Public Quality, Safety & Performance Committee

Thu 13 July 2023, 10:00 - 13:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

1. PRESENTATIONS

1.1. Staff Story

To be led by Michelle Fowler, Organisational Development Manager, Equalities, Diversity & Inclusion, Organisational Development & Workforce

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

2.4. Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 16th May 2023

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

DRAFT Public Quality Safety Performance Committee Minutes 16.05.23_v3.0.pdf (18 pages)

2.5. Review of Action Log

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

QSP Action Log.pdf (3 pages)

2.6. Matters Arising

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

2.6.1. Freedom of Information Requests Report

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

20230422-QSP FOIA Report-FINAL.pdf (5 pages)

3. MAIN AGENDA

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

3.1. Trust Risk Register

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

- RR - QSP -Trust Risk Register - 13.07.2023- V03.pdf (9 pages)
- RISK REGISTER - 26.06.2023 -V03.xlsx (13 pages)
- APPENDIX 2 - Overall Risk Data - 29.06.2023.pdf (2 pages)

3.2. Finance Report for the period ended 31st May 2023 (M2)

To be led by Matthew Bunce, Executive Director of Finance

- Month 2 Finance Report Cover Paper - QSP.pdf (6 pages)
- M2 VELINDRE NHS TRUST FINANCIAL POSITION TO MAY 2023 - QSP.pdf (19 pages)
- Appendix 1 - Velindre 23-24 Month 2 monitoring return Letter.pdf (8 pages)
- Appendix 2 - 2023-24 Velindre Core MMR Template M2.pdf (32 pages)

3.3. Quality, Safety & Performance Report

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

- QSP 13th July - May PMF FINAL Report version 025 (002).pdf (169 pages)

3.4. Integrated Medium Term Plam Quarter 1 Report

To be led by Phil Hodson, Deputy Director of Planning & Performance

- QSP 13th July - IMTP 2023.24 Quarter 1 Update - final.pdf (38 pages)

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4. 2022-2023 ANNUAL REPORTS

4.1. FOR APPROVAL

4.1.1. Trust Clinical Audit Annual Report

To be led by Catherine Pembroke, Clinical Lead for Audit & Quality Improvement; Edwin Massey, Medical Director, Welsh Blood Service and Jacinta Abraham, Executive Medical Director

- Trust Clinical Audit Annual Report 2021-2023 Cover Template.pdf (7 pages)
- VUHNST CLINICAL AUDIT ANNUAL REPORT 2021-23 Final V6.pdf (117 pages)

4.1.2. Infection Prevention & Control Annual Report

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

- Annual report QSP July 2023 Final draft.pdf (28 pages)

4.1.3. Medical Devices Annual Report

To be led by Peter Richardson, Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service

- Annual Report 2023 Medical Devices v0.2.pdf (10 pages)

4.1.4. Information Governance Annual Report

To be led by Matthew Bunce, Executive Director of Finance and Senior Information Risk Owner (SIRO)

- 20230704-IG Annual Report-FINAL.pdf (20 pages)

4.1.5. Sustainability Annual Report (including decarbonisation)

To be led by Jason Hoskins, Assistant Director of Estates, Environment & Capital Development

- Annual Sustainability Report Cover Paper - QSP Committee.pdf (6 pages)
- SUSTAINABILITY ANNUAL REPORT 2022-2023 INTERNAL .pdf (29 pages)

4.2. ENDORSE FOR TRUST BOARD APPROVAL

4.2.1. Performance Annual Report

To be led by Phil Hodson, Deputy Director of Planning & Performance

Final Draft Annual Performance Report 2022-2023 QSP 13th July 2023 - _Cover Paper.pdf (3 pages)
Annex 1 - 2022-2023 DRAFT for QSP 13th July 2023 - Annual Performance Report version 017.pdf (69 pages)

4.2.2. Putting Things Right Annual Report

To be led by Jade Coleman, Quality, Safety & Assurance Manager; Jayne Rabaiotti, Claims & Redress Manager and Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience

Putting Things Right Annual Report 2022-23.pdf (33 pages)

4.2.3. Patient & Donor Experience Annual Report

To be led by Jade Coleman, Quality, Safety & Assurance Manager and Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

Patient and Donor Experience Annual Report 2022-23 (005).pdf (20 pages)

4.2.4. Health & Safety Annual Report

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

Deferred to next meeting on request of Executive Lead

4.2.5. Local Partnership Forum Annual Report

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

LPF Annual Report QSP2023.pdf (6 pages)

4.2.6. Annual Equality, Diversity & Inclusion Report

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

QSP Annual Equality Report 2023.pdf (11 pages)

4.2.7. Gender Pay Gap Annual Report

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

QSP cover paper Gender Pay Gap 2023.pdf (5 pages)
Gender Pay Gap Report 2023.pdf (9 pages)

4.2.8. Welsh Language Annual Report

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

WL Board cover paper for WL Annual Report 22 23.pdf (5 pages)
WL annual performance report 22-23 ENG v1.pdf (12 pages)

4.3. FOR NOTING

4.3.1. Health Technology Wales (HTW) Annual Report

To be led by Susan Myles, Director, Health Technology Wales

HEALTH-TECHNOLOGY-WALES_ANNUAL-REPORT_AW6.pdf (31 pages)

5. NHS WALES SHARED SERVICES

There are currently no items for endorsement.

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

To be led by Gareth Tyrell, Accountable Pharmacist, Procurement NWSSP

NWSSP PTS QSP Submission.pdf (9 pages)

5.2. Surgical Materials Testing Laboratory (SMTL) Annual Report

To be led by Dr Gavin Hughes, Director, SMTL NWSSP

Deferred to next meeting on request of NWSSP

5.3. Medical Examiner Service (MES) Annual Report

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

Deferred to next meeting on request of NWSSP

6. 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. Safeguarding & Vulnerable Adults Management Group Annual Report

To be led by David Harris, Interim Senior Professional Safeguarding & Public Protection; Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience and Nicola Williams, Executive Director of Nursing, AHPs & Health Science

Safeguarding Report 22-23 QSP Paper (002).pdf (6 pages)
Safeguarding and Vulnerable Persons Annual Report 2022-23v2.pdf (19 pages)

7. CONSENT ITEMS FOR ENDORSEMENT

7.1. Business Continuity & Emergency Planning Annual Report

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

QSP BC and EP Annual Report_final.pdf (9 pages)

7.2. Professional Registration/Revalidation Report

To be led by Anna Harries, Head of Professional Standards & Digital, Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Dr Jacinta Abraham, Executive Medical Director

Professional Registration - revalidation 2022-23 annual report Final (005).pdf (19 pages)

8. CONSENT ITEMS FOR NOTING

8.1. Estates Annual Report

To be led by Jason Hoskins, Assistant Director of Estates, Environment & Capital Development

Annual Estates Report Cover Paper - QSP.pdf (6 pages)
Estates Annual Report 22-23 v2.pdf (24 pages)

8.2. People Strategy Annual Update Report

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

QSP cover paper People Strat Annual report 2223final (003).pdf (3 pages)
People Strategy Annual Update Report 202223FInal.pdf (10 pages)

8.3. Trust Integrated Quality & Safety Group Highlight Report

To be led by Zoe Gibson, Interim Head of Quality & Safety, Welsh Blood Service and Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

IQS Highlight report EMB June 2023.pdf (10 pages)

8.4. Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Highlight Report - 20th April 2023

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

Highlight Report - PUBLIC TCS 20.04.23 LF SH.pdf (3 pages)

9. 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. July 2023 Analysis of Triangulated Meeting Themes

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

9.2. July 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?*
- *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 the Annual Reports and core essential business?*

9.3. Committee Effectiveness Survey Report - Reflective Feedback from May 2023 Committee

To be led by Emma Stephens, Head of Corporate Governance

QSP Effectiveness survey feedback_May 2023.pdf (2 pages)

10. 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

11. ANY OTHER BUSINESS

Prior approval by the Chair required.

12. DATE AND TIME OF THE NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 14th September from 10:00-13:00.

13. CLOSE

The Committee is asked to adopt the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

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

ATTENDANCE		
Prof Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Steve Ham	Chief Executive Officer	SHa
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Jacinta Abraham	Executive Medical Director	JA
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Paul Wilkins	Interim Director of Velindre Cancer Service	PW
Peter Richardson	Head of Quality Assurance and Regulatory Compliance – Welsh Blood Service	PR
Emma Stephens	Head of Corporate Governance	ES
Liane Webber	Business Support Officer (Secretariat)	KP

1.0.0	**PRESENTATIONS**	**Action Lead**
1.1.0	**Velindre Cancer Service – Patient Story** Led by Vivienne Cooper (VC), Head of Nursing, Quality, Patient Experience and Integrated Care and Matthew Walters (MW), Operational Senior Nurse Prior to the meeting, the Committee received Jenny's story. Jenny is a highly skilled and very much valued member of Velindre nursing staff who had recently also been a patient of the hospital she had worked in for over 40 years. The story highlighted the challenge and privilege presented to staff at the Cancer Centre in caring for one of their own and in finding the balance between carer and colleague. The Committee heard how staff had cared for five of its own colleagues over the last three years including some to end of life. VC outlined some of the key priorities, including maintaining boundaries, avoiding assumptions about the patient's personal life and, above all,	

	maintaining the confidentiality and dignity at all times. MW explained some of the measures that were employed to ensure good practice when caring for Jenny, including the allocation of less familiar staff members. The significant impact on staff was acknowledged, with clinical psychology (both group and individual) having been offered to staff involved in Jenny's care, to provide additional support where required. Ongoing support from senior members of the team, the Staff Psychologist and Psychology team focused on inpatient care is also available for those affected. Staff were reassured that they should feel confident to speak up if they are struggling and had reported feeling well supported. With a focus on learning – it has become apparent that published literature on caring for a colleague is extremely limited, which presents a clear opportunity for further research in order to increase the level of literature available on the subject to enable staff and colleagues in the wider NHS community to be better prepared for the future. SH suggested that the research be extended to include caring for family members, relatives and friends which presents many of the same challenges. DM highlighted that research had been a subject of much discussion at the recent Nursing Conference, staff had indicated a need for support and education in research, and this should be addressed as a Trust issue, with consideration to be given to how and where the learning can be shared. VC to discuss further opportunities in relation to this with Professor Jane Hopkinson. The Committee conveyed its sincere thanks to Jenny for sharing her powerful and thought-provoking story and endorsed the recommendation to explore research options in relation to caring for a patient who is also a colleague and for this to include an examination of how to care for family members, relatives and friends in such circumstances. *Matthew Walters left the meeting*	**VC**
1.2.0	**Clinical Governance and a Just Culture – Making it a reality** Led by Zoe Gibson, Interim Head of Quality, Safety & Assurance The Committee received a comprehensive presentation from Zoe outlining the core learning gained via her current MSc studies in respect of a positive quality and safety culture. The presentation outlined how organisations can successfully implement a 'just culture' as part of their Clinical Governance and Quality and Safety structure. DM noted that the presentation makes a clear case for the desire to create an environment where people are confident to admit to making a mistake but suggested that this be extended to include feeling able	

	to accept personal limitations and speak out when not feeling confident or able to carry out a particular task. SM noted that the Just Culture work outlined in the presentation is in line with work currently being carried out in Velindre and the wider NHS Wales around minimising employee harm. The Committee thanks Zoe for sharing this thought-provoking work.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** were received from: • Jacinta Abraham, Executive Medical Director • Stephen Harries, Trust Vice Chair and Independent Member	
2.2.0	**In Attendance (additional)** • Emma Rees, Deputy Head of Internal Audit (NWSSP) • Katrina Febry, Audit Lead, Audit Wales • Vivienne Cooper, Head of Nursing, Quality, Patient Experience & Integrated Care (for item 1.1.0) • Matthew Walters, Operational Senior Nurse (for item 1.1.0) • Zoe Gibson, Interim Head of Quality, Safety & Assurance (for item 1.2.0) • Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience • Hilary Williams, Consultant and Associate Medical Director for Health & Safety (deputising for Jacinta Abraham, Executive Medical Director) (for item 3.9.0)	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety and Performance Committee Chair No declarations of interest were raised.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 16th March 2023** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The minutes of the meeting of 16th March 2023 were confirmed as an accurate record. VM highlighted that there were a small number of actions contained in the minutes which were not reflected in the action log. These will be added to the Committee action log retrospectively for completeness. One of these actions referred to the Trust Assurance	

	Framework, to bring a detailed review of two of the areas into this Committee. LF gave a brief update and advised that a full discussion on the strategic risks within the framework was carried out at the recent Strategic Development Committee meeting and deep dives on the specific strategic risks will commence in the July 2023 QSP Committee meeting onwards. The Committee **APPROVED** the minutes from the 16th March 2023 Public Committee.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The action log was discussed and Committee members confirmed that they were sufficiently assured that all actions identified as closed other than 4.2.0 had been completed. • ***Action 3.1.1*** – LF advised that progress is being made following continued email correspondence which has been forwarded to the Chair for information. LF to circulate further to SH and a select number of members to ensure all questions previously asked have been answered. • ***Action 4.2.0*** – HJ highlighted that this action was identified as closed, noting that the progress advises that an email has been sent requesting confirmation of plans for reporting the results of the staff survey and how this will be captured, but does not state how this will be carried out. SfM advised that confirmation of the date of this year's National Staff Survey is still awaited and it will be built into the Committee Cycle of Business when the date is confirmed. It was agreed that a new action would be created to return to the Committee with plans for receiving staff feedback. VM requested that in order to ensure all actions are appropriately captured, draft minutes will be issued to all Independent Members for initial review following each meeting. The Committee **REVIEWED** and **NOTED** the progress made in respect of the open Committee actions.	**LF** **LW/SfM**
2.6.0 **2.6.1**	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair **Medical Devices Report** Led by Cath O'Brien, Chief Operating Officer The Committee were advised that a working group is looking at the new UK regulations as they come in to identify what is needed to prepare for those which are due to be enforced within the next 12-	

	months. VM queried the limited detail regarding strategic decisions needing to be made in respect of the development of software and reagent kits. COB explained that as some CE marked products may not be easily obtainable and thus will need to continue to be manufactured, this will not be fully understood until the regulations are made clear. All information is currently being gathered to enable a decision to be made at the appropriate time. PR further advised that the Regulatory Affairs Manager at WBS had recently been invited to join the British Standards Institute (BSI) Working Group that will be setting the standards arising from the legislation when published. The Committee **NOTED** the information in the report.	
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 and Chief of Staff The Committee received the current extract of risk register, which provided oversight of the management of risks across the Trust and outlining the current risks scoring 15 and above, along with those in a safety domain with a risk level of 12. LF advised that a useful discussion with Audit Committee Independent Members had been held, at which a review of the Trust Risk Register and Trust Assurance templates had been conducted, developments from which are reflected in the paper. A verbal overview of two risks was provided: • **Risk 2465** (*re: VCS "high level of email traffic to medics, particularly those related to clinical tasks"*). PW advised of the complex challenges in respect of clinical workflows and communications and actions being undertaken to mitigate this. An analysis of some email inboxes is underway in order to gain a clearer understanding of the nature of emails being received and enable a plan to be established in order to manage the issue. Digital options are also being reviewed. DM acknowledged the complexities but raised concern that the risk, which had been apparent for a significant length of time, may present the potential of patient harm as a result of medics being distracted by emails arriving during consultations, and sought assurance of a speedy resolution. PW was not aware of consultants raising this as a factor for consideration as, during clinic, they are not usually logged into their email system, but would look into this further.	**PW**
	PW also provided an example of how current booking team	

	escalation processes are compounding the clinical email traffic position which is being addressed. HJ highlighted that this culture of group emailing could make any future subject access requests a much more complex and time-consuming task and TJ raised additional concern that emails sent out to too many people may result in questions, comments or tasks being missed. Clear pathways for escalation are required for each patient contact point to ensure all concerns and questions are addressed appropriately and in a timely manner. SA queried the extent of the issue and whether there had been any incidents of patient harm as a result. PW advised that although there were no apparent incidents of patient harm associated with this, concerns had been raised and therefore it would be considered a potential risk unless there was reason to prove otherwise. • **2774** (re: WBS "*risk to quality/complaints/audit resulting from the use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice*) and **2776** (re: WBS "*risk to performance and service sustainability as a result of ongoing use of outdated legacy systems, leading to the inability to enhance services to meet business needs"*), PR shared a sample reference document showing how risks were assessed and scored by a multi-disciplinary team and outlined some of the measures taken to mitigate these risks. VM commended the positive assurance of Risk 2774 which was clearly articulated with actions clearly defined and was a good example of the standard required for reporting of risks at this level to Committee. *Hilary Williams joined the meeting* DM raised concern over the number of days passed since some of the risks were opened and the perceived lack of urgency to acknowledge this within the action plan, and sought assurance that action is being taken past the identification of risk stage. PW advised that in some instances, e.g., Risk 2612 (*Acute Oncology Service Workforce gaps*) protracted periods of time are to be expected, with the detail reported within Datix but not necessarily demonstrated within the graphs. DM also highlighted that the content in current controls for 3042, 3065, 3087, 3011 are identical to the content in the action plan and therefore does not offer assurance that action is being taken. The Committee were advised that a formal 'deep dive' will be timetabled into the Risk programme of work and documented within future reporting and that level one mandatory risk training is now live in all staff ESR learning matrices; this has been completed by 272	**LF**

	staff (compliance rate of 37%) to date. 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.	
3.2.0	**Triangulated Workforce & Organisational Development Performance Report / Finance Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance A comprehensive report was received and discussed, highlighting current key challenges around the supply and shape of the Velindre workforce (and associated financial risks), providing updates against the Trust Workforce Development Framework actions and outputs. The following was highlighted: • Continued emphasis on recruitment and retention (via the development of a standard toolkit for NHS Wales) within both Divisions. • Widening access, engaging with local educational establishments in relation to career opportunities within the Trust, in addition to accepting Nursing Cadet placements (commencing summer 2023). • Continued robust workforce planning. • Employee relations review, including improvement of processes to minimise employee harm. • A reduction in Trust vacancies (in particular within SACT) from 9% to 7.8% over the past year. • A reduction in agency spend over the past year (from £1.9m to £1.3m), triangulating with the recruitment of permanent new staff. VM queried the level of vacancies and how the figures compare with the last 6-12 months. SfM advised that vacancy figures had dropped slightly and noted particular areas of success (20 vacancies in SACT filled, taking the service to full establishment), but also acknowledged the high staff turnover and the need to focus on recruitment and retention in parallel. HJ requested that this detail be incorporate into the report going forwards. The Committee **NOTED** and **CONSIDERED** the workforce supply and shape updates and associated financial impacts as outlined within the contents of the report.	**SfM**
3.2.1	**Finance Report** Led by Matthew Bunce, Executive Director of Finance	

3.2.2	The finance report outlined the Trust's financial position at year end (March 2023) and highlighted delivery against all Key Performance Indicators (Revenue, Capital, Public Sector Payment Performance). The overall year end position against the profiled revenue budget 2022-23 was an underspend of £0.064m. Discussions took place in relation to the Divisional Savings Target, indicating a higher target following non-delivery of two Workforce schemes during 2022-23. These were, however, replaced with alternative schemes. It was identified that a number of schemes will deliver from April 2023, although a number are also subject to delay. The Committee commended the successful year end position and: • **NOTED** the March 2023 financial report, in particular the yearend financial performance which reported a £0.064m underspend; • **NOTED** the Transforming Cancer Service (TCS) Programme financial report for 2022-23, in particular the reported breakeven position on and the reported £0.131m underspend on the revenue budget; • **NOTED** the core Trust WG Monthly Monitoring Return (MMR) for month 12 Appendix 2. **Anti-Racist Wales Action Plan** Led by Sarah Morley, Executive Director of Organisational Development & Workforce A progress report in respect of Trust implementation of its Anti-Racist Action Plan was received and the following highlighted: • Further development and rollout of the Trust's Equality Impact Assessment process is underway; • Revitalisation of staff networks; • Active participation in a national review of Workforce policies from an anti-racist standpoint and subsequent implementation of these; • Mapping of recommendations and actions against the 7 levels of assurance ahead of the next update at the November Quality, Safety & Performance Committee. The Committee **NOTED** the progress.	
3.3.0	**Velindre Cancer Service Quality & Safety Divisional Report** Led by Paul Wilkins, Director of Velindre Cancer Service *Including:* Brachytherapy Review and Action Plan The Committee received and discussed a comprehensive and detailed report covering key quality, safety and performance	

	outcomes and metrics for Velindre Cancer Service for the period November 2022 to March 2023. The following key points were highlighted: • An overall positive position, with continued positive position in respect of Tier 1 targets; • Timely investigation into incidents categorised as 'severe' or 'moderate', with appropriate associated reporting; • Implementation of additional resource to support managers with the effective and speedy investigation, improvements and closure of incidents; • No healthcare acquired pressure ulcers for the reporting period; • Progress with Business Intelligence colleagues to ensure the required national mortality reporting could be undertaken; • 100% compliance with investigating and responding to formal concerns within 30-working days; • Further work with CIVICA to obtain department-specific information; • A routine Ionising Radiation (Medical Exposure) Regulations (IRMER) inspection was undertaken by Healthcare Inspectorate Wales (HIW) in Radiotherapy on the 10th and 11th May 2023. Positive verbal feedback was received (formal report will be provided by end of June 2023). Positive patient feedback received, no immediate assurances identified, the inspection team was assured that the service was safe, a number of areas of good / exemplary practice identified as well as some areas for further improvement; • HIW has revised its IRMER reporting thresholds which will result in fewer no harm incidents relating to Linac error needing to be reported. Following investigation, no harm had been identified from all such IRMER reportable incidents reported to HIW; • The Brachytherapy peer review improvement plan was provided. In terms of the NRI (Nationally Reportable Incident) VM noted that this issue had been reported to committee some time ago and queried whether a timescale for conclusion of this has been agreed. TJ assured that the Corporate team are supporting the investigation, which is still currently, and expected to be completed, within the timescale. TJ is monitoring this and will provide an update outside of the meeting. NW advised that one NRI – around the SACT booking system – is out of timescales for conclusion but advised that the draft investigation reports have been received and are undergoing some additional work to ensure a fully robust report. This is anticipated to be concluded within the next few weeks. VM noted the Brachytherapy action plan within the report but highlighted that the Brachytherapy Clatterbridge peer review report	**TJ**

	had not been received at this Committee. Given the size of the report this will be circulated to members outside of the committee. VM requested that an overview of the report is submitted to the Committee and adequate outline needed to be added to the Cycle of Business. VM raised some concern about patient information and the absence of the development and process for this. VC advised that a Patient Information Manager is now in place and ongoing work is underway to address this matter. An overview to be included in next VCS report. DM commended the format of the report and raised a query around IRMER compliance issues and incidents, seeking further information on why these incidents happen and assurance that the issue is being well managed with a plan to minimise incidents going forwards. NW indicated that the issues are arising out of system issues with the older kit which has been acknowledged internationally. A positive review was conducted some time ago which indicated that there were no factors missed – this was reported back to HIW who have since reduced the threshold for reporting parameters as a result. NW further assured that no immediate findings of concern had been identified and the Radiotherapy provision was described as safe. The Committee **NOTED**: • Performance against the six domains of Quality; • Issues, corrective actions and monitoring arrangements in place; • Service developments within VCS.	**COB** **LW/NW** **VC**
3.4.0	**Quality, Safety & Performance Report** Led by Cath O'Brien, Chief Operating Officer The Quarter 4 Trust Performance report provided an overview of delivery against the Trust's performance for the period 01/01/2023 - 31/03/2023. PR Advised the committee that in respect of VCS: • Serology turnaround times still require improvement, although new staff are now in place and advancing in training to progress this • Fluctuating platelet demand continues to present challenges • Green shoots of progress evident in Bone Marrow Registry, as avenues explored now beginning to pay off PW advised that during a difficult period for cancer services, good progress is being made in the vast majority of areas. *Lauren Fear left the meeting*	

	VM highlighted that PADR compliance figures have not met the target, this was acknowledged by SfM who advised that continued focus will be placed on this with plans for delivery to be reviewed. However, SfM highlighted that the Pay Progression Policy has now been fully implemented which means that managers receive regular reports for those staff members who are approaching incremental points, with PADRs necessary in order to allow the movement through that increment, which provides an added incentive. The Committee: • **ENDORSED FOR BOARD APPROVAL** the contents of the quarter 4 performance report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3. • **NOTED** that the new style PMF Performance reports will continue to be developed by the PMF Project Group, taking account of suggested changes and ensuring ownership at all levels and full engagement with both Independent Members and Llais representatives.	
3.5.0	**Integrated Medium Term Plan Q4 2022-2023 Progress Report** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital The IMTP 2022-23 year-end report was discussed in detail. It was identified that the key deliverables had, in the main, been achieved and those not yet achieved will be included in the 2023-24 plan review process. It was recognised that a number of projects relate to regional and national services and are therefore not entirely under the control of the Trust. The Trust will seek to further improve the 'cause and effect' relationship between the plan, outputs and outcomes going forward. Overall quality of service continues to be sustained. VM noted that there are a number of missing Q2, Q3 and Q4 objectives/targets and requested that these are addressed in the Q1 report. The Committee **NOTED** the year end position in delivering against the key Trust actions included within the approved IMTP for 2022 – 2025.	**CJ**
3.6.0	**Integrated Quality & Safety Group Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science ***(this was addressed following item 3.2.2)*** *Including:* • Safe Care Collaborative Group	

	• Duty of Quality & Duty of Candour Implementation NW gave a brief outline of the report from the Trust's Integrated Quality & Safety Group that covered meeting outputs for March 2023 and April 2023 and the plans to develop the Trust's Quality Management System. It was identified that the Group continues to mature and still has some way to go before it is fully effective. The following areas were highlighted: • Work is underway to develop the Trust's automated electronic integrated quality metrics dashboard this includes developing the dashboard, the links to the Performance Management Framework, and ensuring identification of the required high-level harm, safety, outcome and experience measures including mortality. • Early development within the five Trust Safe Care Collaborative Projects; 1) Safety Culture (Trust-wide), 2) Donor Adverse Event Reporting (WBS), 3) Haemochromatosis (WBS), 4) Malignant Spinal Cord Compression Pathway (VCS) and 5) SACT Telephone Helpline (VCS). • The current status of the Trust in relation to the implementation of the Duty of Candour and Duty of Quality, that were enacted on 1st April 2023. Good progress in respect of implementation of the Duty of Candour and further development work required in respect of Duty of Quality. VM highlighted the focus on the requirements to meet the duty and levels of assurance in key areas contained within the narrative of the paper as a helpful inclusion which would be useful to see in all papers of this nature coming through the Committee. The Committee: • **NOTED** the discussions that took place and outputs from these meetings; • **NOTED** the plans for the Trust to develop its Quality Management System; • **DISCUSSED** the further work required to develop a robust automated electronic integrated quality dashboard containing required quality, harm and safety metrics so that the Group can undertake its role in effectively triangulating relevant quality metrics from across the Trust.	
3.7.0	**Quality & Safety Quarter 4 Report** Led by Tina Jenkins, Deputy Director of Nursing, Quality & Patient Experience • **Quality & Safety Quarter 4 Report**	

	The Quarter 4 Quality & Safety report provided an overview of delivery against the Trust's responsibilities in relation to key elements of Quality & Safety for the period 01/01/2023 - 31/03/2023. The Committee were advised that: • There had been a decrease in the number of new Ombudsman cases referred to the Trust. • There was a slight reduction in the number of concerns received during the period. • 100% compliance had been achieved in relation to the 2-day and 30-day formal concern response timescales. • Work was underway within the Velindre Cancer Service to facilitate completion of investigations, followed by timely closure in Datix and some improvements had been seen during the quarter. The Committee **DISCUSSED** and **NOTED** the Quarter 4 Trust Quality & Safety report.	
3.8.0	**Quality & Safety Improvement Tracker** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science NW gave a brief outline of the Tracker. It was noted that although a substantial amount of work remains, it is anticipated that this will be completed by July 2023. VM highlighted that this Committee needs to receive appropriate assurance that there are no reporting gaps and this should be contained within the report, along with reference point of the Committees receipt. The Committee: • **NOTED** the Quality & Safety Assurance tracker re-development work undertaken to date and the plans for further development; • **APPROVED** the proposed areas for inclusion; • **APPROVED** the 7 levels of assurance format; • **AGREED** to receive the further amended tracker detailing all open actions at the July 2023 Committee.	
3.9.0	**Trust Clinical Audit Plan 2023-2024** Led by Hilary Williams, Consultant Oncologist The Committee received the Trust 2023-24 Clinical Audit Plan and were advised that the plan had been developed utilising outcomes from analysis of some core Quality & Safety 2022-23 outcomes. The Committee were advised that key quality & safety outcomes for 2022/23 had been used to inform the audit plan.	

	DM highlighted that, given the strength of feeling at the recent Nursing Conference, towards developing research skills, the audit activity which takes place within the Trust could present an ideal 'learning ground' for some of this skill development. The Committee **APPROVED** the contents of the report, which seeks to provide assurance that there is a systematic process for prioritising and delivering clinical audit across Velindre Cancer Centre and the Welsh Blood Service.	
3.10.0	**Information Governance Assurance Report** Led by Matthew Bunce, Executive Director of Finance MB presented a comprehensive Information Governance Report, which provided assurance in relation to management of patient, donor and staff information and associated compliance with legislation and standards covering the period 01/10/2022-31/03/2023. The three current main areas of focus within the Information Governance Assurance Framework are Patient Records, Freedom of Information Act and Information Governance Internal Audit. The Committee were assured that, focusing on these areas will drive improvements in Information Governance systems and processes. The Committee **NOTED** the 2022/2023 Quarter 3 and 4 Information Governance Report.	
4.0.0	**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).	
4.1.0	**Trust Policies for Approval** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals • QS12 Safeguarding and Public Protection Policy • QS02 Allegation and Concerns about a Practitioner in a Position of Trust The Committee **APPROVED** the above policies.	
4.2.0	**Health and Care Standards 2022-2023** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the comprehensive Health and Care Standards 2022-2023 report and:	

	• **APPROVED** the overarching 2022/23 Healthcare Standards Trust status as a level 4; • **NOTED** the Divisional Assurance Highlight Reports; • **NOTED** the plans to consider how the Health and Care Quality Standards (2023) will be implemented and embedded across the Trust and the legacy improvements that will be considered as part of this process.	
5.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
	There were no items for endorsement.	
6.0.0	**CONSENT ITEMS FOR NOTING**	
6.1.0	**Vaccination Programme Board Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science DM raised concern that 56% of Trust-wide staff received flu vaccination when in previous years the figures had been significantly higher. NW noted that where staff had received the flu vaccine outside of the Trust, figures coming from GPs are difficult to obtain, and that all possible actions were taken to improve uptake of the vaccine. NW advised that the 56% figure was similar to the pre-pandemic vaccination levels. The Committee **NOTED** the outcome of the Trust's Autumn 2022 Influenza vaccination programme and the Autumn 2022 COVID-19 vaccination status of Trust staff and that moving forward, Velindre University NHS Trust employees will receive their COVID-19 vaccinations via their local Health Boards.	
6.2.0	**Patient Nosocomial COVID-19 Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the position in relation to patient nosocomial COVID-19 reviews, the next steps and the NHS Wales – Interim Learning Report: National Nosocomial COVID-19 Programme (March 2023).	
6.3.0	**Private Patient Improvement Plan** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the highlights from the Private Patient Improvement Group held on the 21st June 2023 and the delivery to date of the Private Patient Improvement actions, the slippage in the delivery of a number of these actions and the revised delivery dates.	

6.4.0	**Safeguarding & Vulnerable Adults Group Highlight Report** Led by Tina Jenkins, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the key deliberations that took place at the Safeguarding and Vulnerable Adult Group held 11th April 2023.	
6.5.0	**Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub Committee **Paper not received.	
6.6.0	**RD&I Sub Committee Highlight Report** Led by Hilary Williams, Consultant Oncologist The Committee **NOTED** the key deliberations and highlights from the Public Meeting of the Research, Development & Innovation Sub-Committee held on the 28/02/2023.	
6.7.0	**Radiation Protection & Medical Exposures Strategic Group Highlight Report** Led by Hilary Williams, Consultant Oncologist The Committee **NOTED** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 16/03/2023.	
6.8.0	**Body Storage Review and Recommendations (November 2022)** Led by Cath O'Brien, Chief Operating Officer **DM requested for this item to be removed from consent to allow for further discussion** The Committee received the outcome of the Velindre Cancer Service self-assessment response to Welsh Government, following the Body Storage Facilities review and subsequent recommendations received in November 2022. It was identified that further work is required in relation to a number of areas of governance and an appropriate action plan was developed. An update in relation to delivery of actions will be provided at a future Committee meeting. The Committee **NOTED** the content of the report.	**COB**
6.9.0	**Freedom of Information Requests** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff **Paper not received.	

6.10.0	**Nurse Staffing Levels (Wales) Act 2016 Annual Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Quality, Safety & Performance Committee **NOTED** the Annual Assurance Report for 2022/2023 as assurance that the necessary processes and reviews have taken place for Velindre University NHS Trust to remain compliant with its duties under the Nurse Staffing Levels (Wales) 2016 Act.	
6.11.0	**Digital Plan Update** Led by Carl James, Director of Transformation, Planning & Digital HJ queried the statement "In April it was confirmed that the proposed Citadel Health solution was not to be progressed so alternative arrangements need to be established" requesting further detail on these alternative arrangements and an indication of when this will be completed. SH to refer back to CJ to provide assurance as appropriate. The Committee **NOTED** the report.	**SH**
7.0.0	**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).	
7.1.0	**May 2023 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members. ***Members are asked to feedback their considerations regarding key points and outputs that have arisen through the meeting.***	
7.2.0	**May 2023 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members Committee members were reminded of the importance that in order to be able to continually monitor the effectiveness of the Committee a short questionnaire will be circulated following today's Committee requesting completion by all attendees. The aggregated outcomes will be provided at the following Committee and facilitate in year adjustments to be made.	
7.3.0	**Committee Effectiveness Survey Report – Reflective Feedback from March 2023 Committee** Led by Emma Stephens, Head of Corporate Governance	

	ES outlined the results of the March 2023 reflective feedback and reiterated the importance of ensuring all committee members take up the opportunity to provide feedback to support the continuous improvement of the Committee. The Committee **REVIEWED** the March 2023 feedback results and **AGREED** the proposed actions	
8.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members are to identify items to include in the Highlight Report to the Trust Board: • For Alert / Escalation • For Assurance • For Advising • For Information	
9.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
10.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **13th July 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 17th January 2023 Committee					
3.1.1	LF to address governance process for new products prior to coming onstream with NWSSP.	Lauren Fear	**Update 06/07/23 -** Note to close action to be circulated to the Committee prior to the meeting **Update 16/05/23 -** Progress being made following continued email correspondence which has been forwarded to the Chair for information. LF to circulate further to SH and a select number of members to ensure all questions previously asked have been answered. **Update 04/05/2023** - Meeting arranged with NWSSP Colleagues for 09/05/2023.	16/03/2023 now 16/05/2023 now 13/07/2023	OPEN
4.1.0	NW/JA to update Section 7 (Reporting and Assurance Arrangements) of the Trust's Integrated Quality & Safety Group Terms of Reference during six-month review.	Nicola Williams/Jacinta Abraham	TOR being amended and considered at the July 2023 integrated quality & safety group and will include update to Section 7	31/07/2023	OPEN
Actions agreed at the 16th March 2023 Committee					
5.1.0	Removal of reference to a vacant post included in error within the CIVAS@IP5 Service Performance Report.	Gareth Tyrrell	**Update 16/05/2023** – Report to be revised for future submissions from July 2023 Committee.	13/07/2023	CLOSED
5.1.0	Further NWSSP reports to provide explanation of acronyms (to be understood by the public). Performance reports to reflect the current position as opposed to historical. Appendix 1 to include headings.	Gareth Tyrrell	**Update 16/05/2023** – Report to be revised for future submissions from July 2023 Committee.	13/07/2023	CLOSED
6.4.0	CJ to facilitate inclusion of more precise information within the IMTP Quarterly Actions Progress Report, in particular in	Carl James	The revised IMTP action tracker has been revised to ensure a strengthened focus on key actions and	13/07/2023	CLOSED

	relation to key deliverables for the QS&P Committee component.		deliverables. This will be presented to the QSP Committee in September.		
Actions agreed at the 16th May 2023 Committee					
1.1.0	VC to discuss further research opportunities with Professor Jane Hopkinson.	Viv Cooper	A meeting is being set up with Professor Jane Hopkinson with senior nurse to consider opportunities for team research. Progress will be reported through the PNF.	13/07/2023	CLOSED
2.5.0	Staff survey overview to be provided in the next integrated workforce report and onto the QSP Committee Cycle of Business.	Sarah Morley	The National NHS Staff Survey is scheduled to run from September 2023. The date Trust will receive the report is to be confirmed. The Committee will be updated once this report is received.	14/09/2023	CLOSED
3.1.0	***Risk 2465*** – PW to establish whether medics are being distracted by emails arriving during consultations.	Paul Wilkins	An audit has commenced being led by Ian Bevan. Due for completion end of July	13/07/2023	OPEN
3.1.0	A formal 'deep dive' to be timetabled into the Risk programme of work and documented within all future reporting.	Lauren Fear	Now part of regular risk reporting approach	13/07/2023	CLOSED
3.2.0	Future integrated workforce and OD performance reports to include vacancy and turnover trends.	Sarah Morley	This detail is now incorporated in the Supply, Shape and Finance Risks Paper.	14/09/2023	CLOSED
3.3.0	TJ to provide an update on the National Reportable Incident outside of the meeting.	Tina Jenkins	Currently no open National Reportable Incidents	13/07/2023	CLOSED
3.3.0	Brachytherapy Clatterbridge peer review report to be circulated to all Committee members.	Nicola Williams/ Liane Webber	Clatterbridge Peer Report provided via email to all Committee members on 16th May 2023	13/07/2023	CLOSED
3.3.0	Brachytherapy Clatterbridge peer review report and update against action plan to be provided formally to the QSP Committee	Nicola Williams/ Liane Webber		14/09/2023	OPEN

3.3.0	An overview of the Patient Information position and actions being taken to address any areas that require improvement to be provided as part of the next VCS report to the Committee.	Viv Cooper	There is ongoing work to standardise and ensure compliance with required standards in relation to patient information, as agreed and update will be included in the next VCC Divisional QSP report.	13/07/2023	CLOSED
3.5.0	All IMTP actions to include an objective/target in future reports	Carl James	The revised IMTP action tracker has been revised to ensure that all actins are SMART with a clearly stated performance target. This will be presented to the QSP Committee in September.	13/07/2023	CLOSED
6.8.0	A further update in respect of the 'Body Storage Review' including the action plan and status to be provided in September's QSP Committee.	Cath O'Brien		14/09/2023	OPEN
6.11.0	Digital Plan Update - In light of the decision not to progress with Citadel Health Solution, further details to be provided on the alternative arrangements and timescale for completion.	Carl James	The LINC Programme are proposing an extension to 2030 of the existing Intersystem arrangements as the mitigation for the Citadel Health termination. A business case update will be brought to Trust Board shortly (July target) setting out the new arrangements. Arrangements for support of the Prometheus application in WBS will need to be confirmed as part of this process.	13/07/2023	OPEN

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
FREEDOM OF INFORMATION ACT REPORT 2022/23

DATE OF MEETING	13th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Ian Bevan, Head of Information Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	2nd May 2023	Endorsed for noting by the Committee for Assurance

ACRONYMS			
DPA 18	Data Protection Act 2018	EIR	Environmental Information Regulations 2005
DPO	Data Protection Officer	FOIA	Freedom of Information Act 2000
GDPR	General Data Protection Regulation	HoIG	Head of Information Governance
ICO	Information Commissioners Office	IG	Information Governance

IGMAG	Information Governance Management Advisory Group	SIRO	Senior Information Responsible Officer
SAR	Subject Access Requests	VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust	WBS	Welsh Blood Service

1. SITUATION

The purpose of this report is to provide **ASSURANCE** about the way VUNHST manages requests made to the Trust under the Freedom of Information Act (FOIA) and Environmental Information Regulations (EIR), highlighting compliance with applicable legislation and standards, actions to improve the management of responses and actions from lessons learned.

The report outlines key **ASSURANCE** activity for the reporting period 1st January 2023 to 31st March 2023 but also examines the preceding wider period for Quarters 1, 2 and 3 2022/23.

2. BACKGROUND

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

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

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Operational Delivery of the FOI function

Following the departure of Trust FOI Officer in mid-December 2022, The IG Team is temporarily supporting Corporate Governance with the Trust Archivist undertaking the day-to-day work overseen by the HoIG so that compliance is achieved.

3.2 Assurance Data

Compliance data In relation to the provision of **ASSURANCE with** the Freedom of Information Act (FOI) and Environmental Information Regulations (EIR) data for 2022/23 is shown in full below:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	43	23	53.49%
2	58	47	81.03%
3	36	23	63.89%
4	58	54	93.10%
Total for FY 22/23	195	147	75.38%

The Trust received requests for information under the Environmental Information Regulations per quarter as follows:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	1	1	100%
2	2	2	100%
3	0	0	100%
4	0	0	100%
Total for FY 22/23	3	3	100%

3.3 FOIA/EIR Legislative Considerations

The Committee is asked to note that in Quarter 4 (1st January 2023 to 31st March 2023) a number of repeat requests from requestors for essentially identical information have been received. HoIG has engaged with the All-Wales Information Governance Management Advisory Group (IGMAG) and the Information Commissioners Office (ICO) from a practical approach to ascertain what other Trust's and Health Boards are doing to address the common issues and to seek the ICO's view on what best practice is to deal with the highlighted legislative perspective below:

- The Trust is formally refusing to provide information (which is permitted under Section 17 – refusal of request) where a qualified exemption Section 14 (Vexatious or repeated requests) applies.

  As the application of the exemption is a qualified exemption, it means that to apply the exemption a balancing test must be conducted to assess the risk of harm to the Public Interest. In order to provide background, Section 14 states:

"Where a public authority has previously complied with a request for information which was made by any person, it is not obliged to comply with a subsequent identical or substantially similar request from that person unless a reasonable interval has elapsed between compliance with the previous request and the making of the current request"

The application of a blanket balancing test is not appropriate. Therefore, in each instance, the HoIG conducts the appropriate balancing test. It involves examining the individual request, the periodicity of previous requests made by the requestor, and whether those previous requests are substantially similar or identical to a previous request.

If the case is complex or unclear it may also require the examination of previous case law where a case is essentially similar. This approach is intended to avoid non-compliance, potential complaints from requestors and reduce the risk of ICO reviews and/or First-Tier Tribunals.

The Trust has not received any complaints or requests for a review of an original decision where a refusal has been made under Section 14 of the Act.

- The Trust is also receiving an increasing number of requests where the request is asking for personal data of members of Staff. It is assessed that this is so that potential suppliers can contact managers directly to offer goods and services.

- The Committee is asked to note that requests for personal data other than that of the requestor is an absolute exemption under Section 40 of the Act. It means that a balancing test is not required to apply the exemption. It also allows the Trust to protect the rights of its employees to have privacy in the workplace and reduce any risk of non-compliant procurement activity. The Trust has not received any complaints or requests for a review of an original decision where a refusal has been made under Section 40 of the Act .

The Trust is receiving an increasing number of "*round robin*" requests where the request is asking for significant amounts of contractual data and/or procurement of services, whilst the aim of the Act is to permit public scrutiny of decisions taken by Public Authorities on their behalf, it has become evident that some commercial entities may be using the Act to populate CRM systems with the aim of generating income.

As a result, HoIG has requested an all-Wales meeting of FOI leads be held, the attendees will include the ICO. This issue was initially discussed at IGMAG on 12th April 2023. HoIG will keep the Committee informed via EMB as to the outcome of those discussions.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The loss or disclosure of personal information should be an important consideration for all staff on a day-to-day basis as it can seriously damage the Trust's reputation and undermine patients, donors and/or service user's trust.
RELATED HEALTHCARE STANDARD	Health and Social Care (Community Health and Standards) Act 2003, in particular Sections 7 and 8 of the Duty of Quality Statutory Guidance 2023.
	Information - as described in Section 8 of the Duty of Quality Statutory Guidance 2023.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Failure to comply with FOIA/EIR may result in an enforcement notice from the Information Commissioners Office (ICO). This may impact negatively on the reputation of the Trust. Where there is an impact on the rights and freedoms to the Data Subject, this may be reportable to the ICO within 72 hours of the discovery of the breach.
FINANCIAL IMPLICATIONS / IMPACT	No – FOIA/EIR are not yet subject to financial penalties by the ICO.

5. RECOMMENDATION

The Committee is asked to **NOTE** that **EMB** has **ENDORSED** this Freedom of Information Act Update Report for **ASSURANCE**.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	13.07.2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

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 Quality, Safety and Performance Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Summarise the final phase in implementing the Risk Framework.

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**
EMB Run	29.06.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussion around the length of time risks are open versus the scores. This will be considered in the next cycle. .	

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 Trust Board 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 Trust Board.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 13 risks to report to Board and Committee on Datix 14, this includes 12 risks with a current score over 15 and 1 risk 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.
- Considerable work has been undertaken to ensure each risk has an action plan. The action plans are continually under review in divisions with transition to SMART. All risks reported in this report now have action plans in place.
- 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.
- All risks reported are on target with review dates.
- An audit of risk titles has been carried out and titles amended as per the naming conventions on Datix where appropriate. Some risk titles are nationally agreed and remain unchanged on Datix.
- There was discussion in Executive Management Board on what are the key gaps in achieving a level 3 level of assurance, which is defined as "Comprehensive actions have been identified and addressed. The cause of

the performance issue has been identified and is being actively managed." There was an in-depth discussion on given the length of time some risks are open at a high residual score. This suggests actions are not addressing root causes effectively in these cases and this will be the area of focus for the next cycle.

4.2 Risk In Depth Review

Following discussion at the last Quality, Safety and Performance Committee in May it was agreed to look in depth at two risks at the next committee. Further discussion at EMB Run at the beginning of June resulted in agreement that the risks for further discussion on 13.07.2023 would be 3001, Workforce risk, and 3042, Laboratory Information Management System (LIMS). Two risks were discussed, one Velindre Cancer Centre risk and one Welsh Blood risk. The discussion raised the matter of the length of time some risks have been open, with committee members seeking assurance that risks have moved beyond identifying the problem stage. This feedback will be taken forward in ongoing reviews as an area for consideration.

4.3 Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.
- 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.
- As of 23rd June 2023 an Introduction to Risk training has a completion rate of 53.70% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate
Corporate	49.7%
Research Development and Innovation	56.0%
Transforming Cancer Services	48.0%
Velindre Cancer Centre	51.3%
Welsh Blood Service	60.4%

Compliant with statutory and mandatory training a period of six months is set for initial completion, the on-going requirement will be to complete the training every two years.

5. IMPACT ASSESSMENT

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

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

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

6. RISKS

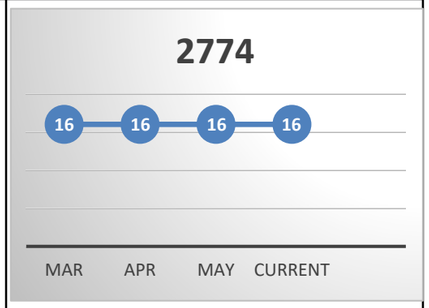
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require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

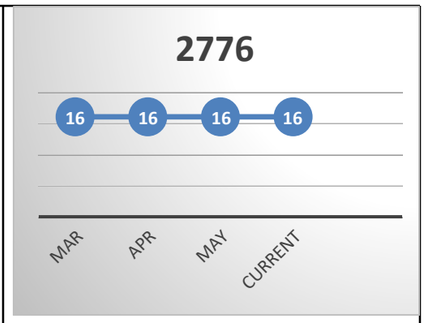
All risks must be evidenced and consistent with those recorded in Datix

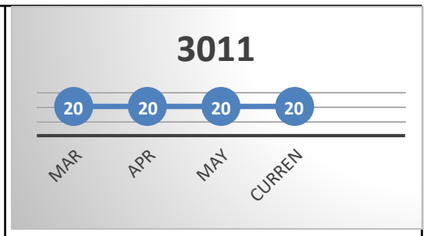
APPENDIX 1

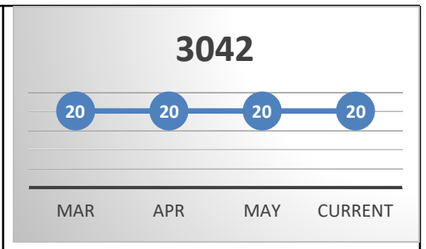
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

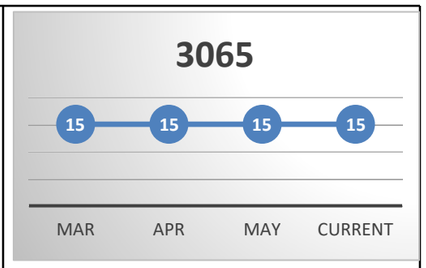
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions,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

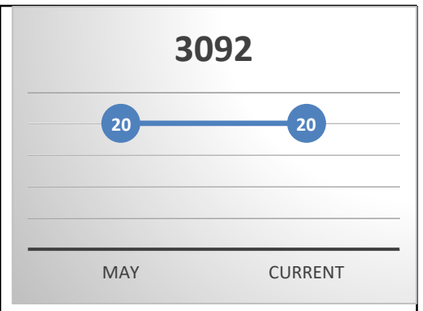
ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	4	01/09/2023	Complete actions for replacement LIMS - see risk 2776 Individual Actions recorded in risk 2776: Secure Funding by 28/04/2023 Tender for replacement LIMS by 31/05/2023 Implement replacement LIMS by 31/07/2024 Report to the Laboratories Digital Transformation Board Due date 31.07.2024	257	

2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	4	01/09/2023	Tender for replacement LIMS Completion of Procurement Brief, URS and supporting documentation. Issue of tender. Report to Laboratories Digital Transformation Board. Update 06/06/2023 - "Due date" extended to 30/06/2023. Tender has been delayed due to other projects being prioritised by Procurement. New estimated timeline proposed by Procurement is to go out to tender by end of June. Due date 30.06.2023 Implement replacement LIMS Report to Laboratories Digital Transformation Board	257	

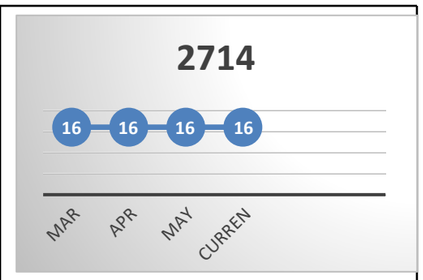
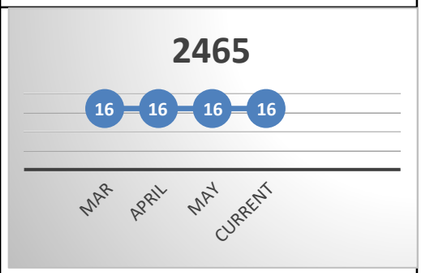
3011	There is a risk to the safety of patient care as a result of delays in scheduling patient appointments due to a technical error in the processing of Outpatient Oncology Note Outcomes leading to possible harm.	Safety	22/12/2022	Velindre Cancer Centre	Immediate escalation to DHCW for investigation. Identified bugs to be resolved. DHCW to extend the Contractor to apply identified development to support resolution of issue. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh Additional support to be identified and put in place to process and book all patient activity. Patients to be contacted by telephone and verbally advised of appointment due within 14 days to reduce risk Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days)	Technical failure of the data shredding process within the national service has meant that not all clinic outcome instructions are being made available within the Outpatient Oncology Note Report, and therefore not acted upon.	15	5	45107	Digital Health Care Wales (DHCW) will be applying a fix/development that will prevent a delay/restart of the servers following automated regular up-dates. This has previously stopped/delayed the shredding process taking place. Delays encountered due to bugs identified during the UAT period. Further development work required with an amended delivery date of 14.07.23. DHSW to maintain communication/up-dates.	201	

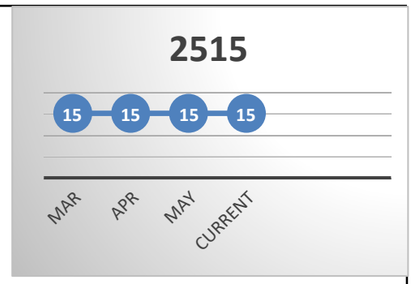
3042	There is a risk to performance IF the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. **NATIONAL LINC RISK**	Performance and Service Sustainability	07/02/2023	Velindre Cancer Centre	Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	The current (InterSystems) contract for TrakCare Lab is due to end in June 2025. The LINC programme has been established to deliver a replacement all-Wales LIMS system - the contract has been awarded to Citadel Health. VCC pathology services are provided to Velindre by C&V ULHB. If the Citadel Health solution is not deployed into C&V UHB before June 2025, there is a risk to service delivery for the C&V-managed pathology laboratory. The national DHCW / LINC programme team have requested this risk be recorded on all HB/Trust risk registers, to ensure appropriate visibility and ongoing monitoring.	20	5	45145	Active ongoing engagement in national programme. Confirmation of internal governance and escalation process across the Trust.Due date: 30.06.2025	154	

3065	There is a risk to COMPLIANCE as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	Compliance	10/03/2023	Corporate Services	Upon identification of the incident, DHCW have put in place temporary measures - effective from 17/02/2023 - to prevent further deletion of mailboxes for staff leaving the NHS Wales. DHCW are also engaging with Microsoft to explore what, if any, opportunity there is to retrieve the deleted emails/mailboxes.	NHS Wales deployed O365 in July 2019. The national tenancy was established with the intention of ensuring emails / mailboxes for staff who left the NHS (i.e. there O365 account was closed) would be retained for a 7ear year retention period, as per the national NHS Wales Email Policy. Investigations prompted by an enquiry by C&V UHB in February 2023 confirmed that this policy was not what was configured on the NHS Wales tenancy. As such, any emails / mailboxes for staff who have left the NHS will have been deleted after 30 days of account closure, unless another form of manual 'hold' was in place on the account. In VUNHST, 'litigation hold' was in place by default on all accounts up to 22/09/2021, when a national change was made to remove litigation hold for VUNHST O365 accounts. As such, the risk for VUNHST is that staff who have left NHS Wales in the period 23/09/2021 - 17/02/2023 will be that emails for those staff will not be retrievable for (e.g.) FoI, evidence for COVID-19 enquiry etc.	15	3	45139	Review staff list to assess impact of mailbox deletion for VUNHST O365 accounts. List of impacted mailboxes has been produced by Digital Services - to be reviewed by Head of IG & Head of Digital Delivery to assess overall impact of deletion. List of impacted mailboxes has been produced by Digital Services Due date 30.06.2023	123	

3092	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	Multiple Risk Domains	27/04/2023	Velindre Cancer Centre	- A series of deep dives to understand problem areas have been undertaken - Clear actions plans have been developed across directorates - An operational management group have been stood up to oversee delivery of actions and determine wider trends, reporting to the Business Planning Group (BPG) and Senior Leadership Team (SLT) - Refresher training being provided across VCC	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	20	8	31/07/2023	summary of actions required by clinicians to address data quality issues with WPAS being collated and will be shared via SMSC in June. Due dte 31.07.2023	75	
3138	Sacyr Appetite There is a risk that Risk that SACYR lose appetite for completing deal due to lack of funding to continue leading to Acorn having to 'down tools' and work on completing Financial Close is delayed.	Financial Sustainability	20/06/2023	Transforming Cancer Services	1) Review of CAPEX supported by Value Engineering considerations for discussion with Welsh Government to seek a spend commitment by way of letter of intent or cash as funding assurance to Acorn 2) Review with Welsh Government an Advanced Works Agreement for site clearance and preparation works in advance of EPSL approval	There is a risk that Risk that SACYR lose appetite for completing deal due to lack of funding to continue leading to Acorn having to 'down tools' and work on completing Financial Close is delayed.	16	8	30/06/2023	Ongoing discussion with Welsh Government at VHSB. Due date 30.06.2023	21	NEW RISK - NO TREND DATA

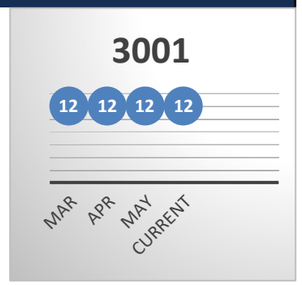
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Sceure 3rd party opinion on clearance	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	15	6	10/07/2023	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Secure 3rd party opinion on clearance 1) application has been submitted stating the anticipated planned clearance areas and schedule to provide NRW with clear view of works including habitat creation requirements Due date 10.7.2023	20	NEW RISK - NO TREND DATA
3140	EPSL Application Approval There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Resolution of habitat management matters to provide NRW with assurance they require 2) Respond to any queries as a matter of priority 3) Liaise with Cardiff Council to agree approach 4) Work with WG to intervene if required 5) Maintain Actions Tracker	There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	15	6	30/06/2023	1) Resolution of habitat management matters to provide NRW with assurance they require - ongoing 2) Respond to any queries as a matter of priority - ongoing 3) Liaise with Cardiff Council to agree approach - ongoing 4) Work with WG to intervene if required - ongoing Due date: 30.06.2023	20	NEW RISK - NO TREND DATA

2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Transforming Cancer Services	1. Discuss with Welsh Government. Capital Expenditure was increased during Competetive Dialogue. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	12	24/05/2023	Continue to monitor interest in line with the financial index. Monitoring of the interest rates, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing. Due date: 30.06.2023	305	
2465	There is a risk to safety as a result of significant increase in email traffic leading to critical emails being missed or not responded to in a timely manner leading to patient care and staff well being	Safety	05/11/2021	Velindre Cancer Centre	staff reminded to be considerate when 'replying to all'	There is a risk of missing critical emails especially critical clinical questions due to the volume of emails. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	4	30/06/2023	An audit/survey to be undertaken to identify themes in order to determine how best to minimise taking into account clinical and service needs. Due date: 30.06.2023 email etiquette to be developed as part of hybrid working tool kit and shared widely. Due date 30.06.2023	613	

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.	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Urologist is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. One Speciality Doctor was appointed to Gynae Oncology Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team. A training schedule for staff is in	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return to work due May 2023.	15	15	45199	to improve resilience in MPE service training of further brachy MPE. Prioritised by Head of Service. Target completion date 31st July due date: 31.07.2023 workforce review in Q1/2 2023 to look at demand for next 5 years. Due date: 31.09.2023	517	

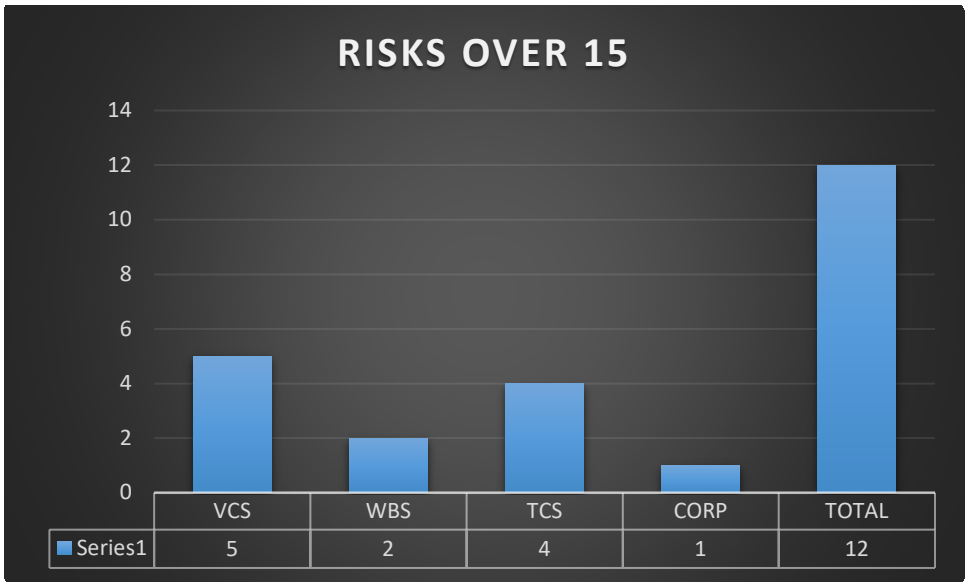
					place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (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	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.						

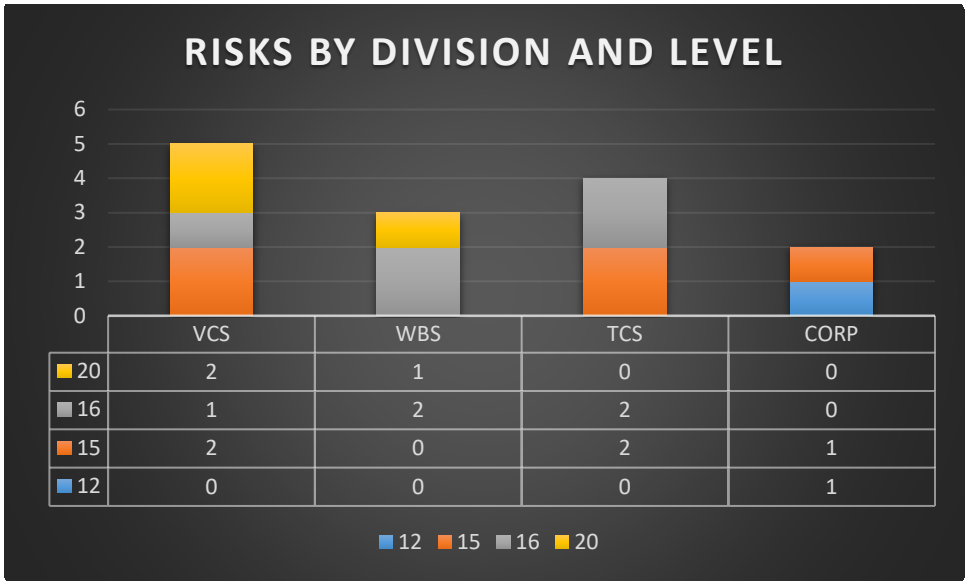
					supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service 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														

ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Corporate Services	Policies and Procedures Managing Attendance @ Work Policy, Training and Toolkit Respect and Resolution Policy, Training and Toolkit Equality, Diversity and Inclusion Policy Managing Organisational Change Policy and Toolkit Hybrid working Flexible working Job descriptions/PADR process Training Development of 'Building our futures together programme' – Leadership Development, Behaviours, Compassionate Leadership Training and education managers on compassionate leadership (Inspire Programme) Access to internal and external training/career development Online resources Wellbeing and Engagement online resources Work in Confidence Platform External awards Corporate Health Standard Platinum Award Time to Change Wales signatory Monitoring of staff wellbeing Annual Staff Engagement Survey Monitoring of sickness absence figures by Board External wellbeing audits Organisational support Staff networks Occupational Health Employee Assistance Programme Mental Health First Aider network Access to Complementary therapy Mindfulness App Individual Stress risk assessments completed by manager	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. HSE defines stress as 'the adverse reaction people have to excessive pressure or other types of demand places on them'. Staff employed by the Trust have a wide variety of roles including clinical and non-clinical, administrative support and patient/donor facing. Work in carried out at VUNHST premises, donation venues, in outreach centres. Some staff work in an agile way, working both at VUNHST premises and other locations including at home. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work. Not all of this will be work related. The risk relates to all Trust employees HSE identifies six main areas that may lead to work-related stress if not properly managed: demands, control, support, relationships, role and change. Demand – workload, ability to do work required, conflicting priorities, work patterns, physical environment and violence and aggression. Control – pace of work and ability to take breaks. Development and use of professional skills. Support – lack of support for staff from managers and colleagues. Staff not know what support is available and how to access it. Relationship – negative behaviours, interpersonal and/or inter-team conflict, perceived unfairness. Bullying. Poor communication. Resolution procedures	12	9	30/06/2023	Divisions/Departments do not all have proactive stress risk assessments Healthy and Engaged steering Group to communicate with Divisions and Departments about stress risk assessments by 30 June 2023. To be monitored by the Healthy and Engaged Steering Group Due date: 09.12.2023 The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio. Due date 22.12.2023	214	

					Purchase of annual leave Financial advice, Salary sacrifice schemes. Blue light discounts. Car lease scheme. Cycle to work scheme Wellbeing activities/events Wellbeing rooms/facilities Healthy and Engaged Steering Group Clinical Psychologist for staff and teams – including proactive programme of engagement. Dialogue with Trade Unions	not accessed in a timely way. Role – lack of clarity and communication around roles and responsibilities. Change – lack of communication or poorly understood communication about proposed changes. Lack of support for staff during periods of change. Home/family/personal issues which may add to stress at work					

Overall Risk Data





	VCS	WBS	TCS	CORP
20	2	1	0	0
16	1	2	2	0
15	2	0	2	1
12	0	0	0	1

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST MAY (M2)

DATE OF MEETING	13/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB RUN	29/06/2023	NOTED

ACRONYMS	
SoFP	Statement of Financial Position
PSPP	Public Sector Payment Performance
IMTP	Integrated Medium Term Plan
LTA	Long Term Agreement
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

nVCC	New Velindre Cancer Centre
EMB	Executive Management Board
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales
CEL	Capital Expenditure Limit

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of May 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	0.003	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.637	3.026	24.416
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	98.8%	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 May'23 is an underspend of **£0.004m**, 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.

Several saving schemes currently remain RAG rated amber and therefore it is important that those schemes that have not yet gone live are reviewed at divisional level with a view to either turn green or find replacement schemes.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2032-24.

2.3 PSPP Performance

PSPP performance for the whole Trust is currently 98.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 98.1%

2.4 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 £0.167m.

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 from 2023-24. However, there remains a risk that the contract performance income does not match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall. This risk will be managed through the Trust's budgetary control procedures.

2.5 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.

The balance and allocation of the recurrent non-recurrent reserve is still to be agreed for 2023/24.

2.6 Financial Risks

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

DHCR – Risk £2.000m / 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 accurately being captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team are reviewing the situation and putting in place plans to address the issues. However, if this is not rectified there is a risk that £2.000m income related to unrecorded activity could be lost.

Non-Delivery of Savings *Risk £0.622m / Likelihood - Medium*

Several schemes remain in amber, with current expectation that these schemes will turn green as this year progresses, however, there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

2.7 Capital

All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Other Major Schemes in development that 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.

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust reported a financial position of **£0.004m** for May'23 which is in line with the IMTP

4. RECOMMENDATION

QSP is asked to:

4.1 **NOTE** the contents of the May 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

4.2 **NOTE** the Velindre Core Monthly Monitoring Return (MMR) submitted to WG for May with accompanying commentary attached as **Appendix 1 & Appendix 2.**

4.3 **NOTE** the TCS Programme financial report for May which is attached as **Appendix 3.** TCS REPORT TO FOLLOW

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Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED MAY 2023/24

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
13/07/2023

1. Introduction

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

2. Background / Context

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

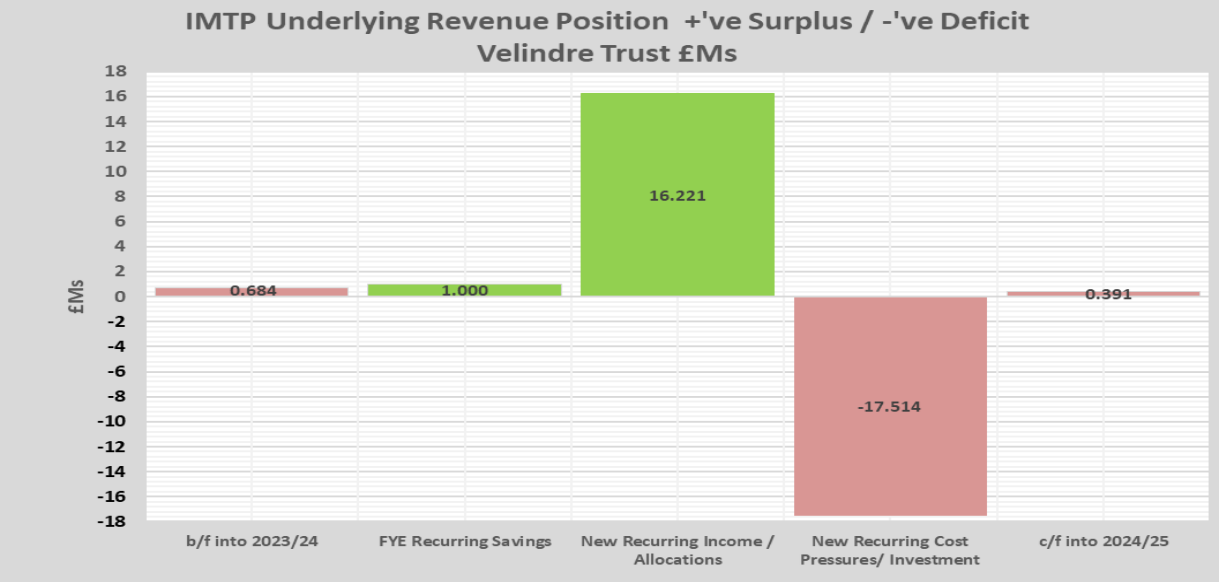
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

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

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

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

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



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.003	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.637	3.026	24.416
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	98.8%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	25	25	0

Revenue

The Trust has reported a **£0.003m** in-month underspend position for May'23, which gives a year to date cumulative underspend of **£0.004m** and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to May'23 of £3.026m and is forecasting to remain within the CEL of £24.416m.

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

	£m
Discretionary Capital	**1.683**
All Wales Capital:	
nVCC Enabling Works	10.896
IRS	10.326
Digital Priority Investment	0.164
RSC Satellite Centre	1.347
Total All Wales Capital	**22.733**
Total CEL	**24.416**

PSPP

During May '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.1%** as at the end of month 2, and a Trust position (including hosted) of **98.7%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2023-24, however a risk of under delivery remains on several schemes that are still RAG rated amber.

Revenue Position

Cumulative				Forecast		
£0.004m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(29.274)	(29.773)	0.500	(185.421)	(185.421)	0.000
Pay	12.869	13.002	(0.133)	76.608	76.608	0.000
Non Pay	16.405	16.768	(0.362)	108.813	108.813	0.000
Total	**0.000**	**(0.004)**	**0.004**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of **£0.004m** 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 planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

4.1 Revenue Position Highlights / Key Issues

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 ability to carry forward a surplus into 2024-25 will depend, in part, on whether energy prices remain at a high level following the volatility seen in 2022/23 period, and also the ability for the Trust to deliver on its recurrent savings target.

