this letter is at Appendix 5)
- **5** Working Days prior to the response due date, if complex and requested by the Director of Corporate Governance and Chief of Staff, the HOIG is to review the letter and supporting documentation to ensure that it is compliant with the FOIA / EIR.

However, if this is NOT requested:

- **5** working days prior to the response due date, the FCO is to present the final version of the supporting letter and information to be released under the FOIA/ EIR to the Director of Corporate Governance and Chief of Staff so that the letter may be approved.
- **1** working day prior to the response due date, the release letter notice and any releasable supporting evidence is to be dispatched to the requestor and the log annotated of its dispatch

8.12.2 **Withholding Information**

For the process aligned with the withholding of information, the following steps are to be followed:

- **7** Working days prior to the response due date, the FCO is to prepare a draft letter (**REPLY**) to the requestor which does NOT support the release of information, this is known as a "refusal notice". (The template for this letter is at Appendix 4)
- **5** Working Days prior to the response due date, if complex and requested by the Director of Corporate Governance and Chief of Staff, the HOIG is to review the letter and supporting documentation to ensure that it is compliant with the FOIA / EIR.
- **5** working days prior to the response due date, the FCO is to present the final version of the supporting letter and information to be **WITHELD** under the FOIA / EIR to the Director of Corporate Governance and Chief of Staff along with a written confirmation from FCO that the course of action prepared is compliant with legislation so that the supporting letter may be approved ready for final dispatch.
- **1** working day prior to the response due date, the supporting letter and information to be released under the FOIA / EIR is to be dispatched to the requestor and the log annotated of its dispatch.

Where information has been released as part of the process begun by the receipt of the request, the consideration of whether or not the information is likely to have been of general public interest will have been undertaken. In light of this, consideration will be given by the Trust to include the information for routine publication as a **RELEASE TO PUBLICATION SCHEME** process.

8.13 **What is redacting information?**

Information that can be released may be mixed with information which cannot be released under the FOIA and/or EIR, this means that information may need to be removed prior to the release of permitted information, this is known as redacting information. At present this is to be done manually, however, it is envisaged that the Trust may invest in redaction software so that risk of human error is reduced.

To ensure that the information to be released is compliant it will require the department to assign two personnel to the information process for release, this will reduce the risk of human error in the short term. For manual redaction it is the responsibility of the Functional Director to allocate this task to two members of their own team. It should be noted that the time taken to redact information is not in addition to the **20** working days required under the FOIA / EIR to respond to a request, the entire process including the final response must be completed within **20** working days. Advice and guidance are available from the HOIG on how to achieve this task.

8.14 **Refusing a request (Exemptions and Exceptions)**

From time to time, the Trust may refuse to release information, these are known as Exemptions under the FOIA and Exceptions under EIR. Under the FOIA these exemptions are defined in two types, they are:

ABSOLUTE – which do not require a test of prejudice or the balance of public interest to be in favour of non-disclosure. These are:

- **Section 21 –** information reasonably accessible to the applicant by other means
- **Section 23 –** Information supplied by, or relating to, bodies dealing with security matters
- **Section 32 –** Court records
- **Section 34 –** Parliamentary privilege
- **Section 36 –** Prejudice to the effective conduct of public affairs (only applies to House of Commons and House of Lords)
- **Section 40 –** Personal information (this is dealt with under GDPR as a Subject Access Request and requires the immediate involvement of the DPO)
- **Section 41 –** Information provided in confidence (but only if this would constitute an actionable breach of confidence – NDA's apply here)
- **Section 44 –** Prohibitions on disclosure

QUALIFIED – by the public interest test, which requires the public body to decide whether it is in the balance of public interest not to disclose information. The qualified exemptions are:
- **Section 22 –** Information intended for future publication (reports, brochures still being worked on but intended to be published in due course)
- **Section 24 –** National Security
- **Section 26 –** Defence
- **Section 27** – International Relations
- **Section 28 –** relations within the UK

- **Section 29 –** The economy
- **Section 30 –** Investigations and proceedings conducted by public authorities
- **Section 31** – Law enforcement
- **Section 33 –** Audit functions
- **Section 35 –** Formation of Government Policy etc
- **Section 36 –** Prejudice to effective conduct of public affairs
- **Section 37 –** Communications with Her Majesty etc and national honours
- **Section 38 –** Health and Safety
- **Section 39 –** Environmental Information
- **Section 42 –** Legal Professional privilege (legal advice provided to LSHW for its business activity)
- **Section 43** – Commercial Interests (this is NOT NDA activity as that is an absolute under Section 41, but rather details of relationships where commercial information may be secret)

A template has been devised in the same manner as the DPIA which is in place to identify risk under GDPR. The template for Qualified Exemptions is held by the FCO. The HOIG is available for advice and guidance throughout the Public Interest Test, on completion of the template for each individual case, and will provide advice and guidance as to whether information may be released or withheld under the application of the exemption/exception.

This may in cases of complexity involve the procurement of legal advice where applicable. The final decision whether to release or withhold information will be made by the CEO/Director of Corporate Governance and Chief of Staff based on the advice they receive from appropriately qualified members of Staff and/or legal support.

This approach will ensure that compliance by design is a feature of the consideration as to whether information is able to be released or not under the FOIA.

The EIR does not have any Absolute Exceptions, they are all subject to the Public Interest Test. EIR Exceptions are:

- **Regulation 12(4)(a)** – Does not hold that information when an applicant's request is received
- **Regulation 12(4)(b)** – Is manifestly unreasonable (this equates to a vexatious request under FOIA)
- **Regulation 12(4)(c)** – is formulated in too general a manner (provided that the applicant has been given assistance with a view to re-framing the request)
- **Regulation 12(4)(d)** – relates to unfinished data or incomplete documents
- **Regulation 12(4)(e)** – would involve the disclosure of internal communications
- And if disclosure would adversely affect:
- **Regulation 12(5)(a)** – international relations, defence, national security or public safety
- **Regulation 12(5)(b)** – the course of justice, fair trial, conduct of a criminal or disciplinary enquiry
- **Regulation 12(5)(c)** – Intellectual Property rights
- **Regulation 12(5)(d)** – Confidentiality of Public Authority proceedings when covered by law

- **Regulation 12(5)(e)** – Confidentiality of commercial or industrial information, when protected by law to cover legitimate economic interest
- **Regulation 12(5)(f)** – interests of the person who provided the information
- **Regulation 12(5)(g)** – Protection of the environment

It is to be noted that if the information is regarding emissions, then Regulation 12(5)(d)-(g) cannot be used

- **Regulation 13** – Personal Data (this is covered under GDPR and is to be treated as a SAR).

The Public Interest Template is to be used to form a logical approach as to whether information can be released or withheld under EIR. The HOIG is available for advice and guidance throughout the Public Interest Test process. On completion of the template for each individual case, he will provide advice and guidance to the Senior Leadership Team as to whether information may be released or withheld under the application of the exception.

From time-to-time where the situation is complex, legal advice may be procured. The final decision whether to release or withhold information will depend on this advice will be made by the CEO/Executive Director of Governance not the FCO and/or HOIG. This approach will ensure that compliance by design is a feature of the consideration as to whether information is able to be released or not under the Regulations.

8.15 **What does vexatious mean?**

On occasion the Trust may receive repeat requests for the same information from the same requestor or a "vexatious" request from a requestor. A vexatious request has no definition in the FOIA / EIR. However, by way of explanation, the Oxford English Dictionary defines the word vexatious as:

> *ADJECTIVE:*
> *Causing or tending to cause annoyance, frustration, or worry.*
> *'the vexatious questions posed by software copyrights'*
>
> *More example sentences/synonyms:*
> > *Law Denoting an action or the bringer of an action that is brought without sufficient grounds for winning, purely to cause annoyance to the defendant. 'a frivolous or vexatious litigant'*

Should the Staff member consider that the request may be vexatious, it is mandatory for he/her to request the support of the HOIG without delay and inform their line manager. This will ensure that the Trust's response is compliant with the FOIA.

Under the EIR the term "***vexatious"*** is replaced by the request being "***manifestly unreasonable"***, it is to be treated exactly the same way as a vexatious request under FOIA with the HOIG being involved at the outset of the receipt of the request.

8.16   **What does round robin mean?**

From time to time, the Trust may receive what is known as a round robin request, this is a request sent to public authorities that is generic in nature. If such a request is received then the FCO is to be contacted so that a compliant response can be formulated. The flow charts at Appendices 1 and 2 may assist those who are preparing information for release or non-release under EIR and the FOIA in ensuring that the correct process is followed.

9.   **Complaints**

9.1   The FOIA Section 45 Code of Practice and ICO Guidance sets out advice for Public Authorities on how they should handle complaints related to the FOIA. This code of practice also applies to the EIR.

9.2   Any written correspondence where the requestor says they are unhappy with the Trust's handling of their request for information or any communication that the Trust is not meeting our obligations as set out in our publication scheme is to be treated as a complaint.

9.3   All complaints will be dealt in the same manner and using the same procedures as the Trust's Handling Concerns Policy. The policy sets out target times for complaint resolution and are included in the Publication Scheme.

9.4   The HOIG and SIRO are to be involved at the very outset of any complaint that involves the FOIA or EIR.

9.5   The Code of Practice covers the additional information that the Trust will need to consider when refusing a request for information. The document "Refusing a request – writing a refusal notice" contains further information and can be accessed here

9.6   A template letter format for a formal refusal notice is contained at Appendix 4, this is purely a template only and each circumstance is different, therefore, the HOIG is to be involved in ensuring that from a compliance and quality perspective that the letter is reviewed prior to final signatory by the Director of Governance and Chief of Staff.

9.7   Section 17(7) of the FOIA requires the Trust to give requestors details of our complaints procedures, including how to make a complaint and the right to complain to the Information Commissioners office under Section 50 of the FOIA.

9.8   It should be noted that although there is no obligation on the Trust to do so, but it may help to resolve matters for the requestor if possible so that a complaint can be avoided.

9.9   The Trust will record all complaints in line with its Handling Concerns Policy. The Trust reviews its Handling Concerns Policy regularly as part of its Policy Review Cycle and in accordance with the Trust's Policy and Procedure for the Management of Trust wide Policies and Other Written Control Documents. The QSPC approve all changes to the Policy and also receives assurance that such reviews take place.

9.10   In cases where the Trust has not followed the correct procedures, it is good practice to make a formal apology to the requestor and take remedial measures to ensure that this does not re-occur.

10.   Internal Review

10.1   Where a requestor submits a request to carry out an internal review of a response made on behalf of the Trust under the FOIA this will be undertaken by the HOIG unless he has been involved in the original request in which case the Director of Corporate Governance and Chief of Staff will nominate another officer to undertake the process.

10.2   The internal review must be carried out in accordance with the Section 45 - Code of Practice – request handling.

10.3   When considering an appeal, all documentation in relation to the original request must be obtained and the process should be considered as a whole, ensuring that the specifics of complaint are thoroughly considered. An appeal must be answered in a timely manner and usually take no more than twenty working days, or 40 days in exceptional circumstances (e.g. the review involves complex analysis).

10.4   Where it is found that information was said not to be held and this was in fact held at the time of the request, or information was withheld and it was found that this should have been disclosed, this should be released within the response to the appeal.

10.5   If information was not held at the time of the request but is subsequently held by the Trust, out of courtesy this should be indicated to the requestor (unless the obligation to confirm or deny is set aside as defined by the FOIA / EIR) and either disclosed or an exemption applied.

10.6   The response to an appeal must inform the requestor that if they are unhappy about the outcome of that appeal they may complain to the ICO. The contact details of the ICO must be provided.

10.7   An appeal outcome must be by letter but may be sent by e mail. A copy must be kept on file.

11. Appendix 1 – FOI Act Processes

- Must be in writing (inc email, letter or via Trust social Media sites).
- Must include the requestor's name.
- Must include an address (postal or email).
- Describe the information requested.

Is the request applicable to the Trust?

Yes – follow the next step of the process

No – Use Appendix 9 to respond

Step 1 — FCO Officer will acknowledge the request via email or letter within **2** working days, log the file onto the FOI Spreadsheet and give it a unique ref number.

Step 2 — FCO Officer will email the FOI request to the Executive Director who has direct responsibility for the information being requested (APPENDIX 10 - Executive Director Responsibilities Portfolio)).
The Executive Director/Nominated Deputy will forward to the relevant person within their dept to gather the information, requesting this to be returned within **10** working days (copy in the FCO).
If the information is not returned within **10** days, the Director of Corporate Governance and Chief of Staff will escalate it to the relevant Executive Director.

Step 3 — Once information is returned to the Executive, it is be reviewed and forwarded to the FCO who will draft a Trust response.

Step 4 — FCO to draft response sent to the Director of Corporate Governance and Chief of Staff for approval.

Step 5 — Draft Trust response approved by Director of Corporate Governance and Chief of Staff

Yes – follow the next step of the process

No – return draft response to Executive Director for further action- repeat step 2 & 3

Step 6 — FCO to send the final approved response to the requestor (PDF Version).

Step 7 — Update Trust records adding the redacted response to the Trust Disclosure Log under the Publication Scheme.

12. Appendix 2 - The cost of responding / applying any exemptions
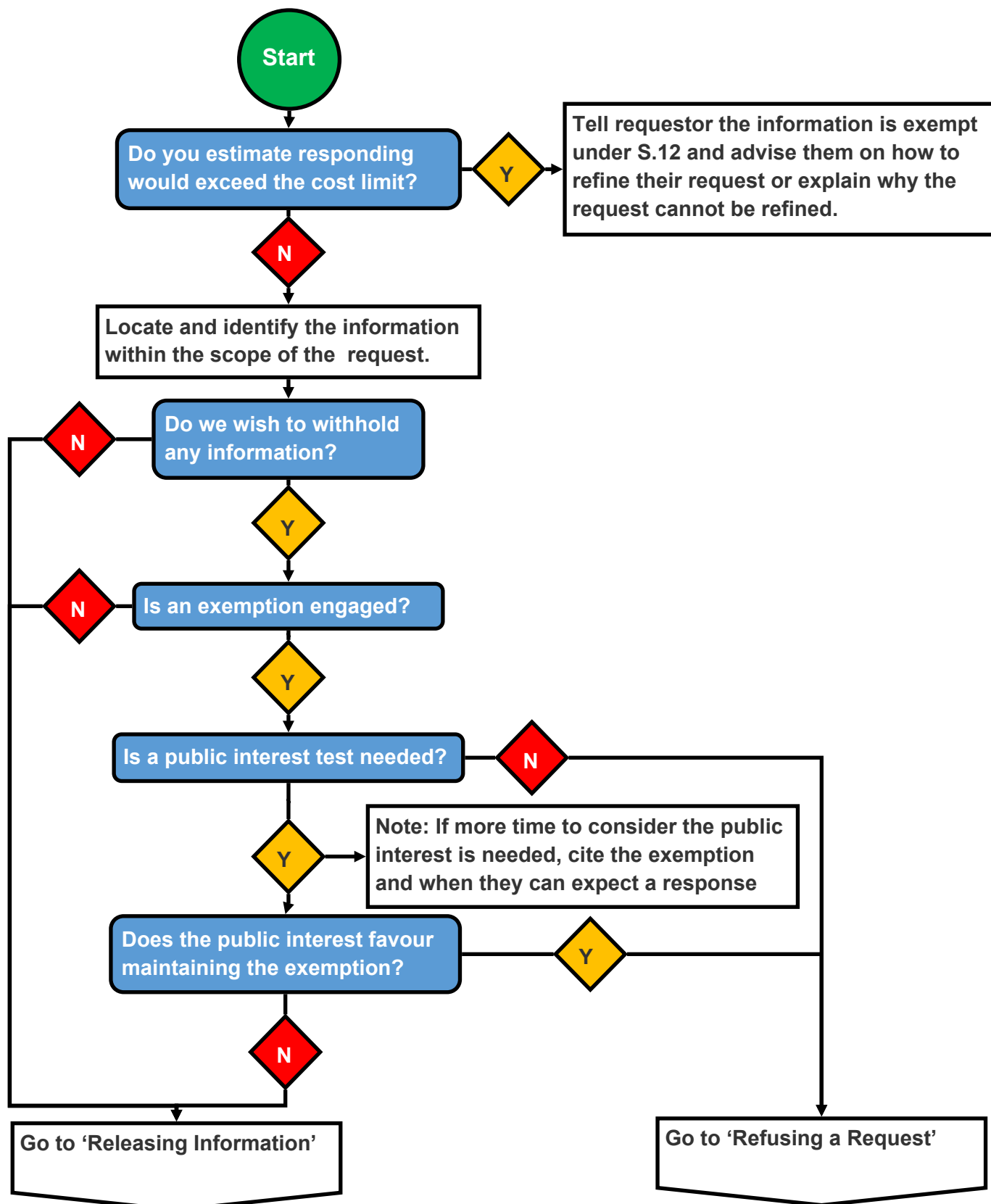
13. Appendix 3 - Releasing information

```
                    ( Start )
                        │
                        ▼
          ┌──────────────────────┐        ┌─────┐      ┌──────────────────────┐
          │ Do you wish to charge│───────▶│  Y  │─────▶│ Issue a fees notice  │
          │ for the information? │        └─────┘      │ and receive fee      │
          └──────────────────────┘                     └──────────────────────┘
                        │                                          │
                     ┌─────┐                                       │
                     │  N  │                                       │
                     └─────┘                                       │
                        │◀────────────────────────────────────────┘
                        ▼
          ┌──────────────────────┐
          │ Extract the information│
          └──────────────────────┘
                        │
                        ▼
          ┌──────────────────────┐        ┌─────┐      ┌──────────────────────┐
          │ Has the requestor    │───────▶│  Y  │─────▶│ Is it reasonably     │
          │ asked for the        │        └─────┘      │ practical to comply  │
          │ information to be     │                     │ with this request    │
          │ provided in a specific│                     └──────────────────────┘
          │ format?              │                          │              │
          └──────────────────────┘                       ┌─────┐        ┌─────┐
                        │                                 │  Y  │        │  N  │
                     ┌─────┐                              └─────┘        └─────┘
                     │  N  │                                 │              │
                     └─────┘                                 │              ▼
                        │                                    │   ┌──────────────────────┐
                        │          ┌──────────────┐          │   │ Explain to requestor │
                        └─────────▶│ Disclose the │◀─────────┘   │ why it is not        │
                                   │ information  │              │ reasonably practicable│
                                   └──────────────┘              │ to provide the       │
                                                                 │ information in the   │
                                                                 │ format requested     │
                                                                 └──────────────────────┘
```

14.   Appendix 4 - Refusing a Request

Start

Exclusion subject to public interest test?

v

Exclusion from the duty to confirm or deny?

N

Does the public interest test favour refusing to confirm or deny that the exempt information is held?

N

Y

Is all the information exempt?

N

Issue refusal notice explaining why you are neither confirming nor denying that the information is held. Inform the requestor about their right to internal review and to complain to the

Y

Redact documents and disclose; OR Collate the non-exempt information into a separate document and disclose

N

v

Issue refusal notice specifying which exemptions are being relied on Explain why the exemptions apply and, where relevant, why the public interest favours non-disclosure. Inform the requestor about their right to internal review and to complain to the ICO

15. Appendix 5 – FOI Act VUHNST final response template

Dear [insert name]

Request under Freedom of Information Act 2000

Thank you for your request for information in which we received on [insert date].

Your Request [insert full request details below]

Velindre University Trust response is shown below: [insert full trust response below including exceptions if required]

I trust this answers your request for information, however, should you not be satisfied with the information supplied or the process of supplying it, you have a right to complain and request a review. You should forward your complaint to:-

    Mr Ian Bevan via FOI.VUNHST@wales.nhs.uk
    HOIG
    Velindre University NHS Trust
    2, Charnwood Court
    Heol Billingsley
    Parc Nantgarw
    Cardiff / Caerdydd
    CF15 7QZ
    Tel / Ffon - 029 20196161

Should you wish to take your complaint further, if you are still unhappy with the decision after review, you can contact the:-
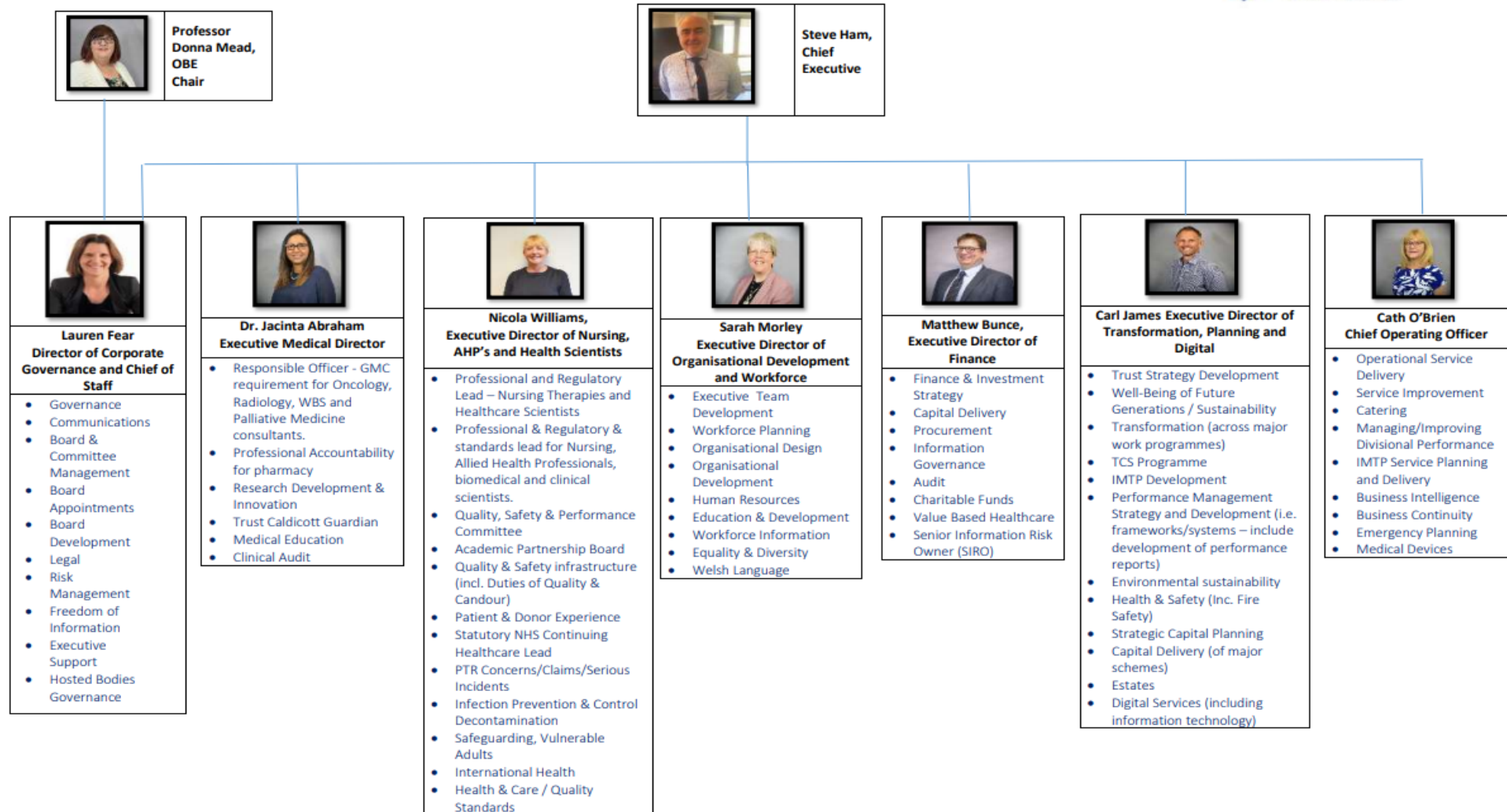
    Information Commissioner's Office - Wales
    2nd Floor,
    Churchill House,
    Churchill Way,
    Cardiff,
    CF10 2HH
    Telephone: 0330 414 6421
    email: wales@ico.org.uk

Yours sincerely

Lauren Fear
Director of Corporate Governance and Chief of Staff
Velindre University NHS Trust
2 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

16. Appendix 6 – FOI Act VUHNST Acknowledgement letter/email template.

Dear [Insert name]

Thank you for your request for the following information, which we received on [insert date]

Your Request.
[insert full request details]

We are currently processing your request and will write to you shortly.

We aim to respond to requests for information within 20 working days of receiving the request.

If we are unable to respond in this time, we will contact you accordingly.

In the meantime if you have any queries then please do not hesitate to contact us.

Yours sincerely

17.   Appendix 7 – FOI Act VUHNST email to divisions to gather data template.

Ref number – [insert FOI ref number]

Dear (insert name(s),

Please note this FOI request, which is formulated correctly under Section 8 of FOIA 2000.

As the Executive/Divisionall leads (delete the element which does NOT apply), could I ask that you send this request to the correct recipients within your departments to permit a response by the mandatory timeframe which is 20 working days from the date of request. The timeline from departments via Executive/Divisional leads is as follows:

Date of receipt: **(insert Date)**

Divisional response deadline – 10 working days: **(Insert Date)**

Approval Deadline - 15 Working days: **(Insert Date)**

Legislative Deadline – 20 working days from date of request: **(Insert Date)**

I know that it may seem that 10 working days is not a lot of time, but this process allows us as a Trust undertake any internal clarification work/balancing tests.

Please note that if information is not held, then the lawful response is "*information not held*" and we do not need to consider it any further. If information is held then we must under legislation provide it unless there would "*harm*" to the public interest or if the exemption is an absolute exemption (e.g. Personal Data).   Withholding information may be a consideration by Executive leads, if so then the Trust must undertake a balancing test. Please do not hesitate to contact me if this is a consideration.

Please see the request below (re-send the full request to avoid any ambiguity):

Kind regards

A N Other
FCO

18.   Appendix 8 – FOI Act VUHNST Re-Use response template

Dear [insert name/s]

Re: *Re-Use Request*

Following your request for the re-use of the information supplied under Freedom of Information:

Re-Use Request

- *[insert full request details]*

Purpose of Re-Use

- *[insert full request details]*

Velindre University NHS Trust Response

Velindre NHS Trust ('The Trust') grants permission to re-use the information provided via provisions within the Freedom of Information Act 2000, its website or otherwise supplied by The Trust with a statement that it may be re-used ('the material') on the following terms and conditions:

- You must reproduce the material accurately. In cases where you want to reproduce material that has been superseded you should make it clear that a more up to date version is available
- You must identify the source of the material and feature the following copyright statement if you publish the material:

"© Velindre University NHS Trust material is reproduced with the permission of Velindre University NHS Trust"

- You must not use the material for the principal purpose of advertising or promoting a particular product or service, or in a way which could imply endorsement by The Trust or generally in a manner which is likely to mislead others
- You must not reproduce our logos
- You must send us, if we ask for it, a complimentary copy and/or subscription of any product or publication that you produce that includes the material. The Trust shall notify you of the address to which it should be sent
- You must ensure that you comply with the terms of associated Data Protection Law
- You must not use the material in ways which are knowingly or potentially libellous or slanderous of individuals, companies or organisations
- You must not use the material for unlawful or illegal purposes.

Disclaimer
Your use of the material under this licence is entirely at your own risk. The Trust makes no warranty, representation or guarantee that the material is error free.

Governing law

This permission is made under the laws of England and Wales and comes under the exclusive jurisdiction of the courts of England and Wales.

I trust this answers your request for re-use, however, should you not be satisfied you have a right to complain and request a review. You should forward your complaint to:-

Mr Ian Bevan via FOI.VUNHST@wales.nhs.uk
HOIG
Velindre University NHS Trust
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff / Caerdydd
CF15 7QZ
Tel / Ffon - 029 20196161

Should you wish to take your complaint further, if you are still unhappy with the decision after review, you can contact the:-

Information Commissioner's Office - Wales
2nd Floor,
Churchill House,
Churchill Way,
Cardiff,
CF10 2HH
Telephone: 0330 414 6421
email: wales@ico.org.uk

Yours sincerely

Lauren Fear
Director of Corporate Governance and Chief of Staff
Velindre University NHS Trust
2 Charnwood Court
Heol Billingsley
Parc nantgarw
Cardiff
CF15 7QZ

19. Appendix 9 – FOI Act VUHNST - Not Applicable to the Trust response template

Dear [insert name/s]

Re : Information Requested Under Freedom of Information Act 2000 – Ref number – [insert FOI ref number]

Thank you for your Freedom of Information request in relation to *[insert full request details]* within Velindre, which we received on the [insert date].

Due to the nature of the services provided by the Trust, as explained below, we do not hold information relating to your request.

Velindre University NHS Trust is a nationally recognised specialist centre of excellence for the provision of non-surgical oncology including radiotherapy and chemotherapy; specialist palliative care; blood transfusion; specialist immunohaematology; antenatal blood testing reference work; and transplant immunology. The Trust provides a range of specialist non-surgical oncology services to approximately 1.5 million people of south east Wales, and to the whole of Wales for some services, working in partnership with the hospitals managed by the Local Health Boards. The Welsh Blood Service collects processes and delivers blood and blood products to hospitals across Wales.

Please follow the link below to the Trusts internet site should you wish to find out more information about our services.

https://velindre.nhs.wales/

Should you require any further assistance, please do not hesitate to contact us at the above address.

Should you not be satisfied with the process followed after receipt of this response, you have a right to complain and request a review.

You should forward your complaint to:-

I trust this answers your request in full, however should you not be satisfied with the information supplied or the process of supplying it, you have a right to complain and request a review. You should forward your complaint to:-

> Mr Ian Bevan via FOI.VUNHST@wales.nhs.uk
> HOIG
> Velindre University NHS Trust
> 2, Charnwood Court
> Heol Billingsley
> Parc Nantgarw
> Cardiff / Caerdydd
> CF15 7QZ
> Tel / Ffon - 029 20196161

Should you wish to take your complaint further, if you are still unhappy with the decision after review, you can contact the:-

Information Commissioner's Office - Wales
2nd Floor,
Churchill House,
Churchill Way,
Cardiff,
CF10 2HH
Telephone: 0330 414 6421
email: wales@ico.org.uk

Yours sincerely

Lauren Fear
Director of Corporate Governance and Chief of Staff
Velindre University NHS Trust
2 Charnwood Court
Heol Billingsley
Parc nantgarw
Cardiff
CF15 7QZ

20. Appendix 10 - Executive Director Portfolio Responsibilities

VELINDRE UNIVERSITY NHS TRUST ORGANISATIONAL CHART

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

Professor Donna Mead, OBE Chair

Steve Ham, Chief Executive

Lauren Fear Director of Corporate Governance and Chief of Staff
- Governance
- Communications
- Board & Committee Management
- Board Appointments
- Board Development
- Legal
- Risk Management
- Freedom of Information
- Executive Support
- Hosted Bodies Governance

Dr. Jacinta Abraham Executive Medical Director
- Responsible Officer - GMC requirement for Oncology, Radiology, WBS and Palliative Medicine consultants.
- Professional Accountability for pharmacy
- Research Development & Innovation
- Trust Caldicott Guardian
- Medical Education
- Clinical Audit

Nicola Williams, Executive Director of Nursing, AHP's and Health Scientists
- Professional and Regulatory Lead – Nursing Therapies and Healthcare Scientists
- Professional & Regulatory & standards lead for Nursing, Allied Health Professionals, biomedical and clinical scientists.
- Quality, Safety & Performance Committee
- Academic Partnership Board
- Quality & Safety infrastructure (incl. Duties of Quality & Candour)
- Patient & Donor Experience
- Statutory NHS Continuing Healthcare Lead
- PTR Concerns/Claims/Serious Incidents
- Infection Prevention & Control Decontamination
- Safeguarding, Vulnerable Adults
- International Health
- Health & Care / Quality Standards

Sarah Morley Executive Director of Organisational Development and Workforce
- Executive Team Development
- Workforce Planning
- Organisational Design
- Organisational Development
- Human Resources
- Education & Development
- Workforce Information
- Equality & Diversity
- Welsh Language

Matthew Bunce, Executive Director of Finance
- Finance & Investment Strategy
- Capital Delivery
- Procurement
- Information Governance
- Audit
- Charitable Funds
- Value Based Healthcare
- Senior Information Risk Owner (SIRO)

Carl James Executive Director of Transformation, Planning and Digital
- Trust Strategy Development
- Well-Being of Future Generations / Sustainability
- Transformation (across major work programmes)
- TCS Programme
- IMTP Development
- Performance Management Strategy and Development (i.e. frameworks/systems – include development of performance reports)
- Environmental sustainability
- Health & Safety (Inc. Fire Safety)
- Strategic Capital Planning
- Capital Delivery (of major schemes)
- Estates
- Digital Services (including information technology)

Cath O'Brien Chief Operating Officer
- Operational Service Delivery
- Service Improvement
- Catering
- Managing/Improving Divisional Performance
- IMTP Service Planning and Delivery
- Business Intelligence
- Business Continuity
- Emergency Planning
- Medical Devices

QUALITY, SAFETY & PERFORMANCE COMMITTEE

QUALITY, SAFETY & PERFORMANCE COMMITTEE CYCLE OF BUSINESS

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR APPROVAL

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

1. SITUATION

The purpose of this paper is to seek **APPROVAL** by the Quality, Safety & Performance Committee for the proposed amendments to the Committee Cycle of Business.

2. BACKGROUND

The formal, annual review of the Quality, Safety & Performance Committee Cycle of Business is not due until the end of this financial year, i.e. March 2024. The full review will encompass a comprehensive engagement process with each of the respective executive leads across the Committee remit, together with the executive lead for the Committee and the Committee chair.

This review of the Quality, Safety & Performance Committee Cycle of Business is an interim review to record the accuracy of some nominal changes for reporting and approval by the Committee.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Review

The purpose of this review is to serve a number of key factors:

i) to formally document the revised Trust Performance Management Framework and how this reports to the Committee
ii) to amend the nomenclature of a number of items of business reported to the Committee for completeness and accuracy
iii) to update the named authors and executive leads for a number of various items of business reported to the Committee to reflect recent staffing changes
iv) to remove the Quality & Safety Improvement Tracker as this is now incorporated into the Integrated Quality & Safety Group Report.

3.2 Proposed amendments to the Cycle of Business

The interim review of the Quality, Safety & Performance Committee Cycle of Business and the resulting proposed amendments have been incorporated into the work programme (*Appendix 1)*. For ease of reference, the proposed changes are summarised below:

3.2.1 Nomenclature:

Previous nomenclature	Revised nomenclature
Welsh Blood Service Performance Management Framework (PMF) Report Velindre Cancer Service Performance Management Framework (PMF) Report Workforce & Organisational Development Performance Report/Finance Report	Performance Management Framework Report and Supporting Analysis: • Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis • Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis • Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis
Workforce & Organisational Development Performance Report/Finance Report	Workforce Supply and Shape & Associated Finance Risks
Putting Things Right Report (inc. Incidents, SIs, Complaints, Compliments, Claims & Patient Experience)	Quality and Safety Quarterly Report (inc. Putting Things Right)
Private Patient Improvement Plan	Private Patient Service Improvement Group Highlight Report & Improvement Plan Update

3.2.2 Executive Lead/Author

Item of Business	Exec Lead	Author
Performance Management Framework Report and Supporting Analysis	✓	✓
Medical Devices Report		✓
Quality and Safety Quarterly Report (inc. Putting Things Right)		✓
Value Based Healthcare		✓
Private Patient Service Improvement Group Highlight Report & Improvement Plan Update		✓
Medical Examiner's Service & Mortality Framework Report		✓
Business Continuity		✓
IMTP Quarterly Actions Progress		✓
Trust Clinical Audit Annual Report		✓
Trust Clinical Audit Plan		✓
Safeguarding & Vulnerable Adults Management Group Annual Report		✓
Putting Things Right Annual Report		✓

Health & Safety Annual Report		✓
Patient & Donor Experience Annual Report		✓
Clinical & Scientific Strategic Board Highlight Report		✓
Freedom of Information Requests (IG & IM&T)		✓
Trust-wide policies and procedures compliance report		✓
Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)	✓	
Implementation of Duty of Quality Update (NWSSP)	✓	✓
Surgical Materials Testing Laboratory (SMTL) Annual Report (NWSSP)	✓	✓
Medical Examiner Service (MES) Annual Report (NWSSP)	✓	✓
Duty of Quality Report (NWSSP)	✓	

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

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5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **APPROVE** the proposed revisions to the Quality, Safety & Performance Committee Cycle of Business outlined in section **3.2** and *Appendix 1*.

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
DONOR / PATIENT / STAFF STORY											
Welsh Blood Service Donor Story	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Three times a year	✓			✓		✓	
Velindre Cancer Service Patient Story	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Three times a year		✓			✓		✓
Staff Story	Executive Director of Organisational Development & Workforce (Sarah Morley)	Variable	Public	Annual			✓				
DIVISIONAL / DIRECTORATE REPORTS											
Welsh Blood Service Quality & Safety Divisional Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Three times a year	✓			✓		✓	
Velindre Cancer Service Quality & Safety Divisional Report	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Three times a year		✓			✓		✓
Digital Service Operational Report	Executive Director of Strategic Transformation, Planning & Digital (Carl James)	Chief Digital Officer (Carl Taylor)	Public	6-monthly		✓			✓		
PERFORMANCE REPORTS											
Performance Management Framework (PMF) Report and Supporting Analysis: • Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis • Blood and Transplant Services – PMF Supporting KPI	Chief Operating Officer (Cath O'Brien), Executive Director of Strategic Transformation, Planning & Digital (Carl James), Executive Director OD & Workforce (Sarah Morley), Executive Director of Finance (Matthew Bunce)	Interim Director of Velindre Cancer Service (Rachel Hennessy), Director of Welsh Blood Service (Alan Prosser), Head of Strategic Planning and Performance (Peter Gorin)	Public	Each Meeting	✓	✓	(by exception)	✓	✓	✓	✓

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

Key: ☐ = Annual Report
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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Data Graphics and Analysis • Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis											
Workforce Supply and Shape & Associated Finance Risks	Executive Director of OD & Workforce (Sarah Morley), Executive Finance Director (Matthew Bunce)	Deputy Director of OD & Workforce (Susan Thomas), Deputy Director of Finance (Chris Moreton)	Public	Each Meeting	✓	✓	(by exception)	✓	✓	✓	✓
Finance Report	Executive Director of Finance (Matthew Bunce)	Head of Financial Reporting (Steve Coliandris)	Public	Each Meeting	✓	✓	✓	✓	✓	✓	✓
MEDICAL & RESEARCH DEVELOPMENT											
Assurance Report Medicines Management Group (including Medical Gases & CDs)	Executive Medical Director (Jacinta Abraham)	Head of SACT and Medicines Management (Bethan Tranter)	Public	Bi Annually	✓			✓			✓
RD&I Sub Committee Highlight Report	Executive Medical Director (Dr Jacinta Abraham)	Head of Research & Development (Sarah Townsend)	Public	Quarterly		✓		✓		✓	✓
QUALITY, SAFETY & ASSURANCE											
Integrated Quality & Safety Group Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Interim Deputy Director Nursing, Quality & Patient Experience (Tina Jenkins)/ Interim Corporate Head of Quality and Safety (Zoe Gibson)	Public	Each meeting from May 2023	~	✓	✓	✓	✓	✓	✓
Trust Infection Prevention & Control Management Group Highlight Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention & Control (Hayley Jeffreys)	Public	Quarterly	✓			✓		✓	✓
Safeguarding & Vulnerable Adults Management Group Highlight Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Persons (Fiona Davies)	Public	Bi Annually (or by exception)		✓			✓		

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

Key: □ = Annual Report
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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Bi Annually (or by exception)		✓			✓		
Medical Devices Report	Chief Operating Officer (Cath O'Brien)	Head of Engineering, Radiotherapy Physics, VCC (Tim Register) Medical Devices Officer, VCC (Jignesh Raiyani) Head of Quality Assurance and Regulatory Compliance, WBS (Peter Richardson)	Public	Bi Annually			✓ (Annual)			✓	
Infected Blood Inquiry Proceedings	Chief Operating Officer (Cath O'Brien)	Business Support Officer (Suzanne Jones)	Public & Private	Bi Annually (or by exception)		✓			✓		
Quality and Safety Quarterly Report (inc. Putting Things Right)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Interim Corporate Head of Quality and Safety (Zoe Gibson)	Public	Quarterly		✓		✓	✓	✓	
Quality & Safety Framework Update	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Public	Bi-Annually		✓			✓		
Value based Healthcare Programme Update	Executive Director of Finance (Matthew Bunce)	Head of Value Based Healthcare (Gwawr Evans)	Public	Bi-Annually	✓			✓			✓
Trust Culture Feedback	Executive Director of Organisational Development & Workforce (Sarah Morley)	Head of Organisational Development (Claire Budgen)	Public	Bi-Annually			✓			✓	
Private Patient Service Improvement Group Highlight Report & Improvement Plan Update	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Directorate Support Officer, CSMO (Gareth Mitchell)	Public	Bi-Annually		✓			✓		

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Radiation Protection and Medical Exposures Strategic Group Highlight Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually		✓			✓		
Medical Examiner's Service & Mortality Framework Report	Executive Medical Director (Jacinta Abraham)	Head of Nursing & Integrated Care (Viv Cooper)	Public	Bi Annually	✓			✓			✓
Patient Nosocomial Transmission Review Update	Executive Director of Nursing, Allied Health Professionals & Health Science (Nicola Williams)	Interim Deputy Director Nursing, Quality & Patient Experience (Tina Jenkins	Public	Quarterly	✓		✓		✓		✓
STRATEGIC TRANSFORMATION, PLANNING & ESTATES											
Highlight Report from the Trust Estates Assurance Group	Executive Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Estates, Environment & Capital Development (Jason Hoskins)	Public	Bi-Annually	✓			✓			
IMTP Quarterly Actions Progress	Executive Director of Strategic Transformation, Planning and Digital (Carl James)	Deputy Director of Planning and Performance (Phil Hodson)	Public	Quarterly	✓	✓		✓		✓	✓
Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report	Executive Director of Strategic Transformation, Planning & Digital (Carl James)	Business Support Officer (Jessica Corrigan)	Public & Private	Each meeting	✓	✓	✓	✓	✓	✓	✓
WORKFORCE											
Anti-Racist Wales Action Plan	Executive Director of Organisational Development & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Bi-annually		✓			✓		

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Gender Pay Gap Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually			✓ Annual from July 23				
Annual Equality, Diversity & Inclusion Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually			✓ Annual from July 23				
ANNUAL REPORTS											
Business Continuity & Emergency Planning	Chief Operating Officer (Cath O'Brien)	Head of Validation & Risk Management (Laurie Thomas)	Public	Annually			✓ (Annual)				
Medical Education Governance Framework	Executive Medical Director (Dr Jacinta Abraham)	Associate Medical Director of Medical Education (Louise Hanna)	Public	Annually				✓			
Trust Clinical Audit Annual Report	Executive Medical Director (Dr Jacinta Abraham)	Clinical Audit Manager (Sara Walters), Clinical Lead for Audit and Quality Improvement (Catherine Pembroke), Medical Director, WBS (Edwin Massey), Interim Corporate Head of Quality and Safety (Zoe Gibson), Executive Medical Director (Dr Jacinta Abraham)	Public	Annually			✓				
Trust Clinical Audit Plan	Executive Medical Director (Dr Jacinta Abraham)	Sara Walters, Clinical Audit Manager VCC Interim Corporate Head of Quality and Safety (Zoe Gibson)	Public	Annually		✓					
Health Technology Wales (HTW) Annual Report		Director, HTW (Susan Myles)	Public	Annually					✓		
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Nursing for Professional Standards & Digital (Anna Harries)	Public	Annually		✓					

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Annual Quality Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Quality & Safety (TBC)	Public	Annually			✓				
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention Control (Hayley Jeffreys)	Public	Annually			✓				
Safeguarding & Vulnerable Adults Management Group Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Groups (Fiona Davies)	Public	Annually			✓				
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality Safety & Assurance Manager (Jade Coleman)	Public	Annually			✓				
Annual Performance Report	Executive Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Planning and Performance (Phil Hodson)	Public	Annually			✓				
Annual Estates Report	Executive Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually			✓				
Annual Sustainability Report (inc. decarbonisation)	Executive Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually			✓				
Health & Safety Annual Report	Executive Director of Strategic Transformation,	Head of Health & Safety (TBC)	Public	Annually			✓				

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
	Planning, Performance and Estates (Carl James)										
Local Partnership Forum Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually			✓				
Annual Report Workforce & Organisational Development (inc. Workforce Planning)	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually			✓				
Welsh Language Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually			✓				
Professional Registration/Revalidation	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Consultant Clinical Oncologist (Mick Button) / Head of Nursing for Professional Standards and Digital(Anna Harries)	Public	Annually			✓				
Patient & Donor Experience Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality Safety & Assurance Manager (Jade Coleman)	Public	Annually			✓				
Annual progress report – Cyber Security Strategic Plan	Director of Transformation, Planning & Digital (Carl James)	Chief Digital Officer (Carl Taylor)	Private	Annually			✓				
Annual Information Governance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public	Annually			✓				
Risk Annual Report	Director of Corporate Governance and Chief of Staff (Lauren Fear)	(Melanie Findlay)	Public	Annually			✓				
Clinical & Scientific Strategic Board Highlight Report	Executive Medical Director (Jacinta Abraham)/	Clinical & Scientific Strategy Lead (Joanna Doyle)	Public	Bi-annually							

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Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)			(from July 2023)							
Communications Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Assistant Director of Communications (Non Gwilym)	Public	Annually			✓				
Annual Risk Summary	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Annually			✓				
Freedom of Information Requests Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Freedom of Information and Compliance Officer (Fay Sparrow)	Public	Annually			✓				
Information Governance Assurance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public	Quarterly		✓		✓		✓	✓
PROFESSIONAL REGULATION											
Professional Nursing Update Report	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Nursing, Professional Standards & Digital (Anna Harries)	Public	Bi-Annually	✓			✓			✓
INTEGRATED GOVERNANCE											
Health & Care Standards / Quality Standards	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Quality, Safety & Assurance (TBC)	Public	Bi Annually		✓			✓		
Trust Risk Register (Board level reporting threshold & TAF)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Each meeting	✓	✓	✓	✓	✓	✓	✓
Freedom of Information Requests (IG & IM&T)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Freedom of Information and Compliance Officer (Fay Sparrow)	Public	Bi Annually		✓			✓		

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Trust-wide policies and procedures for approval	Executive Policy Lead (various)	Policy Lead (various)	Public	Each meeting (as required)	✓	✓	✓	✓	✓	✓	✓
Trust-wide policies and procedures compliance report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Freedom of Information and Compliance Officer (Fay Sparrow)	Public	Every other meeting	✓		✓		✓		✓
COMMITTEE EFFECTIVENESS											
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓						✓
Committee Cycle of Business	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓						✓
Committee Effectiveness Survey Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓						✓
Committee Annual Report for Trust Board	Director of Corporate Governance and Chief of staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓						✓
Hosted Organisations (e.g. NHS Wales Shared Services Partnership (NWSSP)											
Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)/ Managing Director, NWSSP (Neil Frow)	Service Director, TRaMS (Colin Powell) / Head of Technical Services (Gareth Tyrrell)	Public	Quarterly	✓		✓		✓		✓
Implementation of Duty of Quality Update (NWSSP)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)/ Managing Director, NWSSP (Neil Frow)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)	Public	Quarterly	✓		✓		✓		✓

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Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024	Mar 2024
Surgical Materials Testing Laboratory (SMTL) Annual Report (NWSSP)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)/ Managing Director, NWSSP (Neil Frow)	Director, SMTL (Gavin Hughes) Quality Manager, SMTL (Paul Edwards) R&D Manager, SMTL (James Evans)	Public	Annually			✓				
Medical Examiner Service (MES) Annual Report (NWSSP)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)/ Managing Director, NWSSP (Neil Frow)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado) Director of Primary Care Services Division, NWSSP (Andrew Evans)	Public	Annually			✓				
Duty of Quality Report (NWSSP)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)/ Managing Director, NWSSP (Neil Frow)	Medical Director, Corporate Services, NWSSP (Ruth Alcolado)	Public	Annually or by exception					✓		
CIVAS@IP5 Report	TBC	Head of Technical Services (Gareth Tyrrell)	Public								
Ad-hoc reports by exception (dependent on external schedules) e.g. COVID-19, staff surveys, inspection reports, internal audit and Audit Wales reports, internal high level task & finish work e.g. Occult Hepatitis B											
Vaccination Programme Board Update	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Business Support Manager (Kyle Page)	Public	As required		✓					

Quality, Safety and Performance Committee

UPDATED CLAIMS POLICY **(Clinical Negligence and Personal Injury Litigation)**

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable Public Meeting

REPORT PURPOSE	ENDORSE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	To ensure the Trust discharges its responsibilities regarding the management of negligence claims made against the Trust. The Claims Policy has been reviewed and updated to ensure alignment with: • Welsh Risk Pool Procedures • The National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023 • The Health and Social Care (Quality and Engagement Act) (Wales) 2020 • The Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **ENDORSE** the revised Claims Management Policy (Clinical Negligence and Personal Injury Litigation): QS04a.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	26th September 2023.
Executive Management Board	30th October 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Revised policy Endorsed by both.	

7 LEVELS OF ASSURANCE	
NA as a policy	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance *Not required*

APPENDICES	
1.	Revised Claims Management Policy (Clinical Negligence & Personal Injury Litigation): QS04a.

1.   **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

The revised Claims Management Policy is attached in ***Appendix 1***.

This policy has been reviewed and amended to ensure alignment with the legislative requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) Act, The National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023 and The Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020.

2. IMPACT ASSESSMENT

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

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

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

	All 6 domains of quality are positively impacted by this policy.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream

3

	There are financial requirements in respect of executing responsibilities within this policy relating to Clinical Negligence and Personal Injury Litigation
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Click or tap here to enter text. Equality Impact completed and agreed on 25th September 2023.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	This policy ensures Trust compliance with legal responsibilities relating Claims Management.

CLAIMS MANAGEMENT POLICY (CLINICAL NEGLIGENCE & PERSONAL INJURY LITIGATION)

Ref QS 04a

Executive Sponsor & Function:	Director of Nursing, Allied Health Professionals and Health Science
Document Author:	Jayne Rabaiotti, Claims Manager
Approved by:	The Integrated Quality and Safety Group
Approval Date:	26th September 2023
Date of Equality Impact Assessment:	March 2011.
Equality Impact Assessment Outcome:	The Equality Impact Assessment completed in March 2011 and September 2023 continues to be relevant
Review Date:	1st September 2026

Version 9

DOCUMENT CONTROL SHEET

Purpose of document	This Policy describes the claims management process for the timely and cost effective management of claims, including learning from claims to prevent re-occurrence and monitors the effectiveness of relevant procedures. The Policy extends to the importance of supporting staff during the investigation of a claim or other legal proceedings and compliance with the requirement of the Welsh Risk Pool.
Dissemination	The Policy must be disseminated to all services within the Trust and will be made available on the staff intranet.
Implementation	Senior Managers are required to bring the Policy to the attention of all staff.
Review	The Policy is required to be updated 3 years or earlier, depending on new national guidance or legislation.
Equality and Diversity Impact Assessment	Completed and agreed 25th September 2023.

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Appendix 1 – Responsibility & Accountability
Framework Appendix 2 – Scheme of Delegation
Appendix 3 – Extract from Model Standing Order,
Reservation & Delegation of Powers 2021

1. Introduction

1.0   This policy describes the Velindre University NHS Trust Policy for the management of negligence claims made against the Trust.

1.1   The Policy mirrors the objectives of openness, transparency and timelines, as part of the legislative reforms introduced by the Civil Justice System in April 1999, following recommendations made by Lord Woolf.

1.2   It is recognised that both the human and financial cost involved in a claim are powerful incentives for effective risk management. Funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. This policy therefore forms an integral part of the Trust's Risk Management Strategy and is intrinsically linked with the Trust's system for the management and learning from concerns.

1.3   The Trust is committed to ensuring:

- ➢ timely and effective investigation, response and management of any claim, which includes allegations of clinical negligence or personal injury made against the Trust
- ➢ learning from claims to prevent recurrence
- ➢ supporting staff throughout the investigation of a claim
- ➢ ensuring that any healthcare governance issue which may emerge, is addressed promptly and the outcome used to facilitate wider organisational learning.
- ➢ this policy complies with relevant legislation and procedures, including Welsh Risk Pool Procedures, the National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023, the Health and Social Care (Quality and Engagement Act) (Wales) 2020 and the Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020. Any future change in procedures implemented by the Welsh Risk Pool will be followed, and may supersede the procedures laid down in this document.
- ➢ each claim will be assessed on its own merits, taking advice from legal advisers, where appropriate, for resolution of the case.

2.   Purpose

2.0   This Policy has been developed in order to fulfil the Trust's commitments, as described in Section 1 above, and to ensure compliance in the management and handling of all claims.

2.1   All members of staff are expected to co-operate fully in the investigation of a claim and implement lessons learnt where required.

2.2   The Trust will follow the requirements of the Welsh Risk Pool in the management of all claims in a manner consistent with the guidance of being open, honest and transparent.

3.   Scope

3.0   This Policy is to be used by all Trust employees involved in the claims process which applies to the management of the following types of claim:

- Clinical Negligence
- Personal Injury
- Redress Scheme

3.1   The Policy provides additional guidance and direction for seeking advice in respect to Inquests.

3.2   The Trust has a legal duty of care towards those it treats. This duty of care is extended to visitors, staff and third parties. The Trust may be held vicariously liable for the acts or omissions of its staff, visitors and third parties.

3.3   Those who consider they have suffered harm from a breach of duty in care can make a claim for compensation and damages against the Trust. For a claim to be successful, it must be proved that:

- the duty of care was owed;
- the duty of care was breached;
- the breach of duty caused, or materially contributed to the harm caused and
- there were consequences and effects that resulted from the harm.

If a claim is successful, an injured person has a right to financial compensation for the harm sustained, the amount of which is assessed in accordance with the principles of common law, case law and statute.

3.4　The Trust acknowledges the importance of the claims management process within its organisation and will ensure that the appointed Claims Manager has sufficient seniority and profile as required by the Welsh Health Circular (WHC) (97)17 and the Putting Things Right Guidance (2013) Part 8, revised in April 2023. The Trust and relevant nominated committees will support and promote these objectives, including the provision of support through an approved escalation procedure as set out in the Trust's claims management processes.

3.5　The Trust is committed to learning lessons from claims to ensure the continuous improvement in standards of patients and staff safety and services. Incidents and/or feedback/complaints reporting are crucial elements in the claims process, as this is often the first key indicator of a potential claim. Recording and preserving evidence is crucial in determining if the Trust can defend a claim. All staff are required to be aware of the importance of recording and preserving evidence.

3.6　The Claims Manager will support directors, key managers and staff in the claims process and will ensure that where an investigation identifies the need to learn lessons, that appropriate recommendations are made and remedial action taken to prevent future occurrence.

3.7　In addition to the Putting Things Rights Regulations, the Trust is equally committed in complying with the Health and Social Care (Quality and Engagement Act) (Wales) 2020 and the principles of the Duty of Candour and Duty of Quality, which aligns to the Putting Things Right Regulations of being open and transparent in the investigation and management of claims.

3.8　The Act places an onus on all Welsh NHS organisations to be open and honest with service users when things go wrong and put in place learning to prevent a recurrence. The Trust is committed to enhancing service user safety and providing an efficient and effective person-centred, timely and equitable health care system in the context of a learning environment.

3.9　The Trust will have due regard to the Wellbeing of Future Generations (Wales) Act 2015, the Equality Act 2010 and various legislation, that support the Trust's plan in meeting its objectives by promoting a fairer and safe healthcare organisation.

3.10   Due to the complex nature of healthcare, a claim may involve more than one defendant organisation, e.g. acute hospital or GP practice. It is important that notification of a claim is made to the Claims Manager promptly, in order that discussions can take place with the Claimant's solicitor, NHS providers or other external organisations within a timely manner.

3.11   Claims arising from the treatment provided by contracted practitioners are not indemnified and do not form part of the Welsh Risk Pool Scheme. The Trust has no delegated authority to make admissions of liability in respect to such claims or authorise payments in relation to damages or costs.

3.12   This policy does not extend to cases involving procedures for submitting a claim for loss or damage of property and does not apply to claims for reimbursement from the Welsh Risk Pool relating to the Human Rights Act 1998, claims for unlawful imprisonment arising from the activities of Mental Health Services and employment issues.

3.13   The Trust is liable for the actions of all its employees and volunteers, during the legitimate course of their employment and volunteering services. The content of this policy applies to all employees and extends to volunteers acting on behalf of the Trust.

3.14   The Trust will adopt a common and standardised approach in dealing with claims for both clinical negligence and personal injury. The Trust will gather all evidence as expeditiously as possible and, when liability is admitted, will seek to negotiate settlement in a timely fashion to prevent unnecessary delay and increased litigation costs.

3.15   The Trust will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods, where appropriate. Where formal legal action or Court proceedings are unavoidable, the Trust will ensure that it conducts its defence of the claim in a fair and timely manner, ensuring that legal costs are appropriate and proportionate.

3.16   The Trust will comply with the Pre-Action Protocols laid down by the Civil Procedural Rules in dealing with all claims and will ensure a constructive and open approach is taken with the aim of reducing delays and preventing, where possible, formal legal proceedings from commencing.

3.17 The Trust is responsible for complying with the Welsh Risk Pool (WRP) (the National Health Service (NHS) Welsh organisation indemnifier), to ensure that the Trust complies with its statutory and obligatory duties as outlined by the Welsh Risk Pool All Wales Indemnity and Insurance Policy and Scope document revised and effective from 1st September 2023, and guidance on the management of claims.

3.18 Nuisance Claims

The Trust will not settle claims of doubtful merit, however small, purely on a value basis. Similarly, claims of this nature will be defended as appropriate.

The decision to settle a claim will always be based upon an assessment of the Trust's legal liability and the risks and costs associated with the defence of that claim.

4. Objectives

4.0 The Trust acknowledges that its duty is to ensure that the appropriate financial and risk management systems are in place and that any loss is minimised. In seeking to manage risk effectively, the objectives of this Policy are to ensure:

➢ the timely and effective management of claims
➢ a systematic approach is adopted and takes account of legal and best practice requirements for risk management
➢ that the Trust learns from claims to prevent an occurrence
➢ that Trust staff are supported, directed and guided throughout the investigation of a claim and advice provided on other legal matters as and when required e.g. inquests.
➢ there is accountability and responsibility for the management of all claims against the Trust, which are clearly defined
➢ that the Trust complies with the requirements of the Welsh Risk Pool and also with the requirements of the Pre-action Protocol for the Resolution of Clinical Disputes and the Pre-action Protocol for Personal Injury, thereby avoiding the cost penalties associated with non-compliance.
➢ external agencies are involved in the investigation of a claim or legal matter when required
➢ adequate procedures are in place for monitoring the effectiveness of the policy and the claims process.

5.   Definitions

5.0   The definition and meaning of a "concern", relate to complaints, incidents and claims, where a significant litigation risk is presented. The definition for clinical negligence and personal injury negligence claims are outlined below as follows:-

Clinical/Medical Negligence

"*A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of employment and which are admitted as negligent by the employer or are determined as such through the legal process.*"

Personal Injury

"*Any disease or impairment of a person's physical or mental health condition.*"

5.1   **Claim** – a demand for compensation made following a clinical negligence claim and/or adverse incident resulting in damage or loss and/or personal injury, which carries significant litigation risk for the Trust.

5.2   **Claimant** – Any patient or their representative, a member of the public, or employee who instructs solicitors to act on their behalf to pursue a claim against the Trust, or who enters into legal proceedings against the Trust to pursue compensation.

5.3   **Clinical Negligence** – A claim based on an allegation that care fell below a reasonable medical or clinical acceptable standard (care which is less than best practice may still be 'acceptable' in the legal definition and may not be considered 'negligent').

5.4   **Personal Injury** – Harm caused to a patient, staff, or visitor, arising from a breach of common law or statutory duty to take reasonable care to provide safe premises, systems of work, equipment and competent staff.

5.5   **Employer Liability** – In accordance with common law and statutory duty, the Trust is required to ensure that there is reasonable care to provide competent staff, safe plant and equipment, safe premises and safe systems of work. The Trust may be liable to pay compensation to any employee for any injury or loss suffered if a breach

of these responsibilities is established. These circumstances may also give rise to criminal liability.

5.6   **Public Liability** – The Trust is under a duty to take reasonable care in all circumstances to make safe any visitor to its premises. The Trust may be liable to pay compensation to any visitor who sustains injury or loss, as a result of a breach of duty, to take reasonable precautions to protect the visitor or third party.

5.7   **Human Rights** – A claim made against a public body by an individual for a breach of Human Rights legislation.

5.8   **Ex-gratia** – Ex-gratia payments are the responsibility of the Trust and sit outside the remit of the Claims Policy. Further information in relation to ex-gratia payments can be found in Appendix 3

5.9   **Judicial Review** – An action taken to bring court proceedings in which a judge reviews the lawfulness of a decision or action taken by a public body.

5.10   **Conditional Fee Agreements (CFAs)** – Commonly referred to as a 'no win, no fee' agreement in which the Claimant enters into a contract with their legal representative. In the event of a successful claim against the Trust, the court will normally make an order to pay the Claimant's legal costs. For CFAs entered on or after the 1st April 2013 (where the insurance policy was signed on or after that date), with a few exceptions, success fees and insurance premiums will be paid by the claimant not the defendant. A 'success fee' may form part of a CFA. This is an uplift on the solicitor's basic costs that can be recovered from successful claimant damages.

5.11   **Qualified One-Way Costs Shifting -** From the 6th April 2023, claims issued after this date, will see a change in the costs rules relating to recovery of Defendant costs from a Claimant. This means that costs orders made against a Claimant will be enforceable not only against orders for damages under the Civil Procedural Rules
44.14 but against "*any orders for damages or agreements to pay or settle a claim for, damages costs and interest made in favour of the claimant*".

5.12   **Compensation Recovery Unit (CRU)** – The introduction of the social benefits recovery scheme came into effect on the 6th October 1997, following the Social Security (Recovery of Benefits) Act 1997. In recent years, further legislation has been introduced, including the Health, and Social Care (Community Health and Standards) Act 2003. The scheme places the onus of liability to repay social security benefits (known as NHS charges) on the compensator rather than the injured person.   The

Department of Works and Pension govern the NHS charges and CRU payments. When a claim is made against the Trust or a concern is considered under the Redress arrangements of the Putting Things Right Regulations, the Trust is legally obligated to inform the Compensation Recovery Unit. The aim of the Compensation Recovery Unit is to seek to recover the NHS charges incurred as a consequence of an act of negligence on the part of an NHS provider and ensures that a Claimant is not reimbursed twice.

5.13 **Duty of Candour** There is a requirement on all NHS organisations to be open and honest, transparent, fair and impartial.

5.14 **Duty of Quality** There is an obligation for the Trust to provide safe, effective, patient- centred, timely, efficient and equitable health services.

6 Responsibilities

6.0 Subject to the provisions of the Limitation Act 1980, the Trust will be responsible for managing claims that fall within its scope.

6.1 **Chief Executive** – The Chief Executive is the accountable officer for the proper and effective handling of claims for the Trust with overall responsibility for claims management. The Chief Executive is required to ensure that there is a designated Executive Director Lead with clear responsibility for the management of claims. The Chief Executive delegates responsibility to the Executive Director of Nursing, Allied Health Professionals (AHPs) and Health Science in overseeing the function and management of claims.

6.2 **Executive Director of Nursing, Allied Health Professionals (AHPs) and Health Science** – The Executive Director of Nursing, AHPs and Health Science is the Board member/Executive Lead responsible for claims management and for issues affecting clinical negligence, personal injury claims and Redress matters. The Executive Director of Nursing, AHPs and Health Science, is also responsible for ensuring that the Executive Management Board and Trust Board are kept informed of any significant and major developments as they arise.

6.3 **Director of Finance** – The Director of Finance is responsible for maintaining the Losses and Special Payments Register (LaSPaR) and ensuring that any major developments or concerns that pose a financial risk to the Trust, are highlighted to

the Board and relevant Committees accordingly, to safeguard and/or ensure that such financial risk or concern is actioned appropriately.

6.4 **Medical Director** – The Medical Director is responsible for ensuring that medical quality and safety is paramount and has responsibility for providing medical leadership and support in achieving the aims and objectives as set out in this policy.

6.5 **Deputy Director of Nursing, Patient Experience and Corporate Services –** The Deputy Director is required to act upon and oversee the claims function in the absence of the Executive Lead Director of Nursing, AHPs and Health Science, and is assigned reasonable delegated authority to comply with the efficient and timely management of the claims procedures and processes.

6.6 **Divisional Directors** – All divisional directors and service managers have a delegated accountability and responsibility within their divisions for the implementation and adherence to this policy.

6.7 **Trust Head of Quality, Safety and Assurance –** The Trust Head of Quality, Safety and Assurance is accountable to the Director of Nursing, AHPs and Health Science in the implementation of procedures and guidance on quality and safety assurance matters, including monitoring and performance. The Trust Head of Quality, Safety and Assurance is required to deputise in the absence of the Deputy Director of Nursing.

6.7 **Trust Deputy Head of Quality, Safety and Assurance** – In the absence of the Claims Manager, the Trust Deputy Head of Quality, Safety and Assurance is responsible for overseeing the claims management and its function, and will have relevant experience and qualifications, in addition to demonstrating continual professional development, in the management and responsibility of the day to day operation of claims management, including participating in relevant networks and meetings to advance the profile and management of claims and will be responsible for implementing any new procedures, legislation and guidance that will affect the governance arrangements in place for claims management and its functions. The Deputy Head of Quality, Safety and Assurance will also be responsible for ensuring that the Once for Wales Cymru databases, are consistent across all modules (Incidents, Complaints, Claims, Risk Management and Patient Experience), for the purpose of learning lessons and monitoring.

6.8 **Claims Manager -** The Trust is committed to employing a Claims Manager who has the relevant experience and qualifications in the management of claims.

6.8.1   The Claims Manager will be required to demonstrate ongoing continuing professional development in the area of claims management.

6.8.2   The Claims Manager is required to hold sufficient seniority and profile as required by Welsh Health Circular (97)17 and the Putting Things Right Guidance (2013) Part 8 and is accountable to the Director of Nursing, Allied Health Professionals and Health Science, for ensuring compliance with this Policy and for securing the most cost- effective resolution of claims.

6.8.4   The Claims Manager is responsible for taking an active part in the quarterly All Wales Claims Management, Redress and Inquest Networks, to ensure that the claims processes and any new procedures are discussed and implemented in accordance with the Trust's commitment to the Welsh Risk Pool's obligations.

6.8.4   The Trust and relevant nominated committees are required to support and promote the objectives and scope of this policy by ensuring that an appropriate escalation process is in place to achieve equitable, efficient and timely managed claims.

6.8.6   The Claims Manager is required to ensure that throughout the progress of the claim, staff are kept up-to-date on the status and progress of the claim and its outcome.

6.9   Employees, responsibilities, support and guidance

6.9.1   The Trust recognises that the co-operation of staff involved in a claim is crucial and acknowledges that the litigation process can be a difficult, daunting and anxious experience. The process can also be time consuming, slow and lengthy, with some cases taking years rather than months to conclude. The Trust accepts that staff may find this a stressful time and encourages staff to access well-being support and occupational health resources when needed. It is vital that staff are provided the relevant access to services to assist them throughout the litigation period, if required.

6.9.2   A manager who has responsibility for a staff member involved in a claim, owes a duty of care to ensure that there is appropriate support in place. Managers who have concerns, should signpost staff to confidential counselling and wellbeing support when required and/or to Occupational Health for additional support, if necessary. advice and guidance should also be sought from Workforce and Organisational Development when there are concerns relating to any staff member.

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6.9.3 The Trust is required to ensure that guidance is provided to staff who are involved in the claims process and that they have access to training and guidance, at a level appropriate to their role and responsibilities.