Other factors which will determine the carry forward position into 2024-25 will be the Trusts capacity to either fund or mitigate both current and potential new cost pressures which may emerge over the course of the year.

Income Highlights / Key Issues

The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income. All LTA/ SLA documents have been issued in line with the funding flows mechanism agreed at Directors of Finance Forum, with expectation that all LTA/ SLA's will be signed by the 30th June. However, the level of this funding remains a risk compared to the cost of additional capacity investment.

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.

Pay Highlights / Key Issue

Although not yet invoiced the Trust is expecting to receive full funding from WG for the 1.5% consolidated pay award which was accounted for in 2022/23 and processed during May 23 (back dated to April 22).

At this stage the Trust is also expecting to receive full funding for both the one off recovery pay award which will be processed in June, and the 5% consolidated pay award relating to 2023/24 to be paid in July.

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.

As at 2023/24 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

The latest Energy forecast position for 2023-24 from NWSSP suggests a further reduction of c£0.740m from the forecast presented at the IMTP planning stage. This potentially releases funding which will be used to support some of the local growth and cost pressures which are within the service divisions.

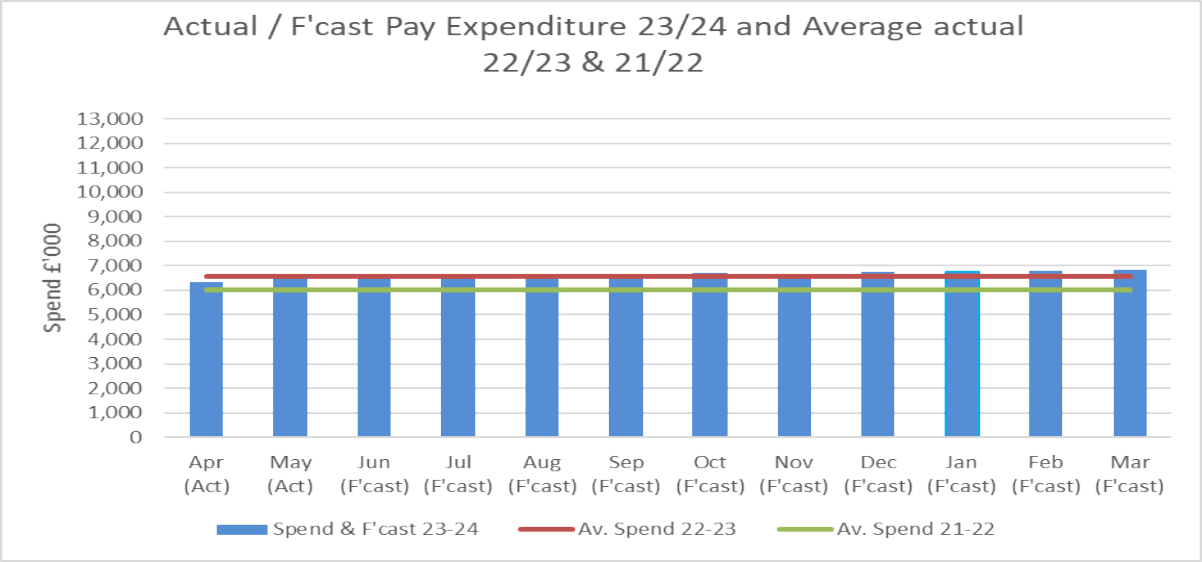
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

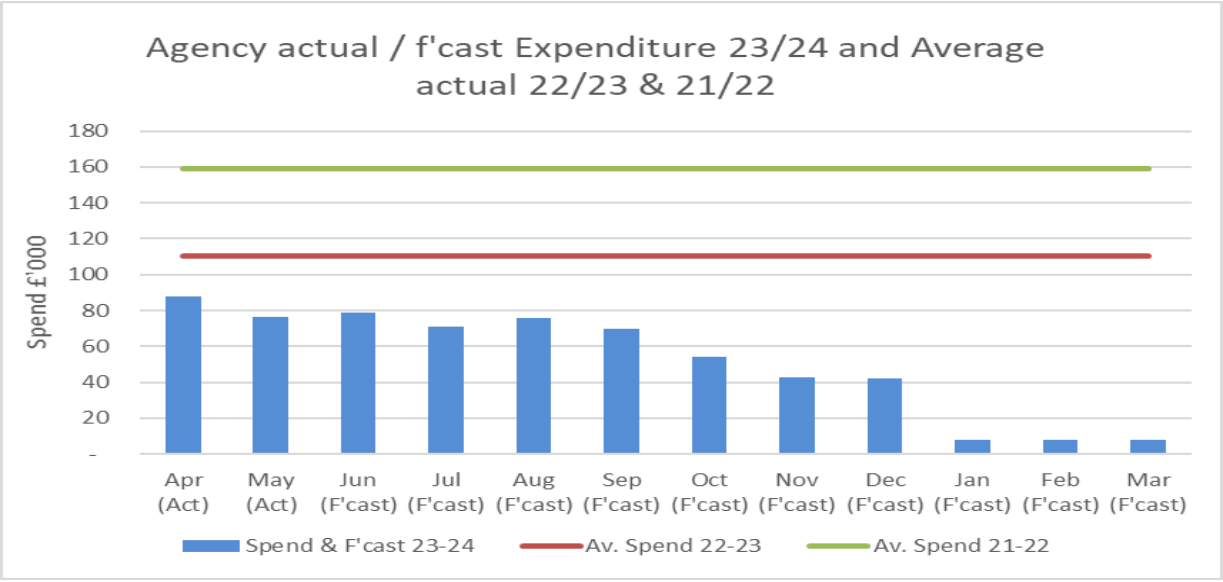
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

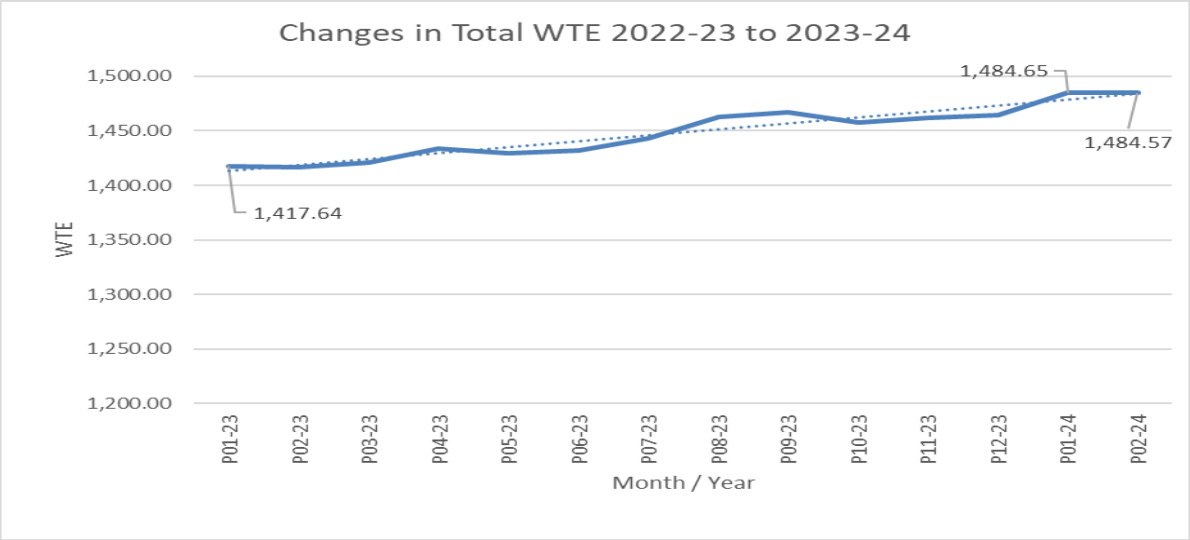
Whilst the pay award for 2023-24 has now been agreed in line with WG reporting guidance for the Trust monitoring returns (MMR) these costs are not yet reflected in the forecast pay spend.

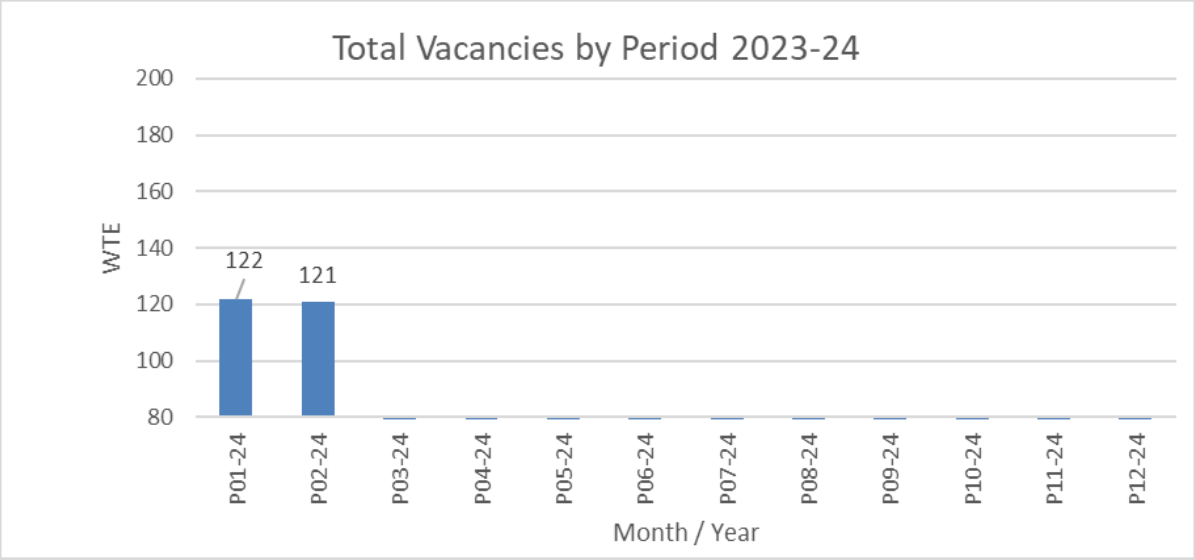
Per the IMTP the Trust is aiming to significantly decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. At this stage of the year we are still expecting to transition the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas. 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 spend on agency for May'23 was **£0.077m,** which gives a cumulative year to date spend of £0.165m and a current forecast outturn spend of circa **£0.623m** (£1.323m 2022/23).

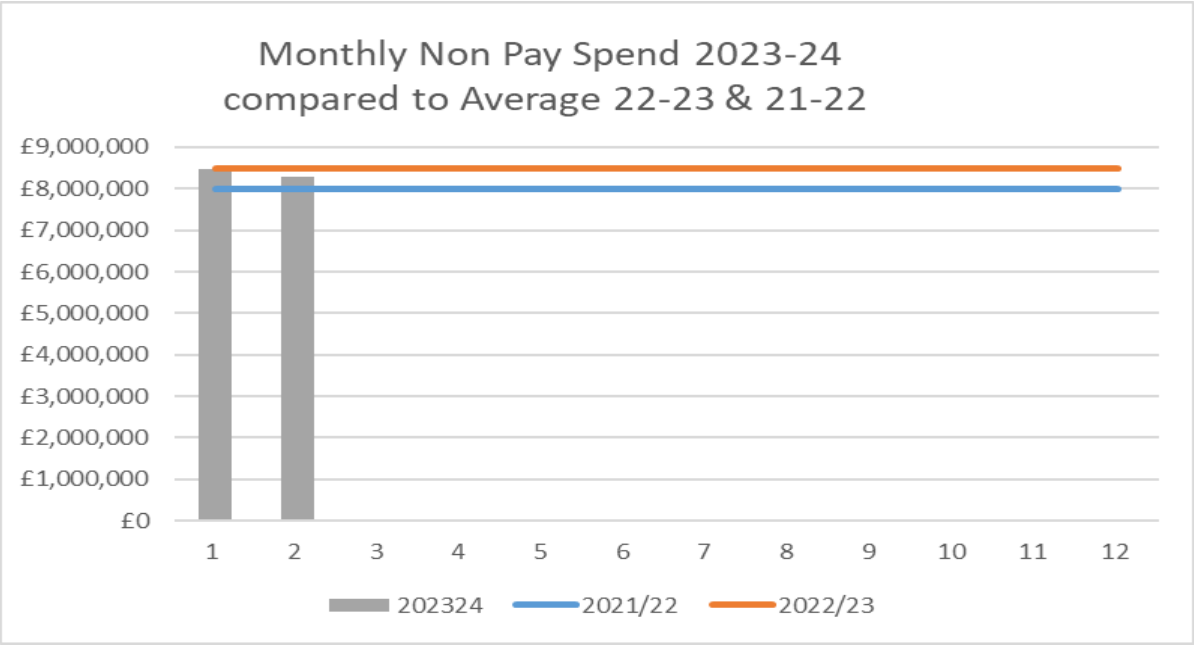




The total Trust vacancies as at May 2023 is 121wte, VCC (78wte), WBS (17wte), Corporate (11wte), R&D (12wte), TCS (0wte) and HTW (3wte).

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 £8.34m per month which is a slight reduction from the previous year average.



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 will be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of 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 allocated to the Trust based on actuals 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 May 23 being £0.167m which is a reduction of £0.073m from the £0.240m being requested as part of the IMTP, however if the Trust is required to support the HB's 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

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners from 2023-24. However, the contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall.

The committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.500m during 2022-23. The recurrent income funding for this additional capacity flows via performance related LTA contracting income from Commissioners.

Whilst the gap in funding has reduced 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%).

Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

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 is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

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.

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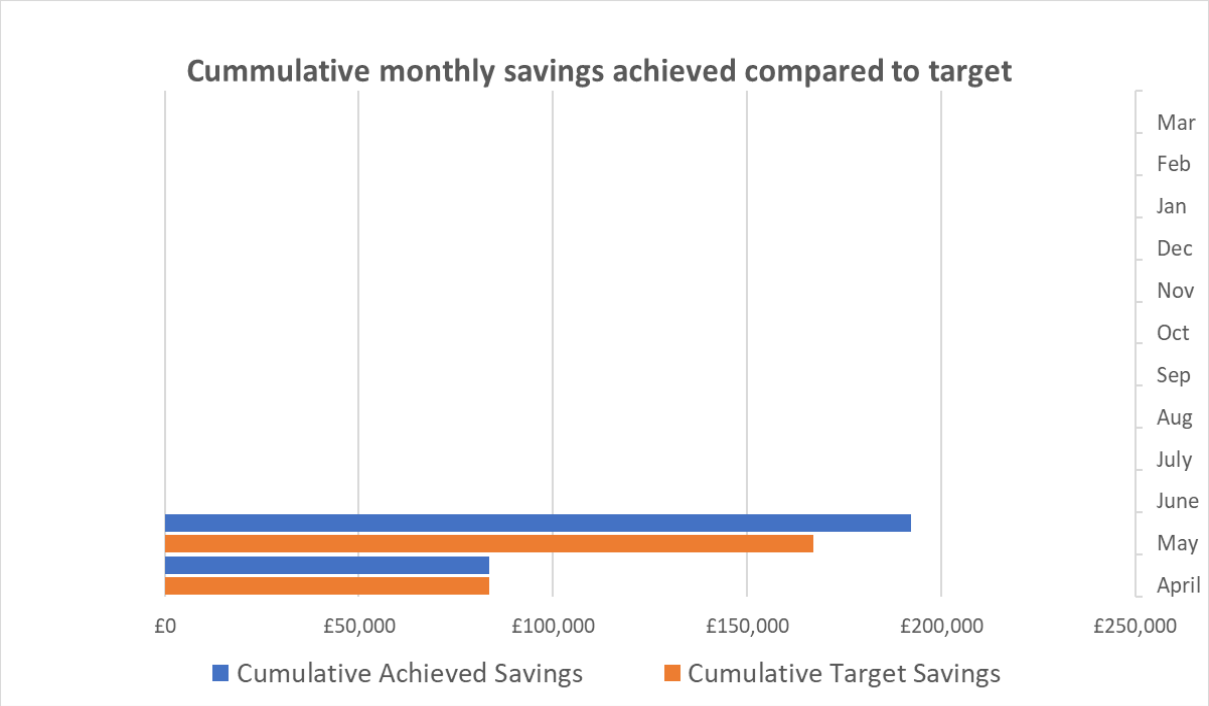
Savings Schemes							
Establishment Control (Corporate)	Green	75	13	13	0	75	0
Procurement Supply Chain (WBS)	Amber	100	0	0	0	100	0
Collection Team Costs Reduction (WBS)	Green	10	2	2	0	10	0
Collection Team Costs Reduction (WBS)	Green	8	1	1	0	8	0
Establishment Control (WBS)	Green	60	10	10	0	60	0
Reduced use of Nitrogen (WBS)	Amber	55	0	0	0	55	0
Reduced Research Investment (WBS)	Green	25	4	0	(4)	25	0
Stock Management (WBS)	Green	125	21	21	0	125	0
Reduced Transport Maintenance (WBS)	Amber	30	0	0	0	30	0
Demand Planning - Volume Driven Benefits (WBS)	Amber	137	0	0	0	137	0
Service Workforce Re-design (VCS)	Amber	50	0	0	0	50	0
Establishment Control (VCS)	Green	175	0	29	29	175	0
Pay Controls - Rationalisation of Service	Amber	150	0	0	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	21	21	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	8	8	0	50	0
Procurement Supply Chain (VCS)	Amber	100	0	0	0	100	0
Total Saving Schemes		**1,275**	80	105	25	1,275	0

Income Generation							
Bank Interest (Corporate)	Green	75	13	13	0	75	0
Sale of Plasma (WBS)	Green	150	25	25	0	150	0
Expand SACT Delivery (VCS)	Green	200	33	33	0	200	0
Private Patient Income (R) (VCS)	Green	50	8	8	0	50	0
Private Patient Income (NR) (VCS)	Green	50	8	8	0	50	0
Total Income Generation		**525**	88	88	0	525	0

TRUST TOTAL SAVINGS		**1,800**	**167**	**192**	**25**	**1,800**	**0**
				115%		**100%**	



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.

The balance and allocation of recurrent and non-recurrent reserves is currently under review for 2023/24 and is depended on a number of factors including the direction of energy prices, the ability to achieve the Trust savings target, and the cost of Covid recovery and planned care backlog capacity not covered by LTA income.

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

DHCR – *Risk £2.000m / 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 accurately being captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team are reviewing the situation and putting in place plans to address the issues. However, if this is not rectified there is a risk that £2.000m income related to unrecorded activity could be lost.

Non-Delivery of Savings - *Risk £0.622m / Likelihood - Medium*

The Trust as part of the IMTP identified £1.800m of Savings and Income Generation to be achieved during 2023-24. This savings target was set to ensure that the Trust had the ability to support local cost pressures, the increase in energy prices and the cost of Covid recovery and planned care backlog capacity not covered by LTA income.

Due to an increased savings target for 2023-24 and the ongoing legacy impact of the pandemic which has resulted in higher than usual sickness levels throughout the Trust, there is a potential inability to enact several of these savings which are currently reflected as RAG rated amber. Current expectation is that these schemes will be implemented and start to deliver as the year progresses, however achievement remains a risk. The Trust will continue to review the savings schemes with a view to either ensure delivery, or to find replacement schemes.

Further rise in Energy Prices above forecast MTP plans- *Risk £0.500m / Likelihood - Low*

Latest forecast from NWSSP suggests a further downward trajectory on energy prices, however a risk remains that costs may increase from the forecast position which was included in the IMTP plan.

Management of Operational Cost Pressures – *Risk £0.900m / 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.

SDEC Funding – *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.

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 @ M2 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	2.688	0.000	8.208	10.896	0.000
Integrated Radiotherapy Solutions (IRS)	10.326	0.307	0.000	10.019	10.326	0.000
IRS Satellite Centre (RSC)	1.347	0.000	0.000	1.347	1.347	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.733	2.995	0.000	19.738	22.733	0.000
Discretionary Capital	1.683	0.031	0.000	1.652	1.683	0.000
Total	24.416	3.026	0.000	21.390	24.416	0.000

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.**

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

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

Performance to date

The actual expenditure to May 2023 on the All-Wales Capital Programme schemes was £2.995m, this is broken down between spend on the nVCC enabling works £2.668m and the IRS £0.307m.

Spend to date on Discretionary Capital is currently £0.031m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

Major Schemes in Development

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

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. These include:

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

8. BALANCE SHEET (Including Hosted Organisations)

The balance sheet will be reported from Month 3.

9. CASH FLOW (Includes Hosted Organisations)

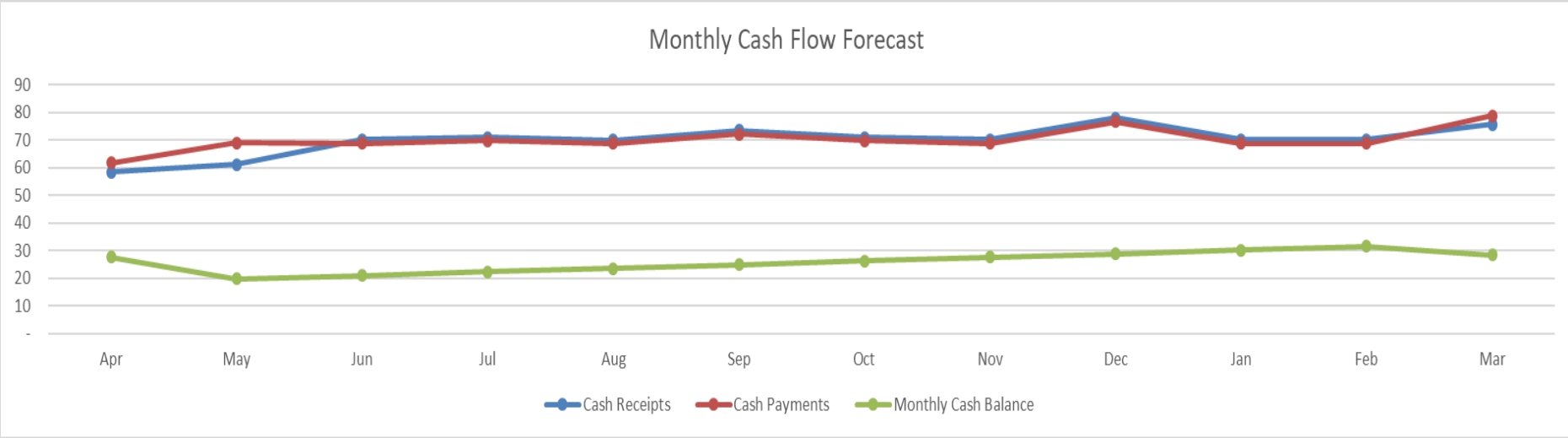
The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of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

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	14.460	18.799	23.870	24.872	23.878	23.894	23.923	23.908	23.906	23.909	23.910	26.158	275.484
2	WG Income	37.581	38.378	41.799	41.631	41.631	41.631	42.605	41.756	41.706	41.756	41.756	43.171	495.401
3	Short Term Loans													0.000
4	PDC				0.000								0.000	0.000
5	Interest Receivable	0.149	0.162	0.176	0.150	0.150	0.150	0.150	0.150	0.150	0.150	0.150	0.150	1.836
6	Sale of Assets													0.000
7	Other	6.156	3.753	4.363	4.382	4.382	7.802	4.401	4.401	12.331	4.428	4.428	6.232	67.059
8	TOTAL RECEIPTS	**58.346**	**61.092**	**70.208**	**71.035**	**70.041**	**73.477**	**71.079**	**70.215**	**78.092**	**70.242**	**70.243**	**75.711**	**839.781**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	32.216	32.309	32.315	32.461	32.483	32.497	32.561	32.593	32.627	32.899	391.482
10	Non pay items	28.882	33.947	34.997	34.291	35.593	38.691	35.996	35.840	43.623	34.970	35.083	45.117	437.031
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment													0.000
14	Capital Payment	1.123	0.394	1.703	3.146	0.846	1.012	1.276	0.553	0.583	1.351	1.205	0.899	14.091
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.062**	**68.916**	**69.746**	**68.754**	**72.164**	**69.755**	**68.891**	**76.767**	**68.914**	**68.915**	**78.916**	**842.604**
17	Net cash inflow/outflow	(3.461)	(7.970)	1.292	1.289	1.287	1.313	1.324	1.324	1.325	1.328	1.328	(3.204)	
18	Balance b/f	31.119	27.658	19.688	20.980	22.269	23.556	24.869	26.194	27.518	28.843	30.171	31.500	
19	Balance c/f	27.658	19.688	20.980	22.269	23.556	24.869	26.194	27.518	28.843	30.171	31.500	28.296	



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	(6.650)	(6.653)	(0.003)	(37.005)	(37.005)	0.000
RD&I	(0.142)	(0.142)	0.000	0.144	0.144	0.000
WBS	(3.214)	(3.214)	(0.001)	(19.816)	(19.816)	0.000
Sub-Total Divisions	**(10.006)**	**(10.009)**	**(0.003)**	**(56.677)**	**(56.677)**	**0.000**
Corporate Services Directorates	**(1.914)**	**(1.903)**	**0.011**	**(11.483)**	**(11.483)**	**0.000**
Delegated Budget Position	**(11.920)**	**(11.912)**	**(0.007)**	**(68.161)**	**(68.161)**	**0.000**
TCS	(0.124)	(0.127)	0.003	(0.611)	(0.611)	0.000
Health Technology Wales	0.000	0.000	(0.000)	0.000	0.000	0.000
Trust Income / Reserves	12.043	12.043	(0.000)	68.772	68.772	0.000
Trust Position	0.000	0.004	0.004	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	**11.753**	**11.962**	**0.210**	**72.971**	**72.971**	**0.000**
Expenditure						
Staff	**8.350**	**8.430**	**(0.080)**	**45.765**	**45.765**	**0.000**
Non Staff	**10.053**	**10.186**	**(0.133)**	**64.210**	**64.210**	**0.000**
Sub Total	**18.403**	**18.616**	**(0.212)**	**109.976**	**109.976**	**0.000**
Total	**(6.650)**	**(6.653)**	0.003	**(37.005)**	**(37.005)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of May 2023 was a small underspend of **£0.003m**, and an expected outturn position of **breakeven**.

Income at Month 2 represents a surplus of **£0.210m**. Overachievement on Private Patients drugs due to activity and VAT savings from delivery SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date overspend of **£(0.080)m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave across several services which is largely offsetting both the vacancy savings target and to support posts appointed without funding

agreement. The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff Expenditure at Month 2 was **£(0.133)m** overspent which is a result of increased activity in a few areas including use of PICC and SACT following treatment returning to Neville 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	**4.478**	**4.541**	**0.064**	**26.674**	**26.674**	**0.000**
Expenditure						
Staff	**3.016**	**3.064**	**(0.047)**	**16.935**	**16.935**	**0.000**
Non Staff	**4.675**	**4.692**	**(0.017)**	**29.555**	**29.555**	**0.000**
Sub Total	**7.691**	**7.755**	**(0.064)**	**46.490**	**46.490**	**0.000**
Total	**(3.214)**	**(3.214)**	0.001	**(19.816)**	**(19.816)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of May 2023 was a small underspend of **£0.001m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.064m** to month 2. Targeted income generation on plasma sales through increased activity is being largely 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 yet to see signs of recovery. WBS have been running campaigns to try and grow the panel in sites such as schools and universities.

Staff reported a **£(0.047)m** overspend to May. 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.

Work continues to be underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff reported a small overspend of **£(0.017)m** to May. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage are being offset by savings against stem cell activity and testing.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.437**	**0.609**	**0.171**	**1.893**	**1.893**	**0.000**
Expenditure						
Staff	**1.864**	**1.834**	**0.030**	**10.454**	**10.454**	**0.000**
Non Staff	**0.487**	**0.678**	**(0.191)**	**2.923**	**2.923**	**0.000**
Sub Total	**2.351**	**2.512**	**(0.161)**	**13.376**	**13.376**	**0.000**
Total	**(1.914)**	**(1.903)**	0.011	**(11.483)**	**(11.483)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of May 2023 was an underspend of **£0.011m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

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

Staff expectation is that vacancies within the division, will help offset 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 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	**0.334**	**0.367**	**0.033**	**3.207**	**3.207**	**0.000**
Expenditure						
Staff	**0.455**	**0.486**	**(0.031)**	**2.831**	**2.831**	**0.000**
Non Staff	**0.021**	**0.023**	**(0.002)**	**0.232**	**0.232**	**0.000**
Sub Total	**0.476**	**0.509**	**(0.033)**	**3.063**	**3.063**	**0.000**
Total	**(0.142)**	**(0.142)**	(0.000)	**0.144**	**0.144**	**0.000**

RD&I Key Highlights / Issues

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

Income variance due to one off increase in trials being recognised, with fluctuations still expected throughout the year

Pay overspend to be neutralised by award funding in month 3.

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**	**0.022**	**0.022**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.110**	**0.116**	**(0.005)**	**0.598**	**0.598**	**0.000**
Non Staff	**0.013**	**0.034**	**(0.020)**	**0.013**	**0.013**	**0.000**
Sub Total	**0.124**	**0.149**	**(0.026)**	**0.611**	**0.611**	**0.000**
Total	**(0.124)**	**(0.127)**	0.003	**(0.611)**	**(0.611)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of May 2023 is a small underspend of **£3k** with a forecasted outturn position of **Breakeven.**

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	**0.258**	**0.258**	**(0.000)**	**1.697**	**1.697**	**0.000**
Expenditure						
Staff	**0.246**	**0.245**	**0.000**	**1.449**	**1.449**	**0.000**
Non Staff	**0.013**	**0.012**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**0.258**	**0.258**	**0.000**	**1.697**	**1.697**	**0.000**
Total	**0.000**	**0.000**	(0.000)	**0.000**	**0.000**	**0.000**

HTW Key Highlights / Issues

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

HTW is funded directly by WG.

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13th June 2023

Andrea Hughes
Welsh Government
Deputy Head of NHS Financial Management
Sarn Mynach
Llandudno Junction
Conwy
LL31 9RZ

Dear Andrea,

Velindre Month 2 (May) Monitoring Return

In line with the guidance issued, please find attached the tables required for Month 2.

1. Table A – Movement of Opening Financial Plan to Forecast Outturn

The Velindre core table has been completed in line with the Trust draft IMTP, NWSSP has then been combined to give the overall Trust Position.

As included in the IMTP the Core Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 core discretionary uplift funding that was not committed 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 non-recurrent component of the energy cost increase in 2022-23 resulted in an underlying surplus being carried forward into 2023-24 which will act as contingency for further anticipated volatility in energy prices. The balance of the underlying surplus is forecast to reduce year-on-year to fund new cost pressures over the 3-year planning period.

Part of the 1.5% core discretionary uplift funding will be required to fund the continuing forecast exceptional energy cost pressure as a result of high energy prices.

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The latest energy forecast position for 2023-24 from NWSSP suggests a further reduction of c£0.740m from the forecast presented at the IMTP planning stage. This potentially releases funding which will be used to support some of the local growth and cost pressures, which are within the service divisions.

The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income. All LTA/ SLA documents have been issued in line with the funding flows mechanism agreed at Directors of Finance Forum, with expectation that all LTA/ SLA's will be signed by the 30th June. However, the level of this funding remains a risk compared to the cost of additional capacity investment.

2. Table A1 – Underlying Position

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

The ability to carry forward a surplus into 2024-25 will depend on energy costs as a result of potential energy price volatility, and also the ability for the Trust to deliver on its recurrent savings target.

Other factors which will determine the carry forward position into 2024-25 will be the Trusts capacity to either fund or mitigate both current and potential new cost pressures which may emerge over the course of the year.

We note the need to consistency report the underlying position and will ensure that this action is taken going forward **(Action Point 1.1).**

3. Table A2 – Risks

There are several financial risks that could impact on the successful delivery of a balanced position for 2023-24. The Trust is taking appropriate actions to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Non-Delivery of Savings - (Medium)

The Trust as part of the IMTP identified £1.800m of Savings and Income Generation to be achieved during 2023-24. This savings target was set to ensure that the Trust had the ability to support local cost pressures, the increase in energy

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prices and the cost of Covid recovery and planned care backlog capacity not covered by LTA income.

Due to an increased savings target for 2023-24 and the ongoing legacy impact of the pandemic which has resulted in higher than usual sickness levels throughout the Trust, there is a potential inability to enact several of these savings which are currently reflected as RAG rated amber. Current expectation is that these schemes will be implemented and start to deliver as the year progresses, however achievement remains a risk. The Trust will continue to review the savings schemes with a view to either ensure delivery or to find replacement schemes. Further detail is provided below under section 7.

Further rise in Energy Prices above forecast IMTP plans- (Low)

Latest forecast from NWSSP continues to suggest a downward trajectory on energy prices, however due to recent volatility a risk currently remains that costs may increase from the forecast position which was included in the IMTP plan.

Management of Operational Cost Pressures – (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 small 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.

As highlighted earlier it is hoped that funding that has been ringfenced to support the increase in energy prices may be released to support some of these Divisional cost pressures.

SDEC Funding – (removed from table for 23/24)

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 of recurrent funding. Until the recurrent funding is confirmed this remains a significant risk to the Trust.

Per the funding award letter, the Trust has received confirmation of the SDEC funding for 2023/24, however recurrent funding beyond 2023/24 has not currently

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been confirmed. In line with the guidance the risk has been removed from the table, however we will continue to flag through the narrative so that WG colleagues continue to be sighted on the risk. **(Action Point 1.2)**

4. Table B – Monthly Positions

The Trust position for the period ended May 2023 as reported in table B is a £0.004m underspend and a forecasted outturn position of breakeven.

The combined table is produced by adding NWSSP to the Trust Core return.

In month drug cost reduction is netted off with income movement. Forecast drug position maintained at IMTP planning assumption but currently under review.

WG Income increase for anticipated recurrent impact of 1.5% consolidated pay award. The one off NHS recovery pay ward and 5% consolidated pay increase is currently excluded from the table.

As previously highlighted the DEL and AME depreciation has been set at the baseline with the first non-cash submission due in June. The accelerated depreciation associated with the current VCC site and the impairment as a result of the nVCC Asda works is therefore excluded.

Pay & Agency (Table B2)

Of the £0.318m agency spend reported in the table as at the end of May, £0.165m relates to Velindre core divisions, with the remaining balance being related to NWSSP.

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

At this stage of the year we are still expecting to transition the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas. 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. **(Action Point 1.3)**

5. Covid-19 (Table B3)

Covid Programme Costs

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Per the allocation letter funding for ongoing national Covid responses, including mass vaccination, and the provision of PPE will be held centrally and allocated on actual costs incurred during 2023-24. It is recognised that any other Covid related programme costs will need to be funded by the Trust.

At present the Trust is only expecting to draw funding from WG towards PPE costs, however if the Trust is required to support the HB's 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:

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners from 2023-24. However, the contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall.

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m for 2022-23. The recurrent income funding for this additional capacity flows via performance related LTA contracting income from Commissioners.

Work continues to be undertaken 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.

6. Savings (Table C – C3)

As highlighted a number of schemes remain in amber, with current expectation that these schemes will turn green during quarter 2, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or the impact of current market conditions on the supply chain.

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 is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. It is however important that we continue to challenge our procurement colleagues

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in trying to deliver savings against the supply chain, but recognise that delivery under current conditions may be a challenge.

The Trust continues to work with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

7. Welsh NHS Assumptions (Table D)

Following discussions with the HB's and other NHS Trusts the I&E position should be in agreement for month 2.

8. Invoiced Income (Table E1)

The Total income for the year is shown within Table E.

As highlighted earlier only the baseline for depreciation has been included at this stage.

In line with the guidance the forecast deprecation and funding requirement in relation to IFRS16 has been updated to include the Trust's Corporate HQ building where the lease was signed during April. The Trust awaits the opportunity to submit a bid to the Capital team to secure the Capital funding.

9. SoFP (Table F)

Not required until Month 3.

10. Cash Flow (Table G)

Cash Flow has been completed for month 2.

11. PSPP (Table H)

Not required until Month 3.

We are however pleased to report that the Trust continues to achieve the 95% target of Non-NHS invoices being paid within 30 days with a performance of over 98% in both April and May.

The Trust will continue to work with NWSSP colleagues with the aim of achieving the 95% NHS invoice target.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

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12. Capital Tables (Table I-K)

The Capital tables have been completed for month 2.

Per the funding award letter for the Radiotherapy Satellite Centre (RSC), the Trust is engaging with WG Capital colleagues to ensure that the expected funding for 2023/24 is included on the Trust CEL.

Please note that the monthly profile spend on the nVCC enabling works will be sent directly to WG Capital colleagues from the NVCC team following this submission.

13. EFL (Table L)

Not required until Month 3

14. Aged Debtors (Table M)

There are no invoices over 17 weeks for Velindre Core.

15. Ringfenced (Table P)

In line with the allocation letter the latest forecast funding requirement in relation to VBHC has been presented in table P.

16. Other

This letter and relevant tables from the MMR will be going to the Trust Quality, Safety and Performance Committee in July 2023.

Conclusion

I confirm that the financial information reported in the Trust monitoring return is in line with the financial strategy information reported to the Velindre Trust Board.

Should you have any queries please do not hesitate to contact Steve Coliandris in the first instance.

Chris Moreton
Deputy Director of Finance

Steve Ham
Chief Executive

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Velindre UNHS Trust **Velindre UNHS Trust**

On behalf of

Matthew Bunce
Executive Director of Finance
Velindre UNHS Trust

VALIDATION SUMMARY 2023-24

Your organisation is showing as :	VELINDRE TRUST
Period is showing :	MAY 23
TABLE A : MOVEMENT	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A1 : UNDERLYING POSITION	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A2: RISKS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B : MONTHLY POSITIONS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B2 : PAY & AGENCY/LOCUM	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B3 : COVID-19	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C, C1, C2 & C3 : SAVINGS SCHEMES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C4 : TRACKER	VELINDRE TRUST IS CURRENTLY SHOWING 7 ERRORS FOR THIS TABLE
TABLE E : RESOURCE LIMITS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E1 : INVOICED INCOME	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE F : STATEMENT OF FINANCIAL POSITION	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE G : MONTHLY CASHFLOW	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE I : CAPITAL RESOURCE / EXPENDITURE LIMIT	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE J: CAPITAL IN YEAR SCHEMES	VELINDRE TRUST IS CURRENTLY SHOWING 1 ERRORS FOR THIS TABLE
TABLE K : CAPITAL DISPOSALS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE L : EFL	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE N : GENERAL MEDICAL SERVICES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE O : GENERAL DENTAL SERVICES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TOTAL ERRORS FOR YOUR MAY 23 RETURN IS	**8 ERRORS ON 2 DIFFERENT TABLE/S**

Velindre Trust

Period : **May 23**

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	4	0

Velindre Trust **Period : May 23**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 14 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	684	0	684	684
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-18,705	-1,191	-17,514	-17,514
3	Planned Expenditure For Covid-19 (Negative Value)	-240	-240	0	0
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	71	0	71	71
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	240	240	0	0
6	Planned Provider Income (Positive Value)	16,150	0	16,150	16,150
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	1,275	750	525	525
9	Planned (Finalised) Net Income Generation	525	50	475	475
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Planning Assumptions still to be finalised at Month 1	0	0		
14	**Opening IMTP / Annual Operating Plan**	**0**	**-391**	**391**	**391**
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	0
20	Additional In Year Identified Savings - Forecast	0	0	0	0
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	-73	-73		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	73	73		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0		
27		0	0		
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36		0	0		
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**-391**	**391**	**391**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**0**			

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	57	57	57	57	57	57	57	57	57	57	57	57	114	684
2	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-1,559	-3,118	-18,705
3	-20	-20	-20	-20	-20	-20	-20	-20	-20	-20	-20	-20	-40	-240
4	6	6	6	6	6	6	6	6	6	6	6	6	12	71
5	20	20	20	20	20	20	20	20	20	20	20	20	40	240
6	1,412	1,412	1,412	1,324	1,324	1,324	1,324	1,324	1,324	1,324	1,324	1,324	2,825	16,150
7												0	0	0
8	40	40	40	128	128	128	128	128	128	128	128	128	80	1,275
9	44	44	44	44	44	44	44	44	44	44	44	44	88	525
10													0	0
11													0	0
12													0	0
13													0	0
14	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16													0	0
17													0	0
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	0	25	13	-37	-37	-37	3	3	3	3	3	58	25	0
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21													0	0
22	-11	-12	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	-23	-73
23													0	0
24	11	12	5	5	5	5	5	5	5	5	5	5	23	73
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	1	-22	-17	37	37	37	-3	-3	-3	-3	-3	-58	-21	0
27													0	0
28													0	0
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35													0	0
36													0	0
37													0	0
38													0	0
39													0	0
40	**1**	**3**	**-4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**1**	**3**	**-4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**

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TABLE A : Movement of Opening Financial Plan to Forecast Outturn

Monthly Positions (- Deficit / + Surplus) reconciles to Table B Monthly Positions	**Ok**
Recurring & Non Recurring Analysis of In Year items is not greater than In Year items	**Ok**
FYE of Recurring items are greater than, or equal to, the In Year Recurring amount	**Ok**
FYE of Recurring items only reported against Recurring items	**Ok**
Has Organisation name being selected	**Ok**

Velindre Trust **Period : May 23**

Table A1 - Underlying Position

This table needs completing monthly from Month: 1

This Table is currently showing 0 errors

	Section A - By Spend Area	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Pay - Administrative, Clerical & Board Members				0		0
2	Pay - Medical & Dental				0		0
3	Pay - Nursing & Midwifery Registered				0		0
4	Pay - Prof Scientific & Technical				0		0
5	Pay - Additional Clinical Services				0		0
6	Pay - Allied Health Professionals				0		0
7	Pay - Healthcare Scientists				0		0
8	Pay - Estates & Ancillary				0		0
9	Pay - Students				0		0
10	Non Pay - Supplies and services - clinical				0		0
11	Non Pay - Supplies and services - general	684			684	(293)	391
12	Non Pay - Consultancy Services				0		0
13	Non Pay - Establishment				0		0
14	Non Pay - Transport				0		0
15	Non Pay - Premises				0		0
16	Non Pay - External Contractors				0		0
17	Health Care Provided by other Orgs – Welsh LHBs				0		0
18	Health Care Provided by other Orgs – Welsh Trusts				0		0
19	Health Care Provided by other Orgs – WHSSC				0		0
20	Health Care Provided by other Orgs – English				0		0
21	Health Care Provided by other Orgs – Private / Other				0		0
22	**Total**	**684**	**0**	**0**	**684**	**(293)**	**391**

	Section B - By Directorate	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Primary Care				0		0
2	Mental Health				0		0
3	Continuing HealthCare				0		0
4	Commissioned Services				0		0
5	Scheduled Care				0		0
6	Unscheduled Care				0		0
7	Children & Women's				0		0
8	Community Services				0		0
9	Specialised Services				0		0
10	Executive / Corporate Areas	684			684	(293)	391
11	Support Services (inc. Estates & Facilities)				0		0
12	**Total**	**684**	**0**	**0**	**684**	**(293)**	**391**

Velindre Trust

Period : **May 23**

This Table is currently showing 0 errors

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END £'000	Likelihood
	Opportunities to achieve IMTP/AOP (positive values)		
1	**Red Pipeline schemes (inc AG & IG)**		
2	**Potential Cost Reduction**		
3	**Total Opportunities to achieve IMTP/AOP**	**0**	
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker	(622)	Medium
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	further rise in energy costs from latest NWSSP forecast	(500)	Low
13	Management of operational Pressures	(900)	low
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26	**Total Risks**	**(2,022)**	
	Further Opportunities (positive values)		
27	Capacity and Backlog Activity Performance	400	Medium
28	Capacity and Backlog Cost Reduction	TBC	Low
29	Vacancy Turnover	400	Medium
30	Emergency Reserve	500	Medium
31	Reduction in Energy prices	740	high
32	Contract Currency review in recognition of underlying cost base.	500	low
33			
34	**Total Further Opportunities**	**2,540**	
35	**Current Reported Forecast Outturn**	**0**	
36	**IMTP / AOP Outturn Scenario**	**0**	
37	**Worst Case Outturn Scenario**	**0**	
38	**Best Case Outturn Scenario**	**2,540**	

Velindre Trust

YTD Months to be completed from Month: 1
Forecast Months to be completed from Month: 1

Table B - Monthly Positions **Period :** May 23

This Table is currently showing 0 errors

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Revenue Resource Limit	Actual/F'cast													0	0
2	Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast													0	0
3	Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast	8,539	8,391	9,258	9,258	9,258	9,258	9,258	9,258	9,258	9,258	9,258	9,266	16,930	109,521
4	WHSSC Income	Actual/F'cast	4,723	4,746	5,148	4,976	4,976	4,976	4,976	4,976	4,976	4,976	4,976	5,029	9,470	59,452
5	Welsh Government Income (Non RRL)	Actual/F'cast	495	450	833	833	833	833	833	833	833	833	833	1,387	945	9,826
6	Other Income	Actual/F'cast	1,041	1,388	1,191	1,187	1,187	1,206	1,206	1,206	1,233	1,233	1,233	1,231	2,429	14,543
7	**Income Total**		**14,798**	**14,975**	**16,431**	**16,254**	**16,254**	**16,273**	**16,273**	**16,273**	**16,299**	**16,299**	**16,299**	**16,914**	**29,773**	**193,342**
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast													0	0
9	Primary Care - Drugs & Appliances	Actual/F'cast													0	0
10	Provided Services - Pay	Actual/F'cast	6,328	6,675	6,508	6,562	6,565	6,694	6,688	6,698	6,759	6,776	6,817	6,842	13,003	79,913
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	3,256	3,670	4,522	4,287	4,285	4,175	4,180	4,170	4,135	4,119	4,078	4,171	6,926	49,048
12	Secondary Care - Drugs	Actual/F'cast	4,659	4,073	4,850	4,850	4,850	4,850	4,850	4,850	4,850	4,850	4,850	4,847	8,732	57,229
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
15	Continuing Care and Funded Nursing Care	Actual/F'cast													0	0
16	Other Private & Voluntary Sector	Actual/F'cast													0	0
17	Joint Financing and Other	Actual/F'cast													0	0
18	Losses, Special Payments and Irrecoverable Debts	Actual/F'cast													0	0
19	Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/F'cast													0	0
21	Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
22	DEL Depreciation\Accelerated Depreciation\Impairments	Actual/F'cast	537	537	537	537	537	537	537	537	537	537	537	537	1,073	6,439
23	AME Donated Depreciation\Impairments	Actual/F'cast	18	18	18	18	18	18	18	18	18	18	18	18	36	213
24	Uncommitted Reserves & Contingencies	Actual/F'cast												500	0	500
25	Profit\Loss Disposal of Assets	Actual/F'cast													0	0
26	**Cost - Total**	Actual/F'cast	**14,797**	**14,972**	**16,435**	**16,254**	**16,254**	**16,273**	**16,273**	**16,273**	**16,299**	**16,299**	**16,299**	**16,914**	**29,769**	**193,341**
27	**Net surplus/ (deficit)**	Actual/F'cast	**1**	**3**	**(4)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**

	B. Cost Total by Directorate		Forecast year-end position £'000
28	Primary Care	Actual/F'cast	
29	Mental Health	Actual/F'cast	
30	Continuing HealthCare	Actual/F'cast	
31	Commissioned Services	Actual/F'cast	
32	Scheduled Care	Actual/F'cast	
33	Unscheduled Care	Actual/F'cast	
34	Children & Women's	Actual/F'cast	
35	Community Services	Actual/F'cast	
36	Specialised Services	Actual/F'cast	167,502
37	Executive / Corporate Areas	Actual/F'cast	13,163
38	Support Services (inc. Estates & Facilities)	Actual/F'cast	5,524
39	Reserves	Actual/F'cast	500
40	**Cost - Total (Excluding DEL & AME Non-Cash Charges)**	Actual/F'cast	**186,689**

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000
28 . Actual YTD surplus/ (deficit)	4

Full-year surplus/ (deficit) scenarios	£'000
33. Extrapolated Scenario	33

			Trend
29. Actual YTD surplus/ (deficit) last month	1		
30. Current month actual surplus/ (deficit)	3		
31. Average monthly surplus/ (deficit) YTD	2	▲	
32. YTD /remaining months	0		

34. Year to Date Trend Scenario	24	

D. DEL/AME Depreciation & Impairments

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	DEL															
41	Baseline Provider Depreciation	Actual/F'cast	517	517	517	517	517	517	517	517	517	517	517	517	1,035	6,208
42	Strategic Depreciation	Actual/F'cast													0	0
43	Accelerated Depreciation	Actual/F'cast													0	0
44	Impairments	Actual/F'cast													0	0
45	IFRS 16 Leases	Actual/F'cast	19	19	19	19	19	19	19	19	19	19	19	19	39	231
46	**Total**		**537**	**537**	**537**	**537**	**537**	**537**	**537**	**537**	**537**	**537**	**537**	**537**	**1,073**	**6,439**
	AME															
47	Donated Asset Depreciation	Actual/F'cast	18	18	18	18	18	18	18	18	18	18	18	18	36	213
48	Impairments (including Reversals)	Actual/F'cast													0	0
49	IFRS 16 Leases (Peppercorn)	Actual/F'cast													0	0
50	**Total**		**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**36**	**213**

E. Accountancy Gains

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
51	Accountancy Gains	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**

F. Energy

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
52	Total Energy Costs	Actual/F'cast	168	144	144	144	144	144	144	144	144	144	144	144	**312**	**1,750**

G. Committed Reserves & Contingencies

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	List of all Committed Reserves & Contingencies inc above in Section A. Please specify Row number in description.															
53		Forecast Only													0	0
54		Forecast Only													0	0
55		Forecast Only													0	0
56		Forecast Only													0	0
57		Forecast Only													0	0
58		Forecast Only													0	0
59		Forecast Only													0	0
60		Forecast Only													0	0
61		Forecast Only													0	0
62		Forecast Only													0	0
63		Forecast Only													0	0
64		Forecast Only													0	0
65		Forecast Only													0	0
66		Forecast Only													0	0
67		Forecast Only													0	0
68		Forecast Only													0	0
69		Forecast Only													0	0
70		Forecast Only													0	0
71		Forecast Only													0	0
72		Forecast Only													0	0
73		Forecast Only													0	0
74		Forecast Only													0	0
75		Forecast Only													0	0
76		Forecast Only													0	0
77		Forecast Only													0	0
78		Forecast Only													0	0
79		Forecast Only													0	0
80		Forecast Only													0	0
81	**Total**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
		Phasing	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Velindre Trust

Table B1 - SOCNE / SOCNI Movement

Period : May 23

This table needs completing monthly from Month 2

Ref	TABLE B: MONTHLY POSITIONS - **MONTHLY MOVEMENT ANALYSIS**														VARIANCE ANALYSIS £'m			VARIANCE ANALYSIS %		
2	Income & Expenditure Categories	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total	v PMA	v PMF	v PMFYF	v PMA	v PMF	v PMFYF
3	Revenue Resource Limit	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
4	Capital Donation / Government Grant Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
5	Welsh NHS Local Health Boards & Trusts Income	0.0	(0.7)	(0.0)	0.1	0.1	(0.0)	0.1	0.1	(0.0)	0.1	0.1	(0.1)	(0.3)	(0.1)	(0.7)	(0.3)	-1.7%	-8.2%	-0.3%
6	WHSSC Income	0.0	(0.4)	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	(0.4)	0.1	0.5%	-6.9%	0.3%
7	Welsh Government Income (Non RRL)	0.0	(0.2)	(0.1)	0.2	0.2	(0.1)	0.2	0.2	(0.1)	0.2	0.2	0.3	0.8	(0.0)	(0.2)	0.8	-9.2%	-31.4%	9.5%
8	Other Income	0.0	0.2	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.1	0.3	0.2	0.1	33.4%	19.5%	1.2%
9	**Total Income**	**0.0**	**(1.1)**	**0.0**	**0.3**	**0.3**	**(0.2)**	**0.3**	**0.3**	**(0.1)**	**0.3**	**0.3**	**0.3**	**0.8**	**0.2**	**(1.1)**	**0.8**	**1.2%**	**-6.7%**	**0.5%**
10	Primary Care Contractor (excl. drugs, incl. NRL expenditure)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
11	Primary Care - Drugs & Appliances	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
12	Provided Services - Pay	0.0	0.3	0.1	0.1	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.4	0.3	0.3	0.4	5.5%	4.4%	0.6%
13	Provider Services - Non Pay (excluding drugs & depreciation)	0.0	(0.7)	(0.1)	0.2	0.2	(0.3)	0.2	0.2	(0.2)	0.2	0.3	0.2	0.2	0.4	(0.7)	0.2	12.7%	-15.5%	0.5%
14	Secondary Care - Drugs	0.0	(0.7)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	(0.6)	(0.7)	0.2	-12.6%	-14.5%	0.3%
15	Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
16	Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
17	Continuing Care and Funded Nursing Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
18	Other Private & Voluntary Sector	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
19	Joint Financing and Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
20	Losses, Special Payments and Irrecoverable Debts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
21	Exceptional (Income) / Costs - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
22	Total Interest Receivable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
23	Total Interest Payable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
24	DEL Depreciation\Accelerated Depreciation\Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
25	AME Donated Depreciation\Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
26	Uncommitted Reserves & Contingencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
27	Profit\Loss Disposal of Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	0.0%	0.0%
28	**Total Expenditure**	**0.0**	**(1.1)**	**0.0**	**0.3**	**0.3**	**(0.2)**	**0.3**	**0.3**	**(0.1)**	**0.3**	**0.3**	**0.3**	**0.8**	**0.2**	**(1.1)**	**0.8**	**1.2%**	**-6.7%**	**0.5%**
29	**Forecast Outturn**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**146.4%**	**-386.6%**	**0.0%**

PMA = Prior Month Actuals
PMF = Prior Month Forecast
PMFYF = Prior Month Full Year Forecast

30	TABLE B: MONTHLY POSITIONS - **PRIOR MONTH**														
31	Income & Expenditure Categories	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total	Forecast
32	Revenue Resource Limit	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
33	Capital Donation / Government Grant Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
34	Welsh NHS Local Health Boards & Trusts Income	8.5	9.1	9.3	9.1	9.1	9.3	9.1	9.1	9.3	9.1	9.1	9.4	109.8	92.1
35	WHSSC Income	4.7	5.1	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	4.9	59.3	49.5
36	Welsh Government Income (Non RRL)	0.5	0.7	1.0	0.7	0.7	1.0	0.7	0.7	1.0	0.7	0.7	1.1	9.1	7.9
37	Other Income	1.0	1.2	1.2	1.2	1.2	1.3	1.2	1.2	1.2	1.2	1.2	1.2	14.4	12.2
38	**Total Income**	**14.8**	**16.1**	**16.4**	**15.9**	**15.9**	**16.5**	**16.0**	**16.0**	**16.4**	**16.0**	**16.0**	**16.6**	**192.6**	**161.7**
39	Primary Care Contractor (excl. drugs, incl. NRL expenditure)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
40	Primary Care - Drugs & Appliances	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
41	Provided Services - Pay	6.3	6.4	6.5	6.5	6.5	6.7	6.7	6.7	6.8	6.8	6.9	6.9	79.5	66.8
42	Provider Services - Non Pay (excluding drugs & depreciation)	3.3	4.3	4.6	4.1	4.1	4.5	3.9	3.9	4.4	3.9	3.8	3.9	48.8	41.2
43	Secondary Care - Drugs	4.7	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	57.1	47.6
44	Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
45	Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
46	Continuing Care and Funded Nursing Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
47	Other Private & Voluntary Sector	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
48	Joint Financing and Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
49	Losses, Special Payments and Irrecoverable Debts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
50	Exceptional (Income) / Costs - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
51	Total Interest Receivable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
52	Total Interest Payable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
53	DEL Depreciation\Accelerated Depreciation\Impairments	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6.4	5.4
54	AME Donated Depreciation\Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
55	Uncommitted Reserves & Contingencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5	0.5
56	Profit\Loss Disposal of Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
57	**Total Expenditure**	**14.8**	**16.1**	**16.4**	**15.9**	**15.9**	**16.5**	**16.0**	**16.0**	**16.4**	**16.0**	**16.0**	**16.6**	**192.6**	**161.7**
58	**Forecast Outturn**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

The 'Current Month' figures would come from the from the existing Table B:

59	TABLE B: MONTHLY POSITIONS - **CURRENT MONTH**													
60	Income & Expenditure Categories	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
61	Revenue Resource Limit	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
62	Capital Donation / Government Grant Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
63	Welsh NHS Local Health Boards & Trusts Income	8.5	8.4	9.3	9.3	9.3	9.3	9.3	9.3	9.3	9.3	9.3	9.3	109.5
64	WHSSC Income	4.7	4.7	5.1	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	59.5
65	Welsh Government Income (Non RRL)	0.5	0.4	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	1.4	9.8
66	Other Income	1.0	1.4	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	14.5
67	**Total Income**	**14.8**	**15.0**	**16.4**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.9**	**193.3**
68	Primary Care Contractor (excl. drugs, incl. NRL expenditure)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
69	Primary Care - Drugs & Appliances	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
70	Provided Services - Pay	6.3	6.7	6.5	6.6	6.6	6.7	6.7	6.7	6.8	6.8	6.8	6.8	79.9
71	Provider Services - Non Pay (excluding drugs & depreciation)	3.3	3.7	4.5	4.3	4.3	4.2	4.2	4.2	4.1	4.1	4.1	4.2	49.0
72	Secondary Care - Drugs	4.7	4.1	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.8	57.2
73	Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
74	Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
75	Continuing Care and Funded Nursing Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
76	Other Private & Voluntary Sector	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
77	Joint Financing and Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
78	Losses, Special Payments and Irrecoverable Debts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
79	Exceptional (Income) / Costs - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
80	Total Interest Receivable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
81	Total Interest Payable - (Trust Only)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
82	DEL Depreciation\Accelerated Depreciation\Impairments	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6.4
83	AME Donated Depreciation\Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
84	Uncommitted Reserves & Contingencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5
85	Profit\Loss Disposal of Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
86	**Total Expenditure**	**14.8**	**15.0**	**16.4**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.3**	**16.9**	**193.3**
87	**Forecast Outturn**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Velindre Trust

Period : May 23

YTD Months to be completed from Month: 1

This Table is currently showing 0 errors

Forecast Months to be completed from Month: 1

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	1,933	2,030	1,983	1,999	1,991	2,000	1,970	1,968	1,986	1,992	1,985	1,992	**3,963**	**23,827**
2	Medical & Dental	1,171	1,251	1,215	1,221	1,216	1,235	1,235	1,235	1,235	1,238	1,250	1,258	**2,423**	**14,762**
3	Nursing & Midwifery Registered	863	912	899	911	918	948	949	954	969	969	984	984	**1,775**	**11,262**
4	Prof Scientific & Technical	240	249	248	250	250	266	274	274	286	289	293	294	**490**	**3,214**
5	Additional Clinical Services	596	627	605	605	605	621	629	629	639	641	649	651	**1,223**	**7,497**
6	Allied Health Professionals	583	612	596	597	596	611	611	611	614	614	614	614	**1,195**	**7,272**
7	Healthcare Scientists	753	791	764	765	764	783	791	797	800	800	809	815	**1,544**	**9,431**
8	Estates & Ancillary	182	194	192	207	218	223	223	223	223	225	225	225	**376**	**2,562**
9	Students	7	8	7	7	7	7	7	7	7	7	7	7	**15**	**86**
10	**TOTAL PAY EXPENDITURE**	**6,328**	**6,675**	**6,508**	**6,562**	**6,565**	**6,694**	**6,688**	**6,698**	**6,759**	**6,776**	**6,817**	**6,842**	**13,004**	**79,914**
	Analysis of Pay Expenditure														
11	**LHB Provided Services - Pay**	6,328	6,675	6,508	6,562	6,565	6,694	6,688	6,698	6,759	6,776	6,817	6,842	**13,003**	**79,913**
12	**Other Services (incl. Primary Care) - Pay**													**0**	**0**
13	**Total - Pay**	**6,328**	**6,675**	**6,508**	**6,562**	**6,565**	**6,694**	**6,688**	**6,698**	**6,759**	**6,776**	**6,817**	**6,842**	**13,003**	**79,913**
		0	0	0	0	0	0	0	0	0	0	0	0		

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	17	25	25	15	15	15	10	10	10	8	8	8	**42**	**166**
2	Medical & Dental	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
3	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
4	Prof Scientific & Technical	3	(5)	0	0	0	0	0	0	0	0	0	0	**(2)**	**(2)**
5	Additional Clinical Services	9	1	5	5	5	5	5	5	5	0	0	0	**10**	**45**
6	Allied Health Professionals	39	29	26	29	34	29	21	15	15	0	0	0	**68**	**237**
7	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
8	Estates & Ancillary	21	26	23	22	22	21	18	13	12	0	0	0	**46**	**177**
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
10	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**88**	**77**	**79**	**71**	**76**	**70**	**54**	**43**	**42**	**8**	**8**	**8**	**165**	**623**
11	**Agency/Locum (premium) % of pay**	**1.4%**	**1.1%**	**1.2%**	**1.1%**	**1.2%**	**1.0%**	**0.8%**	**0.6%**	**0.6%**	**0.1%**	**0.1%**	**0.1%**	**1.3%**	**0.8%**

C - Agency / Locum (premium) Expenditure - Analysed by Reason for Using Agency/Locum (premium)

REF	REASON	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Vacancy	21	29	29	19	19	19	14	14	14	8	8	8	**50**	**202**
2	Maternity/Paternity/Adoption Leave													**0**	**0**
3	Special Leave (Paid) – inc. compassionate leave, interview													**0**	**0**
4	Special Leave (Unpaid)													**0**	**0**
5	Study Leave/Examinations													**0**	**0**
6	Additional Activity (Winter Pressures/Site Pressures)	67	48	50	52	57	51	40	29	28	0	0	0	**114**	**421**
7	Annual Leave													**0**	**0**
8	Sickness													**0**	**0**
9	Restricted Duties													**0**	**0**
10	Jury Service													**0**	**0**
11	WLI													**0**	**0**
12	Exclusion (Suspension)													**0**	**0**
														0	**0**
13	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**88**	**77**	**79**	**71**	**76**	**70**	**54**	**43**	**42**	**8**	**8**	**8**	**165**	**623**
		0	0	0	0	0	0	0	0	0	0	0	0		

Velindre Trust

Period : May 23

This Table is currently showing 0 errors

Table B3 - COVID-19 Analysis

Health Promotion (including Testing, Tracing and Surveillance) - Additional costs due to C19

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	*Enter as positive values*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	**Health Protection (including Testing, Tracing and Surveillance) (Additional costs due to C19) enter as positive values - actual/forecast**														
2	**Provider Pay (Establishment, Temp & Agency)**														
3	Administrative, Clerical & Board Members													0	0
4	Medical & Dental													0	0
5	Nursing & Midwifery Registered													0	0
6	Prof Scientific & Technical													0	0
7	Additional Clinical Services													0	0
8	Allied Health Professionals													0	0
9	Healthcare Scientists													0	0
10	Estates & Ancillary													0	0
11	Students													0	
12	**Sub total Health Protection (including Testing, Tracing and Surveillance) Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Primary Care Contractor (excluding drugs)													0	0
14	Primary Care - Drugs													0	0
15	Secondary Care - Drugs													0	0
16	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A3** - **Complete Analysis to the Right**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Healthcare Services Provided by Other NHS Bodies													0	0
18	Non Healthcare Services Provided by Other NHS Bodies													0	0
19	Continuing Care and Funded Nursing Care													0	0
20	Other Private & Voluntary Sector													0	0
21	Joint Financing and Other (includes Local Authority)													0	0
22	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
23														0	0
24														0	0
25														0	0
26	**Sub total Health Protection (including Testing, Tracing and Surveillance) Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
27	**Total Health Protection (including Testing, Tracing and Surveillance)**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	**Planned Health Protection (including Testing, Tracing and Surveillance) (In Opening Plan)**													0	0
29	**Movement From Opening Planned Health Protection (including Testing, Tracing and Surveillance) Expenditure**	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Health Promotion (including Testing, Tracing and Surveillance) - Funding / Income

30	**Planned Funding**													0	0
31	**Actual/Forecast Funding for C19 Health Protection (including Testing, Tracing and Surveillance)**													0	0
32	**Internal Budget Virement into Covid-19 Health Protection (including Testing, Tracing and Surveillance) (incl pay awards)**													0	0
33	**Total Actual/Forecast Funding**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
34	**Movement from Plan**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35	**Actual/ Forecast Net Outturn - Health Protection (including Testing, Tracing and Surveillance)**	0	0	0	0	0	0	0	0	0	0	0	0	0	0

COVID-19 Vaccination Programme (immunisation)- Additional costs due to C19

A2	*COVID-19 Vaccination Programme ((immunisation) (Additional costs due to C19) enter as positive values - actual/forecast*														
30	**Provider Pay (Establishment, Temp & Agency)**														
31	Administrative, Clerical & Board Members													0	0
32	Medical & Dental													0	0
33	Nursing & Midwifery Registered													0	0
34	Prof Scientific & Technical													0	0
35	Additional Clinical Services													0	0
36	Allied Health Professionals													0	0
37	Healthcare Scientists													0	0
38	Estates & Ancillary													0	0
39	Students													0	0
40	**Sub total COVID-19 Vaccination (Immunisation) Programme Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
41	Primary Care Contractor (excluding drugs)													0	0
42	Primary Care - Drugs													0	0
43	Secondary Care - Drugs													0	0
44	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A3**													0	0
45	Healthcare Services Provided by Other NHS Bodies													0	0
46	Non Healthcare Services Provided by Other NHS Bodies													0	0
47	Continuing Care and Funded Nursing Care													0	0
48	Other Private & Voluntary Sector													0	0
49	Joint Financing and Other (includes Local Authority)													0	0
50	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
51														0	0
52														0	0
53														0	0
54	**Sub total COVID-19 Vaccination (Immunisation) Programme Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55	**Total COVID-19 Vaccination (Immunisation) Programme Expenditure**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
56	**Planned COVID-19 Vaccination (Immunisation) Expenditure (In Opening Plan)**													0	0
57	**Movement From Opening Planned COVID-19 Vaccination (Immunisation) Programme Expenditure**	0	0	0	0	0	0	0	0	0	0	0	0	0	0

COVID-19 Vaccination Programme (immunisation)- Funding/Income

58	**Planned Funding**													0	0

59	**Actual/Forecast Funding for COVID-19 Vaccination Programme (immunisation)**																	0	0
60	**Internal budget Virement into COVID-19 Vaccination Programme (immunisation) (incl pay awards)**																	0	0
61	**Total Actual/Forecast Funding**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
62	**Movement from Plan**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
63	**Actual / Forecast Net Outturn - COVID-19 Vaccination Programme (immunisation)**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Nosocomial, PPE, Long Covid & Other - Additional costs due to C19

A3	**Nosocomial, PPE, Long Covid & Other (Additional costs due to C19)** ***enter as positive value - actual/forecast***																		
64	**Provider Pay (Establishment, Temp & Agency)**																		
65	Administrative, Clerical & Board Members																	0	0
66	Medical & Dental																	0	0
67	Nursing & Midwifery Registered																	0	0
68	Prof Scientific & Technical																	0	0
69	Additional Clinical Services																	0	0
70	Allied Health Professionals																	0	0
71	Healthcare Scientists																	0	0
72	Estates & Ancillary																	0	0
73	Students																	0	0
74	Other (only use with WG Agreement & state SoCNE/I line ref)																	0	0
75																		0	0
76																		0	0
77																		0	0
78	**Sub total Other C-19 Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
79	Primary Care Contractor (excluding drugs)																	0	0
80	Do not Use																	0	0
81	Primary Care - Drugs																	0	0
82	Secondary Care - Drugs																	0	0
83	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see separate line**																	0	0
84	Provider - Non Pay - PPE	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
85	Healthcare Services Provided by Other NHS Bodies																	0	0
86	Non Healthcare Services Provided by Other NHS Bodies																	0	0
87	Continuing Care and Funded Nursing Care																	0	0
88	Other Private & Voluntary Sector																	0	0
89	Joint Financing and Other (includes Local Authority)																	0	0
90	Other (only use with WG Agreement & state SoCNE/I line ref)																	0	0
91																		0	0
92																		0	0
93																		0	0
94																		0	0
95																		0	0
96																		0	0
97																		0	0
98	**Sub total Other C-19 Non Pay**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
99	**Total Other C-19 Expenditure**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
100	**Planned Other C-19 Expenditure (In Opening Plan)**	20	20	20	20	20	20	20	20	20	20	20	20	40	240				
101	**Movement From Opening Planned Other C-19 Expenditure**	11	12	5	5	5	5	5	5	5	5	5	5	23	73				

Nosocomial, PPE, Long Covid & Other - Funding/Income

102	**Planned Funding**	20	20	20	20	20	20	20	20	20	20	20	20	40	240				
103	**Actual/Forecast Funding for C19 Nosocomial, PPE, Long Covid & Other**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
104	**Internal budget Virement into Covid-19 Nosocomial, PPE, Long Covid & Other - Additional costs due to C19 (incl pay awards)**													0	0				
105	**Total Actual/Forecast Funding**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
106	**Movement from Plan**	(11)	(12)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(23)	(73)				
107	**Actual / Forecast Net Outturn - Nosocomial, PPE, Long Covid & Other - Additional costs due to C19**	0	0	0	0	0	0	0	0	0	0	0	0	0	0				

Overall Covid-19 Position

108	**Total Planned COVID-19 Expenditure**	20	20	20	20	20	20	20	20	20	20	20	20	40	240				
109	**Total Actual/Forecast COVID-19 Expenditure**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
110	**Movement from Planned Expenditure**	11	12	5	5	5	5	5	5	5	5	5	5	23	73				
111	**Total Planned Funding**	20	20	20	20	20	20	20	20	20	20	20	20	40	240				
112	**Total Actual/Forecast COVID-19 Funding excluding Virements**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
113	**Total Actual/Forecast COVID-19 Virements**	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
114	**Total Actual/Forecast Funding**	9	8	15	15	15	15	15	15	15	15	15	15	17	167				
115	**Movement from Planned Funding**	(11)	(12)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(23)	(73)				
116	**Net Planned Position**	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
117	**Actual / Forecast Net Impact on overall Financial Position due to Covid-19**	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
118	**Net Movement from Plan**	0	0	0	0	0	0	0	0	0	0	0	0	0	0				