6.9.4 There is a duty on staff to ensure that early collation of evidence is appropriately captured on the RL Datix Once for Wales' incident/feedback modules with provision to escalate to directorate leads and managers as appropriate. It is also a requirement that staff members ensure that evidence is preserved and good record keeping maintained, as this will be fundamental in the investigation of a claim.

6.9.5 Staff are required to engage with the Claims Manager and co-operate fully to ensure that the cost of a claim is minimised. This includes reporting adverse incidents promptly to allow early investigation of potential claims and providing witness accounts and statements, when required, within a timely manner.

6.9.6 Any staff member receiving written notification of a claim or potential claim must not enter into direct correspondence or communication with the claimant or their legal representative. All such notifications are to be directed to the Claims Manager who will take the required action at the earliest available opportunity to avoid any adverse costs consequences.

6.9.7 The Trust will take full responsibility for managing and, where appropriate, settling claims, meeting all financial obligations and will not seek to recover any costs from health professionals, save in exceptional cases, where the health professional was legally found to be acting outside of his/her remit.

6.9.8 Should a case go to trial, staff giving witness evidence will receive support from the Claims Manager and legal advisers, both in conference and prior to attending court. Staff have the option of being accompanied by their union representative should they wish to exercise this right.

6.9.9 It is not the intention of the claims investigation to assess whether employment action against an individual member of staff should be considered. However, if, as a result of the investigation there is prima facia evidence of a breach of the law or professional misconduct, further action may need to be considered. In these circumstances, the appropriate senior manager will determine whether Workforce and OD employment policies should be invoked. Staff should also be aware that in exceptional circumstances their actions might give rise to personal criminal liability and referral to their professional body.

7. Limitation Act 1980

7.0   Subject to the provisions of the Limitation Act 1980, the Trust will be responsible for managing all Trust related claims. The Limitation Act 1980 requires that claims are made within three years of the date of the incident or three years from the date a Claimant became aware of the incident, or from the date when the Claimant could reasonably have been expected to know. For minors, the three-year limitation period will commence on the minor attaining the age of 18. The limitation period will not usually apply to a Claimant incapable of managing and administering their own affairs. In certain circumstances, Courts have discretion to waive the limitation period when necessary.

7.1   A Human Rights Act claim is to be made within one year of the act being committed, or its failure to act.

7.2   A Judicial Review application should be made within three months of the act or the omission.

7.3   The Trust will comply with the requirements of the Welsh Risk Pool in notifying other organisations and bodies of claims arising from service provision and will retain day- to-day management of such claims unless otherwise instructed.

8. Welsh Risk Pool (WRP)

8.1   The Trust will comply with various rules and procedures relating to the Welsh Risk Pool, including its revised Welsh Risk Pool Procedures and All Wales Indemnity and Insurance Policy and Scope Document.

8.2   The WRP currently provides the means by which all Trusts and Health Boards are able to fund their risk exposure for all risks, such as employers and third party liability, including that for clinical negligence.

8.3   The WRP has responsibility for reimbursement of claims handled under the NHS Indemnity, which exceed £25,000. The cases reimbursed mainly relate to clinical negligence and personal injury matters, although the scope of the WRP includes buildings and, in exceptional circumstances, equipment, where an excess of £50,000 is applied.

8.4	The role of the WRP was expanded in 2018, to include responsibility for the appropriate reimbursement of permitted costs and damages arising from Redress cases. Redress cases, introduced in 2011 through the 'Putting Things Right' arrangements, deal with matters where there is a qualifying liability arising from complaints and healthcare reported incidents. Effective use of the Redress process has a direct impact on litigation costs for each organisation, with savings in claimants' costs. Further guidance on the extent of the WRP indemnity is found in the revised All Wales Policy on Insurance, NHS Indemnity and Related Risk Management for/ Potential Losses and Special Payments and Scope of Welsh Risk Pool. The Trust will ensure there is a comprehensive and robust governance framework in place for dealing with the financial management of potential losses and special payments when they do arise and make any necessary changes and updates as required by the Welsh Risk Pool.

8.5	The Welsh Risk Pool Scope document sets out the types of losses arising from legal obligations (with the exception of contractual claims) and losses defined by the losses and special payment manual. For the effective management of the claims function the Trust will have:-
1.	Up-to-date procedures, contract documentation and management practices for the provision and commissioning of healthcare and other services to ensure that they are consistent with the key principles set out in the All Wales Indemnity and Insurance Policy.
2.	Ensure there is indemnity or insurance arrangement which provides appropriate cover for all activities which fall outside of the scope of NHS Indemnity
3.	Ensure there are clear, written policies, procedures and financial arrangements for meeting liabilities arising from negligence claims which are fully consistent with the All Wales Welsh Risk Pool Indemnity and Insurance Policy and the risk pooling arrangements of the Welsh Risk Pool and associated Technical Notes.

8.6	Of note, the Policy has replaced the Welsh Health Circular (WHC) (98) 08 and incorporates the requirements of WHC (2000) 04, which outlines the risk pooling arrangements made for clinical negligence claims received from those person to whom the health body owes a duty of care. It does not, however, apply to other types of legal claims that might be made in respect of purely commercial or employment contracts and specifically excludes any payments made for harm sustained where there is no negligence (i.e. personal accident cover).

8.7	The Welsh Risk Pool All-Wales Indemnity and Insurance Policy now contains an addendum (WHC 04 (2000)) which specifically allows personal accident cover to be purchased where a health body considers it relevant or appropriate to do so, for

example, the Policy does not extend to losses arising from non-emergency vehicles for which the health body is permitted under WHC 04 (2000) to purchase commercial insurance. The decision to enter into agreements for cover for non-negligent harm rests with individual health bodies and cannot be recouped from the Welsh Risk Pool.

8.8   Other losses, including building, equipment and consumable losses, are dealt with under the Welsh Risk Pool Indemnity and Insurance Policy and Scope document, outlined in the Insurance and Indemnity Arrangements section**.**

8.9   The Trust is assessed annually against the Welsh Risk Pool Standard for Claims Management and is responsible for complying with the procedures, as captured in the Welsh Risk Pool Indemnity and Case Reimbursement Procedures. The procedures were introduced in October 2019 and revised following consultation throughout NHS Wales. The revised Welsh Risk Pool Procedures will come into effect from the 1st September 2023. Guidance on the procedures, including revisions and updates are periodically provided by the Welsh Risk Pool and are implemented in accordance with the Trust's governance requirements.

8.10   The review and auditing of claims management is recognised as an essential component of the Trust's risk management systems and governance processes in place. Periodic claims reviews and audits are compulsory and are undertaken both by internal and external auditors, including the Welsh Risk Pool. Following notification of a review or audit, the co-operation of Trust staff will be required, if called upon, to ensure compliance has been achieved and is maintained.

8.11   The Claims Manager is responsible for monitoring the nature and type of claims received to ensure that any claims, which are novel, contentious or repercussive, are reported in advance of settlement to the WRP and, any required approvals are obtained at relevant stages. These may include claims involving some unusual and new features. If not correctly handled, these claims might set an unfortunate precedent for other NHS litigation and might represent test cases for a potential class action, or cases not formally part of a class action but might appear to be similar in kind to concurrent claims against other NHS bodies. In such cases, the Claims Manager will contact the WRP and, where appropriate, NWSSP Legal and Risk Services for advice regarding the further management of the claim.

9. Learning

9.0 The Trust is committed to identifying opportunities for learning and continuous improvement from all events that arise from claims and is responsible for ensuring that a process exists to support its learning by ensuring that there is adequate monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learnt and auditing of learning to prevent and minimise a future occurrence.

9.1 It is important that all directorates involved in a claim capture lessons learnt and the actions of evidence following an event, incident or near miss, regardless if it is the subject of a claim. The basis for this is to diminish the risk of future events. This includes learning lessons from any report issued by the Public Ombudsman for Wales and/or His Majesty's Coroner, following the issue of a Preventable Future Deaths Report.

9.2 Each directorate lead has responsibility for liaising with appropriate staff and ensuring any identified and agreed actions are implemented and monitored.

9.3 The Claims Manager will highlight the potential for 'learning lessons' from claims as they arise through the reporting and governance mechanisms in place and will share learning with the approved management boards and relevant Committees.

10. Delegated Financial Authority

10.0 The Welsh Government has delegated its responsibility for the settlement of claims up to a limit of £1m. The Trust is required to exercise discretion when settling a claim, ensuring that this is within the legal advice provided, and conforms to the Trust's governance arrangements in place for the settlement of cases, including the criteria set out by the Welsh Risk Pool. The levels of financial delegated authorities approved by the Trust are set out in the Trust's Scheme of Delegation (Appendices 2 & 3).

10.1 For claims where the sum exceeds that of the Chief Executive/or nominated Executive Director financial delegated limits, the Trust Board is required to agree the settlement of the claim up to the value of £1m.

10.2 In situations where a decision is necessary and it is not possible to comply with the financial delegated limits because of time constraints, the Chief Executive, or nominated Executive Director, will contact the Trust's Chairperson, or nominated

Independent Member and recommend a course of action (known as a Chairperson's Action). Any action taken in accordance with the Chairperson's Action will be reported at the next available meeting of the Trust Board where retrospective approval will be obtained.

10.3 In accordance with the Welsh Government's delegation to the WRP, the Claims Manager will ensure that when damages in a claim are estimated to exceed that of the Trust's delegated authority of £1m, such claims are reported to the WRP, prior to any decisions taken in the claim.

10.4 The Trust is required to exercise its discretion in settling claims by ensuring that:-

a) It adopts a clear policy for the handling of claims that satisfies the requirements of Section 8 of the National Health Service Putting Things Right – Guidance on dealing with NHS concerns - thereby ensuring that there is clarification upon which the Trust will manage and settle claims. The requirements of which the Guidance will form the basis of the procedure for the day-to-day management of claims

b) Appropriate Welsh Risk Pool (WRP) approvals and settlements under the delegated authorities provision, are obtained

c) Appropriate checklists are completed for every settlement authorised by the Trust within its delegated limit

d) Promotion of good economic practice in the management of claims

e) Assurance is provided from learning from events with the objective of improving standards in patient safety and with the aim of diminishing risk.

11. Legal Advisers – NWSSP Legal and Risk Services

11.1 In accordance with the WRP procedures, the Trust is responsible for instructing NWSSP Legal & Risk Services in the defence or settlement of clinical negligence and personal injury claims.

11.2 Where NWSSP Legal and Risk Services' advice is sought, the Trust will retain the responsibility to direct its solicitors in respect of liability, admission, defence, settlement and general authorities associated with a claim e.g. approval for instruction of an external expert report. However, the Trust will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation;

- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best- and worst-case scenarios; and
- Estimates of legal costs for claimant and defence.

11.3   The final decision to settle a claim or continue with its defence, requires approval by the Executive Director of Nursing, AHPs and Health Science, or by the Chief Executive and/or the Board, taking into consideration the delegated financial limits, as appropriate. Any decision taken to settle a claim or continue with its defence is captured within the quarterly reporting in accordance with the governance processes in place or alternatively, by briefings as directed by the Executive Director of Nursing, AHPs and Health Science.

11.4   The Trust will ensure that, when appropriate, advice is sought from NWSSP Legal and Risk Services, with appropriate expertise, when required to do so, and where there is an indication of a possible risk to the Trust or the Trust's reputation if legal advice is not sought. Advice may be sought in the following circumstances:

- Coroners Inquests
- Responses to Serious Incidents
- Complaints
- General legal advice of a nature that requires legal expertise or specialism

11.5   In all eligible cases, the Claims Manager will work in collaboration with NWSSP Legal & Risk Services in obtaining the necessary legal advice as required.

11.6   Authority to seek legal advice will be required from the Executive Director of Nursing, AHPs and Health Science in the first instance, as the cost of such instruction is not recoverable and will be borne by the Trust.

12.   Reporting Requirements & Structure

12.1   The Claims Manager is required to prepare a claims analysis report on a quarterly basis that will form part of the Putting Things Right quarterly report and annual report. The report outlines information regarding claims, including details of new claims, settled and closed claims within each quarter, the number and aggregate value of compensation claims in progress, including their outcome and any remedial action taken or proposed. Learning undertaken in relation to new, settled and closed claims,

and any resultant changes in practice which have occurred, or which might be needed.

12.2 Claims are escalated through governance arrangements routinely. Any case requiring escalation will be raised with the Deputy Head of Quality, Safety and Assurance in the first instance.

12.3 **The Executive Management Board** (EMB) is responsible for
   a) promoting a climate of openness
   b) ensuring prompt incident reporting and investigation
   c) being assured that clear explanations are provided to patients who have concerns or complaints
   d) ensuring directorate compliance regarding claims to comply with WRP reporting requirements.

12.4 **Trust Quality, Safety and Performance Committee**
The Committee receives quarterly reports on the management and status of all claims activities against the Trust in the format specified by section 8 of the Putting Things Right Guidance and WRP guidance, which includes updates on the learning undertaken to prevent recurrence and future risk to the Trust.

12.5 **Trust Integrated Quality and Safety Group**
Provides oversight to support the Board, Executive Team and Divisional senior Leadership Teams in meeting their Quality and Safety responsibilities and helps to ensure quality is at the centre of decision making across the Trust.

12.6 **Trust Health, Fire and Safety Management Board**
The Trust's Health, Fire and Safety Management Board reviews health and safety claims as part of the Trust's health and safety governance processes. Any health and safety event, which could potentially result in a claim, is highlighted to the Board as part of the Trust's governance requirements. Learning that is implemented following a decision taken to settle a health and safety claim is captured in the quarterly reporting and cascaded down to the Health and Safety Management Group.

12.7 **Audit Committee**
The Director of Finance is responsible for updating and reporting the value and incidences relating to the Special Losses and Compensation payments to the Audit Committee.

13. Claims Management Process/Procedures

13.1   The Claims Manager will ensure that claims management processes/procedures are developed which supports and embraces the objectives contained in this Policy and the Putting Things Right Guidance.

13.2   The Claims Management Procedure will set out the processes for the day-to-day operational and practical management of claims and associated matters.

13.3   The Executive Management Board delegates the authority for the approval of the Compensation Claims Management Policy to the Quality & Safety Performance Committee.

14. Databases & Systems

14.1   The Trust will maintain the following databases in compliance with the governance and risk framework as outlined below:-

14.2   **The RL Datix Once for Wales (OfW) Claims, Inquests and Redress Modules**
The Once for Wales Concerns Management System has been designed to bring consistency to the use of electronic tools used by all NHS Wales health bodies. The system is a cloud-based platform adopted by the Trust to comply with best practice in relation to cyber security and has the benefit of an All Wales approach in adopting integrated functions.

The modules encompass wider functionality and delivers extensive specifications for incorporating integration across Welsh NHS organisations. These modules form the Trust's Claims management database and captures up-to-date information relating to claims, inquests and redress.

Staff are required to ensure that they submit timely incidents or near misses on the Incident Module and, where concerns are raised, for these to be reported via the Feedback Module. All relevant information is required to be uploaded and all fields completed to allow for a seamless, effective co-ordination and management of the claims handling function.

14.3   **The Losses and Special Payments Register (LaSPaR)**
LaSPaR is a computerised database previously introduced by the Welsh Government to replace previous paper based systems with a national standardised format for actioning write-offs or special payments approval. All NHS organisations are required to have procedures in place to record details of losses incurred by the Trust and any

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special payments made. The register is required to capture all payments, including details of the reason to make the payment. The register forms part of the Trust's annual accounts and is subject to scrutiny by auditors and the Trust's Audit Committee. The main objectives of LaSPaR are to:

- Ensure that health bodies monitor all aspects of losses and special payments, from initial registration to final outcome, on a case by case basis;
- Allow health bodies and the Welsh Government to identify settlement/claimant costs, provisions, and defence or other administration costs provisions, and to action any subsequent adjustments; and
- Ensure that all payments and income recoveries are identified separately and that analyses can be performed on all transactions

14.4 Detailed guidance on the management of losses and special payments are provided within the losses and special payments chapter within the NHS Wales Manual for Accounts. The Trust is required to ensure that arrangements are in place for compliance with the requirements of the manual and the Welsh Risk Pool procedures and All-Wales Indemnity and Insurance Policy and Scope document. In particular the Losses and Special Payments Manual requires that health bodies throughout NHS Wales have effective systems for:-

a) The control and safe custody of health service property
b) Administration of property including that of patients, and
c) Recording, reporting and investigating losses and special payments

14.5 Compensation claims (including redress settlements), are captured on the LaSPaR database spreadsheet and updated by the Claims Manager and authorised staff, to ensure that relevant financial information is up-to-date and complies with auditing requirements. These payments are monitored closely to ensure that any trends or potential risk is analysed, highlighted and reported and escalated within the Trust's governance framework.

14.6 The Trust is responsible for ensuring that patient and staff confidentiality is maintained when accessing the databases outlined above and that staff comply with the Trust's information governance policies and procedures, as required.

14.7 The Trust requires any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately

inform the Chief Executive and the Director of Finance or inform an officer charged with appropriately informing the Director of Finance and/or Chief Executive.

14.8　The procedure for submitting a claim for loss or damage of property is found in the Trust's document "Procedure for Submitting a Claim for Loss or Damage of Property". The procedure provides guidance to Trust staff in relation to claims concerning loss of damage of personal property.

Losses and Compensation claims are defined as;
"Losses, damage to/or loss of personal belongings through no fault of the individual".

14.9　The "Procedure for Submitting a Claim for Loss or Damage of Property" outlines the responsibilities of the accountable directors and panel members, and sets out the process to be followed in the event of losses involving staff and service users.

14.10　The differences between a Loss and Special Payment is outlined below:-

Loss
Relates to the loss of money or property belonging to the Trust (e.g. theft, damage to buildings, loss of cash, bad debts and loss or obsolescence of stock). Pharmacy Stock is defined as drugs kept on Trust's premises.

Special Payments
Special Payments are made outside the normal day-to-day business of the Trust (e.g. compensation payments for clinical negligence and employer's liability claims, to staff for loss/damage to personal property whilst on Trust premises).

14.11　Appendices 3 and 4 outline the financial authorities delegated in accordance by the Welsh Government and includes the Trust's Model Standing Orders – Reservation and Delegation of Powers 2021.

15.　Link between Claims, Incidents & Complaints (Concerns)

15.1　The Trust will be committed to ensuring that there is need for a close connection between complaints, incidents, claims (collectively known as concerns) and other risk related information.

15.2　The triangulation of concerns are dealt with under a collective governance arrangement and meet the requirements of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as updated in April 2023, to

ensure an effective concerns process is in place that identifies risks and trends through the analysis, gathering and scrutiny of data collection.

15.3 Claims may be identified as a result of an incident, complaint, request for records or correspondence from a claimant or solicitor indicating that a claim is being considered. There may be further circumstances that also indicate a potential claim, examples of which are outlined below:-

- Where a Serious Incident Investigation or Coroner's Inquest identifies a breach in the duty of care owed
- Where there has been an allegation of professional misconduct
- Where a response to a complaint implies acceptance of liability of a potential claim.

15.4 The outcome of all investigations are reviewed through the appropriate forum i.e. by the relevant divisional management group, to ensure that any lapse in action/provision of service identified during the investigation is acted upon and monitored to ensure that lessons are learnt and evaluated to improve services with the aim of preventing a future occurrence.

15.5 Adverse incidents or outcomes, which could lead to a claim for negligence, should be reported to the Claims Manager to consider the likelihood of a potential claim. The following information should be supplied:-

- Details of the potential claimant
- Date and details of incident/outcome, giving rise to a potential claim
- Names and contact details of relevant members of staff involved in witnessing the incident
- Statements by such relevant members of staff and witnesses
- Any further documentation which is considered relevant.

16. Putting Things Right (PTR) Redress Scheme

16.1 The Trust adopts a pro-active stance to the management and resolution of potential claims identified through the 'Putting Things Right' process.

16.2 The Deputy Head of Quality, Safety and Assurance will work with the Claims Manager and concerns/investigation leads within divisions to highlight concerns where identified breaches in the legal duty of care are established.

16.3   When a concern handled via the Putting Things Right Regulations identifies that a breach of duty has potentially caused/or has caused harm which does not exceed the PTR threshold, and the breach or breaches in the duty of care has been approved by the Putting Things Right Panel, followed by a Regulation 26 response issued to the service user or representative, the matter is transferred to the Claims Manager to investigate further under the Redress Scheme with a view to determining a qualifying liability.

16.4   As part of the Putting Things Right process, the Claims Manager will be responsible for liaising with relevant staff to obtain in-house comments as part of the investigation process, including comments from clinicians, nursing leads and professionals within their capacity and speciality when considering causation. When it is not possible to establish causation, the Claims Manager will liaise with the Claimant, or the Claimant's clinical negligence accredited solicitor, to instruct a suitably qualified expert on a joint basis, with a view to seeking an opinion to determine qualifying liability.

16.5   When a qualifying liability is established the Claims Manager will be responsible for evaluating, assessing and quantifying Redress cases. Where there is difficulty in quantifying the case, the Claims Manager will seek advice from NWSSP Legal and Risk solicitors following approval by the Executive Director of Nursing, AHPs and Health Science.

16.6   Prior to making an admission in relation to qualifying liability and making an offer of compensation in matters where the value of a Redress case is less than the PTR threshold of £25,000, the Claims Manager will be responsible for convening a Putting Things Right Redress Panel and bringing the matter before the Panel to consider liability and the offer of compensation. This may also include seeking approval on one or more of the remedies available under the Putting Things Right Regulations e.g. the associated cost of remedial treatment.

16.7   Where a Redress case is considered to be in excess of the PTR threshold of
£25,000, if a qualifying liability were to be determined, the matter must not proceed under the Putting Things Right Regulations. The Claims Manager will, instead, be required to inform the service user or their representative to seek independent legal advice.

16.8 The Claims Manager will be responsible for obtaining a Compensation Recovery Unity (CRU) Certificate from the Department of Works and Pension (DWP), in accordance with legislative requirements, and will be required to obtain approval, within the financial delegated limits set, for settling any NHS/CRU charges incurred as part of a financial compensation settlement. The Claims Manager will be responsible for providing the outcome to the CRU on all Redress matters. Where CRU exceeds that of £3,000, in accordance with the Welsh Risk Pool Procedures, the matter will be referred to NWSSP Legal and Risk Services for advice.

16.9 The Deputy Head of Quality, Safety and Assurance will direct the nature and involvement of the Claims Manager in any subsequent investigation of an incident or reported concern that involves a potential breach of the legal duty of care by the Trust.

16.10 The Trust is to ensure that there is an appropriate forum to enable lead members of staff for complaints, risk and claims to meet on a regular basis to discuss risk and ensure that the identification of any trends and/or remedial action that may be required are highlighted and signposted for action accordingly.

17. Payments made under the Putting Things Right Regulations - NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

17.1 The Trust is required to ensure that all requests for compensation associated with a possible negligence claim, should only be made in the event of the Trust being liable for the claimant's loss. Payments requiring financial compensation arising out of any episode of negligence must satisfy the requirements of the Welsh Government's delegated authority and WRP guidance as follows:-

17.2 Concerns involving a qualifying liability in tort are to be resolved by the settlement of damages up to a maximum of £25,000 under Redress

17.3 Concerns (i.e. claims for negligence) exceeding £25,000 and formal claims for negligence below £25,000 are to be resolved in accordance with the relevant Pre-Action Protocols and Civil Procedure Rules.

18. The Putting Things Right Panel

18.1 Following an investigation into a PTR concern, in accordance with the Trust's Terms of Reference, the Putting Things Right Panel will convene and make a decision on one or either of the following:-

- breach of duty has occurred
- causation (harm) that has resulted in a qualifying liability

Authorisation is required by the PTR Panel before making any admissions on breach of duty and causation, including any financial offers of compensation and/or remedial treatment to put the Claimant back into the position he/she would have been in, but for the negligence

18.2 The Putting Things Right Panel is chaired by the Executive Director of Nursing, AHPs and Health Science and consists of the Deputy Director of Nursing, Clinical PTR Lead, Clinical Director and/or Medical Director, Nursing leads, Directorate leads, the Trust's Head of Quality, Safety and Assurance and Deputy Head of Quality, Safety and Assurance and Claims Manager in addition to members of staff invited to attend.

18.3 Approval is authorised by the Chair and is based upon the following considerations:

- the strength and merits of the case

- the remedies available under the Redress Scheme

- the likelihood/requirement of settling the case and its associated cost

- Any lessons learnt

18.4 If a decision is made to proceed with a financial offer and that offer is subsequently accepted, correspondence will state that the payment is made in full and final settlement of the concern.

18.5 The complainant is advised that they will be unable to pursue a claim for the same matter, as outlined by the Putting Things Right procedures.

18.6 The relevant Divisional Director has responsibility for liaising with appropriate staff, ensuring any identified and agreed learning and actions arising from the Panel, are implemented and monitored.

19. Inquests

19.1 Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries.

19.2 The Coroner will consider both oral and written evidence during the course of an inquest. Inquests are public hearings and can be held with or without juries - both are considered equally valid. Under Rule 8 of the Coroners (Inquest) Rules 2013, Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicabl

19.3 Coroners are independent judicial officers, appointed by the local authority, and are either doctors or lawyers responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009.

19.4 Under section 5 of the Act, a Coroner is responsible for determining:

- who the deceased was;
- how, when and where the deceased came by his or her death; and,
- the particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.

19.5 A coroner is obliged to investigate deaths where there is a reasonable suspicion that the deceased has:-

- died a violent or unnatural death,
- where the cause of death is unknown or
- if the deceased died while in custody or state detention as defined by section 1(2) of the Coroners and Justice Act 2009.

19.6 The Coroner will also investigate where the deceased has not been seen by the doctor issuing the medical certificate, or during the last 14 days before the death.

19.7 The Coroners and Justice Act 2009 conferred on Coroners the power to require a witness e.g. a clinician, nurse, police officer etc. to provide a written statement and to call a witness to appear at an inquest, and to determine the evidence to be heard.

19.8 The Claims Manager will liaise with the Coroner following notification of an inquest and will liaise accordingly with staff to provide a written statement, providing guidance as required.

19.9 If a staff member is informed of an inquest direct by a Coroner, Coroner's Officer or Police Officer and a witness statement or information is requested in relation to a death, it is the responsibility of the staff member to ensure that it is reported to the Claims Manager immediately. The Claims Manager will, on behalf of the staff member, liaise thereafter with the Coroner and co-ordinate the statement and/or any information that is required.

19.10 When a staff member is called upon to attend an inquest, the Claims Manager and an appropriately appointed senior manager will attend the inquest in a supporting capacity.

19.11 In instances where there are concerns involving the Trust's reputation, failings in service or care, likelihood of a possible Prevention of Deaths Report being issued or if Article 2 is invoked by the Coroner, the Trust will be required to consider seeking legal assistance from NWSSP Legal and Risk to represent the Trust at the inquest hearing.

20. Information Governance /Confidentiality

20.1 The Trust is responsible for ensuring that staff are aware of their obligations and duties to ensure that information, records and disclosure are processed and managed in accordance with applicable legislation, codes of practice, standards and Trust policy.

20.2 There is a requirement for all staff to process sensitive personal data, information, documents and records in accordance with the legislation contained within the Data Protection Act 2018, the retained EU General Data Protection Regulations 679/2016 (UK GDPR), Access to Health Records Act 1990, The Freedom of Information Act 2000, Environmental Information Regulations 2004 and the Caldicott Principles. The Trust Data Protection and Confidentiality Policy contains further information.

20.3   Staff are required to pay particular attention when transferring and/or communicating any sensitive data, information, documents and records that form part of a concern and must take the utmost care to ensure information is, at all times, safe and protected. When a need exists to exchange any information that forms part of a claim, it is the responsibility of Trust staff to maintain security and confidentiality in order to minimise the risk of loss at all times.

20.4   Staff are required to comply with legislation, codes of practice, standards and relevant Trust Policies together with applicable divisional/associated organisational directions and/or guidance, to ensure that suitable precautions are taken to protect against any accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to data, information, documents and records whether employee or patient, donor or service user, held on a computer or held manually, regardless of the method of communication, which includes verbal, electronic or written.

20.5   Reports and correspondence which do not have, as their sole or dominant purpose, actual or prospective litigation, are likely to be disclosable to parties with or without authorisation from the data subject. This will include incident reports and investigations, complaints or investigations and any associated e-mails.

20.6   Trust staff who are requested to disclose records to any legal representative or where the intention to pursue a claim has been indicated by an individual should notify the Claims Manager.

20.7   The Claims Manager is responsible for ensuring that all relevant records and information relating to a claim are obtained and protected. Records protection will usually include the clinical record and any supplementary documents (e.g. incident and complaint investigations).

20.8   The Claims Manager is responsible for maintaining claims information via the Datix Management System. Access to the database is restricted; any claims that are reported to the Executive Management Board, Quality, Safety and Performance Committee, or sub-committees, are anonymised to protect the confidentiality of data.

20.9   Closed files are to be placed in archive storage for a minimum period of 10 years

21. Equality and Impact Assessment

21.1   The Trust is committed to ensuring that the Trust does not discriminate against individuals or groups.

21.2   The Trust has undertaken an Equality Impact Assessment to ascertain if the Policy and procedures outlined in this document will directly impact on any group in respect to gender, including maternity and pregnancy, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or any other protected characteristics.

21.3   The assessment has found that there is no likely impact to the equality groups highlighted above. Where impact is likely this has been assessed in accordance with national guidance and statute. Where appropriate, the Trust will take action to minimise any direct impact on equality and will ensure that it meets its responsibilities in accordance with human rights legislation.

22. External Agencies

22.1   The Trust's Deputy Head of Quality, Safety and Assurance will determine if external agencies should be involved in the claim investigation process as follows:-

- Where the circumstances give rise to a suspicion of an unlawful act, an Executive Director will be responsible for the decision as to whether the matter should be reported to the Police.

- Where the circumstances give rise to concerns in relation to professional conduct, the appropriate professional lead will be responsible for reporting the matter to the relevant professional body.

- The Trust Deputy Head of Quality, Safety and Assurance will advise if the matter should be reported to Health Inspectorate Wales (HIW), or other regulatory or statutory body.

22.2   NHS Executive

From the 1st April 2023, the Welsh Government has introduced the NHS Executive made up of the following component organisations:

- Delivery Unit

- Finance Delivery Unit
- Improvement Cymru
- Health Collaborative

The key purpose of the NHS Executive is to drive improvements in the quality and safety of care to achieve better, fairer healthcare outcomes for the people of Wales. The Claims Manager will liaise with the NHS Executive, when required, and will comply with any reporting requirements to fulfil the claims and inquests management function. This will include submitting any reports that could potentially impact upon the Trust's reputation. The Trust is required to ensure that the NHS Executive is made aware of any potential reputational impact from media or press coverage e.g. inquests.

23. Monitoring

23.1 The effectiveness of this policy will be reviewed on an annual basis by the monitoring arrangements in place in relation to claims management and the compliance with the WRP Reimbursement Procedures. The Quality and Safety Performance Committee will monitor claims performance via the quarterly Putting Things Right reports and the Trust's Putting Things Right Annual Report, highlighting the position in respect of all claims and the learning identified.

23.2 The Claims Policy will be received by the Integrated Quality and Safety Group, Executive Management Board and Quality and Safety Performance Committee for approval and noting.

24. The Duty of Candour

24.1 Following the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the Duty of Candour is now a statutory requirement which comes into force from the 1st April 2023. It underpins the Welsh Government's commitment to openness and learning, vital for the provision of safe, effective and person-centred health and social care. The aim of the Act is designed to improve accountability, promote responsibility through the development of safer systems, engage staff in the improvement of services, strengthen the delivery of quality care and create an enhanced service user experience, built on trust and mutual understanding.

Although the statutory duty applies specifically to NHS organisations, individual healthcare staff are predominantly representatives of the NHS and are therefore

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responsible for their interactions with service users, their families and advocates and are required to follow relevant procedures and policies.

The statutory duty of candour places a requirement on NHS bodies to follow a set process, evidencing the series of prescribed actions undertaken when the duty of candour is triggered. It works alongside current governance processes involving:-

- **Management of concerns (both formal and informal)**
  The duty is aligned with the Putting Things Right Regulations, updated in 2023. These Regulations will exist alongside the Duty of Candour and will continue to support the Trust's culture of openness and transparency.

- **Compliance with fundamental care quality standards and relevant statutory regulation e.g. Health Care Inspectorate Wales.**

  Monitoring and assurance of the Trust's process will continue as a fundamental priority. Where inefficiencies are found in the delivery of care and quality, rapid remedial action will be taken to address deficiencies. This will not only improving our services but put in place necessary safeguards to minimise future risk to the Trust's service users and staff.

- **Effective investigation of, and learning from, concerns**

  In compliance with the statutory Duty of Candour and Putting Things Right Regulations, proportionate investigation and learning will remain at the heart of the Trust's commitment to improve the Trust's services and enable learning to be shared. This not only encourages better outcomes across NHS Wales but also ensures staff are able to raise concerns in a safe and protected environment.

- **Statutory and professional duty of candour**

  There are two types of duty that involve candour:-
  - professional

  - statutory

  Professional Duty - Healthcare professionals are required to comply with their professional duty of candour**,** which states:
  "*Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress".*

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Statutory Duty - NHS organisations are responsible for regulating the statutory duty of candour, while regulators of specific healthcare professions, such as the General Medical Council (GMC), Nursing (RCN), and Midwifery Council (NMC) will oversee the professional duty.

The new statutory duty compliments the existing professional duty of candour and has the same aims – to encourage openness and learning to improve the quality of our care.

The statutory duty of candour also encompasses specific requirements for 'notifiable safety incidents'. When a notifiable safety incident occurs, the professional duty alone will no longer be sufficient to meet the requirements.