Velindre Trust

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Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Non Pay	Budget/Plan	14	14	14	78	78	78	78	78	78	78	78	78	28	740		168	572			
11		Actual/F'cast	14	10	12	46	46	46	85	85	85	85	85	140	24	740	3.22%	168	572	450	290	290
12		Variance	(0)	(4)	(2)	(32)	(32)	(32)	8	8	8	8	8	63	(4)	0	*(14.88%)*	0	0			
13	Pay	Budget/Plan	26	26	26	51	51	51	51	51	51	51	51	51	52	535		485	50			
14		Actual/F'cast	26	55	40	46	46	46	46	46	46	46	46	46	81	535	15.11%	485	50	300	235	235
15		Variance	0	29	15	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	29	0	*56.45%*	0	0			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	40	40	40	128	128	128	128	128	128	128	128	128	80	1,275		653	622			
20		Actual/F'cast	40	65	52	92	92	92	131	131	131	131	131	186	105	1,275	8.21%	653	622	750	525	525
21		Variance	(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0	*31.38%*	0	0			
22	Variance in month		(0.21%)	62.97%	31.38%	(28.52%)	(28.52%)	(28.52%)	2.25%	2.25%	2.25%	2.25%	2.25%	45.09%	31.38%							
23	In month achievement against FY forecast		3.12%	5.09%	4.10%	7.20%	7.20%	7.20%	10.30%	10.30%	10.30%	10.30%	10.30%	14.61%								

Velindre Trust

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Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan	5	5	5	11	11	11	11	11	11	11	11	11	10	110		60	50			
2		Actual/F'cast	5	5	5	11	11	11	11	11	11	11	11	11	10	110	9.09%	60	50	0	110	110
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
4	Variable Pay	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	15	15	15	15	15	15	15	15	15	15	15	15	29	175		175	0			
11		Actual/F'cast	15	15	15	15	15	15	15	15	15	15	15	15	29	175	16.67%	175	0	50	125	125

12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
13		Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14	Changes in Bank Staff	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16		Budget/Plan	6	6	6	26	26	26	26	26	26	26	26	26	13	250		250	0			
17	Other (Please Specify)	Actual/F'cast	6	35	21	21	21	21	21	21	21	21	21	21	42	250	16.67%	250	0	250	0	0
18		Variance	0	29	15	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	29	0	*233.33%*	0	0			
19		Budget/Plan	26	26	26	51	51	51	51	51	51	51	51	51	52	535		485	50			
20	Total	Actual/F'cast	26	55	40	46	46	46	46	46	46	46	46	46	81	535	15.11%	485	50	300	235	235
21		Variance	0	29	15	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	29	0	*56.45%*	0	0			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of	Budget/Plan		15	15	15	15	15	15	15	15	15	15	15	15	29	175		175	0			
2	Agency/Locums paid at a	Actual/F'cast		15	15	15	15	15	15	15	15	15	15	15	15	29	175	16.67%	175	0	50	125	125
3	premium	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
4		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5	Non Medical 'off contract'	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6	to 'on contract'	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8	Medical - Impact of	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9	Agency pay rate caps	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11	Other (Please Specify)	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13		Budget/Plan		15	15	15	15	15	15	15	15	15	15	15	15	29	175		175	0			
14	Total	Actual/F'cast		15	15	15	15	15	15	15	15	15	15	15	15	29	175	16.67%	175	0	50	125	125
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			

Table C3- Savings Schemes SoCNE/SCNI Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
1		Budget/Plan		26	26	26	51	51	51	51	51	51	51	51	51	52	535
2	Pay	Actual/F'cast		26	55	40	46	46	46	46	46	46	46	46	46	81	535
3		Variance		0	29	15	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	29	0
4		Budget/Plan		14	14	14	78	78	78	78	78	78	78	78	78	28	740
5	Non Pay	Actual/F'cast		14	10	12	46	46	46	85	85	85	85	85	140	24	740
6		Variance		(0)	(4)	(2)	(32)	(32)	(32)	8	8	8	8	8	63	(4)	0
7		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Primary Care Drugs	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Secondary Care Drugs	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	CHC/FNC	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
13		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Primary Care Contractor	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Healthcare Services	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Provided by Other NHS	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Bodies	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Non Healthcare Services	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Provided by Other NHS	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Bodies	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Other Private &	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
23	Voluntary Sector	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
24		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
25		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Joint Financing & Other	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
27		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
28		Budget/Plan		40	40	40	128	128	128	128	128	128	128	128	128	80	1,275
29	Total	Actual/F'cast		40	65	52	92	92	92	131	131	131	131	131	186	105	1,275
30		Variance		(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0

Velindre Trust

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This Table is currently showing 7 errors

Table C4 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	40	40	40	128	128	128	128	128	128	128	128	128	80	1,275	750	525	0	525
	Month 1 - Actual/Forecast	40	65	52	92	92	92	131	131	131	131	131	186	105	1,275	750	525	0	525
	Variance	(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	40	40	40	128	128	128	128	128	128	128	128	128	80	1,275	750	525	0	525
	Total Actual/Forecast	40	65	52	92	92	92	131	131	131	131	131	186	105	1,275	750	525	0	525
	Total Variance	(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0	0	0	0	0
Net Income Generation	Month 1 - Plan	44	44	44	44	44	44	44	44	44	44	44	44	88	525	50	475	0	475
	Month 1 - Actual/Forecast	44	44	44	44	44	44	44	44	44	44	44	44	88	525	50	475	0	475
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	44	44	44	44	44	44	44	44	44	44	44	44	88	525	50	475	0	475
	Total Actual/Forecast	44	44	44	44	44	44	44	44	44	44	44	44	88	525	50	475	0	475
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	84	84	84	172	172	172	172	172	172	172	172	172	167	1,800	800	1,000	0	1,000
	Month 1 - Actual/Forecast	84	109	96	136	136	136	175	175	175	175	175	230	192	1,800	800	1,000	0	1,000
	Variance	(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	84	84	84	172	172	172	172	172	172	172	172	172	167	1,800	800	1,000	0	1,000
	Total Actual/Forecast	84	109	96	136	136	136	175	175	175	175	175	230	192	1,800	800	1,000	0	1,000
	Total Variance	(0)	25	13	(37)	(37)	(37)	3	3	3	3	3	58	25	0	0	0	0	0

Velindre Trust

Period : May 23

Table D - Income/Expenditure Assumptions

Annual Forecast

	LHB/Trust	Contracted Income	Non Contracted Income	Total Income	Contracted Expenditure	Non Contracted Expenditure	Total Expenditure
		£'000	£'000	£'000	£'000	£'000	£'000
1	Swansea Bay University		51,982	**51,982**		5,055	**5,055**
2	Aneurin Bevan University		78,800	**78,800**		9,289	**9,289**
3	Betsi Cadwaladr University		53,808	**53,808**		7,650	**7,650**
4	Cardiff & Vale University	25,114	70,438	**95,552**		5,173	**5,173**
5	Cwm Taf Morgannwg University	10,453	52,607	**63,060**		10,165	**10,165**
6	Hywel Dda University	15,025	13,587	**28,612**		5,336	**5,336**
7	Powys		3,334	**3,334**		1,275	**1,275**
8	Public Health Wales		8,686	**8,686**		398	**398**
9	Velindre			**0**			**0**
10	NWSSP			**0**			**0**
11	DHCW		1,520	**1,520**		4,874	**4,874**
12	Wales Ambulance Services		2,275	**2,275**		1,080	**1,080**
13	WHSSC	53,007	55	**53,062**		600	**600**
14	EASC			**0**			**0**
15	HEIW		56,494	**56,494**		14	**14**
16	NHS Executive			**0**			**0**
17	**Total**	**103,599**	**393,586**	**497,185**	**0**	**50,909**	**50,909**

Velindre Trust

This Table is currently showing 0 errors

Period : May 23

Table E - Resource Limits

1. BASE ALLOCATION

		STATUS OF ISSUED RESOURCE LIMIT ITEMS				Total Revenue Resource Limit	Recurring (R) or Non Recurring	Total Revenue Drawing Limit	Total Capital Resource Limit	Total Capital Drawing Limit	WG Contact and Date Item First Entered Into
		HCHS	Pharmacy	Dental	GMS						
		£'000	£'000	£'000	£'000	£'000	(NR)	£'000	£'000	£'000	Table
1	LATEST ALLOCATION LETTER/SCHEDULE REF:										
2	Total Confirmed Funding					0					

2. ANTICIPATED ALLOCATIONS

3	DEL Non Cash Depreciation - Baseline Surplus / Shortfall					0					
4	DEL Non Cash Depreciation - Strategic					0					
5	DEL Non Cash Depreciation - Accelerated					0					
6	DEL Non Cash Depreciation - Impairment					0					
7	DEL Non Cash Depreciation - IFRS 16 Leases					0					
8	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)					0					
9	AME Non Cash Depreciation - Donated Assets					0					
10	AME Non Cash Depreciation - Impairment					0					
11	AME Non Cash Depreciation - Impairment Reversals					0					
12	Removal of Donated Assets / Government Grant Receipts					0					
13	Total COVID-19 (see below analysis)	0	0	0	0	0					See below analysis
14	Removal of IFRS-16 Leases (Revenue)					0					
15	Real Living Wage (Care Homes)					0					
16						0					
17						0					
18						0					
19						0					
20						0					
21						0					
22						0					
23						0					
24						0					
25						0					
26						0					
27						0					
28						0					
29						0					
30						0					
31						0					
32						0					
33						0					
34						0					
35						0					
36						0					
37						0					
38						0					
39						0					
40						0					
41						0					
42						0					
43						0					
44						0					
45						0					
46						0					
47						0					
48						0					
49						0					
50						0					
51						0					
52						0					
53						0					
54						0					
55						0					
56						0					
57						0					
58						0					
59						0					
60	Revenue Working Balances Request					0					
61	Capital Working Balances Request					0					
62	Capital IFRS16 Leases Working Balances Request					0					
63	**Total Anticipated Funding**	0	0	0	0	0		0	0	0	

3. TOTAL RESOURCES & BUDGET RECONCILIATION

64	Confirmed Resources Per 1. above	0	0	0	0	0		0	0	0
65	Anticipated Resources Per 2. above	0	0	0	0	0		0	0	0
66	**Total Resources**	0	0	0	0	0		0	0	0

ANALYSIS OF WG FUNDING FOR COVID-19 INCLUDED ABOVE

		Allocated Total £'000	Anticipated HCHS £'000	Anticipated Pharmacy £'000	Anticipated Dental £'000	Anticipated GMS £'000	Total RRL £'000	WG Contact and date item first entered into table.
67	Health Protection (including Testing, Tracing and Surveillance)						0	
68	COVID-19 Vaccination (Immunisation) Programme						0	
69	PPE						0	
70	Long Covid						0	
71	Nosocomial						0	
72							0	
73							0	
74							0	
75							0	
76							0	
77							0	
78							0	
79							0	
80							0	
81							0	
82							0	
83							0	
84							0	
85							0	
86							0	
87							0	
88							0	
89							0	
90							0	
91							0	
92							0	
93							0	
94							0	
95							0	
96							0	
97	**Total Funding**	0	0	0	0	0	0	

Velindre Trust

Period : **May 23**

This Table is currently showing 0 errors

Table E1 - Invoiced Income Streams - TRUSTS ONLY

Ref		Swansea Bay ULHB	Aneurin Bevan ULHB	Betsi Cadwaladr ULHB	Cardiff & Vale ULHB	Cwm Taf Morgannwg ULHB	Hywel Dda ULHB	Powys LHB	Public Health Wales NHS Trust	Welsh Ambulance NHS Trust	Velindre NHS Trust	NWSSP	DHCW	HEIW	WG	EASC	WHSSC	Other (please specify)	Total	WG Contact, date item first entered into table and whether any invoice has been raised.
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1	**Agreed full year income**	5,524	34,844	3,083	33,441	24,180	3,786	1,756	1,156	30	0	0	406	1,313	6,959		59,452	14,543	**190,475**	
	Details of Anticipated Income																			
2	DEL Non Cash Depreciation - Baseline Surplus / Shortfall														0				**0**	Gary Young M1
3	DEL Non Cash Depreciation - Strategic														0				**0**	
4	DEL Non Cash Depreciation - Accelerated																		**0**	
5	DEL Non Cash Depreciation - Impairment																		**0**	
6	DEL Non Cash Depreciation - IFRS 16 Leases														231				**231**	Gary Young M1
7	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)																		**0**	
8	AME Non Cash Depreciation - Donated Assets														213				**213**	Jackie Salmon M1
9	AME Non Cash Depreciation - Impairment																		**0**	
10	AME Non Cash Depreciation - Impairment Reversals																		**0**	
11	Total COVID-19 (see below analysis)														167				**167**	See below analysis
12	Removal of IFRS-16 Leases (Revenue)														233				**233**	Gary Young m1
13	Real Living Wage (Care Homes)																		**0**	
14	VBHC														1,107				**1,107**	Ruchard Dudley M1
15	WRP														(262)				**(262)**	Andrea Hughes M1
16	1.5% consilidated Pay Award recurernt funding														1,178				**1,178**	Gwen Kohler M1
17	Covid Recovery non-consolidated payment																		**0**	
18	5% 2023/24 pay award funding																		**0**	
19																			**0**	
20																			**0**	
21																			**0**	
22																			**0**	
23																			**0**	
24																			**0**	
25																			**0**	
26																			**0**	
27																			**0**	
28																			**0**	
29																			**0**	
30																			**0**	
31																			**0**	
32																			**0**	
33																			**0**	
34																			**0**	
35																			**0**	
36																			**0**	
37	**Total Income**	**5,524**	**34,844**	**3,083**	**33,441**	**24,180**	**3,786**	**1,756**	**1,156**	**30**	**0**	**0**	**406**	**1,313**	**9,826**	**0**	**59,452**	**14,543**	**193,342**	

	ANALYSIS OF WG FUNDING DUE FOR COVID-19 INCLUDED ABOVE	**Allocated** £'000	**Anticipated** £'000	**Total** £'000	**WG Contact, date item first entered into table and whether any invoice has been raised.**
38	Health Protection (including Testing, Tracing and Surveillance)			**0**	
39	COVID-19 Vaccination (Immunisation) Programme			**0**	
40	PPE	0	167	**167**	Richard Dudley Month 2 not raised
41	Long Covid			**0**	

42				0
43				0
44				0
45				0
46				0
47				0
48				0
49				0
50				0
51				0
52				0
53				0
54				0
55				0
56				0
57				0
58				0
59				0
60				0
61				0
62				0
63				0
64				0
65				0
66				0
67				0
68	Total Funding	0	167	167

Velindre Trust **Period :** **May 23**

This table needs completing monthly from Month: 3
This Table is currently showing 0 errors

	Table F - Statement of Financial Position For Monthly Period	Opening Balance Beginning of Apr 23	Closing Balance End of May 23	Forecast Closing Balance End of Mar 24
	Non-Current Assets	**£'000**	**£'000**	**£'000**
1	Property, plant and equipment			
2	Intangible assets			
3	Trade and other receivables			
4	Other financial assets			
5	**Non-Current Assets sub total**	**0**	**0**	**0**
	Current Assets			
6	Inventories			
7	Trade and other receivables			
8	Other financial assets			
9	Cash and cash equivalents			
10	Non-current assets classified as held for sale			
11	**Current Assets sub total**	**0**	**0**	**0**
12	**TOTAL ASSETS**	**0**	**0**	**0**
	Current Liabilities			
13	Trade and other payables			
14	Borrowings (Trust Only)			
15	Other financial liabilities			
16	Provisions			
17	**Current Liabilities sub total**	**0**	**0**	**0**
18	**NET ASSETS LESS CURRENT LIABILITIES**	**0**	**0**	**0**
	Non-Current Liabilities			
19	Trade and other payables			
20	Borrowings (Trust Only)			
21	Other financial liabilities			
22	Provisions			
23	**Non-Current Liabilities sub total**	**0**	**0**	**0**
24	**TOTAL ASSETS EMPLOYED**	**0**	**0**	**0**
	FINANCED BY: **Taxpayers' Equity**			
25	General Fund			
26	Revaluation Reserve			
27	PDC (Trust only)			
28	Retained earnings (Trust Only)			
29	Other reserve			
30	**Total Taxpayers' Equity**	**0**	**0**	**0**

	EXPLANATION OF ALL PROVISIONS	Opening Balance Beginning of Apr 23	Closing Balance End of May 23	Closing Balance End of Mar 24
31				
32				
33				
34				
35				
36				
37				
38				
39				
40	**Total Provisions**	**0**	**0**	**0**

	ANALYSIS OF WELSH NHS RECEIVABLES (current month)	£'000
41	Welsh NHS Receivables Aged 0 - 10 weeks	0
42	Welsh NHS Receivables Aged 11 - 16 weeks	0
43	Welsh NHS Receivables Aged 17 weeks and over	0

	ANALYSIS OF TRADE & OTHER PAYABLES (opening, current & closing)	£'000	£'000	£'000
44	Capital	0	0	0
45	Revenue	0	0	0

	ANALYSIS OF CASH (opening, current & closing)	£'000	£'000	£'000
46	Capital	0	0	0
47	Revenue	0	0	0

Velindre Trust

Period : May 23

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only													0
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only													0
3	WG Revenue Funding - Other (e.g. invoices)													0
4	WG Capital Funding - Cash Limit - LHB & SHA only													0
5	Income from other Welsh NHS Organisations													0
6	Short Term Loans - Trust only													0
7	PDC - Trust only													0
8	Interest Receivable - Trust only													0
9	Sale of Assets													0
10	Other - (Specify in narrative)													0
11	TOTAL RECEIPTS	0	0	0	0	0	0	0	0	0	0	0	0	0
	PAYMENTS													
12	Primary Care Services : General Medical Services													0
13	Primary Care Services : Pharmacy Services													0
14	Primary Care Services : Prescribed Drugs & Appliances													0
15	Primary Care Services : General Dental Services													0
16	Non Cash Limited Payments													0
17	Salaries and Wages													0
18	Non Pay Expenditure													0
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only													0
21	Capital Payment													0
22	Other items (Specify in narrative)													0
23	TOTAL PAYMENTS	0	0	0	0	0	0	0	0	0	0	0	0	0
24	Net cash inflow/outflow	0	0	0	0	0	0	0	0	0	0	0	0	
25	Balance b/f		0	0	0	0	0	0	0	0	0	0	0	
26	Balance c/f	0	0	0	0	0	0	0	0	0	0	0	0	

Velindre Trust

Period : May 23

This table needs completing on a quarterly basis

Table H - PSPP

NOTE: Data to 1 decimal place

30 DAY COMPLIANCE

	PROMPT PAYMENT OF INVOICE PERFORMANCE	Target %	ACTUAL Q1 Actual %	ACTUAL Q1 Variance %	ACTUAL Q2 Actual %	ACTUAL Q2 Variance %	ACTUAL Q3 Actual %	ACTUAL Q3 Variance %	ACTUAL Q4 Actual %	ACTUAL Q4 Variance %	YEAR TO DATE Actual %	YEAR TO DATE Variance %	FORECAST YEAR END Forecast %	FORECAST YEAR END Variance %
1	% of NHS Invoices Paid Within 30 Days - By Value	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
2	% of NHS Invoices Paid Within 30 Days - By Number	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
3	% of Non NHS Invoices Paid Within 30 Days - By Value	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
4	% of Non NHS Invoices Paid Within 30 Days - By Number	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%

10 DAY COMPLIANCE

	PROMPT PAYMENT OF INVOICE PERFORMANCE		ACTUAL Q1 Actual %	ACTUAL Q1	ACTUAL Q2 Actual %	ACTUAL Q2	ACTUAL Q3 Actual %	ACTUAL Q3	ACTUAL Q4 Actual %	ACTUAL Q4	YEAR TO DATE Actual %	YEAR TO DATE	FORECAST YEAR END Actual %	FORECAST YEAR END
5	% of NHS Invoices Paid Within 10 Days - By Value													
6	% of NHS Invoices Paid Within 10 Days - By Number													
7	% of Non NHS Invoices Paid Within 10 Days - By Value													
8	% of Non NHS Invoices Paid Within 10 Days - By Number													

Velindre Trust

Period : May 23

This Table is currently showing 0 errors

Table I - 2023-24 Capital Resource / Expenditure Limit Management

£'000	
Approved CRL / CEL issued at :	

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	F'cast £'000	Variance £'000
	Gross expenditure						
	All Wales Capital Programme:						
	Schemes:						
1				0			0
2				0			0
3				0			0
4				0			0
5				0			0
6				0			0
7				0			0
8				0			0
9				0			0
10				0			0
11				0			0
12				0			0
13				0			0
14				0			0
15				0			0
16				0			0
17				0			0
18				0			0
19				0			0
20				0			0
21				0			0
22				0			0
23				0			0
24				0			0
25				0			0
26				0			0
27				0			0
28				0			0
29				0			0
30				0			0
31				0			0
32				0			0
33				0			0
34				0			0
35				0			0
36				0			0
37				0			0
38				0			0
39				0			0
40				0			0
41				0			0
42	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
	Discretionary:						
43	I.T.			0			0
44	Equipment			0			0
45	Statutory Compliance			0			0

46	Estates			0			0
47	Other			0			0
48	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
	Other (Including IFRS 16 Leases) Schemes:						
49				0			0
50				0			0
51				0			0
52				0			0
53				0			0
54				0			0
55				0			0
56				0			0
57				0			0
58				0			0
59				0			0
60				0			0
61				0			0
62				0			0
63				0			0
64				0			0
65				0			0
66				0			0
67				0			0
68				0			0
69	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
70	**Total Expenditure**	**0**	**0**	**0**	**0**	**0**	**0**
	Less:						
	Capital grants & Capital AME (e.g. dilapidations):						
71				0			0
72				0			0
73				0			0
74				0			0
75				0			0
76	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
	Donations:						
77				0			0
78	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
	Asset Disposals:						
79				0			0
80				0			0
81				0			0
82				0			0
83				0			0
84				0			0
85				0			0
86				0			0
87				0			0
88				0			0
89				0			0
90	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
91	***Technical Adjustments***			**0**			**0**
92	**CHARGE AGAINST CRL / CEL**	**0**	**0**	**0**	**0**	**0**	**0**
93	**PERFORMANCE AGAINST CRL / CEL (Under)/Over**		**0**			**0**	

Velindre Trust

Period : May 23

YTD Months to be completed from Month: 2
Forecast Months to be completed from Month: 2

This Table is currently showing 1 errors Check validations at cell X1

Table J - In Year Capital Scheme Profiles

Ref:	All Wales Capital Programme: Schemes:	Project Manager	In Year Forecast Min. £'000	In Year Forecast Max. £'000	Capital Expenditure Monthly Profile April £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	YTD £'000	Total £'000	Risk Level
1																	0	0	
2																	0	0	
3																	0	0	
4																	0	0	
5																	0	0	
6																	0	0	
7																	0	0	
8																	0	0	
9																	0	0	
10																	0	0	
11																	0	0	
12																	0	0	
13																	0	0	
14																	0	0	
15																	0	0	
16																	0	0	
17																	0	0	
18																	0	0	
19																	0	0	
20																	0	0	
21																	0	0	
22																	0	0	
23																	0	0	
24																	0	0	
25																	0	0	
26																	0	0	
27																	0	0	
28																	0	0	
29																	0	0	
30																	0	0	
31																	0	0	
32																	0	0	
33																	0	0	
34	Sub Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Discretionary:																		
35	I.T.																0	0	
36	Equipment																0	0	
37	Statutory Compliance																0	0	
38	Estates																0	0	
39	Other																0	0	
40	Sub Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Other Schemes (Including IFRS 16 Leases):																		
41																	0	0	
42																	0	0	
43																	0	0	
44																	0	0	
45																	0	0	
46																	0	0	
47																	0	0	
48																	0	0	
49																	0	0	
50																	0	0	
51																	0	0	
52																	0	0	
53																	0	0	
54																	0	0	
55																	0	0	
56																	0	0	
57																	0	0	
58																	0	0	
59																	0	0	
60																	0	0	
61	Sub Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
62	Total Capital Expenditure		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Velindre Trust

Period : May 23

Table K - Capital Disposals

This Table is currently showing 0 errors

A: In Year Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 23)	MM/YY (text format, e.g. Apr 23)	MM/YY (text format, e.g. Feb 24)	£'000	£'000	£'000	£'000	
1								0	
2								0	
3								0	
4								0	
5								0	
6								0	
7								0	
8								0	
9								0	
10								0	
11								0	
12								0	
13								0	
14								0	
15								0	
16								0	
17								0	
18								0	
19								0	
	Total for in-year				0	0	0	0	

B: Future Years Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. April 24	MM/YY (text format, e.g. April 24)	MM/YY (text format, e.g. Feb 25)	£'000	£'000	£'000	£'000	
20								0	
21								0	
22								0	
23								0	
24								0	
25								0	
26								0	
27								0	
28								0	
29								0	
30								0	
31								0	
32								0	
33								0	
34								0	
35								0	
36								0	
37								0	
38								0	
	Total for future years				0	0	0	0	

Velindre Trust

Period : May 23

This Table is currently showing 0 errors
This table needs completing monthly from Month: 3

Table L: EXTERNAL FINANCING LIMIT

REF	*NET FINANCIAL CHANGE*	Full Year Per WG £'000 A	Full Year Per Trust £'000 B	Planning Variance £'000 C	Actual to date £'000 D
1	Retained surplus/(deficit) for period			0	
2	Depreciation			0	
3	Depreciation on Donated Assets			0	
4	DEL and AME Impairments			0	
5	Net gain/loss on disposal of assets			0	
6	Profit/loss on sale term of disc ops			0	
7	Proceeds of Capital Disposals			0	
8	Other Income (specify)			0	
9	***APPLICATION OF FUNDS***				
10	Capital Expenditure			0	
11	Other Expenditure/ IFRS 16 Lease Payments Exc. Interest & VAT (ROU)			0	
	MOVEMENTS IN WORKING CAPITAL				
12	Inventories			0	
13	Current assets - Trade and other receivables			0	
14	Current liabilities - Trade and other payables			0	
15	Non current liabilities - Trade and other payables			0	
16	Provisions			0	
17	Sub total - movement in working capital	**0**	**0**	**0**	**0**
18	**NET FINANCIAL CHANGE**	**0**	**0**	**0**	**0**
	EFL REQUIREMENT TO BE MET BY				
19	Increase in Public Dividend Capital			0	
20	Net change in temporary borrowing			0	
21	Change in bank deposits and interest bearing securities			0	
22	Net change in finance lease payables			0	
23	**TOTAL EXTERNAL FINANCE**	**0**	**0**	**0**	**0**

Velindre Trust

Table M - Debtors Schedule

	11 weeks before end of May 23 =	**Period:**	**May 23**
	17 weeks before end of May 23 =	15 March 2023 01 February 2023	

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD	1120707	16/02/23	£80.00	£80.00	Yes, valid entry for period	80.00		15 June 2023	06/06/2023 - AP has forwarded a request for authorisation
SWANSEA BAY UNIVERSITY HEALTHBOARD	1120708	16/02/23	£80.00	£80.00	Yes, valid entry for period	80.00		15 June 2023	13/06/2023 - Hamid still looking at to resolve why still outstanding - it seem credit notes (whic
SWANSEA BAY UNIVERSITY HEALTHBOARD	2016811	16/02/23	(£96.00)	(£96.00)	Yes, valid entry for period	-96.00		15 June 2023	13/06/2023 - Hamid still looking at to resolve why still outstanding - it seem credit notes (whic
SWANSEA BAY UNIVERSITY HEALTHBOARD	2016812	16/02/23	(£96.00)	(£96.00)	Yes, valid entry for period	-96.00		15 June 2023	13/06/2023 - Hamid still looking at to resolve why still outstanding - it seem credit notes (whic
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121092	27/02/23	£12,102.17	£12,102.17	Yes, valid entry for period	12,102.17		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121093	27/02/23	£12,804.52	£12,804.52	Yes, valid entry for period	12,804.52		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121094	27/02/23	£29.65	£29.65	Yes, valid entry for period	29.65		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121095	27/02/23	£846.00	£846.00	Yes, valid entry for period	846.00		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121096	27/02/23	£338.40	£338.40	Yes, valid entry for period	338.40		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
CWM TAF MORGANNWG UNIVERSITY HEALTHBOARD	1121100	27/02/23	£23,856.00	£23,856.00	Yes, valid entry for period	23,856.00		26 June 2023	08/06/2023 - copy invoice to Kate Fletcher & Elaine Williams with assurances to get authorise
			49,744.74	49,744.74		49,744.74	0.00		

Invoices paid since the end of the month		
Total outstanding as per MR submission date	**49,744.74**	**0.00**

Velindre Trust Period : May 23

Table N - General Medical Services This Table is currently showing 0 errors
Table to be completed from Q2 / Month: 6

Operating Expenditure - ring fenced GMS budget

SUMMARY OF GENERAL MEDICAL SERVICES FINANCIAL POSITION		LINE NO.	WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
Global Sum		1					
Practice support payment		2					
Total Global Sum and MPIG		3				0	0
QAIF Aspiration Payments		4					
QAIF Achievement Payments		5					
QAIF - Access Achievement Payments		6					
Total Quality		7				0	0
Direct Enhanced Services	(To equal data in Section A (i) Line 31)	8				0	
National Enhanced Services	(To equal data in Section A (ii) Line 41)	9				0	
Local Enhanced Services	(To equal data in Section A (iii) Line 94)	10				0	
Total Enhanced Services	**(To equal data in section A Line 95)**	11		0	0	0	0
LHB Administered	(To equal data in Section B Line 109)	12				0	
Premises	(To equal data in section C Line 138)	13				0	
IM & T		14				0	
Out of Hours	(including OOHDF)	15				0	
Dispensing	(To equal data in Line 154)	16				0	
Total		17	0	0	0	0	0

SUPPLEMENTARY INFORMATION

Directed Enhanced Services *Section A (i)*	LINE NO.	£000's	£000's	£000's	£000's	£000's
Learning Disabilities	18				0	
Childhood Immunisation Scheme	19				0	
Mental Health	20				0	
Influenza & Pneumococcal Immunisations Scheme	21				0	
Services for Violent Patients	22				0	
Minor Surgery Fees	23				0	
MENU of Agreed DES						
Asylum Seekers & Refugees	24				0	
Care of Diabetes	25				0	
Care Homes	26				0	
Extended Surgery Opening	27				0	
Gender Identity	28				0	
Homeless	29				0	
Oral Anticoagulation with Warfarin	30				0	
TOTAL Directed Enhanced Services (must equal line 8)	31		0	0	0	0

National Enhanced Services *A (ii)*	LINE NO.	£000's	£000's	£000's	£000's	£000's
INR Monitoring	32				0	
Shared care drug monitoring (Near Patient Testing)	33				0	
Drug Misuse	34				0	
IUCD	35				0	
Alcohol misuse	36				0	
Depression	37				0	
Minor injury services	38				0	
Diabetes	39				0	
Services to the homeless	40				0	
TOTAL National Enhanced Services (must equal line 9)	41		0	0	0	0

Local Enhanced Services *A (iii)*	LINE NO.	£000's	£000's	£000's	£000's	£000's
ADHD	42				0	
Asylum Seekers & Refugees	43				0	
Cardiology	44				0	
Care Homes	45				0	
Care of Diabetes	46				0	
Chiropody	47				0	
Counselling	48				0	
Depo - Provera (including Implanon & Nexplanon)	49				0	
Dermatology	50				0	
Dietetics	51				0	
DOAC/NOAC	52				0	
Drugs Misuse	53				0	
Extended Minor Surgery	54				0	
Gonaderlins	55				0	
Homeless	56				0	
HPV Vaccinations	57				0	
Immunisations (inc Pertussis excluding DES - Childhood Imm & Influenza & Pneumococcal Imm	58				0	
Learning Disabilities	59				0	
Lithium / INR Monitoring	60				0	
Local Development Schemes	61				0	
Mental Health	62				0	
Minor Injuries	63				0	
MMR	64				0	
Multiple Sclerosis	65				0	
Muscular Skeletal	66				0	
Nursing Homes	67				0	
Orthopaedic (Upper Limb GPwSi/Clinical Assessments)	68				0	
Osteopathy	69				0	
Phlebotomy	70				0	
Physiotherapy (inc MT3)	71				0	
Referral Management	72				0	

Respiratory (inc COPD)	73				0	
Ring Pessaries	74				0	
Sexual Health Services	75				0	
Shared Care	76				0	
Smoking Cessation	77				0	
Substance Misuse	78				0	
Suturing	79				0	
Swine Flu	80				0	
Transport/Ambulance costs	81				0	
Vasectomy	82				0	
Weight Loss Clinic (inc Exercise Referral)	83				0	
Wound Care	84				0	
Zoladex	85				0	
	86				0	
	87				0	
	88				0	
	89				0	
	90				0	
	91				0	
	92				0	
	93				0	
TOTAL Local Enhanced Services (must equal line 10)	94		0	0	0	0

TOTAL Enhanced Services (must equal line 11)	95		0	0	0	0

GENERAL MEDICAL SERVICES
Operating Expenditure

		WG Allocation	Current Plan	Forecast Outturn	Variance	Year to Date
LHB Administered ***Section B***	**LINE NO.**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Seniority	96					
Doctors Retention Scheme Payments	97					
Locum Allowances consists of adoptive, paternity & maternity	98					
Locum Allowances : Cover for Sick Leave	99					
Locum Allowances : Cover For Suspended Doctors	100					
Prolonged Study Leave	101					
Recruitment and Retention (including Golden Hello)	102					
Appraisal - Appraiser Costs	103					
Primary Care Development Scheme	104					
Partnership Premium - GP partners	105					
Partnership Premium - Non GP Partners	106					
Supply of syringes & needles	107					
Other (please provide detail below, this should reconcile to line 128)	108					
TOTAL LHB Administered (must equal line 12)	109				0	0

Analysis of Other Payments (line 108)	**LINE NO.**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Additional Managed Practice costs **(costs in excess of Global Sum/MPIG)**	110					
CRB checks	111					
GP Locum payments	112					
LHB Locality group costs	113					
Managing Practice costs **(LHB employed staff working in GP practices to improve GP services)**	114					
Primary Care Initiatives	115					
Salaried GP costs	116					
Stationery & Distribution	117					
Training	118					
Translation fees	119					
COVID vaccination payments to GP practices	120					
	121					
	122					
	123					
	124					
	125					
	126					
	127					
TOTAL of Other Payments (must equal line 108)	128					0

Premises ***Section C***	**LINE NO.**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Notional Rents	129					
Actual Rents: Health Centres	130					
Actual Rents: Others	131					
Cost Rent	132					
Clinical Waste/ Trade Refuse	133					
Rates, Water, sewerage etc	134					
Health Centre Charges	135					
Improvement Grants	136					
All other Premises (please detail below which should reconcile to line 146)	137					
TOTAL Premises (must equal line 13)	138				0	0

Analysis of Other Premises (Line 137)	**LINE NO.**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
	139					
	140					
	141					
	142					
	143					
	144					
	145					
TOTAL of Other Premises (must equal line 137)	146					0

Memorandum item

Enhanced Services included above but in dispute with LMC (TOTAL)	147					
Enhanced Services included above but not yet formally agreed LMC	148					

GENERAL MEDICAL SERVICES
Dispensing

Dispensing Data	LINE NO.	WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
Cost of Drugs and Appliances, after discounts and plus container allowance (and plus VAT where applicable)						
Dispensing Doctors	149					
Prescribing Medical Practitioners - Personal Administration	150					
Dispensing Service Quality Payment	151					
Professional Fees and on-cost						
Dispensing Doctors	152					
Prescribing Medical Practitioners - Personal Administration	153					
TOTAL DISPENSING DATA (must equal line 16)	154				0	0

Velindre Trust

Period : **May 23**

Table O - General Dental Services

This Table is currently showing 0 errors

Table to be completed from Q2 / Month: **6**

Operating Expenditure from the revenue allocation for the dental contract

SUMMARY OF DENTAL SERVICES FINANCIAL POSITION		WG Allocation	Current Plan	Forecast Outturn	Variance	Year to Date
Expenditure / activities included in a GDS contract and / or PDS agreement	**LINE NO.**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Gross Contract Value - Personal Dental Services	1				0	
Gross Contract Value - General Dental Services	2				0	
Emergency Dental Services (inc Out of Hours)	3				0	
Additional Access	4				0	
Business Rates	5				0	
Domiciliary Services	6				0	
Maternity/Sickness etc.	7				0	
Sedation services including GA	8				0	
Seniority payments	9				0	
Employer's Superannuation	10				0	
Oral surgery	11				0	
OTHER **(PLEASE DETAIL BELOW)**	12				0	
TOTAL DENTAL SERVICES EXPENDITURE	13		0	0	0	0

OTHER (PLEASE DETAIL BELOW) - Activities / expenditure not included in a GDS contract and / or PDS agreement. This includes payments made under other arrangements e.g. GA under an SLA and D2S, plus other or one off payments such as dental nurse training	**LINE NO.**		**£000's**	**£000's**	**£000's**	**£000's**
Emergency Dental Services (inc Out of Hours)	14					
Additional Access	15					
Sedation services including GA	16					
Continuing professional development	17					
Occupational Health / Hepatitis B	18					
Gwen Am Byth - Oral Health in care homes	19					
Refund of patient charges	20					
Design to Smile	21					
Other Community Dental Services	22					
Dental Foundation Training/Vocational Training	23					
DBS/CRB checks	24					
Health Board staff costs associated with the delivery / monitoring of the dental contract	25					
Oral Surgery	26					
Orthodontics	27					
Special care dentistry e.g. WHC/2015/002	28					
Oral Health Promotion/Education	29					
Improved ventilation in dental practices	30					
Attend Anywhere	31					
	32					
	33					
	34					
	35					
	36					
	37					
	38					
	39					
	40					
	41					
	42					
TOTAL OTHER (must equal line 12)	43			0		0

RECEIPTS

TOTAL DENTAL SERVICES INCOME (Enter as a negative value)	44				0	

Velindre Trust **Period May 23**

This table needs to be completed from month 3

	Table A: Allocation Paper (23/24 New Ring Fenced)		WG Annual Allocation	Current Plan	1 April	2 May	3 June	4 July	5 August	6 September	7 October	8 November	9 December	10 January	11 February	12 March	Total YTD	Total Annual	Total Variance against WG Allocation (+over/-under spend)	
Recove	Recovery Funding (£120m)	Plan															0	0		ok
Recove		Actual/Forecast - not yet committed															0	0		
Recove		Actual/Forecast - committed															0	0		
Recove		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Value B	Value Based Funding (£14m)	Plan	1,107	1,107	91	98	116	68	78	89	94	94	94	95	95	95	189	1,107		ok
Value B		Actual/Forecast - not yet committed															0	0		
Value B		Actual/Forecast - committed			91	98	116	68	78	89	94	94	94	95	95	95	189	1,107		
Value B		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Regions	Regional Integration Fund (£132.7m)	Plan															0	0		ok
Regions		Actual/Forecast - not yet committed															0	0		
Regions		Actual/Forecast - committed															0	0		
Regions		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Genom	Genomics for Precision Medicine Strategy (£10.1m)	Plan															0	0		ok
Genom		Actual/Forecast - not yet committed															0	0		
Genom		Actual/Forecast - committed															0	0		
Genom		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Critical	Critical Care Funding (£18.7m)	Plan															0	0		ok
Critical		Actual/Forecast - not yet committed															0	0		
Critical		Actual/Forecast - committed															0	0		
Critical		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

	Table B : Additional In-Year (23/24 Anticipated & Allocated)		WG Annual Allocation	Current Plan	April	May	June	July	August	September	October	November	December	January	February	March	Total YTD	Total Annual	Total Variance against WG Allocation (+over/-under spend)	
Urgent	Urgent Emergency Care Allocations	Plan															0	0		ok
Urgent		Actual/Forecast - not yet committed															0	0		
Urgent		Actual/Forecast - committed															0	0		
Urgent		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Mental	Mental Health (SIF) Allocations	Plan															0	0		ok
Mental		Actual/Forecast - not yet committed															0	0		
Mental		Actual/Forecast - committed															0	0		
Mental		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Planned	Planned Care	Plan															0	0		ok
Planned		Actual/Forecast - not yet committed															0	0		
Planned		Actual/Forecast - committed															0	0		
Planned		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Value B	Value Based Health Care	Plan															0	0		ok
Value B		Actual/Forecast - not yet committed															0	0		
Value B		Actual/Forecast - committed															0	0		
Value B		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Recove	Recovery	Plan															0	0		ok
Recove		Actual/Forecast - not yet committed															0	0		
Recove		Actual/Forecast - committed															0	0		
Recove		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Spare	Spare	Plan															0	0		ok
Spare		Actual/Forecast - not yet committed															0	0		
Spare		Actual/Forecast - committed															0	0		
Spare		Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

List below which allocations have been included in the In-Year Plan Sections (state if received or anticipated)

	Urgent Emergency Care Allocations (Confirm in below text 'Allocated' or 'Anticipated')	£000s	WG Annual Allocation	Current Plan	April	May	June	July	August	September	October	November	December	January	February	March	Total YTD	Total Annual
0																	0	0
0																	0	0
0																	0	0
0																	0	0
0																	0	0
0																	0	0
0																	0	0
Urgent	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	Mental Health (SIF) Allocations (Confirm in below text 'Allocated' or 'Anticipated')	£000s
0		
0		
0		
0		
0		
0		
0		
0		
Mental	Total	0

	Planned Care (Confirm in below text 'Allocated' or 'Anticipated')	£000s
0		
0		
0		
0		
0		
0		
0		
0		
Planned	Total	0

	Value Based Health Care (Confirm in below text 'Allocated' or 'Anticipated')	£000s
0		
0		
0		
0		
0		
0		
0		
0		
Value B	Total	0

	Recovery (Confirm in below text 'Allocated' or 'Anticipated')	£000s
0		
0		
0		
0		
0		
0		
0		
0		
Recove	Total	0

	Spare (Confirm in below text 'Allocated' or 'Anticipated')	£000s
0		
0		
0		
0		
0		
0		
0		
0		
Spare	Total	0

QUALITY, SAFETY & PERFORMANCE COMMITTEE

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

DATE OF MEETING	13/07/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance / Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT / Performance Review VCC SLT / Performance Review Executive Management Board	18th June 2023 19th June 2023 29th June 2023	**NOTED** **NOTED** **NOTED**

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

1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD MAY 2023/24

1.1 This paper reports on the performance of our Trust for the month of May 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 Executive Summary, in Section 2, gives a high-level overview, drawing attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas. The Performance Management Framework (PMF) Scorecards, in Section 5, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

1.3 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.

Each KPI is supported by data that explains 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. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

1.4 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.

1.5 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.

2. VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY FOR MAY 2023

The following paragraphs provide a high-level executive summary of our Trust-wide performance against key performance metrics through to the end of May 2023 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.1 Cancer Centre Services Overview

Targets were met for Pressure Ulcers, Falls, SEPSIS, SACT emergency waiting times, Hospital Acquired Thrombosis, Physiotherapy, Occupational Therapy and Speech and Language Therapy waiting times.

There were four Delayed Transfers of Care (DToCs) in May, resulting from of bed capacity challenges across the wider healthcare system. It is anticipated this could continue as capacity within Health Boards remains challenged. Invariably, this will influence the ability for Velindre Cancer Centre to discharge. Led by the Delivery Unit, work continues across the system at a national level to explore the wider challenges for managing delayed discharges. Velindre Cancer Centre is a member of that group, allowing system wide knowledge to form part of our planning assumptions moving forward.

In this reporting period, SACT 21-day performance showed a further reduction. The causes are multifactorial including increased referrals, booking team resources shortages due to ill health, as well as PICC (Peripherally Inserted Central Catheter) scheduling capacity. It is recognised that whilst these issues create a pressure on the pathway which leads to reduced performance, further challenges with staffing resource are compounding opportunities to recover. Current pressures are being recognised in nursing with not only high levels of maternity leave but more concerning, increased levels of vacancies with poor interest during the recruitment phase. This follows well publicised resource pressures across NHS. Despite this, the service is working with Workforce and Organisational Development colleagues to develop a further recruitment campaign and is in active discussion with HEIW to determine other opportunities for recruitment further afield.

The capacity within the SACT booking team has been reviewed and additional resource has been identified as part of a wider proposal to support data quality management. In an attempt to explore all options, VCC's service improvement team have also been deployed to work with SACT, reviewing the pathway as a priority. We continue to experience operational challenges with the bedding in of the Digital Health Care Record (DHCR) with the prioritisation of the administrative functions to support the clinical delivery of service.

PICC capacity has been immediately increased by 20%, whilst further work will be undertaken to review service utilisation and booking rules. Additionally, a peer review of the IV access service is commencing in July with colleagues from Aneurin Bevan University Health Board (ABUHB). Improvements undertaken by the service have also led to weekly referral and waiting time data being available to the service manager to better help manage demand and resultant activity.

Following the adoption of revised Quality Performance Indicators (QPIs), the radiotherapy service continues to show underperformance against all of the performance metrics. This in part is related to the interpretation and categorisation of patients against the definitions for each group of patients in the new radiotherapy QPIs (which replaced the Royal College of Radiologists Joint Collegiate Council for Oncology's targets in January 2023). We continue to work with the Clinical Oncology Sub-Committee (COSC) national group to

standardise reporting, share best practice and align the application of the new measures in a consistent manner in line with national reporting standards.

A formal capacity planning group is working to deliver a balanced demand and capacity plan, including individual plans for Brachytherapy, Medical Physics and delineation planning and scanning. In addition, as part of a wider programme of pathway work, a clinically led group has reviewed current pathways against defined optimum pathways in order to identify variation and clarify where focused work is required. Baseline data is being sourced to support this work from Business Intelligence.

An activity list is produced from the digital systems followed by a manual review to cross check the activity list against digital system reports, to ensure that all patients are managed through the treatment pathway. This does lead to additional staff pressure but, needs to continue until further warehouse developments and changes are made. Patients continue to be prioritised in line with national guidance.

Data quality related to the implementation of DHCR remains an issue and is creating a significant administrative burden. Significant progress has been made in processing the backlog of unprocessed outcomes. This has been undertaken with additional resource. The DHCR Operational Group has completed a piece of work to identify the additional resource required to support the ongoing management of DHCR and the changes that have come with the new system. The paper will be presented to the DHCR Project Board in July, alongside a paper on the requirements for further refresher training and the resource required to support this on an interim basis.

2.2 Welsh Blood Service Overview

WBS have continued to perform well during May and all clinical demand was met. At 98% quality incident investigations closed within 30 days has improved again this month and continues to exceed the 90% target.

WBS have continued to perform well during May and all clinical demand was met, despite a number of bank holidays. At 98% quality incident investigations closed within 30 days has improved again this month and continues to exceed the 90% target.

There were two reportable events submitted to the MHRA in May:

SABRE-106 (submission 02/05/2022) "Malaria residency not assessed correctly"

A donor's malarial residency status was correctly assessed via screening questions and the required malaria test sample was taken; however, the electronic donor record was not updated correctly. This was the donor's third attendance. It was then established that the donor's malaria residency had been incorrectly assessed on two previous occasions. This presents a risk that the donor was positive for malaria at the time of the first and second donations, and contaminated blood components could have entered the supply chain.

- A deferral was immediately applied to the donor record.

- Malarial screening of archived samples was undertaken for previous donations from this donor (18/02/12 and 17/08/20). Both results were negative, therefore there was no actual risk to patient safety.
- A lookback process has been completed; no products required discard.
- An additional 174 donor records were checked, with only one further issue identified. This has been included in the RCA report and recorded separately within Datix.
- To ensure this issue does not exist for other donors with a declaration of previous malaria residency Digital Services will run a report to identify all donors declaring they were born outside of the UK; further checks will be made to ensure RN review was completed as expected – any anomalies will be reported and managed as a separate event.
- Training awareness has been delivered to all collection team RNs.
- A peer review of the RN process will be undertaken to identify additional learning or service improvements.
- WBS have not received any reports of transfusion transmitted malaria.
- Malaria residency not assessed correctly (date notified 02/05/2023) – the incident was complex and highlighted the potential for further issues around assessment of malaria residency which required exploration. A root-cause analysis has been undertaken and has highlighted additional staff training is required. This is now underway.
- Deviation from platelet release process. Platelets released before all testing results were available (date notified 22/05/2023). Testing results confirmed negative before transfusion therefore no clinical risk. Investigation complete and a number of preventative actions identified.

SABRE 107 (submission 22/05/23): “Contingency Issue PC (CIPC) used to issue unreleased platelet.”

This was a “near miss” event - if the platelets had been needed for an urgent transfusion they could have been transfused before the bacteriology results were known; this may have had an adverse patient impact if bacterial growth had occurred. A root cause analysis investigation has been undertaken.

- The system does not prevent issue of stock via CIPC - this is reliant on users making the correct decision about its use.
- A new stock of platelets had been received by the Stock Holding Unit but were still under ‘12-hour bacteriology hold’.
- The person undertaking issuing of platelet felt under pressure to issue platelets that were required urgently by a customer hospital late at night.
- They made an error of judgement, believing their decision was safe as the platelet would be released from hold by the time it arrived at the customer hospital and if there had been a positive result the platelet would have been recalled.
- The staff member recognises their error and has undertaken reflective practice.
- Junior staff members must be supported in their decision making in such circumstances
- The process will be updated to introduce the requirement for formal authorisation of the use of the CIPC by the on-call medic or on-call SMT lead

An additional reportable event was submitted to the MHRA in February and has been included in this report because, due to the reporting cycle, the PMF for February was taken to EMB only and not to the QSP meeting.

SABRE-105 (submission 10/02/2023) “BactAlert failure”

The larger of two BactAlert modules failed, resulting in the blood establishment computer system (eProgesa) allowing platelets to be released without live bacteriology monitoring taking place. This presented a risk that positive results were not recorded and units with bacterial growth could have been released to customer hospitals for transfusion.

- Remedial action to support business continuity was managed via the WBS Emergency planning group.
- The immediate risk was from platelets available for transfusion on days 6 and 7 (these are safe for transfusion up to day 5).
- Affected platelets were identified and all hospitals notified immediately, enacting the product recall process, and quarantining affected platelets.
- Neonatal platelets were imported to cover requests from customer hospitals.
- All remaining WBS stock was converted to a 5 day shelf-life.
- A specialist engineer repaired the fault.
- The old BactAlert system has since been replaced with a completely new system (this was a scheduled change and not in direct response to this event).
- A fix has been applied within the new system to prevent a similar event occurring.

Donor satisfaction continues to be above the 95% target and has remained at 97% in May. Donor award events recommenced in May and this has resulted in positive feedback from our donors. 7,203 donors were registered at donation clinics with 6 informal concerns (0.08%) reported during this period. All were managed within the 2 working day deadline as ‘early resolution’. No formal concerns were raised during May.

Reference Serology turnaround performance continued to meet target in May, after achieving target in April for the first time in 8 months. Performance continues to be impacted by ongoing training of new staff, however, this is a much improved picture compared to recent months.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage reduced again in May and met target for the second month in a row. This is attributed to the planned changes to production made in April. The May bank holidays brought about significant challenges in maintaining the balance between supply and demand, however platelet expiry was kept controlled by modelling expected issues against production.

Collection efficiency is slightly below the 1.25% target at 1.13%. Contributory factors influencing the May performance include short term staff sickness and staff vacancies.

Performance for new bone marrow volunteers improved slightly in May but was well below target with only 160 new volunteers (131 from blood and 29 from swabs). The summer months are typically lower due to the reduced blood donor clinics in educational establishments. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analysing the data from previous swab recruitment campaigns to inform the way forward. 466 eligible donors attended blood sessions with a 28% conversion rate.

The total stem cells collected in May was 3 (2 collections were cancelled for patient reasons and 2 for donor reasons). The total stem cell provision for the service was 4 (3 collected and 1 imported for a Welsh patient). 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.

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 employee 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 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 5.99% to May 2023 still above the Welsh Government Target of 3.45%. Trust wide PADRs this month remains at 72% for a third consecutive month, whereas Statutory and mandatory training remains above target at 87% and has been consecutively on target for the whole year to May 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

2.4 Nursing and Quality

The Trust's Quality & Safety Framework is approved and the Integrated Quality & Safety Governance Group has been established and monthly meeting being held. The Divisions will need to develop Service level Quality and Safety metrics and these to be included within the Performance Management Framework. Corporate and Divisional Quality Hubs are in the process of being established. The Trust's Nursing Standards have been approved and launched.

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (98%) and 'Your Velindre experience?' (68%) 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

Steady improvement in the rolling 12-month number of significant IT business continuity (11); however, this remains a focus of work for the team, with a view to achieving the target of 6 incidents in a rolling 12 month period. The Digital Services team continue to implement improvements to address the legacy IT estate in VCC, which is where the majority of the incidents are occurring. This work will continue through 2023/24.

Performance in respect of the timescales for resolving service requests and incidents remains largely stable at approx. 80% for both indicators. Team capacity remains a contributory factor – 2wte Service Desk Officers commenced work in early June 2023 – performance expected to improve through Q1 into Q2 2023/24.

Reporting arrangements for two indicators are still being developed, routine reporting delayed due to competing priorities. Aim is to establish routine reporting in Q2 2023/24 for the following indicators:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role (interviews scheduled for July 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. Initial reporting has been developed for WBS Appointments System (>99.9% uptime) However, these reports are still undergoing validation to ensure accuracy of the reported data.

2.7 Estates Infrastructure and Sustainability

The period through to May has realised high levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment has progressed significantly with three posts currently out to advert. The Team are focussed on management through the availability of data which is now evident through the consolidation of compliance figures.

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.

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. 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.

2.8 Finance

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of £0.004m 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 planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.773m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to May'23 of £3.026m and is forecasting to remain within the CEL of £24.416m.

During May '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.1%** as at the end of month 2, and a Trust position (including hosted) of **98.7%** compared to the target of 95%.

At this stage the Trust is currently planning to fully achieve the savings target during 2023-24, however a risk of under delivery remains on several schemes that are still RAG rated amber.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

4. RECOMMENDATIONS

4.1 The Quality, Safety and Performance Committee is asked to **DISCUSS AND REVIEW** the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3.

5.1 Cancer Services Scorecard as at May (Month 2) 2023/24

QSF Domain	Cancer Services Safety Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	➔	KPV.01
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	➔	KPV.02
	% Patients with a Sepsis NEWS score >or= 3 receiving all 6 treatment elements within 1 hour	National	Monthly	100%	100%	100%	✓	➔	KPV.03
	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	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	1	✗	➔	KPV.04
	Hand Hygiene compliance against best practice standards	Prof. Std.	Monthly	TBA	TBA	TBA	✓	➔	KPV.08
	Number of Health and Safety Incidents recorded	Local	Monthly	9	0	3	✗	➔	KPV.56
	% compliance for staff who have completed the Core Skills and Training Framework Level 1	National	Monthly	85%	85%	85%	✓	➔	KPV.59

	Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents	**Local**	**Monthly**	**0**	**0**	**0**	✓	➔	KPV.54

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓

QSF Domain	Cancer Services Effectiveness Scorecard			Performance as at Month 02 (May)			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**	**4**	✗	➔	KPV.05
	% Personal Appraisal Development Reviews (PADR) Compliance	**National**	**Monthly**	**72%**	**85%**	**70%**	✗	↓	KPV.56
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.43%**	**3.54**	**6.13%**	✗	↓	KPV.57

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓

QSF Domain	Cancer Services Experience Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	**Prof. Std.**	**Monthly**	**95**	**95%**	**98%**	✓	➔	KPV.11
	% of 'formal' concerns responded to within 30 working days	**Local**	**Monthly**	**100**	**85%**	**100**	✓	➔	KPV.12
	Number of Incidents of violence and aggression to staff	**Local**	**Monthly**	**7**	**0**	**0**	✓	↑↓	KPV.53

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓

QSF Domain	Cancer Services Timeliness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	16% 45%	✗	➔	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	9% 49%	✗	➔	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	80% 100%	81% 94%	✗	➔	KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	53% 56%	✗	➔	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
	% Outpatients seen within 30 minutes of scheduled time	Local	Monthly	paused	100%	paused	✗	➔	KPV.22
	% Patients receiving equitable and timely access to Therapy Services	Local	Monthly	100%	100%	100%	✓	➔	KPV.23
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Cancer Services Efficient Scorecard			Performance as at Month 02 (May)			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	% Outpatient Did Not Attend (DNA) rates	National	Monthly	3%	5%	nda	✓	➔	KPV.24
	Electricity performance in kilowatt hours (kWh)against target consumption budget profile	National	Monthly	N/A	263k	296k	✗	↑↓	KPV.62
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Monthly	N/A	175k	178k	✗	↑↓	KPV.62

	Water performance usage in cubic metres against target consumption	**Local**	**Monthly**	**N/A**	**1750m3**	**1550m3**	✓	🡅	KPV.67
	Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile	**National**	**Monthly**	**£0k**	**£0k**	**£3k**	✓	🡆	KPV.71
	VCC expenditure (£k) on Bank and Agency staff against target budget profile	**National**	**Annually**	**£99k**	**£99k**	**£66k**	✓	🡅	KPV.72
	Cost Improvement Programme – VCC achievement of savings (£k) in line with profile	**National**	**Monthly**	**N/A**	**£40k**	**£68k**	✓	🡅	KPV.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Cancer Services Equitable Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	KPV.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	KPV.79
	Diversity of Workforce – % People with a Disability	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	KPV.80
	% of Workforce declared Welsh Speakers at Level 1	**National**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	KPV.81
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

5.2 Blood and Transplant Scorecard as at May (Month 2) 2023/24.

QSF Domain	Blood and Transplant Safety Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Health and Safety Incidents recorded	Local	Monthly	5	N/A	10	✗	➔	KPI.57
	Quality Incidents closed within 30 days	Local	Monthly	96%	90%	98%	✓	🡅	KPI.11
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	2	✗	🡇	KPI.30
	Numbers of critical and major non-conformances through external audits or inspections	Best practice	Monthly	0	0	0	✓	➔	KPI.32
	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	95%	85%	93%	✓	🡅	KPI.59
	Number of Staff RIDDOR Incidents, injuries, and work-related accidents.	Local	Monthly	0	0	0	✓	➔	KPI.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable ➔ fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Blood and Transplant Effectiveness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	New Whole Blood Donors	Local	Quarterly	1660	2750				KPI.27
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	97%	✗	🡇	KPI.04
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	117%	✓	🡇	KPI.05
	Red Blood Cell Stock Level (below 3 days)	Local	Monthly	0	0	0	✓	➔	KPI.07
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	8%	✓	🡅	KPI.25
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.7%	✓	🡇	KPI.26
	New Apheresis Donors	Local	Quarterly	21	14				KPI.19
	Number of Stem Cell Collections per month	Local	Monthly	6	7	3	✗	🡇	KPI.13

	New Bone Marrow Donors	National	Monthly	1742	333	160	✗	🡅	KPI.20
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	National	Monthly	86%	85%	87%	✓	🡇	KPI.56
	% Rolling average Staff sickness levels	National	Monthly	6.8%	3.54%	7.16%	✗	🡅	KPI.58
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Blood and Transplant Experience Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Donor/ Staff Experience	% Unsuccessful Venepuncture	Best practice	Monthly	1.7%	2.0%	0.9%	✓	🡅	KPI.14
	% Part Blood Bags collected	Best practice	Monthly	2.7%	3.0%	2.5%	✓	🡇	KPI.16
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	🡅	KPI.09
	Number of Concerns	Local	Monthly	9	N/A	6	✓	🡅	KPI.28
	% Responses to informal concerns within required 2-day timescale	Local	Monthly	100%	100%	100%	✓	🡆	KPI.06
	% Responses to formal concerns within 30 working days	Local	Monthly	100%	90%	N/A	✓	🡆	KPI.03
	Number of incidents of violence and aggression to staff	Local	Monthly	1	0	4	✗	🡅🡇	KPI.53
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Blood and Transplant Timeliness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%				KPI.17
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	95%	✓	→	KPI.18
	% Reference Serology Turnaround Times (2 working days)	Best practice	Monthly	70%	80%	81%	✓	→	KPI.23
	% Turnaround Time (Deceased Donors Typing / Cross matching)	Best practice	Quarterly	84%	80%				KPI.24
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Blood and Transplant Efficient Scorecard			Performance as at Month 02 (May)			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	Whole Blood Collection Productivity	Best practice	Monthly	1.12	1.25	1.13	✗	→	KPI .08
	Manufacturing Productivity	Best practice	Monthly	418	392	424	✓	↑	KPI.10
	% Controllable Manufacturing Losses	Best practice	Monthly	0.06%	0.5%	0.03%	✓	→	KPI.12
	Electricity performance kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	140k	130k	✓	→	KPI.63
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	71k	59k	✓	→	KPI.63
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	250m3 Mar	250m3 Mar	✓	↑	KPI.67
	Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£1k	✓	→	KPI.71
	WBS expenditure (£k) on Bank and Agency staff against target budget profile	National	Annually	£0k	£0k	£1k	✗	↓	KPI.72
	Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	National	Monthly	N/A	£32k	£27k	✓	→	KPI.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Blood and Transplant Equitable Scorecard			Performance as at Month 02 (May)			Compliance against Target Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.81
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

5.3 Trust-wide Services Scorecards as at May (Month 02) 2023/24

Estates Services.

QSF Domain	Estates Safety Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Carbon Emissions – carbon parts per million by volume	National	Annually	2020/21 C/m3	TBA	118.9 C/m3	✓	➔	EST.06
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Effectiveness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Compliance with Sustainable Development Assessment Tool (SDAT)	Local	Annually	TBA	TBA	TBA	✓	➔	EST.25
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Timeliness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% PPM undertaken completed against plan	Local	Quarterly	90%	95%	90%	✗	➔	EST.54
	% Reactive maintenance achieved within agreed days/hours	Local	Quarterly	80%	95%	80%	✗	➔	EST.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Efficient Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Trust HQ Electricity performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	2011	1696	✓	🡅	EST.64
	Trust HQ Gas performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	1437	1680	✗	🡅	EST.64
	Trust Waste Recycling performance by weight (Kg)	Local	Monthly	4500Kg	4500Kg	5500Kg	✓	🡅	EST.68
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

Health and Safety Services

QSF Domain	Health and Safety Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% RIDDOR reportable incidents of workforce	Local	Quarterly	0	0	0	✓	🡆	H&S.14
	% Fire Action Plan actions implemented	Local	Quarterly	78%	100%	78%	✗	🡆	H&S.17
	Number of Health and safety incidents recorded	Local	Monthly	15	0	13	✗	🡅🡇	H&S.55
	% Fire Drills completed accordance with schedule	Local	Quarterly	paused	100%	paused	✓	🡆	H&S.16
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Health and Safety Effectiveness Scorecard – Trust-wide position			Performance as at Month 02 (May)			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	% staff overall compliance with Level 1 (Essential) Level 2 (fire Warden) & Level 3 Fire safety training	Local	Monthly	89%	85%	88%	✓	➔	H&S.27
	% Training compliance – Manual Handling (level 1 and 2), Health & Safety, Violence and Aggression (module A and B) and Display Screen Equipment	Local	Monthly	80%	85%	80%	✗	↑	H&S.26
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Health and Safety Experience Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	Number of Incidents of violence and aggression to staff	Local	Monthly	7	0	4	✗	↑	H&S.43
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Workforce and Organisational Development

QSF Domain	Workforce and OD Safety Scorecard – Trust-wide position			Performance as at Month 01 (April)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	87%	85%	87%	✓	↑	WOD.19
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Effectiveness Scorecard – Trust-wide position			Performance as at Month 02 (May)			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	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%	✗	↑↓	WOD.36
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54%	5.99%	✗	↓	WOD.37
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Experience Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	March 23	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% staff who rate Trust as a good employer	National	Annually	TBA	TBA	TBA	✓	→	WOD.13
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Equitable Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	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 ↓									

Digital Services

QSF Domain	Digital Safety Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance against NCSC "10 Steps to Cyber Security" best practice standards	Local	Bi-annual	88%	90%	88%	→	↑	DIG.62
	Number of significant IT business continuity incidents	Local	Monthly (rolling 12 months)	12	6	11	↑	↓	DIG.61
	Cyber Security - % of employees clicking on internal phishing campaigns	Local	Quarterly	TBA	TBA	TBA	-	-	DIG.63
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Experience Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% User satisfaction with Digital Service Desk	Local	Quarterly	87%	95%	87%	→	✗	DIG.51
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Timeliness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% Digital Service Desk requests resolved within agreed (SLA) timescales	Local	Monthly	81%	85%	81%	➔	-	DIG.58
	% Digital Service Desk incidents resolved within agreed (SLA) timescales	Local	Monthly	80%	85%	79%	↓	-	DIG.59
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Efficient Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	TBA	99%	TBA	-	-	DIG.69
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Finance Services

QSF Domain	Finance Timeliness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	➔	FIN.60
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Finance Efficient Scorecard – Trust-wide position			Performance as at Month 02 (May)			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	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.004 m)	✓	➔	FIN.71
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.115 m	£0.77m	✓	↑	FIN.72
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£1.673 M	£1.673 M	✓	➔	FIN.73
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.084 m	£0.108 m	✓	↑	FIN.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Performance Management Framework supporting KPI Data Graphics and Analysis

ANNEX 1: CANCER SERVICES

SAFETY

KPI Indicator KPV.01

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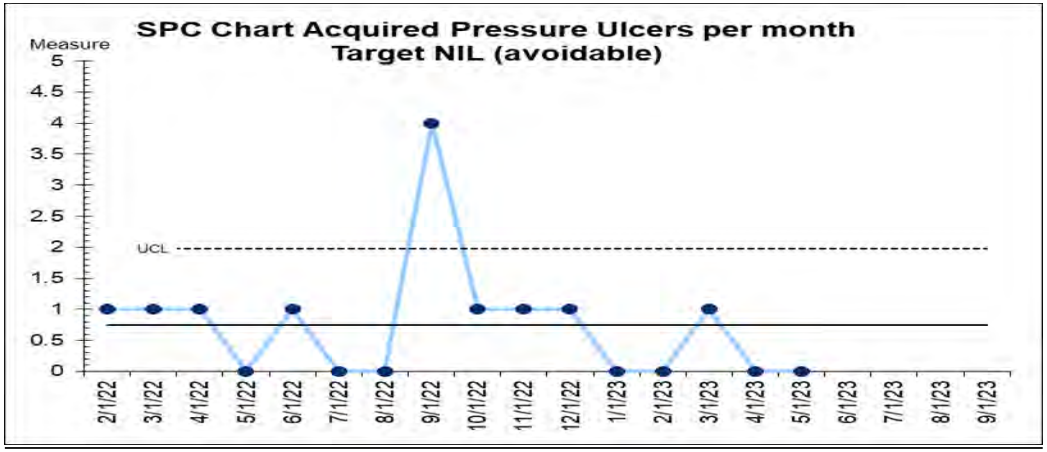
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Mar22	Apr22	May 22	Jun 22	Jul 22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number	1	1	0	1	0	0	4	1	1	1	0	0	1	0	0
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC chart shows common cause or normal variation, apart from Sept '22 over the last 15 months.

Performance

No avoidable Pressure Ulcers in month

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.02

Return to Top

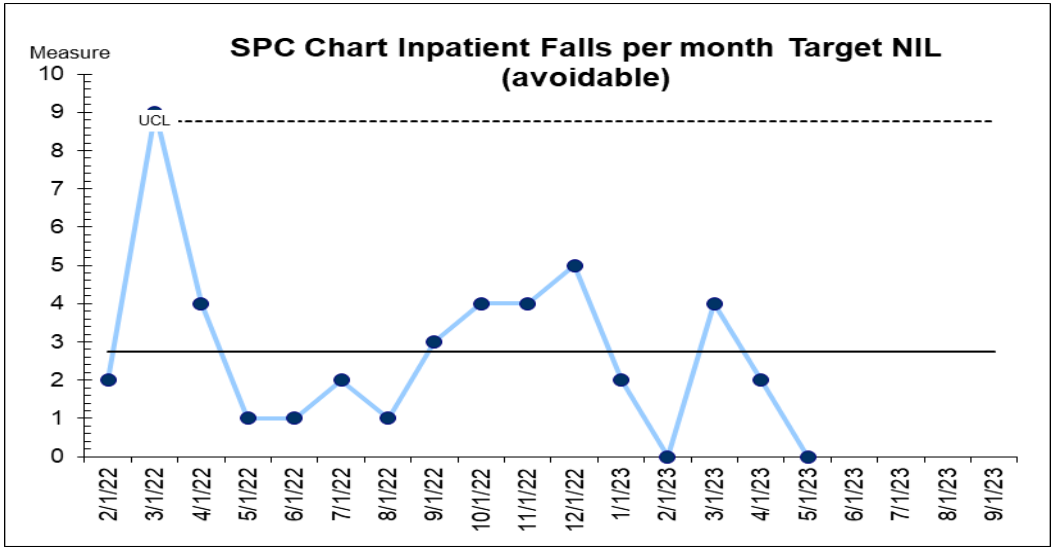
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number	9	4	1	1	2	1	3	4	4	5	2	0	4	2	0
Avoidable Falls	0	1	1	0	2	0	1	2	2	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months, with a 'special cause' variation of 9 falls in March.

Performance

No avoidable falls in May 2023

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.03

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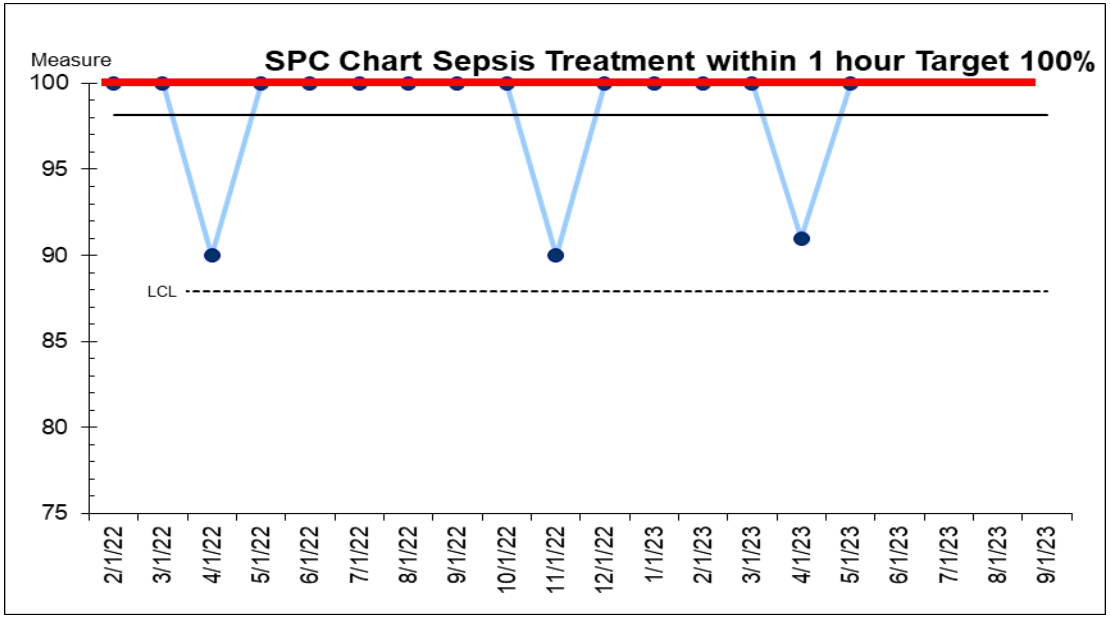
Patients with a NEWS Score Greater Than or Equal to 3 who Receive All 6 Elements in Required Timeframe

Target: 100%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

	Mr22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	100	90	100	100	100	100	100	100	90	100	100	100	100	91	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



SPC Chart Analysis

The SPC chart shows common cause or normal variation for the 15 month period.

Performance

Assessment of current performance, set out key points:

20 patients in total were admitted to VCC with query sepsis
12 patients were diagnosed with SEPSIS and all were compliant with sepsis 6
6 patients were treated as query SEPSIS but not diagnosed as SEPSIS and each received full compliance with the sepsis 6 bundle
2 patients – the bundle was started – abx were not given based on medical decisions. Neither of these patients were diagnosed with SEPSIS – other causes were clearly documented.
Another positive this month – documentation was very good, every patient had either a clinical note or a DAL and the diagnoses were clearly documented for all patients involved in the audit.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate
Continued 100% compliance with the sepsis bundle

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.08

Return to Top

Hand Hygiene compliance against Best Practice

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance

VCC	Mr22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Hand Hygiene															
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Performance Target measures are in development

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.07

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Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

Incidence of Potentially (avoidable) Hospital Acquired Thromboses (HAT)

VCC	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Hospital Acquired Thromboses	1	0	0	0	1	0	0	0	0	0	0	0	2	1	0
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:

On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period February 2022 to April 2023

VCC	Mr22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
C.diff	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
E.coli	0	0	0	0	1	0	0	0	0	1	3	1	0	1	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	1	0	0	1	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	0	0	0	0	1	4	1	0	1	1

Performance

Assessment of current performance, set out key points:

- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Reviewing individual cases using an MDT approach to identify any lessons to be learnt and training.	To be completed within 2 weeks of positive result	IPCT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- **Engagement with medical colleagues in the RCA process impacted by workload and rotation.**

KPI Indicator KPV.54

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Graph title - Number of RIDDOR reportable incidents by Division

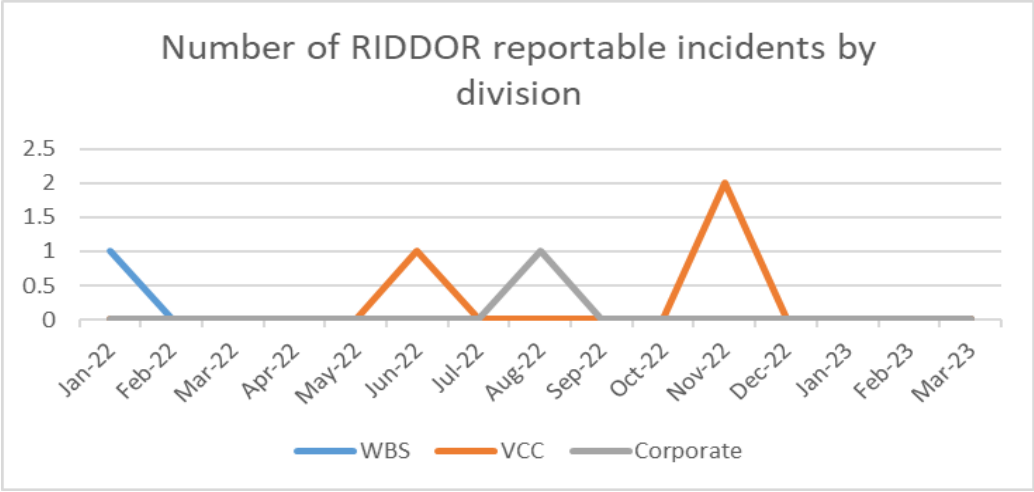
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard -

Performance - remains stable

	Mar -22	Apr -22	May- 22	Jun- 22	Jul- 22	Aug -22	Sep -22	Oct- 22	Nov -22	Dec -22	Jan- 23	Feb -23	Mar 23	Apr 23	May 23
WBS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VCC	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0
Corporate	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

Lessons learned from previous RIDDOR incidents implemented	Timescale Q4 2022/23. VCC H&S Integrated care and Ed& Dev

Expected Performance gain
Lessons learned and implemented

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale :**

Expected Performance gain
Lessons learned to prevent reoccurrence of incident and prevent similar ones

Risks to future performance

Incomplete incident investigation – **action** quality check by H&S, implementation of manager H&S training including risk assessment and incident training.

Operational pressures making it challenging for staff to training – **Action –** flexible onsite provision of training

Some departments not completing departmental inspections – escalated to SLT.

KPI Indicator KPV.59

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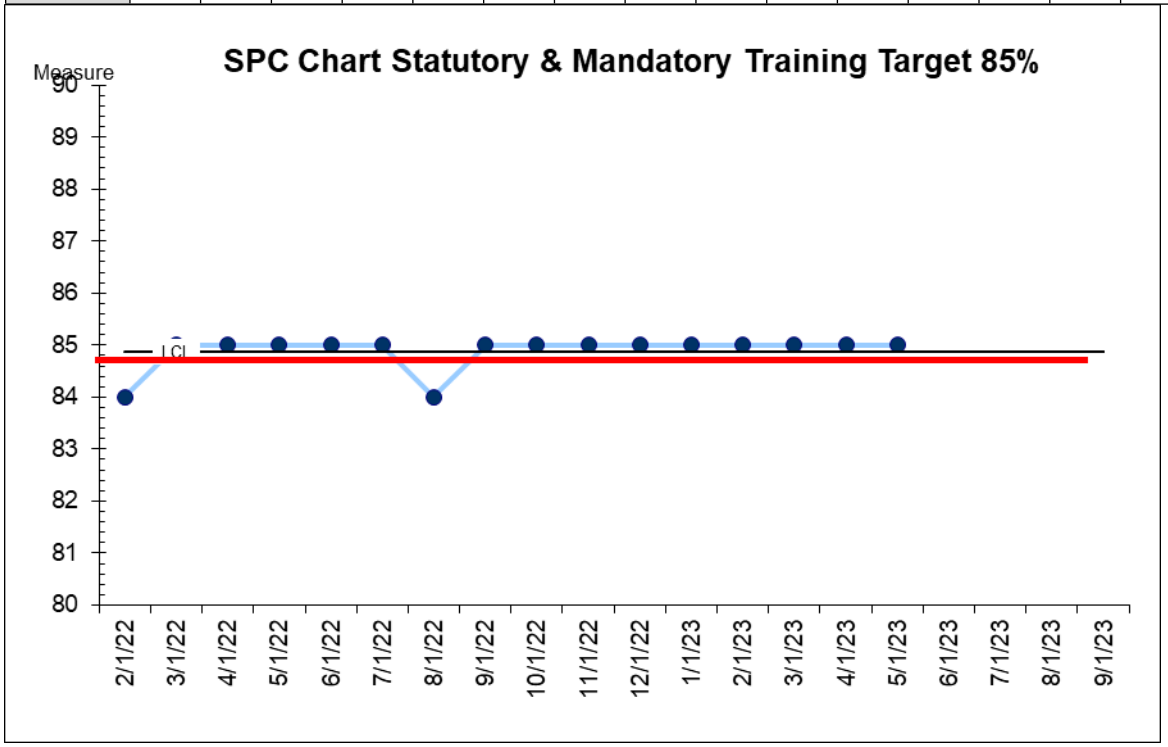
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Ma22	Apr 22	My 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	85	85	85	85	85	84	85	85	85	85	85	85	85	85	85
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 84% against the 85% target, with the target being met for the last 6 months

Performance

Assessment of current performance, set out key points:

Statutory and Mandatory compliance for this month reports as 85.37% compliance and remains just above the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As compliance is just above the Trust target level, managers should continue to ensure staff are completing all statutory and mandatory modules and look to increase this compliance rate.	N/A	Ongoing, all managers in the division

Expected Performance gain – immediate

To continue to improve compliance for statutory and mandatory training.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Education and Development team will proactively work on the Stat. & M and compliance framework in the All Wales network	Continuous	Head of OD
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Continuous	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.

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.

KPI Indicator KPV.56

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Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

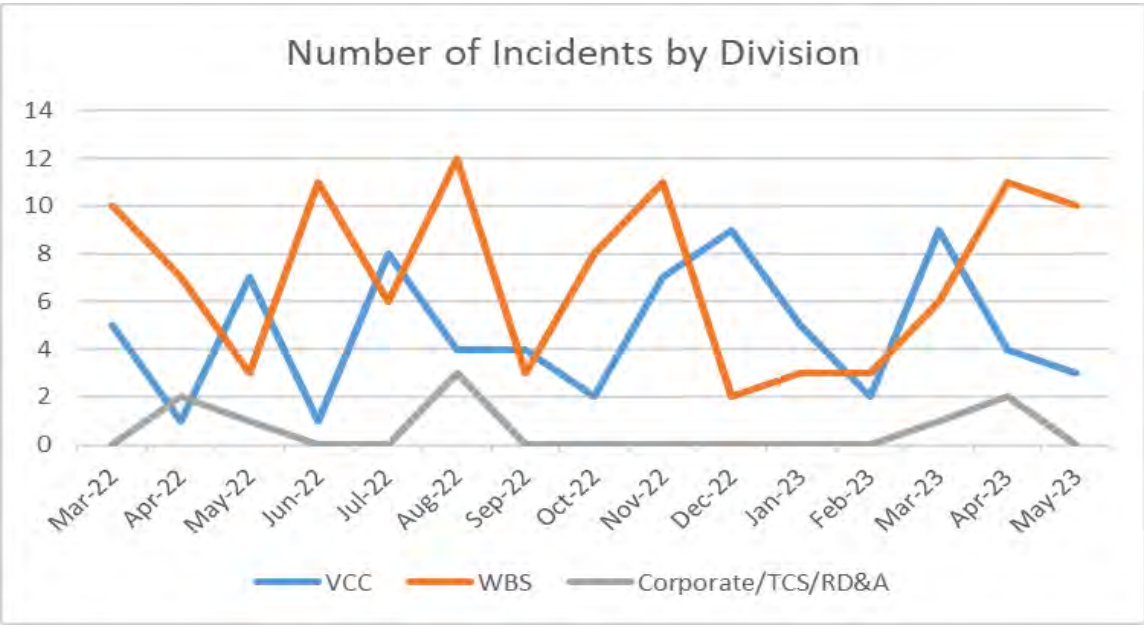
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Feb -22	Mar-22	Apr -22	May-22	Jun -22	Jul-22	Aug-22	Sep-22	Oct -22	Nov-22	Dec-22	Jan -23	Feb-23	Mar 23	Apr 23	May 23
VCC	7	5	1	7	1	8	4	4	2	7	9	5	2	9	4	3
WBS	4	10	7	3	11	6	12	3	8	11	2	3	3	6	2	10
Corporate	1	0	1	1	0	0	2	0	0	0	0	0	0	0	2	0



Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training scheduled January, March 2023 and April	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 – **action** monitoring and short incident training January and March 2023 at VCC and Corporate

Some departments not completing departmental inspections at VCC

action – refresh of Dept. inspection process

EFFECTIVENESS

KPI Indicator KPV.05

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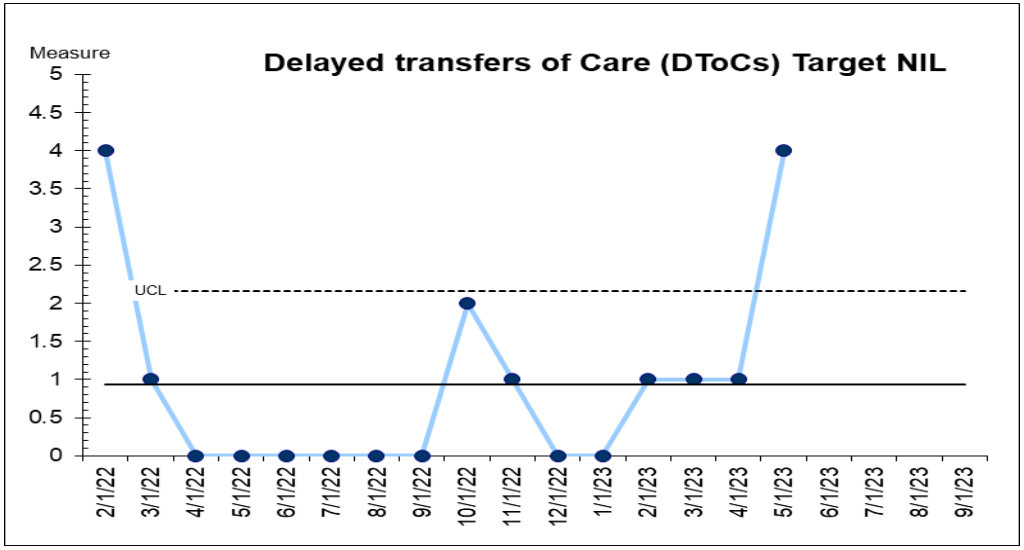
Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	No v 22	Dec 22	Jan 23	Feb 23	Ma r 23	Apr 23	Ma y 23
Actual %	1	0	0	0	0	0	0	2	1	0	0	1	1	1	4
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC Chart shows a 'special cause' or exceptional variation in May of 4 DToCs

Performance

Assessment of current performance, set out key points:

There were 4 DToC reported in May 2023.

Repatriation:

One patient was awaiting repatriation to local DGH.

Patient 1: 2 day delay

PoCD

Two patients were delayed due to awaiting start dates for Community Resource Team.

Patient 1: 10 day delay

Patient 2: 4 day delay

One patient was delayed due to awaiting start of a new home care package, however was then transferred to YCR.

Patient 1: 14 day delay

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
VCC Nurse leads now have membership of the new Pathways of Care Delays National Group system access has been granted and training has been provided by the DU, BI have assisted and data is now being uploaded nationally as required.		Matthew Walters Senior Operational Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Membership of all Wales POCD group, opportunity to discuss with HB colleagues and review national data including VUNHST data identifying themes and patterns.		Matthew Walters Senior Operational Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.56

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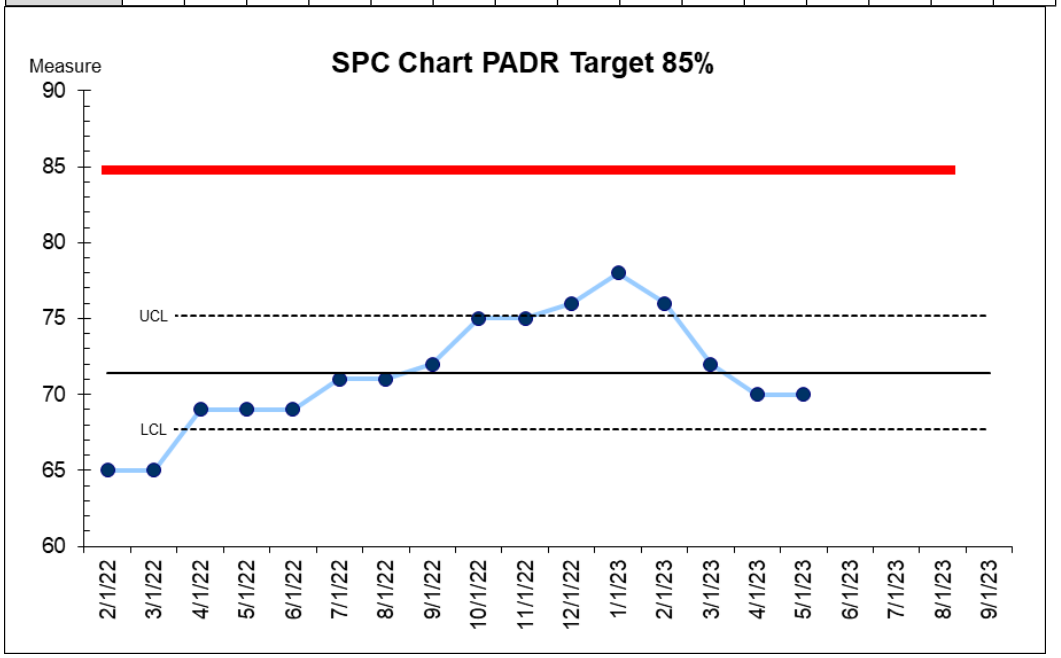
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

VCC Position	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Au g22	Sep 22	Oct 22	No v 22	Dc 22	Jan 23	Fe b 23	Ma r 23	Ap r 23	Ma y 23
Actual %	65	69	69	69	71	71	72	75	75	76	78	76	72	70	70
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows some improvement for the last 15 months but returning to averaging 70%, and consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

PADR compliance has increased slightly this month and is reporting as 70.30%. Compliance remains below the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale	Lead:
Managers in Clinical Audit (25%), CSMO (57.69%), Nursing (59.18%), Pharmacy (53.52%), Private Patients Office (50%), Medical Staffing (63.64%), and Psychology Section (30%) to understand (from BI) who hasn't received their PADR and to ensure these are scheduled to take place as a priority. *To note that some of the areas noted above have low staffing numbers, which is reflecting in the % and in some areas there has been no change or a decrease in compliance from the previous month. Given the target compliance rate is not being met, urgent action is required to increase PADR compliance and other areas, where compliance is not at the target rate should also plan in outstanding PADRs*	31/07/23	Various line managers depending on the area

Expected Performance gain - immediate

Hope to see an improvement in overall compliance and specifically across the areas mentioned above.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPV.57

Return to Top

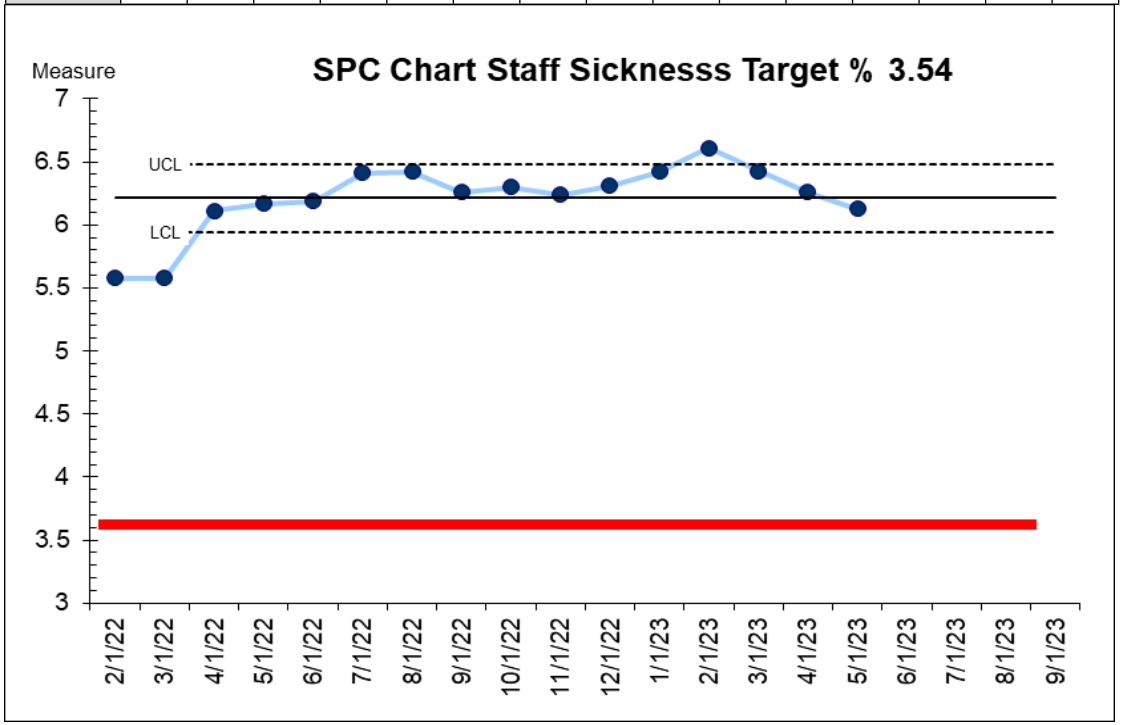
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

VCC Position	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	5.58	6.18	6.28	6.19	6.41	6.42	6.26	6.30	6.24	6.31	6.42	6.61	6.43	6.26	6.13
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 15 months, with the overall average 6.2% sickness level remaining higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

In month sickness has decreased this month to 4.52%.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:
Managers in Operational Services (8.44%), Radiotherapy (6.30%) and Nursing (6.61%) to review sickness absence cases in their areas and discuss any actions necessary with the People Team, ensuring that the absences are being managed under the MAAW Policy. *Psychology (16.89%) are also reporting high levels of absence. Given that there are low staffing numbers in these areas, this will impact the % reported, however managers in this area are also asked to review any absences*.	31/07/23	Various line managers depending on the area

Expected Performance gain - immediate

Reassurance that all sickness absence cases are being managed in line with policy. Monthly KPI meetings with People Advisors to support sickness absence management continue to take place.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

PATIENT EXPERIENCE.

KPI Indicator KPV.11

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% 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	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Would you recommend us? %						89	89	88	nda	nda	93	96	95	95	98
Your Velindre Experience? %									nda	nda	84	86	82	82	68
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 2 surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCC, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCC is the 'Would you recommend us?' one.

The 98% in MaY was due to 55 survey responses to the VCC 'Would you recommend us? CIVICA survey.

44 patients responded to "Your Velindre Experience" CIVICA survey. Of these 44 responses, 28 responded 9/10 and 10/10. 11 patients responded 7 and 8 out of 10, with 5 patients scoring 5 and below. Review of the responses identify

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 QSP report	Ongoing	Head of Nursing/SLT
• Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	SLT
• Directorates to develop plans to increase response rate.	Ongoing	SLT
• Q+S team to work with each directorate to provide further analysis on responses		Q+S manager
• CIVICA working group established with attendees from each directorate		

Expected Performance gain – immediate

Patient Experience and Concerns manager in post since February 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Patient Engagement Hub to undertake focussed project to understand reason for low response rates	April 2023	Head of OSD

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPV.12

Return to Top

Number VCC formal complaints received under Putting Things Right within 30 days

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Mar 22	Apr 22	M 22	Jun 22	Jul 22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %					100	100	100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

- Target deadline has been achieved

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Patient Experience and Concerns manager in post since February 2023

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.53

Return to Top

Graph title - Incidents of Violence and Aggression

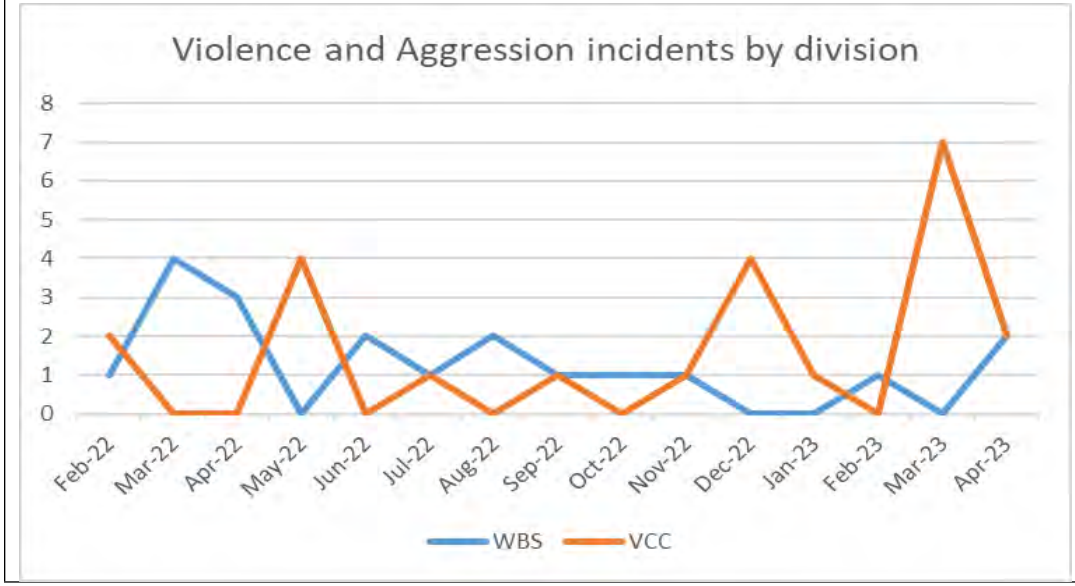
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard –

Performance - Stable

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar 23	Apr 23	May 23	**Total**
WBS	4	3	0	2	1	2	1	1	1	0	0	1	**0**	**2**	**4**	**24**
VCC	0	0	4	0	1	0	1	0	1	4	1	0	**7**	**2**	**0**	**27**



Service Improvement Actions – Immediate (0 to 3 months)

Incidents at VCC include – 3 incidents of dangerous driving/verbal aggression in car park – **actions** - being reviewed to identify actions, 3 incidents involving a confused patient on FFW, additional training provided for staff, one patient requiring intervention with a behavioural contract, **action** contract issued.	Timescale VCC and WBS safety advisors Q 1 & 2 2023

Expected Performance gain – immediate Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit	H&S Team Timescale :Q3&4 2023

Expected Performance gain – longer-term

Risks to future performance

VCC and Corporate – V&A from patients and families due to treatment delays

VCC management of confused patients on FFW. Aggression in relation to parking pressures.

WBS – verbal aggression from donors.

TIMELINESS

KPI Indicator KPV.14

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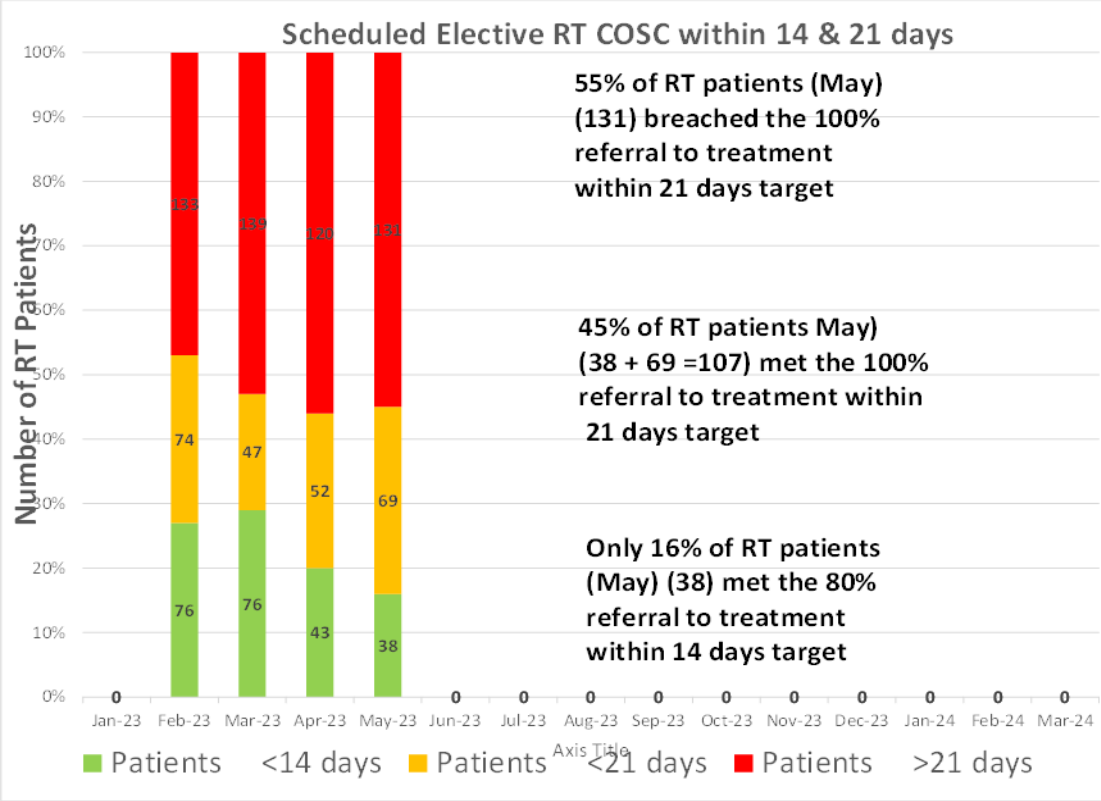
Elective Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	
Target: 80% within 14 Days and 100% within 21 Days (COSC)	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Ongoing challenges post DHCR in establishing a fully validated position. User system compliance errors contributing as a result of move to COSC categorisation. Validation resources currently insufficient to address range of issues identified.

Number of referrals	238	
treated within 14 days of referral (80% target)	38	16%
treated within 21 days of referral (100% target)	107	45%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Retraining for clinical teams underway along with pathway review team scrutinising breach reasons.	Commenced and ongoing	Helen Payne
Additional validation resources to be provided.	Commenced	Helen Payne
Task and finish group established to provide detailed action plan to address immediate challenges and short term pathway improvements	plan in place by end of June	Kathy Ikin

Expected Performance gain – immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.	October 2023	Tom Rackley

Expected Performance gain – longer-term

Changes to patient pathway in line with COSC timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has commenced

KPI Indicator KPV.15

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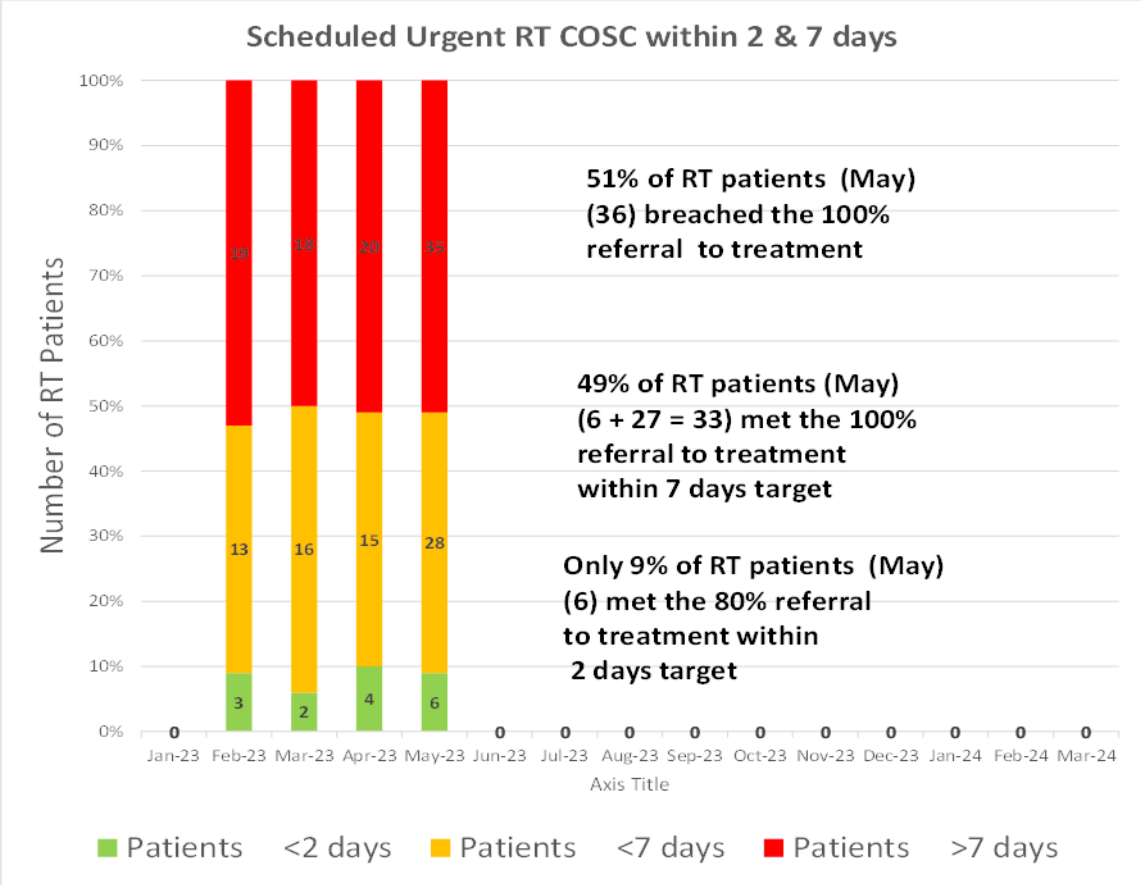
Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)

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



SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months 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	67	
treated within 2 days of referral (80% target)	6	9%
treated within 7 days of referral (100% target)	33	49%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.16

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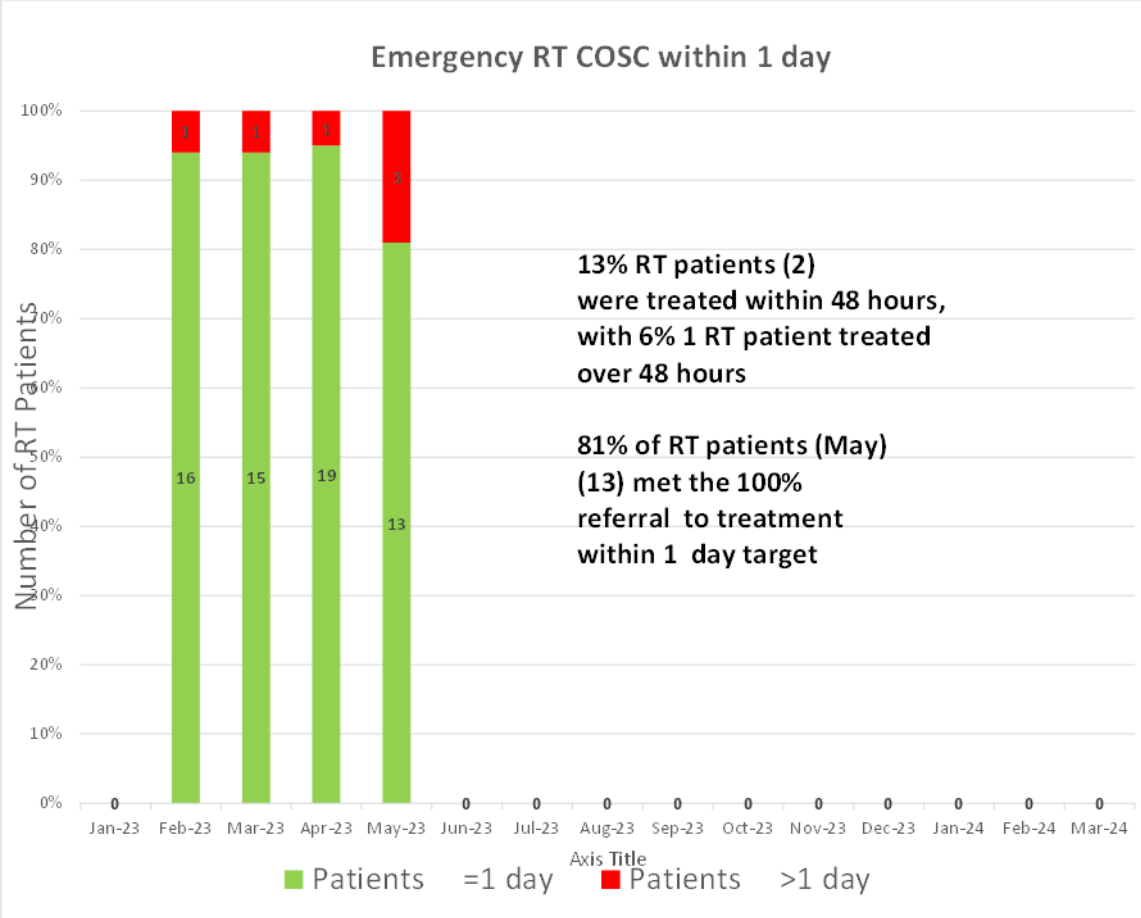
Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Target Achieved

Number of referrals	16	
% treated within 24 hours of referral	13	81%
% treated within 48hours of referral	15	94%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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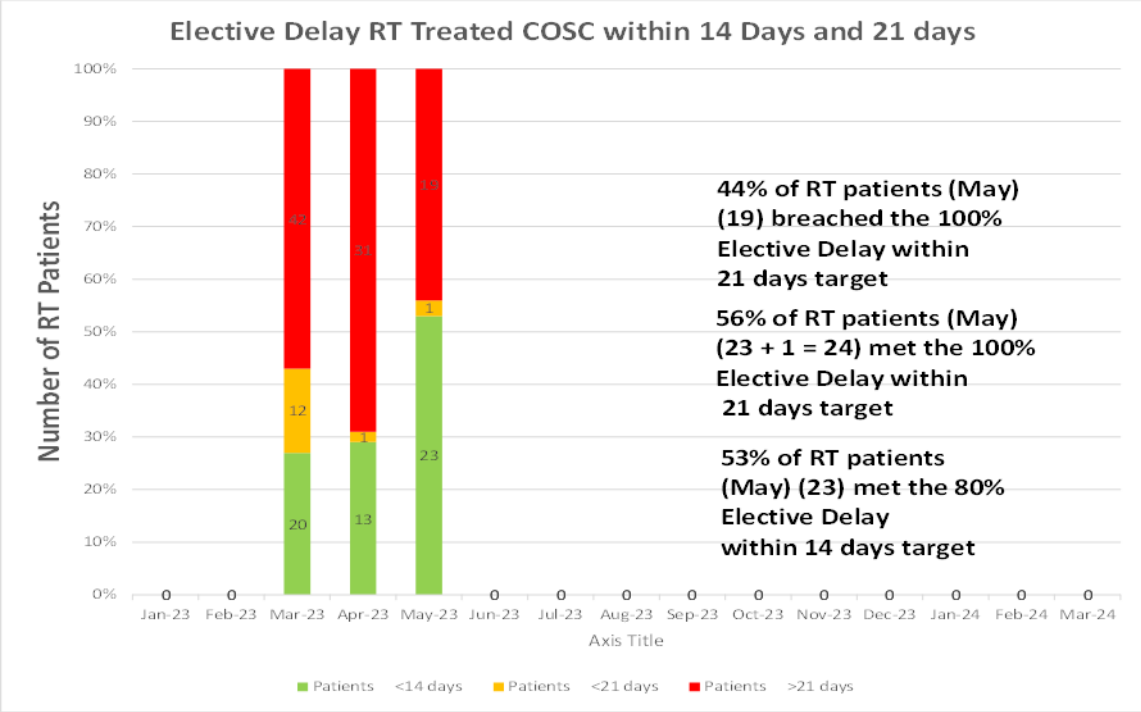
Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

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



SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	43	
treated within 14 days of referral (80% target)	23	53%
treated within 21 days of referral (100% target)	24	56%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.20

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Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	71	69	61	59	66	77	89	96	98	96	97	98	98	93	90
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	118	116	146	147				14	6	12	9	9	8	26	40
Within 21 days	400	375	375	355				341	354	322	336	388	409	343	354

The number of patients scheduled to begin non-emergency SACT treatment in April 2023 (369) was lower than the number in March (409) and may be due to the Easter Holiday period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Attendances	2,189	2,344	2,015	2,315	2,357	2,214	2,316	2,180	2,047	2,276	2,017	1,832
2020/21 Attendances	1,219	1,212	1,375	1,537	1,641	1,696	1,941	1,891	1,982	1,957	1,975	2,253
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,189	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							

This high level of activity was a major factor in the improvement in both the overall performance but also the reduction in breaches and the volume of patients treated nearer the target days.

Performance

Of 394 patients treated, 40 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)	33	5	1	1

19 patients were primarily as a result of booking capacity, 9 were attributed to administrative delays associated with referrals to the PICC insertion service and 7 were day case resource (nurse/pharm).

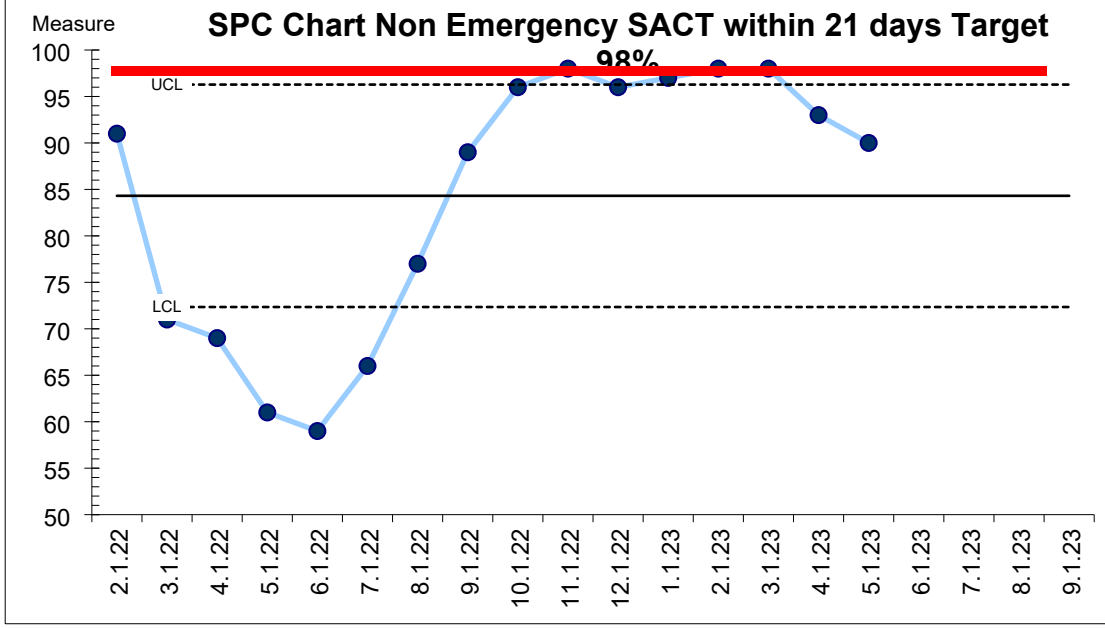
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Through DH and CR Ops group, impact assessment to be submitted to increase SACT Treatment Booking Team resource.	**21/06/23** **01/07/23**	BT
Review and confirm resource requirements of PICC service		MW
Continue to progress SACT nurse and booking review recommendations.		BT

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Re-determine the impact of continued growth in demand across SACT teams	**01/08/23**	BT/WJ
• Determine additional staff resources/ recruitment plan to meet revised	**01/09/23**	BT



SPC Chart Analysis
The system improvements leading to recovery have been maintained over recent months

forecasts across all staffing groups (nursing, pharmacy and booking teams) • Engage with HB partner to deliver onVCC strategy to deliver care closer to home		

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

KPI Indicator KPV.21

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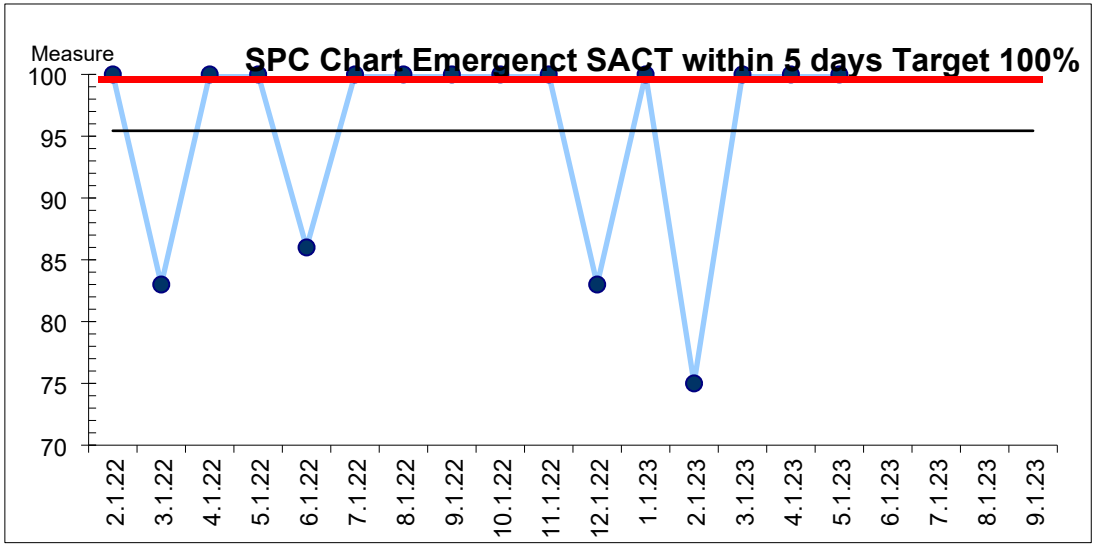
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul2 2	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Ma r 23	Apr 23	Ma y 23
Actual %	83	100	100	86	100	100	100	100	100	83	100	75	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	1	0	0	2	0	0	0	0	0	1	0	1	0	0	0
Within 5 days	6	7	9	7			0	5	6	5	8	3		5	0



SPC Chart Analysis

The SPC chart shows a fluctuating process with average 95 % against the 100% target, however note small numbers involved.

Performance

11 patients referred for emergency SACT treatment were scheduled to begin treatment in May 2023. All 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 +)

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

•

KPI Indicator KPV.22

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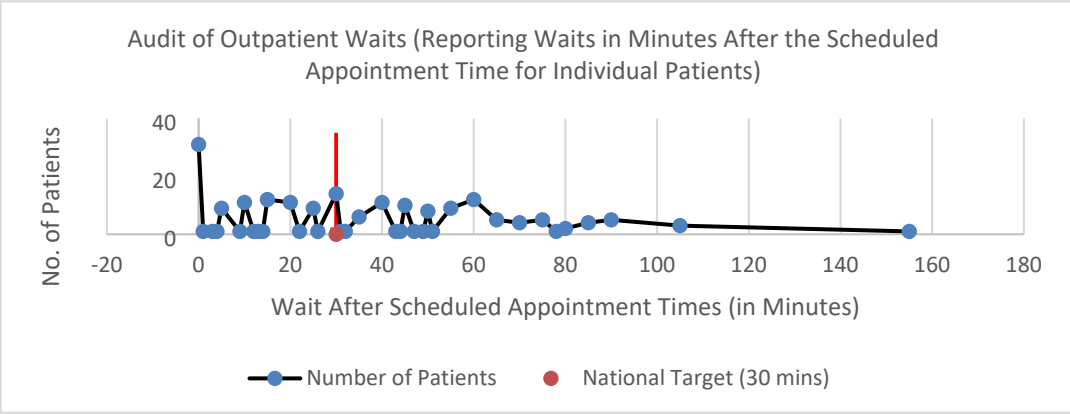
Outpatient Appointments seen within 30 minutes of Scheduled Time

Target: 100%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %					70	47	57	68							
Target 100%	100	100	100	100	100	100	100	100							



Performance reported for September 2022 was 57%.
Note: This is based on a sample size of 2% of the total number of patients seen at outpatients in Aug. (305 patients)
Reporting had been paused between December 2021 and June 2022 over concerns regarding the representativeness of the sample size and ongoing discussions to move the data collection to an integral part of outpatient processes. These discussions have not produced a sustainable solution to date.

Performance

Assessment of current performance, set out key points:
Currently paused due to DHCR implementation

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
•	31/12/2022	Head of OSD
	Ongoing	Lead Nurse, OPD

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•	Q1/2 2023	Head of OSD

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.23

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Equitable and Timely access to Therapy Services (Dietetics; Physiotherapy; Occupational; SLT)

Target: 100% for all Therapies

SLT Lead: Viv Cooper/Kate Baker

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days															
Dietetics	100	100	100	100	100	96	95	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
SLT	100	67	100	100	100	100	100	100	100	100	100	100	100	100	100
Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks															
Dietetics	100	100	100	100	100	100	100	100	98	100	91	100	98	84	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	67	100	100	100	100	100
SLT	100	100	100	100	100	100	50	100	100	100	100	100	100	100	100
Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks															
Dietetics	100	100	100	100	100	100	100	100	100	100	100	100	100	96	94
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	78	100	100	100	100	97	100	78	100	100	96	100	96	100	100
SLT	96	100	100	100	100	96	100	100	100	100	100	100	100	100	100

Performance

For the month of May, breaches occurred for Dietetics

Routine outpatients = x5 breach.

All breaches occurred due to vacancies. We had a turnover of locums, a gap where we lost 2 locums and the start of a new locum. Limited clinic cover meant these patients breached.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Ongoing recruitment to fill vacancies • Review cross cover arrangements within each team. Small team makes cross cover a challenge. • Maintaining locum where possible cover for dietetics while recruitment is underway. • Linking with local Health Boards to see where more joint up working can occur	Ongoing	Head of Therapies

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Assessment of current performance • Developing a Therapies workforce plan		Head of Therapies

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- A current risk is open on the Directorate risk register regarding the challenge of therapies recruitment nationally which is affecting VCC. We prioritise cover on a daily basis. This is particularly affecting Dietetics at present while we hold 2.9wte qualified vacancies in April 2023.
- Securing locum staff with the appropriate skill set is also a challenge.

EFFICIENCY

KPI Indicator KPV.24

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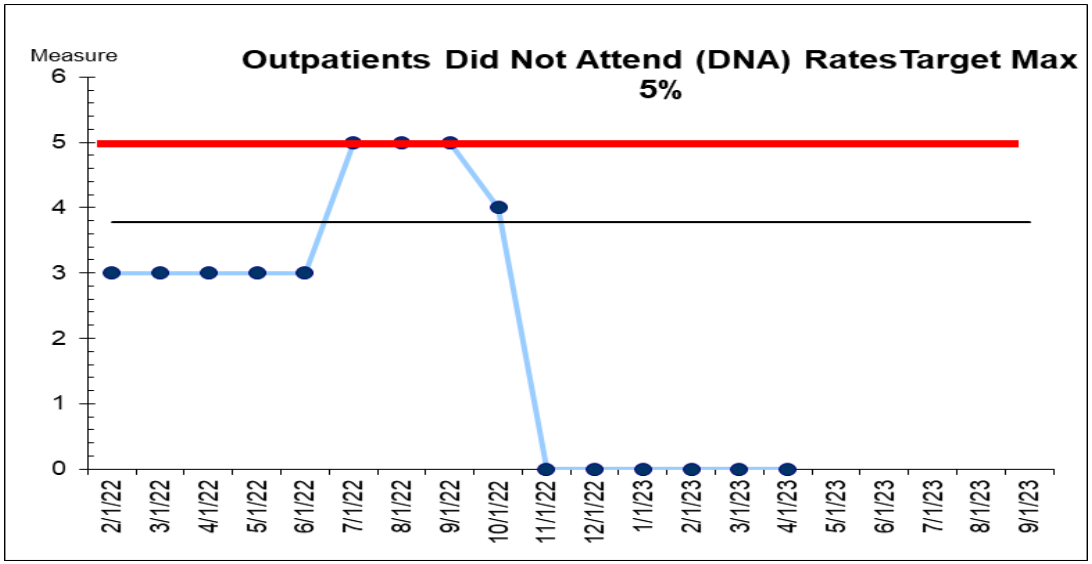
Outpatient Did Not Attend (DNA) Rates

Target: maximum 5%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	3	3	3	3	5	5	5	4	nda	nda	nda	nda	nda	nda	nda
Target Max 5%	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5



SPC Chart Analysis

The SPC chart shows common cause variation for the period to October '22 when data was available

Performance

Assessment of current performance, set out key points:

Currently paused due to DHCR implementation

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• No actions Required		L Miller

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.62

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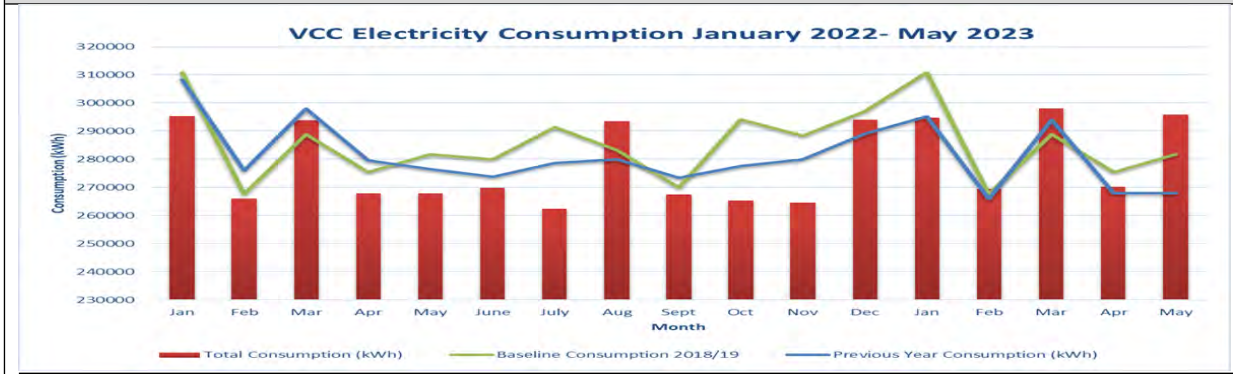
VCC - Energy (Gas and Elect) performance consumption

Target: -2% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh	293942.33	267927.50	267929.50	269902.00	262487.50	293616.00	267497.7	265245.59	264630.40	294036.80	294787.10	269560.00	298017.60	270209.7	295933
Target number previous year	292012.20	274046.91	271065.26	268232.86	273081.31	274313.66	267955.13	272050.74	274341.89	283318.39	289376.95	260652.95	288063.48	262568.95	262570.91
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	2%	-2%	2%	-2%	-2%	-2%	-2%	-2%	-2%

Performance

Assessment of current performance, set out key points:
Currently, Electricity and Gas both below 2018/19 baseline consumption target and following similar pattern to previous year.

Gas data continues to decrease due to energy optimisation on ward areas.

Electricity increase due to increase air conditioned units across site.

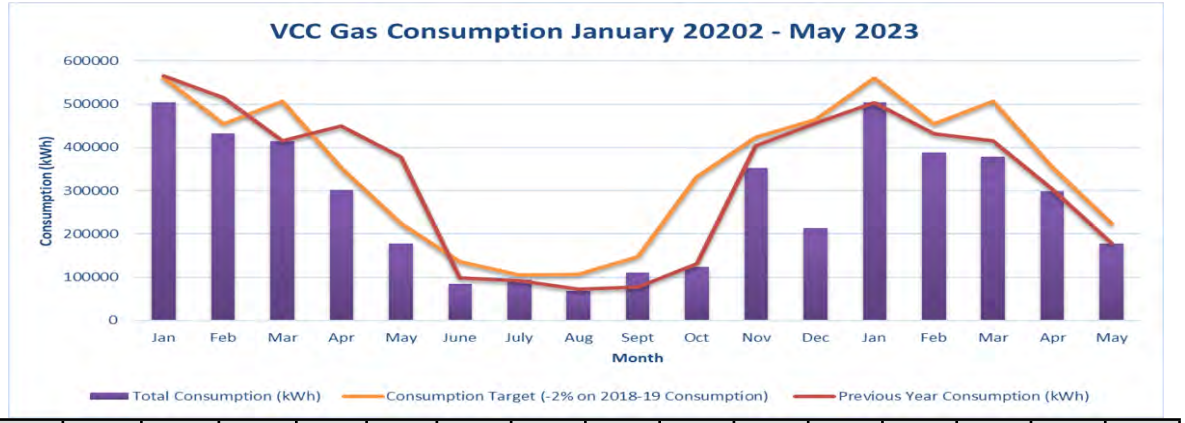
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	**3 months**	Milburn Mounter
BMS upgrades	**3 months**	Milburn Mounter

Expected Performance gain - immediate
Continue to monitor energy performance
Promote ways to reduce electricity usage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Metering strategy	**12 months**	Jason Hoskins
Plant optimisation	**12 months**	Jon Fear



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh)	415161.49	302009.08	178115.55	84995.18	94369.57	67609.2,	111414.96	123658.88,	351983.95	213654.29	503927.87	388474.24	379193.76	299086.8	177794.13
Target number previous year	406,737	441,204	369,333	96,680	89,534	70,735	76086	128,945	395,764	446,228	494017	423,674	406,858	295968.90	174553.24
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%

Expected Performance gain – longer-term
Continue to monitor consumption, increase metering.
Plant optimisation.

Risks to future performance

Set out risks which could affect future performance
Anticipation of increased electricity usage due to heatwave / increase of air conditioning units.

KPI Indicator KPV.67

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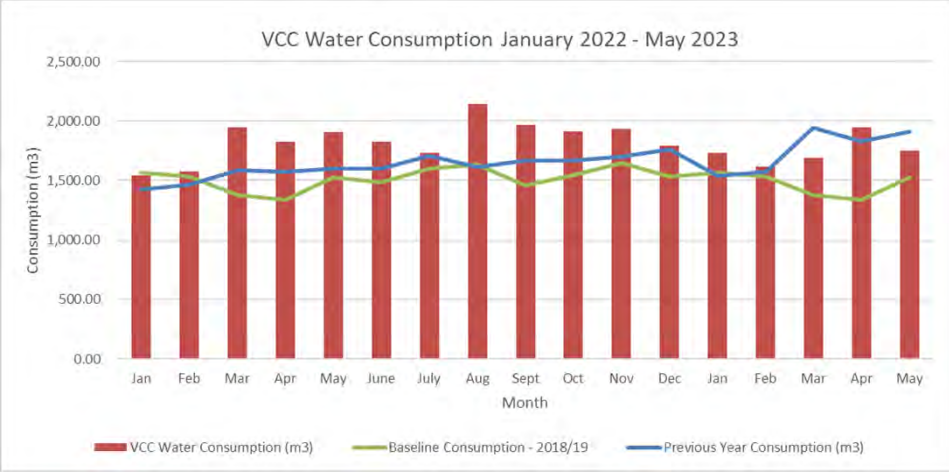
Graph title -Water

Target: Continued monitoring to identify and mitigate trends

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:

Decrease in May consumption comapred to previous year

- There has been an increase in water consumption at VCC compared to compared to the baseline data due to an increased flushing regime to comply with water safety regulations
- Across all sites there has also been Increased hygiene requirements to comply with IP & C guidance

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Capturing water data at WBS has changed year therefore [previous data is displayed in quarters] Going forward, increased monitoring and integration into the BMS to ensure monthly figures are monitored	3 months	**Matthew Bellamy**
Integrating the water consumption to the BMS at VCC	3 months	**Milburn Mounter**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

• Increased metering across all sites • Dedicated resource to capture the metering	**12 months**	Jason Hoskins

Expected Performance gain – longer-term

Continue to monitor consumption resulting in targeted initiatives and improvements reducing consumption.

Risks to future performance

Increased flushing regimes to adhere to water safety regulations

KPI Indicator KPV.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC 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 £k	14	2	3										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

VCC Revenue reported Position for May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	11.753	11.962	0.210	72.971	72.971	0.000
Expenditure						
Staff	8.350	8.430	(0.080)	45.765	45.765	0.000
Non Staff	10.053	10.186	(0.133)	64.210	64.210	0.000
Sub Total	18.403	18.616	(0.212)	109.976	109.976	0.000
Total	(6.650)	(6.653)	0.003	(37.005)	(37.005)	0.000

Performance

The reported financial position for Velindre Cancer Services as at the end of May 2023 was a small underspend of **£0.003m**, and an expected outturn position of **breakeven**.
Income at Month 2 represents an overachievement of **£0.210m**. Overachievement on Private Patients drugs due to activity and VAT savings from delivery SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date overspend of **£(0.080)m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave across several services which is largely offsetting both the vacancy savings target and to support posts appointed without funding agreement. The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff Expenditure at Month 2 was **£(0.133)m** overspent which is a result of increased activity in a few areas including use of PICC and SACT following treatment returning to Neville Hall.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Quarterly Performance Reviews with each Directorate	30/06/2023	Paul Wilkins

Expected Performance gain - immediate
Opportunities and challenges understood.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Investment process and funding flows linked to contract performance income	Sept 2023	Chris Moreton

Expected Performance gain – longer-term
Identification of resource opportunities and challenges with emphasis on delivering Value Based Healthcare

Risks to future performance

Set out risks which could affect future performance

- Balance of organisational capacity, demand, and available workforce.

KPI Indicator KPV.72

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Usage of Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

VCC Position	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	874	66	60										
Target per IMTP £0.435M Forecast		99	99	99	39	38	38	8	8	8	0	0	0

Performance

The spend on agency for May 23 was £0.060m, which gives a cumulative year to date position of £0.126m and a forecast outturn position of c£0.655m.

At this stage of the year the division is expecting to reduce the use of agency by transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Radiotherapy Workforce Plan addressing substantive employment	July 2023	Kathy Ikin

Expected Performance gain - immediate

Reduced agency premium

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Sustainable workforce modelling and deployment	Dec 2023	Paul Wilkins

Expected Performance gain – longer-term

Reduced reliance on agency via sustainable workforce

Risks to future performance

Set out risks which could affect future performance

- Workforce market, demand, significant change programmes

KPI Indicator KPV.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	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 Cumm	700	40	68										
Target £950k Forecast		40	40	40	92	92	92	92	92	92	92	92	92

VCC Cost Improvement Programme – Target £950k

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							
Service Workforce Re-design (VCS)	Amber	50	0	0	0	50	0
Establishment Control (VCS)	Green	175	0	29	29	175	0
Pay Controls - Rationalisation of Service	Amber	150	0	0	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	21	21	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	8	8	0	50	0
Procurement Supply Chain (VCS)	Amber	100	0	0	0	100	0
Total Saving Schemes		**650**	29	58	29	650	0
Income Generation							
Expand SACT Delivery (VCS)	Green	200	33	33	0	200	0
Private Patient Income (R) (VCS)	Green	50	8	8	0	50	0
Private Patient Income (NR) (VCS)	Green	50	8	8	0	50	0
Total Income Generation		**300**	50	50	0	300	0
TRUST TOTAL SAVINGS		**950**	**79**	**108**	**29**	**950**	**0**

Performance

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%).
Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green as the year progresses, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

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 is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

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.

Service Improvement Actions – Immediate (0 to 3 months)

	Actions: what we are doing to improve • Extraordinary Savings meetings with SLT for alternative delivery should targets not be met	**Timescale:** 31/03/24	**Lead:** Paul Wilkins
	Expected Performance gain - immediate Delivery of current savings and planned savings for 23/24 financial year		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	**Timescale:** Dec 2023	**Lead:** Paul Wilkins
	Expected Performance gain – longer-term Delivery of efficiencies		
	Risks to future performance		
	Set out risks which could affect future performance • Balance of organisational capacity, demand, and available workforce.		

EQUITY

KPI Indicator KPV.81

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% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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
- insert text

KPI Indicator KPV.78

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Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator KPV.79

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Diversity of Workforce % Black, Asian and Minority Ethnic people applying Wales version of Workforce Race Equality Standard (WRES)

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator KPV.80

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Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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

ANNEX 2: BLOOD AND TRANSPLANT SERVICES

SAFETY

KPI Indicator KPI.57

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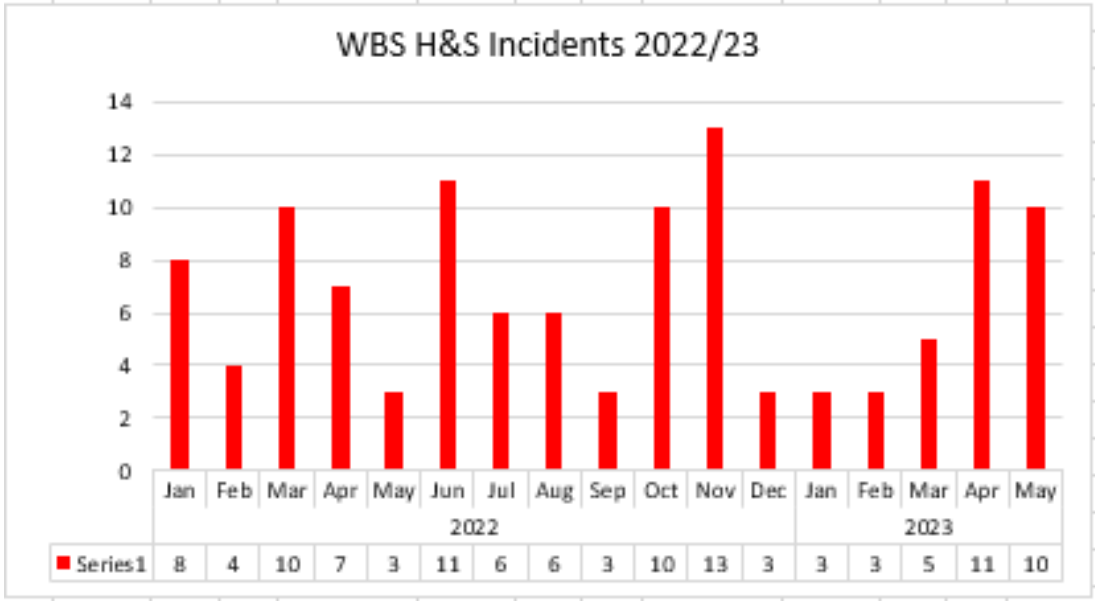
Health & Safety Total number of incidents by division

WBS Target: Continued monitoring to identify and mitigate trends

SLT Lead: Sarah Richards

Current Performance against Target or Standard – stable

Performance



Incidents that relate to Staff/Contractor.

(Include Accident, Behaviour including violence & aggression, Work related ill health, infrastructure inc staffing, facilities, environment, Security/Safeguarding.

excluding non-H&S related incidents, Ill health, non-work related, Infrastructure, including staffing, facilities, environment excluding non-H&S related incidents, fire, & Security.

No discernible trend in incidents that are reported at WBS. Mainly reported from Collection teams. However, incident reporting rates are at a good level enabling us to monitor and investigate H&S incidents that may occur.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale :	Lead:
H&S and Environmental Compliance Manager at WBS continuing to monitor and work with relevant sections to investigate incidents. Continue to monitor incident data at divisional and Trust H&S meetings. Report Incident numbers and categories to SMT – monthly. Identify trends and actions to mitigate trends. Ensure incidents investigated, lessons learned & actions implemented.	Ongoing	Trust and divisional H&S Env Compliance Manager

Expected Performance gain - immediate

Continue to monitor incidents. Embed Investigation training organized by Q&S.
Embed use of Datix Investigation module.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale :	Lead:
Continue to encourage / promote incident reporting. Ensure that investigation training organized by Q&S is embedded long term for H&S incidents. Embed training long term in use of Datix system. Monitor incident data at divisional and Trust H&S meetings. Continue to identify trends and actions to mitigate. Proactive improvement in management of H&S use of HSG65 audit & staff training.	Ongoing	Trust and divisional H&S Managers

Expected Performance gain – longer-term

Continue to monitor incidents highlight problems and focus on these to prevent re-occurrence of incidents. Embed long term Investigation training organized by Q&S leading to improved investigation of incidents, identification of lessons learned and prevention of reoccurrence of incidents. Embed use of Datix Incident reporting module.

Risks to future performance

N/A

KPI Indicator KPI.11

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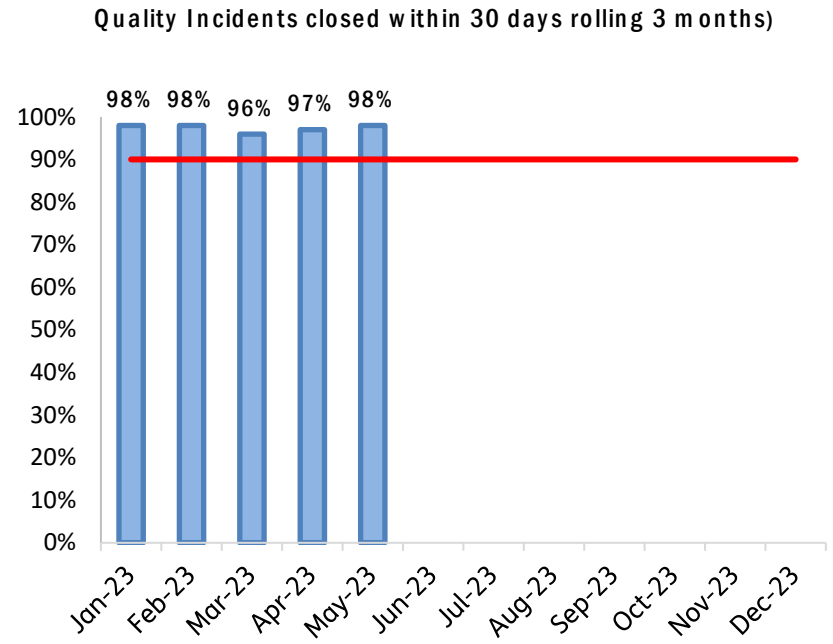
% Quality Incidents (recorded in DATIX & QPulse), closed within 30 days over a rolling 3-month period

Target: 90%

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	85	86	86	98	99	98	98	97	96	96	98	98	96	97	98
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
Quality incident investigations continue to exceed the target of 90% closed within 30 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Continue to closely monitor performance. Each incident report is reviewed within a working day of being reported ensuring effective risk assessment and investigation detail is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause.	Every incident reported is reviewed within 1 working day of being reported	Peter Richardson

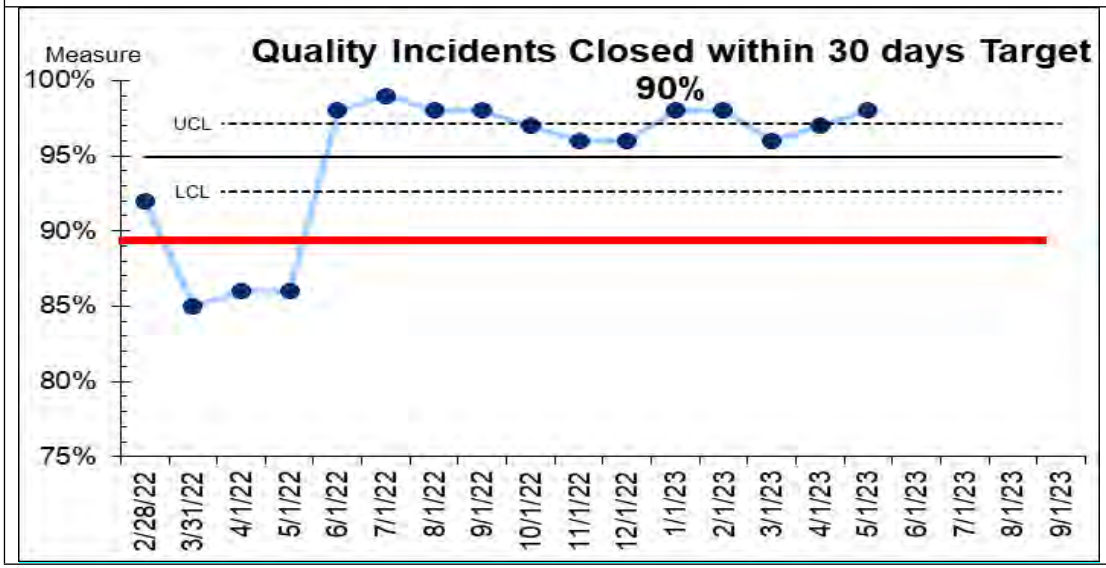
Expected Performance gain - immediate.
We expect the multidisciplinary approach to investigating complex incidents to enable faster identification of root cause and more effective preventative action to be put in place.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Close monitoring of actions to address incidents. The QA Triage Team have changed the day they issue weekly updates alerting owners/managers of actions that are likely to breach close-out deadlines.	Weekly updates	Peter Richardson

Expected Performance gain – longer-term.
Performance is on target and will be continued to be monitored.