24.2   Definitions

Statutory Duty of Candour	To act with openness and honesty with service users or their families/advocates, when a service user is harmed by the provision of healthcare, regardless if a concern is raised.
Professional Duty of Candour	The individual duty professionally owed.
Concern	Refers to a claim, complaint, incident or enquiry.
Openness	Free to express concerns and questions answered honestly.
Transparency	Sharing a true account of performance and outcomes with staff, service users, the public and regulators.
Notifiable adverse outcome	An adverse event which caused, or has the potential to cause, harm to a service user which may be a factor in the duty of candour being triggered.
Apology	Saying sorry. An expression of meaningful sorrow or regret.
Harm	More than minimal harm. Level of harm is defined as: death, severe harm or moderate harm, includes psychological harm.
Healthcare	Provision provided in Wales under virtue of the National Health Service (Wales) Act 2006 for or in connection with:- a) the prevention, diagnosis or treatment of illness;

	b) the promotion and protection of public health;
Illness	Includes any disorder or disability of the mind and any injury or disability requiring medical or dental treatment, nursing or therapy.
Service user	Person to whom healthcare is given by an NHS organisation/provider.
Review	Clarification of an incident and an assessment as to the level of harm that has occurred or could occur to the service user when considering if the threshold for triggering the duty of candour has been met.
Investigation	In-depth analysis and enquiries made to understand what has happened. This may involve a number of investigative techniques and methodologies including, 5 whys, root cause analysis, fish bone tool etc. The investigation will require the need to identify learning.
Once for Wales Datix Cymru	A reporting and management digital platform for concerns, comprising claims/inquests, incidents, redress, feedback (complaints) modules.

24.3 When does the Duty of Candour apply?

Every event is likely to be different and, at times, complex. Two conditions must be met in order for the duty to be triggered:-

1. A service user experiences, or could experience, unintended or unexpected harm, that is more than minimal.
2. The provision of healthcare was or may have been a factor.

It is important to note that the duty is triggered not only when harm is known to have occurred, but also in cases where the circumstances are such that a person could experience harm from an incident or occurrence, at some point in the future.

24.4 Harm that is unintended or unexpected

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The Duty of Candour requires that harm must be unintended or unexpected.

Many interventions come with inherent risks. These risks should be identified and discussed with a service user as part of the consenting process. If, for example, a medication has a known risk of adverse reaction, the Duty of Candour will not be triggered in the event that the risk materialises and the service user has consented to the risk. In this sense, "unexpected harm" has not been identified because the risk is one which was expected as part of the consequence of treatment.

In situations regarding side effects and adverse reactions to medications, the harm threshold of more than minimal, has to be met to trigger the Duty of Candour. The materialisation of a known risk will not trigger the duty. However, complications associated with care that was not discussed as a risk of the healthcare provided, may meet the requirements to activate the trigger.

24.5 Grading Harm

The concept of "more than minimal" harm is not defined in law. The level of harm framework under the Putting Things Right Regulations will apply when determining if the duty of candour is triggered. The trigger will occur when moderate harm or above is identified, or likely, at some time in the future, to cause or potentially cause moderate harm or above, to the service user. The duty will be triggered on:-

- Death
- Severe Harm
- Moderate Harm, including psychological harm.

Further information in relation to the Duty of Candour can be found in the Handling Concerns Policy.

25.   Resources

25.1   The implementation and management arrangements associated with this policy will give rise for the release of investigators to investigate a claim.

26.   Implementation

26.1   The function of this policy will be maintained by the Corporate Quality & Safety Team.

27. Policy Conformance / Non Compliance

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

28. Distribution

28.1 The policy will be available via the Trust Intranet Site and the Claims Manager. Where staff do not have access to the intranet, the staff member's line manager must ensure that their staff have access to a copy of this policy.

29. Review

29.1 The Claims Manager will review the operation of the policy as necessary and at least every 3 years

30. Contact Information

30.1 The Claims Manager can be contacted as follows:- Jayne.Rabaiotti@wales.nhs HandlingConcernsVelindre@wales.nhs.uk. Contact telephone number: 02920196161

31. References and Legislation

31.1 This Policy complies with:-

- PTR Guidance – Clinical Negligence and Personal Injury Litigation: Claims Handling: Putting Things Right – Guidance on dealing with concerns – Clinical Negligence and Personal Injury Litigation: Structured Settlements

- Health and Social Care (Quality and Engagement) (Wales) Act 2020

- The Civil Procedure Rules 1998

- Welsh Health Circular (WHC) (2000) 04 replacing the Welsh Health Circular (WHC) (98) 08

- WHC(99)128 – Handling Clinical Negligence Claims: Pre-Action Protocol

- Welsh Health Circular addendum (WHC 04 (2000))

- The Welsh Risk Pool Services Concerns and Compensation Claims Management Standard

- The Welsh Risk Pool Protocols and procedures including the Case Reimbursement Procedures and periodic reimbursement updates and Welsh Risk Pool Indemnity provisions

- The Trust's Standing Orders and Standing Financial Instructions

- Protocol for Referring Clinical Negligence Claims to Legal & Risk

- Duty of Candour

- The Welsh Risk Pool revised All-Wales Indemnity and Insurance Policy and Scope Document effective from 1st September 2023

- Welsh Risk Pool Procedures (revised)

RESPONSIBLIITY AND ACCOUNTABILITY FRAMEWORK – Velindre University NHS Trust

Organisation chart - Concerns Management

Chief Executive
Steve Ham

Director of Nursing, Allied Health Professionals & Health Science

Deputy Director of Nursing, Patient Experience & Corporate Services

Velindre Cancer Service Head of Nursing, Quality, Patient Experience and Integrated Care

Head of Quality, Safety & Assurance

Welsh Blood Service Head of Nursing

Velindre Cancer Service Quality and Safety Manager

Deputy Head of Quality, Safety and Assurance

Welsh Blood Service Complaints and Patient Experience Manager

Velindre Cancer Service Complaints and Patient Experience Manager

Quality, Safety and Assurance Manager

Quality, Safety and Assurance Manager

Quality, Safety and Assurance Manager

Claims Manager

Corporate Quality and Safety Administrator

Corporate Quality and Safety Administration Assistant

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SCHEME OF DELEGATION

Matter Delegated	Approving Officer
Approving individual losses and special payment claims in accordance with current Assembly guidance and Velindre University NHS Trust Model Standing Orders - Reservation and Delegation of Powers 2021: Please see Appendix referred to below	
• Up to £5,000	Claims Manager & Quality, Senior Quality and Safety Assurance Managers
• up to £100,000	Chief Executive/Executive Director of Nursing Allied Health Professionals and Health Science
• Over £100,000 and up to £1,000,000	Trust Board
• Over £1,000,000	
	Welsh Government/Welsh Risk Pool
<u>**Notes:**</u> These limits relate to damages and/or costs payable	

**Extract from Velindre University NHS Trust Model Standing Orders –
Reservation and Delegation of Powers 2021:**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HANDLING CONCERNS POLICY

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ENDORSE FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	To ensure the Trust discharges its responsibilities regarding concerns handling the Trust Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour) QS03 has been reviewed and updated to ensure alignment with: • The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour). • National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011). • The Putting Things Right Guidance (PTR) (2023). • Public Service Ombudsman for Wales Act (2019). • Duty of Candour Procedure (Wales) (2023).

	• NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **ENDORSE** the revised version of the Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour): QS03.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality and Safety Group	25th July 2023.
Executive Management Board	31st July 2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Policy endorsed for onward approval.

7 LEVELS OF ASSURANCE	
NOT REQUIRED AS A POLICY FOR APPROVAL	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** Not required

APPENDICES	
1.	Revised Trust Handling Concerns Policy

1. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The revised Handling Concerns Policy is attached in ***Appendix 1***. This policy has been extensively reviewed and amended to ensure alignment with the legislative requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) Act, the requirements of the Duty of Candour procedures (2023) and updated Putting Things Right Guidance (2023).

2. IMPACT ASSESSMENT

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

If yes - please select all relevant goals:
 • Outstanding for quality, safety, and experience   ☒
 • An internationally renowned provider of exceptional clinical services   ☒
    that always meet, and routinely exceed expectations
 • A beacon for research, development, and innovation in our stated   ☐
    areas of priority

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* [STRATEGIC RISK DESCRIPTIONS](#)	06 - Quality and Safety

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	All 6 domains of quality are positively impacted by this policy.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required
	Not applicable

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are financial requirements in respect of executing responsibilities within this policy relating to NHS redress procedures.

EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Yes - please outline what, if any, actions were taken as a result
	Click or tap here to enter text.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirements to comply with Duty of Quality, Duty of Candour and Putting Things Right Regulations. This policy ensures Trust compliance with these legal responsibilities from a handling of concerns perspective.

Ref QS03

Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour)

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Corporate Head of Quality, Safety and Assurance
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	
Version:	5

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1.   Executive Summary

This policy has been developed to ensure that Velindre University NHS Trust (the Trust) discharges its statutory responsibilities for the robust, effective, and timely handling of concerns (complaints, claims, and patient safety incidents) through ensuring organisation wide learning and continuous improvement, in line with the requirements set out within:

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2023).
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).

2.   Policy Statement

The Trust fully acknowledges that, as a provider of specialist and complex healthcare services, there will be occasions where things will go wrong.

When such occasions occur the Trust will ensure a robust response that is in line with the key principles and statutory requirements of Health and Social Care Quality and Engagement (Wales) Act (2020), the Duty of Quality (2020), the Duty of Candour (2022) and National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011), to ensure an open and transparent concerns handling, with and a strong focus upon learning and continuous improvement, required to ensure the provision of safe, timely, effective, efficient, equitable and person centred care.

2.1 Policy Key Principles

A culture of psychological safety, openness, and transparency.	Robust & proportionate Investigations.	Local procedures will be in place to support delivery in line with the requirements of National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations (2011). Putting Things Right Guidance.
Staff will be equipped with role appropriate concerns handling knowledge and information.	Individuals raising concerns will be engaged in the handling process.	Staff involved in a concern will be able and encouraged to access support.
Consistent concern management and reporting Systems in place across the Trust.	Continuous improvement through learning.	A bi-lingual service will be provided through an active Welsh Language offer.
Learning will be shared across the Trust.	Early resolution of concerns will be promoted, and unnecessary escalation avoided.	Concerns will be managed in a timely manner in line with Putting Things Right Regulations.

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3. Scope of Policy

This policy applies to all people engaged in work for the Trust and host organisations, including those employed on a contract of employment and those working on a bank or agency contract

There is an acknowledgement that the Putting Things Right Regulations and Duty of Candour may not apply in their entirety to some hosted organisations, however, the principles and requirements of the Regulations should be adopted where appropriate as good practice.

The Policy relates to concerns regarding:

- Services, care, and treatment provided by the Trust.
- Services provided by the Trust's employed staff.
- Services provided by independent contractors.
- Services provided by independent or voluntary sector(s) funded by the Trust.

This policy *does not* apply to concerns relating to:

- Clinical services provided privately, even when provided within Trust premises.
- Staff contract of employment, e.g., concerns raised though the Respect and Resolution Policy or The Procedure for NHS Staff to Raise Concerns (whistleblowing).
- Public Services Ombudsman investigations.
- Alleged failure of the Trust to comply with a request for information under the Freedom of Information Act (2000).
- Trust disciplinary proceedings arising from the investigation of a concern.
- Civil Proceedings.
- Individual Patient Funding Request (IPFR).
- Police criminal investigations.

If a concern raised is excluded from the scope of Putting Things Right Regulations (PTR) the Trust will advise the complainant, in writing as soon as reasonably practicable of the reason(s) for the decision. If any excluded matter forms part of a wider concern, the issues within scope of the Putting Things Right Regulations can be managed under this policy.

4. Aims & Objectives

The Trust is committed to dealing with concerns in a timely, open, honest, transparent, accessible, and equitable manner, with a strong focus upon ensuring that organisational learning and continuous improvement takes place, in accordance with the NHS Wales Duty of Candour.

The aim of this Policy is to:

- Ensure the Trust has robust arrangements in place for the effective handling and monitoring of concerns.
- Provide assurance to the Board and external bodies of the commitment to implement the requirements of the regulations National, the Health and Social Care Quality and Engagement (Wales) Act 2020 and Duty of Candour Procedure (2023).
- Define concern handling roles, responsibilities, and processes.

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5. Definitions

Adverse event/incident	An event which causes or has the potential to cause unexpected or unwanted effect involving the safety of the patients, users, or other persons.
Claim	Allegations of negligence and/or demand for compensation made following an untoward incident resulting in clinical negligence or personal injury to a member of staff, patient, member of the public or damage to property.
Complainant	A person notifying the concern/complaint.
Complaint	Any expression of dissatisfaction.
Concern	Any complaint, claim or reported patient/ donor incident to be handled under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
Duty of Candour	A requirement to ensure healthcare providers are open and transparent with people who use services when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Duty of Quality	A legal responsibility for Welsh Ministers and NHS bodies secure improvements in the quality of services they provide, supporting the achievement of ever higher standards of person-centered care services in Wales.
Early Resolution	Concerns that could potentially be resolved to the complainant's satisfaction either immediately or within 2 working of receipt.
External body / Agency	An organisation that has an official advisory or regulatory role that has been mandated to regulate the corporate and professional activities of NHS Trusts.
Investigation	A formal approach of gathering information in a systematic and methodical way.
Nationally Reportable Incident	A patient or donor safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare.
Never Event	Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.
Near Miss	An occurrence, which but for the luck or skilful management would in all probability have become an incident.

Qualifying Liability	A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient/ donor/ service user in consequence of any act or omission by a health care professional and which arises in connection with the provision of qualifying services.
Redress	The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability in tort; the giving of an explanation; the making of a written apology and the giving of a report on the action that has been, or will be, taken to prevent similar occurrence
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

6. Roles and Responsibilities

In line with the Regulations the roles and responsibilities for Concern Handling at VUNHST are:

6.1 Chief Executive Officer

The Trust Chief Executive Officer has overall responsibility for dealing with concerns and ensuring investigations are undertaken in an appropriate manner, within appropriate timescales and that lessons learned are implemented within the Trust.

6.2 Responsible Officer

The Responsible Officer is accountable for the effective day to day operation of the Trust's arrangements for dealing with concerns in an integrated manner. The Director of Nursing, Allied Health Professionals and Health Science is the Responsible Officer for the Trust and ensures arrangements are in place to:

- Deal with concerns in line with the Regulations.
- Ensure a Duty of Candour is applied where appropriate.
- Allow for the consideration of qualifying liabilities; and
- For incidents, complaints and claims to be dealt with under a single governance arrangement.

6.3 Strategic Oversight

A nominated Independent Member is responsible for maintaining a strategic overview of the Putting Things Right arrangements and the Duty of Candour and their operation, including:

- Overseeing how organisational arrangements are operating at a local level.
- Ensuring that concerns are dealt with in compliance with the regulations.
- Ensuring the Duty of Candour is triggered where relevant.
- Ensuring arrangements are in place to review the outcome of all investigated concerns to ensure that any failure in provision of service identified during the investigation are acted

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upon, learnt from, and monitored to prevent recurrence. The nominated Independent Member is the individual with responsibility for the Quality, Safety & Performance Committee.

6.4   Corporate Quality and Safety Team

The Corporate Quality & Safety team is responsible for ensuring the Trust has appropriate policies, procedures, support, and training in place for the management of Concerns across the organisation through.

- Receipting and grading PTR Concerns and providing acknowledgement letters within required timescales.
- Developing Concerns / Putting Things Right/ Duty of Candour related policies and procedures.
- Providing/sourcing concerns handling, investigation and Datix Cymru training to ensure staff across the organisation are equipped with the knowledge and skills to undertake their role in concerns handling and investigation.
- Overseeing appropriate divisional investigative processes and adherence with national timescales
- Leading on 'Serious Harm' investigations
- Leading on all Public Services Ombudsman Reviews / investigations
- Leading on all Redress processes
- Leading on all Duty of Candour reporting
- Leading on Vexatious Concerns Management
- Auditing compliance with Putting Things Right and Duty of Candour
- Oversight of learning and dissemination of learning
- Development of Concern reports for Executive Management Board, Quality, Safety & Performance Committee and Trust Integrated Quality and Safety Group
- Development and Publishing Trust Annual Concern Report
- Leading on liaison and meeting requirements of other external bodies such as: Coroner's Office; Shared Services – Legal and Risk, Police; and Citizen Voice Body for Health and Social Care, Wales
- Representing the Trust at National Concern related meetings.

6.5   Executive Management Board

The Executive Management Board is responsible for overseeing the Trust's Concerns Management process and outcomes, including policies, procedures, and reporting in line with legislative and national requirements; training provision and compliance; identification of and compliance with key performance indicators; meaningful analysis; investigative processes; audit and operational assurance mechanisms; ensuring that remedial action is taken; Duty of Candour mechanisms are in place; and appropriate lessons are identified and shared.

6.6   Quality Safety and Performance Committee

The Quality, Safety and Performance Committee provide assurance reports to the Trust Board in relation to how the Trust is meeting its responsibilities under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011) and Duty of Candour Procedure (Wales) (2023), whilst highlighting any exceptions, risks, or potential risks in respect of this. The Committee's oversight includes ensuring the provision of appropriate training,

policies, procedures, and reports in line with legislative and national requirements; identification of and compliance with key performance indicators; meaningful analysis. investigative processes; audit and operational assurance mechanisms; ensuring remedial action is taken and appropriate learning identified, addressed, and shared

6.7 Corporate Head of Quality, Safety and Assurance

The Head of Quality, Safety and Assurance is responsible as the Senior Investigations Manager (SIM) for the Trust in line with the requirements of the PTR regulations, and is responsible for:

- Oversight of the handling and consideration of concerns in accordance with this policy.
- Auditing Trust and Divisional concern handling arrangements.
- Ensuring robust interface arrangements with the Divisions are in place to ensure effective divisional concern handling processes and outcomes.
- Development, integration and embedment of a comprehensive concern investigation and redress systems.
- Embedment of robust Duty of Candour processes and procedures.
- Providing assurance to the Executive Management Board (EMB) and Quality, Safety and Performance Committee on the Trust concern management performance.
- Ensuring mechanisms are in place for learning, and continuous improvement initiatives to be shared across the Trust.

6.8 Service Directors (including hosted Organisations)

(Corporate / Divisional Directors, Clinical Directors, Medical Directors, Chief Scientific Officers, and Heads of Nursing.)

Service Directors are responsible for achieving compliance with the Regulations, the Duty of Candour, and this policy through ensuring:

- The provision of robust local concern handling arrangements across all provided and commissioned services.
- Concerns are managed within required timescales and performance measures.
- Datix Cymru is the primary repository for all concerns and associated documentation
- All investigations are fully and accurately recorded and stored in Datix Cymru.
- A culture of openness, transparency, psychological safety, learning, improvement is promoted, encouraged, and embedded into practice.
- Employees receive role appropriate concerns handling training
- Employees understand their individual roles and responsibilities in concerns handling.
- Cross-divisional and Trust wide approach to concern handling, communication, co-ordination, liaison, and reporting.
- Adequate and appropriate support is available and offered to employees who are involved in, or are the subject of a concern
- Availability and release of employees trained in investigations analysis to support required investigations.
- All identified learning is addressed and shared to enable continuous improvement to prevent re-occurrence of issues arising and optimise quality and safety of service provision.

6.9 Departmental Managers

All managers across the Trust are responsible for ensuring:

- Employees and volunteers are aware of this policy and their roles and responsibilities within it.
- A culture of openness, transparency, psychological safety, empowerment, learning, improvement, and timely concerns handling is promoted, encouraged, and sustained in practice.
- Processes are in place to ensure effective management of concerns and discharge responsibilities in line with Putting Things Right Guidance and Duty of Candour Procedure.
- Ensuring all concerns and associated communications and documentation are recorded at time of report and stored within Datix Cymru system.
- Provision of robust and timely feedback of concern outcomes, lessons learnt and improvement opportunities with colleagues.
- Employees are provided with role specific training for both concerns handling and operation of Datix Cymru system.
- Display and provision of relevant patient/ donor concern reporting information and sign posting within clinical areas e.g. 'How to raise a concern' and Llais (Citizen Voice Body for Health and Social Care).
- All identified lessons learnt, and improvement actions are addressed, implemented, or escalated as appropriate.

6.10 Putting Things Right Panel

The Trust Putting Things Right panel are responsible for the consideration and progress of Regulation 26 concerns where a breach in the duty of care has been identified. Responsibilities identified include:

- Determination and or validation of whether a breach of duty has occurred.
- Determination of whether the breach of duty described has caused harm.
- Consideration of engaging an independent clinical expert if a decision on breach of duty cannot be reached.
- Consideration of engaging of an independent clinical expert in collaboration with the person raising the concern where causation is in question or further clarity as to the degree of harm is required.
- Agreement of communication pathways to communicate the decision of the panel to both the person raising the concern and staff affected by the concern.
- Agreement of award of financial compensation in cases where a Redress remedy applies.
- Ensuring robust systems to capture and record decision making processes and outcomes.

6.11 Responsibility of all Staff

All staff must ensure:

- Adherence to this policy, divisional/ departmental concerns, and Duty of Candour procedures.
- All individuals notifying/reporting concerns are treated with honesty, transparency, respect, and courtesy.
- All concerns are treated confidentially.
- Understanding of their individual role and responsibilities for reporting, handling and

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escalating concerns, incidents, and near misses.
- Awareness of available supportive resources.
- Co-operation and engagement in investigation processes.
- All concerns are addressed or escalated at time of report.
- Role specific concern management and Datix Cymru training and education is undertaken.
- Report all near misses, safety incidents and concerns in line with divisional and departmental processes.

7. Duty of Candour

The Trust will adhere to the legal requirements and discharged its responsibilities in line with the Health and Social Care (Quality and Engagement) (Wales) Act (2020) and Duty of Candour Procedure (Wales) (2023).

7.1 When does the Duty of Candour apply?

For the Duty of Candour to be triggered the following two conditions must be met:

- **A service user experienced, or may have experienced, unintended, or unexpected harm (physical or psychological harm or in the case of an individual that is pregnant, loss or harm to the unborn child) that is "more than minimal." Although there is no legal definition of minimal harm, in practice this relates to moderate harm or above:**

  ''Moderate Harm: A service user experiences a moderate increase in treatment and significant but not permanent harm, e.g., being given medication, that they have a known allergy to, and this leads to a significant reaction requiring 4 or > days in hospital before recovery.'

  'Severe Harm: A service user experiences a permanent disability or loss of function e.g., being given medication, that they have a known allergy to, and this leads to brain damage or other permanent organ damage.'

  'Death: A service user dies e.g., being given medication, they have a known allergy to, and this leads to their death.'

- **The provision of healthcare "was" or "may have been" a factor in the patient or donor suffering that outcome.**

To ensure appropriate consideration of the Duty of Candour requirements the Trust will consider each event upon an individual basis and determine whether a 'notifiable adverse outcome' has occurred, and the Duty triggered.

7.2 Requirements of Duty of Candour

- The trust is legally required to adhere to the conditions of the Duty of Candour and will therefore ensure that Duty of Candour Procedure (Wales) 2023 is followed.

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7.3 Duty of Candour Procedure

- To ensure the Trust fulfils its legal obligations it will ensure the following robust process is in place:

7.3.1 Stage 1 – Rapid Review- Identification of a 'Notifiable Adverse Outcome'

Incidents or Concerns graded at moderate harm or higher will receive a rapid review that is undertaken within 48 hours of report to determine whether a notifiable adverse outcome has occurred, and the Duty of Candour triggered. All rapid reviews will be recorded in the Datix Cymru system in line with Trust Incident Reporting policy and processes.

7.3.2 Stage 2 – 'In Person Notification'

The Trust will ensure that the 'In Person Notification is undertaken in line with the Duty of Candour procedure (2023), by a suitably trained and skilled individual, either in person, via telephone or audio visually, and completed at the time the Trust first become aware the Duty of Candour procedure has been triggered.

The in-person notification will consistently include:

- A meaningful apology
- An explanation of the actions and further enquiries that the Trust will undertake to investigate the circumstances of the notifiable adverse outcome
- Details of the nominated point of contact,
- An offer of support and details of any appropriate support information
- If the in-person notification is made later than 30 working days after the Trust first became aware of the notifiable adverse outcome an explanation for delay should be included.

7.3.3 Stage 3 - Written Communication

The Trust will ensure a formal letter is issued by the Service Director or nominated deputy to the service user/ person acting on their behalf within five working days of the "in-person" notification.

The formal letter will include:

- Reiteration of the verbal apology
- Date of notification
- An account of the incident to date and explanation of the actions that the organisation will take as part of the procedure and the investigation
- Point of Contact details
- Details of available support
- If "in-person" notification was later than 30 days after the date on which the incident occurred, an explanation of the reason for the delay is required.

7.3.4 Stage 4 - The Review/Investigation

The division in collaboration with the service user or person acting on their behalf will conduct an open, transparent, and proportionate investigation of the incident in accordance with the Regulations and Duty of Candour procedure (2023). Once complete the investigation outcome will be

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communicated to the service user or their representative in accordance with regulation 24 or regulation 26 and 31, where the Redress arrangements apply.

7.4   Record Keeping

The Trust will ensure that all correspondence, decisions made, actions and relevant documents are kept in accordance with the Duty Candour Procedure within Datix Cymru. Documentation should include but is not limited to:

- Outcomes of Rapid Review to establish whether the duty has been triggered.
- Notification of the Duty.
- Attempts to contact the service user/person acting on their behalf.
- Any decision by the service user/person acting on their behalf not to be contacted in relation to the Duty of Candour
- Investigation of the notifiable adverse outcome, which is undertaken by the Trust, including the response or interim report issued under regulations 24, 26 or 31 of the 2011 Regulations.

7.5   Consent

The Trust will ensure that relevant consent procedures are followed in line with the Putting Things Right guidance and Duty of Candour procedure. In cases where a representative is acting on behalf of a service user with capacity, consent for the representative to act will be obtained from the service user and will be kept under review throughout the process.

In situations where the service user/person acting on their behalf indicate that they do not wish to engage or communicate with the Trust, the individuals wishes should be respected, but investigation of the incident must continue so that lessons can be learned, and quality improvements made.

7.6   Serious Case Reviews

In the event of adverse outcomes effecting large numbers of patients/ donors are identified following retrospective serious case reviews, or following a decision made by the medical examiner service or a coroner's inquest, where the cause of death attributed was not known at the time of the incident, the Trust will ensure Duty of Candour Procedures are followed for all affected individuals.

7.7   Incidents that occurred before 1st April 2023

The Duty of Candour is not intended to operate in respect of adverse outcomes which occurred before the 1st of April 2023.

7.8   Reporting to External Bodies

The Trust will fulfil its external reporting responsibilities in line with the requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) ((Duty of Quality and Duty of Candour), National Serious Incident reporting procedure, regulators, Medical Examiner Service, His Majesty's Coroner and Welsh Government.

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7.9 When more than one NHS organisation is involved in the Duty of Candour Procedure

In situations where the Trust is part of an episode of care with other NHS Organisation(s) in which the Duty of Candour is triggered, the Trust will fulfil its responsibilities in line with the Duty of Candour procedures (Wales) (2023).

8. Concerns Management

8.1 Early Resolution Concerns

The Trust will manage Early Resolution Concerns in line with The Putting Things Right Guidance, ensuring resolution achieved to the satisfaction of the complainant within 2 working days from receipt. In circumstances where resolution has not been achieved within this period, but the complainant does not wish to raise a formal concern, the Trust will aim to resolve the concern(s) within 5 working days from receipt. If following this time, the concern remains unresolved, the concern(s) will be managed in line with the regulations as a formal concern.

8.2 Concerns Notified by a Third Party

The Trust will ensure that concerns notified by a third party acting as a representative on behalf of another are handled in line with the Regulations ensuring a best interest assessment is completed and proportionate response considered.

8.3 Concerns Received from Assembly Members/Members of Parliament

The Trust will ensure that concerns received from the Welsh Government, an Assembly Member, Member of Parliament, or other elected members on behalf of their constituent, are dealt with as soon as possible and a response provided at the earliest opportunity. For the sharing of personal data, the Trust will adhere to the requirements of The Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order (2002).

8.4 Concerns Relating to Children and Young People.

Where a concern is notified by a child or young person, the Trust will ensure it meets its support, assistance, and advocacy responsibilities in line with the Welsh Government's 'Model for Delivering Advocacy Services to Children and Young People in Wales.'
In the event of concerns being received on behalf of a child or young person the Trust will determine whether the child or young person wishes to raise a concern themselves, or if they are happy for the person who raised the concern to represent them. In cases where the child or young person is not willing to allow the concern to be investigated, the Trust will assess the individual situation and where appropriate seek specialist advice to support decision making. In any circumstance where safeguarding issues are identified the Trust will evoke the Wales Safeguarding procedures.

8.5 Concerns Raised by Prisoners

The Trust will handle and investigate concerns raised by prisoners in the same manner as all concerns, in accordance with the Regulations and with the offer and right of access to advocacy services provided by Llais, Social Care or mental health services as appropriate.

8.6 Concerns raised by individuals Lacking Capacity or Vulnerable Adults

The Trust will ensure that all concerns raised by individuals lacking capacity or vulnerable adults and handled in an equitable and accessible manner with reasonable adjustments and enhanced support and advocacy services provided as required.

In circumstances where concerns regarding mental capacity are raised the Trust will ensure all assessments align with the requirements of Mental Capacity Act (2005). During this process, if any safeguarding and public protection issues are identified the Trust will evoke the All-Wales Safeguarding Procedures.

8.7 Concerns raised through Advocacy Services

The Trust will work in collaboration with Advocacy services and ensure that concerns raised on behalf of patients/ donors are managed in line with the Regulations.

8.8 Concerns from Solicitors / Intention to Litigate /Requests for Compensation

The Trust will ensure that concerns, litigation intents and compensation requests are managed by the Corporate Quality and Safety Team, in accordance with the governance and framework of the regulations, with exception of a concern in respect of which court proceedings have already been issued, including the pre-action stage of those proceedings which should not be further investigated.

8.9 Concerns from people with a Disability

In line with the Equality Act (2010), the Trust will make reasonable adjustments to ensure that the concerns process is accessible, and reasonable adjustments provided for service users who have a disability.

8.10 Concerns and British Sign Language (BSL)

The Trust recognises BSL as a recognised language and will ensure the concerns process is accessible to service users who communicate through BSL through the provision of services and reasonable adjustments as appropriate.

8.11 Concerns from Blind and Partially Sighted Individuals

The Trust will ensure that it has in place alternative methods for communication, including access to Braille and large print versions to support and enable concerns to be raised by individuals who are blind or partially sighted.

8.12 Concerns involving Contracted Services

The Trust will ensure that all contracted services are aware of and understand this policy, its application in practice, and their role and responsibilities in concerns management and adherence with the Regulations.

9. Welsh Language

When dealing with concerns the Trust will take account of its statutory duties in relation to the provision of services in Welsh and will ensure compliance with the duties set under the Welsh Language (Wales) measure (2011) and Welsh Language Standards. All concerns received in Welsh will be responded to in Welsh under the regulations and the Trust will ensure:

- All written communication is provided in Welsh.
- Welsh interpretation for telephone or face-to-face meetings.
- Provision of bilingual information resources.
- Adopt a proactive approach to language choice and need in Wales.
- Ensure Welsh Language Needs are met.

10. Reporting Concerns

In line with the Regulations, the Trust has a single point of contact for raising a concern:

Executive Director Nursing AHP's & Health Science Velindre Trust Head Quarters
2 Charnwood Court
 Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Email: handlingconcernsvelindre@wales.nhs.uk

Telephone: 029 20196161

10.1 Management and Investigation of Concerns

The Trust will ensure that concerns are managed and investigated in the most relevant, proportionate, efficient, and effective way in line with the Regulations, Duty of Candour Procedure, this policy, and local procedures.

10.2 Acknowledging PTR Concerns

The Trust will ensure that all concerns managed under the Regulations and Duty of Candour Procedure with acknowledgement being issued in writing within 5 working days of receipt and will include:

- Point of Contact details
- An offer of a meeting or discussion to review and discuss their concern and the concerns process.
- The opportunity to meet with relevant staff involved in relation to the concern/s raised.
- Response timescales.
- Details of advocacy and support services.
- Information advising that a patient's clinical records will need to be accessed as part of the investigation.
- A copy of the Putting Things Right leaflet.

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10.3 Formal Response Timescales limit

The Trust will provide a full and comprehensive response/interim report within 30 working days from the date the concern is received, if the Trust is unable to comply with this standard, the Trust will:

    (a) notify the service user, outline the reason for the delay, and advise when the response will be available; and

    (b) send the comprehensive response/interim report as soon as reasonably practicable and within 6 months, or 12 months for concerns being handled under Regulation 33 of the Regulations.

10.4 Concerns received from Medical Examiners

The Trust will ensure robust corporate procedures are in place to receive and respond to concerns received from the Medical Examiner's office.

10.5 Concerns Referred to Coroner's Inquest

The Trust will ensure that robust procedures are in place to investigate concerns referred to HM Coroners Service in line with the Regulations.

10.6 Consent to Investigate Concerns

The Trust will ensure that the consent policy is followed, and patient/ donor consent obtained for all concern investigations that require access to medical records, if the patient/donor does not provide consent the Trust will take a view on whether an investigation without access to the medical records would be possible and beneficial.

10.7 Consent Involving Other Organisations

Where the Trust is notified of a concern that involves the functions of more than one responsible body/organisation, it will firstly seek the consent of the complainant (within 2 working days of concern receipt), Within 2 days of consent receipt the Trust will contact all relevant organisations and the lead organisation will be identified in discussions with the complainant and involved organisations.

11. Time limits for notification of a Concern

The Trust aligns the time limits for notification of a concern with the Regulations and requires concerns to be notified no later than 12 months from the date on which the concern occurred, or if later,12 months from the date the person raising the concern realised they had a concern. Concerns received after these timescales will be considered by the Trust to determine the reason for the delay in reporting and the possibility of investigation being thorough and fair due to the time lapse.

12. Withdrawal of Concerns

The Trust acknowledges that a concern can be withdrawn at any time by the complainant, with such withdrawal requests can be provided in writing or verbally and will be acknowledged in writing by the trust. Despite withdrawal the Trust will ensure the concern continues to be investigated.

13. Nationally Reportable Incidents

The Trust will ensure a concern raised by a complainant that has already been reported and investigation commenced as a nationally reportable incident will be managed in accordance with the Regulations, with the investigation progressing in line with Nationally Reportable Incident policy, ensuring the person raising the concern is kept informed of investigations and outcomes.