Risks to future performance

	Set out risks which could affect future performance. • Anticipated short-term absence of key QA staff during Q1 may impact our ability to prepare for the MHRA inspection due in Q2. The QA team are working with other operational teams to free up suitably experienced staff should it be needed.
	**SPC Chart Analysis** The SPC chart shows common cause or normal variation over a 12 month period. The average performance of 95% consistently exceeding the 90% target.

KPI Indicator KPI.30

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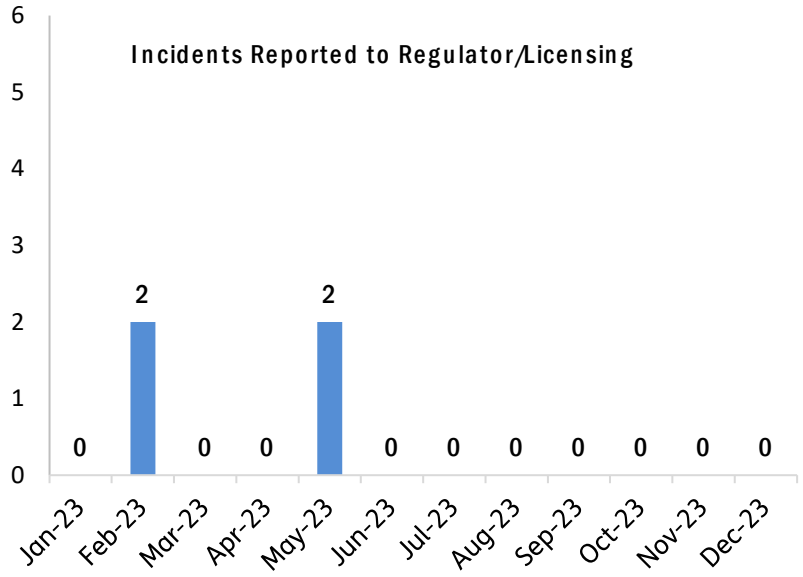
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	0	3	0	0	1	1	0	0	0	2	0	2	0	0	2
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 were two reportable events submitted to the MHRA in May:

• **SABRE-106 (02/05/2022) "Malaria residency not assessed correctly"**
At a recent collection session, a donor's malarial residency status was correctly assessed, and a malaria test sample was taken at donor screening. However, the digital donor record was incorrectly updated, this triggered an investigation. It was subsequently established that the donor's malaria residency was incorrectly assessed on two previous occasions.

This presents a risk that the donor tests for malaria at previous donations could have been positive, potentially resulting in contaminated blood components entering the supply chain.

• S**ABRE 107 (22/05/23): "Contingency Issue PC (CIPC) used to issue unreleased platelet."**

The CIPC procedure was incorrectly used and resulted in a Potential "near miss" - if the platelets were needed for an urgent transfusion they could have been transfused before the bacteriology results were known; this may have had an adverse patient impact if bacterial growth had occurred.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE reports, is monitored via existing processes and reported to the Regulatory Assurance and Governance Group (RAGG).	Progress is monitored via monthly reporting into RAGG.	Peter Richardson

Expected Performance gain - immediate
N/A

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve Actions will be introduced as outcome of root cause analysis of these incidents.	**Timescale:**	**Lead:**
	Expected Performance gain – longer-term N/A		
	Risks to future performance		
	N/A		

KPI Indicator KPI.32

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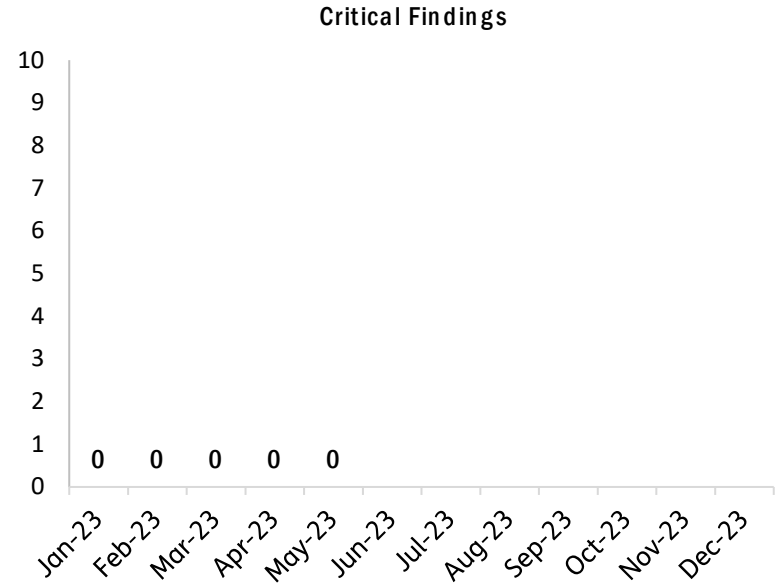
Numbers of critical and major non-conformances through external audits or inspections

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points.

A UKAS inspection of 17043:2010 occurred on 19/05/23, no major findings were raised.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Audit schedule for 2023/24 has been completed and risk assessed. All findings in forthcoming audits will have a CAPA assigned to ensure continuous improvement. Information Governance Audits of the respective WBS Departments has commenced.	March 2024.	Peter Richardson

Expected Performance gain – immediate: N/A

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

Anticipated short-term absence of key QA staff during Q1 may impact our ability to prepare for the MHRA inspection due in Q2. The QA team are working with other operational teams to free up suitably experienced staff should it be needed.

KPI Indicator KPI.59

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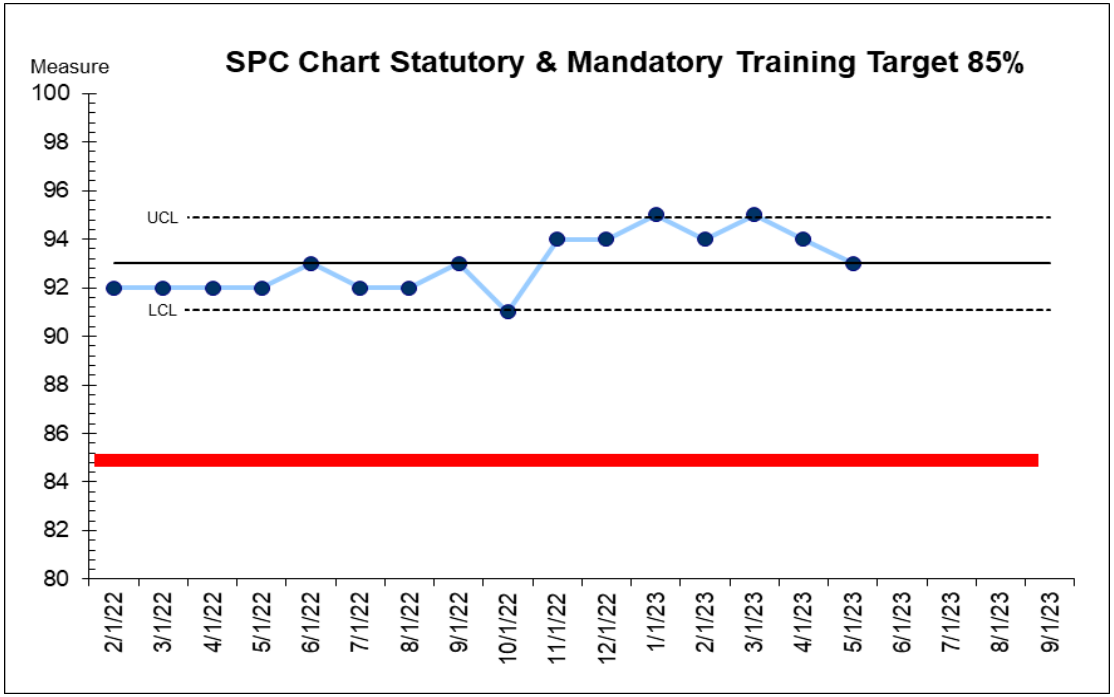
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	92	92	92	93	92	92	93	91	94	94	95	94	95	94	93
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 92.5% against the 85% target.

Performance

Assessment of current performance, set out key points:

Statutory & Mandatory (S&M) target compliance is being met.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
WOD provides WBS SMT with monthly compliance data to show progress against target. Where figures decrease, the service will decide what action to take.	Monthly ongoing	Senior People & OD Business Partner

Expected Performance gain - immediate

All staff are compliant and appropriately trained in their roles.

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 S&M and compliance framework in the All Wales network.	Continuous	Head of OD
The WBS Senior Business Partner will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Continuous	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.

Risks to future performance

Set out risks which could affect future performance

Recruitment and sickness levels may affect staffing levels and ability to release staff to undertake training.

KPI Indicator KPI.54

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Number of Staff RIDDOR Incidents, injuries and work-related accidents

Target: NIL

SLT Lead: Sarah Richards

Current Performance against Target or Standard

WBS Position	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

If performance is not at required level, set out what the main causes are:
No RIDDOR reportable incidents reported for WBS since January 2022. Number of RIDDOR reportable incidents remains low. No discernible trends.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring, investigation and mitigation of incident.	Ongoing	WBS H,S&Env Compliance Manager

Expected Performance gain - immediate
Continue without H&S incidents and report RDDOR related incidents.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to monitor RIDDOR incidents.	Ongoing	WBS H,S&Env Compliance Manager

Expected Performance gain – longer-term
Continue with low numbers of RIDDOR incidents. H&S inspections on WBS sites and venues to identify hazards that may cause incidents of near misses. Ensure that these are mitigated.

Risks to future performance

Set out risks which could affect future performance
Staffing pressures could impact on overall Health and Safety Performance.
Limited control over RIDDOR incidents, can only carry out H&S inspections and audits to highlight the hazards, mitigate and try to prevent RIDDOR incidents occurring.
If a RIDDOR incident occurs investigate and implement measures to prevent re-occurrence.

EFFECTIVENESS

KPI Indicator KPI.04

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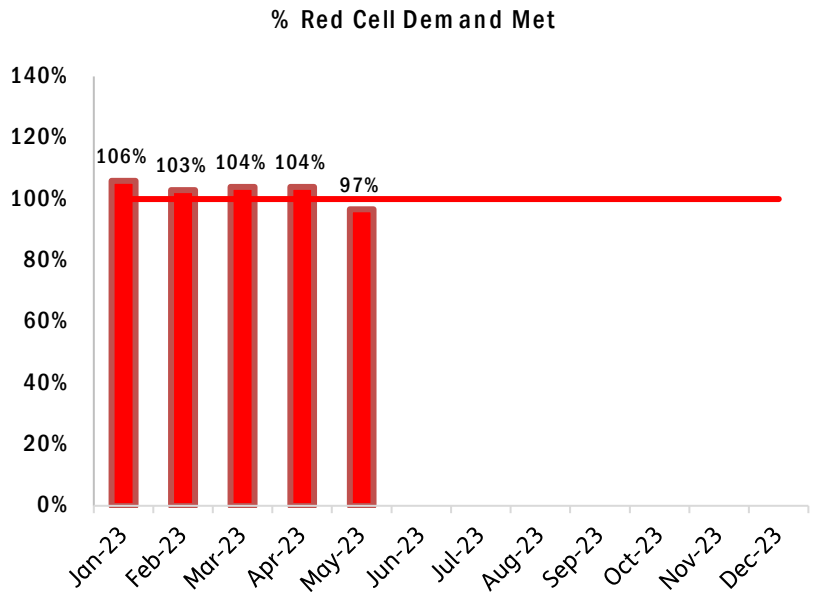
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	100	102	102	100	107	112	105	115	115	94	106	103	104	104	97
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

May contained three bank holidays which provided less bleed days for the manufacture of red cells, resulting in 97%.

April was used to build stock in preparation for May bank holidays, therefore, all clinical demand was met. No mutual aid was required.

Demand (full weeks) averaged at 1413 units per week which is slightly higher than the previous period.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified.	Daily **Lead:** Jayne Davey / Tracey Rees

Expected Performance gain - immediate.
Reviewed daily to support responses to changes in demand.

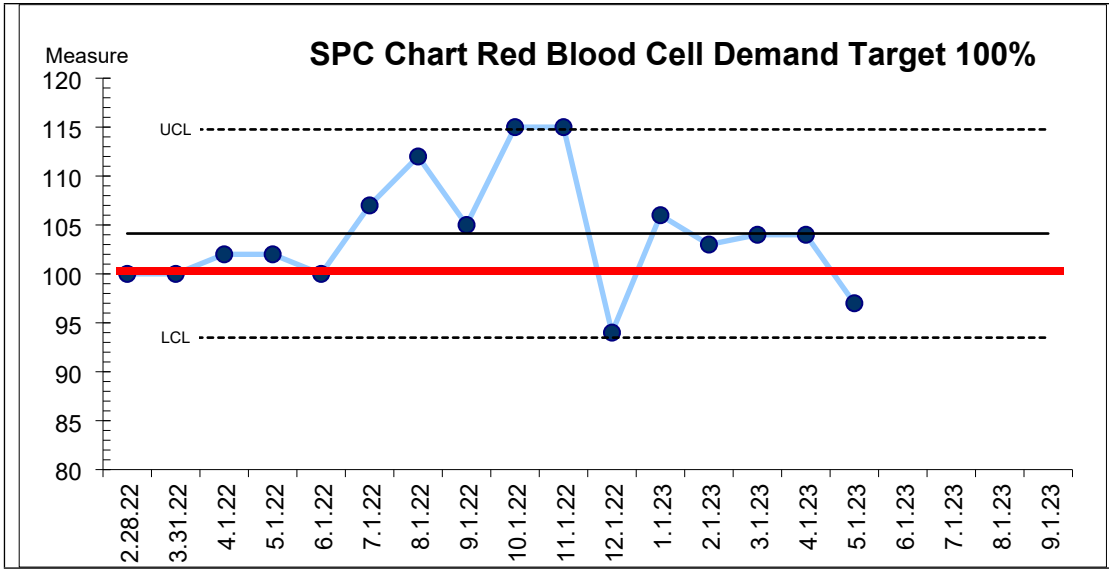
Service Improvement Actions – tactical (12 months +)

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. Impact of industrial action on ability to collect sufficient blood donations (ongoing).



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.

KPI Indicator KPI.07

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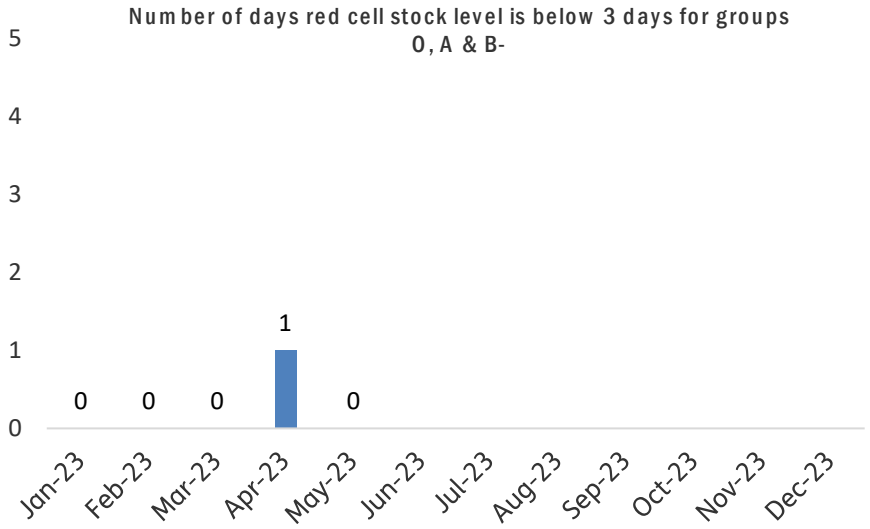
Red Blood Cell Stock Level (below 3 days) – number of days in the month when red cell stockholding fell below 3 days for blood groups O, A and B+

Target: zero days

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	0	0	0	4	6	0	0	0	0	0	0	0	0	1	0
Target (days)	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 no days in May where stock for Blood Groups **O, A & B-** fell below 3 days:

A Blue Alert for **A -** was declared on 25th May 2023 and was in place for one week to protect stocks and allow recovery of the stock position. This does not impact clinical use of blood.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meeting. At the meetings, business intelligence data is reviewed which facilitates operational responses to the challenges identified.	Daily Business as Usual (BAU) **Lead:** Tracey Rees

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Daily **Lead:** Alan Prosser

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.
Impact of industrial action on ability to collect sufficient blood donations (ongoing).

KPI Indicator KPI.05

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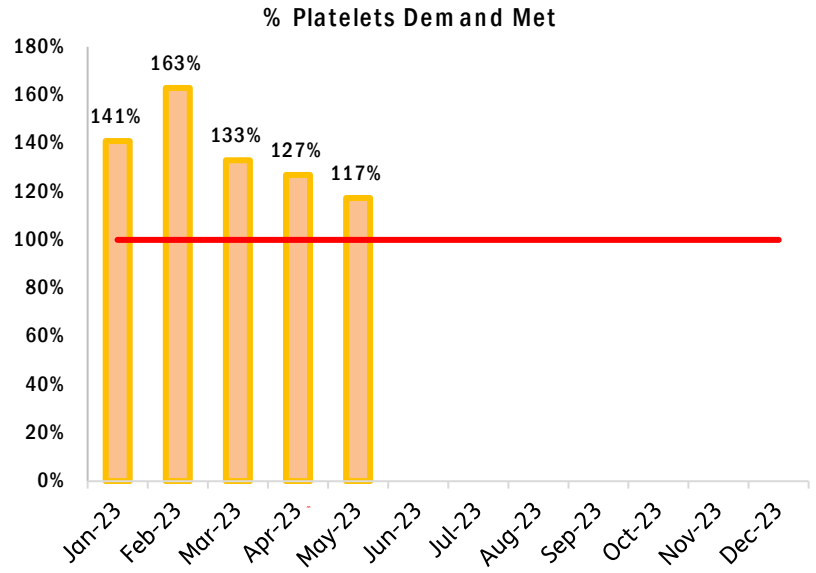
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	125	150	125	128	145	164	132	126	139	145	141	168	133	127	117
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



NB: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.

Performance

Assessment of current performance, set out key points:
All clinical demand for platelets was met representing a strong performance against this metric. Platelet demand was 170 units per week on average. This is higher than the previous period, with the May bank holidays added considerable challenge to meeting this performance target.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring to alter production as required	**Lead:** Tracey Rees Daily - BAU **Timescale:** **Tracey Rees Timescale**

Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs.

Service Improvement Actions – tactical (12 months +)

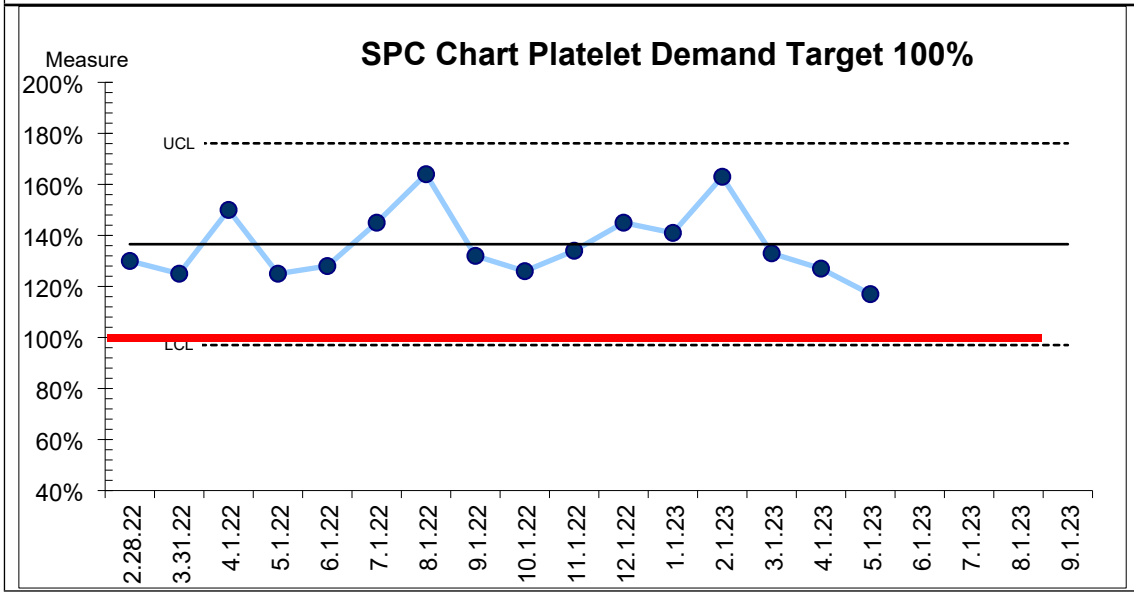
Actions: what we are doing to improve A focus on balance of aphereis versus pooled platelets and timing of aphereis clinics will be conducted as part of the WBS futures programme under Labortory Modernisation. Consideraton of a digital tool to enable prediction/requirement for platelet production will also be include	**Timescale:** 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.

Impact of industrial action on availability of sufficient platelet supply to meet demand (ongoing).



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 140% consistently exceeding the 100% target.

KPI Indicator KPI.25

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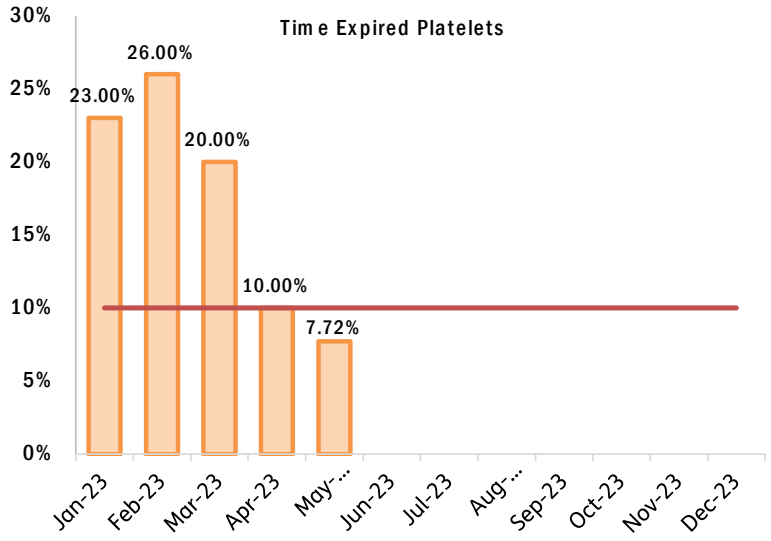
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	14	16	15	23	19	30	25	14	15	27	23	25	20	10	8
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before they 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.

Performance

Assessment of current performance, set out key points:

Platelet expiry improved and met target in May because of the changes to production made in April. Whilst the May bank holidays provided a significant challenge in balancing supply and demand, expiry levels were controlled by modelling expected issues against production in platelet manufacturing.

NB:

- Platelet expiry is based on a % of production, as platelet production reduces, the % contribution to expiry for each individual platelet increases.
- Production is set at 165 per week on the basis that the average demand was impacted by a single exceptional week. This was amended for bank holiday weeks.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:** Tracey Rees **Timescale:**
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings.	Daily (BAU)
b. Pooled platelet reductions have been implemented and are being reviewed as a measured approach to the declining demand trend.	
c. A Platelet Strategy Board will be established to co-ordinate the work of the two Task and Finish Groups convened following the November 2022 platelet review and other ongoing work. This will sit under the WBS Futures Initiative under the Lab Services Modernisation Programme.	June 2023
d. Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1). This action has been delayed due to insufficient capacity within the Business Intelligence Team.	Q2 - TBC

Expected Performance gain – immediate.

Controlled platelet production leading to reduced wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Reviewing the clinic collection pan for Apheresis (Task & Finish Group 2) 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.	Qtr 2 & 3 onwards **Lead:** Jayne Davey

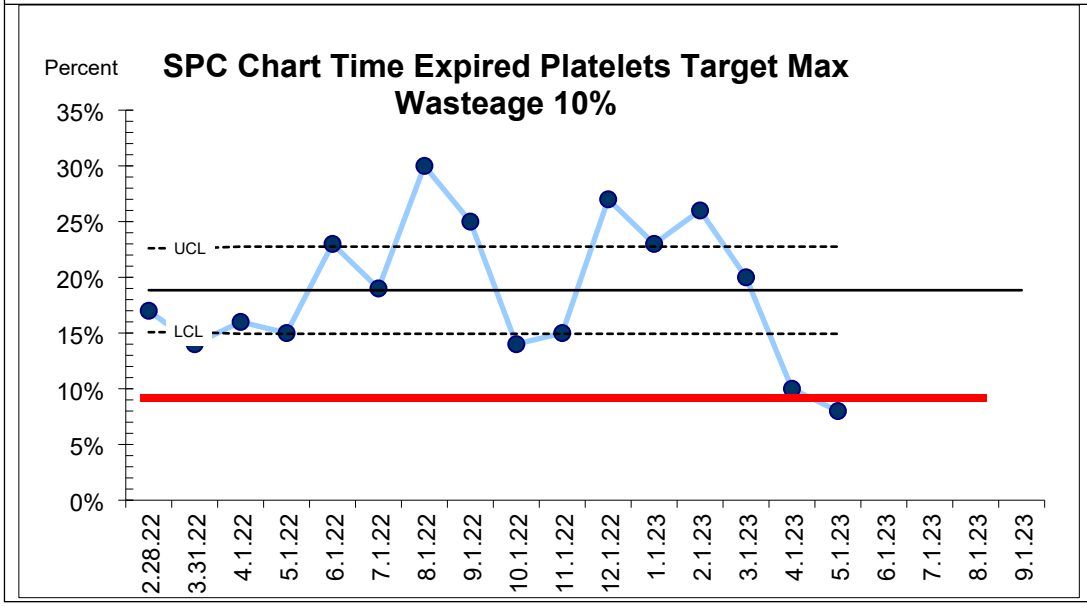
Expected Performance gain – longer-term.

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%.

KPI Indicator KPI.26

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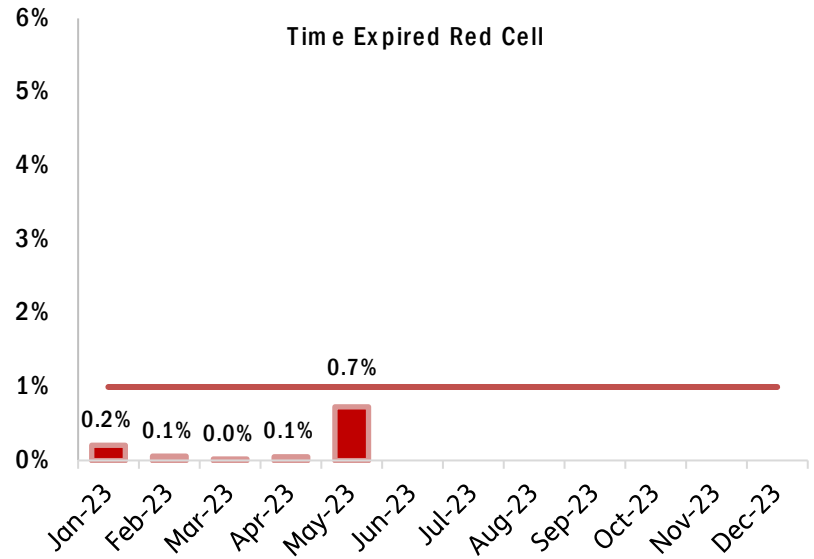
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	0.08	0.08	0.00	0.02	0.01	0.03	0.35	0.01	0.33	0.36	0.21	0.05	0.02	0.05	0.7
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

Assessment of current performance, set out key points:
Performance of this metric has met target.

The expiry rate increased in May due to Group **B+** units stock exceeding demand.

Red cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
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.

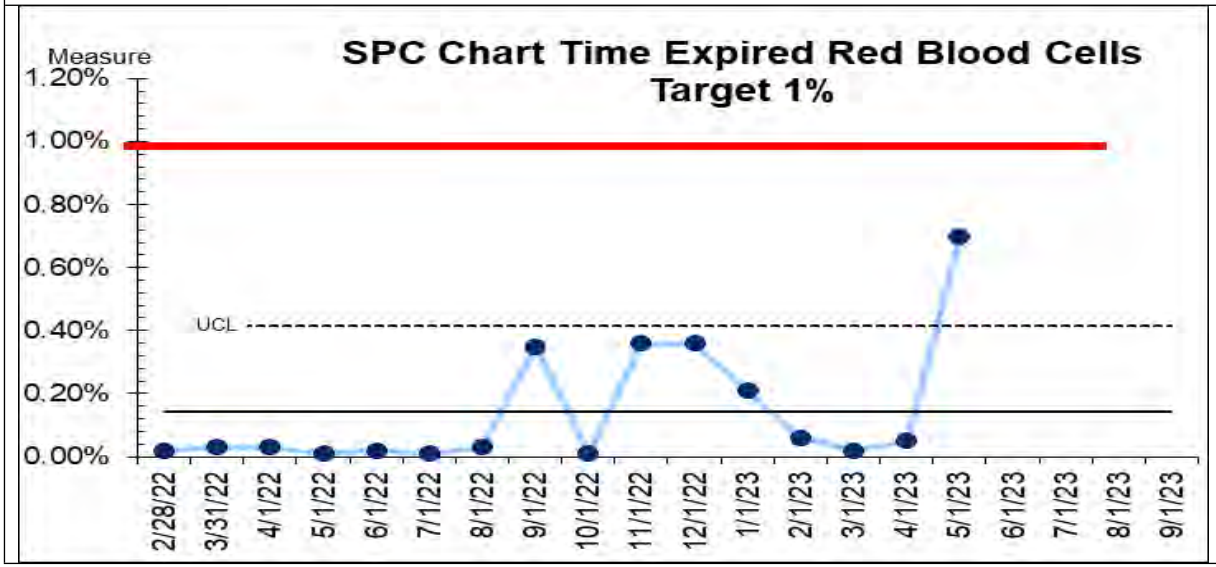
Service Improvement Actions – tactical (12 months +)

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.
- Industrial action also presents a risk – mitigation of the risks from industrial action are to increase stock holding, if the strikes do not affect collection, then stock holding may be higher than optimal levels.



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 0.10% remains well within the maximum 1%

KPI Indicator KPI.13

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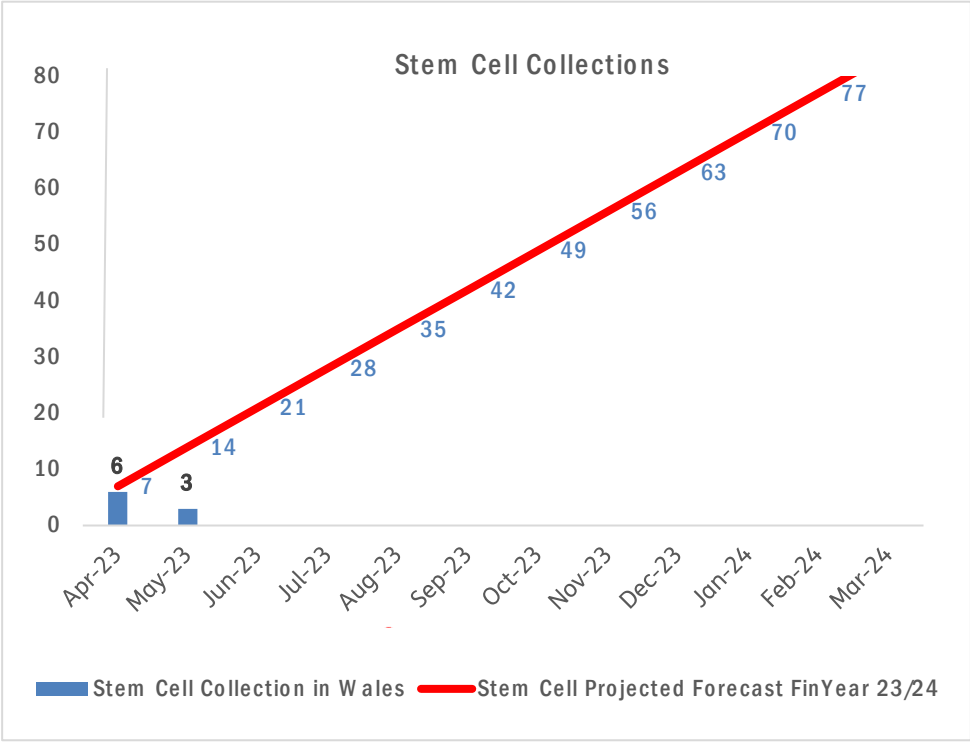
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Cumulative Actual	47	1	2	8	8	12	14	14	15	19	23	26	32	3	6
Cumulative Target p/a	80	7	14	20	27	34	40	47	54	60	67	74	81	7	14



Performance

3 collections were performed during May. 2 collections were cancelled for patient reasons and 2 for donor reasons.

The total stem cell provision for the Service was 4, made up of 3 collections and 1 imported for a Welsh patient.

The Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

NB: Projected Forecast detail does not include stem cells collections 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. 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:** Qtr 1 **Lead:** Tracey Rees

Expected Performance gain - immediate.
As above

	Service Improvement Actions – tactical (12 months +)	
	Implementation of the five-year strategy.	**Timescale:** Qtr 2 2023 onwards **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.	

KPI Indicator KPI.19

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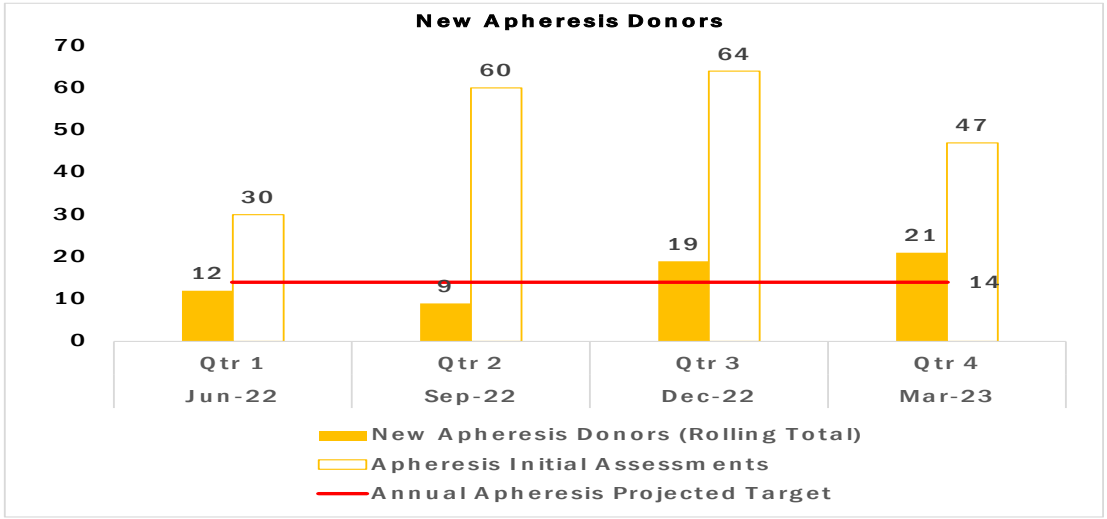
Number of New Apheresis Donors 14 per quarter (+56 per annum)

Target: 14 per quarter

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Quarterly Actual	12			9			19			21					
Quarterly Target	14			14			14			14					
Cumulative Actual	12			21			40			61					
Cumulative Target 56 pa	14			28			42			56					



Performance

Assessment of current performance, set out key points:

All demand for apheresis derived platelets has been met. There were 21 new apheresis donors in Quarter 4, as reported in March 2023. This was 7 above the quarterly recruitment target of 14 and 5 above 56 as the 2022/23 target with 61 new apheresis donors. Low platelet demand continues at present, with apheresis activity focused on special bleeds provided by existing donors.

All demand for apheresis derived platelets has been met.

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** **Q2 2023/24**
Incorporate recruitment requirements into Platelet Strategy programme of works	**Lead:** Jayne Davey

Expected Performance gain – longer-term

Sustained growth in apheresis panel.

Risks to future performance

Capacity to release staff for enhanced training.

KPI Indicator KPI.27

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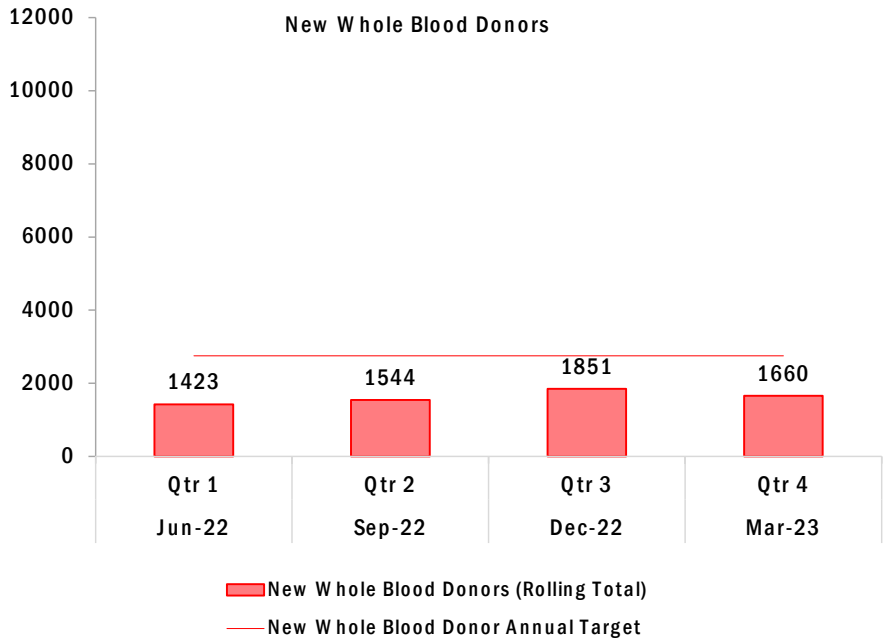
Number of New Blood Donors (2750 per quarter) recruited to the Donor Panel

Target: 11000 per annum

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Quarterly updated	**1423**			**1544**			**1851**			**1660**					
Cumul-ative Target 11000 p/a	2750			5500			8300			11000					



Performance

Assessment of current performance, set out key points:

At 6,478, new donor figures did not meet the annual target of 11,000 for the 2022/23 financial year.

The requirement to intensify appointment management by donor blood type throughout a prolonged O Positive and O Negative Blood Shortage Blue Alert, lasting from March 2022 to August 2022, 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 90.6%, appointment uptake from existing donors was above target for 2022/23. However, this success provided less opportunities for non-donors to book their first donation.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	**Timescale**
Creating a new community partnership targeting donations made through their 'workplaces', in consideration of the new business world post-COVID with more staff working from home.	By June 2023 **Lead:** Andrew Harris

Expected Performance gain – immediate.

Making potential new donors aware of the opportunities to donate around them and encouraging organisations to educate staff on WBS.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale**
Donor Strategy is in development which aims to increase opportunities for both young donors and ethnic minority donors to give blood. There is a planned increase in clinics to be held at education settings in 2023/24.	2024-2027 **Lead:** Andrew Harris **Timescale** 2023/24 **Lead:** Aiysha Baillie

	Expected Performance gain – longer-term Likelihood of hitting target will depend on the overall demand for blood increasing back to pre-COVID levels, and the donation sessions being held at education settings and businesses.
	Risks to future performance
	Set out risks which could affect future performance Fluctuations in the demand for blood.

KPI Indicator KPI.20

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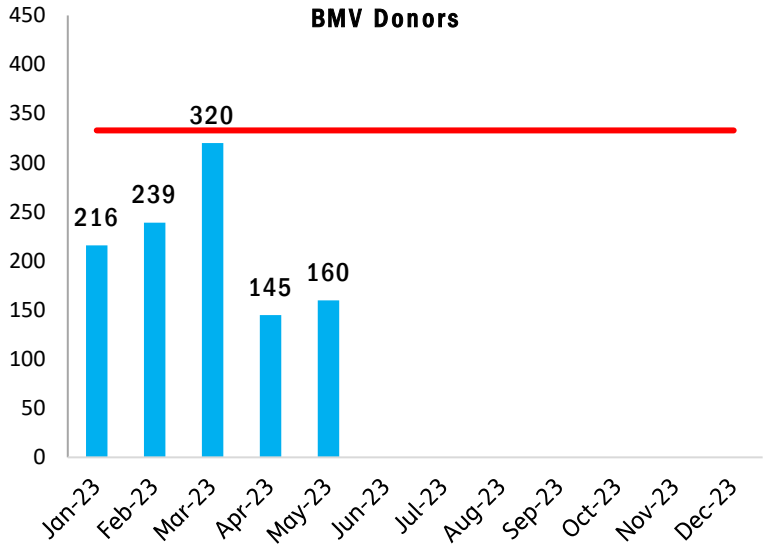
Number of New Bone Marrow Registry (WBMDR) Volunteers aged 17 – 30 recruited in month (4000 per annum cumulative)

Target: 4000 per annum (333 per month)

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
No. of new donors per month	283	141	163	200	215	243	151	203	315	137	216	239	320	145	160
Target Per/Month	333	333	333	333	333	333	333	333	333	333	333	333	333	333	333
Cumulative Actual Performance 4000 p/financial year	2582	138	327	496	679	856	995	1198	1531	1667	1883	1422	1742	145	305



Performance

Performance in May improved slightly but was well below target with only 160 new BMVs (131 from blood and 29 from swabs).

The summer months are typically lower due to the reduced blood donor clinics in educational establishments. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analysing the data from previous swab recruitment campaigns to inform the way forward.

466 eligible donors attended blood sessions with a 28% conversion rate.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale
Recovery Plan is being implemented to increase recruitment of bone marrow volunteers, including: • Establishing key contacts in the National BAME Transplant Alliance (NBTA) to discuss opportunities for using their expertise to support our recruitment process. • Visits to Armed Forces to discuss marketing opportunities. • Advertising around World Cancer Day & Blood Donor Week. • Pilot with donors who requested further info on session to understand why they aren't signing up. • Pilot to understand why swab kits aren't returned despite two follow up emails.	Quarters 1-4 **Lead:** Jayne Davey / Tracey Rees

	• Paid advertising. • WBMDR Website refresh. • Engagement with external marketing companies. • Develop Ambassador Programme • Focus groups • Engaging ethnic minority communities. • Staff Champions – extended training for collection team champions.	
	Expected Performance gain – immediate. Increased number of bone marrow volunteers joining register.	
	Service Improvement Actions – tactical (12 months +)	
	Actions: what we are doing to improve The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, continues to be developed.	**Timescale** Quarter 2 (2023) **Lead:** Jayne Davey / Tracey Rees
	Expected Performance gain – longer-term. Meet current agreed targets with a strategy in place to enable increased recruitment as required.	
	Risks to future performance	
	Set out risks which could affect future performance. Failure to align to UK Stem Cell Strategic Forum recommendations agreed by Welsh Government.	

KPI Indicator KPI.56

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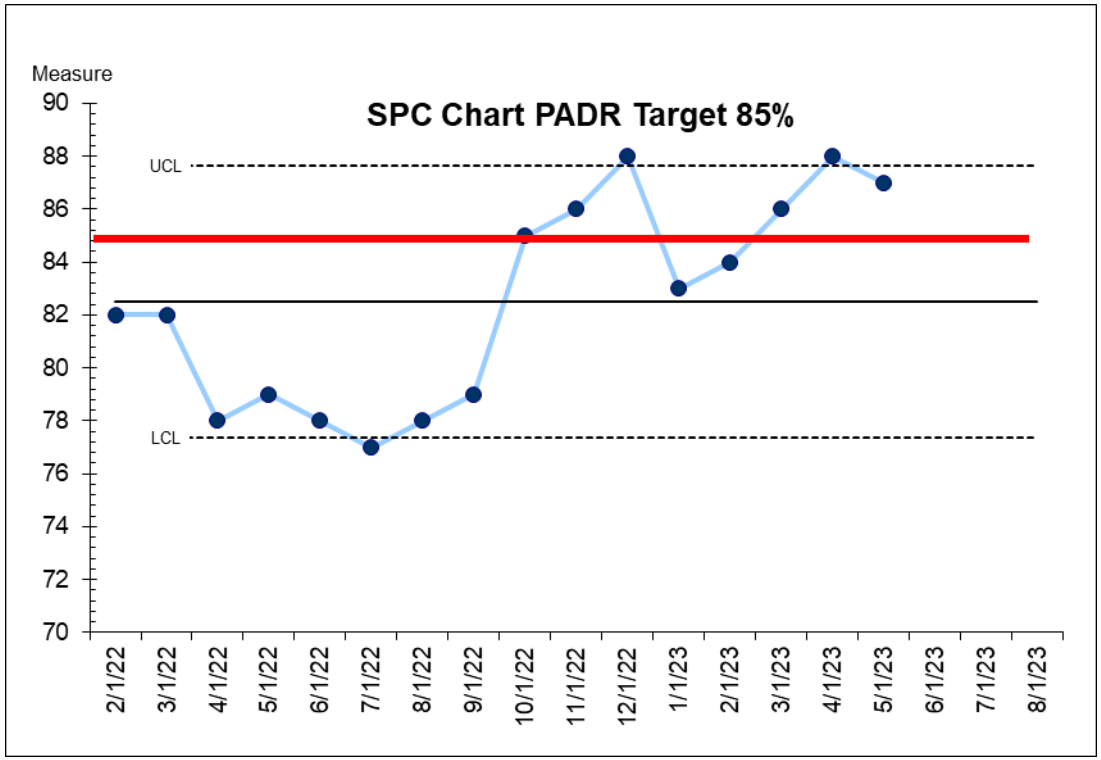
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	82	78	79	78	77	78	79	85	86	88	83	84	86	88	87
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows common cause variation for the last 15 months averaging 81%, but with an improving trend now meeting the 85% target.

Performance

Compliance has increased this month and are now above target, demonstrating the effort made in this area to achieve compliance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
WBS is provided with monthly reports to identify which staff are due their PADR.	Monthly ongoing	ESR Manager
Each team is booking in PADR meetings with their teams, in advance of the deadlines.	Monthly ongoing	Service Managers

Expected Performance gain - immediate

Staff that are due incremental pay increases will receive these on time when PADR meetings are undertaken in a timely manner.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Current measures are working well. Regulatory compliance has now been met, and will be monitored for compliance ongoing.

Risks to future performance

Set out risks which could affect future performance

If further strike action takes place, this could have an impact on achieving compliance, with a depleted workforce.

KPI Indicator KPI.58

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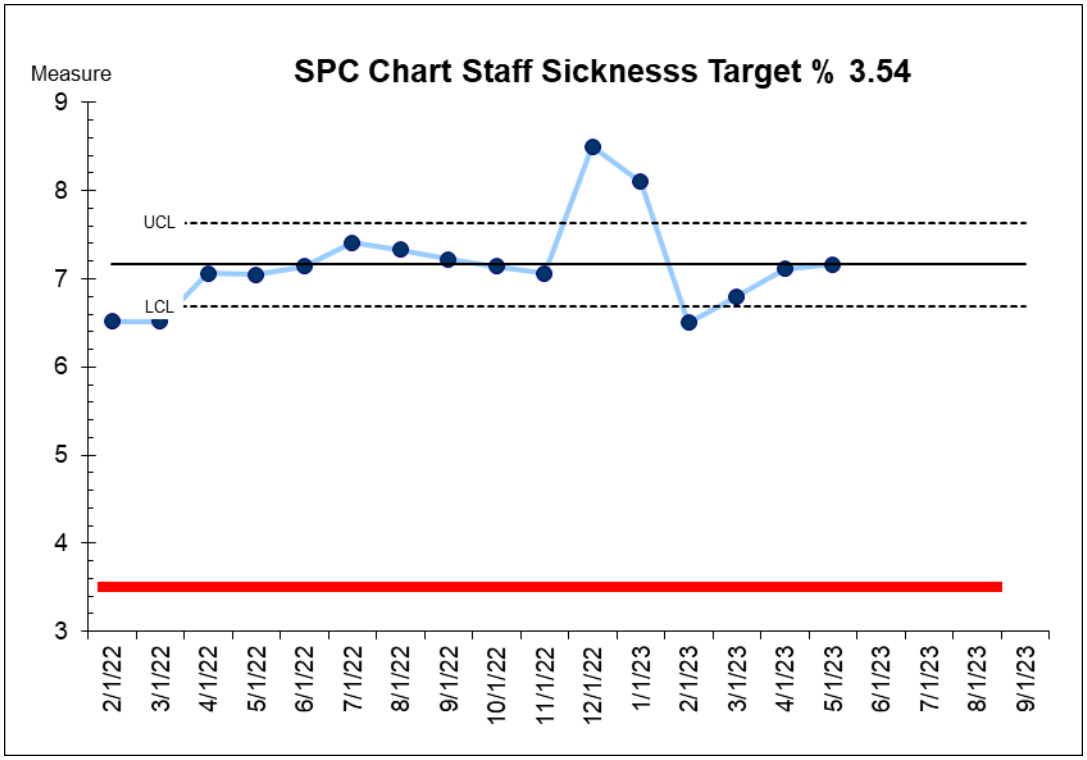
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	6.52	7.05	7.04	7.14	7.41	7.33	7.22	7.14	7.06	8.5	8.1	6.5	6.8	7.11	7.16
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 15 months with the overall average 6.9% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

Sickness absence has marginally increased overall. Short-term and long-term sickness have both increased, which has impacted on figures overall.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Guidance on management of COVID infections has been refreshed and communicated to all staff.	Ongoing	Director of WOD
The People and OD team continue to have monthly support meetings with managers to assist them in management of sickness absence.	Monthly	People and Relationship Advisors

Expected Performance gain - immediate

WBS continue to implement any recommended measures to ensure COVID Risk Assessments are followed and staff are able to limit their exposure to COVID infections in the workplace.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale	Lead:
There are lots of wellbeing initiatives taking place throughout the year and staff are regularly reminded about the Wellbeing offers that they can access at any time.	**Ongoing**	Head of OD

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Strikes and Recruitment pressures could increase sickness absence.

DONOR & STAFF EXPERIENCE

KPI Indicator KPI.09

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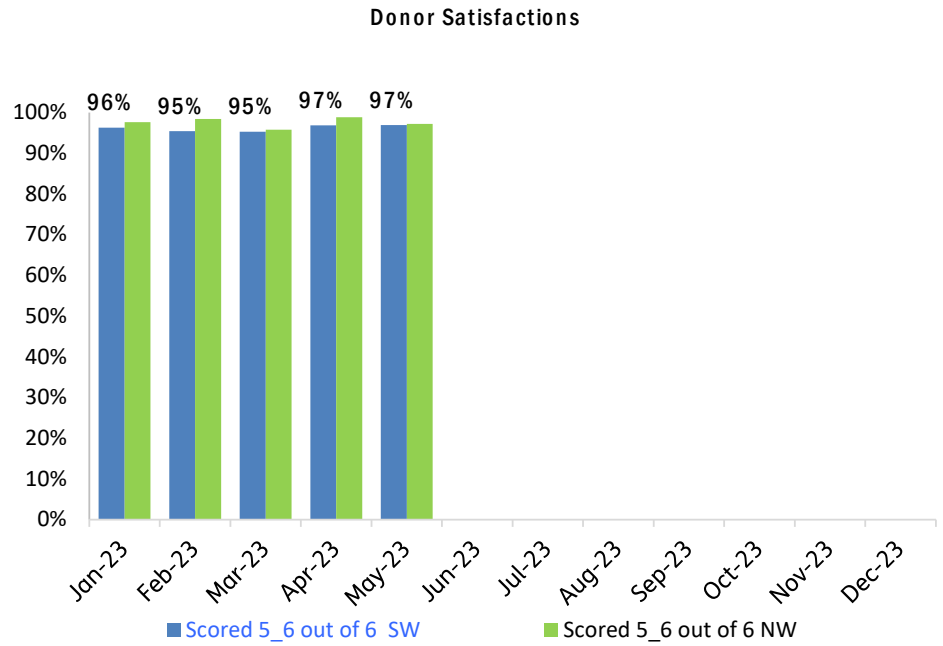
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	97	96	96	97	96	97	97	96	96	95	97	97	95	97	97
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95



Performance

Assessment of current performance, set out key points:
At 97.0% donor satisfaction exceeded target for May. In total there were 936 respondents to the donor survey, 153 from North Wales (scoring satisfaction at 97.2%), and 761 from South or West Wales (scoring satisfaction at 96.9%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported on 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

KPI Indicator KPI.14

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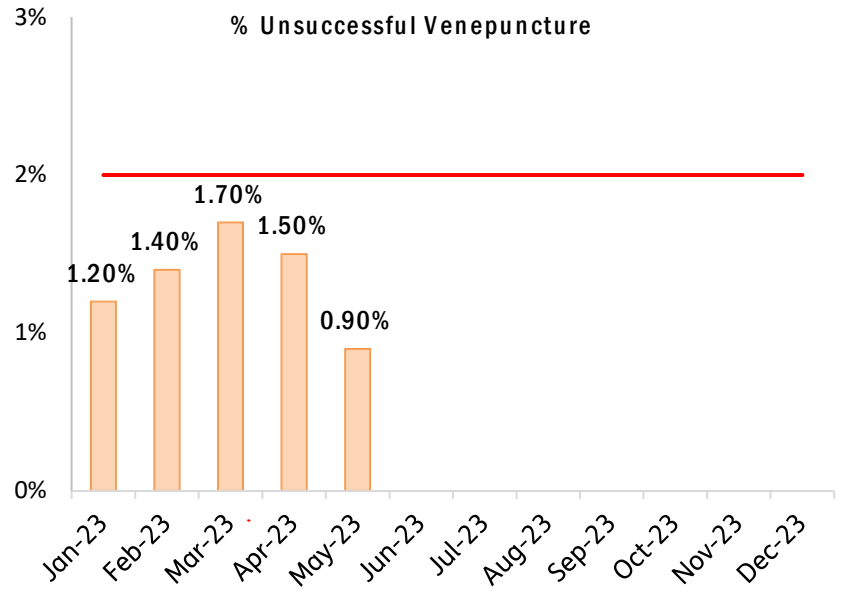
% Unsuccessful Venepuncture (FVP)

Target: 2%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	1.5	1.2	1.1	1.0	1.2	1.4	1.4	1.5	1.8	1.6	1.2	1.4	1.7	1.5	0.9
Target 2%	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2



Performance

Assessment of current performance, set out key points:
Performance target has been met and the unsuccessful venepuncture rate was stable during May 2023. No issues or practice trends have been identified.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale
Unsuccessful venepuncture rate remains stable and within tolerance. Continuous monitoring to continue to both provide assurance and identify any practice trends to identify improvement opportunities.	Continuous **Lead:** Edwin Massey

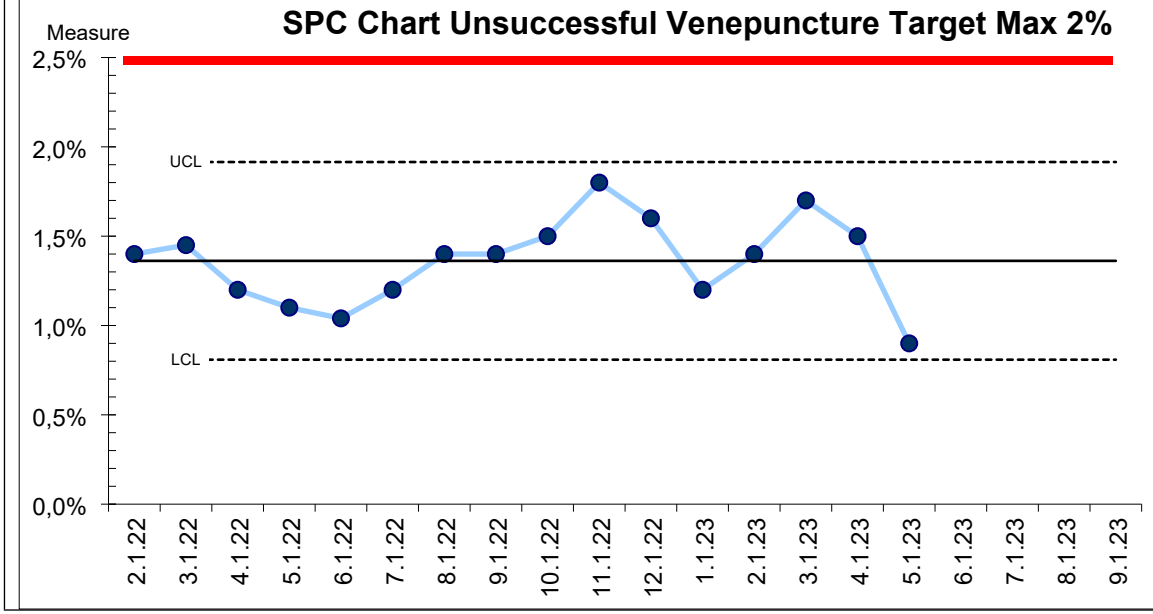
Expected Performance gain – immediate.
To ensure continuous provision of safe, effective, efficient, equitable care provision for donors across Wales.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: Lead: Edwin Massey
Continuous monitoring and oversight to ensure safe and high-quality care provision.	

Expected Performance gain – longer-term.
To minimise unsuccessful venepuncture occurrences to ensure provision of high quality, safe and efficient care provision to donors across Wales.

Risks to future performance
Nil identified.



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 1.4% consistently within the required maximum 2% target.

KPI Indicator KPI.16

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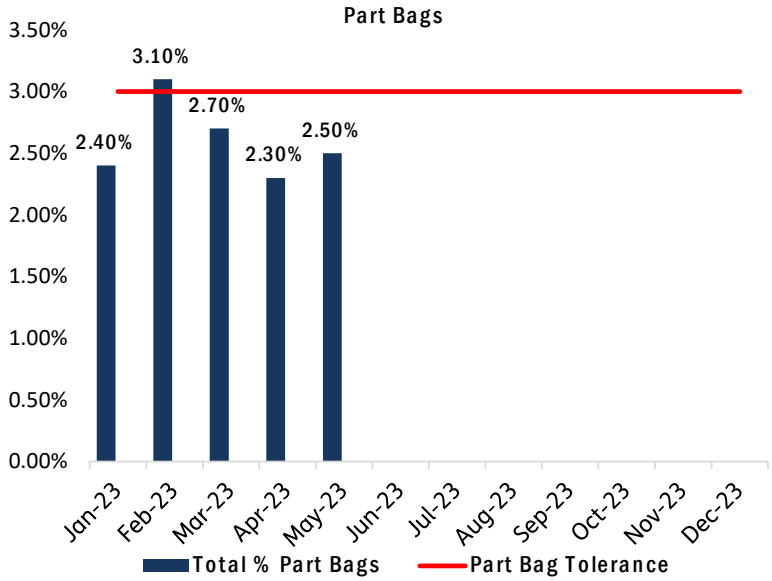
% Part Blood Bags Collected

Target: 3%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	2.32	2.30	2.21	2.02	2.09	2.00	2.30	2.60	2.92	2.26	2.4	3.1	2.7	2.3	2.5
Target Below 3%	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3



NB. Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).

Performance

At 2.5% the part bag rate in May remains stable and below 3% target on an All-Wales basis. A 'Whole Blood' clinic in Talbot Green was re-established in May 2023, and this was the only clinic to breach tolerance at 3.6%. However, this performance is not considered statistically significant due to low number of donors bled (n=56).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
Continuous analysis of part bag incidents across all collection teams to minimise part bag incidences and identify and address any practice trends or issues.	Continuous **Lead:** Edwin Massey

Expected Performance gain - immediate.
Minimise Part Bag rates across Wales.

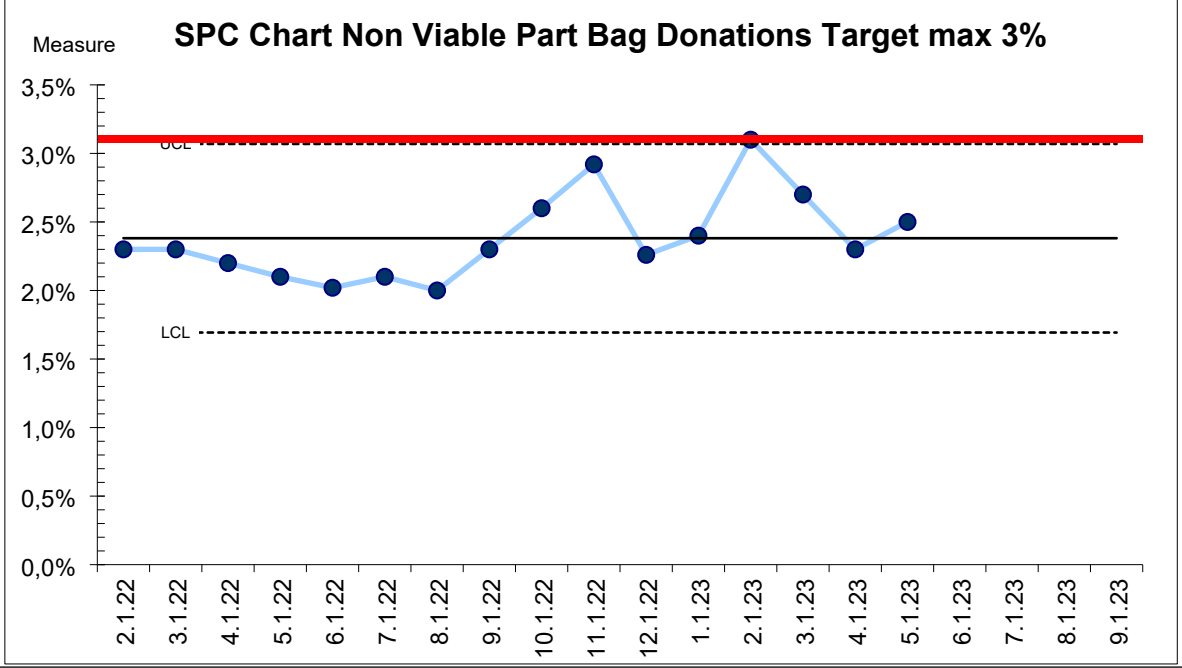
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale**
Continue oversight and trend analysis. Address identified trends as required.	On-going **Lead:** Edwin Massey

Expected Performance gain – longer-term.
Minimise part bag rates

Risks to future performance

New staff recruitment and induction/ training period within collection teams with impact upon initial level of knowledge and skills.
Need to discontinue collection due to individual clinical requirements e.g., Donor Adverse Event or late donor information, which although clinically appropriate will result in a part bag.



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 2.4%.

KPI Indicator KPI.28

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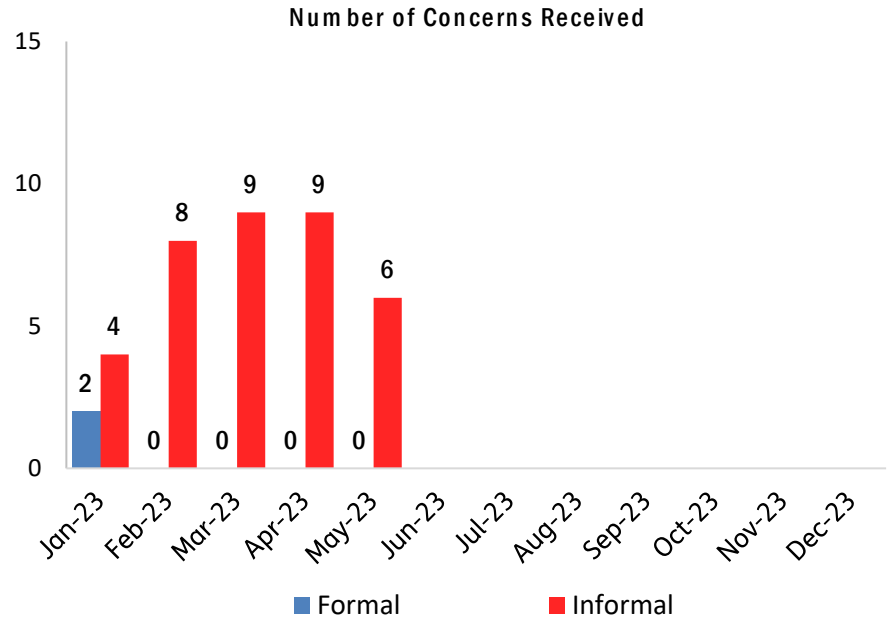
Number of WBS "Formal" and "Informal" concerns received from blood donors

Target: NIL

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual Formal	0	0	2	2	0	0	0	1	1	1	2	0	0	0	0
Actual Informal	8	9	6	3	4	2	6	7	7	6	4	8	9	9	6
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:

During May 2023 the Service received no formal concerns. However, 6 informal concerns were received, managed as "Early Resolution" and resolved within the 2 working day deadline.

7,203 donors were registered at donation clinics. 6 informal concerns represent 0.08% of all donations in May 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Time scale
– Continuous oversight and management of concerns in line with Putting Things Right Regulations. – Review of all concerns received to ensure learning and improvement opportunities are addressed.	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate.

Improved performance, improved donor experience and satisfaction.

Service Improvement Actions – tactical (12 months +)

Actions:	Timescale
Continue to Review current practices to reduce concerns in line with donor feedback.	On-going **Lead:** Zoe Gibson/Julie Reynish/Julie Curry

Expected Performance gain – longer-term.

Utilisation of service user feedback to improve service provision, donor experience and satisfaction.

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.06

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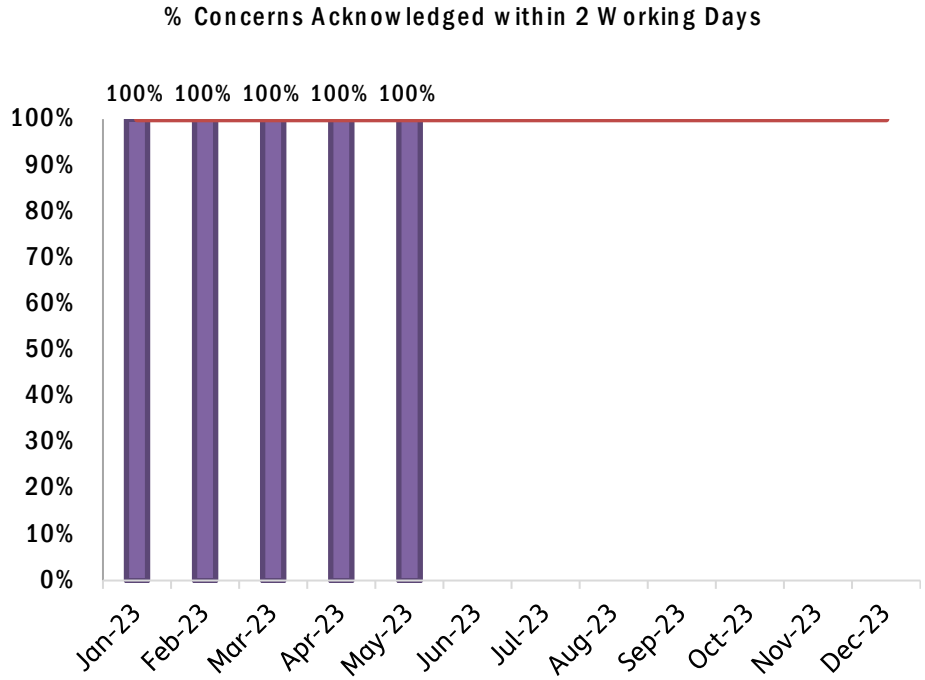
% All concerns acknowledged under "Putting Things Right" (PTR) within required 2-day Timescale

Target: 90%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	100	100	88	100	100	100	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



Performance

Assessment of current performance, set out key points:
All individual concerns were addressed by relevant heads of departments and managed within the 2 working day timeline for early resolution. 6 donors were contacted to discuss their concerns and were happy with outcomes of conversations and actions.

The 2 informal concerns originally lodged in October 2022, and reopened April 2023 were managed by VCC/Corporate team and a formal response was issued by the Trust Chief Executive on 30/05/23, and the record closed.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** Ongoing **Lead:** Edwin Massey
Continued monitoring and assurance of standard being achieved.	

Expected Performance gain – immediate.
Effective management of concerns in line with Putting Things Right Regulations.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve.	**Timescale** Ongoing **Lead:** Edwin Massey
Continued oversight and monitoring of concerns management to ensure response time responsibilities continue to be met.	

Expected Performance gain – longer-term.
Improved donor satisfaction and experience through service improvement.

Set out risks which could affect future performance

KPI Indicator KPI.03

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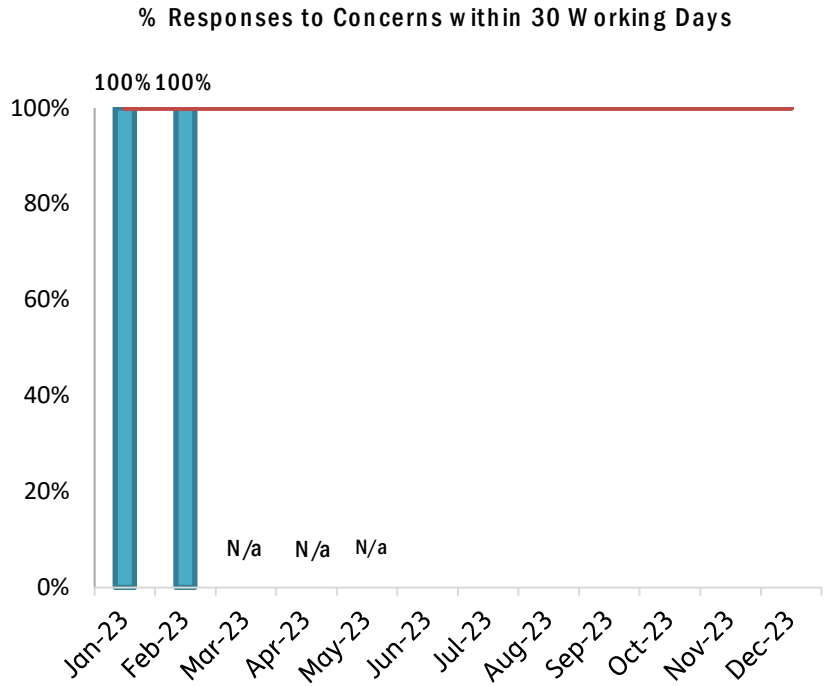
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



NB:
Performance against target only shown the month when a formal concern has been raised.
Under Putting Things Right (PTR) guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

Performance

Assessment of current performance, set out key points:
There were no formal concerns raised or due to be closed in May 2023.

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. – 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.

KPI Indicator KPI.53

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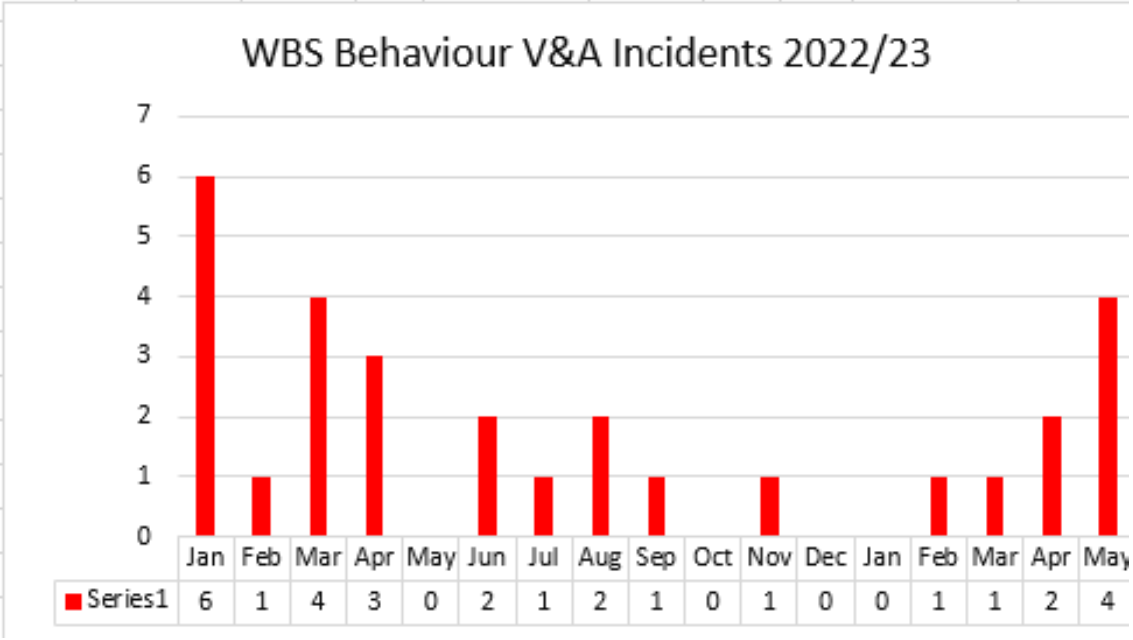
Health & Safety Total number of violence and aggression incidents by division	
Target: Continued monitoring to identify and mitigate trends	**SLT Lead: Sarah Richards**
Current Performance against Target or Standard - stable	**Performance – fluctuating dependent on individual incidents - no discernible trends available**



Cases at WBS involve angry Donors that may turn up late for an appointment or may need to be turned away from donating due to medical issues or failure to meet the criteria to safely donate. No physical V&A incidents to date.

If performance is not at required level, set out what the main causes are: Donors at venues are the main cause of the V&A incidents experienced at WBS, e.g. late / missed appointments, turned away from donating due to not meeting criteria etc.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring. Review each case. Training on ESR.	Q4 2022 and Q 1 & 2 2023	VCC H&S Advisor WBS Health Safety & Env Mgr

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring of V&A cases at WBS. SOP in place. Discussion on a case-by-case basis with the Collections and Nursing Managers to decide the most appropriate course of action. Collection Team Training V&A and Customer Service	Q3&4 2023	H&S Team Ed & Dev

Expected Performance gain – longer-term

Collection team staff trained with the ability to deal with any V&A incidents.
Team staff that can safely de-escalate the situation.
Robust SOP in place to provide guidance to team staff on the ground and managers on dealing with V&A incidents.

Risks to future performance –

Set out risks which could affect future performance

Team staffing – stretched team's increases stress levels may impact on ability to deal with a potential V&A situation.

Communication with donors when booking to donate. Ensure that they are aware of the donation criteria and are provided with update / confirmation of their donation times and date.

TIMELINESS

KPI Indicator KPI.17

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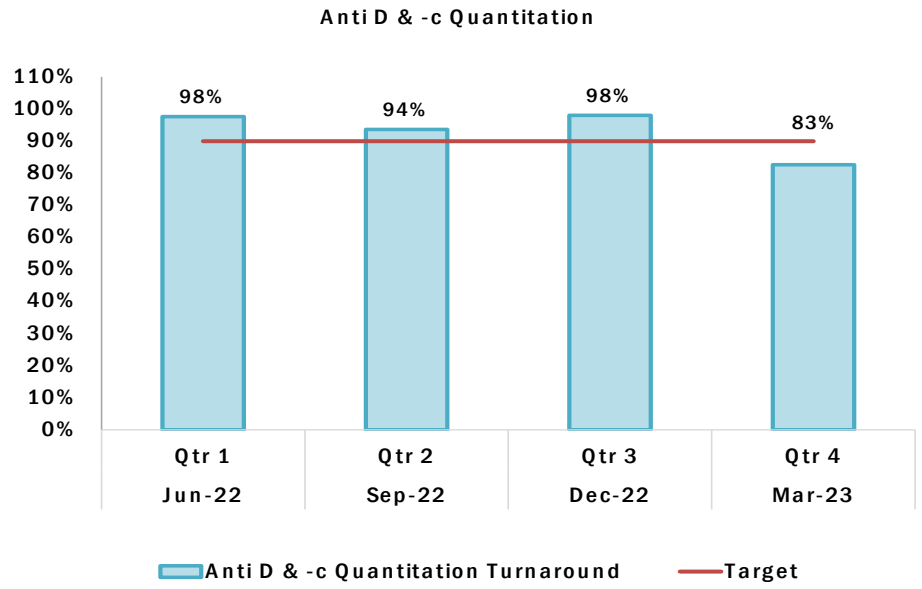
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	96	100	99	83	99	96	99	99	96	97	96	60	92	97	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	



Performance

On Target

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

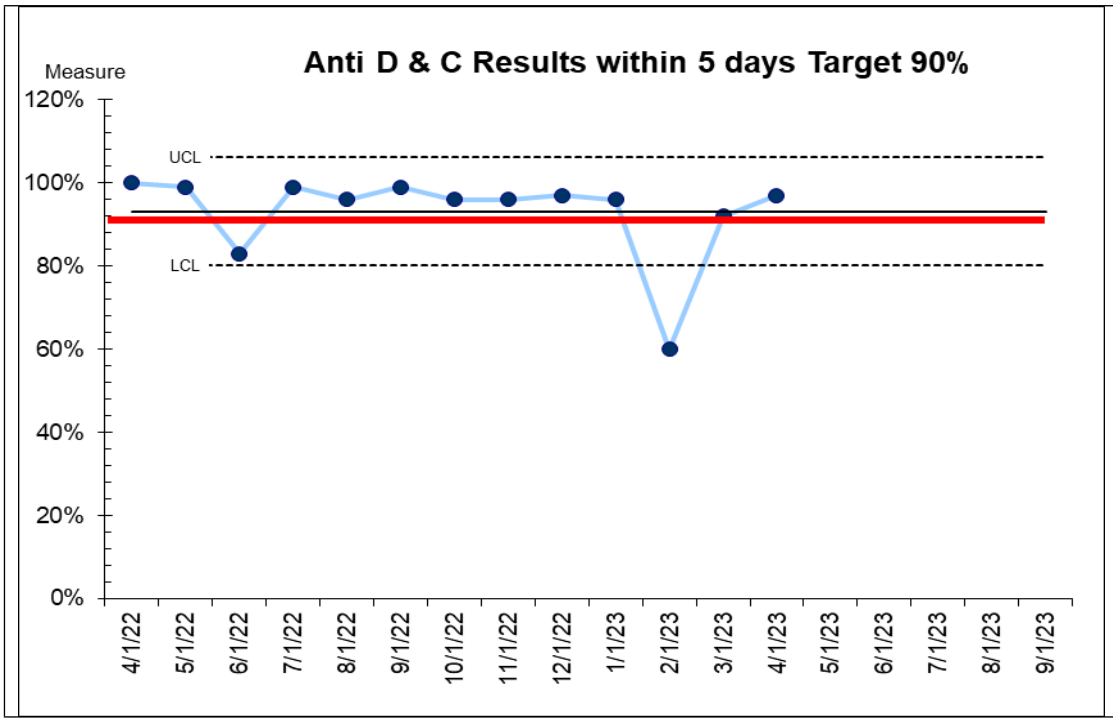
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four. However, the average performance of 96% exceeds the 90% target overall.

KPI Indicator KPI.18

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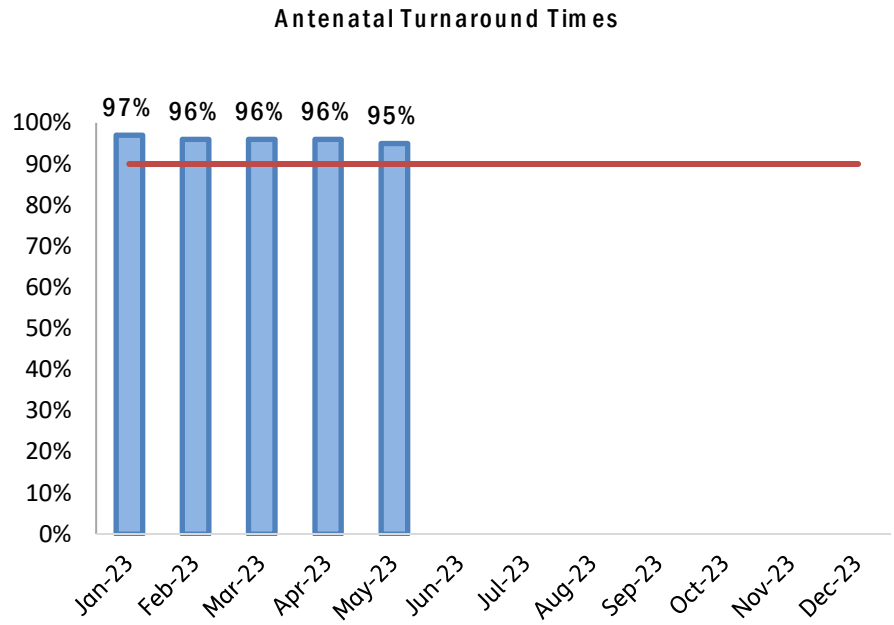
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	96	95	96	95	96	97	97	98	96	87	97	96	96	96	95
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 95% the turnaround time performance for routine Antenatal tests continued to exceed target in May 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.

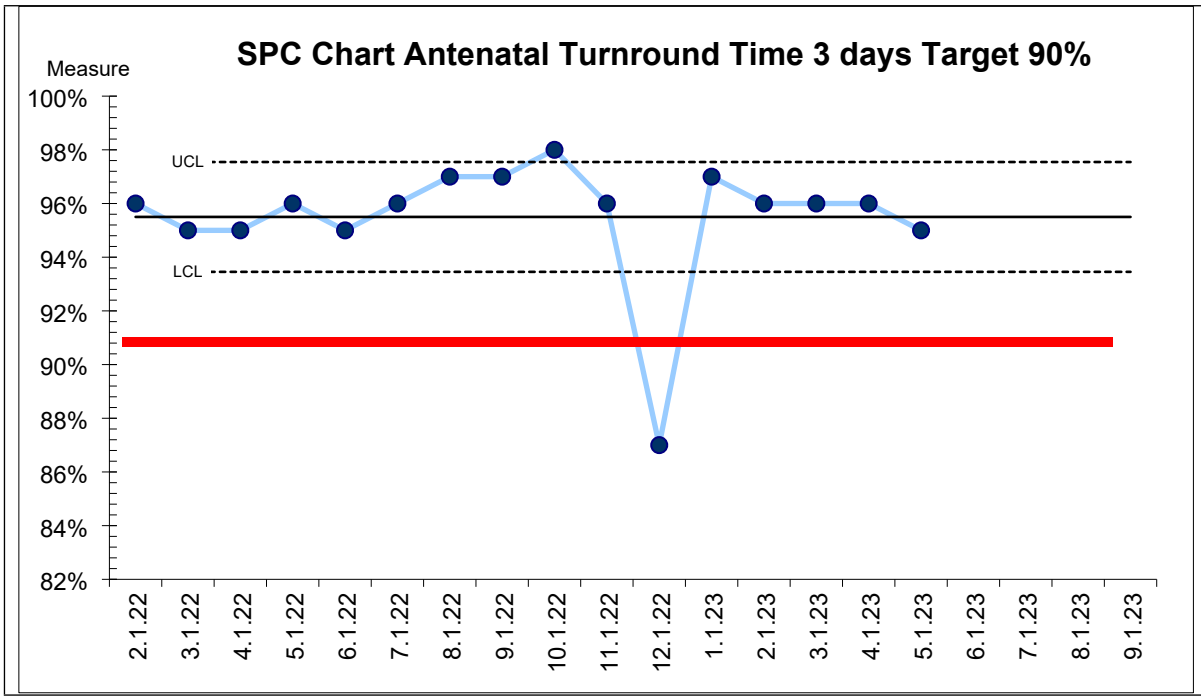
Service Improvement Actions – tactical (12 months +)

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



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.

KPI Indicator KPI.23

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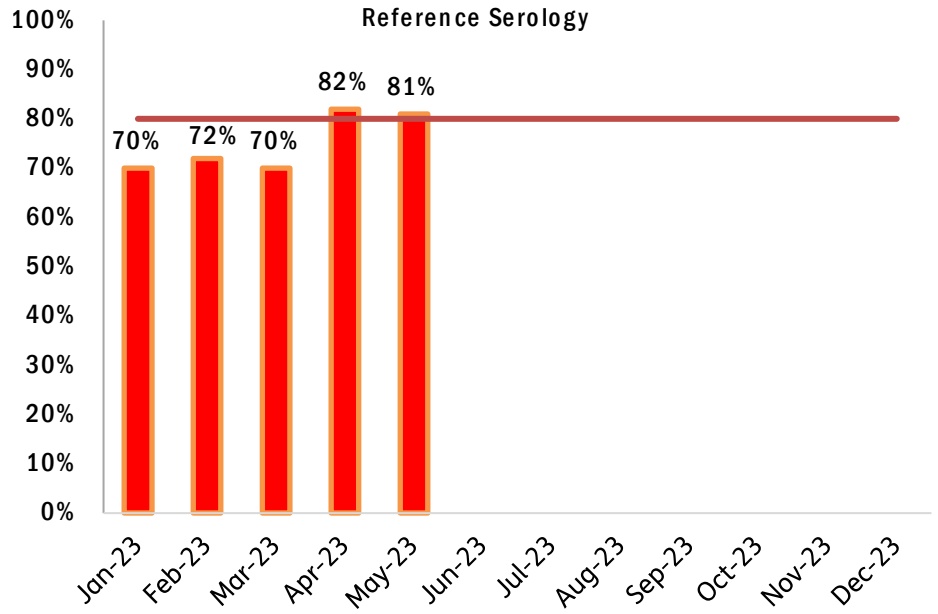
Reference Serology Turnaround Times – results provided to hospital within 2 working days

Target: 80%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	65	68	68	63	80	61	73	77	65	61	70	72	70	82	81
Target 80%	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80



Performance

Assessment of current performance, set out key points:
Reference Serology 'Turnaround' performance met target in May.

NB:
Turnaround performance over 5 working days is at 93% for May (following on from 93% in 5 days achieved in March & April) and shows a consistent improvement and closer performance to the NHSBT benchmark of 95%.

Compatibility testing (approx. 43% of referrals) continues to meet clinical target whilst all "Time-Critical" tests continue to be prioritised and completed on time maintaining safety of clinical care.

Performance continues to be impacted by ongoing training of new staff; however, this is an improving picture compared to recent winter months.

Service Improvement Actions – Immediate (0 to 3 months)

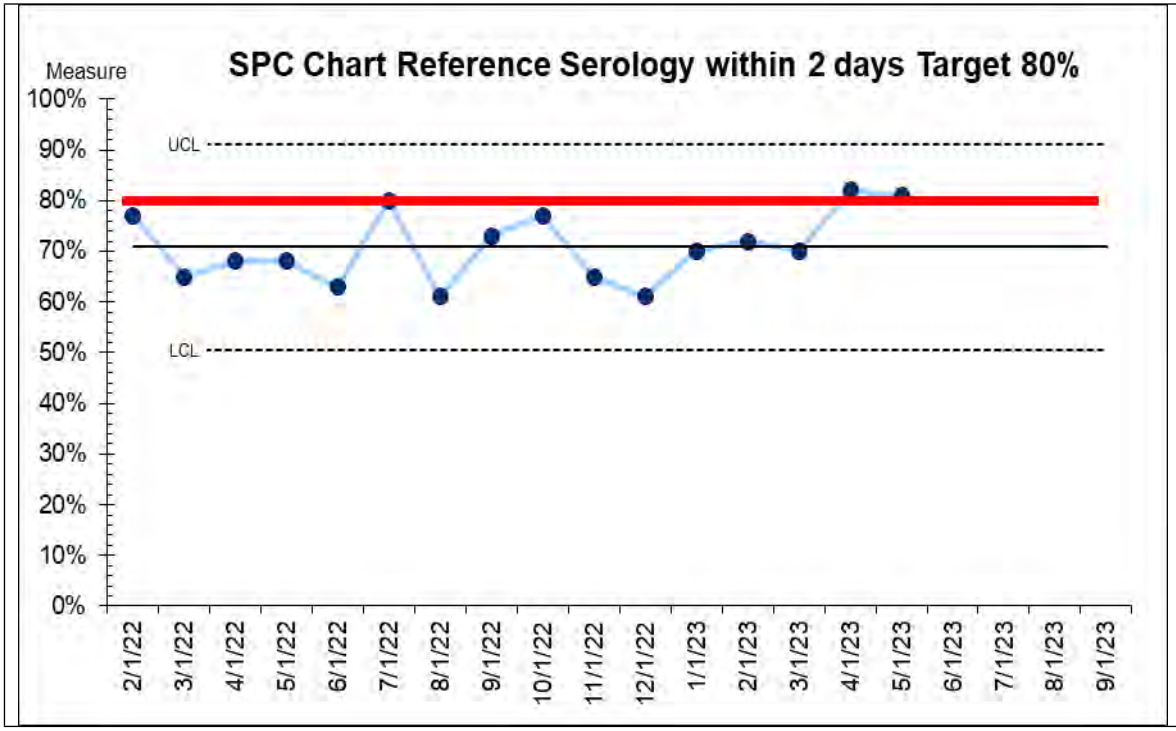
Actions: what we are doing to improve	Timescale	Lead:
• An additional Band 6 trainee Specialist Biomedical Scientist resource to increase complex testing has been appointed. Training is expected to be completed in July.	July 2023	Tracey Rees
• An additional trainee Band 6 Specialist Biomedical Scientist has been appointed, with training expected to take 18-24 months.	April 2025	

Expected Performance gain - immediate.
Improvement in Reference Serology Turnaround times

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• A service improvement project linked to the use of the new automated analyser is ongoing. A number of automated tests are currently embedding (ABO, Rh, & partial red cell phenotyping). • Further validation for additional Red Cell Phenotyping was expected to be completed by the end of March 2023, but was not achieved due to the prioritised staff training.	June 2023	Tracey Rees

	• Validation for additional Red Cell Phenotyping is now expected to be completed by the end of June 2023.		
	Expected Performance gain – longer-term. Improved analytical efficiency and testing turnaround times.		
	Risks to future performance		
	Set out risks which could affect future performance. The target requires review as it is not in line with other UK services. Specifically, NHSBT target is set at 95% within 5 working days, IBTS 100% within 7 working days		



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, the average performance of 70% consistently falls to meet the 80% target.

KPI Indicator KPI.24

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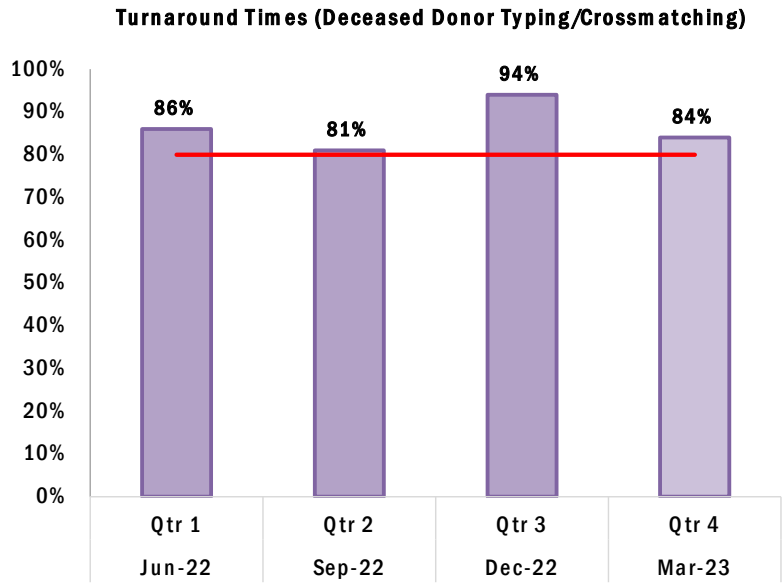
Number of Deceased Donor Typing / Cross Matching reported in month

Target: 80% Quarterly

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Actual %	86			81			94			84					
Target 80%	80			80			80			80					



Performance

Assessment of current performance, set out key points:
Performance for this quarter above target at 84%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to monitor performance	Ongoing	Tracey Rees

Expected Performance gain - immediate.
N/A

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.

EFFICIENCY

KPI Indicator KPI.08

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Whole Blood Collection Efficiency – number of Blood Components Collected per Standardised Full Time Equivalent Staff Member

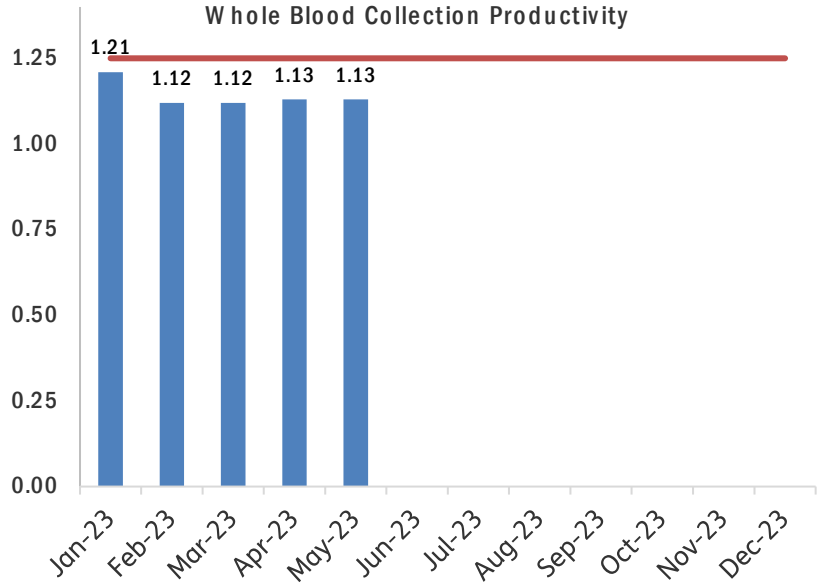
Target: 1.25 Weighted Factor

SLT Lead: Jayne Davey

Current Performance against Target or Standard

Performance

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual FTE	0.99	1.07	1.12	1.15	1.13	1.15	1.22	1.10	1.03	1.02	1.21	1.12	1.12	1.13	1.13
Target 1.25 FTE	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25



Assessment of current performance, set out key points:

Collection efficiency performance in May failed to meet target.

Contributory factors influencing the May performance include:

1. Reduced clinics duration due to short notice sickness absence.
2. Reduction of clinic hours because of fire alarm activation on session.
3. Existing vacancies yet to be filled across Wales, which, with 8 staff in training has impacted staffing capacity at larger sessions.
4. Lower donation capacity due to staff sickness in North Wales resulting in donation sessions staged with 2 donor chairs. Usually, these teams operate 4-6 donation chairs, depending on the venue size.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve

- Daily review of stock levels in conjunction with the wider service to support correct 'days of blood' by-blood group stock levels.
- 7 staff in training for 12 weeks on starting. Once trained the staff will supplement staffing levels to maximise clinic capacity.
- Further recruitment to fill funded vacancies planned in June & July 2023.

Timescale:
by August 2023

Lead:
Jayne Davey

Expected Performance gain – immediate.

Improved ability to respond to demand by increasing donor appointment opportunities and improved ability to record Collection Team 'non donor' working hours (i.e., personal appraisals/e-learning/training).

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve

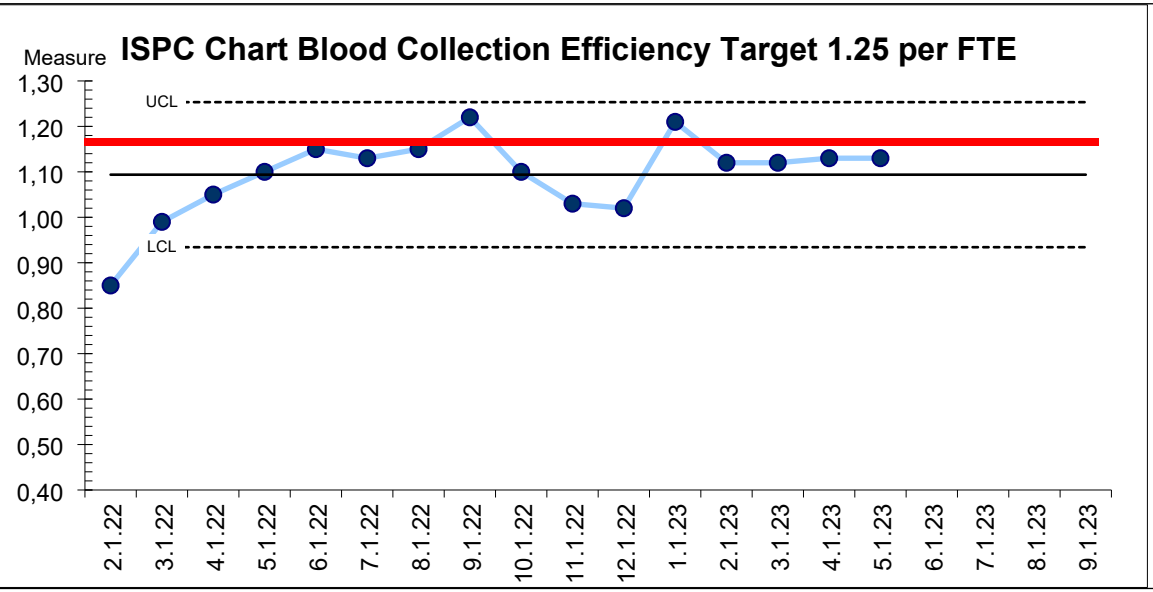
– Daily monitoring of hospital demand to support increases in collections capacity if required.	Quarter 1
– Updating the efficiency reporting tool to capture non-donor facing hours, leading to improved accuracy in reporting 'Collection Efficiency'.	Quarter 1
– Review all opportunities to maximise donation clinic efficiency.	**Lead:** Jayne Davey

Expected Performance gain – longer-term.
Improved accuracy of reporting.

Risks to future performance

Set out risks which could affect future performance.

– Industrial action.
– Increase in hospital demand.
– Increase in sickness.



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The improving trend approaching the target productivity target of 1.25 FTE has remained consistent over the past few months. However, the average performance of 1.10% currently fails to meet the target.

KPI Indicator KPI.10

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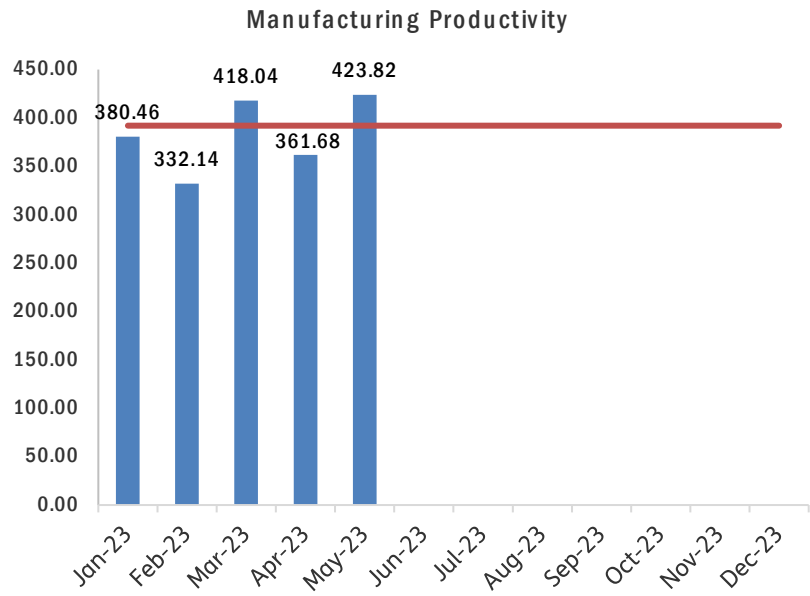
Blood Product Manufacturing Productivity

Target: 392 per month

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	332	386	386	377	416	391	357	372	401	356	380	332	418	362	424
Target 392	392	392	392	392	392	392	392	392	392	392	392	392	392	392	392



NB: Manufacturing Efficiency is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.

Performance

Assessment of current performance, set out key points:
The Manufacturing & Distribution department continues to operate effectively with performance for May within acceptable variance (10%). Also review of the SPC chart demonstrates this is variation around the target.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework. Identifying the acceptable fluctuation range will improve interpretation and monitoring of this standard.	**Lead:**

Expected Performance gain - immediate.

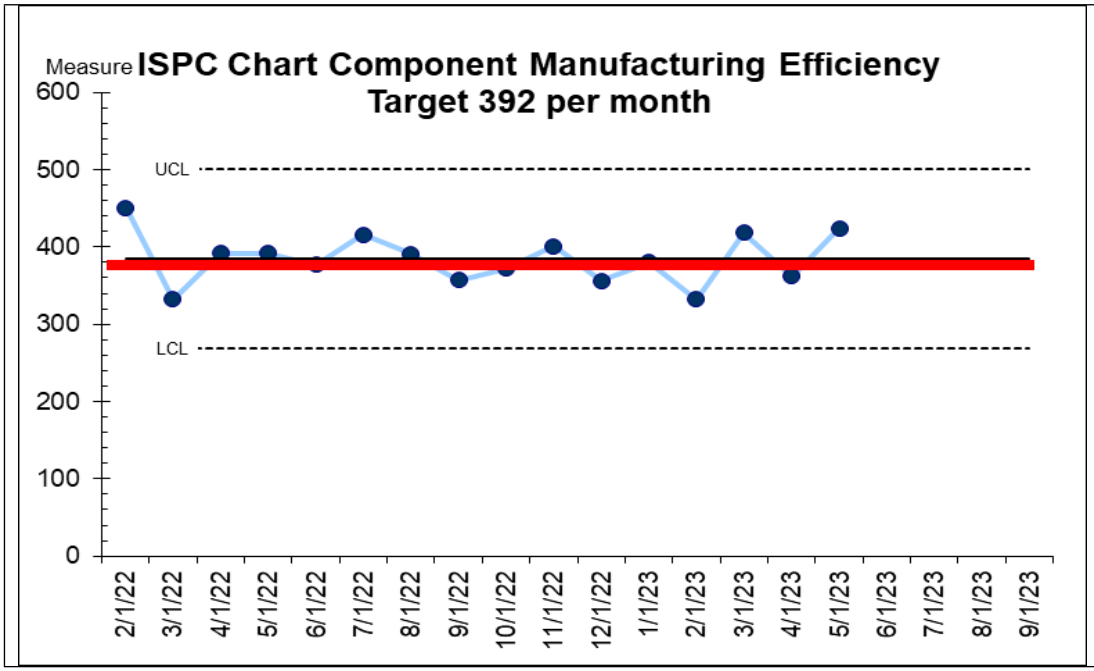
Service Improvement Actions – tactical (12 months +)

As Above	**Timescale:** **Lead:**

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. With the average performance of 400 just above the target.

KPI Indicator KPI.12

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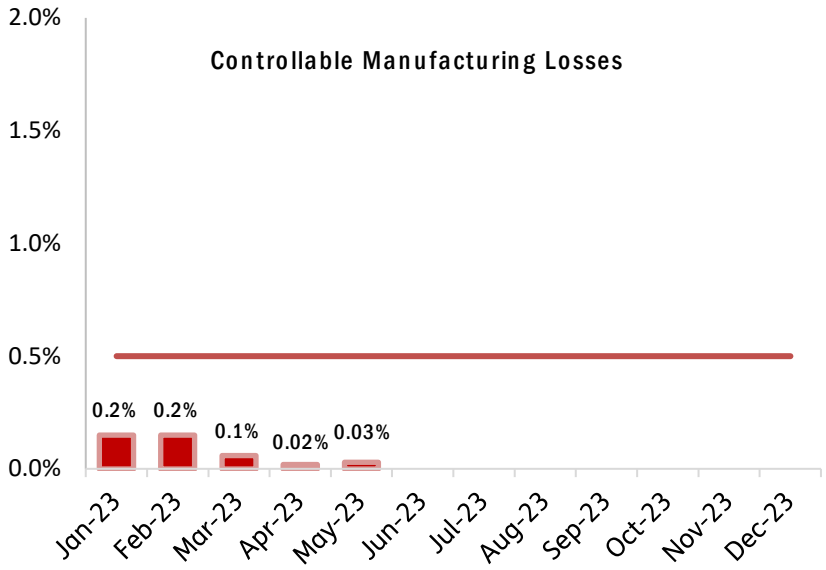
Controllable Manufacturing Losses - % of unusable Red Cell donations against total collections

Target: maximum 0.5% per month

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	0.03	0.03	0.06	0.1	0.1	0.2	0.05	0.03	0.13	0.05	0.15	0.15	0.06	0.02	0.03
Target Max 0.5%	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5



Performance

Assessment of current performance, set out key points:
Controllable losses were low at 0.03% and remain within tolerance and below the target of 0.5% representing good performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Active management of the controllable losses is in place, including vigilance and reporting of all units lost.	Business as Usual, reviewed monthly	Tracey Rees

Expected Performance gain - immediate.
Ongoing monitoring of losses to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.

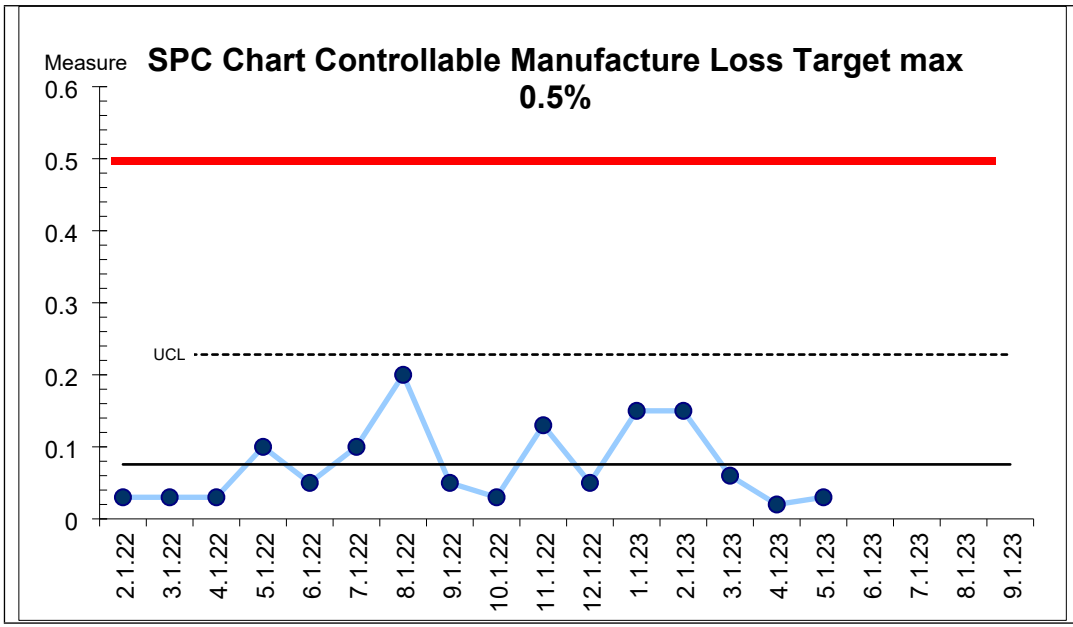
Service Improvement Actions – tactical (12 months +)

	Timescale:	**Lead:**
N/A		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.
N/A



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 0.1% is consistently within the required maximum 0.5% target.

KPI Indicator KPI.63

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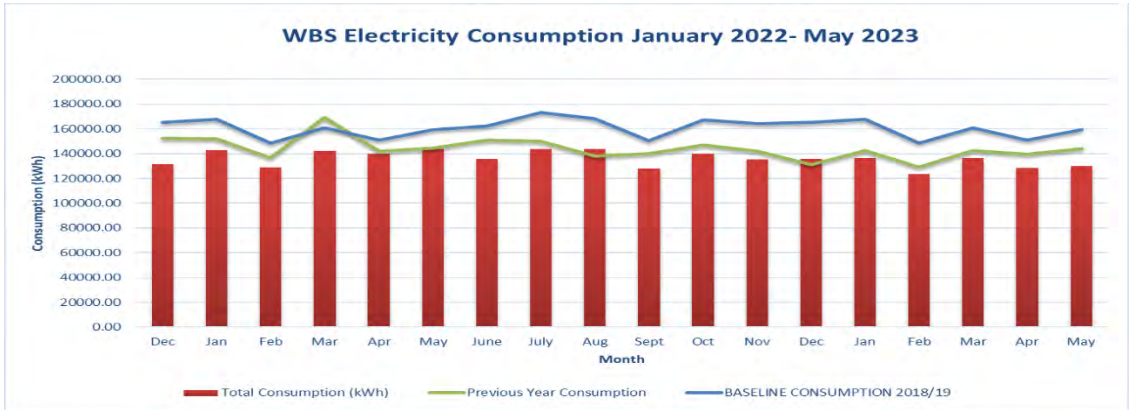
WBS - Energy (Gas and Elect) performance consumption

Target: -3% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar 22	Apr22	My22	Jun22	July22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh)	142494.30	139706.40	143839.00	136016.20	143888.40	143968.80	128059.82	140033.03	135393.79	135804.47	136437.92	123728.62	132305.10	128603.9	129804.7
Target number previous year	147453.58	137940.11	140141.72	146471.75	145412.51	133847.87	135755.57	142701.36	138024.70	127410.08	138294.65	125162.30	138219.47	135515.21	139523.83
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

Performance

Assessment of current performance, set out key points:

Electricity and Gas consumption following similar pattern to previous year, with some reduced electricity usage February to June 2022.

Spike in gas usage at Talbot Green and Bangor sites following boiler service

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	3 months	Milburn Mounter

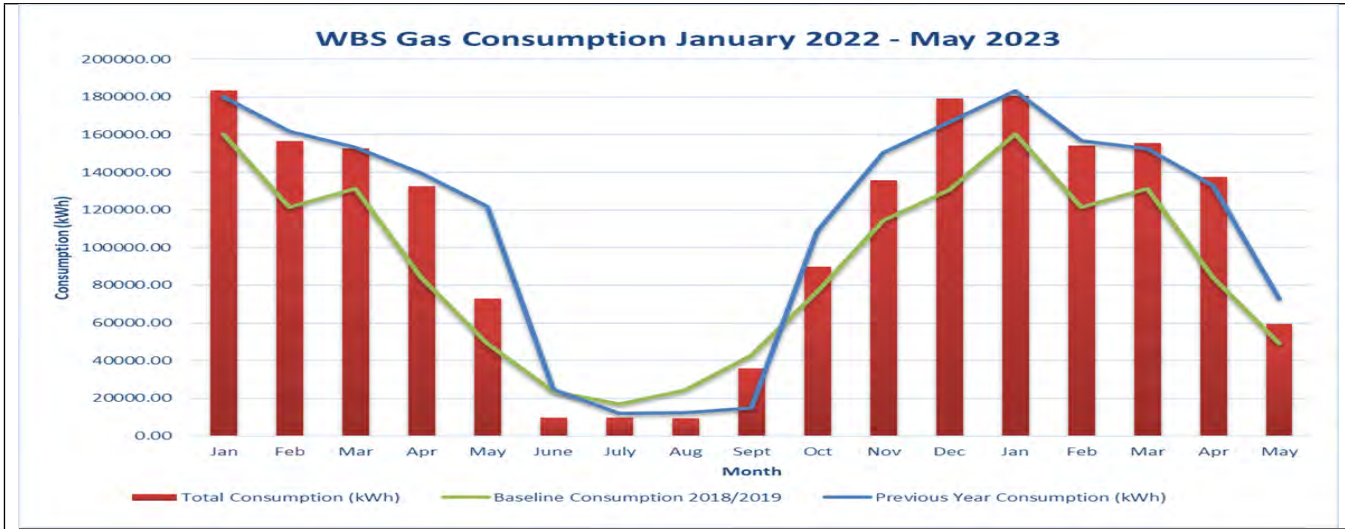
Expected Performance gain - immediate

Continue to monitor energy performance

Promote ways to reduce electricity usage.

Communication and engagement campaign for energy reduction (for staff working from home and in the office) to be held.

At Talbot Green, work to address increase gas consumption is underway, including reducing the Outdoor Air Temperature which triggers the heating being on. This will be under review with lab staff to ensure it is the correct temperature of services.



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 2 3	Mar 23	Apr 23	May 23
Actual Number (kWh)	150 456. 05	132 580. 87	728 20.4 3	976 0.5 6	955 6.4 0	937 7.9 0	3571 1.02	89680 .78	135716 .44	179090 .93	180564 .58	154244 .21	155424 .94	137515 .21	59395. 68
Target number previous year	148 531. 25	135 212. 31	118 264. 06	239 69. 35	118 01. 26	120 24. 33	1437 3.16	10563 6.38,	145757 .13	161491 .63	177834 .71	151952 .26	148075 .24	128603 .44	70635. 82
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Metering strategy	12 months	Jason Hoskins

Expected Performance gain – longer-term

Continue to monitor consumption

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.67

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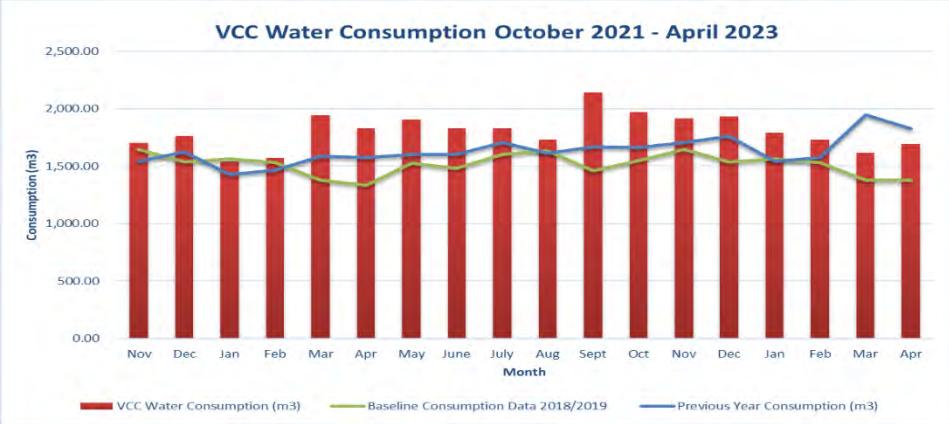
Graph title -Water

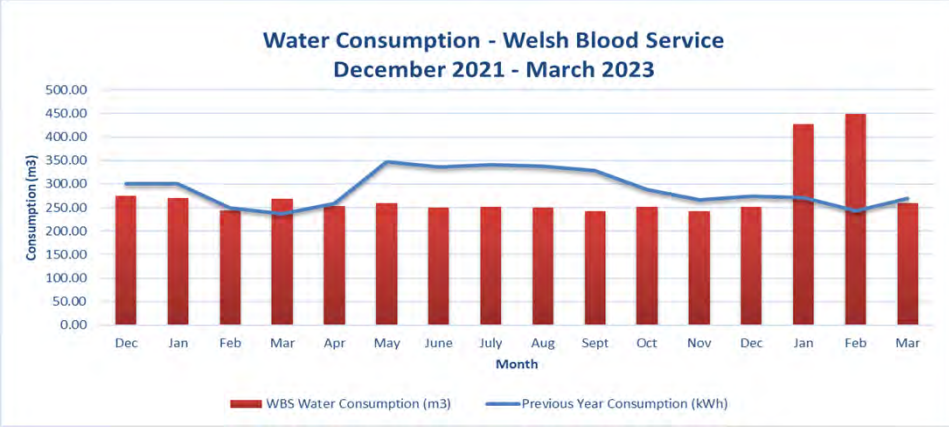
Target: Continued monitoring to identify and mitigate trends

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available





If performance is not at required level, set out what the main causes are:

January figures are awaited from our utilities provider.

- Across all sites there has also been Increased hygiene requirements to comply with IP & C guidance
- There has been a significant increase in water consumption at Talbot Green this due to a water meter fitted
- Upgraded water meters at two sites to have tighter control & management of water consumption

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Capturing water data at WBS has changed year therefore [previous data is displayed in quarters] Going forward, increased monitoring and integration into the BMS to ensure monthly figures are monitored	3 months	**Matthew Bellamy**
Integrating the water consumption to the BMS at VCC	3 months	**Milburn Mounter**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

• Increased metering across all sites • Dedicated resource to capture the metering	**12 months**	Jason Hoskins

Expected Performance gain – longer-term

Continue to monitor consumption resulting in targeted initiatives and improvements reducing consumption.

Risks to future performance

Increased flushing regimes to adhere to water safety regulations

KPI Indicator KPI.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS 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 £k	1	0	1										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

WBS Revenue Position as at May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	4.478	4.541	0.064	26.674	26.674	0.000
Expenditure						
Staff	3.016	3.064	(0.047)	16.935	16.935	0.000
Non Staff	4.675	4.692	(0.017)	29.555	29.555	0.000
Sub Total	7.691	7.755	(0.064)	46.490	46.490	0.000
Total	(3.214)	(3.214)	0.001	(19.816)	(19.816)	0.000

Performance

The reported financial position for the Welsh Blood Service at the end of May 2023 was a small underspend of **£0.001m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.064m** to month 2. Targeted income generation on plasma sales through increased activity is being largely 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 yet to see signs of recovery. WBS have been running campaigns to try and grow the panel in sites such as schools and universities.

Staff reported a **£(0.047)m** overspend to May. 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.

Work continues to be underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff reported a small overspend of **£(0.017)m** to May. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage are being offset by savings against stem cell activity and testing.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Quarterly Performance Reviews	31/03/24	Alan Prosser
• WTAIL Bone Marrow Business Plan	Jun 2023	

	Expected Performance gain - immediate Identification of recovery trajectory for Bone Marrow. Financial opportunities and challenges understood.		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Review of productivity and operating model requirements	**Timescale:** Sept 2023	**Lead:** Alan Prosser
	Expected Performance gain – longer-term Identification of resource opportunities and challenges with emphasis on delivering Value Based Healthcare		
	Risks to future performance		
	Set out risks which could affect future performance • Competing demand, available resources and service resilience.		

KPI Indicator KPI.72

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Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

WBS Position	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	100	7	1										
Target Per IMTP £0k Opening Forecast		0	0	0	0	0	0	0	0	0	0	0	0

Performance

The spend on agency for WBS during May 23 was £0.001m, which gives a cumulative year to date spend of £0.008m and a forecast outturn spend of £0.013m. Agency spend within facilities and administrative support is being targeted with the aim to remove use over the next couple of months.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Facilities review of operating model and remove reliance on temporary support • Departmental planned removal of usage into vacancies	Sep 2023	Sarah Richards

Expected Performance gain - immediate

Planned reduction of agency use

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Implement model • Departmental planned removal of usage into vacancies	Sep 2023	Sarah Richards/SMT

Expected Performance gain – longer-term

Sustainable operating model

Risks to future performance

Set out risks which could affect future performance

- Workforce constraints

KPI Indicator KPI.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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 Cummulative	500	32	27										
Target £700k Forecast		32	32	32	67	67	67	67	67	67	67	67	700

WBS Cost Improvement Programme for 2023-24 - Target £700k

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							
Procurement Supply Chain (WBS)	Amber	100	0	0	0	100	0
Collection Team Costs Reduction (WBS)	Green	10	2	2	0	10	0
Collection Team Costs Reduction (WBS)	Green	8	1	1	0	8	0
Establishment Control (WBS)	Green	60	10	10	0	60	0
Reduced use of Nitrogen (WBS)	Amber	55	0	0	0	55	0
Reduced Research Investment (WBS)	Green	25	4	0	(4)	25	0
Stock Management (WBS)	Green	125	21	21	0	125	0
Reduced Transport Maintenance (WBS)	Amber	30	0	0	0	30	0
Demand Planning - Volume Driven Benefits (WBS)	Amber	137	0	0	0	137	0
Total Saving Schemes		**550**	38	34	(4)	550	0
Income Generation							
Sale of Plasma (WBS)	Green	150	25	25	0	150	0
Total Income Generation		**150**	25	25	0	150	0
TRUST WBS SAVINGS		**700**	**63**	**59**	**(4)**	**700**	**0**
				100%		100%	

Performance

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%).
Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

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 is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.
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.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Extraordinary Savings meetings with SLT for year delivery should targets not be met	31/03/24	Alan Prosser

	Expected Performance gain - immediate Delivery of current savings and planned savings for 23/24 financial year		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	**Timescale:** Dec 2023	**Lead:** Alan Prosser
	Expected Performance gain – longer-term Delivery of efficiencies		
	Risks to future performance		
	Set out risks which could affect future performance • Competing demand and implementation of operating models		

EQUITY

KPI Indicator KPI.81

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% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPI.78

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Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator KPI.79

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Diversity of Workforce % Black, Asian and Minority Ethnic people applying Wales version of Workforce Race Equality Standard (WRES)

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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
-

KPI Indicator KPI.80

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Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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
-

ANNEX 3: TRUST-WIDE SERVICES

SAFETY

KPI Indicator H&S.14

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Graph title - Number of RIDDOR reportable incidents by Division

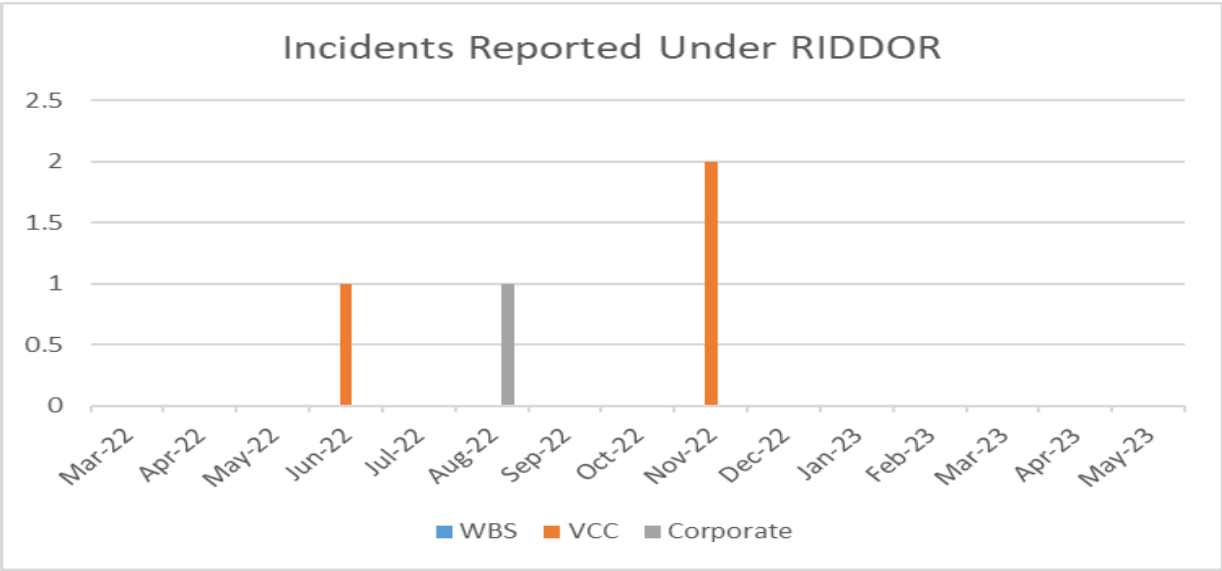
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard -

Performance - remains stable

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar 23	Apr 23	May 23
WBS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VCC	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0
Corporate	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

Lessons learned from previous RIDDOR incidents implemented	Timescale Q4 2022/23. VCC H&S Integrated care and Ed& Dev

Expected Performance gain
Lessons learned and implemented

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain
Lessons learned to prevent reoccurrence of incident and prevent similar ones

Risks to future performance

Incomplete incident investigation – **action** quality check by H&S, implementation of manager H&S training including risk assessment and incident training.

Operational pressures making it challenging for staff to training – **Action –** flexible onsite provision of training

Some departments not completing departmental inspections – escalated to SLT.

KPI Indicator H&S.17

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KPI 4 – Percentage of actions closed

Target: 100%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q4 2021-22			Q1 2022-23			Q2 2022-23			Q3 2022 -23			Q4 2022-23			Q1 2023-24		
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Actual %			73			64			71			76			78			
Target			100			100			100			100			100			100

Analysis

NB: KPI set to quarterly reporting at Trust Estates Compliance meetings prior to new Performance Management Framework arrangements in 2022 and this frequency of reporting will remain.

Performance

If performance is not at required level, set out what the main causes are:

a) Current mandated NWSSP module for recording FRAs is not functioning correctly [loss of access; failure to save data] which has affected review and update of FRAs.

b) NWSSP have small fund from WG to update/replace FRA module and all-Wales task & finish group currently working on this issue.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Review FRAs and keep hardcopy for upload onto NWSSP system.	2022/23 Q3	Trust FSM

Expected Performance gain - immediate

a) Issue outside Trust control; FRAs are reviewed and updated with potential lag for formal update on NWSSP module.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
A) NWSSP and working group to consider next steps and roll out across Wales.	n/a	n/a

Expected Performance gain – longer-term

a) Continuation of FRA reviews on robust, sustainable platform

Risks to future performance

Set out risks which could affect future performance

a. Non-compliance with statutory and mandatory duties.

b. Failure to identify and manage risk.

KPI Indicator H&S.16

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KPI 10 - Percentage of premises/Zones where fire drills or evacuation exercises have been undertaken in the past 12 months.

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q4 2021-22			Q1 2022-23			Q2 2022-23			Q3 2022 -23			Q4 2022-23			Q1 2023-24		
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Actual %			*nda*			*nda*			*nda*			*nda*			*nda*			
Target			100			100			100			100			100			100

Analysis

Fire drills / exercises have been held in abeyance due to the pandemic and current working practices.

It is anticipated that the Trust will pick these up again as part of the return to normal business activity in Q3.

Performance

If performance is not at required level, set out what the main causes are:

a) Divisions to reinstate regular schedule of evacuation drills / exercises

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Divisions to establish schedule of regular drills/exercises.	Q2	Divisional leads

Expected Performance gain - immediate

a) Staff have opportunity to practice learning.

b) Evaluation of procedures leading to change/improvement [Lessons Learnt]

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
n/a	n/a	n/a

Expected Performance gain – longer-term

As immediate performance gain(s) above.

Risks to future performance

Set out risks which could affect future performance

a) Failure to identify deficiencies in existing emergency procedures

KPI Indicator H&S.55

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Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

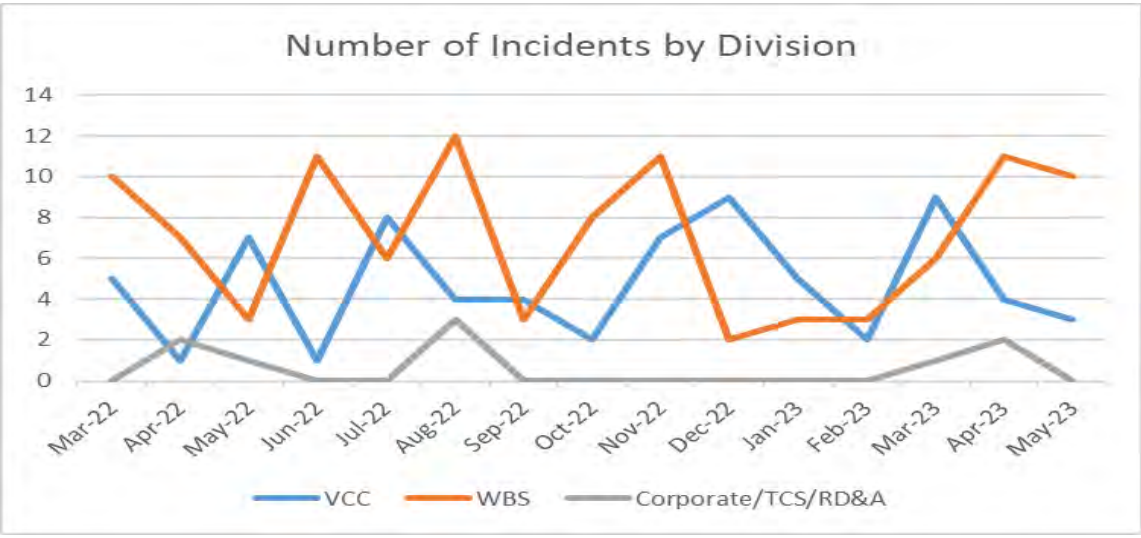
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Mar -22	Apr-22	May -22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov -22	Dec-22	Jan-23	Feb-23	Mar 23	Apr 23	May 23
VCC	5	1	7	1	8	4	4	2	7	9	5	2	9	4	3
WBS	10	7	3	11	6	12	3	8	11	2	3	3	6	2	10
Corporate	0	1	1	0	0	2	0	0	0	0	0	0	0	2	0



VCC – 2 patient accident slip trip fall ongoing pattern with chairs in SACT ongoing discussion to RA and SOP in development /ongoing investigation. Assigned investigator conducting assessment.
Staff incident – member of staff struck by barrier, additional signage in place.
WBS – 4 behaviour V&A / 2 contact with object / 4 manual handling / all accidents being investigated no clear trends. Further discussion on the use of roll cage use as this appears to be a theme. Inanimate Load Training is a priority

Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training scheduled January March and April 2023 VCC.	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 – **action** monitoring and short incident training January and March 2023 at VCC and Corporate
Some departments not completing departmental inspections
action – refresh of dept inspection process

KPI Indicator WOD.19

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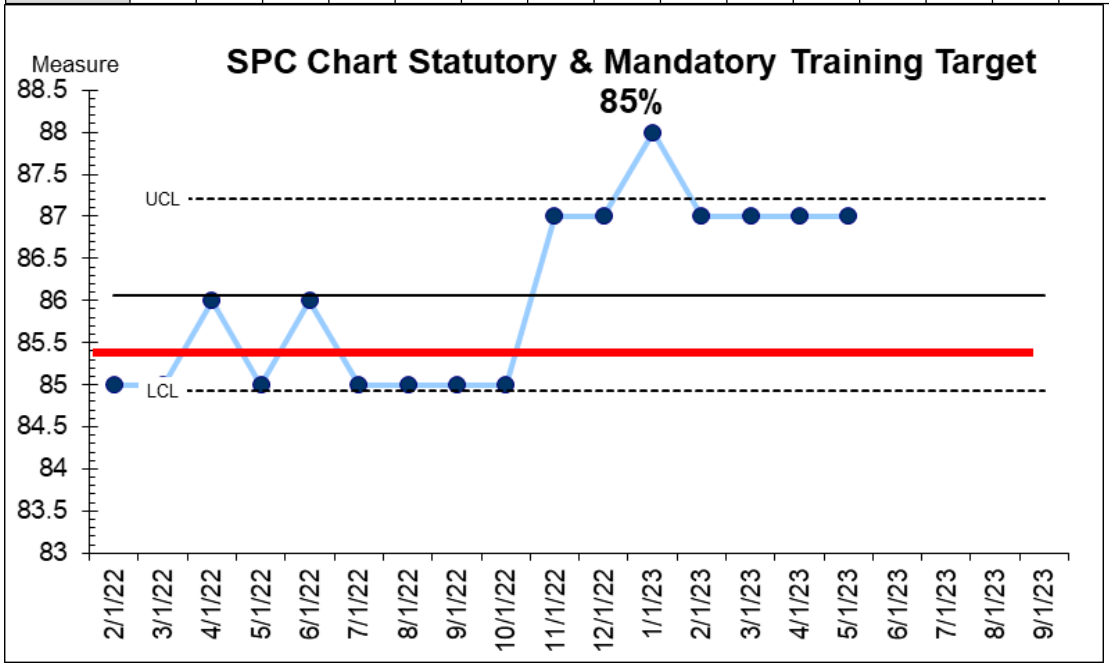
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	85	86	85	86	85	85	85	85	87	87	88	87	87	87	87
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 84% against the 85% target, with the target being met for the last year.

Performance

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to support managers in monthly 121's ensuring compliance is regularly reviewed	Ongoing	People and OD Team

Expected Performance gain - immediate

Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Education and Development team will proactively work on the Stat. & Mand compliance framework in the All Wales network	**Monthly**	Head of OD People and OD Senior Business Partner
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.		

Expected Performance gain – longer-term

Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.
Having well trained and developed workforce will ensure the safe and quality delivery of services across the Trust.

Risks to future performance

Set out risks which could affect future performance

- Future predicated wave of COVID and Flu may affect staffing levels and ability to release staff to undertake training.

KPI Indicator H&S.43

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Graph title - Incidents of Violence and Aggression

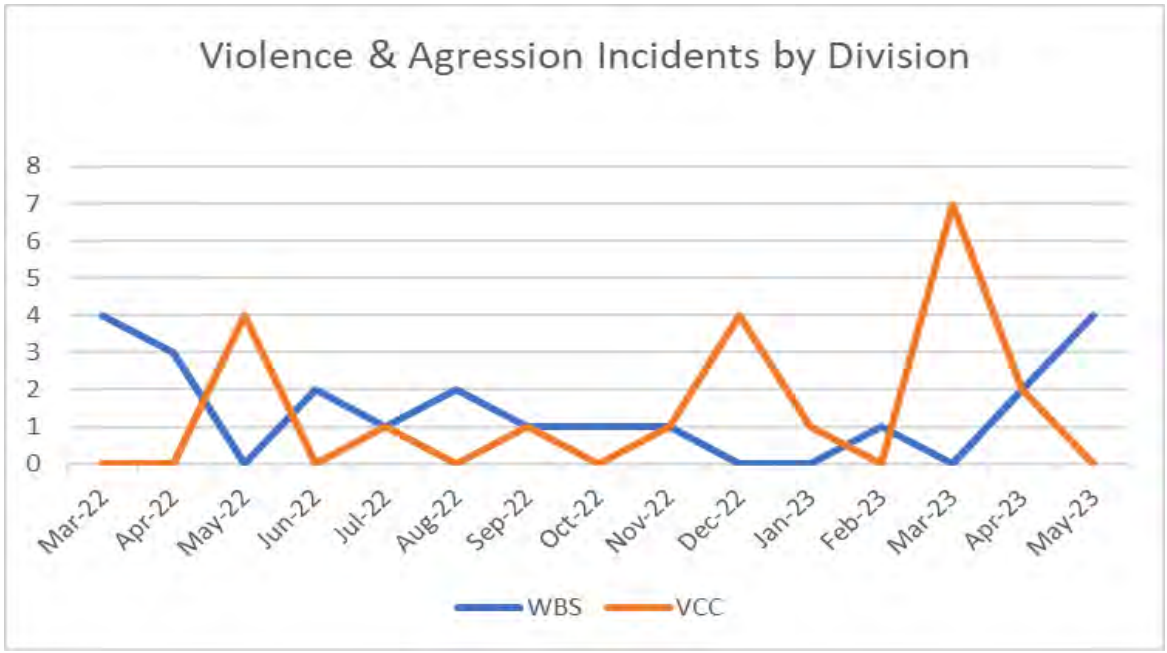
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard –

Performance - Stable

	Mar -22	Apr -22	May -22	Jun-22	Jul-22	Aug -22	Sep -22	Oct -22	Nov -22	Dec -22	Jan-23	Feb -23	Mar 23	Apr 23	May 23	Total
WBS	4	3	0	2	1	2	1	1	1	0	0	1	0	**2**	**4**	**26**
VCC	0	0	4	0	1	0	1	0	1	4	1	0	7	**2**	**0**	**25**



WBS – 4 behaviour V&A – Training provided to staff to support dealing with such instances
Retrospective note 1 of the incidents in VCC that occurred during April resulted in issue of behaviour contract. This will be monitored moving forward

Service Improvement Actions – Immediate (0 to 3 months)

The four incidents recoreded in WBS were behavioural, relating to donors not being able to give blood. Staff training has been rolled out to support dealing with such issues.	Timescale VCC and WBS safety advisors Q 1 & 2 2023

Expected Performance gain – immediate Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit	H&S Team Timescale:Q3& 4 2023

Expected Performance gain – longer-term

Risks to future performance

VCC and Corporate – V&A from patients and families due to treatment delays
VCC management of confused patients on FFW. Aggression in relation to parking pressures.
WBS – verbal aggression from donors.

KPI Indicator EST.06

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% reduction in Carbon Footprint/Emissions by 2025 against 20/22 baseline

Target: -16% against 2020/21

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr23	May 23
Actual Number	164.45	131.07	104.41	104.46	102.74	110.99	124.43	173.50	159.92	215.57	181.39	189.03	149.441	118.975
Target -16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%

Target = -16% Carbon Footprint/Emissions Statutory Regulations reduction by 2025 against 2021/22 baseline – measure carbon parts per million by volume

Performance

Assessment of current performance, set out key points:

- The carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Continuing monitoring	XX/XX/XX	AN Other
• Improvement to monitoring energy through the BMS	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Reduced carbon footprint

Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator DIG.61

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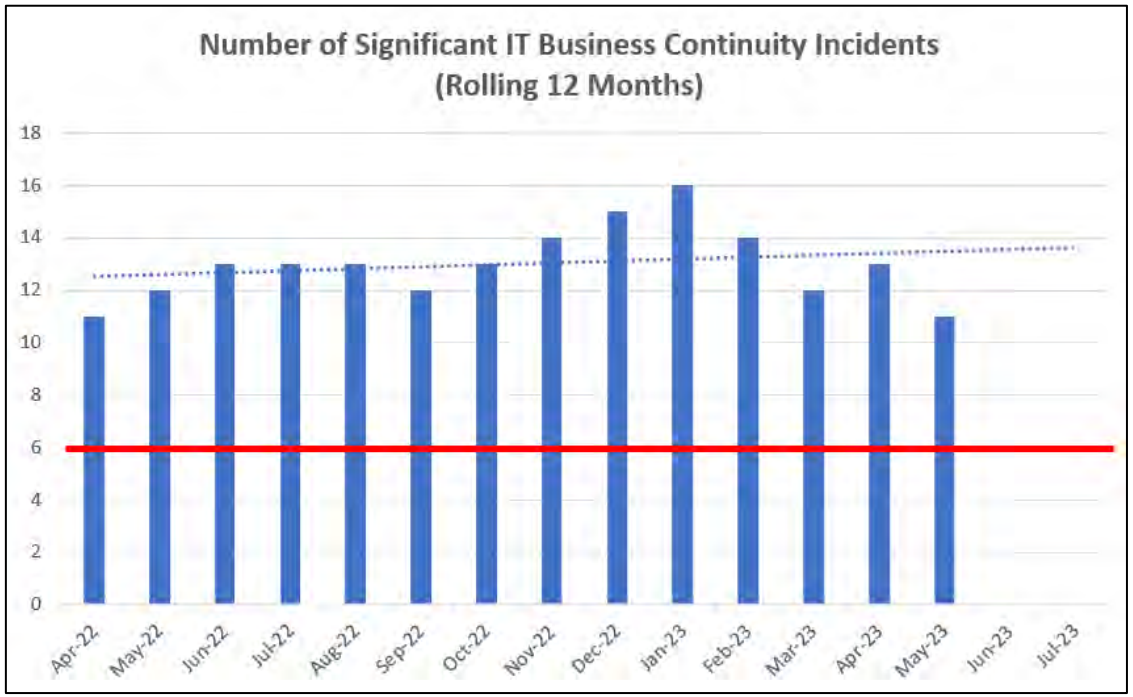
Digital Infrastructure: Number of Significant IT Business Continuity Incidents (Rolling 12 Months)

Target: 6 Incidents (Rolling 12 Months)

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual	-	11	12	13	13	13	12	13	14	15	16	14	12	13	11
Target	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6



Performance

Assessment of current performance, set out key points:

- In month reported figure reflects number of significant IT business continuity incidents in the previous 12-months.
- Significant volume of outages through mid/late-2022, steadily downward trend in recent months reflects improved stability
- Outages generally relate to network and application outages in VCC – some incidents relate to outages associated with national applications (e.g. WCP, LIMS) and/or ageing local IT infrastructure equipment / inefficient network design.
- Outages associated with national applications are reviewed via national service management boards, with the aim of reducing the likelihood of future service interruptions.
- Recruitment of additional band 6 IT infrastructure resource into VCC team ongoing – failed recruitment in June 2023, role back out to advert.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• External baseline assessment of VCC network / IT infrastructure – delayed from Dec 22	31/03/2023 (delayed to Q2 2023/24)	DMH
• Recruitment of additional technical expertise to support planned IT infrastructure works – delayed from Dec 2022.	28/02/2022 **(ONGOING)** (1 of 2 roles filled)	DMH

Expected Performance gain – immediate

Reduced number of service outages, improved resilience and performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Full telephony upgrade, as part of Trust-wide telephony platform	31/03/2024	DMH
• Removal of 'end of life' / legacy IT infrastructure	31/03/2024	DMH

	Expected Performance gain – longer-term Reduced number of service outages, improved resilience and performance.
	Risks to future performance
	Set out risks which could affect future performance • Number of 'end of life' IT equipment in operational use in VCC – replacement being expedited as part of ongoing technology refresh programme. • Limited resources / skills within Digital Services team – recruitment ongoing to increase capacity. Training credits and associated plan to be delivered through 2023/24.