Where a concern is received, and it becomes apparent that there has been a serious incident that the Trust was previously unaware of, the Trust will ensure the incident is reported within Datix Cymru system and the National Reportable incident process followed, whilst informing the complainant of the process, the potential that 30-working day response timeframe will not be achieved, and details of expected timing of response.

13.1 No Qualifying Liability – Regulation 24

The Trust will ensure that requirements of the Regulations and associated investigations and reporting requirements are met.

In events where further correspondence is received from the person raising the concern, expressing dissatisfaction, the Trust will ensure the concern is I be reopened, investigated, and acknowledged within 2 days. If a complainant is dissatisfied with their response and there are no new issues to investigate, the Trust will manage in accordance with the Regulations with the concern not being reopened and a meeting with the complainant offered, if the complainant remains dissatisfied following this the Trust will advise the complainant to refer their concerns to the Public Services Ombudsman of Wales.

13.2 Interim Report (Regulation 26) – When a Breach of Duty is identified, and harm has, or likely to have occurred, resulting in a possible qualifying liability

- The Trust will ensure compliance with the Regulations, in cases where the Trust considers following investigation that both breaches in the duty of care have been identified and potential for harm, or actual harm identified in line with the requirements of establishing a qualifying an interim report under Regulation 26 will be issued within 30 working days from whichever is the later from: The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the "in person" notification under Regulation 4(1) of the Duty of Candour Regulations was given.

The Trust will ensure that i in cases where a breach in the duty of care is identified that the case will be progressed and considered by the Trust's Putting Things Right Panel to inform the interim Regulation 26 response, ensuring the inclusion of the following detail:

- A summary of the nature and substance of the issues contained in the concern.
- A description of the investigation undertaken to date
- A description of why in the opinion of the Trust there is or may be a qualifying liability.
- A copy of any relevant medical records.
- An explanation of how to access legal advice without charge.
- An explanation of advocacy and support services which may be of assistance.
- An explanation of the process for considering liability and Redress.
- Confirmation that the full investigation report will be made available to the person seeking Redress.

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- An offer of an opportunity to discuss the contents of the interim report with appropriate staff.
- The interim report should receive final approval and signed off by the Executive Director Nursing, AHP's and Health Science.

If it is not possible to issue a Regulation 26 interim response within the required 30 working day timeframe, the Trust will ensure the person raising the concern will be informed of the reason for the delay and the interim response sent within 6 months of whichever is the later, either:

- The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the "in person" notification under Regulation 4(1) of the Duty of Candour Regulations was given.

Once the interim response is issued, the Trust will ensure the matter is forwarded to the Trust Claims Manager for further investigation under the Redress arrangements as referenced within the Regulations.

13.3 Post Closure contact - Public Service Ombudsman of Wales

The Trust will ensure compliance with the Public Services Ombudsman (Wales) Act (2019) and inform any individuals that are dissatisfied with the Trust final response of their right to contact the Public Service Ombudsman for Wales, who will review the matter on their behalf.

The Ombudsman's contact details are: Phone: 0300 790 0203
E-mail: ask@ombudsman.wales Website: www.ombudsman.wales
Address: Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

13.4 Investigation by the Public Service Ombudsman of Wales (PSOW) - timeframes

On receiving a complaint from the PSOW, the Trust will provide an acknowledgement of receipt to the PSOW within 5 days and will investigate and respond to the PSOW within 20 days. If for any reason required timescales are difficult to achieve the Trust will request an extension from PSOW.

In response to conclusions received from the PSOW the Trust will ensure that identified opportunities for learning and improvement are actioned and shared.

13.5 Redress

The Trust will ensure compliance with the Redress requirements of the Regulations, including.

- The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability.
- The giving of an explanation.
- The making of a formal apology.
- The provision of a report on the action/s which has been, or will be, taken to prevent a similar occurrence from arising.
- Care/remedial treatment.

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Following an opinion from an independent expert, the report findings are shared with the appropriate division and relevant staff members involved in the investigation, as required. If a breach of duty exists, a Regulation 26 response is issued, and the matter is referred to the Trust Claims Manager for ongoing management of the concerns under the Redress arrangements.

In circumstances when a person is seeking Redress, the Trust will ensure findings of the investigation are recorded in an investigation report in accordance with Regulation 31, with the report that contains:

- copies of any independent expert advice used to determine whether there is a liability.
- a statement by the Trust confirming whether there is a liability and
- the rationale for the Trust decision.

The Trust will ensure the report is provided in line with the Regulations to the person who raised the concern.

Where an investigation report cannot be provided within the set 12-month timescale, the Trust will inform the person raising the concern of both the reason for the delay and expected date for response.

13.6 Regulation 33 Response

The Trust will ensure compliance with Regulation 33 ensuring that when financial compensation is due, a Regulation 33 response will be completed by the Trust Concern Manager, to provide an appropriate financial offer to settle the matter on a full and final basis with approval from the Executive Director of Nursing, Allied Health Professionals and Health Science. Following the issue of this response the person raising the concerns will have six months to accept the offer, If, after that time, no response is received, the concern will be closed within 9 months.

13.7 CRU Certificate

The Trust Claims Manager is responsible for requesting a CRU certificate from the Department of Work and Pensions where it is established that harm may have occurred. This is in accordance with the Trust's statutory obligation. Where harm is found to have occurred in relation to the NHS Charges/recoverable benefits (CRU), the Trust Claims Manager will arrange the appropriate payment and discharge of the CRU Certificate, as necessary. Where the NHS charges/CRU amounts to over £3,000 the matter is passed to NWSSP Legal and Risk Services for advice in accordance with the Welsh Risk Pool guidance.

14.   Behaviour, Conduct and Unreasonable Demands during a Concerns Investigation

The Trust will ensure that people raising concerns are heard, understood, and respected. On occasions there may be times when persons raising the concern acts out of character and become determined, forceful, angry and make unreasonable demands of staff, in such circumstances the Trust has a zero-tolerance policy on unreasonable, unacceptable abusive or aggressive, or violent behaviour.

For the purpose of this policy, unreasonable, unacceptable, abusive, or aggressive, or violent behaviour is considered as:

- Behaviour that produces damaging or harmful effects, physically or emotionally on other

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people.

- Persistent unacceptable behaviour is demonstrated on several occasions within a given period of time.

Examples of unacceptable or aggressive or abusive behaviour recognised by the Trust include:

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g., both written and oral.
- Demands for responses within unrealistic timescales, repeatedly phoning, writing, or insisting on speaking to particular members of staff.

15. Monitoring Arrangements

The Trust will ensure a record is held of the following matters:

- Each concern notified.
- The outcome of each concern.
- The time taken to investigate the concern.
- The reasons where any investigation exceeded the 30-day time period.

The Trust will ensure that this information, and comprehensive analysis of concerns activity and learning will be reported to the Executive Management Board and Trust Quality and Safety Performance Committee on a quarterly basis. The Trust Integrated Quality &Safety group will provide oversight for the quarterly reports and will ensure the triangulation and robust analysis of data.

The Trust will prepare and publish an annual PTR report annually by the 31st of October regarding the delivery of the Regulations and application of the Duty of Candour in line with the requirements of the Regulations, Duty of Candour, and PTR Guidance, and will be clearly displayed on the Trusts internet site.

16. Learning from Concerns

The Trust will ensure that it has arrangements in place to review and assess the outcome of any concern that has been subject to an investigation under the Regulations, to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

- Recognised, acknowledged, owned, and acted upon
- Where improvement requires embedding, an improvement plan will be developed using the template action plan within the complaint's manual
- Identify learning for wider sharing across the Trust and share as appropriate, including the means to share across the wider NHS sector if suitable.
- Reviewed and reported regularly within the service divisions and Trust wide to ensure improvements are established minimising the risk of reoccurrence.
- Ensure that learning is used to target any problem areas and consider if there is potential to improve policies, procedures, and services.

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17. Supporting Staff

17.1 Staff involved in Concerns

The Trust will ensure it discharges its responsibilities for staff involved in concerns and will provide a psychologically safe environment for staff involved in Concerns investigations through:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. Velindre University NHS Trust will work towards a culture where human error is understood to be a consequence of flaws in the systems, not necessarily the individual.
- Providing ongoing support via Line Managers, Clinical Supervisors, Workforce department, Occupational health colleagues and Trade Union representatives.
- Ensuring the provision of mentorship and coaching as required.
- Signposting staff to their Employee Wellbeing Service/Occupational Health/Employee Assistance Programmes.
- Providing and maintaining up to date information on the support systems currently available for staff including counselling services offered by professional bodies.

17.2 Concerns Containing Allegations against Staff

Where concerns raised contain allegations against a staff member(s), the Trust will ensure relevant staff member/s receive a copy of the key issues identified at the beginning of the investigation and provide support as required throughout the process.

18. Concerns and Disciplinary Procedure

Any Disciplinary Proceedings undertaken in relation to a concern will be managed under the Trust Disciplinary policy. Equality Impact Assessment

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

The Trust will develop an understanding of why some members of the community who may wish to raise a concern might not feel able to do so. This may be due to cultural, social, gender and other reasons, including sensory loss, any of which might result in ineffective communication. Staff should be mindful of the issues which might act as a barrier to people raising a concern and look for ways to assure people that it is safe for them to raise an issue.

19. Policy Compliance

The Trust and its Divisions will ensure adherence to this policy and will provide role specific concern and Duty of Candour training to enable staff to possess the required knowledge to fulfil both their concern management roles and responsibilities and compliance with the Regulations and Duty of Candour procedure.

20.   Information Governance

The Duty of Confidentiality is an important aspect in relation to concerns handling. All Trust Staff are required to maintain the complainant's confidentiality and are required to protect personal data as outlined by legislation including the Common Law Duty of Confidentiality and the Data Protection Act 2018 which includes the retained EU GDPR 679/2016 (known as UK GDPR). UK GDPR sets out the key data protection principles, rights of individuals (known as Data Subjects), and obligations for processing personal information.

The Trust acts as a "Data Controller" in respect of personal data as defined in Article 4 UK GDPR. Staff responsible for processing personal data are to follow the 'seven data protection principles' which are contained in Article 5 UK GDPR, this means that whenever they process Personal Data, they must do so; lawfully, fairly and transparently; Only process it for specific, explicit and legitimate purposes; Ensure that in relation to the purposes of processing that the data is adequate, relevant and limited for that purpose; Ensure that the data processed is accurate, kept up to date and stored in a format which permits the data subject to be identified and kept for no longer than is absolutely necessary. Staff must also ensure that when the data is processed that appropriate technical and organisational measures are in place to protect the integrity and confidentiality of the Data. The final data protection principle is accountability; all Staff are accountable for the data that they process. The obligation to comply with the data protection principles sits alongside the eight Caldicott principles, Section 8 of the Human Rights Act 1998, Section 40 of the Freedom of Information Act 2000, and Section 13 of the Environmental Information Regulations 2004.

Information in relation to complaints should not be disclosed/copied/ shown to any external agency without the permission of the Responsible Officer or nominated deputies on a "need to know basis."

All requests for access to such information should be directed in the first instance to the appropriate manager or nominated deputy or service lead for the subject of the concern.

The Trust has adopted the NHS Wales Records Management Code of Practice Health and Social Care 2022, as well as supporting the development of the Wales Accord on the Sharing of Personal Information (WASPI) as a legally binding framework.

All staff are bound by their Contractual Duty of Confidentiality regardless of their role and are required to respect the personal data and privacy of others. All staff must not access information about any individual who they are not providing care or treatment for, or in relation to the administration of services unless in a professional capacity. They are not permitted to access their own data, any request for their own personal data must be made as a Subject Access Request. The Trust Head of Information Governance can provide further information and advice if required in relation to access rights and the lawful sharing of personal data.

The Information Commissioner's Office (ICO) has detailed guidance on data sharing on its website and has issued a data sharing code of practice, the Code of Practice can be accessed https://ico.org.uk/for-organisations/guide-to-data-protection/ico-codes-of-practice/data-sharing-a-code-of-practice/

It must be noted that the threshold for reporting a data breach to the Information Commissioner is much higher than that contained within the Duty of Candour, this is because Article 33(1) UK GDPR states:

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"In the case of a personal data breach, the controller shall without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the Commissioner, unless the personal data breach is unlikely to result in a risk to the rights and freedoms of natural persons. Where the notification under this paragraph is not made within 72 hours, it shall be accompanied by reasons for the delay".

The Trust Head of Information Governance must be contacted where a data breach has occurred so that an assessment of risk to the rights and freedoms of the natural person (data subject) can be made, this is to ensure alignment between Duty of Candour and Data Protection legislation requirements.

Advice and guidance in relation to any aspect of Information Governance considerations can be obtained from the Trusts Head of Information Governance.

VelindreInformationGovernance@wales.nhs.uk

21. Managing Media Interest / Media Communications

The management of media interest/ in relation to incidents, either individually or generally, will be undertaken by the Trust's Communications Department.

22. References

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) 6+lesgulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2013).
- Putting Things Right Guidance update (2023)
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
- Civil Procedural Rules

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NHS Wales Red Cell Shortage Plan

DATE OF MEETING	16/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ENDORSE FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	LEE WONG, BLOOD HEALTH TEAM LEAD - WBS
PRESENTED BY	Alan Prosser, Director WBS
APPROVED BY	Cath O'Brien, Chief Operating Officer

EXECUTIVE SUMMARY	The NHS Wales Red Cell Shortage Plan is a collaborative document produced by WBS in conjunction with transfusion committees and subject matter experts across all health boards in Wales. The plan defines the actions to be taken in the event of a blood shortage including roles and responsibilities for both WBS and hospitals. The Plan underwent full consultation in July 2023 (please see below for details) and will be submitted for approval at the Blood Health

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	National Oversight Group (BHNOG) meeting in October 2023. The plan has been amended to align with other UK Blood Services in terms of trigger levels and alert nomenclature and was informed by a national "Dim Gwaed" tabletop exercise within NHS Wales.

RECOMMENDATION / ACTIONS	*The Quality Safety and Performance Committee are requested to endorse this document for approval by Velindre UNHS Trust Board.*

GOVERNANCE ROUTE	
	Date
Hospital Transfusion Committees/Teams (HTC/HTT) in each HB	(01/08- 01/09/2023)
Blood Health National Oversight Group (BHNOG)	(01/08 – 01/09/2023)
Emergency Planning Advisory Group (EPAG)	(01/08 - 01/09/2023)
Welsh Blood Service Senior Leadership Team	(01/08 – 01/09/2023)
Emergency Medical Retrieval & Transfer Services (EMRTS)	(01/08 – 01/09/2023)
Executive Management Board	October 2nd 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The NHS Wales Red Cell Shortage Plan was issued for consultation via transfusion and emergency planning networks in August 2023. Relevant comments and amendments have been incorporated into the plan as part of the consultation process.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance *Please see refer to Appendix 1 for the Detailed Definitions of 7 Levels of Evaluation to Determine*

	RAG Rating / Operational Assurance and Summary Statements of the 7 Levels

APPENDICES	
1	NHS Wales Red Cell Shortage Plan

1.   SITUATION

The NHS Wales Red Cell Shortage Plan identifies the actions, roles and responsibilities of all Health Boards and the WBS in the event of a red cell shortage. The Plan identifies the different levels of alerts and actions that should be taken in each alert level. It provides HBs with a framework on which they can further develop their own protocols and procedures should a red cell shortage occur.

2.   BACKGROUND

The Plan identifies the strategic approach that NHS Wales should take if there was a red cell shortage. The plan defines each of the alert levels and the actions for both the WBS and the Health Boards. It also defines trigger levels for each alert level.

3.   ASSESSMENT

See above

4.   SUMMARY OF MATTERS FOR CONSIDERATION

To note new trigger levels (days stock) have been adopted for alert levels to Wales and new nomenclature for alerts, namely BLUE alert is being replaced with PRE-AMBER alert.

This helps align Wales with other UK blood service shortage plans.

5.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**

If yes - please select all relevant goals:
- Outstanding for quality, safety and experience ☒
- An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations
- A beacon for research, development and innovation in our stated ☐ areas of priority
- An established 'University' Trust which provides highly valued ☐ knowledge for learning for all.
- A sustainable organisation that plays its part in creating a better future ☐ for people across the globe

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK* *DESCRIPTIONS*	**Choose an item** Service Delivery
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☒
	[Please include narrative to explain the selected domain in more than 3 succinct points]. This plan help ensure the safety and sufficiency of supply within Wales is maintained and managed at times of demand/supply pressure across NHS Wales.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	As this is an all-Wales plan a request has been sent to Welsh Government to understand whether the EQIA is considered at an all-Wales level across NHS Wales and Welsh Government rather than VUNHST. Preparatory work is also ongoing in VUNHST whilst awaiting the response.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

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

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

APPENDIX 1

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

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

NHS Wales Red Cell Shortage Plan

The following plan has been drafted by Welsh Blood Service (WBS) in collaboration with NHS Wales Hospital Transfusion Teams and the Blood Health National Oversight Group (BHNOG)

Executive Summary

1.1 This document sets out the plan in the event in a shortage of allogeneic (i.e. donor) red blood cells and has been produced by the WBS, in collaboration with Hospital Transfusion Committees/Teams (HTC/HTT) across Wales, Emergency Planning Advisory Group Leads (EPAG) and the Blood Health National Oversight Group (BHNOG).

1.2 Hospitals and the WBS should work together to reduce the risk of red cell shortages through the effective management of both the supply and demand for blood. This includes use of Patient Blood Management (PBM) principles and appropriate conservation strategies.[1]

1.3 This document updates the integrated plan for blood shortages originally published by Welsh Government (WG) in the 2009 document '*CONTINGENCY PLANNING - AN INTEGRATED PLAN FOR THE MANAGEMENT OF BLOOD SHORTAGES*[2]' and builds on the principles of the original and subsequent plans.

1.4 It identifies actions to be taken by both the WBS and hospitals/Health Boards (HBs) in the event of a potential or actual red cell shortage. The latest version incorporates feedback received as a result of the blood shortage tabletop exercise run in October 2022.

1.5 The plan ensures that patients who need blood receive a transfusion regardless of their geographical location.
The arrangements are designed to ensure that:

- Access to red cells is equitably available for all essential transfusions to patients.
- Overall red cell usage is managed so that the most urgent cases receive sufficient red cells for their needs.

1.6 A shortage of red cells may be associated with a platelet shortage. Please refer to the WBS Platelet Shortage Plan[3] for further information.

1.7 The Red Cell Shortage Plan describes four phases dependent on WBS red cell stock levels - Green, Pre-Amber, Amber and Red. The green phase is focused on the implementation of Patient Blood Management (PBM) principles to ensure blood is used appropriately and prudently.

1.8 In each HB/hospital there are established business continuity planning arrangements, within services which would be activated to manage red cell shortages in the Amber and Red phases. Should the situation deteriorate to such an extent, command & control measures should be activated as detailed in Major Incident Plans/Business Continuity and other Emergency Response Plans

1.9 The Pre-Amber alert is used specifically by the WBS when stocks risk falling into Amber phase. Hospital staff will receive a Pre-amber notification of a potential shortage, which has not yet breached the Amber threshold. This phase has been introduced to encourage greater collaborative working between hospitals and the WBS e.g. agreed reduction in stock levels, negotiation of orders etc. to actively manage the national supply chain and alleviate the necessity to progress to a more formal alert level thereby averting more severe shortages. This is business continuity management and will be managed via the respective Pathology Business Continuity process.

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2.0   Background

2.1.   The Civil Contingencies Act[4] (2004) (Ref) requires NHS organisations to demonstrate that they can deal with disruptive incidents while maintaining services. As part of Emergency Preparedness, Resilience and Response (EPRR), there is a requirement for services to develop business continuity plans to respond to supply issues such as a shortage within the blood supply chain, and to ensure the effective use of available blood components when blood stocks fall below pre-determined levels[4]. These plans will be critical to ensuring transfusion support remains available for the patients who need it most.

2.2   Although severe red cell shortages are rare in Wales and the UK generally recent experiences such as the COVID 19 pandemic and industrial action have exposed the fragility of the blood supply chain. This has sometimes resulted in prolonged periods of shortage as several multi factorial issues are managed.

2.3   The original integrated plan for the management of red cell shortages incorporated a framework to manage shortages in a variety of situations, including but not exclusive to:

- Short-term shortages, caused by, for example, adverse weather.
- Very acute shortages caused by, for example, security issues, which stop donors donating.
- Prolonged blood shortages, which could result from a number of circumstances e.g. the introduction of further measures to reduce the risk of disease transmission by transfusion or a pandemic.
- Unexpected increases in demand e.g. mass casualty incidents

3.0   Planning Principles

3.1   The following plan is designed to ensure that the WBS, together with Transfusion Services and the wider hospitals/HBs in Wales work in a collaborative process, to provide an integrated approach to manage red cell supply avoid shortages and minimise any impact on patients as far as possible.

3.2   The plan is designed to operate routinely even when there is no shortage. Where there are modest reductions in the blood supply, for example <10% reduction, appropriate use of blood conservation strategies (PBM) together with the active management of the blood supply chain should avoid the activation of formal blood shortage arrangements.

3.3   The appropriate use of donor blood and the use of effective alternatives to blood are important public health and clinical governance issues. This plan is designed to build on actions taken by hospitals/health boards (HBs) to improve transfusion safety and effectiveness in accordance with the Blood Health Plan[5].

4.0   Plan Structure

4.1   The plan is structured to provide a framework of actions for WBS and hospitals/HBs at four phases (refer Fig. 1 below). A summary table of the Blood Shortage categories & actions is shown in Appendix 1.

<table>
<tr><td>

Green Alert
Target blood stocks maintained; supply aligned to demand

</td></tr>
<tr><td>

Pre - Amber Alert
Forecasts indicate that stock(s) are under pressure, requests for stock reductions and negotiations for stock management are likely to occur

</td></tr>
<tr><td>

Amber Alert
Reduced availability of blood for a prolonged period with limited ability to recover stocks

</td></tr>
<tr><td>

Red Alert
Severe and/or prolonged shortages or imminent threat to the blood supply

</td></tr>
</table>

Fig. 1

4.2   During the Green phase, the WBS will maintain normal operations, target blood stocks are maintained, and supply is aligned to demand. Hospital/HBs will be encouraged to advocate PBM principles for prudent and appropriate use.

4.3   In the Pre-Amber phase, the WBS will issue a Pre-Amber alert notification to hospitals informing them of potential pressures on the supply chain and negotiating with hospitals to take appropriate action to protect supply. Activation of this alert will follow the guidance defined in **WBS SOP /BCM- 001: Blood Shortage Alert - Distribution and Testing arrangements**. Recipients will be requested to distribute this alert notification to relevant clinical and management teams across their health board this will include escalation through Pathology business continuity response routes to familiarise themselves with actions in Amber should this be necessary. This action is intended to prevent the requirement to move to Amber phase. This alert may apply to either a single blood group or a number or all of the blood groups.

4.4   The WBS will actively manage stock to minimise the risk of blood shortages. However, if red cell stocks fall lower than the pre-determined level then shortage plans may be activated and communications to move to an Amber phase will be issued. These will follow guidance as for Pre-Amber alert but will also be escalated to the Welsh Government. This may apply to either a single blood group or to a number or all of the blood groups.

4.5   Should the WBS identify a severe, imminent threat to the blood supply then, they will communicate a move directly to the Red phase. This will follow guidance as for Pre-Amber and Amber alerts in addition to the guidance for Red.

4.6   Each hospital/HB are required to have, as part of their overall emergency planning, an escalation process through their established governance structures to respond to alerts from the WBS. This will be via the respective service Business Continuity Management process, where there are escalation processes articulated. The response may require a reduction in both blood stocks and red cell use. It is recommended that use of red cells should be prioritised according to the guidance in Appendix 2.

5.0   WBS Actions

5.1   Stock levels are reviewed daily through WBS Resilience meetings and collection/manufacturing activities are monitored to ensure stock levels are kept at the pre-determined target levels. Monthly Capacity/Demand Planning meetings are used to set strategic direction. However, if these measures are unable to support the stock position, then either a divisional Emergency Planning meeting or a Trust meeting using the bronze/silver/gold command structure will be established and several additional actions may be taken.

These actions include but are not limited to:

- Calling more donors or targeting donors of a specific blood type. This might also mean deferring donors of blood groups that are plentiful and replacing with those of the group under pressure. This will be at the discretion of the Collections Manager/Donor Engagement Manager
- Extending shifts in the manufacturing/testing departments to increase manufacturing.
- Extending the opening times of current scheduled donor sessions/establish new donor sessions.
- Increased monitoring of stock ensuring it is distributed according to age and group mix, to keep wastage to a minimum.
- Utilising our mutual aid arrangements with other UK blood services.
- Activation of the BHNOG Blood Shortage Group (BSG) (Refer to Appendix 5 for Terms of Reference)

If these actions prove to be unsuccessful, WBS will declare a red cell shortage and invoke WBS **Standard Operating Procedure (SOP) /BCM- 108: Business Continuity Plan – Blood Shortage**. This will be communicated via the Shortage Alert process and escalated to the appropriate phase.

6.0 Hospital Business Continuity Response

6.1   Each hospital/HB should have the ability to set up appropriate operational, tactical and strategic business continuity arrangements to respond to, and deal with blood supply chain issues.

6.2   Blood component shortages in the Amber and Red phases would need to be escalated in this way in the same way as staffing shortages (e.g. strikes) fuel shortages, shortages of oxygen or any other critical service disruption for the care of patients. This is business continuity management. For the purposes of an Amber or Red blood shortage alert the appropriate Business Continuity command and control structures will be established and should include key staff in the organisation including, key staff supporting blood transfusion will be subject matter experts to assist in the decision-making process during the shortage.

Business Continuity Response
Essential
Consultant Haematologist responsible for Transfusion
Hospital Transfusion Committee Chair (or equivalent)
Transfusion Laboratory Manager
Transfusion Practitioner
As appropriate stakeholders from:
Clinical Directors of departments which are high blood users, in particular those with urgent/emergency need for blood e.g. critical care, acute medicine, accident and emergency, anaesthesia, surgery, obstetrics & paediatrics,

6.3   The responsibility of the hospital business continuity management process and associated command and control structures, if an escalated state is to provide strategic guidance and formulate arrangements to manage the appropriate use of red cells in both the Amber and Red operational phase, as part of their existing business continuity and emergency response arrangements.

6.4   Proposed generic actions for hospitals at Green, Pre-Amber, Amber and Red are defined in Appendix 3. The actions are dependent on the local case mix and configuration of services within each HB. These should be included within Pathology Service business continuity plans.

6.5   Routinely, Business Continuity Plans should clarify the roles and responsibilities of staff and give clear guidance for internal communication. Consideration should be given to centralising hospital/HB stock and modification of surgical lists.

6.6   Once the arrangements have been agreed the documentation should be managed by the Hospital Transfusion Team (HTT) and senior clinical staff representing the main users of blood.

6.7   Should the alert move from Pre-Amber to Amber and a red cell shortage occur, WBS will activate their emergency plan and notify HTTs to implement their business continuity incident response arrangements. In an Amber or Red shortage, actions within hospitals may need to be reviewed daily by relevant clinical service leads and the Chair of tactical group as appropriate.

6.8   It is recommended that each HB response should have senior hospital management support i.e. from the Chief Executive and/or Medical Director's teams to ensure their effectiveness. If in Red alert, there will be a strategic and tactical command and control arrangements and Clinical staff should be aware of their responsibilities as appropriate and be willing to accept that a decision-making process, is necessary when the supply of red cells is limited.

6.9   If an Amber alert is declared all requests to the transfusion laboratory should be reviewed by senior laboratory staff and referred to the hospital Haematology Specialist Registrar or consultant if request does not comply with current British Society Haematology (BSH) guidance.

6.10   If a Red alert is activated all requests to the transfusion laboratory should be reviewed by hospital Haematologists (registrar or Consultant) for appropriateness before the order is placed with WBS.

6.11   If the WBS are unable to meet a request (except in an emergency) and no suitable alternative is available then the request will be referred to a WBS Consultant for advice.

6.12   It is recommended that hospitals/HBs refer to the Welsh Blood Service (WBS) Red Cell Shortage Plan – Summary Document (**https://wbs-intranet.cymru.nhs.uk/bht/policies-guidance-forms/policies/**) for practical use during a red cell shortage.

7.0   Indications for Transfusion

7.1   The indications for transfusion are taken from UK national guidelines for the use of blood components and are provided in the '*Indication Codes for Transfusion: an Audit Tool[6]*'. Whilst it is acknowledged that clinical judgement plays an essential part in the decision to transfuse or not, the purpose of drawing available transfusion guidelines together into a single resource is to help clinicians prioritise the use of blood transfusion. It is recommended that the national indication codes for blood transfusion are used to document the indication for transfusion. These are available on the transfusion request form, as a QR code on the All-Wales Transfusion record and as an app for use on IOS & Android phones*.*

7.2   It is recognised practice that patients undergoing elective surgical operations should not require transfusion support if their Haemoglobin (Hb) concentration is pre-optimised before surgery. Assuming normovolaemia has been maintained, the Hb can be used in conjunction with clinical assessment to guide the appropriate use of red cell transfusion.

7.3   Patient Blood Management (PBM) measures to avoid the use of blood transfusion include pre-operative iron replacement for iron deficiency anaemia, and the use of tranexamic acid for surgical patients likely to have at least moderate blood loss (>500ml) or >10% blood volume loss in children and patients weighing less than 50kg.

7.4   Overreliance on group O D negative red cells may have a negative impact on the management of this scarce resource. Blood services worldwide encounter recurrent shortfalls of O D negative red cells.   It is important that patients are prioritised with respect to their transfusion needs to identify those where the use of O D negative cells is essential. Group O D positive red cells may be used for individuals of non-childbearing potential where no anti-D is detectable. Hospitals are directed to the Management and Use of O D Neg Red Cells guidance[7].

7.5   The provision of O D negative red cells for use in the pre-hospital setting should also be retained for individuals of child-bearing potential. The emergency service currently advocates the use of O D Positive for individuals of non-childbearing potential but the service provision to supply may need to be reviewed to determine its suspension or reduction in units provided. This will need to be a multidisciplinary decision.

7.6   Ensure that unused blood is returned to stock in a timely manner to avoid time expiry/out of temperature wastage.

8.0   Operation of the Plan

8.1   Green

8.1.1   All routine operations should be undertaken. Collections and manufacturing activities will be performed in accordance with anticipated demand.

8.1.2   Hospitals are requested to send daily stock levels to WBS and to review optimum stock levels on a 12 monthly basis in collaboration with WBS.

8.1.3   WBS manage red cell collections to maintain appropriate stock levels across all groups as necessary.

8.1.4.   Hospitals/HBs will develop their Business Continuity Blood Management Arrangements and integrate into their business continuity response structures.

8.1.5   Implementation of PBM principles incorporating the prudent and appropriate use of blood is advocated (ref Appendix 6).

8.2   Pre-Amber Alert

WBS Actions

8.2.1   Hospitals/HBs will be advised via the Pre- Amber alert notification that WBS blood stocks are under pressure with negotiations on orders of component(s) likely to occur.

8.2.2   The WBS will maintain clear communications and logistics plans to support hospitals as effectively as possible during shortages. Communications will be sent out on a clear schedule ensuring everyone in the supply chain is informed. This will include invoking the shortage alert protocol.

8.2.3   The WBS will review hospital/HB stock levels and compare with total stock. Demand forecasting will be used to inform allocation strategies.

8.2.4   The WBS will follow their internal Business Continuity Plan

Hospital Transfusion Team Actions

8.2.5   For the blood groups subject to alert hospital transfusion teams should aim to maintain stocks at their optimum level or 10% below this if possible.

8.2.6   Hospitals transfusion teams are requested to send daily stock updates to the WBS by 9.30 a.m.

8.2.7   Conserve O D negative red cells for O D negative patients and individuals of childbearing potential in an emergency.

8.2.8   Review stock holding age range and accept shorter dated blood where there is an opportunity to use it. Where possible avoid requesting fresh red cells for stock.

8.2.9   Establish communications with key clinical teams in high use areas about a potential move to Amber alert and the implication of this.

8.2.10   Ensure clear and effective communication of the pre-Amber alert both within the transfusion team and to key stakeholders.

Hospital Clinical Team Actions

8.2.11   Use of red cells should be in accordance with appropriate use and prudent Patient Blood Management (PBM) principles (Appendix 6).

8.2.12   Review triggers for red cell use by using a restrictive transfusion programme where identified in PBM guidance.

8.2.13   Use tools available to support decisions to transfuse including alternatives to transfusion e.g. intraoperative cell salvage, IV iron for anaemia and use of the NBTC Blood Components App to guide decisions.

8.2.14   Ensure clear and effective communication of the pre-Amber alert to relevant clinical colleagues.

8.2.15.   Clinical teams must familiarise themselves with the requirements of an Amber alert and prepare for the establishment of a tactical Business Continuity Response Group as appropriate.

8.3   Amber Alert

8.3.1   In addition to the measures in the Pre Amber phase, the following measures will be added:

8.3.2.   If stocks fall to a pre-determined level or an imminent threat to the blood supply is identified, the WBS will communicate a move to the Amber phase. This may apply to either a single blood group or to a number of blood groups or to all of the blood groups.

8.3.3   Hospitals will be expected to inform and convene their Business Continuity Response tactical Group and if necessary, escalate and integrate this with emergency incident command and control arrangements. The Business Continuity tactical Response Group will define which members of staff will participate in the shortage management and how a reduction in usage will be achieved.

8.3.4   Information from the WBS about blood shortages will be communicated to hospitals by sending the relevant Blood Shortage Alert message. The information will include the nature of the shortage and any actions, which need to be taken by hospitals as part of their business continuity response.

8.3.5   This information will also be forwarded to the Welsh Government.

8.3.6   Hospitals may be required to revise their usage and stockholding further. This will be agreed in discussion and consultation with each HB ensuring no risk to patient safety because of reductions.