KPI Indicator DIG.62

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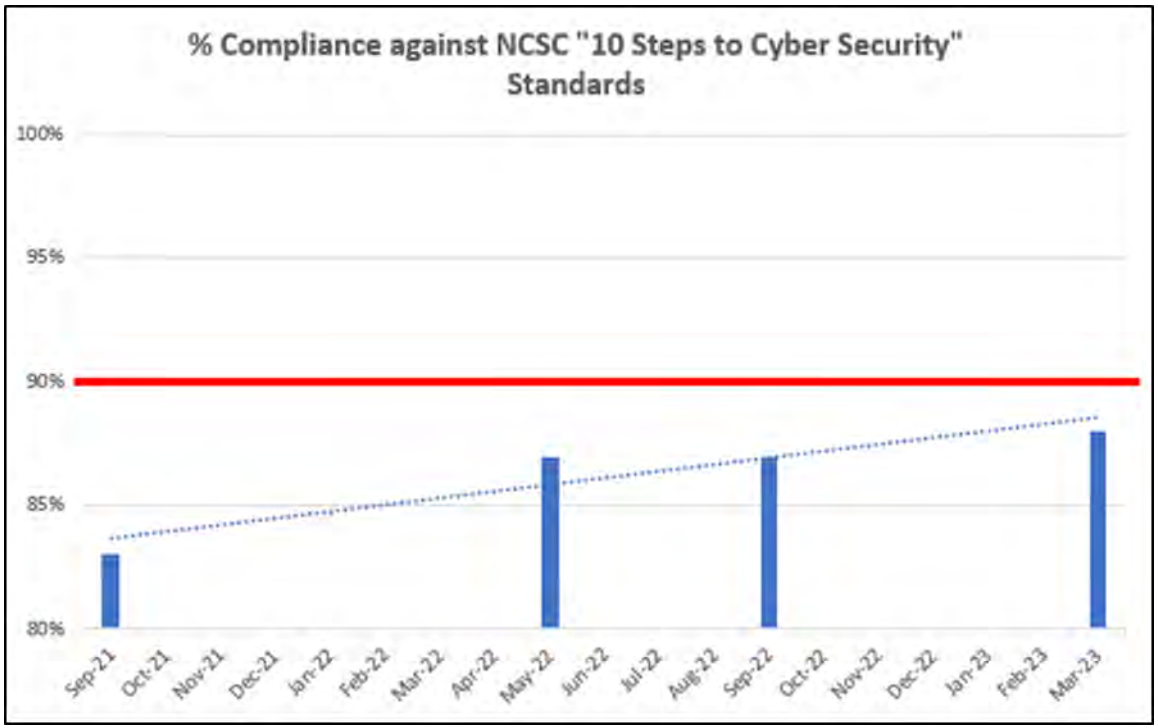
% compliance against NCSC "10 Steps to Cyber Security" best practice standards

Target: 90%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual (%)	-	-	-	87	-	-	87	-	-	-	-	-	88	-	-
Target (90%)	-	-	-	90	-	-	90	-	-	90	-	-	90	-	-



Performance

Assessment of current performance, set out key points:

- First assessment – undertaken Sep 2021. Mid Year review completed in March 2023. Next update Sep 2023.
- Performance slightly improved since Sep 2022 update.
- Progress slowed due to delay in recruiting to Cyber Security Officer/Manager role. Competitive marketplace – difficult to recruit.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Recruit replacement Cyber Security Manager – interviews scheduled for July 2023	30/01/2023 (delayed)	DMH
• Deploy various IT infrastructure (e.g. new firewalls) to enhance cyber security posture)	Ongoing	DMH
• Re-establish regular simulated phishing campaigns for staff.	30/01/2023 (delayed)	DMH

Expected Performance gain - immediate

Original performance target aimed to achieve target compliance (90%) by 31/03/2023. Work will continue with the aim of achieving this target in September 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Board Development Sessions re: Cyber Security.	30/09/2023	DMH
• Deploy various IT infrastructure, further vulnerability monitoring etc. to enhance cyber security posture.	Ongoing	DMH

	• Increase number of cyber security staff within Digital Services team.	30/06/2023	DMH
	Expected Performance gain – longer-term Original performance target aimed to achieve target compliance (90%) by 31/03/2023. Work will continue with the aim of achieving this target in September 2023.		
	Risks to future performance		
	Set out risks which could affect future performance • Limited cyber security capacity / expertise within Digital Services team. Cyber Security Officer left Trust in July 2022 – failure to recruit replacement after two rounds of recruitment. New Band 7 Cyber Security Manager role approved via Scrutiny – interviews scheduled for July 2023 • Board-level understanding of cyber security requires further development.		

KPI Indicator DIG.63

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Cyber Security – % of employees clicking on internal phishing campaigns

Target: TBA

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Target TBA	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Performance

Assessment of current performance, set out key points:
Currently unable to routinely report compliance.
Aim to establish reporting in Q4 2023/23 – delayed pending recruitment of Cyber Security Manager (interviews scheduled for July 2023).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Re-establish regular simulated phishing campaigns for staff (delayed due to failure to recruit Cyber Security Officer – new Band 7 role created)	30/01/2023 **(DELAYED)**	DMH

Expected Performance gain - immediate
TBC

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• n/a	n/a	n/a

Expected Performance gain – longer-term
TBC

Risks to future performance

Set out risks which could affect future performance

- Limited cyber security capacity / expertise within Digital Services team. Cyber Security Officer left Trust in July 2022. Failure to recruit replacement following two attempts – job description updated to Band 7 Cyber Security Manager, interviews scheduled for July 2023

EFFECTIVENESS

KPI Indicator WOD.36

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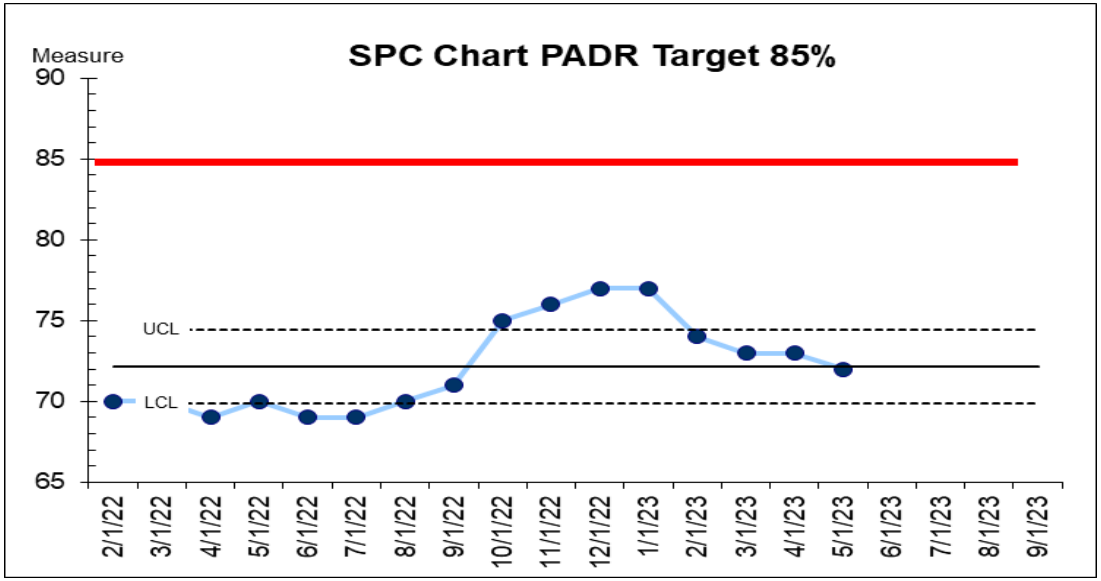
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	70	69	70	69	69	70	71	75	76	77	77	74	73	73	72
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows a special cause deteriorating trend over the last 15months months, averaging 72%, and consistently falling short of the 85% target.

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 we see once more a decline in the Trust wide data with a specific cause for concern in Transforming Cancer Services that has been below 50% consecutively since November 2022.

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

KPI Indicator WOD.37

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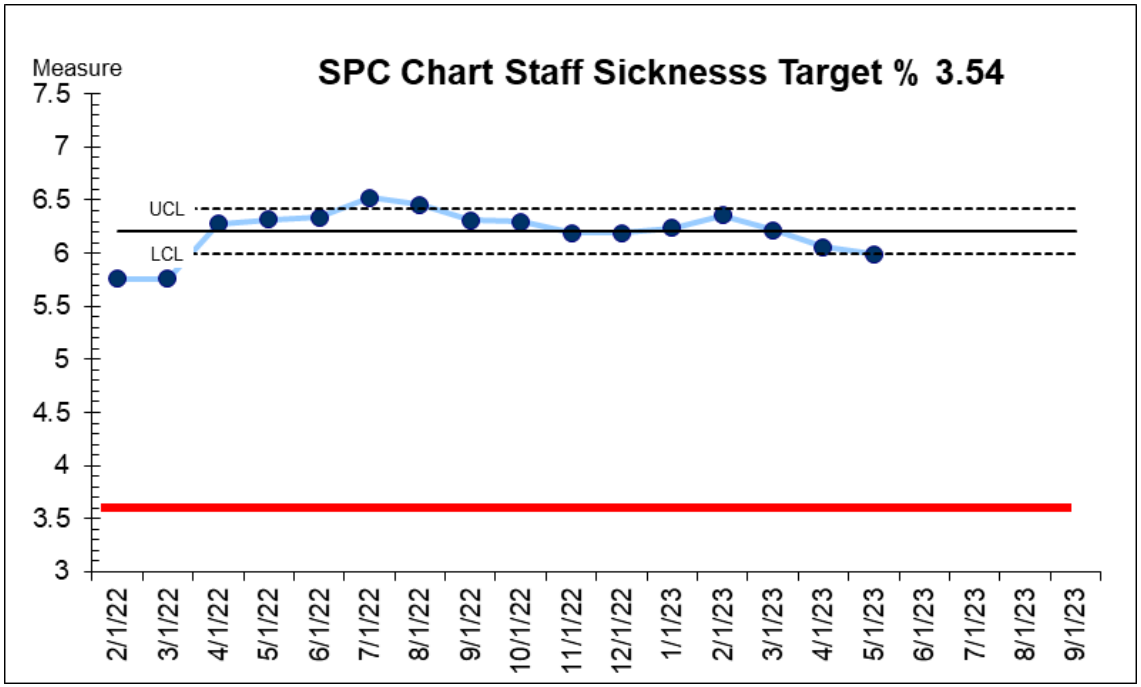
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19	6.19	6.24	6.36	6.22	6.06	5.99
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 15 months with the overall average 5.6% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

There is a slight decline in sickness following the winter months and as the People and Relationship Team continue to support managers in the application of the sickness policy.

Short-term absence has once more dropped to 1% in May 2023 therefore prioritisation on long-term management will be key going forward.

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients	01/09/2023 01/08/2023	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

Regular monitoring against the application of the policy will ensure our staff are supported and encouraged to improve their health and areas where there are concerns are provided with immediate interventions to improve practice.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engegments sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (HealthShield, Wagestream etc.) • Reaccreditation of platinum corporate health standards	30/04/2024 Ongoing	Head of OD Head of OD and Trust Board

	• Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

KPI Indicator EST.25

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Delivering wider social value (Sustainable Development Assessment Tool (SDAT)

Target: TBA

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard

Trust	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target 85%															

[Graph and data to be inserted under development]

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text • insert text • 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 • insert text • 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
- insert text

KPI Indicator H&S.27

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KPI 7 – Compliance with fire safety training need analysis (TNA): ***Basic Awareness*** [Level 1]

Target: 85%

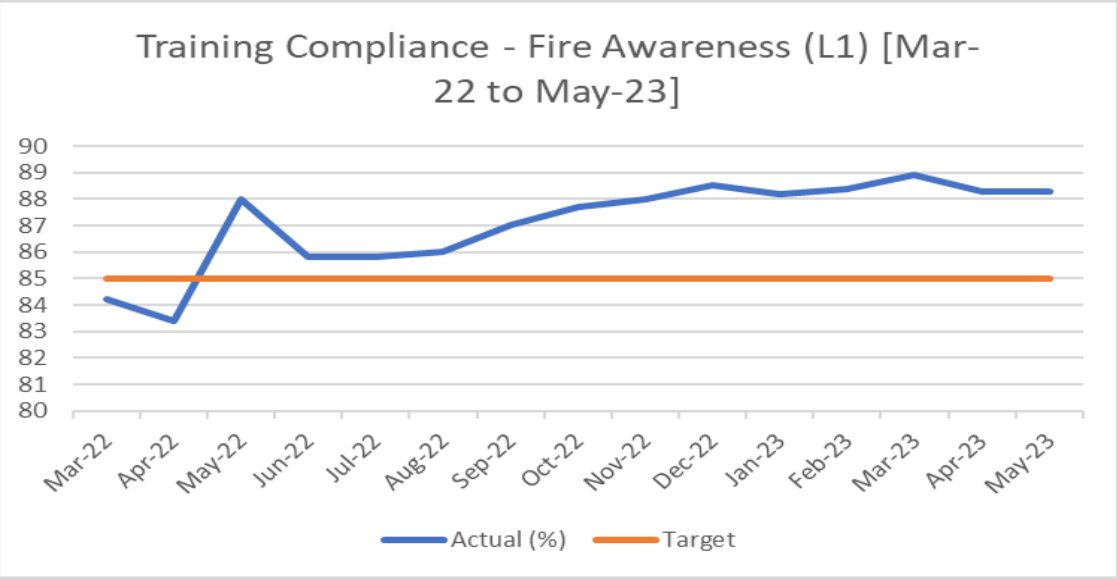
SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

MONTH	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual (%)	84	83	88	86	86	86	87	88	88	89	88	88	89	88	88
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

nda – No Data Available

NB: KPI previously set to quarterly reporting at Trust Estates Compliance meetings prior to new Performance Management Framework arrangements in 2022.



Analysis

Complince has remeianed static with no marked increae compared to previous month [April 2023].

Performance

If performance is not at required level, set out what the main causes are:

- Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e., agile/hybrid working.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training.	COMPLETE Q1	Trust FSM Trust FSM

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	Trust FSM

Expected Performance gain – longer-term

- Staff have wider access to training which can be delivered at a time and place to suit their needs.
- Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

a) Failure of Trust and staff to comply with statutory and mandatory duties.

b) Insufficient training has the potential to result in fire incident.

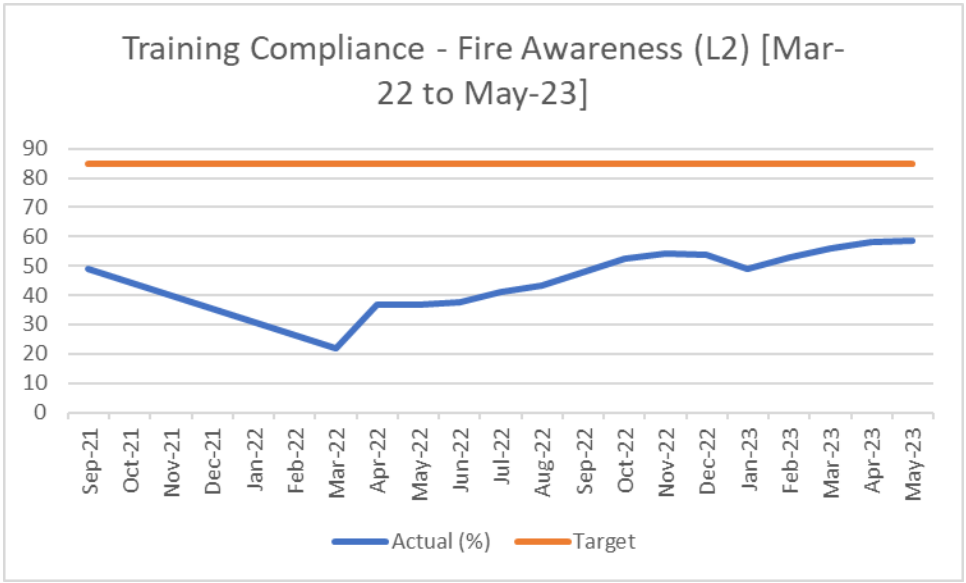
KPI 8 – Compliance with fire safety training need analysis (TNA): ***Operational Response*** [Level 2]

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

ONTH	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-21	Oct-22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual (%)	22	37	37	38	41	43	49	53	54	54	49	53	56	58	59
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Analysis

Marginal improvement in complince caompared to previous month [April 2023].

Performance

Despite marginal rise in training compliance, figures still below Trust benchmark due to service needs and resurgence of the pandemic, some training for staff has been restricted; both the FSM and Trust Ed & Dev team are actively working with departments to identify alternative approaches to the delivery of fire training.

Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e. agile/hybrid working.

49.0

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training.	Q1	Trust FSM

Expected Performance gain - immediate

Divisions and managers accept some ownership of training and advise how staff can receive training to fit in with current ways of working and other barriers.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	As KPI 7

Expected Performance gain – longer-term

Staff have wider access to training which can be delivered at a time and place to suit their needs. Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties. Insufficient training has the potential to result in fire incident.

KPI 9 - Compliance with fire safety training need analysis (TNA): ***Tactical Response*** [Level 3]

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q1 2022-23			Q2 2022-23			Q3 2022-23			Q4 2022-23			Q1 2023-24		
	Apr 22	May 22	Jun 22	Jul 22	Apr 22	May 22	Jun 22	Jul 22	Apr 22	May 22	Jun 22	Jul 22	Apr 23	May 23	Jun 23
Actual %	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Analysis

As noted under KPI 7, a paper was submitted to the Trust Education Steering Group in July to rationalize fire training into three distinct levels including fire [Tactical] response.

Performance

If performance is not at required level, set out what the main causes are:

- Lack of clarity on training criteria

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Adopt more structured TNA for fire safety as outlined in paper to the trust's Education Steering group	Q2	Trust FSM Trust Ed & Dev team

Expected Performance gain - immediate

a) Managers and staff have clearer idea of the training they need to complete.

b) Training can be more focused around staff groups / departments.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
n/a	n/a	n/a

Expected Performance gain – longer-term

n/a

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties. Insufficient training has the potential to result in fire incident.

KPI Indicator H&S.26

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Graph title - Trust Health and Safety Training Compliance by Course

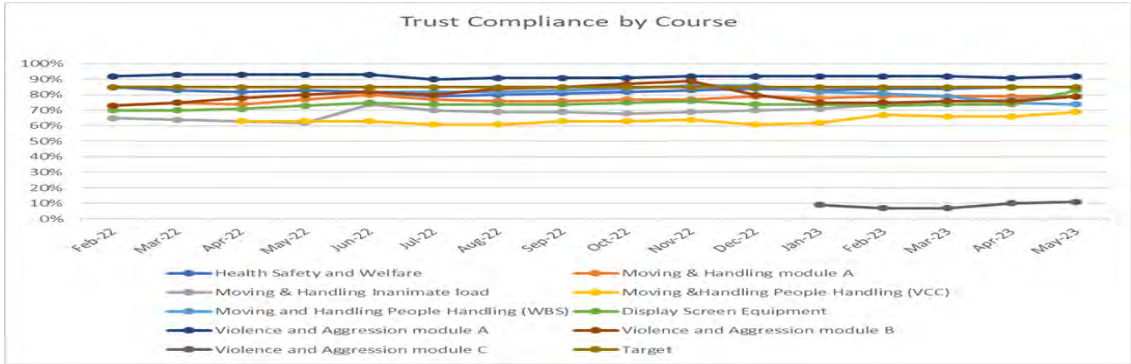
Target: 85%

SLT Lead: Carl James

Current Performance against Target or Standard – below 85% in 7 out of 9 areas

Performance - Level below target

	Health Safety and Welfare	Moving & Handling module A	Moving & Handling Inanimate load	Moving &Handling People Handling (VCC)	Moving and Handling People Handling (WBS)	Display Screen Equipment	Violence and Aggression module A	Violence and Aggression module B	Violence and Aggression module C
Mar-22	83%	75%	64%			70%	93%	75%	
Apr-22	82%	74%	63%	63%		71%	93%	78%	
May-22	83%	77%	62%	63%		73%	93%	80%	
Jun-22	82%	80%	74%	63%	82%	75%	93%	82%	
Jul-22	79%	77%	70%	61%	82%	74%	90%	80%	
Aug-22	80%	76%	69%	61%	82%	74%	91%	84%	
Sep-22	81%	76%	69%	63%	83%	74%	91%	85%	
Oct-22	82%	77%	68%	63%	84%	75%	91%	87%	
Nov-22	83%	77%	69%	64%	86%	76%	92%	89%	
Dec-22	84%	79%	70%	61%	86%	74%	92%	80%	
Jan-23	83%	78%	71%	62%	82%	74%	92%	75%	9.00%
Feb-23	84%	79%	74%	67%	81%	73%	92%	75%	7%
Mar-23	84%	79%	76%	66%	79%	74%	92%	76%	7%
Apr 23	85%	79%	77%	66%	75%	74%	91%	76%	10%
May 23	85%	79%	79%	69%	74%	83%	92%	79%	11%



Service Improvement Actions – Immediate (0 to 3 months)

Provision of training is maintaining if not marginally improving the overall position. Positive feedback received from the divisions in response to the onsite delivery model, rolled out through the course of this year.

The TNA conducted earlier in the year also identified an increase need for training which has resulted in an extra 324 training courses. Consolidation against this uplifted figure demonstrates that training figures are improving. V&A Module C continues to improve with marginal gains. Note this training has only recently been identified and there is a body of people identified through TNA earlier this year.

Action Additional dates added to the calendar up to December to support chieving compliance

Timescale and Lead Q1 2023/24 Lead: Department Heads

Expected Performance gain – immediate steady improvement in compliance

Service Improvement Actions – tactical (12 months +)

Actions: As above

Timescale:Q1 & Q22023/24 Lead: Departmental Heads

Expected Performance gain – longer-term Compliance with WG 85% target

Risks to future performance

Staff unable to be released due to operational pressures. - **Action** courses timetabled before rotas released. Dialogue with departments about scheduling courses. Staff access to IT equipment – Action DigiHub available for ESR training.

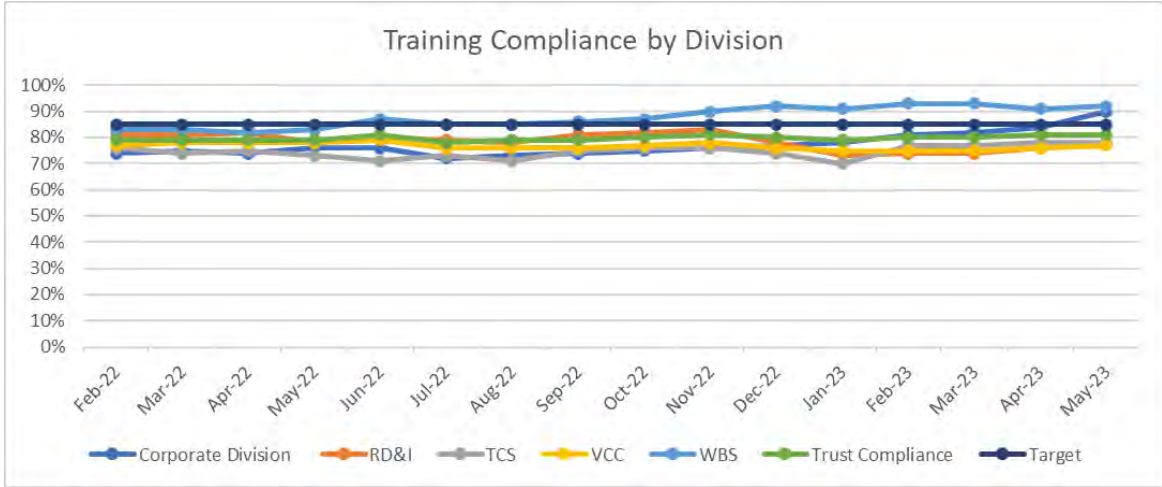
Volume of Statutory and Mandatory training which staff have to complete online

Graph title - Trust Health and Safety Training Compliance by Division

Target: 85%

Current Performance against Target or Standard – Below 85% I 5 out of 5 areas

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar23	Apr 23	May 23
Corporate Division	75%	74%	76%	76%	72%	73%	74%	75%	76%	77%	78%	80.70%	82%	84%	90%
RD&I	81%	82%	78%	80%	79%	78%	81%	82%	83%	78%	73%	74%	74%	76%	78%
TCS	74%	75%	73%	71%	73%	71%	75%	76%	76%	74%	70%	77%	77%	78%	78%
VCC	78%	78%	78%	79%	76%	76%	76%	77%	78%	76%	75%	75%	75%	76%	77%
WBS	83%	82%	83%	87%	85%	85%	86%	87%	90%	92%	91%	93%	93%	91%	92%
Trust Compliance	79%	79%	79%	81%	78%	79%	79%	80%	81.20%	80%	79%	80%	80%	81%	81%



SLT Lead: Carl James

Performance - Level below target

On the back of actions listed last month the overall picture has marginally improved. Continue to manage.

There is sufficient capacity in terms of training places offered, the challenge remains releasing staff to attend face-to-face training and staff completing mandatory online training.
Volume of Statutory and mandatory training required.

Timescale
Q1 2023/24
Lead: Departmental Managers

Expected Performance gain – steady improvement in compliance

Service Improvement Actions – tactical (12 months +)

Actions: As above

Timescale:
Q1 & Q2 2023/24
Lead: Departmental Managers

Expected Performance gain – longer-term Compliance with WG 85% target

Risks to future performance

Staff unable to be released due to operational pressures. –

Staff unable to be released due to operational pressures.

Volume of Statutory and Mandatory training which staff have to complete on line

STAFF EXPERIENCE

KPI Indicator DIG.51

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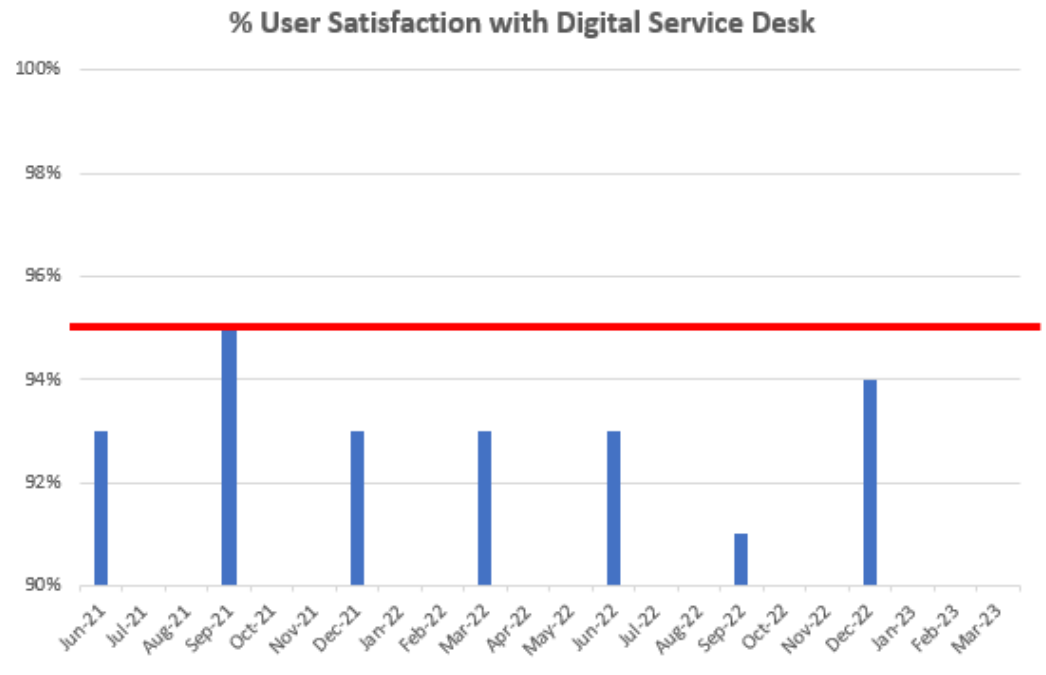
Digital Service Desk % User Satisfaction with Digital Service Desk

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Actual %	93%			91%			94%			87%					
Target 95%	95%			95%			95%			95%					



Performance

Assessment of current performance, set out key points:

Quarterly measure – next performance due to be reported in July 2023, for Q1 2023/24.

Previous dip in performance partly linked to staffing capacity challenges associated with various recruitment within the team. Two Service Desk Officers promoted within the team in Q4, presenting some short term capacity challenges. Recruitment of replacement staff completed – both started in post in June 2023.

New Digital Operations Manager role has been created – focus of role is to achieve a range of improved performance in respect of 1st and 2nd line IT support. Successful recruitment – commenced in post in early June.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Routine review of performance and associated feedback within Digital Services Infrastructure Team meetings to identify areas for improvement.	Ongoing	G Daniels

Expected Performance gain - immediate

Aiming to achieve and subsequently maintain 95% target by April 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy new IT Service Management (ITSM) tool, to support improved ways of working across Digital Service Desk.	31/03/2024	G Daniels
• Automation of Service Desk activities – improved turnaround time to resolution.	31/03/2024 (ongoing)	G Daniels

	• Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing)	G Daniels
	Expected Performance gain – longer-term Improved customer experience, to ensure 95% target is maintained.		
	Risks to future performance		
	Set out risks which could affect future performance • Unable to fund procurement of new ITSM tool. • National ITSM project (part of the All Wales Infrastructure Programme) does not proceed at sufficient pace.		

KPI Indicator WOD.13

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% staff who rate us as a good employer in Annual Staff Survey

Target: TBA%

SLT Lead: Carl James

Current Performance against Target or Standard

Trust	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %															
Target 90%															

[Graph and data to be inserted under development]

SPC Analysis

The SPC chart above, shows common cause or normal variation for the period January to September 2021.

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

TIMELINESS

KPI Indicator DIG.58

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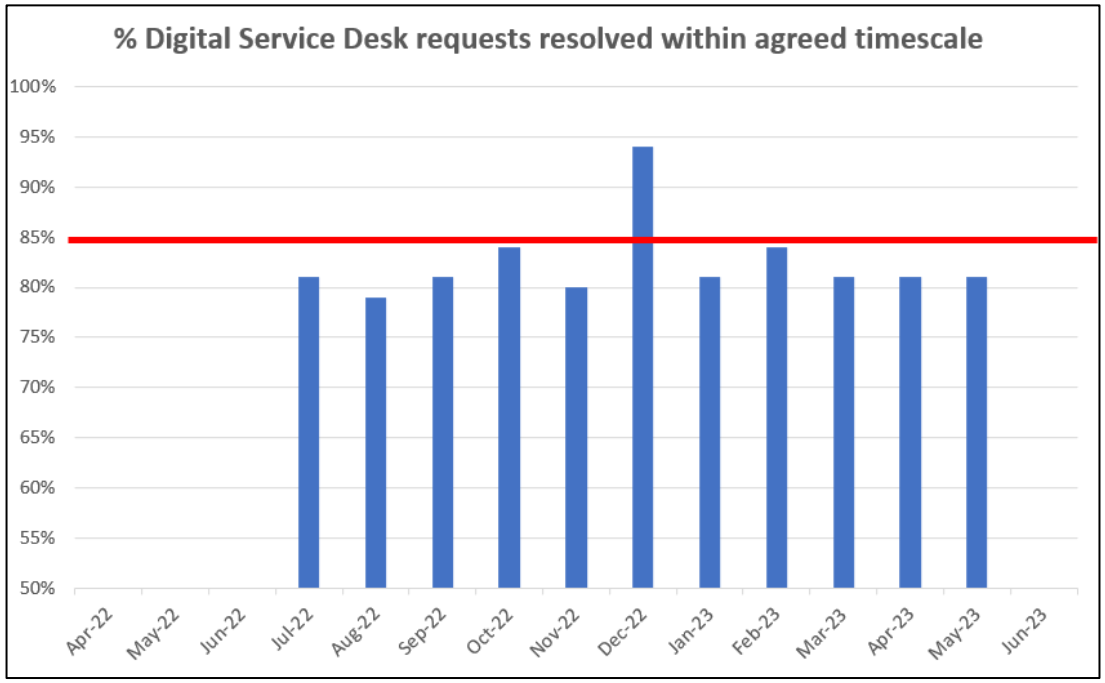
Digital Services: % Service Requests resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	n/a	n/a	n/a	n/a	81%	79%	81%	84%	80%	94%	81%	84%	81%	81%	81%
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points :

Performance largely stable at approx. 81%.

Recruitment of 2 x Service Desk Officers – started work early June 2023.

Work ongoing to improve the quality and timeliness of service desk responses, to include increased use of automation – focus on increasing rates of first-time fixes by 1st line support team.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Backfill 2 wte Service Desk Officer staff.	31/05/2023 **(COMPLETED)**	DMH

Expected Performance gain - immediate

Aim to routinely achieve 85% target by start of Q2 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution.	31/03/2024 (ongoing)	G Daniels
• Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing)	G Daniels

Expected Performance gain – longer-term

Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance

- Current IT Service Management (ITSM) tooling (Service Point – maintained by DHCW) insufficient to support required improvements to Digital Service Desk workflows (e.g. automation).
- Initial scoping exercise completed as part of All Wales Infrastructure Programme (AWIP) – procurement to take place through 2023/24.

KPI Indicator DIG.59

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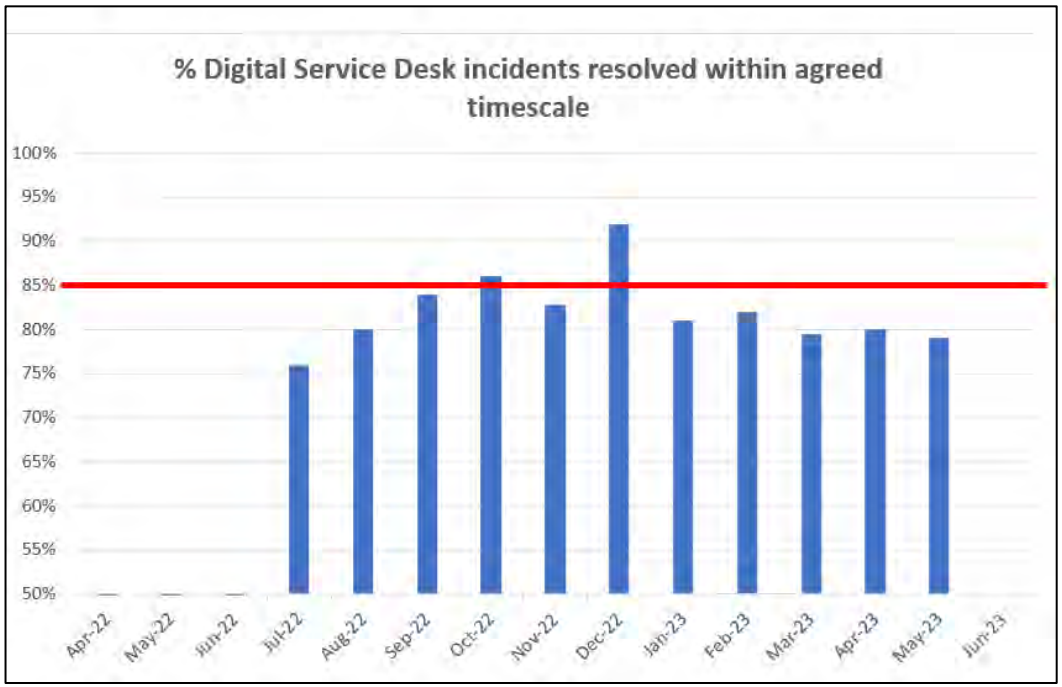
Digital Services: % Incidents resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	n/a	n/a	n/a	n/a	76%	80%	84%	86%	83%	92%	81%	82%	80%	80%	79%
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points:

Target attained for first time in December 2022; however, performance currently stable at approx. 81%.

Recruitment of 2 x Service Desk Officers completed.

Work ongoing to improve the quality and timeliness of service desk responses, to include increased use of automation – focus on increasing rates of first-time fixes by 1st line support team.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Backfill 2 wte Service Desk Officer staff.	31/05/2023 **(COMPLETED)**	DMH

Expected Performance gain - immediate

Aim to routinely achieve 85% target by start of 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution.	31/03/2024 (ongoing)	G Daniels
• Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing)	G Daniels

Expected Performance gain – longer-term

Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance

- Current IT Service Management (ITSM) tooling (Service Point – maintained by DHCW) insufficient to support required improvements to Digital Service Desk workflows (e.g. automation).
- Initial scoping exercise completed as part of All Wales Infrastructure Programme (AWIP) – procurement to take place through 2023/24.

KPI Indicator EST.54

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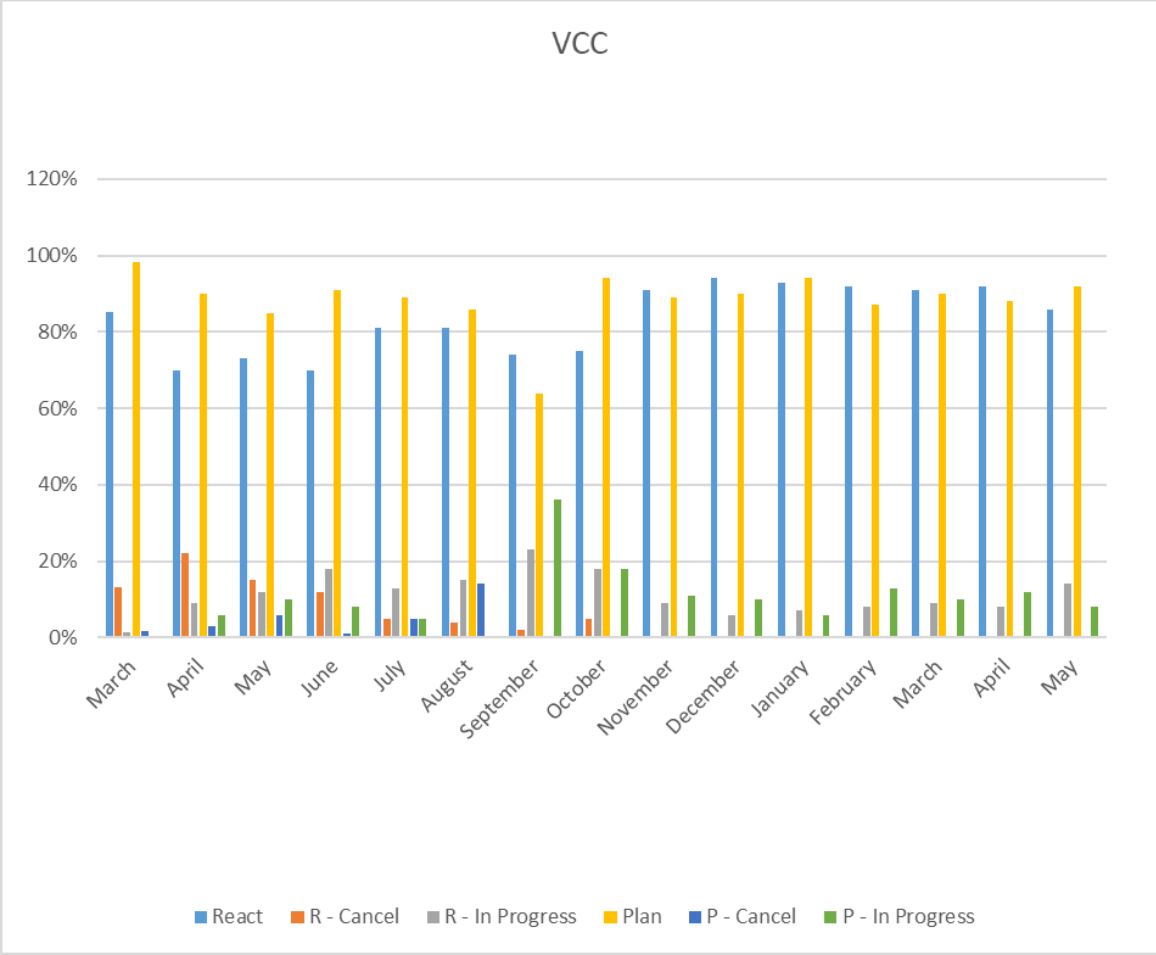
Graph title – 15 month Data PPM & Reactive Work Orders Velindre Cancer Centre	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Short Term Source contractors for additional support to maintain a level of service delivery	0-3 months	Jonathan Fear

Planned Tasks – 86% In Progress – 14%
Reactive Tasks – 92% In Progress Jobs – 8%
Cancelled Jobs – 0% Planned & Reactive
There is a marked improvement on the compliance levels at VCC due to recruitment & additional planning and management of Planned and Reactive tasks. There were also no cancelled jobs during this period.

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	recruitment phase 6 months CAFM Improvements ongoing	Jason Hoskins

Expected Performance gain – longer-term
Continue to improve compliance levels at VCC and across the Trust. Further recruitment posts to support longer term goals.

Risks to future performance
Works are being prioritised to ensure high risk and statutory activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

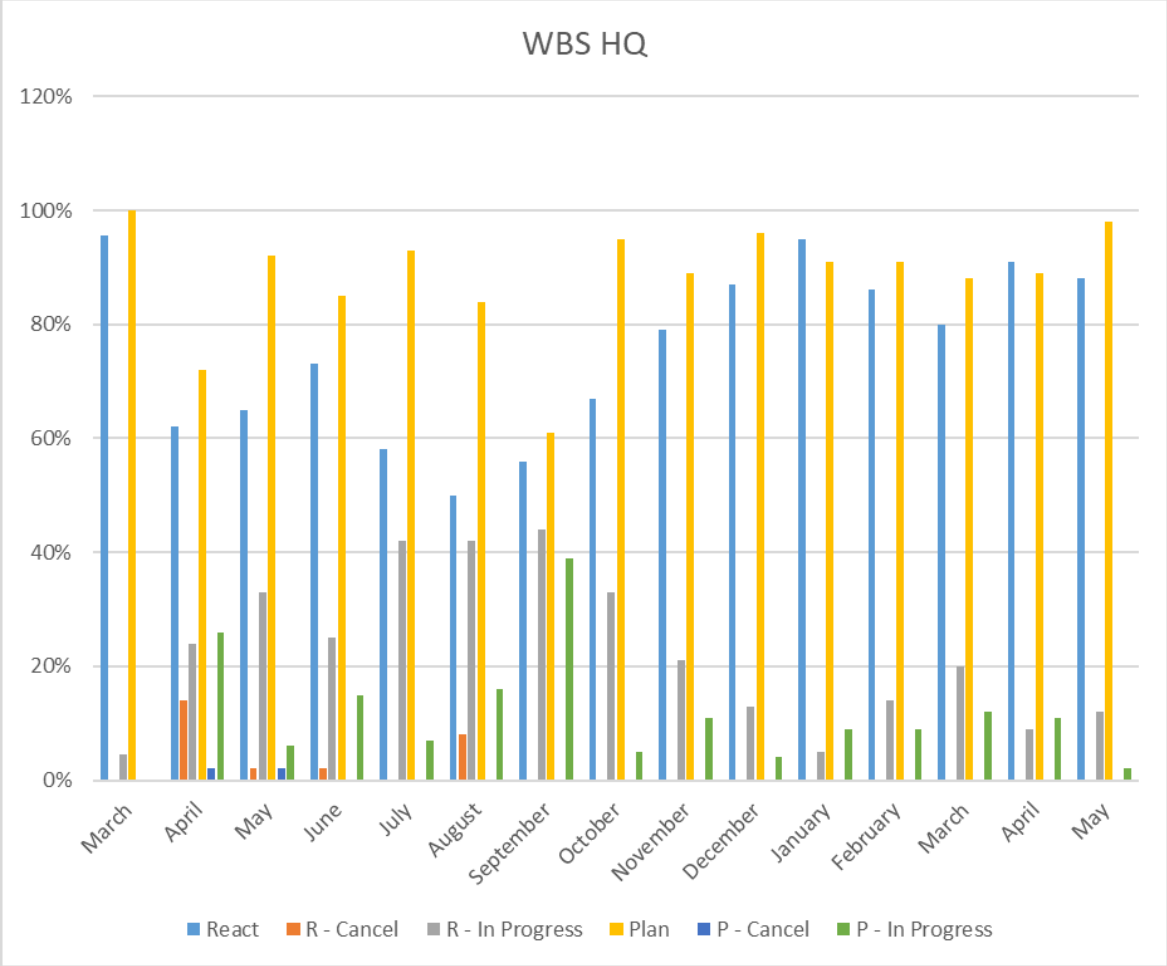
Graph title – 15 month Data PPM & Reactive Work Orders WBS HQ

Target: 95% compliance of completion of PPM & Reactive tasks

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:

The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Planned Tasks – 98% Planned In Progress – 2%
Reactive Tasks – 88% In Progress Jobs – 12%
Cancelled Jobs – 0% Planned & Reactive
Compliance has improved this month and has hit its target above 98%

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

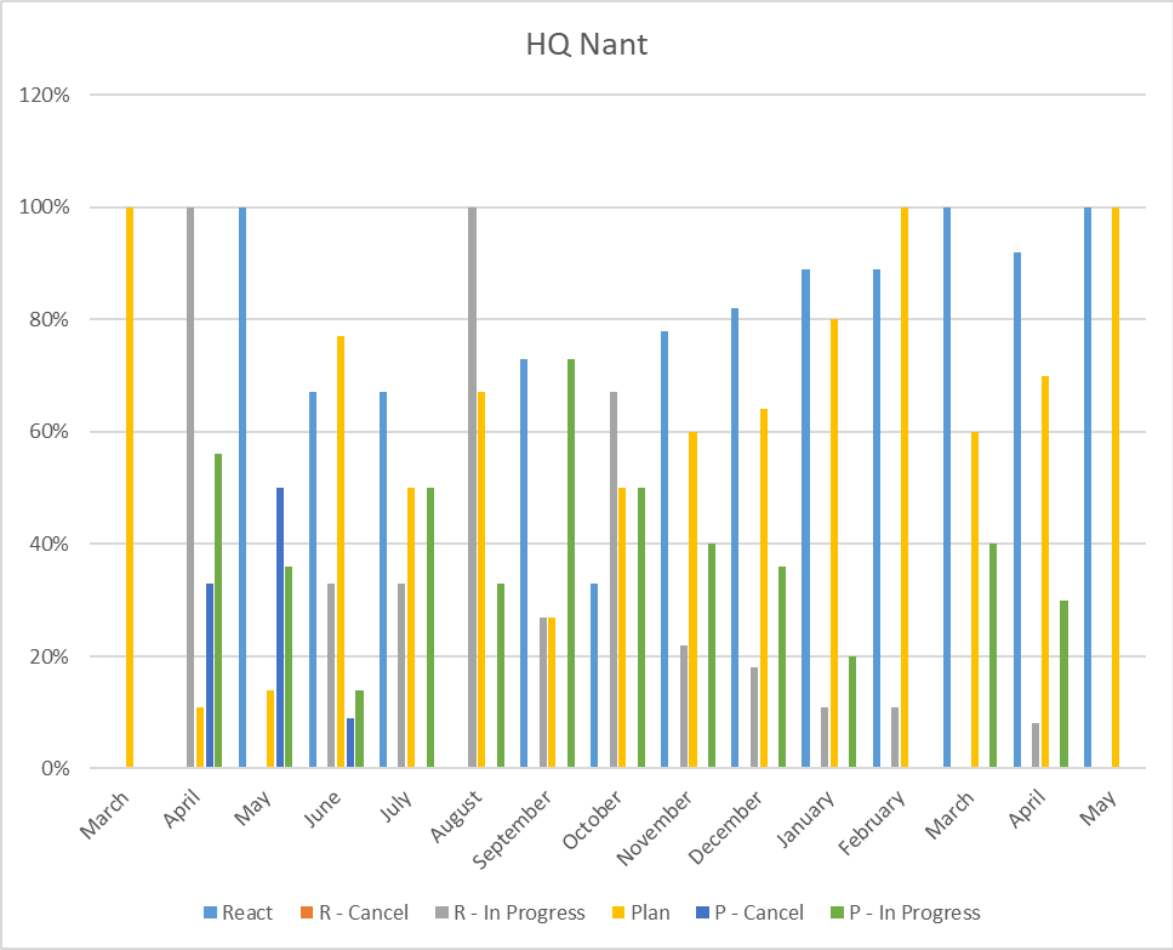
Expected Performance gain – longer-term

Decreased number of late/cancelled jobs as there will be an adequate workforce. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Works are being prioritised to ensure high risk and statutory activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders Headquarters Nantgarw	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:

The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Planned Tasks – 100 Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Maintain high figures of compliance.

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

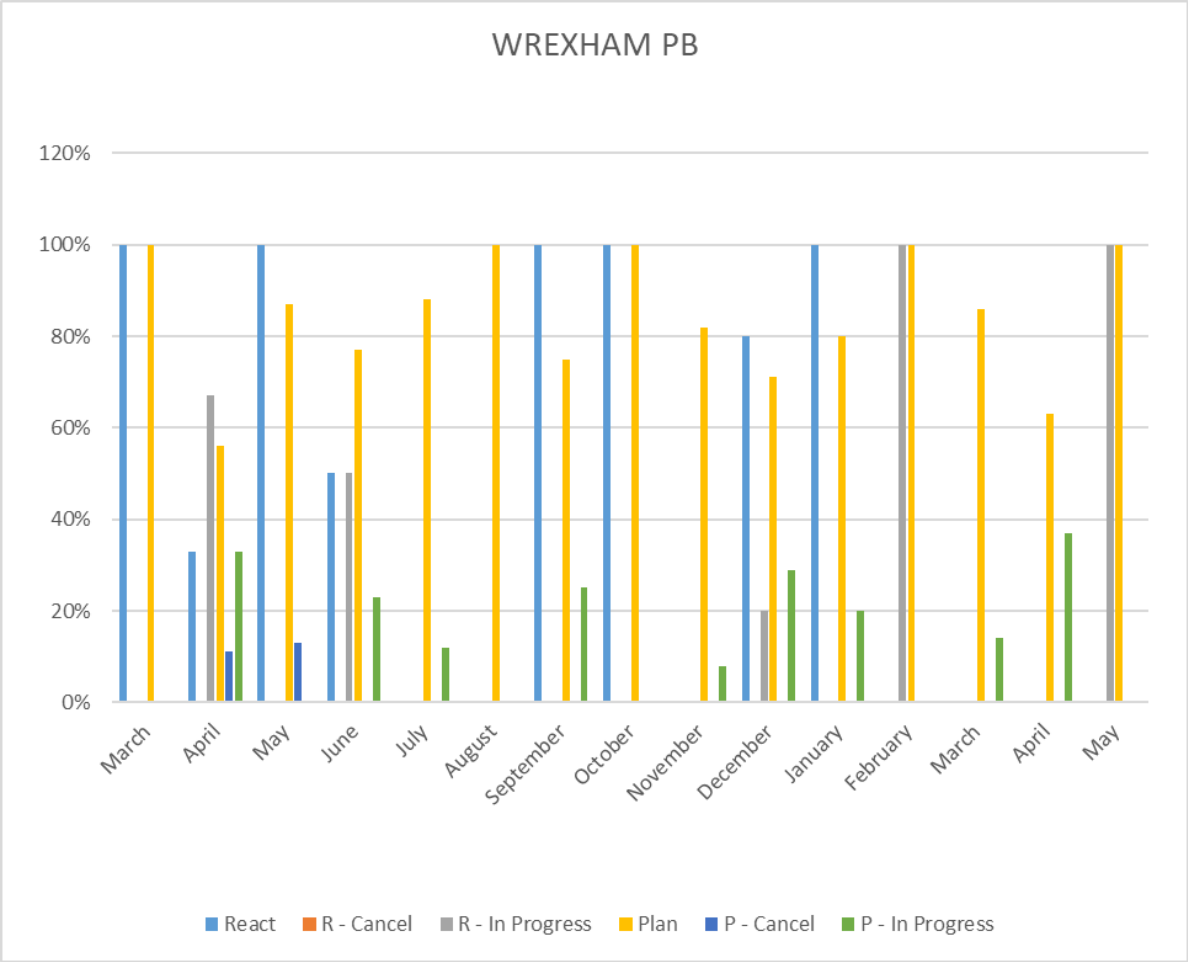
Expected Performance gain – longer-term

No cancelled jobs in this period however improvements are required to adress Planned tasks in HQ Nantgarw.

Risks to future performance

Works are being prioritised to ensure high risk activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full with, recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders Headquarters NantgaWrexham	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Expected Performance gain - immediate
Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Maintain High Standards of compliance

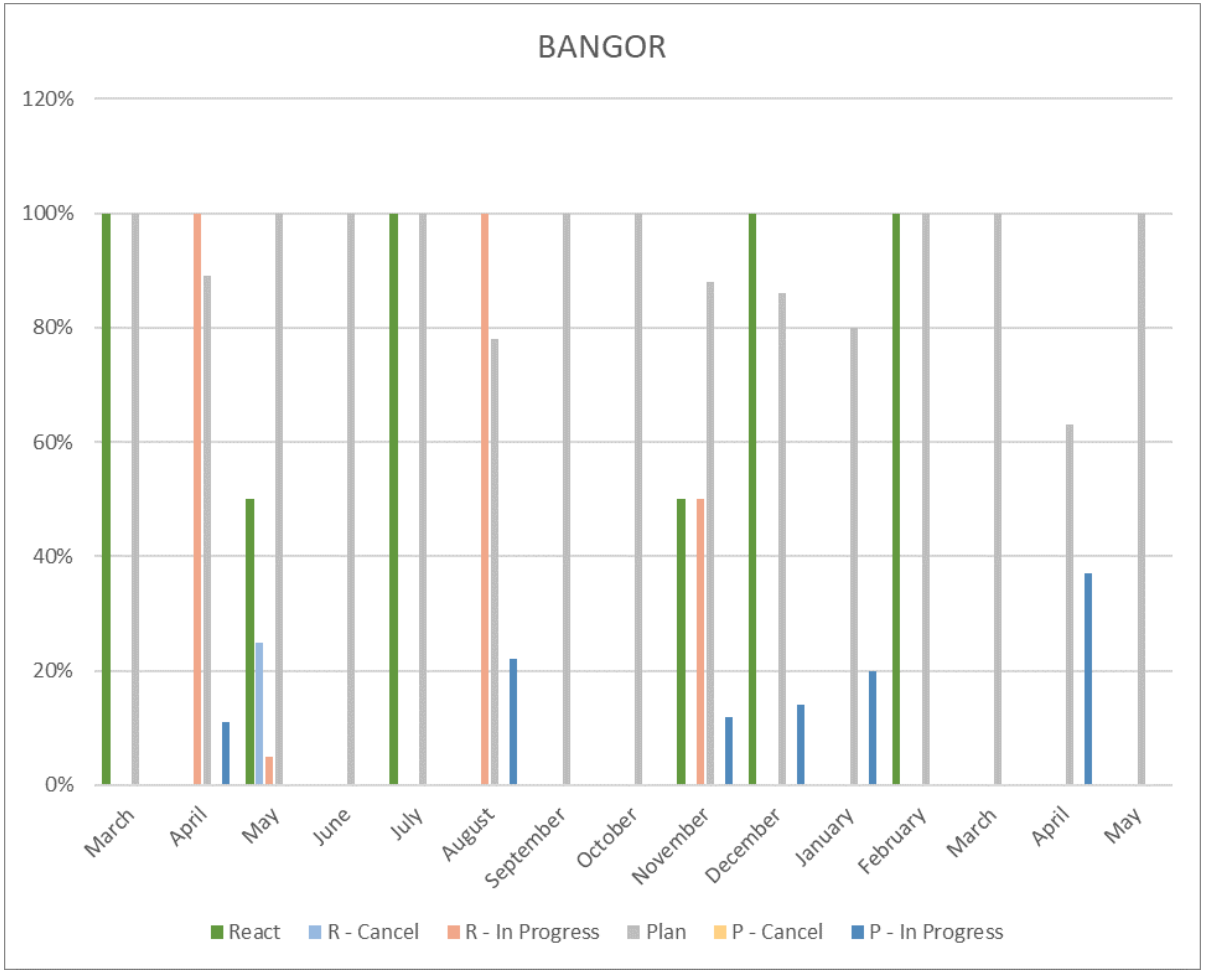
Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance
Maintain High Levels of Compliance.

Graph title – 15 month Data PPM & Reactive Work Orders Bangor	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
The estates team is currently completing the final stages of recruitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale: 0-3 months**	**Lead: Jonathan Fear**
Planned Tasks – 100% Planned in Progress – 0% Reactive Tasks – 100% In Progress Jobs – 0% Cancelled Jobs – 0% Planned & Reactive		

Expected Performance gain - immediate
Maintain High Levels of Compliance.

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Maintain High Levels of Compliance.

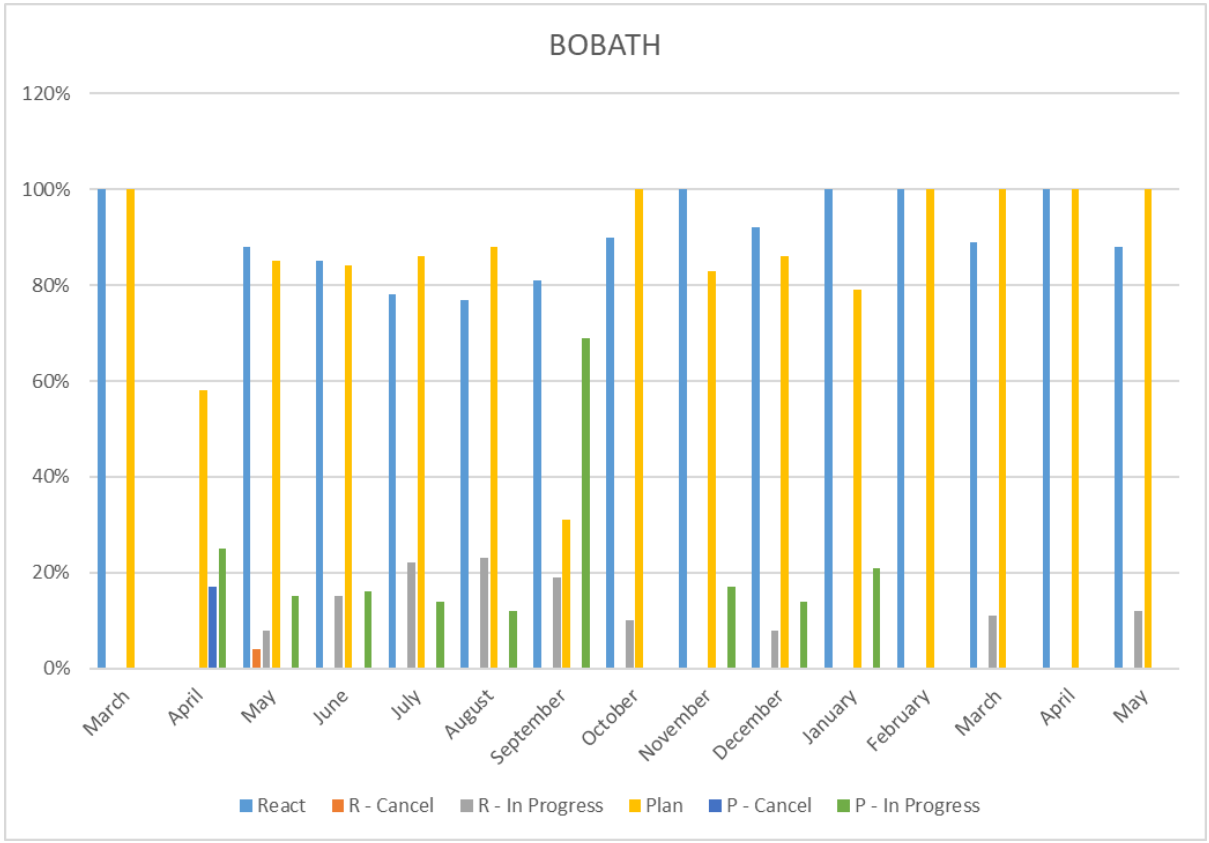
Graph title – 15 month Data PPM & Reactive Work Orders 19 Park Road

Target: 95% compliance of completion of PPM & Reactive tasks

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:

he estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale: 0-3 months**	**Lead: Jonathan Fear**
Short Term Source contractors for additional support to maintain a level of service delivery		

Expected Performance gain - immediate

Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 88% In Progress Jobs – 12%
Cancelled Jobs – 0% Planned & Reactive

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term

0% of late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards
Improve reactive task compliance.

Risks to future performance

EFFICIENT

KPI Indicator FIN.71

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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										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(6.650)	(6.653)	(0.003)	(37.005)	(37.005)	0.000
RD&I	(0.142)	(0.142)	0.000	0.144	0.144	0.000
WBS	(3.214)	(3.214)	(0.001)	(19.816)	(19.816)	0.000
Sub-Total Divisions	**(10.006)**	**(10.009)**	**(0.003)**	**(56.677)**	**(56.677)**	**0.000**
Corporate Services Directorates	**(1.914)**	**(1.903)**	**0.011**	**(11.483)**	**(11.483)**	**0.000**
Delegated Budget Position	**(11.920)**	**(11.912)**	**(0.007)**	**(68.161)**	**(68.161)**	**0.000**
TCS	(0.124)	(0.127)	0.003	(0.611)	(0.611)	0.000
Health Technology Wales	0.000	0.000	(0.000)	0.000	0.000	0.000
Trust Income / Reserves	12.043	12.043	(0.000)	68.772	68.772	0.000
Trust Position	0.000	0.004	0.004	0.000	0.000	0.000

Performance

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of £0.004m 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 planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions addressed through Divisional Action Plans		M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Non Delivery of recurrent savings plans
- Contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall.

KPI Indicator FIN.72

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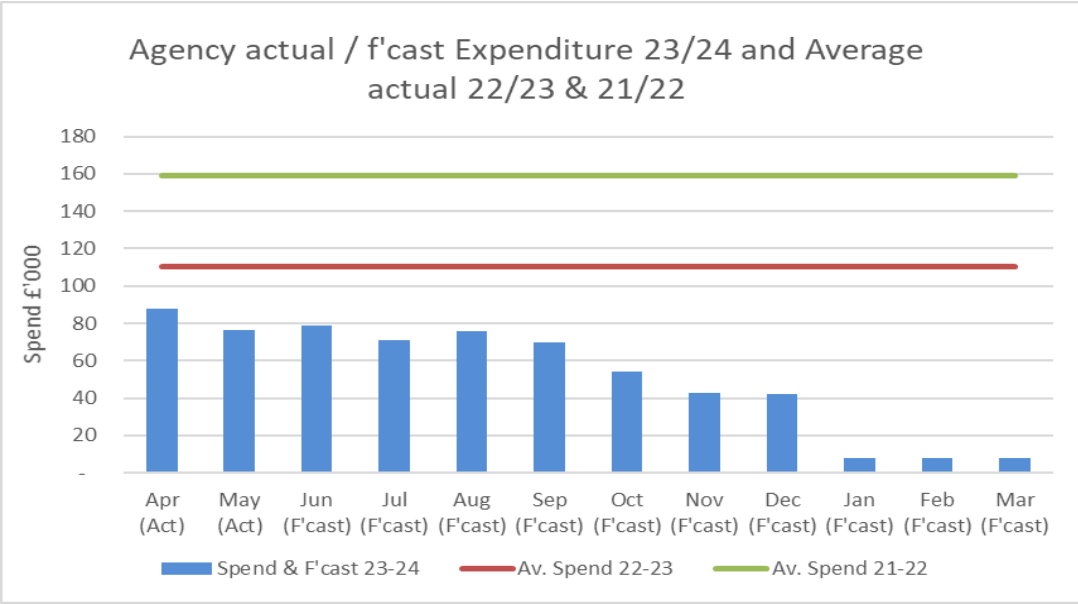
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

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										
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for May'23 was **£0.077m,** which gives a cumulative year to date spend of £0.165m and a current forecast outturn spend of circa **£0.623m** (£1.323m 2022/23).

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

At this stage of the year the expectation is that the Radiotherapy, Medical Physics and Estates agency staff will transition into substantive positions within the Trust which is following investment decisions in these areas. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Actions addressed via Divisional action plans		Matthew Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	27.8	1.389m	1.637m										
Target £24.416m CEL		1.389m	1.637m										

Capital Position as at May 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M2 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	2.688	0.000	8.208	10.896	0.000
Integrated Radiotherapy Solutions (IRS)	10.326	0.307	0.000	10.019	10.326	0.000
IRS Satellite Centre (RSC)	1.347	0.000	0.000	1.347	1.347	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.733	2.995	0.000	19.738	22.733	0.000
Discretionary Capital	1.683	0.031	0.000	1.652	1.683	0.000
Total	24.416	3.026	0.000	21.390	24.416	0.000

Performance

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.773m**, and Discretionary funding of **£1.683m.**

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 202223.

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

Performance to date

The actual expenditure to May 2023 on the All-Wales Capital Programme schemes was £2.995m, this is broken down between spend on the nVCC enabling works £2.668m and the IRS £0.307m. Spend to date on Discretionary Capital is currently £0.031m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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										
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

Performance

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%).
Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

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 is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

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.

KPI Indicator FIN.60

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Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

	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	Apr 24	May 24
Trust Position															
Capital & Revenue Invoices	95	98	98												
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	

Performance

During May '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.1%** as at the end of month 2, and a Trust position (including hosted) of **98.7%** compared to the target of 95%.

Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to maintain performance throughout 2023/24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.	31/03/2024	M Bunce

Expected Performance gain – longer-term.

Ensured compliance

Risks to future performance

Set out risks which could affect future performance

KPI Indicator EST.64

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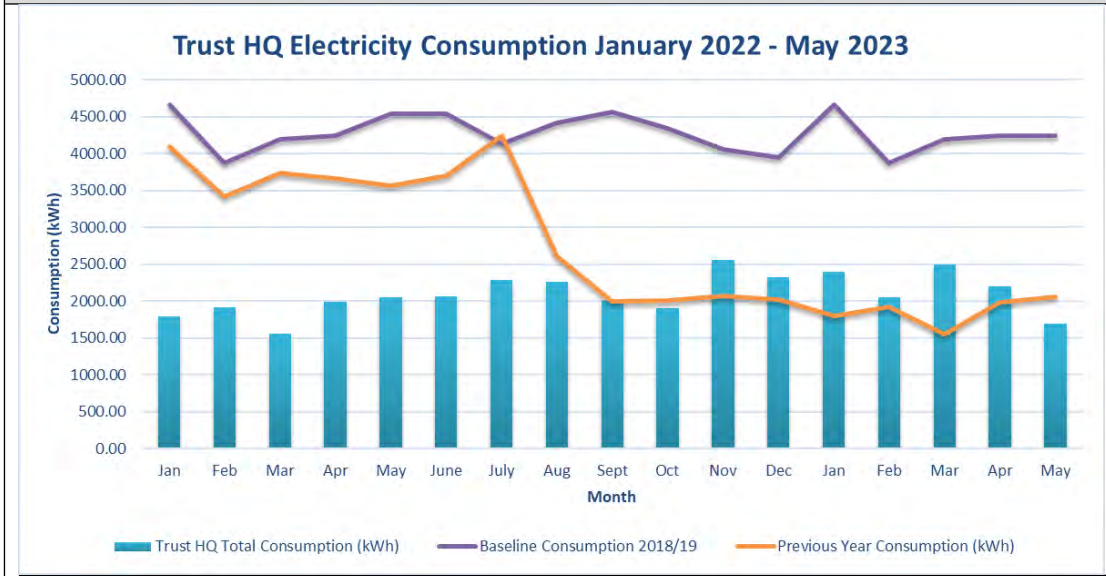
Trust HQ - Energy (Gas and Elect) performance consumption

Target: -2% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual Number (kWh)	1557.00	1991.00	2053.00	2064.00	2284.00	2263.00	1526	1905	2553	1835	2403	2501	2502	2203	1696
Target number previous year	4018.00	3587.78	3492.72	3628.94	4155.20	2560.74	1962.94	1966	2029	1975	1761	1879.64	1525.86	1951.18	2011
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%

Performance

, The boiler heating is thought to be short circuiting around the boiler circuit. The Trust is currently waiting for quotes to make adjustments to the header heating system to ensure the boiler flow temperature will be circulating the central heating system increase radiator temperatures. The issues was identified and rectified by the Estates Manager, and going forward enhanced monitoring of consumption at Trust HQ will be undertaken (with dedicated staff member reviewing the BMS).

Electricity continues to be consistently lower than the baseline figures from 2018/19.