8.3.7   Requests for blood may go through a WBS Consultant if considered inappropriate.

8.3.8   Transfusion teams will be asked to consider
- Reduction in reservation periods
- Reduction of stocks in remote fridges
- Reduction of irradiated stock ordering more as and when required.
- Limiting requests for phenotyped units for stock and ordering on a named patient basis

8.3.9   Initiation of the BHNOG Blood Shortage Group by WBS (ref Terms of Reference Appendix 4).

8.3.10   If patient care is adversely affected by the red cell shortage this must be communicated to the patient by the Consultant in charge of their care as defined in Duty of Candour regulations. WBS consultants will provide advice as required. Any adverse incident must be reported to the Serious Hazards of Transfusion (SHOT) haemovigilance monitoring scheme.

8.3.11   If, stocks continue to fall, the WBS may communicate that a greater reduction in usage is required. This may be within the Amber phase or be accompanied by the escalation of a move to the Red phase.

8.4   Red Alert

8.4.1   WBS will declare a Red alert if there is a severe shortage of red cells, or if an imminent severe threat to the supply of red cells is identified.

8.4.2   WBS will communicate with hospitals as in the Amber phase and will include all the actions identified in Amber.

8.4.3   In addition to the alert notifications WBS will chair an all-Wales meeting to include representatives from Velindre Exec. Board, each HB, the BHNOG Blood Shortage Group and Welsh Government.

8.4.4   Velindre will be required to provide a 'No Surprises' communication to Welsh Government

8.4.5   Actions will include a further reduction in stockholding and a reduction in usage to be agreed with hospital teams.

8.4.6.   There will be a requirement to consider appropriate transfusions (Appendix 2) and emergency framework for blood rationing[8].

8.4.7   All requests for red cells will need to be agreed with WBS medical consultants prior to issue.

8.4.8   Hospitals/HBs are directed to the National Blood Transfusion Committee (NBTC) guidance and triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage[8]. This has been adapted from Canadian guidance[9] for UK practice and aligns with guidelines used by other UK Blood Services e.g. NHS Blood & Transplant (NHSBT). Appendix 4a & 4b outlines the algorithm for triaging patients in the context of a severe national shortage.
This will include a strategic, tactical and operational command and control structure.

9.0   Impact and monitoring of shortages

9.1   Most declared shortage scenarios will need to be accompanied by a reduction in red cell usage by hospitals/HBs.

9.2   Where the required reduction in usage is quite small it is anticipated that hospitals/HBs will be able to achieve this through the implementation of PBM/ conservation/ appropriate use measures. However, hospitals may also have to consider cessation of procedures in Category 3 (Appendix 2) to achieve the required reductions in usage.

9.3   In a prolonged shortage this will inevitably have an impact on elective surgery and waiting lists. In a more severe shortage reductions in usage will need to be achieved by cessation of some or all procedures in Category 2 (Appendix 2).

9.4   In a more severe shortage where, for example, 50% or more of the red cell supply becomes unavailable it is likely that only patients in Category 1 (Appendix 2) would be treated.

9.5   Hospitals/HBs should report adverse incidents in patients with the operation of this plan through local governance systems, SHOT, Serious Adverse Blood Reactions and Events (SABRE) and to the WBS as appropriate. SHOT reporting criteria can found on the SHOT UK website.[10]

9.6   During shortages the WBS will work collaboratively with hospitals/HBs to monitor red cell usage. It is recognised that hospital caseload and case-mix will vary but where hospitals are unable to meet the recommended reductions in stockholding and use, the haematologist with responsibility for blood transfusion and/or the Transfusion Laboratory Manager will be expected to discuss the hospital needs with a WBS Consultant.

9.7   The WBS Blood Health Team (BHT) will work closely with the Hospital Transfusion Teams, and HBs to support and share PBM and prudent management principles.

10.0 Recovery from shortages

10.1   The WBS will use the Blood Shortage Alert protocol to communicate changes in red cell stock levels and inform when hospitals can move to Amber, Pre-Amber or Green status. The recovery alert should be communicated to all relevant staff.

10.2   The Hospital Transfusion team will disseminate the information as above. The WBS Emergency Planning Group (EPG) and the HB Business Continuity tactical Response Group should convene at the earliest opportunity to review the effect of the blood shortage and amend the local arrangements as necessary.

10.3   Recommendations, lessons learnt, or impacts experienced during the shortage alerts should be collated and a debrief should be held with hospitals to discuss. The report should also be fed back through the Hospital Transfusion Committees as appropriate.

10.4   All hospital SHOT reports submitted as a result of blood shortages should be reviewed for recommendations and lessons learnt.

11.0 References

1. Health Board Blood conservation measures letter: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2021/12/Conservation-letter-Final-Nov-21.pdf
2. CONTINGENCY PLANNING - AN INTEGRATED PLAN FOR THE MANAGEMENT OF BLOOD SHORTAGES
3. Platelet Shortage plan – In Progress
4. Civil Contingencies 2004 https://www.legislation.gov.uk/ukpga/2004/36/contents
5. Blood Health Plan: https://gov.wales/sites/default/files/publications/2021-09/nhs-wales-blood-health-plan.pdf#:~:text=The%20Blood%20Health%20Plan%20%28BHP%29%20has%20been%20developed,strategic%20aims%20can%20be%20defined%20as%20follows%3A%201.
6. NBTC Ind codes (https://www.transfusionguidelines.org/uk-transfusion-committees/national-blood-transfusion-committee/responses-and-recommendations
   & NBTC Blood Component App: *https://apps.apple.com/gb/app/blood-components/id1221434626*
7. Management and Use of O D Neg Red Cells: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2022/01/All-Wales-Guidance-for-the-Management-Use-of-O-D-Neg-Red-Cells_v2_Dec-2021.pdf
8. Doughty, H., Green, L., Callum, J. and Murphy, M. (2020). Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood *Transfusion Committee. British Journal of Haematology.*
   https://onlinelibrary.wiley.com/doi/10.1111/bjh.16736
9. National Advisory Committee on Blood and Blood Products, Canada.
   https://nacblood.ca/resources/shortages-plan/emergency-framework-final.pdf
10. SHOT UK*: https://www.shotuk.org/reporting/*

12.0 Useful Documents

Hunt, B., Allard, S., Keeling, D., Norfolk, D., Stanworth, S. and Pendry, K. (2015). A practical guideline for the haematological management of major haemorrhage.
 https://b-s-h.org.uk/guidelines/guidelines/haematological-management-of-major-haemorrhage/

South Wales Trauma Network (2020). Damage Control Resuscitation (Adult Major Trauma Patients): Clinical Guideline CG07.

Emergency preparedness, resilience and response guidance for UK hospital transfusion teams
https://pubmed.ncbi.nlm.nih.gov/32020684/

Preoperative patient blood management during the SARS – CoV-2 pandemic
https://b-s-h.org.uk/guidelines/guidelines/gpp-preoperative-patient-blood-management-during-the-sars-cov-2-pandemic/

Clinical Guide to surgical Prioritisation from Federation of Surgical Specialty Association
https://fssa.org.uk/userfiles/pages/files/covid19/prioritisationmaster280122.pdf

13.0 APPENDICES

Appendix 1   Summary of Blood Shortage Categories and Actions
Appendix 2   Indication for Transfusion
Appendix 3   Proposed Actions for HBs/hospitals at each Alert Phase
Appendix 4a   Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for Triage Team (Part 1)
Appendix 4b   Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for triage Team (Part 2)
Appendix 5   BHNOG Blood Shortage Group Terms of Reference
Appendix 6   PBM guidance

Appendix 1: Summary of Blood Shortage Categories & Actions

WBS STATUS LEVEL	WBS BUSINESS STATUS	RISK to WBS SERVICE	WBS CONTINUITY PLAN	WBS COMMUNICATIONS	HEALTH BOARD (HB)/HOSPITAL RESPONSE / ACTION
GREEN >7 days	**Normal operations -** Target blood stocks maintained	Collections & manufacturing in line with anticipated demand	**Supply aligned to demand.** Monitor blood stocks and increase specific 'blood group' collections to maintain stock levels where necessary.	WBS activate donor communications in line with targeted groups	Normal operational status. Hospitals expected to send daily stock updates to WBS
PRE - AMBER <3 days	**Hospitals notified of anticipated shortage**	Forecasts indicate that stock will come under pressure; negotiations for stock management may occur to avoid increased pressure and escalation to an amber alert	**Pre-Amber shortage declared.** Review stock levels held in Health Boards. Compare total stocks with forecast demand and inform HBs of position negotiating where appropriate. WBS will supply targeted information on usage. Emergency Planning blood shortage group meeting held, monitored/escalations via daily Resilience Meetings Increase targeted publicity / recruitment activity. Targeted information on usage will be supplied by WBS. Discuss mutual aid with other UK services	Blood shortage alerts to be sent to: Hospital/HB Transfusion teams via agreed alert procedure Internal WBS contacts HB Emergency Planning Leads Medical Directors CEO/MD VUNHST	HBs are advised that WBS stocks are under pressure. Hospitals should aim to maintain stocks at their optimum levels or aim for a reduction of 10% if possible. Negotiations on orders of components under pressure are likely to occur. Hospitals are required to send daily stock updates to WBS by 9.30 am. Follow advice on pre-Amber alert including implementation of patient blood management and appropriate use principles
AMBER <2 days	**Blood Stock(s) depleted.** WBS has reached 2 days or less in (A & O) blood groups	Unable to recover or increase collection capacity to meet demand in coming days. No ability to import.	**Amber Shortage declared.** Increase publicity / recruitment activity. Hold additional or extended blood collection clinics where possible. Extend shifts in laboratories to increase manufacturing/testing as appropriate. Discuss mutual aid with other UK Blood Services Increased monitoring of stock ensuring distribution by age to reduce wastage. Issues/requests may be triaged by WBS consultants. Daily Emergency Planning group meetings The BHNOG BSG to review and agree stock holding levels for major trauma centres	Alerts to be sent to: Hospital/HB Transfusion Teams via agreed alert procedure & weekly meetings Internal WBS Contacts HB Emergency Planning Leads Medical Directors Welsh Government CEO/MD VUNHST	Hospitals should aim for a minimum reduction of 10% in optimum stock levels. Hospitals should conserve stocks and WBS will review orders. Rationing may be applied. HBs should convene a Business Continuity tactical Response Group to manage blood shortages. Hospitals are required to send daily stock updates to WBS by 9.30 am. Follow advice on Amber alert including implementation of patient blood management and appropriate use principles
RED <1 day	**Stock(s) in critical position or Major Incident disruption.**	Severe prolonged shortages or imminent threat to the blood supply	**Red Shortage declared.** As for Amber alert WBS will chair an all-Wales meeting to include representatives from Velindre Exec board, health board representatives and Welsh Government	Alerts to be sent to: As for Amber alert Daily updates to hospitals	As for Amber alert Hospitals are required to send daily stock updates to WBS by 9.30 am. Hospital orders will be managed by consultant discussions and prioritised. A HB Business Continuity tactical Response Group will be activated and respond to notifications from WBS.

Appendix 2: Indication for Transfusion

To simplify the management of patients in a general red cell shortage a prioritisation system has been created using three broad patient categories. This is to assist hospitals with prioritising patients to achieve the required reduction in red cell usage. It is recognised that clinical judgement is an essential part of decision-making for individual patients.
Non

OPTIMISE ALL PATIENT BLOOD MANAGEMENT STRATEGIES	
Category 1 These patients will remain highest priority of transfusion. RED Phase	*Resuscitation* Resuscitation of life-threatening / on-going blood loss including trauma. If ongoing major haemorrhage with expected poor prognosis review appropriateness of continuing transfusion support *Transfusion- dependent anaemias including thalassaemia.* Review the need for transfusion and delay if not symptomatic with anaemia. Haemoglobinopathy patients on regular transfusion programmes follow amber alert guidance but also increase interval between red cell exchanges or consider using transfusion as interim measure.

	Surgical support[1]
	If less than 0.5 days stock
	Priority 1a: *procedures can be supported with donor blood with exceptions**
	Priority 1b: emergency procedures **cannot** be supported with donor blood.
	These should be reviewed on an individual case basis taking into account blood group and correction of anaemia.
	Non-surgical anaemias
	Continue to transfuse in
	   a. life threatening anaemia including patients requiring in-utero support and high dependency care/SCBU.
	   b. Stem cell transplantation or chemotherapy already commenced***
	Review cadaveric organ transplants and delay, if possible, particularly if large volume of blood is required e.g. liver/cardiac.

	Surgical support[1]
	If 0.5 - 1 day's stock
	Priority 1a & 1b: procedures can be supported which are likely to require donor blood support. These should be reviewed on an individual case basis taking into account blood group and correction of anaemia.
	Delay starting:
	   a. Stem cell transplantation, or chemotherapy
	   b. Living related organ transplantation
	Delay prophylactic transfusion:
	   a. In severe bone marrow failure syndrome if patient not symptomatic with anaemia

Category 2 These patients will **not** be transfused in the RED phase.	*Surgery/Obstetrics* Cancer surgery (palliative); Symptomatic but not life-threatening post-operative or post-partum anaemia; Urgent*** surgery
	Priority 2 and 3 surgeries Consider postponing if likely to require blood. Support on an individual case basis taking into account blood group and correction of anaemia
	Non-surgical anaemias Symptomatic but not life-threatening anaemia
Category 3 These patients will **not** be transfused in the AMBER	*Surgery* Consider postponing priority 4 surgeries if likely to require blood. Support on an individual case basis considering blood group and correction of anaemia

	Chronically transfused patients
	1. Haemoglobinopathy: Patients on Red Cell Exchange (RCE) programme –
	    a. Reassess use of red cells during previous exchanges to ensure optimising red cell component usage.
	    b. If available, use the depletion mode in the apheresis machine if safe to do so and results in less blood use.
	    c. Consider increasing interval for RCE.
	    d. Consider top-up red cell transfusion post partial exchange to reduce number of red cells required.
	2. All Patients: (including haemato-oncological patients receiving chemotherapy) Reduce transfusion threshold to 70g/l if no contraindication.
	3. Maximise Use of all PBM measures: i.e. use of Tranexamic acid, use of cell salvage, optimisation of pre-op anaemia, minimise iatrogenic anaemia by limiting blood sampling

1 Clinical Guide to surgical Priortisation from Federation of surgical Specialty Association

*   Emergency – patient likely to die within 24 hours without surgery.
**   With the exception of poor risk aortic aneurysm patients who rarely survive but who may require large volumes of blood.
***   Urgent – patient likely to have major morbidity if surgery not carried out.
****   Planned haemopoietic stem cell transplant or chemotherapy may be deferred if possible.

Appendix 3: Proposed Actions for hospitals/HBs at each Alert phase

Green Alert/Phase

Ensure use of Patient Blood Management and the appropriate use of blood as follows:

- Ensure appropriate membership and functioning of Hospital Transfusion committee (or equivalent) and Hospital Transfusion team.
- Ensure that effective blood transfusion policies for the appropriate use of red cells are in place, implemented & reviewed.
- Ensure that education and training is provided to all staff involved in the blood transfusion process and is included in induction programmes for new staff as appropriate.
- Send daily stock levels to WBS.
- Consider the establishment of stock sharing between hospital transfusion laboratories to utilise stocks more effectively across HBs.

Ensure the appropriate use of blood and effective alternatives in clinical situations where blood is used as follows:

- Implement relevant guidance on the appropriate use of blood and alternatives.
- Ensure that guidance is in place for the medical and surgical use of red cells and other blood components such as platelets and fresh frozen plasma (FFP)
- Establish local protocols to empower blood transfusion laboratory staff to query clinicians about the appropriateness of requests against local/national guidelines for use.
- Ensure procedures to empower transfusion laboratory staff that appropriate clinical information is provided with requests for blood.
- Implement regular monitoring and audit of usage of red cells, platelet & FFP in all clinical specialities.
- Schedule internal blood shortage exercises and extend the operational response to involve clinicians and decision making.
- In liaison with BHT and Blood Stocks Management System (BSMS) agree optimal and minimal stock holding

Pre-Amber Alert/Phase

- Ensure Business Continuity response arrangements are in place and that the group can be convened quickly if a potential Amber alert is called.
- Review haemoglobin triggers for red cell transfusions in accordance with PBM guidance.
- Use tools e.g. NBTC Indication codes app for guidance on appropriateness of transfusion, to support clinical decision making and consider transfusion alternatives.
- Support supply chain if requested by WBS to advertise local donation clinics.

All patients

- Minimise iatrogenic anaemia (reduce frequency and volume) of samples from patients. Only take if it affects their clinical management.
- Use a restrictive red cell transfusion threshold (Hb 70g/l) unless patient is bleeding, has acute coronary syndrome or is on a chronic transfusion programme.
- Advocate single unit transfusion (or equivalent volumes for children from 1 year or adults with low body weight) in patients who are not bleeding or on chronic transfusion programmes. Reassess the patient clinically after each unit and perform Hb test to determine if further transfusion is required.

Surgical Patients

- Ensure patients with anaemia scheduled for elective surgery are properly diagnosed and treated prion to surgery.
- Ensure early pre-assessment of patients in priority Categories 2 & 3 (Ref. appendix 2). Treat deficiencies with appropriate supplements.

- Optimise care of patients in Category P1 with IV iron infusions pre-operatively
- Review pre-op Hb level and expected blood loss. Use tranexamic acid and intraoperative cell salvage (ICS), unless contraindicated in adults if pre-op HB low or intraoperative blood loss greater than 500ml. Record any contraindications.
- Advocate the use of ICS including ensuring access to ICS equipment and appropriately trained staff.
- Use point-of care coagulation testing to guide intraoperative blood component management.
- Consider use of post-operative IV and/or oral iron in anaemic patients to avoid transfusion.

Patients requiring chronic transfusion programmes.
- Use alternatives to transfusion where appropriate (refer relevant guidelines)
- Review protocols for transfusion used to maintain Hb levels above a target level during curative radiotherapy.

Transfusion Laboratory Teams
- Hospitals should aim to maintain stocks at their optimum levels or aim for a reduction of 10% if possible.
- Conserve O D Neg red cells for O D Neg patients in accordance with guidelines
- Transfuse group specific red cells wherever possible.
- Ensure regular monitoring and audit of red cells in all clinical specialities.
- Enter hospital stock levels to the WBS daily by 09.30 a.m.
- Accept shorter dated red cells where you are confident, they can be used.
- Start communications with high users about a potential move to Amber and likely consequences of this.
- Actively manage stockholding for optimum use, consider if safe:
  - Reducing reservation period
  - Reducing stock levels in remote fridges
  - Reducing levels of irradiated stock and ordering as required
  - Limiting requests for stock phenotyped units, ordering on a named patient basis
  - Stock sharing across health boards
- Report any delays /incidents to SHOT.

Amber Alert/Phase

All Patients
- Decision to transfuse should be consultant led unless it is an emergency.
- Where component use is prolonged e.g. major haemorrhage, trauma or pre-hospital setting. Review transfusion support to consider the appropriateness of continued treatment.
- Clinical team should liaise with transfusion laboratory to consider supply of components.
- Consideration should be given to reviewing the transfusion trigger for all patients particularly in haemato-oncology or critical care unless contra-indicated.

Surgical
- Continuation of elective surgery will depend on current stock levels and anticipated demand.

Patients requiring chronic transfusion programmes.
- As for pre-Amber

Transfusion Laboratory Teams
- As for pre-Amber and:
- Reduction of the reservation period wherever possible
- Consider the use of temperature loggers in blood transport boxes where appropriate to reduce wastage because of uncertainty in the cold chain
- Consider further reduction or removal of stock in remote issue fridges especially those used for elective surgery.
- Weekly meetings held with Hospital Transfusion Teams/EMRTS/Business Continuity tactical Response Group/EPRR leads as appropriate.

<div style="background:red">

Red Alert/Phase

- As for Amber and:
- **Mandatory** entry of daily stock levels by 09.30am
- Reduce stockholding to the level agreed with WBS.
- Reduce usage to the level agreed in collaboration with the WBS.
- Daily review of the blood shortage and impact on patient care by Business Continuity Response Group.
- Assessment of all requests by a Consultant Haematologist to minimise inappropriate requests.
- Consider removal of all red cell stock from remote issues fridges except for emergency units and issue components directly from laboratory
- Sites with no staff on site laboratory will need to consider transport arrangements to ensure adequate blood component availability.
- Order of priority based on clinical need. Clinical teams are advised to follow the NBTC guidance and triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage[8] which outlines the algorithm.
- Establishment of stock sharing between hospital transfusion laboratories to utilise stocks more effectively across HBs.
- The enactment of a predetermined policy on dealing with major bleeding that should utilise guidance in this document on when to stop blood component support.

</div>

N.B. In both the Amber & Red phases of alert unless the request is an emergency if WBS is unable to meet a blood request and where no alternative can be found, this will be referred to a WBS Medical Consultant.

Appendix 4a: Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for Triage Team (Part 1)

Emergency Framework for Blood Rationing – Algorithm for Triage Team (Part 1)

Patient needing or predicted to need massive transfusion

NO → Follow guidance from Emergency Blood Management Group and the Contingency Blood Shortage Plan

YES

General Exclusion Criteria

A. Severe burns of patient with any 2 of the following:
   i)   Age >60yrs
   ii) >60% of total body surface area affected
   iii) Inhalation injury requiring mechanical ventilation
B. Cardiac arrest where the cause is not considered reversible
C. Advanced, progressive baseline cognitive impairment
D. Advanced, progressive untreatable neuromuscular disease
E. Metastatic malignant disease with expected survival less than 6 months
F. Advanced and irreversible immunocompromise
G. Severe and irreversible acute neurologic event or condition
H. End-stage organ failure meeting the following criteria:
   i)   *Heart* – NYHA class III or IV heart failure
   ii) *Lungs* – COPD with FEV1 <25% predicted, baseline PaO$_2$< 7 KPa, or secondary pulmonary hypertension; Cystic fibrosis with post-bronchodilator FEV1 <30% or baseline PaO$_2$ <55mmHg; Pulmonary fibrosis with VC or TLC <60% predicted, baseline PaO$_2$ <7 KPa, or secondary pulmonary hypertension; primary pulmonary hypertension with NYHA class III or IV hear failure, right atrial pressure > 10mmHg, or mean pulmonary arterial pressure > 50mmHg.

Does patient meet one of the above general exclusions?

YES → Do not transfuse. Re-assess as per guidelines

NO

Specific Exclusion Criteria based on clinical factors specific to patient populations (see Appendix B for specific details for each)

- Trauma with significant or non-survivable brain injury
- Ruptured Abdominal Aortic Aneurysm with cardiac arrest, or unresponsive to fluid resuscitation or not eligible for surgery
- Organ transplant
- Other: mortality likely >80%

→ Go to page 2 of algorithm

'Specific Exclusion Criteria Based on Clinical Factors' in the box above – further details on this can be found in the full guidance document at https://onlinelibrary.wiley.com/doi/10.1111/bjh.16736

Reproduced from Appendix B of *Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood Transfusion Committee.*

Appendix 4b: Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for triage Team (Part 2)

Emergency Framework for Blood Rationing – Algorithm for Triage Team (Part 2)
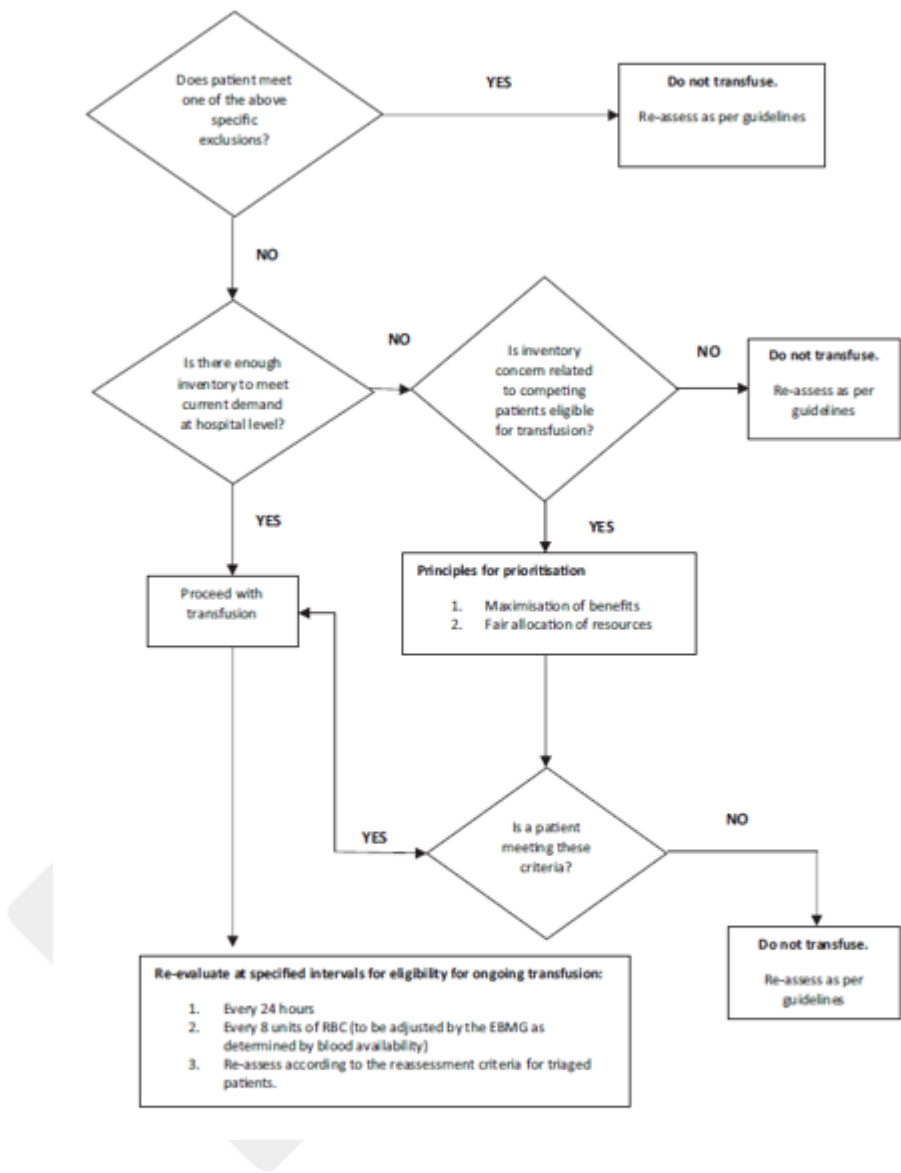
Reproduced from Appendix B of *Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood Transfusion Committee.*

Appendix 5: BHNOG Blood Shortage Group Terms of Reference

1. Purpose

The Blood Health National Oversight Group (BHNOG) Blood Shortage Group (BSG) was established in response to ongoing challenges within the blood supply chain. These have been particularly evident over the last 12 – 18 months with both the Welsh Blood Service (WBS) and other UK services facing significant challenges securing supply to meet demand.
This resulted in the establishment of a group at a national level, comprising of key stakeholders, to facilitate management of the blood supply chain including the appropriate use of blood. Building on established structures and recognising that BHNOG already comprised much of the required membership, the establishment of the BSG, was agreed with reporting to BHNOG.
The purpose of the BSG is to work with key stakeholders to ensure the appropriate use of blood using patient blood management principles. If a pre-Amber alert or escalation to an Amber or Red phase / alert does occur that this is effectively communicated and managed within the Health Boards (HBs) using relevant shortage documentation[1].

2. Aim

The aim of the BSG is to escalate, communicate and manage any challenges to the blood supply chain in collaboration with other key stakeholders to avoid blood shortages. This can be applied to any blood components but excludes blood products which would be managed by the Intravenous Immunoglobulin (IVIG) Group. The BSG will ensure any shortages are effectively managed and communicated to clinical colleagues ensuring blood is given to those patients most in need.

3. Governance
The BSG is accountable to BHNOG and follows recognised governance pathways defined in the BHNOG ToR[2].

4. Chair
The BSG group will be chaired by current BHNOG chair. A Deputy chair will also be selected from within the group's membership.

5. Membership
BHNOG Chair
Director Welsh Blood Service (WBS)
Consultant with BHP responsibility/Medical Director WBS
BHNOG Work Stream Leads
Blood Health Team (BHT) Lead
BHNOG Rep for Transfusion Lab Manager Forum
Welsh Government Representative

The representatives identified in the membership table above will be defined as core members of the BSG. Other members may be co-opted as necessary onto the group at the agreement of the Chair.

6. Meeting Frequency
The BSG will meet on an ad-hoc basis and will depend on:
- Information regarding current and predicted stock levels both within in Wales and rest of the UK. This will include analysis of demand, collection activity, availability of mutual aid.
- Any critically identified issues within Wales that could impact on national supply
- Extended alerts or threats to the blood supply with limited ability to improve national stocks.
- Meetings will be convened by the WBS Director or nominated Deputy in liaison with the BHNOG Chair when one of the criteria above has been reached.
- Extraordinary meetings may be convened at the discretion of the WBS director.

Administrative Support
BSG is hosted by the WBS, which supports the administration of the meetings. These arrangements allow for organisation of meetings; documenting and maintaining records of all meetings held; and effective communication on behalf of the committee.

7. Documentation Required

- Notes of the preceding meeting & action log
- Documentation supporting agenda items e.g. resilience data, demand data, wastage and issuing data etc.

8. Remit

- The BSG will work with BHNOG work stream leads and other key stakeholders strategically across Wales to support the blood supply chain both within the transfusion community and across the wider clinical setting
- Work with relevant large blood user clinical groups to support individualised patient blood management in appropriate care pathways; this will encompass developing practices to support safety and minimise the avoidable use of blood transfusion
- If escalation to a pre-Amber, Amber or Red alert does occur that this is effectively communicated and managed within the Health Boards using relevant shortage documentation and established routes of escalation.
- Ensure any shortages are effectively managed and communicated to clinical colleagues ensuring blood is given to those patients most in need.

9. References

1. WBS Blood Shortage plan: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2020/08/WBS-Red-Cell-Shortage-Plan_July-2020_final.pdf

2. BHNOG TOR: https://bhnog.wales.nhs.uk/wp-content/uploads/2021/12/BHNOG-Approved-ToR.pdf

Appendix 6: Patient Blood Management Principles

1. Implement best practice conservation measures	
a. Reduce the need for blood	
i. Pre-habilitate- (where time allows)	Where expected blood loss >500ml **OR** the transfusion risk is >10% **OR** the patient requires a group & save then complete the following: ✓ Full Blood Count to check for anaemic status ✓ If Haemoglobin (Hb) <130g/l check haematinics as per All Wales preoperative Anaemia Pathway ✓ Consider intravenous iron if < 8 weeks to surgery.
ii. Reduce intra-operative blood loss	✓ Give Tranexamic acid where indicated ✓ Monitor clotting state (where available) using Point of Care coagulation management (e.g. ROTEM/TEG) ✓ Measure blood loss and use alternatives wherever possible ✓ Use interventions, such as permissive hypotension, determined by patient and procedure. ✓ Use cell salvage to achieve a target post-op Hb & reduce allogeneic transfusion
b. Give blood only when needed	
➤ Use the NHSBT Blood Component App. Document the rationale for all transfusions given above guidance threshold (available IOS & Android free of charge) *https://www.bloodcomponents.org.uk/* ➤ Use the British Society of Haematology (BSH) Platelet Summary Guidance ➤ *https://b-s-h.org.uk/media/17121/summary-bcsh-platelet-guideline-appendix-1-final- reviewed-may-2019.pdf* ➤ Comply with the All Wales use of O D Negative Red Cells Summary Guidance ➤ *https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2020/05/O-D-Neg-Guidance- Summary-final.pdf* ➤ Implement weight adjusted red cell guide to prescribe the minimum no. units for non-bleeding adults to achieve a target threshold. This will support single red cell transfusion strategy. ➤ Review requirements for transfusion dependant patients	
2. Match demand with supply	
➤ Clinical areas must work in close collaboration with their Senior Management Teams, Hospital Transfusion Teams (HTT) and the WBS to ensure continuity of supply ➤ Clinical teams must consider the potential for blood loss, before embarking on any procedure and plan management. Where blood will be required despite the prudent measures outlined above, do not proceed without confirmation that transfusion services can meet requirements. ➤ It is recommended this is specifically addressed in all WHO checklist, pre-operative briefings.	

Education material to support this guidance is available using the Blood Assist App (available on IOS & Android free of charge) *https://www.bloodassist.co.uk/*

Further information can be provided by contacting the Blood Heath Team *wbs.bloodhealthteam@wales.nhs.uk* and at the *https://wbs-intranet.cymru.nhs.uk/bht/*

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

POLICY MANAGEMENT REVIEW AND COMPLIANCE STATUS: OCTOBER 2023

DATE OF MEETING	16/11/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kay Barrow, Corporate Governance Manager Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to provide the Quality, Safety and Performance Committee (QSPC) with assurance on the continuing progress that has been made on the current policy compliance status as at October 2023. As at October 2023, of the policies **111** under review, **55 (49.5%)** are in date and **56 (50.5%)** have passed their review date. Of the 56 policies that have passed their review date, **10** are classified as All Wales policies, and **1** has been archived. The policy compliance review undertaken for the period March 2023 to October 2023, highlighted that the number of policies outside their review dates has reduced by **9.6%**.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: a) **NOTE** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. b) **NOTE** the Quality, Safety and Performance Committee Policies Extract Compliance Report as of **October 2023**, included at **Appendices 1 to 7**. c) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	30/10/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board:
- **REVIEWED** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.
- **NOTED** the Quality, Safety and Performance Committee Policies Extract Compliance Report as of **October 2023**, included at **Appendices 1 to 7**.
- **ENDORSED** the Policy Extract Compliance Report for submission to the November 2023 Quality, Safety and Performance Committee.

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

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

APPENDICES

Appendix 1	Quality and Safety Policy Status Update October 2023
Appendix 2	Health and Safety Policy Status Update October 2023
Appendix 3	Infection, Prevention and Control Policy Status Update October 2023
Appendix 4	Information Governance Policy Status Update October 2023
Appendix 5	Planning, Performance and Estates Policy Status Update October 2023
Appendix 6	Digital Services Policy Status Update October 2023
Appendix 7	Workforce and Organisational Development Policy Status Update October 2023

1. SITUATION

1.1 A risk-based phased approach was adopted for the Policy Compliance Audit. A comprehensive review was initiated towards the end of February 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.

1.2 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.

1.3 The purpose of this report is to provide the Quality, Safety and Performance Committee with assurance on the continuing progress that has been made on the current policy compliance status as at October 2023.

The Quality, Safety and Performance Committee is asked to:

a) **NOTE** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b) **NOTE** the Quality, Safety and Performance Committee Policies Extract Compliance Report as of **October 2023**, included at **Appendices 1 to 7**.

c) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

2. BACKGROUND

2.1 There will never be a fixed static number of Trust wide policies in the Document Control Register, as they may increase/decrease in number due to a multitude of variables, such as being subsumed into another policy; archived; change of classification from a policy to a procedure/guidance, etc.

2.2 As at February 2023, of the policies 112 under review, **50 (45%)** are in date and **62 (55%)** have passed their review date. Of the 62 policies that have passed their review date, **16** are classified All Wales policies, and **11** have been archived.

2.3 The annual policy compliance review undertaken for the period February 2022 to February 2023, highlighted that the number of policies outside their review dates has reduced by **4.5%**. Table 1 details the policies outside their review dates at the start of the audit review programme compared to the position as at February 2023, and the number of policies approved by the Quality, Safety and Performance Committee (QSPC) to January 2023.

Table 1: Overview of Policy Progress as at February 2023

Number of policies outside their review date February 2022	**66**
Number Policies outside their review date February 2023	**63**
Number of approved by QSPC	**32**

2.4   Table 2 highlights the progress made by each Directorate in reviewing their policy position during the first year of the audit review programme. The current position as at October 2023 is provided in section 4.

Table 2: Audit Review Programme Policy Status as at February 2023

Directorate/ Department	Policies outside review date Feb 2022	Policies approved Feb 2022 – Jan 2023	Policies outside review date Feb 2023
Quality & Safety	7	7	5
Health & Safety	0	*1	2
Infection, Prevention & Control	4	6	9
Information Governance	4	4	3
Corporate Communications	1	0	1
Estates	9	4	5
Digital	6	5	2
Workforce & Organisational Development	**35	5	36

To Note: *The figures in Table 2 include All Wales Policies.*
*The policy approved for Health and Safety was reviewed and approved but was not outside its review date.
**Workforce & Organisational Development policies were not included until tranche two commencing in April 2022.

3.   ASSESSMENT

3.1   The Document Control Register is regularly reviewed with collaborative engagement undertaken with each of the respective policy leads on a regular basis. The purpose of the ongoing collaborative engagement exercise is to confirm and validate the following:

- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

3.2   The importance of planning the review of the policy *in advance* of its review date to ensure it remains in date has been highlighted to each of the policy leads during the audit review. The Document Control Register has been updated to incorporate a trigger

point to help facilitate this. As part of the continuous life cycle of a policy, there will never be a fixed static point as a result, during the last 12 months further policies fell outside of their review date.

3.3   **Policy Audit Review**

A summary of the outcome of the latest policy review work is included at *Appendices 1 to 7.* The following summarises the outcome of the review undertaken during March to October 2023 and highlights the following:

   i.   Progress of policies identified for review, updates and approval by the Quality, Safety and Performance Committee (QSPC) tracked from March 2023 to October 2023.
   ii. An update of the Policy Audit Compliance Status is included in 4.1.
   iii. Ongoing monitoring focuses on the status of policies under review, a breakdown of some of the detail is included in sections 5 and 6.

3.3.1   **Policy Audit Findings**

- *Quality and Safety*

  A total of 11 Quality and Safety Policies were included in the review process, one of which is an All Wales policy. In summary:

  o In October 2023, five policies are outside their review date, and six in date.
  o During March to September 2023, three policies were taken through the governance process and approved at QSPC.

  Appendix 1 provides detail on the status of the Quality and Safety policies from March 2023 to the most recent review in October 2023.

- *Health and Safety*

  A total of nine Health and Safety Policies have been included in the review process, in summary:

  o In September 2023, two policies were transferred from Infection, Prevention & Control to the ownership of Health & Safety.
  o In October 2023, of the eleven policies now included in the review, eight policies are outside their review date, and three in date.
  o One policy was taken through the governance process in October 2023 and approved via a Committee Chair's Urgent Action.

  Appendix 2 provides detail on the status of Health and Safety policies from March 2023 to the most recent review in October 2023.

- ***Infection, Prevention and Control***

  A total of 19 IPC policies were originally included in the review, three of which are All Wales policies. In summary:

  - Prior to February 2023:
    - two policies were removed as they had been superseded by the National IPC Manual;
    - one was removed as it had been superseded by the Water Safety Policy that transferred to the ownership to Estates; and
    - one archived as it was Guidance and not covered by the review process.
  - In March 2023, the Infection Prevention Control Management Group advised that the Policy for the Management of Occupational Exposure to Blood and High-Risk Body Fluids and the Sharps Policy are no longer IPC policies and have been transferred to the ownership of Health and Safety.
  - In August 2023 one policy was archived as the guidance is now included in the NHS Scotland National Infection Control Manual (NIPCM).
  - Of the remaining 12 policies as at October 2023, one policy is outside of its review date, and 11 are in date.
  - During March to September 2023, one policy was taken through the governance process and approved at QSPC.

  Appendix 3 provides detail on the status of the Infection, Prevention and Control policies from March 2023 to the most recent review in October 2023.

- ***Information Governance***

  A total of seven Information Governance policies have been included in the review process. In summary

  - In October 2023, three policies are outside their review date, and four in date.
  - There were no policies taken through the governance process during March 2023 to September 2023.

  Appendix 4 provides detail on the status of the Information Governance policies from March 2023 to the most recent review in October 2023.

- ***Corporate Communications***

  One Corporate Communications policy was included in the review process, the Social Media Policy. This is an All Wales policy with Health Education and Improvement Wales (HEIW) leading on the review of this policy. Updates on progress will be provided in future reporting.

  A further policy was transferred to Corporate Communications from Workforce & OD, the Dealing with Anonymous Communications Policy. This policy is past its review date and is currently being reviewed.

- ***Planning, Performance and Estates***

  A total of 15 Planning, Performance and Estates were originally included in the review process. In summary:

  - ○ Prior to February 2023:
    - ▪ two policies were removed as they were Protocols and not included in the review process;
    - ▪ one Policy was added as it transferred ownership from Infection, Prevention and Control.
  - ○ Of the remaining 14 policies as at October 2023, nine policies are outside their review date, and five are in date.
  - ○ During March to September 2023, one policy was taken through the governance process and approved at QSPC.

  Appendix 5 provides detail on the status of the Planning, Performance and Estates policies from March 2023 to the most recent review in October 2023.

- ***Digital Services***

  A total of six Digital Services policies were originally included in the review process. In summary:

  - ○ In December 2022, the Staff Mobile Phone Policy was transferred from Communications to Digital Services where a comprehensive review is being undertaken as it was outside of its review date.
  - ○ Of the seven policies as at October 2023, three policies are outside their review date, of which two are All Wales Policies and currently under review.
  - ○ There were no policies taken through the governance process during March 2023 to September 2023.

  Appendix 6 provides detail on the status of the Digital Services policies from March 2023 to the most recent review in October 2023.

- ***Workforce and Organisational Development***

  A total of 53 policies were originally included in the audit review process for Workforce and Organisational Development (WOD) however, six policies were archived at the start of the review with 47 policies remaining as part of the review process. In summary:

  - ○ In March 2023, the Dealing with Anonymous Communications Policy was transferred to Corporate Communications where a comprehensive review is being undertaken as it was outside of its review date.

o Of the remaining 46 policies, 21 are in date and 25 policies were outside of their review date, of which 3 were All Wales policies.
o There were no policies taken through the governance process during March 2023 to September 2023.

For All Wales policies this is a significantly improved position and is as a result of a new approach to the review of the All Wales policies and procedures agreed at the Welsh Partnership Forum Business Committee meeting held on 8th June 2023.

The core element of this new approach is to move away from using a review date as a prompt for review of an existing policy. The new approach will recognise key prompts for review and provide an option for a transactional review where changes/updates to an existing policy are more administrative than material.

The Welsh Partnership Forum Business Committee also confirmed that All Wales Workforce & OD policies remain extant until replaced by an updated version approved by the Welsh Partnership Forum.

NHS Wales Employers will issue this schedule on a quarterly basis as confirmation of policies remaining extant to provide clarity and support organisations from a governance and assurance perspective.

The Policy Database has been updated to reflect the review of the All Wales Policies by the Welsh Partnership Forum Business Committee. **Appendix 7** provides detail of the status of the Workforce and Organisational Development policies from March 2023 to the most recent review in October 2023.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

4.1   Policy Audit Compliance Status

The findings of the Policy Audit Compliance Status for each of the directorates outlined above is reported against the following categories:
o An overview of the status of the policies
o Rationale for policies archived
o Policies passed review dates
o Policy risk assessment

- *Policy Status*

As at October 2023, of the policies **111** under review, **55 (49.5%)** are in date and **56 (50.5%)** have passed their review date. Of the 56 policies that have passed their review date, **10** are classified as All Wales policies, and **1** has been archived.

The policy compliance review undertaken for the period March 2023 to October 2023, highlights that the number of policies outside their review dates has reduced by **9.6%**.

Table 3 highlights the progress made by each Directorate in reviewing their policy position during the March to October 2023.

Table 3: Audit Review Programme Policy Status as at October 2023

Directorate/ Department	Policies outside review date Feb 2023	Policies approved Mar 2023 – Oct 2023	Policies outside review date Oct 2023
Quality & Safety	5	3	5
Health & Safety	2	0	8
Infection, Prevention & Control	9	1	1
Information Governance	3	0	3
Corporate Communications	1	0	2
Planning, Performance & Estates	5	1	9
Digital Services	2	0	3
Workforce & Organisational Development	36	0	25

Table 4 provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee.

Table 4: Overall Policy Status – October 2023

Policy Status	Number of Policies
Policies in date	55
Policies review date passed – action underway/required (excluding All Wales Policies)	45
All Wales Policies with review dates passed – awaiting national review	10
Policies Archived	1

- *Archived Policies*

One policy to date have been archived. Table 5 below provides information on the rationale for the archived policy.

Table 5: Rationale for Archived Policies

Directorate/ Department	Policy Title	Rationale
Infection, Prevention and Control	Infection Prevention and Control within Building Development, Change and Adaptation Policy	Included in Chapter 4 of IPC 05 – NHS Scotland National Infection Control Manual (NIPCM)

5. POLICIES PASSED THEIR REVIEW DATES

Table 6 below provides a summary of the number of policies currently outside their review date in October 2023 compared to the position in February 2023.

Table 6: Policies Outside their Review Date

Directorate/ Department	Policies outside review date Feb 2023	Policies outside review date Oct 2023
Quality & Safety	5	5
Health & Safety	2	8
Infection, Prevention & Control	9	1
Information Governance	3	3
Corporate Communications	1	2
Planning, Performance & Estates	5	9
Digital Services	2	3
Workforce & Organisational Development	36	25

6. 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 7 below provides an overall breakdown of policies audited that have passed their review dates by Directorate. In summary:

- ○ 54 policies are in date with no risk assessment required.
- ○ 46 policies are outside their review date with low risk
- ○ 10 policies outside their review dates with moderate risk

Table 7: Policy Risk Assessment Status

Policy Directorate	Policy in date with no risk assessment required	Policy review date passed low risk	Policy review date passed moderate risk	Policy review date passed high risk
Health and Safety	3	7	1	0

Policy Directorate	Policy in date with no risk assessment required	Policy review date passed low risk	Policy review date passed moderate risk	Policy review date passed high risk
Quality and Safety	6	4	1	0
Information Governance	4	1	2	0
Corporate Communications	0	1	1	0
Digital Services	4	1	2	0
Infection, Prevention and Control	11	1	0	0
Planning, Performance & Estates	5	6	3	0
Workforce and Organisational Development	21	25	0	0
OVERALL RISK ASSESSMENT STATUS	**54**	**46**	**10**	**0**

The risk assessment status for each policy is detailed in **Appendices 1 to 7.**

7. NEXT PHASE OF POLICY AUDIT COMPLIANCE STATUS

In addition to the continuous review and monitoring of those policies that fall within the Quality, Safety and Performance Committee, the remainder of the audit review will continue to focus on the following and will be reported to the respective Committee in the timescales indicated:

- Research, Development and Innovation Committee remit: December 2023 – March 2024
- Charitable Funds Committee remit: December 2023 – March 2024
- Audit Committee remit: December 2023 – March 2024
- Strategic Development Committee remit: January – March 2024

Following which, all Trust wide policies will have been subject to a comprehensive rigorous review as outlined above by the end of March 2024.

8. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☐ for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply

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

	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents has an associated EIA. The EIA will be refreshed when GC01 is due for review.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

9.   RISKS

The Policy Compliance Audit is a continuous review of the status of Trust wide policies to ensure compliance with GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents.

Undertaking a continual policy review cycle will ensure a collaborative and inclusive approach to ensure policies do not go past their review date.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No** **Please refer to Appendices 1 to 7**
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1: QUALITY AND SAFETY POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
QS 01	Incident Reporting and Investigation Policy	Executive Director of Nursing, AHPs and Health Sciences	Mar-25	Policy in date	Policy in date with no risk assessment required	
QS 02	Safety Alert Procedure	Executive Director of Nursing, AHPs and Health Sciences	Jan-24	Policy in date	Policy in date with no risk assessment required	
QS 03	Handling Concerns Policy	Executive Director of Nursing, AHPs and Health Sciences	Apr-23	Policy review date passed – action underway/required	Policy review date passed with low risk	Revised policy scheduled for consideration at November QSPC
QS 04a&b	Compensation Claims Policy & Compensation Claims Procedure	Executive Director of Nursing, AHPs and Health Sciences	Sep-22	Policy review date passed – action underway/required	Policy review date passed with low risk	Revised policy scheduled for consideration at November QSPC
QS 07	Medical Gas Cylinders Policy	Executive Medical Director	Dec-21	Policy review date passed – action underway/required	Policy review date passed with moderate risk	Policy remains extant whilst review underway
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	May-26	Policy in date	Policy in date with no risk assessment required	

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
QS 12	Safeguarding & Public Protection Policy	Executive Director of Nursing, AHPs and Health Sciences	May-26	Policy in date	Policy in date with no risk assessment required	
QS17 All Wales Velindre Adopted	Consent to Examination or Treatment - All Wales	Executive Medical Director	Jul-22	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 19	Ionising Radiation Safety Policy	Executive Medical Director	Mar-26	Policy in date	Policy in date with no risk assessment required	
QS 25	Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Executive Director of Nursing, AHPs and Health Sciences	Nov-23	Policy in date	Policy in date with no risk assessment required	
QS 31	International Health Partnership Related Activity Policy	Executive Director of Nursing, AHPs and Health Sciences	Dec-19	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway

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APPENDIX 2: HEALTH AND SAFETY POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
QS 09	Latex Policy	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 14	Safer Manual Handling Policy	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 15	Management of Violence & Aggression Policy	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 18	Health Safety & Welfare Policy	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy in date	Policy in date with no risk assessment required	
QS 24	Medical Devices & Equipment Management Policy	Director of Strategic Transformation, Planning & Digital	Jan-24	Policy in date	Policy in date with no risk assessment required	
QS 26	Safe Use of Display Screen Equipment	Director of Strategic Transformation, Planning & Digital	May-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 30	Lone Working Policy	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 33	Control of Substances Hazardous to Health (COSHH)	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
QS35	Sharps Safety Policy	Executive Director of Nursing, AHPs and Health Sciences	Oct-26	Policy in date	Policy in date with no risk assessment required	Revised policy approved by Committee Chair's Urgent Action on 25/10/2023.
QS 36	Workplace Equipment Policy	Director of Strategic Transformation, Planning & Digital	May-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway
QS 37	Policy for the Management of Occupational Exposure to Blood and High-Risk Body Fluids	Director of Strategic Transformation, Planning & Digital	Sep-22	Policy review date passed – action underway	Policy review date passed with moderate risk	Policy remains extant whilst review underway. Policy review complete and scheduled to commence the governance process.

APPENDIX 3: INFECTION, PREVENTION AND CONTROL POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
IPC 00	Framework Policy for Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Nov-23	Policy in date	Policy in date with no risk assessment required	Out for consultation and to IPCMG in December 2023 to commence the governance process.
IPC 01	Viral Gastro Enteritis (including Norovirus) Policy	Executive Director of Nursing, AHPs and Health Sciences	Mar-25	Policy in date	Policy in date with no risk assessment required	
IPC 03 All Wales Velindre Adopted	Aseptic Non-Touch Techniques (ANTT)	Executive Director of Nursing, AHPs and Health Sciences	Jul-22	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk	Policy remains extant whilst review underway. Endorsed in IPCMG June 2023. EQIA to be undertaken to take policy through governance process.
IPC 04	Decontamination Policy	Executive Director of Nursing, AHPs and Health Sciences	Mar-25	Policy in date	Policy in date with no risk assessment required	
IPC 05 All Wales Velindre Adopted	NHS Scotland National Infection Control Manual (NIPCM)	Executive Director of Nursing, AHPs and Health Sciences	Apr-24	Policy in date	Policy in date with no risk assessment required	
IPC 07	Methicillin Resistant Staphylococcus Aureus (MRSA)	Executive Director of Nursing, AHPs and Health Sciences	May-25	Policy in date	Policy in date with no risk assessment required	

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
IPC 10	Hand Hygiene Policy	Executive Director of Nursing, AHPs and Health Sciences	Nov-25	Policy in date	Policy in date with no risk assessment required	
IPC 11	Specimen Collection, Handling and Transport Policy	Executive Director of Nursing, AHPs and Health Sciences	Nov-23	Policy in date	Policy in date with no risk assessment required	Policy remains extant whilst review underway. Out for consultation and to IPCMG in December 2023 to commence the governance process.
IPC 13	Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldt-Jakob Disease) Minimising the Risk of Transmission	Executive Director of Nursing, AHPs and Health Sciences	Mar-26	Policy in date	Policy in date with no risk assessment required	
IPC 15	Control and Management of Multi Drug Resistant Bacteria	Executive Director of Nursing, AHPs and Health Sciences	Jun-24	Policy in date	Policy in date with no risk assessment required	
IPC 18	Tuberculosis Management	Executive Director of Nursing, AHPs and Health Sciences	Dec-24	Policy in date	Policy in date with no risk assessment required	

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
IPC 21	Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	Executive Director of Nursing, AHPs and Health Sciences	Sep-25	Policy in date	Policy in date with no risk assessment required	

APPENDIX 4: INFORMATION GOVERNANCE POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead(s)	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
IG 01	Records Management Policy	Executive Director of Finance	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 02	Data Protection & Confidentiality Policy	Executive Director of Finance	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 04 All Wales Velindre Adopted	Information Security Policy	Executive Director of Finance	Jan-23	All Wales Policy review date passed – awaiting national review	Policy review date passed with moderate risk	Under review by IGMAG. Policy remains extant whilst review underway.
IG 08	Freedom of Information Act Policy	Director Corporate Governance and Chief of Staff	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 08a	FOI Standard Operating Procedure	Director Corporate Governance and Chief of Staff	Apr-22	Policy review date passed – action underway	Policy review date passed with low risk	Revised SOP scheduled for consideration at November QSPC
IG 09 All Wales Velindre Adopted	Information Governance Policy	Executive Director of Finance	Jan-23	All Wales Policy review date passed – awaiting national review	Policy review date passed with moderate risk	Under review by IGMAG. Policy remains extant whilst review underway.
IG 13	Confidentiality Breach Reporting Policy	Executive Director of Finance	Jul-25	Policy in date	Policy in date with no risk assessment required	

APPENDIX 5: PLANNING, PERFORMANCE AND ESTATES POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
PP 01	Fire Safety Policy	Director of Strategic Transformation, Planning & Digital	Sep-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Policy review complete and scheduled to commence the governance process.
PP 02	Security Policy	Director of Strategic Transformation, Planning & Digital	Jan-22	Policy review date passed – action underway/required	Policy review date passed with moderate risk	Policy remains extant whilst review underway. Finalising updates following consultation in preparation for submission through the governance process.
PP 03	Environmental Policy	Director of Strategic Transformation, Planning & Digital	May-25	Policy in date	Policy in date with no risk assessment required	
PP 04	Asbestos Policy	Director of Strategic Transformation, Planning & Digital	Nov-25	Policy in date	Policy in date with no risk assessment required	
PP 05	Control of Contractors	Director of Strategic Transformation, Planning & Digital	Nov-25	Policy in date	Policy in date with no risk assessment required	
PP 06	Business Continuity & Emergency Planning Policy	Chief Operating Officer	Jul-26	Policy in date	Policy in date with no risk assessment required	

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
PP 08	Waste Management Policy	Director of Strategic Transformation, Planning & Digital	Mar-21	Policy review date passed – action underway	Policy review date passed with low risk	Currently undergoing EQIA. Policy remains extant whilst review underway.
PP 09	Water Safety Policy	Director of Strategic Transformation, Planning & Digital	Nov-25	Policy in date	Policy in date with no risk assessment required	
PP 10	Medical Gas Piped Systems Policy	Director of Strategic Transformation, Planning & Digital	Aug-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
PP 11	Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Director of Strategic Transformation, Planning & Digital	Aug-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
PP 12	Operational Policy for High Voltage Electricity Supply Systems	Director of Strategic Transformation, Planning & Digital	Aug-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
PP 13	Electrical Low Voltage Policy	Director of Strategic Transformation, Planning & Digital	Sep-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
PP 14	Ventilation Policy	Director of Strategic Transformation, Planning & Digital	Aug-23	Policy review date passed – action underway	Policy review date passed with moderate risk	Policy remains extant whilst review underway.

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
PP16	Cleaning Manual	Chief Operations Officer	May-10	Policy review date passed – action underway/required	Policy review date passed with moderate risk	Transfer from Infection Prevention & Control IPC 22 Previously Management and Control of Environment (Cleaning) - Renamed Cleaning Manual Policy remains extant whilst review underway. Comprehensive review undertaken. Finalising updates following consultation in preparation for submission through the governance process.

APPENDIX 6 : DIGITAL SERVICES POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3-year cycle)	Policy status	Policy Risk assessment	Comments
IG 03 All Wales Velindre Adopted	Email Use Policy	Director of Strategic Transformation, Planning & Digital	Jun-18	All Wales Policy review date passed – awaiting national review	Policy review date passed with moderate risk	Under review by IGMAG. Policy remains extant whilst review underway.
IG 05	Software Policy	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 06	Anti-Virus Policy	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 07 All Wales Velindre Adopted	Internet Use Policy	Director of Strategic Transformation, Planning & Digital	Jan-23	All Wales Policy review date passed – awaiting national review	Policy review date passed with moderate risk	Under review by IGMAG. Policy remains extant whilst review underway.
IG 10	Staff Mobile Phone Policy	Director of Strategic Transformation, Planning & Digital	Mar-12	Policy review date passed – action underway	Policy review date passed with low risk	Previously GC 10 Policy remains extant whilst review underway. Comprehensive review being undertaken
IG 11	Data Quality Policy	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy in date	Policy in date with no risk assessment required	
IG 14	Information Asset Policy	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy in date	Policy in date with no risk assessment required	

APPENDIX 7: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY STATUS UPDATE OCTOBER 2023

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 01 All Wales Velindre Adopted	Respect and Resolution Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 02 All Wales Velindre Adopted	Disciplinary Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 05	Equality & Diversity Policy	Executive Director of OD and Workforce	Sep-25	Policy in date	Policy in date with no risk assessment required	
WF 07 All Wales Velindre Adopted	Protocol on Collective Consultation on Proposed Redundancy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 08 All Wales Velindre Adopted	Managing Attendance at Work Policy	Executive Director of OD and Workforce	Under review by NHS Wales Employers	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee. Policy remains extant whilst review underway.
WF 09 All Wales Velindre Adopted	Capability Policy and Procedure	Executive Director of OD and Workforce	Under review by NHS Wales Employers	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee. Policy remains extant whilst review underway.
WF 10 All Wales Velindre Adopted	Accessing NHS Pension and Retirement Policy (incorporating 2015 Scheme)	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF12	Study Leave Policy, Procedure & Guidelines	Executive Director of OD and Workforce	Nov-13	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Comprehensive review being undertaken
WF 14 All Wales Velindre Adopted	Special Leave Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 15 All Wales Velindre Adopted	Employment Break Scheme	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 28	Recruitment of Locum Doctor Policy	Executive Director of OD and Workforce	Apr-17	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Comprehensive review being undertaken
WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	Executive Director of OD and Workforce	Aug-18	Policy review date passed – action underway	Policy review date passed with low risk	Policy Review completed and incorporating WF49 Shared Parental Leave Policy. Being submitted through governance process
WF 35	Annual Leave and Bank Holiday Policy	Executive Director of OD and Workforce	Mar-20	Policy review date passed – action underway	Policy review date passed with low risk	Revised policy scheduled for consideration at November QSPC
WF 30	PADR Policy	Executive Director of OD and Workforce	May-20	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Comprehensive review being undertaken

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 19	Policy for Employing Ex-Offenders and people with a criminal record	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy Review completed. Being submitted through governance process
WF 20 All Wales Velindre Adopted	Exit Policy & Procedure	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 31	Sabbatical Leave Policy for Consultant Medical Staff	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Comprehensive review being undertaken
WF 43	Mental Health, Wellbeing & Stress Management Policy	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. Comprehensive review being undertaken
WF 23 All Wales Velindre Adopted	Flexible Working Policy and Procedure	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 24 All Wales Velindre Adopted	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 26 All Wales Velindre Adopted	Reserve Forces Training and Mobilisation Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 27 All Wales Velindre Adopted	Secondment Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 21	Close Personal Relationships in the Workplace	Executive Director of OD and Workforce	Feb-21	Policy review date passed – action underway	Policy review date passed with low risk	Impact of EIA being assessed as part of policy review. Policy remains extant whilst review underway.
WF 13	Adverse Weather Policy	Executive Director of OD and Workforce	Mar-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 45	Homeworking Policy	Executive Director of OD and Workforce	Apr-21	Policy review date passed – action underway	Policy review date passed with low risk	Review underway. Capture homeworking as part of the Flexible Working Policy WF23. Policy remains extant whilst review underway.
WF 45a	COVID 19 Extraordinary Ad Hoc Home Working Policy and Guidance for Managers and Staff	Executive Director of OD and Workforce	Apr-21	Policy review date passed – action underway/required	Policy review date passed with low risk	Review underway. Capture homeworking as part of the Flexible Working Policy WF23. Policy remains extant whilst review underway.
WF 34	Incremental Credit Procedure for Staff starting or re-joining the NHS	Executive Director of OD and Workforce	Oct-25	Policy in date	Policy in date with no risk assessment required	*Change from Policy to Procedure*
WF 53	Redundancy and Security of Employment Policy	Executive Director of OD and Workforce	Apr-21	Policy review date passed – action underway	Policy review date passed with low risk	Revised policy scheduled for consideration at November QSPC

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 36 All Wales Velindre Adopted	Menopause Guidance	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 38 All Wales Velindre Adopted	NHS Wales Model Voluntary Early Release Scheme	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 17	Policy on Reimbursement of Removal and Associated Expenses	Executive Director of OD and Workforce	Jun-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 42 All Wales Velindre Adopted	All Wales NHS Dress Code - Free to Lead, Free to Care	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 49	Shared Parental Leave Policy	Executive Director of OD and Workforce	Dec-21	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway. To be incorporated into the rewrite and new Maternity, Adoption and Parental Leave Policy WF29
WF 44	Working Time Directive Policy	Executive Director of OD and Workforce	Sep-25	Policy in date	Policy in date with no risk assessment required	
WF 16	Welsh Language Policy	Executive Director of OD and Workforce	May-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 40	Supporting Staff who are Carers	Executive Director of OD and Workforce	May-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 18	Alcohol, Drugs & Substance Misuse Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 47 All Wales Velindre Adopted	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 22	Professional Registration Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 50 All Wales Velindre Adopted	Pay Progression Policy	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 51 All Wales Velindre Adopted	Upholding Professional Standards in Wales (Medical Staff Only)	Executive Director of OD and Workforce	Extant	Policy in date	Policy in date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee
WF 52a All Wales Velindre Adopted	Redeployment Procedure	Executive Director of OD and Workforce	Aug-25	Policy in date	Policy In date with no risk assessment required	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3-year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 52b All Wales Velindre Adopted	Organisational Change Policy	Executive Director of OD and Workforce	Under review by NHS Wales Employers	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk	Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee. Policy remains extant whilst review underway.
WF 56	Smoke Free Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 46	Supporting Transgender Policy	Executive Director of OD and Workforce	Aug-22	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.
WF 54	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Executive Director of OD and Workforce	Jul-23	Policy review date passed – action underway	Policy review date passed with low risk	Policy remains extant whilst review underway.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PATIENT NOSOCOMIAL COVID-19 UPDATE

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing And Quality
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing And Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Trust is part of the National Nosocomial Programme Board and is implementing the national requirements in relation to patient Nosocomial COVID-19 reviews in line with the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19, published in March 2021. • There have been **49** potential incidences of patient nosocomial COVID-19 infection within Velindre Cancer Service.

	• The Peer Review Panel has held 14 meetings and the Executive Nosocomial Panel has met on 7 occasions. • There have been no patients affected by nosocomial COVID-19 transmission since December 2022. • No failings have been identified, resulting in no cases being referred to legal and risk for further scrutiny regarding breach of duty.

RECOMMENDATION / ACTIONS	To NOTE **t**he position in relation to patient nosocomial COVID-19 reviews and next steps of the national programme.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	**30/10/31**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Noted report	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES
Nil

1.   SITUATION

This paper is to provide the Quality Safety & Performance Committee with progress in respect of patient nosocomial COVID-19 reviews prior to submission to the Quality, Safety & Performance Committee. The Executive Management Board is asked to NOTE the position in relation to patient nosocomial COVID-19 reviews and next steps.

2. BACKGROUND

The Trust is part of the National Nosocomial Programme Board and is implementing the national requirements in relation to patient nosocomial COVID-19 reviews in line with the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19, published in March 2021.

3. ASSESSMENT

3.1 *Current position in relation to patient Nosocomial COVID-19 reviews:*

There have been 49 potential incidences of patient nosocomial COVID-19 infection within Velindre Cancer Service. The Peer Review Panel has held 14 meetings and the Executive Nosocomial Panel has met on 7 occasions.

A summary of the status of all patient COVID-19 nosocomial investigations.

	No Harm	Low Harm	Moderate Harm	Severe Harm	Death	TOTAL
Indeterminate 3-7 days of admission	10	3	0	0	2	15
Probable 8-14 days of admission	12	0	1	0	6	19
Actual > 14 days of admission	10	2	1	0	2	15
TOTAL	32	5	2	0	10	49

As previously reported, the review by the Executive Nosocomial Panel has brought an added robustness and scrutiny to the process, and to agree the next steps in relation to each case. No failings have been identified, resulting in no cases being referred to legal and risk for further scrutiny regarding breach of duty.

There have been no patients affected by nosocomial transmission of COVID-19 since December 2023 on first floor ward at VCS.

3.2 *Patient / Family Contact*

Each case has been reviewed by the Executive Nosocomial Panel, and a risk benefit approach (including considering the time that may have passed and/or the

severity of the infection since acquiring a nosocomial COVID-19 infection at the Trust) into determining whether a patient or family member would be contacted regarding a nosocomial COVID-19 infection taking place at the Trust.

The Executive Nosocomial Panel agreed a process for patient and/or family contact following nosocomial COVID-19 infection. An initial telephone call would be made by the Deputy Director of Nursing & Patient Experience and a follow up letter using agreed template will be sent within a few days.

There was an issue identified in locating next of kin contact details on our digital systems and medical records. This issue has also been reported in other Health Board areas and a harm versus benefit approach taken.

Some VCS records had no recorded next of kin contact details, other records had names and contact numbers of friends or family members, however, do not state the relationship to patients or next of kin status. This issue has been raised with the division and reported to the outpatient improvement group as an improvement action. The Claims Manager has also developed draft next of kin guidance for approval at the November 2023 Integrated Quality and Safety Group. To date we have sent 4 letters to family members and met with a patient's next of kin, to provide feedback and support. There are 2 more families that we are continuing to attempt to contact.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

If further nosocomial COVID-19 cases occur at the Trust, the last occurred that was probable was on the 17th of October 2022, real time feedback and updates will be provided as has occurred over the last 18 months. The Trust has been requested by the NHS Executive to submit a summary of learning and reflections following this review. This is currently being collated.

5.   IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	An assurance update report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	As no failings were identified there are no legal implications

6.   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP

OCTOBER 2023

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Fiona Davies, Head of Safeguarding & Vulnerable Persons
PRESENTED BY	Fiona Davies, Head of Safeguarding & Vulnerable Persons
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	• Velindre University NHS Trust fulfilled all duties and statutory obligations to safeguard and support patients, donors, staff and the organisation. • Overall continuous progress made. However, the vacant Head of Safeguarding & Vulnerable Adult post resulted in pausing some planned activity. The new appointee commenced on the 16th October 2023 and there is a prioritised plan in place.

| | • Two safeguarding risks have been effectively managed, reduced and removed from the risk register: validity of safeguarding training data and DBS policy. Two new safeguarding risks were identified: safeguarding training compliance and dementia training compliance. Training compliance improvement is an identified priority for the 2023/2024 workplan |
| | • The Trust has been commended for its progress with the Once for Wales Management System and Training Dashboard following the National Safeguarding Service Safeguarding Maturity Matrix Peer Review |

| **RECOMMENDATION / ACTIONS** | The Quality, Safety & Performance Committee is asked to NOTE the deliberations at the Safeguarding & Vulnerable Adult Group held in July & October 2023 |

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Safeguarding & Vulnerable Adults Management Group (SVAMG)	12/10/2023
Executive Management Board (EMB)	30/10/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***Safeguarding & Vulnerable Adults Management Group***- Agreed the content of the report. ***Executive Management Board***- Discussed and noted the report, approved to develop a Trust Sexual Safety Policy and approved a revised Mental Capacity Act Assessment form.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6

APPENDICES	
Appendix 1.	Velindre University NHS Trust Safeguarding & Vulnerable Persons Workplan 2023-24

1.   SITUATION

This paper is to provide the Quality, Safety and Performance Committee with an overview of the key deliberations that have taken place during the Trust Safeguarding and Vulnerable Adults Management Group meetings that took place during July and October 2023. This report is provided to the Committee bi-annually.

2.   BACKGROUND

Safeguarding is underpinned by an increasingly complex statutory framework to support and protect Children and Adults who could be or are at risk of experiencing abuse, neglect or other kinds of harm.

The safeguarding agenda within the Trust is a broad and diverse landscape, which includes the development of workstreams and improvement initiatives to support vulnerable persons who access all our services. The Safeguarding and Vulnerable Persons Group is the delivery and assurance group that monitors the Trust's Safeguarding and Vulnerable Persons responsibilities and covers the following areas:

- Safeguarding activity across the Trust
- Training & development
- National policy and guidance
- National Safeguarding Maturity Matrix and self-assessment
- Regular monitoring of the safeguarding and vulnerable persons annual workplan
- Compliance with vulnerable person's standards including older persons, dementia and learning disability
- Identifying transferable learning from published safeguarding reviews.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key areas to highlight:

ALERT / ESCALATE	No items to alert or escalate
ADVISE	• **_Safeguarding Training Compliance_:** Ask & Act Group training ccompliance is extremely low: 30% within WBS and 40% at VCS. This is due to the vacant Head of Safeguarding and Vulnerable Persons post. The new post holder has commenced and sessions are booked in across the two divisions between January and May 2024. Across the divisions targeted action is seeing an improvement in other areas of safeguarding training with an overall compliance figure of 72%. This will be further improved due to the targeted work being undertaken in respect of Mental Capacity Act (MCA) Training being delivered by the newly appointed Practice Educator for MCA. • **_Head of Safeguarding & Vulnerable Persons Vacancy_:** The new appointee commenced on the 16th October 2023. Priority will be given to recommencing the supporting vulnerable group work and ensuring that the required outcomes of the Safeguarding and Vulnerable persons 2023-24 workplan are delivered. • **_Women's Right Network_:** During this reporting period the Women's Right Network commissioned and published a report 'When We Are At Our Most Vulnerable', this report highlights the numbers of alleged sexual assaults and rapes of adult and child patients, staff and possibly visitors at NHS and private hospital estates in England and Wales as reported by Police force areas. The Trust has is part of the NHS Wales Safeguarding Service response. The terms of reference of the National Group were shared and the Trust has submitted a comprehensive response to the NHS Executive regarding our local arrangements.

	The Group strongly proposed that the Trust should progress with the development of a Sexual Safety Policy pending the development of an All Wales Policy. Executive Management Board approved the development of this policy as a Trust workforce policy. • **The Trust Domestic Abuse Workplace policy:** The group identified that the Trust Domestic Abuse Policy expired in 2021. This has been identified to workforce colleagues. • **Section 5 (Concerns about Practitioners or people in a position of Trust):** audit findings of section 5 (concerns about practitioners and those in a position of Trust) cases recorded on Datix was presented to the group. Areas identified for improvement and recommendations, are included in the group workplan.

ASSURE	• ***Trust Safeguarding and Vulnerable Adult Work Plan***: The approved Safeguarding and Vulnerable Adult work plan ***(attached in Appendix 1***) was discussed, and the following points highlighted:
	  o 2 actions (13%) have been achieved
	  o 8 actions (53%) are on track to be delivered with identified timescales
	  o 5 actions (33%) have been delayed. The following workstreams will be prioritised:
	    1. Training compliance
	    2. Re-establish the 'Supporting Vulnerable Groups Forum' - meeting booked for 24/11/23
	    3. Discussions have commenced with the Once for Wales team regarding recording safeguarding supervision within the safeguarding module.
	
	• ***Safeguarding Maturity Matrix 2022-2023***: The Safeguarding Maturity Matrix is a self- assessment that aims to provide assurance, share practice and drive improvements. A peer review was undertaken in September 2023 by a representative from Public Health Wales Safeguarding Team who provided positive assurance in respect of the Trust's self-assessment and

took some positive learning from what has been achieved in the Trust to share nationally. This included.

- o The Trust adopting the NHS Wales reporting form
- o Implementation of the Datix Once for Wales Datix Module
- o The Trust-wide training compliance dashboard
- o The Trust Virtual assessment safeguarding guidance

The required improvements identified through the Trust's Self-assessment have been included in the work plan of the group.

- *Mental Capacity Act*: A temporary Practice Educator for Mental Capacity Act was appointed in September 2023. Since coming into post the Practice Educator has arranged a number of training sessions for staff during October- December 2023, reviewing and updating the Mental Capacity Act pages on the Trust Intranet and developing a new Mental Capacity Act assessment form.

- **Mental Capacity Act Assessment Form**
  The group reviewed a proposed new Mental Capacity Act assessment form. The new form is more comprehensive than the current assessment form used at the Cancer Centre. The group endorsed this form and it was approved by the Executive Management Board.

- **The Safeguarding Risk Register**
  A comprehensive discussion in respect of the current safeguarding and vulnerable groups risks took place. There were 3 risks on the register. It was identified that two safeguarding risks had been removed. These were the Preparedness of Liberty Safeguards and Safeguarding resilience.

  Safeguarding Training Compliance Reporting Accuracy remained at a risk rating of 6. It has been identified that ESR has not been providing accurate training figures. In

	addition, the Group identified two risks that required assessing and adding onto the safeguarding risk register. It was noted that the concerns related to dementia and safeguarding training. The Trust has recently appointed a Practice Educator for Person Centred Dementia Care and a new Head of Safeguarding and Vulnerable Persons joined the Corporate Team in October. Training in these two areas will take priority to improve the Trust's current position.
INFORM	• *Speaking Up Safely Framework***:** The national Speaking Up Safely framework in the context of safeguarding was discussed. The need to embed this work into the culture of the organisation is imperative for supporting safe care and staff well-being. The Head of Safeguarding and Vulnerable Groups attended the first speaking Up Safely Task & Finish Group held in October 2023. • *PREVENT DUTY*: The required statutory instrument to update the PREVENT DUTY guidance was heard in Parliament on the 7th September 2023, with a view for the updated guidance to come into force on the 31st December 2023. This 3-month window should allow the health sector and other statutory partners time to review the guidance and take account of any changes. The Head of Safeguarding and Vulnerable Groups will undertake a comprehensive review to identify any delivery gaps. The initial review has identified that the Trust is in a positive position as PREVENT e-learning is mandatory to all staff across the Trust. It is also included in level 2 Safeguarding Adults and Children e-learning packages. The current training compliance for PREVENT basic Awareness is 82%.

4. IMPACT ASSESSMENT

<table>
<tr>
<td colspan="2">TRUST STRATEGIC GOAL(S)</td>
</tr>
<tr>
<td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
Choose an item</td>
</tr>
<tr>
<td colspan="2">If yes - please select all relevant goals:

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

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

Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒
</td>
</tr>
</table>

	1. Legislation and national procedures outline a duty to report children and adults at risk, when concerns of abuse or neglect are identified.
	2. Public protection and service improvements for vulnerable persons is also outlined within legislation and national guidance.
	3. A quality measures framework is in place and relevant workstreams are monitored, reviewed, and acted upon via 'Safeguarding and Vulnerable Adults Management Group' and 'Supporting Vulnerable Groups' forum.
	4. Safeguarding principles reinforce a patient centred approach.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	As this is a highlight report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	There are a number of legal implications in respect of compliance with matters contained within the report if the relevant legislative requirements are not met- this report does not identify any legal risks currently.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Safeguarding support resilience* Datix 2474
WHAT IS THE CURRENT RISK SCORE	6
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*No impact*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Accepted risk with increased mitigations.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Highlight Report from the Radiation Protection and Medical Exposures Strategic Committee (RPMESC)

DATE OF MEETING	16/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Talboys, Head of Nuclear Medicine & Kathy Ikin, Head of Radiation Services
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
EMB	30/10/2023	NOTED

1. **PURPOSE**

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the Radiation Protection and Medical Exposures Strategic Committee (RPMSC) on the 21/09/2023. Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety and Performance Committee.
ADVISE	***Leadership for Ionising Radiation – Head of Medical Physics and Clinical Engineering Role and Medical Leadership*** As highlighted throughout the meeting, there is a need to consider the ionising radiation leadership element of the Head of Medical Physics and Clinical Engineering role that has been vacant for some time. A number of Trust policies concerning the use of ionising radiation remain without formal ownership which would be ascribed to a leadership position within Medical Physics and Clinical Engineering. This is also applicable for key policy and procedural areas where there is not an identified medical lead for radiation. Currently, employees within the Trust are assuming the role of the authorised radiation employer (as highlighted in the HIW inspections within the past 12 months for Radiotherapy and Nuclear Medicine) due to the deficit in these leadership roles. There is broad agreement for this role that will have regulatory and leadership accountability, for all medical physics and clinical engineering disciplines, alongside specific responsibilities for training, education and research. Significant progress has been made with a new role description completed, which has been to job evaluation and translation, and is complete for recruitment to commence. ***HASS Disposal*** A project team has been convened to manage the disposal of the research HASS sources following agreement at EMB to dispose. Initial meetings conducted to scope the project and identify with procurement colleagues an appropriate route of disposal. ***HIW Inspection Radiotherapy*** The HIW inspection report has been issued and a formal Trust response to the action plan has been provided. The actions are currently ongoing and being managed by Claire Davies. ***HSE Inspection WBS*** The HSE inspection resulted in notices of contravention and an improvement plan concerning training and contingency plans was required. The Trust response has been accepted by HSE and a short-term extension was requested and accepted to implement the actions. All actions are on the anticipated timeline for completion with formal response back to HSE in due course.

	Clinical Evaluation / Pregnancy and Breastfeeding Trust Policy – Professional ownership New guidance has been issued by the SOR regarding inclusive pregnancy enquiries for those undergoing ionising radiation procedures. A project group has been convened to review and update the policy for Trust ratification and adoption. To note, the policy does not have a nominated radiation employer Trust representative. ***HSE Consent Process – financial risk and Professional ownership*** The HSE will be starting a new consent process in October 2023 on a five-year rolling programme. The point at which the Trust will be required to complete the application is not currently known as determined by the HSE. Operational completion of the forms will come under the remit of the RPMEOG. EMB will need to consider financial aspects (several thousands of pounds per application) and corporate ownership of the process.
ASSURE	***Classification of Nuclear Medicine and Brachytherapy Staff*** Compliance regarding the classification of NM and RT staff under IRR17 is assured to EMB. ***Radon Monitoring*** Radon Monitoring in the Trust identified the mechanical workshop as requiring remedial work to reduce the levels of radon in the working environment. Remediation has been completed, follow up monitoring is being undertaken to assure that remedial works are effective in reducing radon concentrations. ***Appointment of Radiation Supervisors*** A new process has been developed by Radiation Protection Service to improve efficiency in the appointment process.
INFORM	
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 21/09/2023.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	

INTERNAL AUDIT REPORT: Digital Strategy & Transformation Programme	

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	STEPHEN CHANEY, ACTING HEAD OF INTERNAL AUDIT
PRESENTED BY	Emma Rees, Deputy Head of Internal Audit / Simon Cookson Director of Audit and Assurance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The purpose of this report is to present the Digital Strategy and Transformation Programme.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	

Page 1 of 5

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Audit Committee	19/11/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Audit Committee noted the Internal Audit Report: Digital Strategy & Transformation Programme.

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

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1.   SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2.   BACKGROUND

The purpose of this audit was to provide assurance over the implementation of the Trust's Digital Strategy.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust has a Digital Strategy in place and has defined an appropriate operating model that is being implemented to enable delivery of the Digital Strategy.

The Digital Strategy considers digital inclusion, although we note that delivery on the actions in this area is at an early stage. The Digital Strategy also considers the technology in use within the organisation.

Successful delivery of the Digital Strategy will require a cultural shift within the organisation to a truly digital first culture.

The key management actions identified are:

- Ensuring the governance framework enables appropriate visibility of digital.
- Ensuring a transition to a digital culture.
- Ensuring the delivery of the digital inclusion action plan and communication of the aims of digital.

5. IMPACT ASSESSMENT

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

If yes - please select all relevant goals:
- Outstanding for quality, safety and experience ☒
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒
- A beacon for research, development and innovation in our stated areas of priority ☒
- An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- A sustainable organisation that plays its part in creating a better future for people across the globe ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	07 - Digital Transformation - Failure to Embrace New Technology	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☐
	Timely	☐
	Effective	☐
	Equitable	☐
	Efficient	☐
	Patient Centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	
	Not required for Internal Audit reports.	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.	
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required	
	Not required for Internal Audit reports.	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.	

Page 5 of 5

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • Failure to deliver IMTP objectives; • TAF 07 – Digital Transformation.
WHAT IS THE CURRENT RISK SCORE	Linked to five medium priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit.
All risks must be evidenced and consistent with those recorded in Datix	

Digital Strategy & Transformation Programme

Final Internal Audit Report

August 2023

Velindre University NHS Trust

Contents

Review reference:	VT2324 – 02
Report status:	Final
Fieldwork commencement:	16 May 2023
Fieldwork completion:	21 July 2023
Debrief meeting:	21 July 2023
Draft report issued:	22 August 2023
Management response received:	8 October 2023
Final report issued:	10 October 2023
Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	Carl James, Director of Strategic Transformation, Planning & Digital
Distribution:	Carl Taylor, Chief Digital Officer David Mason-Hawes, Head of Digital Delivery
Committee:	Audit Committee

controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The objective of the audit was to provide assurance over the implementation of the Trust's Digital Strategy.

Overview

We have issued reasonable assurance on this area.

The Trust has a Digital Strategy in place and has defined an appropriate operating model that is being implemented to enable delivery of the Digital Strategy.

The Digital Strategy considers digital inclusion, although we note that delivery on the actions in this area is at an early stage. The Digital Strategy also considers the technology in use within the organisation.

Successful delivery of the Digital Strategy will require a cultural shift within the organisation to a truly digital first culture.

The key management actions identified are:

- Ensuring the governance framework enables appropriate visibility of digital.
- Ensuring a transition to a digital culture.
- Ensuring the delivery of the digital inclusion action plan and communication of the aims of digital.

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance.	
	Low to moderate impact on residual risk exposure until resolved.	None

Assurance summary[1]

Objectives	Assurance
1 Progress	Reasonable
2 Digital Operating Model	Reasonable
3 Digital literacy & Inclusion	Reasonable
4 Older Technology	Reasonable

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Publication of Digital Strategy	1	Operation	Medium
2	Governance Framework	1	Operation	Medium
3	Digital Culture	2	Operation	Medium
4	Digital Inclusion	3	Operation	Medium
5	Older Technology Impact	4	Operation	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Velindre University NHS Trust (the 'Trust' or 'organisation') a review of the Digital Strategy and Transformation Programme was undertaken.

2. Detailed Audit Findings

Objective 1: Appropriate progress is being made in implementing the Trust's Digital Strategy, with appropriate reporting and oversight maintained.

2.1 There is a Digital Strategy in place for the Trust, this links to the organisation's 5 strategic goals, and defines digital in terms of Velindre services users and staff by using user stories, including for a cancer patient and a blood donor.

2.2 We note that although the digital strategy has been approved, it has not been published or made widely available. As such, the Trust is not communicating or pushing forwards on its aims as a digital first organisation. **Matter Arising 1**

2.3 The strategy provides context in terms of changes that have already been made in the structure of digital and the leadership and governance framework, and notes the need for a culture change within the organisation for digital transformation to be successful.

2.4 The strategy provides a vision which is broken down into themes, each of these has objectives and specific actions, the themes being:

- Ensuring foundations;
- Digital inclusion;
- Safe and secure services;
- Working in partnership;
- Digital organisation; and
- Insight driven services.

2.5 The Trust's IMTP references the Digital Strategy in a number of areas, with it being identified as a supporting and enabling strategy. The IMTP also notes the link to divisional objectives and the Velindre Futures and includes the digital plan as an appendix.

2.6 As part of our audit work, we tracked the progress of a number of actions and objectives within the Digital Strategy. We note that progress is being made against the digital objectives, with some key actions noted:

- Work has started to define and implement a new strategy for telephone services;
- A proposal has been submitted for a revised approach to business intelligence;
- Work is underway to enable outcome reporting (PROMS) under the Value Based Healthcare programme;

- A supplier engagement programme is being developed which will better enable linkages with suppliers and academia; and
- Work is continuing to improve the cyber security position of the Trust.

2.7   There is a framework for governance and oversight of digital, although we note that the reporting arrangements are split across Committees, with no single committee in place that is responsible for digital.

2.8   The Strategic Development Committee has responsibility for oversight of the Digital Strategy itself, with the Quality, Safety and Performance Committee having oversight of the operational delivery of digital. We also note that there is reporting to the Executive Management Board (EMB), and digital forms part of the performance management framework. Digital is also integrated into the divisional programmes with reporting and decision making at the Velindre Futures forum and with the WBS modernisation programme.

2.9   Our review of Committee business confirmed that this governance structure is operating as defined, with regular reporting on the relevant aspects of digital to each committee.

2.10   The nature of the current governance structure for digital is spread across a number of governance arrangements therefore, there is no single forum where it comes together with full oversight. This means that whilst Digital is being discussed at a broad range of places and avoids siloes there is a potential for the committees and leads to miss opportunities to gain a full picture.

2.11   We also note that, although there is a Chief Digital Officer (CDO), there is no named Director of Digital role Whilst there is a difference in name the CDO performs similar duties albeit without being an Executive level role. The current arrangement is working appropriately however with the CDO attending core groups and committees and the lead executive being engaged in digital issues. We note that there is a trend within NHS Wales to establish a Director of Digital role as a full Executive role.

2.12   The fragmented governance arrangements and the lack of a digital director may mean that digital is not fully visible, in particular outside the Trust and as such may not be matching the Trust's stated "digital first" ambition. **Matter Arising 2**

2.13   Our review of the detail contained in the reporting to committees confirmed that reporting accurately reflects the current picture and includes reporting on key risks to the achievement of digital objectives.

Conclusion

2.14   The Trust has an approved Digital Strategy which is clear about the aims of the Trust and contains key actions and objectives to drive digital transformation, although we note that it has not yet been published. The Digital Strategy is linked to the overall Trust Strategy and IMTP and progress is being made on delivery of key items within the Digital Strategy. There is a governance and oversight framework in place for digital and reporting within this framework is accurate. We note however that the framework is split across multiple groups and so the visibility

of digital may not fully reflect the Trust's stated ambitions. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 2: The organisation has defined an appropriate digital operating model that supports staff and enables transformation, together with a roadmap for implementation of the Digital Strategy.

2.15 An appropriate target digital operating model has been set out in order to define how digital services are to be structured in order to deliver the Digital Strategy, in particular at a high level, with a more detailed operating model to be developed following external consultancy work. This model contains 4 key themes:

- Digital Service Design;
- Digital Integrated Platform;
- Digital Organisation; and
- Ecosystem.

2.16 We note that the Trust has a large programme of digital transformation work due to both Velindre Futures and the WBS modernisation. The focus on transformation may lead to the day-to-day support function being under resourced and a lack of ability to improve extant services. As part of the implementation of the operating model, the service management framework is to be developed to better support the organisation in addition to enabling digital transformation. We note that the Digital team has been restructured and now it is just one team, with one service desk.

2.17 The implementation of the digital model is to be via a digital programme that brings all the elements together and defines a governance structure for management. A paper to this effect and seeking approval was presented to the SDC (December 2022) and EMB (June 2023). This has been approved, and the programme is currently being established.

2.18 The operating model as defined enables the alignment of people, processes and technology in order for digital to support the organisational objectives.

2.19 Within the digital service the model shows the creation of "digital squads" to enable links with operational services and agile development. We also note the intent within the Digital Organisation theme to establish a digital champions network to further link digital with services.

2.20 Digital services have developed a Digital Services Resource plan to define the resource need, both in terms of skills and number of staff, which is needed to provide the required service for the organisation. Work was undertaken to improve the resourcing following this, and we note that there is an explicit intent to redo this work in light of the new operating model in order to ensure that all the required skills are considered. There is also work ongoing both within DHCW and HEIW to define the required digital skills across NHS Wales.

2.21 In terms of skills within the wider organisation, the digital model theme "Digital Organisation" explicitly includes skills development, with an objective to develop a digital education and training programme. In addition, the "Digital Ecosystem"

theme includes digital inclusion for patients and donors and the use of universities and technical partners for delivery of digital products.

2.22 The Digital Design theme sets out an overall process for delivering digital services with a flow from discovery to development to live. This enables service processes to be reassessed and redesigned, and we note the intent to create long term ownership of services and to design clinically led services which would embed digital within the organisation.

2.23 The model sets out a mechanism to define the appropriate technology within the Digital Integrated Platform theme, which is split into reference architecture, essential and core services, tailored services and data and insight services.

2.24 The current model sets out some specifics for technology, with Office 365 being included, along with a requirement for cloud-based services. In addition, the model references both the National Data Repository and Local Data Repository in terms of the insight services.

2.25 We note that the Trust is a heavy user of, and therefore is reliant on, the national systems provided by DHCW. This may act as a drag as the Trust has limited influence on both development and timing, and as such may not be able to maximise the potential presented by the new cancer centre and WBS modernisation.

2.26 The Strategy does not explicitly contain a roadmap that defines how the objectives and actions will be delivered across the organisation, with no timescales set for actions. The Trust has engaged an external consultancy to assist in the development of the digital structures within the Trust and this includes setting out a roadmap for delivery of the new operating model.

2.27 The component projects which make up the Digital Strategy are identified across a variety of documents, including the strategy itself, the IMTP and the Digital Workplan. These all include lead officers and indications of timeframes, and as such provide a roadmap for delivery of the strategy objectives.

2.28 We note that there are resource gaps identified within the digital plan, and work is currently underway to identify resources (staff) to mitigate these.

2.29 We also note that there is ongoing work to develop sub-strategies and plans to support the digital strategy, including:

- Architecture;
- Software development; and
- Service desk and support.

2.30 We note however, that although the organisation has stated a commitment to "digital first" and is putting plans in place, the current picture does not show this and in similar to other organisations in NHS Wales digital is not fully embedded with services.

2.31 For the operating model to effectively work to deliver the strategy, the organisational culture needs to be a digital one, where digital is embedded and there

is ownership of digital from top to the bottom. We note that Velindre is not yet within this space, with the Digital Programme still being formed at the Executive level, with the lack of a single top-level group to coordinate and own digital, a lack of full understanding of digital at operational level and the organisation retaining some silos in relation to digital work. **Matter Arising 3**

2.32 The model contains a digital programme of work alongside the divisional modernisation programmes, however there is currently a lack of clarity over where some items should sit would rest, with it currently being at EMB.

2.33 We note that this is changing, and the model is being established, however until the understanding of digital is there it won't be fully effective.

Conclusion:

2.34 The Trust has defined an operating model which is being implemented in order to deliver on the Digital Strategy's objectives. The operating model appropriately covers the key components, including people, processes and technology. We note that delivery of this model relies on a digital culture within the wider organisation however this is not yet fully in place. There is a roadmap that defines how the Digital Strategy components will be implemented and resource gaps are being identified. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 3: Processes are in place to ensure the digital literacy of staff and digital inclusion for service users is sufficient to enable delivery of digital transformation.

2.35 The Digital Strategy specifically considers the digital competencies of staff within the Digital Organisation theme, which notes a requirement to strengthen digital education and training and work to develop the core digital competence of the workforce. The key objectives within this are stated as:

- Create strong digital leadership at all levels of the organisation;
- Build a highly skilled digital team that has the capacity and capability to deliver our digital ambitions; and
- Create a digitally literate workforce which embraces the use of technology to improve the services we provide.

2.36 There is a recognition of the need to develop staff competency, the digital competency of staff is also included within Digital Inclusion theme, and there are specific actions defined to improve and develop staff skills. These actions include digital skills audits; developing a digital champions network; resuming Office 365 deployment; providing guides; and a programme of lunch and learn sessions.

2.37 A digital inclusion action plan has been drafted which includes all the key items to improve staff digital competence, however we note that many of the actions are at an early stage, or have yet to commence. In particular, although a profile for a digital champion has been drafted, there has been no identification of these, and the range of information on the learning system is limited at present to materials related to the Cansic replacement, with no information on digital issues or O365.

2.38 There has been some information delivery and as part of the learning at work week there were sessions on Microsoft forms, Teams and user centred design.

2.39 As noted above the organisational culture is not currently a digital one and staff do not always understand what digital means and the role of the digital directorate together with their role in ensuring digital delivery. The identification of champions alongside the communication of digital intent and a strong programme of digital skills development is key to ensuring that the organisation culture changes. **Matter Arising 4**

2.40 The Digital Strategy is explicit on the need to ensure all patients / donors are included and able to use digital offerings, with Digital Inclusion containing core objectives:

- Digitally connect our donors, patients and carers and staff to our services 24/7;
- Place information which is uncomplicated and accessible into the hands of patients and donors to enable them to make better decisions about the services and support they require;
- Deliver the technology which supports the provision of more services at home and as locally as possible;
- Provide our staff with the technology to work from a wide range of locations across Wales; and
- Reduce digital exclusion of people across Wales.

2.41 The Trust is clear about how it wants to move forward in this space, has a stated ambition, has signed the Digital Inclusion Charter and developed an accreditation action plan. The Trust also has representation on the Digital Inclusion Alliance for Wales and so there is ongoing development of a wider community approach.

2.42 We note however that many of the core actions are at an early stage, and without digital inclusion work being in place the impact of the Trust's digital solutions may be reduced.

Conclusion:

2.43 The Digital Strategy explicitly considers digital inclusion and competency, and there are action plans in place in order to drive this forward. We note that delivery of this is at an early stage however, and the success of the implementation of the Digital Strategy and operating model will rely on this area moving forward. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 4: Processes are in place to identify out of date technology and the level of technical debt and mitigate the risks resulting in these in relation to the delivery of the Digital Strategy.

2.44 We note that the Trust contains legacy technology, both hardware and software.

2.45 In order to fully identify and baseline the services in place an external consultancy has been engaged. As part of this discovery work the requirement to baseline the current technologies was noted.

2.46 The older hardware in place is identified and we note that there has been good progress in removing and updating this.

2.47 The risks associated with the existence of legacy technologies have been noted within the Trust's risk management process. The Trust risk register includes two high rated risks (2774 and 2776) relating to the use of older technology within WBS, in particular LIMS, which notes the impact on delivery of services. There are also additional, lower scored risks held on the digital services risk register relating to the presence of older technology which focus on the risk of disruption and loss of service.

2.48 The new cancer centre, and the WBS modernisation programme offer opportunities for digital transformation and service redesign using modern technology and agile digital delivery. The use of older IT systems can act as a constraint and lead to a risk to the delivery of the Digital Strategy and successful digital transformation, however the risks as currently stated do not fully articulate this. **Matter Arising 5**

2.49 The Digital Strategy includes a theme in relation to the use of technology, Ensuring Foundations, the key objectives of which include:
- Develop 'fit-for-the future' technologies that are resilient with a hybrid of cloud and data centre / on premise deployment;
- Design all systems around the national principles (e.g. open; inter-operable;) to support integration across organisations;
- Implement a range of national systems, to support a once for Wales approach, including Welsh Clinical Portal, Welsh Patient Administration System, Welsh Laboratory Information Systems and electronic prescribing;
- Continually develop and maximise the benefits of our existing business systems, including the Blood Establishment Computer System (eProgesa) and Digital Health Care Record;
- Implement local solutions relevant and appropriate to the needs of the population we serve; and
- Design and implement a new strategy for the telephony services used across the Trust, to include the adoption of new digital telephony services, such as those available via Microsoft Teams.

2.50 As such the Digital Strategy sets out an aim to ensure that the Trust uses modern technology for the delivery of services.

2.51 As noted previously the new cancer centre and the WBS modernisation programme offer opportunities to deploy modern digital applications and technologies. We note that a more detailed roadmap to modernisation will be developed following the baselining work currently underway.

Conclusion:

2.52 There are processes in place to identify older technology in use and there are actions defined in order to mitigate the risks resulting from these. The use of older technologies presents a risk to the successful delivery of digital transformation, however this aspect of the risk is not fully articulated. Accordingly, we have provided **reasonable assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Digital Strategy Publication (Operation)	Impact
We note that although the Digital Strategy has been approved, it has not been published or made widely available. As such the Trust is not communicating or pushing forwards on its aims as a digital first organisation.	There may be a lack of clarity and understanding of the Trusts digital intent

Recommendations	Priority
1. The digital Strategy should be published, and a communications exercise undertaken to publicise the strategy and the Trusts digital intent.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	The Digital Strategy has been approved and it is being prepared for publication alongside the refreshed Trust strategy and other enabling strategies. This will include an engagement plan.	31st October 2023	Chief Digital Officer

Matter Arising 2: Governance Framework. (Operation)	Impact
The nature of the current governance structure for digital is fragmented with no single forum where it comes together with full oversight. This means that there is a potential for the committees and leads to miss opportunities to gain a full picture. We also note that although there is a Chief Digital Officer, there is no Director of Digital. The current arrangement is working appropriately with the CDO attending core groups and committees and the lead executive being engaged in digital issues. We note that there is a trend within NHS Wales to establish a digital director role The fragmented governance arrangements and the lack of a digital director may mean that digital is not fully visible, in particular outside the Trust and as such may not be matching the Trust's stated "digital first" ambition.	The visibility of digital may be lacking compared to the Trust ambition.

Recommendations		Priority
	The governance structure for digital should be re-considered, with further consideration given to establishing a group where all digital items are considered.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
	A Digital Programme Group is being established which will bring Digital together for oversight into the Executive Management Board. An Executive / Board level review will be needed to look at the case for creating a single forum where Digital is owned in the Board committees	31st October 2023 for Digital Programme Group 30th November for Exec/Board Review	Chief Digital Officer Director of Strategic Transformation, Planning & Digital

Matter Arising 3: Digital Culture. (Operation)	Impact
Although the organisation has stated a commitment to "digital first", the current picture does not show this and digital is not embedded with services. For the operating model to effectively work to deliver the strategy, the organisational culture needs to be a digital one, where digital is embedded and there is ownership of digital from the top to the bottom. We note that Velindre is not yet within this space, with the lack of a top-level group to coordinate and own digital, a lack of full understanding of digital at operational level and the organisation retaining silos in relation to digital work. The model contains a digital programme of work alongside the divisional modernisation programmes, however there is currently a lack of clarity over where some items should sit would rest, with it currently being at EMB.	Successful delivery of the Digital Strategy and operating model may be impacted

Recommendations	Priority
Work should be undertaken to change the digital culture within the organisation: - Communication of Digital Strategy and its aims; - Embedding digital within the service and ensuring ownership; and - Ensuring staff understand digital and their role in successful delivery of digital transformation.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
The Digital Programme is in the process of being set up and the first meeting to confirm arrangements and terms of reference is scheduled for the 5th Oct. The proposed remit for the Digital Programme includes work on VUNHST as a digital organisation. The communication of the Digital Strategy is to be completed by the end of October 2023.	31st October 2023	Chief Digital Officer

Matter Arising 4: Digital Inclusion. (Operation)	Impact
Many of the core actions relating to digital inclusion and competency are at an early stage, and without digital inclusion work being in place the impact of the Trust's digital solutions may be reduced. As previously noted the organisational culture is not currently a digital one and staff do not always understand what digital means and the role of the digital directorate together with their role in ensuring digital delivery. The identification of champions alongside communication of digital intent and a strong programme of digital skills development is key to ensuring that the organisation culture changes	Successful delivery of the Digital Strategy and operating model may be impacted

Recommendations	Priority
Work to progress the digital inclusion action plan and digital skills and awareness within the organisation should be accelerated.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
A Digital Inclusion action plan is in place. This will be reviewed and opportunities where the work can be accelerated will be identified and included in the next IMTP where appropriate. Where further investment would be required to accelerate the work a business case will be prepared for EMB	30th November 2023	Chief Digital Officer

Matter Arising 5: Older Technology Risks. (Operation)	Impact
The new cancer centre, and the WBS modernisation programme offer opportunities for digital transformation and service redesign using modern technology and agile digital delivery. However, the use of older IT systems can act as a constraint and lead to a risk to the delivery of the Digital Strategy and successful digital transformation. However, the risks as currently stated do not fully articulate this.	Successful delivery of the Digital Strategy and operating model may be impacted

Recommendations	Priority
The risk relating to the use of older technologies on the delivery of the Digital Strategy and the Trusts digital transformation aims should be clearly stated.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
Review risks to the Digital Strategy relating to the use of older technologies and make sure they reflected accurately in risk registers and the Trust Assurance Framework	31st October 2023	Chief Digital Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE	

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE	

DATE OF MEETING	16th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1   This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 12th October 2023.

1.2   Key highlights from the meeting are reported in section 2.

1.3   The Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	There were no items to advise the Quality, Safety & Performance Committee.
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	**Communications & Engagement** The Communication and Engagement paper was delivered to the TCS Programme Scrutiny Sub-Committee. The team were thanked for the Summer Jamboree. NG highlighted another Jamboree is being arranged for 31st October. Information will be circulated. The TCS Programme Scrutiny Sub-Committee **noted** the Communications and Engagement Paper. **TCS Programme Finance Report** The TCS Programme Finance Report was delivered to the TCS Programme Scrutiny Sub-Committee. This report outlines the financial position as of August 2023. The overall forecast outturn for the programme is an overspend of £2.7153m for the financial year 2023 – 2024 against a budget of £11.641m. It was highlighted that no capital funding has been allocated to the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.700m has been made to Welsh Government. No revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year. A funding request of £0.041m is being made to the Trust. It was highlighted that the Trust is not anticipating further judicial review costs for this year. Further clarity is also being sought in relation to the £0.041m. LF to clarify directly with Independent Members exactly what the £0.041m is relating to.

	The TCS Programme Scrutiny Sub-Committee **noted** the financial position for the TCS Programme and associated projects for 2023 – 2024 as at 31st August 2023.
APPENDICES	None.