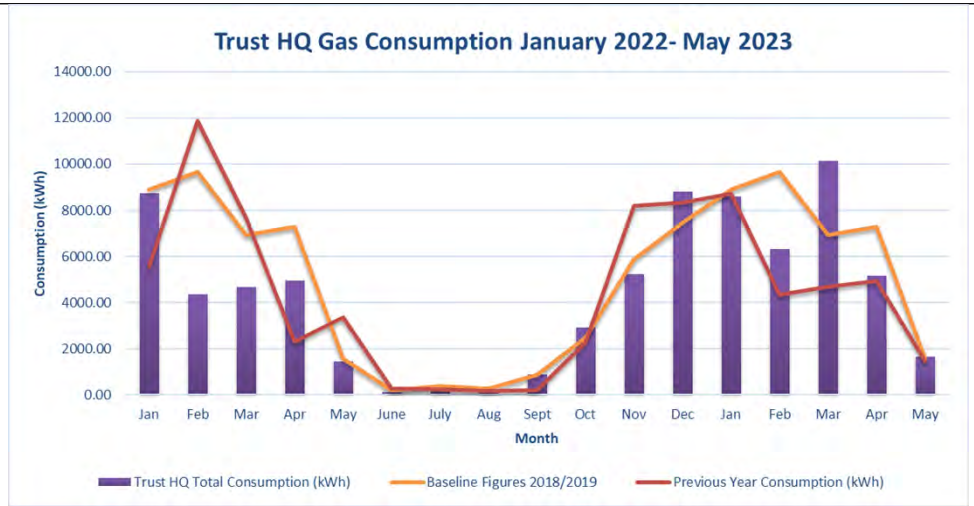
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	**3 months**	Milburn Mounter

Expected Performance gain - immediate

Continue to monitor energy performance

Promote ways to reduce electricity usage. Communication campaign underdevelopment to promote to staff how to reduce electricity / heating usage.



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh)	4685.28	4941.05	1466.12	111.35	222.79	178.62	156.29	2913	4952	8809.65,	8585.83	6331.76	10124.91	4728.34	1679.63
Target number previous year	7504.62	2248.12	3306.55	283.73	241.91	185.98	207.84	2220.93	803.36	8152.77	8554.67	4255.87	4591.57	4792.82	1436.8
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Metering strategy	12 months	Jason Hoskins
Dedicated staff member reviewing BMS	6 moths	Milburn Mounter

Expected Performance gain – longer-term

Continue to monitor consumption

Energy and Estates Optimisation project is currently being scoped for Trust Headquarters to review how to more efficently use the estate.

Risks to future performance

Set out risks which could affect future performance

Increase in gas usage due to cold weather.

KPI Indicator EST.68

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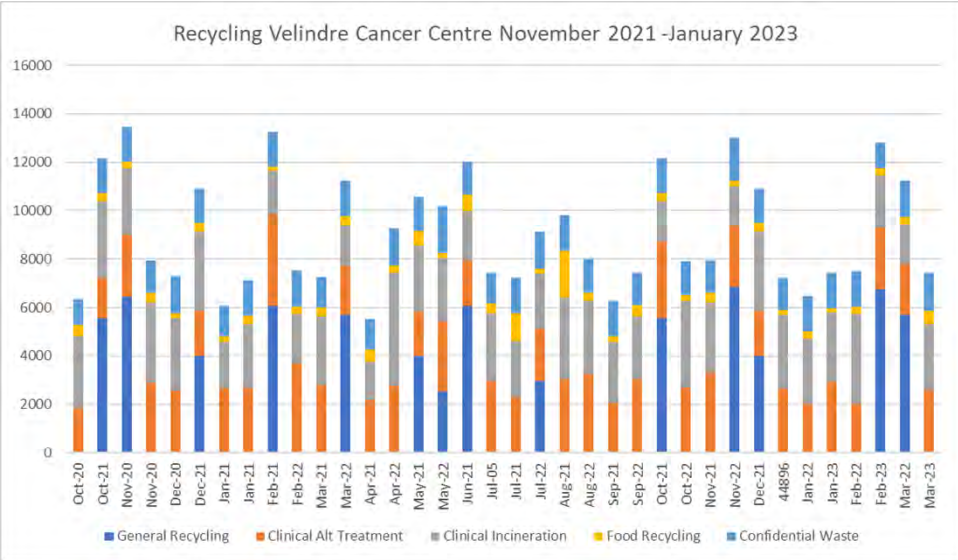
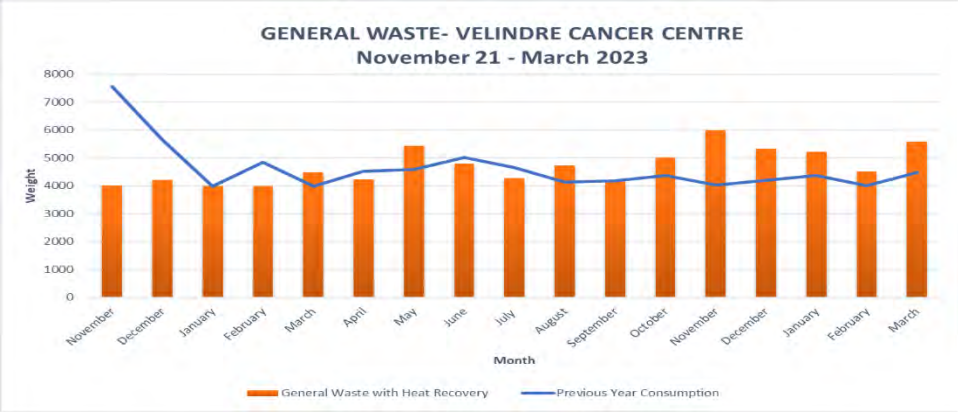
Graph title -Waste	
Target: Continued monitoring to identify and mitigate trends	**SLT Lead: Carl James**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**





If performance is not at required level, set out what the main causes are:

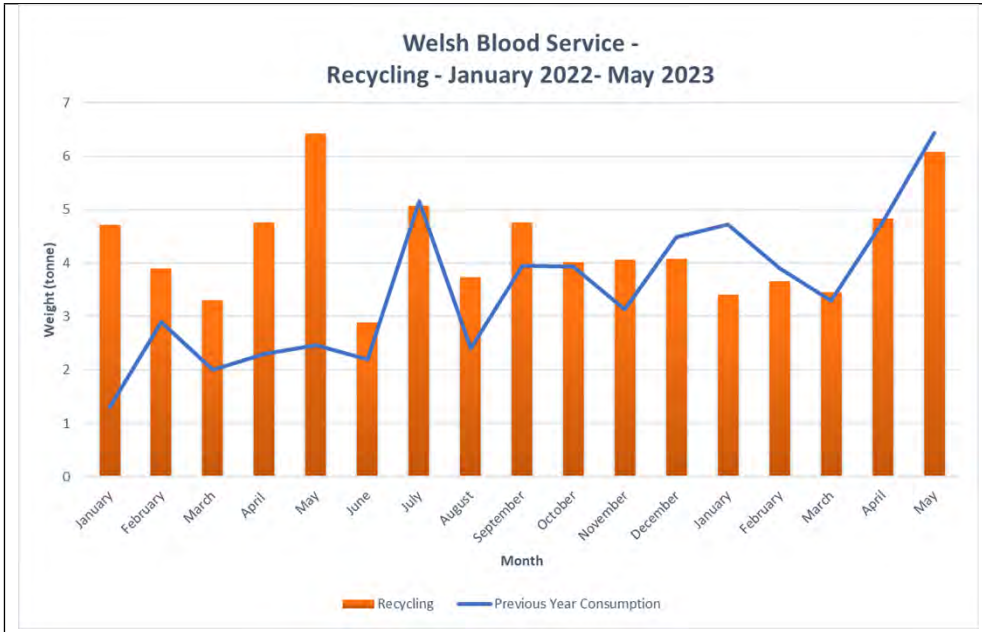
Recycling has increase compared to previous year at VCC & WBS. The food bin trial has begun rollout in VCC. Alongside the introduction of food bins, staff are provided with information about the new waste stream.
VCC Recycling graph now includes confidential waste.
Communication Events held in Talbot Green and VCC to engage with staff and promote waste streams.

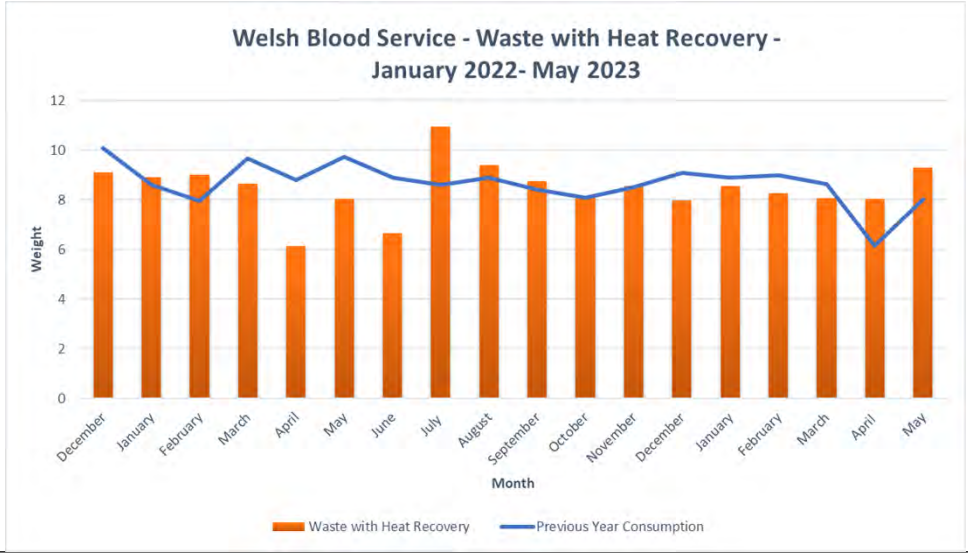
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Introduction of food waste bins to all staff kitchens in VCC	3 months	**Dave Harding**
Improved signage with new bins	3 months	**Rhiannon Freshney**

Expected Performance gain - immediate
Looking to invest in new bins at VCC (in line with the WBS bins).

Service Improvement Actions – tactical (12 months +)





- Removal of plastic cups on Donor clinics – full roll out of biodegradable cups on - Waste promotional / educational events and guidance for staff	**12 months** **12 months**	Matthew Bellamy Rhiannon Freshney / Dave Harding

Expected Performance gain – longer-term
Reduction of general waste and increase in recycling

Risks to future performance

KPI Indicator DIG.69

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Digital Service % uptime of critical systems (% availability by service, excl. planned maintenance windows)

Target: 99%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Target 99%	99	99	99	99	99	99	99	99	99	99	99	99	99	99	

Performance

Assessment of current performance, set out key points:

- Currently unable to report performance.
- Initial list of critical systems identified:
  - eProgesa
  - WBS Appts. System (client & public-facing service)
  - WTAIL IT Systems
  - Prometheus (WBS)
  - WPAS
  - WCP
  - WNCR
  - ChemoCare
  - WellSky (Careflow)
  - RISP / Synapse
- Performance reporting established for WBS Appts. System, subject to validation of data. Aiming to provide first reported performance in May 2023 – reports will aim to cover locally-managed systems in the first instance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Proof of Concept for IT network and end user performance monitoring solution.	30/06/2023 (Pilot due to begin in April 2023)	DMH

Expected Performance gain – immediate

TBC

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy IT, network and end user performance monitoring platform	30/09/2023 (Pilot due to begin in April 2023)	DMH

	Expected Performance gain – longer-term TBC
	Risks to future performance
	Set out risks which could affect future performance • Insufficient funding available to enable permanent deployment of required monitoring solution.

EQUITABLE

KPI Indicator WOD.81

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% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 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

Welsh speakers 116 headcount (4%)

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
- insert text

KPI Indicator WOD.78

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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	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 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
-

KPI Indicator WOD.79

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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	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 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

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
-

KPI Indicator WOD.80

Return to Top

Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 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

People with a Disability 70 (4%)

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	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (QUARTER 1)

DATE OF MEETING	13/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCS Senior Leadership Team	June 2023	Noted
WBS Senior Management Team	June 2023	Noted
Executive Management Board	29th June 2023	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 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.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 This report provides an update (position as of 15th June 2023) of progress against the quarter 1 actions (April – June 2023) which were included within the IMTP for 2023/24. These updates are provided in the form of the monitoring templates for WBS and VCS (*See Annex A and Annex B*).

2.2 Due to the timing of the end of Quarter 1 (April to June 2023), this position is an early assessment of progress against IMTP actions and has been prepared for submission to the QSP Committee, meeting to be held on 13th July 2023.

2.3 The table below gives a high-level overview of progress made in the delivery of Q1 actions for WBS and for VCS.

Welsh Blood Service:

2.4 WBS are making satisfactory progress, categorised as '*green or yellow*', against all 15 of their actions.

2.5 VCS are making satisfactory progress, categorised as '*green or yellow*', against 19 of their 22 actions.

2.6 However, three actions are currently assessed as 'amber'. This is defined as *'Delays in implementation / action paused due to external issues beyond our control*'. These three actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.22)
- Implementation of national prehabilitation to rehabilitation deliverables by 2025/26 (pg. 29)
- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025) (pg. 30)

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	**9 Q1 actions**	**9 Q1 actions**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	**6 Q1 actions**	**10 Q1 actions**
AMBER	Delays in implementation / action paused due to external issues beyond our control		**3 Q1 actions**
RED	Challenges causing problems requiring recovery actions to be identified		
Total IMTP 2023/23 Quarterly Actions		**15 Q1 actions**	**22 Q1 actions**

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability

	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required (Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP)
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **NOTE** the progress made in the delivery of the agreed IMTP (2023 – 2026) quarter 1 actions for both the Velindre Cancer Service and the Welsh Blood Service.

APPENDIX A

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 as at 15/06/2023.

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 Q1**	**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.	**Q1 objective partially completed.** Preparation of recovery map underway. Meeting with software agents to discuss automation of the recovery map scheduled for w/c 26/06/23.	
	Develop and implement strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow	• Increased stem cell donor panel • Increase in stem cells supply • Improved resilience in stem cell supplies	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved. Develop implementation plan.	Launch and implement strategy.	Post implementation review.	**Q1 objectives partially completed.** Development of strategy has commenced. Workshop with key stakeholders to take place in July 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 Q1**	**Progress Rating**
	Donor Registry) by 2023/24.	• Improved clinical outcomes in Wales/globally • Increased income levels					Development of the strategy included within the WBS Futures Programme.	
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 • Wider population/donor education • Development of rich data to	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.	**Q1 objective partially completed.** Strategy in final stages of development. Focus groups with donors and the public are being arranged to ensure full engagement with stakeholders.	

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 Q1**	**Progress Rating**
		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. • Compliance with the NICE guidance.	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.	**Q1 objectives completed.** All Anaemia Team positions have been recruited and now in post. Baseline data from DHCW analysed and initial information shared with end users in Anaemia stakeholder meeting staged on 15/06/23. Further analysis ongoing.	

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 Q1**	**Progress Rating**
		• Improved efficiency • Cost efficiencies.						
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 Donor Registry	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.	**Q1 objective completed.** Mobile Donation Collection Units are now being deployed at locations across Wales.	
	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and conditions	Continue phased implementation of OCP (2019) outcomes.	Continue phased implementation of OCP (2019) outcomes.	Complete implementation of OCP (2019) outcomes.	Prepare OCP 2 process in relation to clinically led service model.	**Q1 objective completed.** The phased implementation of	

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 Q1**	**Progress Rating**
		across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Complete new job descriptions.	Complete review of existing service model.	Develop workforce plan. Provide and promote leadership learning opportunities.	Complete OCP 2 consultation. Implement new clinically led collection team model.	the 2019 OCP continues. New job descriptions have been completed in preparation for the establishment review pending completed implementation of the 2019 OCP.	
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste • Reduce wastage.	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of platelet planning tool.	Planning tool developed and in routine use. Review the clinic collection pan for Apheresis to ensure the clinic times are optimised.	Clinical and Scientific roadmap established to predict future trends e.g. cold platelets. Begin development of platelet strategy.	Continue development of the platelet strategy.	**Q1 objectives partially completed.** Platelet Strategy group yet to be established. Development of platelet planning tool ongoing.	

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 Q1**	**Progress Rating**
	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.	**Q1 objective completed.** WG DPIF (Digital Priorities Investment Fund) support secured to support procurement activity; further DPIF monies set aside to support implementation costs – to be confirmed following selection of preferred vendor via formal procurement.	
	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	**Q1 objective completed.** Supplier engagement days held in May 2023, with costings obtained from potential vendors. Business case and URS being developed to support formal procurement.	

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 Q1**	**Progress Rating**
	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.	**Q1 objectives completed.** **Testing strategy:** Testing and data input to national database, now part of business as usual. **Look Back:** There have been 3 confirmed lookbacks identified to date. Completion of lookback documentation is ongoing and monitored for compliance by WBS Blood Health Team. **Input into SaBTO Review:** The project is running to plan and data is being submitted online by Health Board staff	

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 Q1**	**Progress Rating**
							using a Microsoft Forms platform	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2023/24.	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create 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	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to support Continuous Improvement culture.	6 month review of Quality Hub delivery. Implementation of eQMS. Review amended Change Management process	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and functionality.	**Q1 objectives completed.** Draft Terms of Reference (ToR) for the Divisional Quality Hub have been submitted to Senior leadership Team for agreement. 3 subgroups have been confirmed and agreed, with TORs being drafted. The pilot of electronic signatures is under way, and the action plan for next steps is agreed and will be taken forward by project group. The draft URS is complete, and engagement with NWSSP is underway. A mini tender is to be undertaken, and	

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 Q1**	**Progress Rating**
			update processes				WBS is awaiting feedback from Procurement regarding next steps. Feedback form Change Management workshops collated and processes being updated.	
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety • Improved patient experience • Reduction in avoidable waste/costs	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.	**Q1 objectives partially completed.** The tender for the Foetal D Testing Kit is being issued by procurement w/c 19/06/23 with the aim to award in September.	
SP5: Achieving excellence in research,	Work with Welsh Government to	• Secure the supply chain for	Develop project plan for supply of recovered	Renegotiate/renew supply contracts for	Commence validation of leucocyte	Scope Source Plasma collection	**Q1 objectives partially completed.**	

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 Q1**	**Progress Rating**
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)**	develop and introduce a Plasma for Medicines service model for Wales.	Immunoglobulins in Wales • Reduces need for importation • Cost avoidance/reduction • Avoids patient rationing.	plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme (subject to WG policy decision).	filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and recovered plasma.	Awaiting commercial information relating to the national fractionation contract to finalise the business case. Details are expected to be released on 16/06/23 & the business case to be completed by mid-July 23.	
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	Refresh of Programme Business Case (PBC). Further development of Outline Business Case (OBC) to incorporate Laboratory Services	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.	**Q1 objectives completed.** Refresh of Programme Business Case (PBC) underway. Further development of Outline Business Case (OBC) underway.	

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 Q1**	**Progress Rating**
		• Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Modernisation.					
SP7 Develop great people and a great place to work **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	• Enhanced workforce capacity & capability to meet need. • Enhanced Leadership capacity & capability • Improved staff satisfaction • Improved staff well-being • Improved service quality, safety and donor satisfaction.	Consult on new Senior Leadership Team (SLT) workforce model and recruit to roles where there are substantive job holders.	Permanently recruit to remaining SLT roles where there are currently only seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce	Permanently recruit to remaining SLT roles where there are 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	Review of newly implemented SLT workforce model. Phased implementation of new Clinical Services workforce model. Phased implementation of new Laboratory Services workforce model.	**Q1 objectives completed.** The consultation was launched in April 2023, and is now paused to consider feedback. The consultation is due resume on 22/06/23 June and close on 30/06/23.	

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 Q1**	**Progress Rating**
				in Laboratory Services.	model for Laboratory Services.			

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

APPENDIX B

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 as at 15/06/2023.

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction	Complete 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 .	• Service model and new SLA in development following review. • Recruitment to additional posts commenced.	
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	Installation and commissioning of second replacement linear	• First replacement linear accelerator fully commissioned and clinically	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• 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.	commenced in advance of installation of second replacement linear accelerator.	accelerator at VCS	operational. Patients routinely treated using new linear accelerator from June 2023.	
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	Optional appraisal to be completed to identify and agree service model required to address capacity gap. Continue to	Business case to be completed (if required) to address additional resource requirement. Continue to	Continue to implement local actions.	• Engagement with Cardiff and Vale UHB with respect to the development of a revised SLA relating to the provision of anaesthetic	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved productivity and efficiency levels • Improved patient satisfaction	support. 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	implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	implement local actions		services progressed. Cardiff and Vale UHB colleagues considering options. • Operational Management Group continues to meet prior to handover to new service improvement group.	
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP - Radiology Informatics System Procurement.**	• Improved diagnostics information • Better information sharing and enhanced clinical decision-making	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support National implementation	Development of a local implementation plan to support National implementation	• Initial scoping work commenced. • Ongoing engagement with project board.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction						
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding				

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Reduction in avoidable admissions • Improved patient satisfaction						
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	• Initial scoping session undertaken. • Ongoing discussion on scope and engagement with senior medical staff scheduled for July.	
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	Identify possible funding requirements and develop business case to support change of	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 workstream to complete work before the end of June 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**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved patient • Satisfaction • Reduction in avoidable admissions	service model / finance				• Draft VCC CNS Competency Framework developed.	
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 programme.	
Trust Strategic Goals 1, 2 and 5	**Expansion of VAPP services by Q4 2023/24**	• Provision of care at home/close to home		Develop service model for expansion of service (to include opportunities for	Develop workforce plan. Develop financial plan	Realise service expansion subject to any resource requirement	• Scoping work commenced.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Reduced patient needs to travel • Increased patient experience / satisfaction		service transformation).	and supporting business case.	being secured. Evaluation of service change.		
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with national timeframes**	• Improved quality • Improved patient safety • Improved information (access to and sharing of) • Improved levels of efficiency and productivity • Reduction in carbon emissions	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier Map business processes and consider the effects ePMA will have on ways of working	Develop local procurement specification Identify resource required for implementation team Develop business case to support recruitment of implementation team Develop project plan for implementation	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• Project finding secured. • Project initiated.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
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	• SACT capacity improvement plan developed. Plan delivery will be overseen by newly constituted capacity group which reports to VCS Business Planning Group. Improvement plan includes focus on SACT bookings, nursing and pharmacy.	
Trust Strategic Goals 1 and 2	**Enhance the Velindre Cancer Services SACT telephone helpline to provide 24hr**	• Improved quality • Improved patient safety • Improved access	Establish working group as part of the Safe Care Collaborative Technical capability to	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	• Working group established and service improvement coaching support identified.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	advice, triage service and achieve required standards by Q3 2023/24	• Improved clinical outcomes • Reduced waiting times • Improved patient experience	record all telephone calls is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.			standards in accordance with the VCS Generic Patient Enquiry implementation action plan	• Digitalisation of UKONS tool in progress and VCC-specific guidelines for the escalation of calls in development.	
Trust Strategic Goals 1, 2 and 4	**Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a focus on supporting improved system-wide Suspected Cancer Pathway compliance.	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for improvement	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation of pathway improvements where possible Review ways of working and identify	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere Continued engagement in Safe Care Collaborative Programme	• Programme steering group established. • Four workstreams defined, terms of reference developed and group members identified. • Project Support Officer recruited in conjunction with Wales Cancer Network to	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			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 specific pathways for focus Identify service improvements / opportunities for	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.	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	Identify new ways of working and opportunities for workforce reconfiguration	support Suspected Cancer Pathway specific improvement activity. • Collection of baseline data commenced. • Workshop focused on patient pathways, processes and ways of working with Breast site specific team undertaken and follow up meetings scheduled. • Melanoma site specific team identified as next focus of 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**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			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 Initiate service improvement projects in conjunction with the Safe Care Collaborative within MSSC pathway and				improvement work. • Capacity and capability review of medical secretaries commenced. • Safe Care Collaborative projects initiated (SACT Telephone Helpline and MSCC pathway). • Attend anywhere project scoping 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**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			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					
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	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	Develop supporting business case(s) Initiate phased delivery of the Project	• Project group yet to be established.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Reduced carbon emissions			phased transition			
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 • Improved patient experience	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define timelines Review funding streams and commissioning models to facilitate prehabilitation service development.	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	• Ongoing engagement with Prehab and Rehab south-east Wales collaborative and WCN prehabilitation group. • Contributed to development of draft prehabilitation guidelines which are currently subject to a consultation exercise (due to conclude July 2023). • Local steering group to be established to	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							• oversee development of an action plan to support implementation of prehabilitation guidelines following consultation period (to conclude July 2023).	
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	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works	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	• 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**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved staff well-being • Reduction in carbon emissions • Reduced staff sickness	Continued engagement between nVCC project team and VCS.			implemented to support nVCC.		
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	• Engagement with health boards on structure and remit of project board. Terms of reference to be finalised.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
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	• VCS Acute Oncology Working Group established. Scope of work defined and workstreams identified.	
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 radiotherapy within VCS and as part of a regional model.	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan Identify possible funding options	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service Review and develop agreed costed model for palliative radiotherapy	Develop business case to support palliative radiotherapy model if required	• Continued engagement with national programme.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
					Identify opportunities for workforce redesign and develop associated workforce plan			
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 • Enhanced organisational reputation for quality of service	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments Establish working group to develop service model to support delivery of internal	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and where appropriate commence business case developments for agreed treatments in phased	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer Develop strategy and service model to support adoption of motion management	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners Expand SRS service to support the routine treatment of patients with more than 3 metastases	• Horizon scanning process and structure in development. • Engagement with commissioning health boards on plans to introduce IMN for eligible patients. Business case to be developed for consideration by commissioners in autumn 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**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			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 neuroendocrine tumours Identify additional resource required to expand HDR	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 with prostate cancer if required Identify additional resource		Identify additional resource required to support the expansion of the SRS service and develop business case, if required	• Continued active engagement with WHSSC appraisal process in support of potential commissioning of PRRT service at VCS. Hosted site visit by WHSSC appraisal panel.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24					
				Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			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 of new indications for Stereotactic Ablative Radiotherapy (SABR)	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 required Train Medical Physics Expert to support				

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
				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 VCS agreed scope and prioritisation of phase 1b	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• VCS operational working group established to oversee review of ways of working and to determine resource and capability gaps. • Divisional action plans developed to ensure optimisation of DHCR. • Formal recommendations prepared on resourcing for consideration by the project board.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
				Q2	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			(VCS specific) agree scope and prioritisation of phase 2					
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 • Physical space to support innovation and development working across the region/Wales/wider	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 delivery between and with primary and community care and Velindre	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 care and Velindre	• Scoping work initiated. • Workshop scheduled.	

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

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2021/2023

DATE OF MEETING	13/07/2023
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	Sara Walters, Clinical Audit Manager Catherine Pembroke, Clinical Lead for Audit and Quality Improvement Edwin Massey, Medical Director WBS Zoe Gibson, Interim Head of Trust Quality and Safety Jacinta Abraham, Executive Medical Director
PRESENTED BY	Catherine Pembroke, Clinical Lead for Audit and Quality Improvement Edwin Massey, Medical Director, WBS Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	This Annual Report reflects the Trust Clinical Audit Programme delivered as defined by the Trust Clinical Audit plan and covers the period from 1st April 2021 to 31st March 2023. It provides an overview of the clinical audit activity and clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service.

	2 key achievements for the Trust Clinical Audit teams are firstly; the implementation of a digital system for clinical audit called AMaT : Audit management and tracking, which will streamline the audit process as well as dissemination of outcomes and tracking of actions. Secondly, the achievement of 'reasonable assurance rating' following an internal audit in January 2023 on the Trust Clinical Audit processes and governance, reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning). The report demonstrates the diverse portfolio of high-quality clinical audit undertaken across the Trust and describes how this is impacting on patient and donor care in our local services, as well as national and international platforms. The appendix provides detail on each project undertaken including the outcomes and recommendations made.

RECOMMENDATION / ACTIONS	**APPROVE** the contents of the VUNHST Clinical Audit Annual Report 2021-2023 and to continue to support the function of Clinical Audit prior to the report being submitted to the Quality, Safety & Performance Committee.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC QSMG	15/06/2023
VCC SLT	20/06/2023
EMB	26/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS An overview of the Velindre section of the report was discussed at VCC QSMG and was approved prior to being sent to VCCSLT for information. The Trust report was presented at EMB and was well received. The main highlights included the Internal Audit Jan 2023: Reasonable Assurance Rating, the introduction of AMaT a digital audit tool and the development of the integrated quality	

and safety group. One of the key comments was to consider how AMaT and Tendable reporting can be integrated moving forward.

7 LEVELS OF ASSURANCE - N/A	
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**

APPENDICES	
1	Clinical Audit Annual Report 2021-2023

1. SITUATION

This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. There was no report submitted for the year 2021/22 as per strategic business continuity decisions taken during the Covid 19 pandemic. So, this Annual report aims to cover a 2-year period from April 2021 to the end of March 2023 which is reflected in the substantial content of the report.

2. BACKGROUND

The diversity of our Trust Clinical Audit portfolio reflects the wide-ranging clinical services provided and the clinical expertise that accompanies it. We have audits ranging from local, good practice interventions which have improved patient and donor experience, to significant contributions to National practice changing audits, some of which have received UK recognition and publication. We have met our criteria to participate in all required national audits and have also won awards through international conference poster submissions on our invaluable contribution of real-world patient data from VCC. Of note, in WBS a clinical audit cycle on preoperative anaemia testing has contributed to a successful Value Based Health Care award which is being used to scale up the initiative across Wales. Also, a significant change in eligibility criteria for blood donation was successfully implemented in Wales as demonstrated by the audit of For Assessment of Individualised Risk (FAIR) below. We continue to provide an important leadership role, in our interactions with several organisations including the NHS Wales National Clinical Audit and Outcome Review Body, Wales Cancer Network, National Institute for Health and care

Excellence,(NICE), Royal College of Radiology, and the Blood Health National Oversight Group.

3. ASSESSMENT

3.1 Velindre Cancer Centre Summary

The Audit team seek to support, facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2021/2022 a total of 164 projects have been submitted, 98 active, 55 completed, 4 on hold and 7 discontinued. Throughout the year 2022/2023 a total of 159 projects have been submitted, 97 active, 48 completed, 2 on hold and 12 discontinued. Exemplary SSTs include Urology, Palliative Care, Neuro-oncology and Lung whose audits have contributed to peer reviewed, posters and awards. Areas of good practice remain patient-focused with addressing holistic needs for Urology patients, Macmillan Lung cancer pathways and Head and Neck patient surveys. The commitment to 30-day mortality review reinforces its importance and the high standards we uphold. The Lung SST All Wales Genetics Pathway Quality Improvement project has brought meaningful change to patients care on a national level. Treatment review of stereotactic radiosurgery for neuro-oncology has helped to inform practice and toxicity rates. Both of these projects will be presented at national conferences. The Advanced Future Planning Strategy, led by Palliative Care, was published in the British Medical Journal in February 2022.

3.2 Welsh Blood Service

The Welsh Blood Service (WBS) provides compatibility testing and other diagnostic services related to blood, cellular therapies and organs. The WBS also collects cells for cellular therapies and blood components, which are provided along with medicines derived from plasma, some drugs and vaccines to the NHS in Wales and also to other countries.

There are many synergies for the two operational divisions of the Trust. Bone marrow and stem cells are predominantly supplied by the WBS for the treatment and cure of cancers. 25-30% of blood components are provided as part of the supportive treatment for patients with cancer. More blood components are transfused in the Velindre Cancer Centre than some general hospitals in Wales. The stem cells for treating cancers and other disorders are collected in the Velindre Cancer Centre site.

Despite the challenges of the pandemic, with changes in the way we provide existing services, and the addition of new services such as the national distribution of COVID

vaccines, clinical audit has continued to be performed to assure the governance of the organisation. The WBS contributes to international audit and performance monitoring through UK 4 nation, European and wider international initiatives in all areas. These include the Serious Hazards of Transfusion haemovigilance scheme for patients and donors, The UK Health Security Agency (UKHSA) Infectious Diseases Annual Surveillance Report and European Blood Alliance bench marking surveys.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Velindre Cancer Service

The audit report does highlight the need for improvement within the service and we will aim to implement these in the coming years. In line with Velindre Future Program, we aim to align ourselves with Service Improvement, Patient Safety, Morbidity and Mortality and Education to create a Quality Improvement Hub. The intention for this is to provide a focus group to help educate, support and mentor project proposals to ensure maximal output and to implement sustained change. In order to encourage a culture of Quality Improvement (QI) and Audit within the Cancer Centre we aim to engage with SSTs by improving the dialogue between our two groups to ensure we address key areas of concern. We will require SSTs to define the local implications from the National Audits we participate in at the end of every audit year. We also need to foster education and support for our trainees and trainers so that they are well versed in the audit/ QI methodologies and principles. We also realise there is a need to present this ongoing work for the benefit of others and proposals are underway for a six-monthly hospital-wide audit meeting.

4.2 Welsh Blood Service

Audit of the appropriate use of these services internally for our own patients and across Wales are an important part of assurance for the Trust. Unlike VCC the WBS does not have staff specifically employed to support or undertake audit other than the generic requirement in the job descriptions and job plans of staff in clinical roles to participate in audit.

Key points that need addressing

- Enablement of a consistent trust wide culture of innovation, learning, improvement and clinical audit to support the provision of safe, effective, person-centred care provision.
- Provision of Clinical Audit support across both divisions.
- The potential for improved integration of audit, quality and service improvement in quality improvement hubs

- Limited opportunities to disseminate and showcase work within the Trust, especially in the absence of an integrated audit team
- The need to adapt a whole system approach that enables collaborative working both with all Health Boards and Trusts across Wales, and internally within our own departments.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 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	Choose a domain/domains. Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐ Clinical Audit is closely aligned to the Trust Quality and Safety Agenda as it embeds quality and learning and drives a culture of continuous improvement.

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
	There are no specific equality implications related to the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	**N/A**
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

CLINICAL AUDIT Report 2021/2023

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2021/2023

1. INTRODUCTION

This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. There was no report submitted for the year 2021/22 as per strategic business continuity decisions taken during the Covid 19 pandemic. So this Annual report aims to cover a 2 year period from April 2021 to the end of March 2023 which is reflected in the substantial content of the report.

2. EXECUTIVE SUMMARY

In keeping with our organisational focus on Quality and Safe care, Clinical Audit continues to evolve within the Trust and has played an increasingly important role in helping us to evidence and embed Quality within our systems. With strong clinical leadership, organisational support and new dedicated roles in place, there is a growing confidence and ambition for clinical audit at VUNHST. This is reflected in the Internal Audit feedback demonstrating reasonable assurance and the successful introduction of a digital Audit tool AMaT (described below) which can be used across the Trust. The impact of this digital tool will be transformational and allow us to maximise the measurement and learning from clinical audit outcomes.

Clinical Audit is a key member of the relatively newly formed Trust Integrated Quality and Safety Group and is part of the Quality and Safety Management groups within the divisions, reporting to the Trust Quality Safety and Performance committee. The importance of triangulation of clinical outcomes with learning and improvement, and good business intelligence to support the clinical audit function, have been identified as 2 important themes, through these committees. There is a renewed interest in Clinical Quality Improvement (QI) and the need to identify champions, train our staff and embed a culture of QI across the Trust as a driver for clinical transformation. This is aligned to the Safe Care Collaborative agenda which the Trust has fully signed up to.

The diversity of our Trust Clinical Audit portfolio reflects the wide-ranging clinical services provided and the clinical expertise that accompanies it. We have audits ranging from local, good practice interventions which have improved patient and donor experience, to significant contributions to National practice changing audits, some of which have received UK recognition and publication. We have met our criteria to participate in all required national audits and have also won awards through international conference poster submissions on our invaluable contribution of real-world patient data from VCC. Of note, in WBS a clinical audit cycle on pre operative anaemia testing has contributed to a successful Value Based Health Care award which is being used to scale up the initiative across Wales. Also, a significant change in eligibility criteria for blood donation was successfully implemented in Wales as demonstrated by the audit of For Assessment of Individualised Risk (FAIR) below. We continue to provide an important leadership role, in our interactions with several organisations including the NHS Wales National Clinical Audit and Outcome Review Body, Wales Cancer Network, National Institute for Health and care Excellence, (NICE), Royal College of Radiology, and the Blood Health National Oversight Group

We recently submitted our Trust Clinical Audit plan for the coming year 2023/24 and we have described within it, a clear set of priorities that we intend to achieve moving forward. We can build on our current position of a strong commitment and understanding of the value of clinical audit in blood and cancer as evidenced in this comprehensive report.

3.0 VELINDRE UNIVERSITY NHS TRUST

3.1 Internal Audit of Trust Clinical Audit Process and Governance

A recent internal audit (January 2023) sought to provide the Trust with assurance that Velindre University NHS Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services. Overall, a 'Reasonable' assurance rating was reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning)
The following areas of improvement were identified and relevant actions are now being taken which will be fully realised in this 2023/34 Clinical Audit plan.:

- Particular focus will now be given to ensure that the Clinical Audit Actions are SMART and regularly reviewed
- Discussions are underway to with regards to the feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation
- Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.
- Review of SST meetings to establish how discussions are documented with progress of clinical audits.
- The full implementation of a Digital Clinical Audit platform AMaT will be achieved by March 2024 Across Trust, which will provide the foundation for standardisation of approach and systematic reporting.

3.2 Trust Integrated Quality and Safety Group

The establishment of this Trust group has helped to centrally position Clinical Audit to ensure that all Clinical Audit Activity is captured and that it is informed and influenced by the triangulation of all available sources of Quality data. The Business Intelligence system to support this triangulation is in its early stages but aims to eventually have a live dashboard that can be interrogated.
High level incidents and themes from complaints that have been identified by the group for inclusion in the planned programme include communication, the treatment helpline, SACT bookings and the offer of a chaperone. Work on developing projects around some of these issues are underway and will be added to the plan in due course.
In addition, the group provides a feedback mechanism so that learning can be shared and issues identified can be escalated.

3.3 AMaT

AMaT is a web-based Audit Management and Tracking tool to streamline all of auditing requirements into one simple, easy-to-use system. Innovation purchased the AMaT license and software on behalf of the organisation in April 2022 for a 2 year period; this was funded by HTW and was supported by the executive team in March 2022. The funding will cover the cost of the system until 31st March 2024, at this stage financial resource will be required to renew the licence.

A number of LHB's have purchased AMaT recently and are in the process of implementation. There could be a scope to make it an all Wales system.

It will help modernise the clinical audit department and help shape the work we are undertaking with regards to defining the project approval process. It will digitise the manual system we currently use and remove the administrative task of reporting and following up of actions.

Users can input and access data in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility.

AMaT is a web-based system, you can therefore securely share information with others instantly and can be customised to meet the specific needs of departments.

There are a number of Modules available:

- Clinical Audit and improvement projects
- Ward, Area & Service projects
- Cumulative long-term audits and improvement projects
- Guidance activity and compliance statements
- Inspections recommendations & Actions
- Quality Improvement
- Mortality and Morbidity Review (MaMR) (restrictions)

4.0 VELINDRE CANCER CENTRE ANNUAL REPORT

4.1 Foreword: Velindre Cancer Centre

This report demonstrates that the clinical audit department at Velindre Cancer Centre, led by Sara Walters, has a successful framework in which to support professional groups in completing projects. Our exemplary involvement with six National Audits not only raises the profile of the hospital but ensures we're contributing and holding ourselves account to the national benchmarking of standards. The department has also been actively involved in Site-Specific Team meetings to ensure their priorities and interests are supported. Introduction of an Audit Management and Tracking system (AMaT) will allow for streamlining of processes and dissemination of work within the hospital.

The cancer centre as whole, as well as the audit department, has been subject to unprecedented challenges in terms of both workload and limitations in resources. This is reflected in the smaller number of projects undertaken this year. The Service Improvement Group has had to pause its activity due to COVID secondments and the team and subsequent education/ mentorship have ceased temporarily. We are now working closer together so that respective teams have opportunities for greater support and closer collaboration in the future. Patient safety and high quality care has to be a priority and our aim is to encourage and create space for Audit and Quality Improvement (QI) within the clinical environment, so that this can become embedded within our culture at VCC. We aspire to create an environment for continuous learning and mentorship so we can deliver the high quality healthcare we strive to achieve.

Key points that need addressing

- Fostering a culture of Audit/QI/Patient Safety reporting within Velindre Cancer Centre
- Integration of Audit and Service Improvement teams to create a Quality Improvement Hub
- Improve Senior House Officer engagement with audit and QI
- Increase patient engagement/representation in majority of projects
- Increase opportunities to disseminate and showcase work within hospital
- Improve the relevance of National Audit data to our local population. This needs to be better understood and articulated.

In order to address these key issues, we now have a 3-year plan in which we outline some suggestions in improving systems so that QI and Audit become core values amongst all professional groups. These include:

Education

In an attempt to foster a culture of audit and QI within the cancer centre we need to ensure people are well equipped with the core principles and skillsets. A 'Fundamentals of Quality Improvement' led by HEIW will be held for trainees on 27th September.

We also aim to deliver a VCC-specific specialty-trainee/trainer 9-month educational QI/Audit program with structured academic workshops and project-specific mentorship. (Please see attached publication and proposed framework). We will ensure that patient engagement and participation are a vital component of the program. This will be a pilot project and will aim to commence in September 2023. An annual QI/Audit event will be held in June following the academic program. The objective would be for trainees to showcase their work to the hospital and for others to learn. There would be prize giving to demonstrate recognition of outstanding achievements. If, following formal review, this is thought to be successful we would aim to expand this to other professional groups including nursing, pharmacists, radiotherapy and physics in subsequent years.

We also need to revise the induction packs for SHOs who typically rotate to VCC 3-6 monthly. This would include

- A brief survey to ascertain prior knowledge and experience
- A written summary of audit/QI principles including references for further reading
- An academic fundamentals session held by service improvement/audit team
- A list of 'ready to go' projects defined as relevant by previous SHO cohort/SSTs. Designed to be short, achievable projects with 3-6 month placements

Departmental Engagement

We propose bi-annual meetings with Site-Specific Teams and professional groups (physics, pharmacy, nursing and radiotherapy) in order to address the following key issues

- Annual key-performance indicators for that year (start with 1-2 a year)
- Patient reported Outcome Measures (PROMS)
- Patient safety (by encouraging a culture of DATIX reporting within SST and teams)
- This will allow important clinical and safety issues to be addressed as well as ensuring that projects are properly planned, completed, supervised and reviewed
- How National Audits are applicable to VCC patient population

We also hope to connect with the Patient Safety group who are aiming to foster a culture of openness and constructive discussion concerning DATIX reporting. This will serve as platforms for further QI/audit projects.

Dissemination of Information

In order to display the successful audit work taking place within the cancer centre we propose a six-monthly hospital-wide Audit/QI afternoon. All professional groups will be invited to present completed projects either in oral or poster formats. A quarterly newsletter highlighting success stories would supplement this.

Electronic Audit System

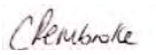
As an institution, we need to move away from excel spreadsheets. Introduction of AMaT will allow for streamlining of processes and dissemination of information. We hope to be able to fully utilise this resource and encourage SSTs to collate KPIs and PROMS

Clinical Oncology Quality Improvement and Audit Forum

We will be attending the Clinical Oncology Quality Improvement and Audit Forum held at the Royal College of Radiologists. We hope this will allow us to network, learn and implement best practice within the organisation

In Conclusion

This report demonstrates the substantial audit activity and the hard work of others taking place within Velindre Cancer Centre. This is particularly impressive given the unprecedented challenges the currently faced by the NHS. It does, however, demonstrate a need to align audit and service improvement departments in an attempt to develop a QI hub. It highlights a need to build upon education and mentorship as well as departmental engagement to ensure the projects are most applicable to the population we serve. Looking to the future, through the newly formed Velindre Futures Programme at VCC and the local implementation of the National Quality and Safety Framework, I have every confidence that there are significant opportunities for Clinical Audit and QI to be embedded within our organisation in a meaningful way. I would like to acknowledge Ms Sara Walters and the audit department who have worked exceptionally during a difficult time.



Catherine Pembroke
Clinical Lead for Audit and Quality Improvement

4.2 Velindre Cancer Centre Summary

The Clinical Audit Department remains an essential pillar within the Clinical Governance structure in Velindre Cancer Centre. The Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments.
The Clinical Audit team continue to provide and quality assure data for the National Clinical Audit and Outcome Review Plan. Participating in these collaborative projects ensures that we are involved in the dialogue and improving the quality of care on a national scale. Predetermined performance indicators allow us to benchmark our own practice ensuring we can demonstrate good standards of care within our SSTs. Greater involvement with Site Specific Team (SST) and undergraduate medical students has been a huge success and will continue to strengthen in the years to come.

The Audit team seek to support, facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2021/2022 a total of 164 projects have been submitted, 98 active, 55 completed, 4 on hold and 7 discontinued. Throughout the year 2022/2023 a total of 159 projects have been submitted, 97 active, 48 completed, 2 on hold and 12 discontinued. Exemplary SSTs include Urology, Palliative Care, Neuro-oncology and Lung whose audits have contributed to peer reviewed, posters and awards. Areas of good practice remain patient-focused with addressing holistic needs for Urology patients, Macmillan Lung cancer pathways and Head and Neck patient surveys. The commitment to 30 day mortality review reinforces its importance and the high standards we uphold. The Lung SST All Wales Genetics Pathway Quality Improvement project has brought meaningful change to patients care on a national level. Treatment review of stereotactic radiosurgery for neuro-oncology has helped to inform practice and toxicity rates. Both of these projects will be presented at national conferences. The Advanced Future Planning Strategy, led by Palliative Care, was published in the British Medical Journal in February 2022.

The audit report does highlight the need for improvement within the service and we will aim to implement these in the coming years. In line with Velindre Future Program, we aim to align ourselves with Service Improvement, Patient Safety, Morbidity and Mortality and Education to create a Quality Improvement Hub. The intention for this is to provide a focus group to help educate, support and mentor project proposals to ensure maximal output and to implement sustained change. In order to encourage a culture of Quality Improvement (QI) and Audit within the Cancer Centre we aim to engage with SSTs by improving the dialogue between our two groups to ensure we address key areas of concern. We will require SSTs to define the local implications from the National Audits we participate in at the end of every audit year. We also need to foster education and support for our trainees and trainers so that they are well versed in the audit/ QI methodologies and principles. We also realise there is a need to present this ongoing work for the benefit of others and proposals are underway for a six monthly hospital-wide audit meeting.

The annual report demonstrates the consistent commitment from healthcare professionals working within Velindre Cancer Centre to fully engage with clinical audit as a driver for change and improve the quality of care for our patients.

4.2.1 Infographic

4.3 CLINICAL AUDIT DEPARTMENT

Clinical Lead for Audit and Improvement	Catherine Pembroke
Clinical Audit Manager	Sara Walters
Clinical Audit Officer	Rachael Kipling
Clinical Audit Support Officer	Becky Quinlan
Clinical Audit Support Officer	Janzib Alyas

4.4 National Audit

Velindre participates in the cancer related national audits set out by the National Clinical Audit and Patients Outcomes Programme (NCAPOP), where annual participation is a requirement. These include NLCA (Lung), NOGCA (Oesophago-gastric), and Prostate Cancer (NPCA), Breast (NABCOP), NBoCA (Bowel), NACEL (Care at end of life).

The Welsh Cancer Network supports NHS Wales' participation in National Cancer Audit and have published A Cancer Improvement Plan for NHS Wales 2023-2026 which sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities.

A new national centre of excellence to strengthen NHS cancer services by looking at treatments and patient outcomes right across the country has been established. The National Cancer Audit Collaborating Centre will deliver five new national cancer audits in breast cancer (primary and metastatic), ovarian, pancreatic, non-Hodgkin lymphoma and kidney cancer. These will be added to the planned programme once established.

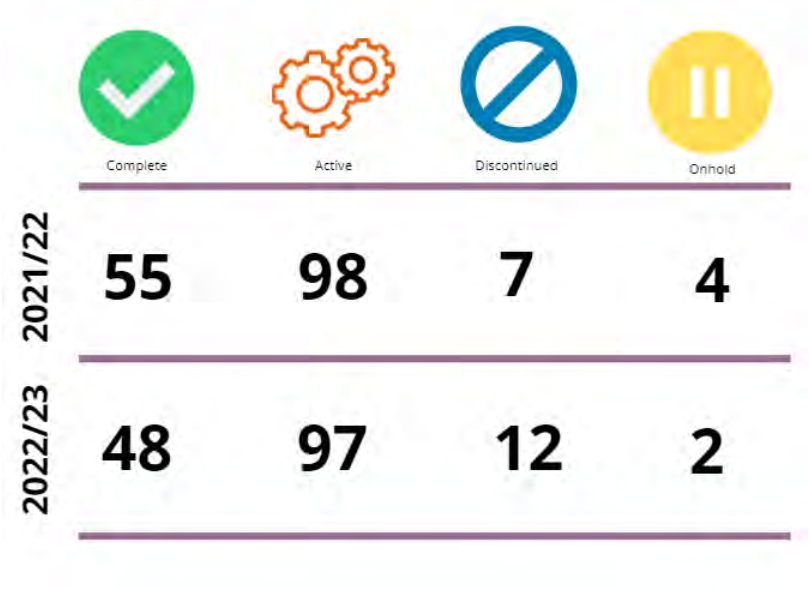
Other National topic specific audits are set by NCEPOD (National Confidential Enquiry for Patient Outcome and Death), RCR (Royal College of Radiologists audits) and NOTCH (The National Oncology Trainees Collaborative for Healthcare Research.

The team will work closely with the SST's to ensure key recommendations and areas for learning from National audits are identified and implemented where appropriate. As these National audits are led by the WCN and data submitted from a health board level the recommendations are not always applicable to Velindre services.

4.5 Clinical Audit Activity

The table below demonstrates the current audit activity within Velindre Cancer Centre.

	Total 2021/2022	**Total 2022/2023**
Completed	55	48
Active	53	45
Ongoing/Continuous	45	52
On Hold	4	2
Discontinued	7	12
Total	**164**	**159**



4.5.1 Discontinued audits

Discontinued Audit	Reason
CDK4-6 inhibitors during the COVID- 19 pandemic – administration, safety & outcomes. Real world data from the UK.	This project will be discontinued. National data has been published and therefore too late for data submission.
An evaluation of patient understanding and experience of bowel preparation in patients undergoing radical radiotherapy for gynaecological cancer.	This project was part of a masters and was originally put on hold due to COVID. The lead has now left Velindre and the project has been discontinued.
Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	With the rest of the Patient Support Unit team, It was a large project and ultimately we didn't have the capacity or staffing to devote the time that was required to complete it.
Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	Was delayed due to COVID and maternity leave. this will be discontinued as data collected previously is now outdated
Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	Discontinued no SSC attended to undertake and no other resource to take forward
Service Evaluation - Real World Experience of Foundation Medicine Testing at Velindre Cancer Centre	Discontinued. CD contacted on numerous occasions email now undeliverable. Unable to get copy of results.
A service evaluation of physiotherapy unscheduled care referrals	Audit was on hold due to the changes going on within unscheduled care/ ambulatory care at the moment. It is now felt that it was no longer relevant, will send any updates.
Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neoadjuvant chemotherapy given with pegfilgrastim	Project lead left the organisation and there is no resource to complete the project.
Breast cancer radiotherapy and secondary cancer	No SSC uptake and no resource within the team
National Service Evaluation project, evaluating the "Safety and Efficacy of Atezolizumab in combination with *nab*-Paclitaxel	Missed national deadline for submission this was due to the clinical governance concerns raised by VCC with the RMH
PARP inhibitors	Unable to start this audit due to other commitments, thus discontinued.

Nasogastric (NG) tubes patient experience	Dietitians & Speech therapists that were doing this audit did not have time or resources to complete it.
Outcome of ADT and docetaxel for hormone-sensitive metastatic prostate cancer	No longer required due to change in practice
A review of dry mouth and its management	Audit has been discontinued as too busy with pandemic and related clinical pressures.
DM, BMI, Chemo Regime , PS and comorbidities Influencing Clinical Outcome in patients with Metastatic Pancreatic Cancers	Audit discontinued as lead rotated to Swansea.
Investigation & Management of iron deficiency anaemia in patients with gastrointestinal malignancy:	Paused implementation of iron infusion policy due to COVID restrictions and pressures on day unit etc. data was never finished, would now be too old and not relevant so close audit down.
Scoping project Patient views on how the service should look	Moved to patient experience
Audit on Measure yourself concerns and wellbeing questionnaire	Staff Members undertaking audit have left the trust, Other staff unaware of Audit.

4.6 Clinical Audit Action Plan

A clinical audit action plan has been developed and is monitored by the department in conjunction with the SST's. All audit activity and action plans are discussed within the quarterly meetings and updated accordingly. The introduction of AMaT will help automate this and leads will be required to update their actions in a timely manner. A SMART action guide will be developed to assist leads to develop SMART action plans.

4.7 Planned Clinical Audit Programme

The Planned Clinical Audit Programme is a proactive approach to carrying out audit within each SST. The programme is developed before the start of each financial year with the aim of identifying areas for audit including National and local priorities. The programme is prominently made up of key indicators of practice, NICE guidelines, patient experience, local concern and national audits; these are identified and prioritised within each SST through the implementation of new radiotherapy techniques, the introduction of new drugs with specific toxicities and any serious adverse events. The Trust Integrated Quality Group will help develop and inform the plan moving forward.

4.8 Student Selected Components (SSCs) at Velindre Cancer Centre

Cardiff School of Medicine offers a range of opportunities to tailor learning and study specific aspects in depth. As well as intercalating and opportunities to study abroad, there are hundreds of Student Selected Components (SSCs) from which to choose.
For those students with a real interest in oncology this offers an opportunity to work closely with an oncology consultant. There is also the opportunity to work collaboratively with oncologists and clinicians in other hospitals, e.g. surgeons, gastroenterologists, radiologists. Past students have had their work published in scientific journals and have presented their work in International Meetings.
The Clinical Audit Department inducts and supervises the 3rd, 4th and 5th year medical students (SSC) each year. During 2021/22 10 year 3 and 10 year 4 students attended to undertake the or SSC at Velindre. In addition, one year 2 and one year 5 electives also attended. For Year 2022/23 6 year 3 and 8 year 4 attended.

We provide the medical students with the opportunity to attend a number of interesting short virtual sessions on key oncological topics including immunotherapy, radiotherapy and clinical trials. These sessions are provided by the junior doctors and have received excellent feedback from the students.

A new development for the academic year 2022/23, included a virtual presentation event during the last week of their 6-week block. This will provide an opportunity to present their work at a multidisciplinary forum and will be provided with a certificate for presenting. The presentations are judged by an expert panel and the top 3 presenters received a prize. The aim of this session is to provide an opportunity for all students to present their work, which will be a key skill expected of clinicians throughout their career.

4.9 Site /Service Specific Teams (SST)

The SST's key roles are to provide a forum for multi-disciplinary service planning, development, audit and research in tumour site and service specific issues, providing recommendations to Velindre Cancer Centre on required service changes and approaches to realising these. They are also required to be accountable for the delivery of excellent, efficient, equitable and safe tumour specific service by VCC and to monitor quality and timeliness of services according to national standards.

4.10 Breast Site Specific Team
4.11 Colorectal Site Specific Team
4.12 Gynaecology Site Specific Team
4.13 Head & Neck Site Specific Team
4.14 Lung Site Specific Team
4.15 Palliative Care Service Specific Team
4.16 UGI Site Specific Team
4.17 Urology Site Specific Team
4.18 Neuro-oncology Site Specific Team
4.19 Other Sites and Services

4.10 BREAST SITE SPECIFIC TEAM

4.10.1 Breast Clinical Audit Activity

**Figures exclude mandatory national audits and continuous monitoring*

4.10.2 National Audits and Continuous Monitoring

4.10.2.1 The National Audit of Breast Cancer in Older Patients (NABCOP) was established in April 2016. It assesses the processes of care and outcomes for women aged over 70 years compared with women 50-69 years. NABCOP's results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. It is run by the Association of Breast Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England and is commissioned by HQIP.

The NATCAN's programme of work includes two new breast cancer audits. The first audit will look at primary breast cancer, while the second will focus on secondary (metastatic) breast cancer, for women and men of all ages.

The CEU has been managing the NABCOP since April 2016, and the work of the NABCOP and lessons learned will be used to inform the planning and delivery of the two new audits. Resources from the NABCOP such as the guide to the breast cancer pathway for older women, and the fitness assessment for older patients in the breast clinic, continue to be made available.

4.10.4 Areas of good practice and improvement

4.10.4.1 Re-audit ER/HER2 misreporting

An audit was undertaken during 2017 following an incident where by a patient was treated as having oestrogen receptor negative breast cancer (ER) on the basis of a negative ER result instead of positive (+). A review of the medical records indicated an error in the noting of the ER status. Therefore, the patient was treated on this basis rather than the correct ER positive result. The audit identified areas for improvement and an action plan was devised. A re-audit was scheduled during 2020 however there have been delays in reporting due to COVID.
In total the records of 1145 were reviewed, and no error in treatment were identified. There were a small number of documentation errors, however this did not impact on treatment. There has been a significant improvement in the availability of source data within WCP, principally the histopathology results for patients diagnosed through the screening service at Breast Test Wales. Limitations of the CMDS function in Canisc/WCP means that ER/HER2 are not recorded as a set field making interrogation of data difficult.

4.10.4.2 Evaluation of the BAPS App

The BAPS app was launched in February 2019, with the aim of standardising information given to patients post breast surgery in a more interactive fashion, empowering patients with an understanding of why the exercises are important, motivating them to achieve their goals in their own home and optimising the patient care pathway from surgery to radiotherapy.

In order to assess patient feedback at the point of planning for radiotherapy to assess the usage and effectiveness of the app, a patient survey was devised in October 2021 - 50 Questionnaires were distributed to patients who were undergoing RT with a 54% response rate. Only 41% of responses were aware of the baps app. 64% of these were told about it by their breast care nurse. 30% of these patients actually used the baps app post surgery. Recommendations include:

- Need greater advertising of the baps app to widen use.
- Need to revise the inspirational hold element of the app

4.10.4.3. The impact of the COVID pandemic on our breast cancer patients

The main aim of the project was to determine whether the COVID-19 pandemic had an impact on the stage of breast cancer at referral. The results demonstrated a higher proportion of advanced breast cancers were seen amongst the post-COVID cohort. Stage I was the most common stage in the pre-COVID group, whereas Stage IIA was most commonly seen in those referred post-COVID. T stage and N stage of early cancers were similar in both groups. Treatment patterns also differed with more patients being referred for neoadjuvant chemotherapy post COVID.

4.10.5 Posters and Publications

4.10.5.1 Eribulin Treatment for Patients with Metastatic Breast Cancer: The UK Experience - A Multicentre Retrospective Study

This study examined real-world data from patients who received eribulin for metastatic breast cancer (MBC) collected from 14 hospitals across the UK.
Anonymized data were collected retrospectively from patients with MBC who had received eribulin. The data included the hormone-receptor status, histological diagnosis, age, prior chemotherapy, response to eribulin, progression-free survival (PFS), and overall survival (OS). Among 577 patients analysed, the median age was 56 years, and most patients (73%) were estrogen-receptor positive. The median OS was 288 days and the PFS was 117 days. The median OS was higher among older patients. The median OS was also higher in patients who received eribulin after fewer prior lines of chemotherapy

These retrospective data suggest that eribulin can be successfully used in older patients with MBC. Eribulin treatment was more effective in earlier-line settings, which, while predictable, supports consideration of eribulin as a second-line treatment option.

4.11 COLORECTAL SITE SPECIFIC TEAM

4.11.1 Colorectal Clinical Audit Activity

**Figures exclude mandatory national audits and continuous monitoring*

4.11.2 National Audits and Continuous Monitoring

4.11.2.1 The National Bowel Cancer Audit is a collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. It aims to improve the quality of care and survival of patients with bowel cancer; it is now well established and has collected data since 2005. The National Bowel Cancer Audit is designed to provide vital information with regards to diagnosis, treatment, and outcomes; the main focus is to help make sure that people with bowel cancer receive the best care possible. However Systemic Anti-Cancer Therapy (SACT) and Radiotherapy data is not available for patients treated in Wales. NBOCA are currently in the process of obtaining access to RTDS data for Wales regarding.

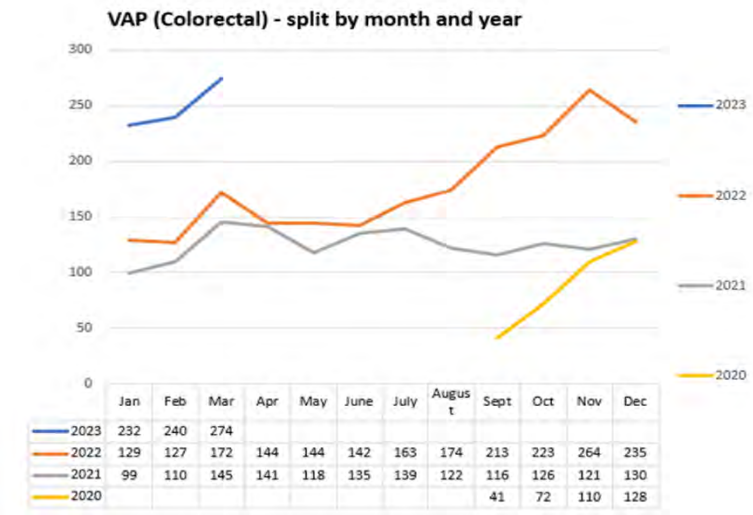
4.11.3 Areas of good practice and improvement

8.2.3.1 Colorectal 'Support Group' - There is currently no Support Group in the South East Wales area for people with or those affected by Colorectal/Bowel Cancer. For some time Velindre have been looking at setting up a support group and wanted to find out if this is something that people would find helpful. The survey also provided the opportunity to identify if there are any specific topics/issues that people are keen to discuss and topics that might be useful. The survey confirmed that there was a lot of interest in a colorectal support group in the area. However, there were patients who felt that it wasn't for them. The colorectal team are working on setting this up, potentially in a virtual format in the first instance.

4.11.3.2 VAP Clinic

In the past 2.5 years the VAP clinic has undertaken 4500 CRC assessments. The team now assess approximately 250 CRC patient per month and CRC makes up 61% of the VAP workload.

As you can see from the graph below – CRC VAP has grown year on year.



	Jan	Feb	Mar	Apr	May	June	July	August	Sept	Oct	Nov	Dec
2023	232	240	274									
2022	129	127	172	144	144	142	163	174	213	223	264	235
2021	99	110	145	141	118	135	139	122	116	126	121	130
2020									41	72	110	128

The are two main CRC prescribers who aim to be autonomous and not 'bother' the CRC teams unless outside out scope of experience. This enables the consultants to concentrate on the new referrals, more complex patients or those needing scan results.

4.11.3.3 Neoadjuvant Radiotherapy

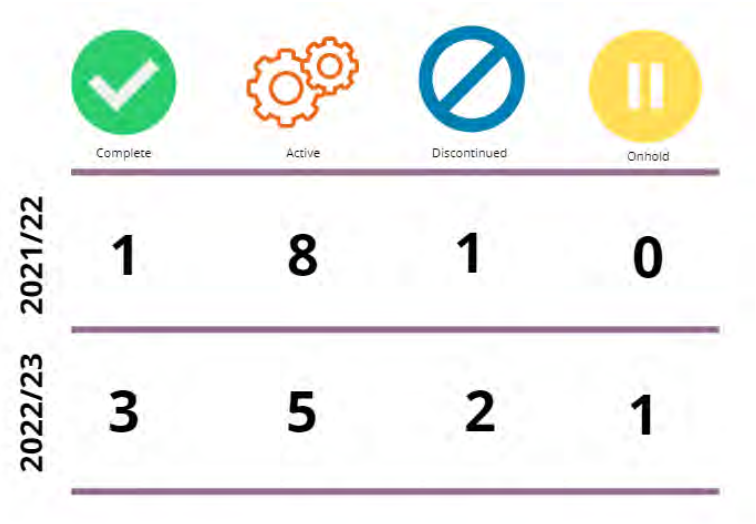
The Colorectal team have adopted the use of Total Neoadjuvant Therapy into our practice in keeping with the most relevant and up to date clinical trials data. This is on the audit plan for 2023/24

4.11.3.4 DPYD Testing

We reached 1000 patients tested in Wales for DPYD testing, an initiative led by the colorectal SST with more than 70 patients testing with a DPYD variant and having their does adjusted to prevent severe toxicity

4.12 GYNAECOLOGY SITE SPECIFIC TEAM

4.12.1 Gynaecology Clinical Audit Activity



**Figures exclude mandatory national audits and continuous monitoring*

4.12.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site

4.12.3 Areas of good practice and improvement

4.12.3.1 Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction

Historically patients all received the same dose in the same area. Since 2016, IGBT (image guided brachytherapy) has been used at Velindre, where MRI (or CT) may be used to create a more specific treatment plan for the patient and their cancer. 193 Patients' data with cervical cancer were collected in this retrospective study. They were divided into 2 cohorts, patients who had treatment before March 2016 had standard planning brachytherapy (control) and patients who had treatment after March 2016, who received IGBT

Comparison of the cohort groups found 35.3% of the control group had died in contrast to 30.1% of the protocol group. Between both groups, 113 patients were found to have at least 1 toxicity on the LENTSOMA grading system. 82.4% of the control group developed a toxicity associated with their radiotherapy/brachytherapy whereas the protocol group only had 56.3% of patients with a reported toxicity.

Overall, from all of the data, we can see that the IGBT cohort had much better local control and a reduced proportion of the cohort developing toxicity from the Brachytherapy compared to the standard planning cohort.

Recommendations: Continue following up patients and re-do yearly/ 2 yearly. Additionally, data from previous years (2014 and before) could be used to increase the data from the standard planning (control) cohort.

4.13 HEAD & NECK SITE SPECIFIC TEAM

4.13.1 Head & Neck Clinical Audit Activity

**Figures exclude mandatory national audits and continuous monitoring*

4.13.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site.

4.13.3 Areas of good practice and improvement

4.13.3.1 To assess the use of Pembrolizumab in the metastatic /non resectable HNSCC at Velindre Cancer Centre

The introduction of single agent Pembrolizumab took place during the background of the Covid-19 pandemic. Initially, immunotherapy was utilised as a short-term goal to avoid myelosuppression, but as experience with the drug grows, it is increasingly seen and utilised as an option for patients whom are relatively asymptomatic or have non-bulky disease.

CPS scoring appears to be under-utilised, with only 38% of eligible patients having a CPS performed. One patient had a PDL-1 score performed. As at the time of writing, this audit did not reveal a trend, potentially due to the small sample size.

The most common reason for stopping Pembrolizumab therapy was patient deterioration or end of life (50%). The second most common reason was disease progression (both clinical and radiological) (25%). The number of patients in this audit were small, however this result illustrates the poor prognosis of patients with metastatic or locally advanced SCC of the head and neck that do not promptly respond to systemic therapies. Of the 38% of patients that had CPS performed, two patients had CPS scores (20 and 85) that could suggest a positive response to Pembrolizumab, however, alternative treatments were chosen. Further inspection of these patient's notes showed that the patient with a CPS score of 85 had disease recurrence invading the vertebra and brachial plexus. The second patient with CPS 20 was found to have progressive lung and new liver metastases. In both cases, chemotherapy was chosen as 1st line treatment - presumably due to the site of recurrence, associated morbidity and desire for prompt disease response. Physician preference would additionally be a contributing factor.

Recommendations: Results to be fed back to the Head and Neck department and explore the teams experience with the drug to date including reasons for low CPS scoring requests. As a department we can aim to device a system to ensure appropriate testing and utilisation is implemented. The aim would be to re-audit approximately 1 year after implementation.

4.13.3.2 Total treatment time and time from surgery to RT in Post-Operative Radiotherapy in Head and Neck Cancer

Results of our Service, Treatment within 6 weeks, Target: 96%, VCC Compliance 54%. Treatment within 5 weeks, Target 75%, VCC Compliance 20%. Lack of staff in Pathology department has been recognised, this audit data can be used to create a business case to hire more Pathologist.

Discussion among Oncology consultants if, a rota can be made to expedite start of RT. 46 Patients in 1 years = 4 patients in 1 month, i.e. 1 patient / week on Average. Review and Compare LRC and mortality between above three groups and see if it has made a difference.

4.14 LUNG SITE SPECIFIC TEAM

4.14.1 Lung Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	6	5	1	0
2022/23	2	4	0	0

**Figures exclude mandatory national audits and continuous monitoring*

4.14.2 National Audits and Continuous Monitoring

4.14.2.1 The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit.

The NLCA has previously achieved outstanding levels of NHS participation with data being used to drive improvements in the quality of care for people with lung cancer. The RCP aims to build on this success by delivering a new NLCA that incorporates key advances in the field of lung cancer, diagnosis and treatment, whilst retaining the most successful elements of the previous audit.

Wales has managed to reach the target of 90% of lung cancer patients being assessed by a lung cancer nurse specialist, a significant benefit to our patients and a testament to the dedication of our nurses and the investment from the health boards.

NSCLC resection rate (15.8%), chemotherapy in SCLC (65%) and systemic anticancer therapy for stage IIIB–IV, PS 0–1 NSCLC patients (54%) remain below the audit standards and have remained static for the past few years. There was no formal outlier process this year, but on these measures, Wales does not appear to be performing as well as England.

There will be multiple reasons for this apparent gap, including data capture errors. However, only 4% of SCLC patients received their chemotherapy within 14 days, which suggests data processing alone will not explain the underperformance. These findings have been consistent over a number of years and need a systematic investigation led by the Welsh Cancer Network to explain these findings. The static nature of these key performance indicators despite many improvement initiatives suggests that in addition to continuous improvement more radical changes are needed, e.g. lung health checks and rapid diagnostic hubs. Recovery planning after the pandemic would be an opportunity to trial some of these initiatives.

4.14.3 Areas of good practice and improvement

4.14.3.1 All Wales NSCLC genetics pathway quality improvement project

Introduction: All cases of locally advanced/metastatic non-small cell lung adenocarcinoma require biomarker testing at diagnosis to identify patients who may benefit from targeted therapy. In Wales, DNA and RNA NGS is routinely available via the All Wales Medical Genomics Service (AWMGS) within 14 days of sample receipt. The All Wales National Optimal Pathway (NOP) for Lung Cancer recommends genomics results are available within 10 days of biopsy.

Methods: Lung MDTs were invited to take part in a retrospective audit of the NGS pathway within Wales; data from patient records and laboratory information management systems were analysed to identify requesting patterns, turnaround times (TAT) and incidence of actionable variants.

Results: Data was submitted from 7 MDTs for 53 patients with NGS testing between October 2020 and May 2021. 40 (75.5%) patients had both DNA and RNA NGS, the remainder had

DNA NGS +/- FISH testing for ALK/ROS/NTRK gene rearrangements. Median TAT from biopsy to results for DNA and RNA NGS was 26 days and 25 days, respectively (figure 1); MDTs with reflex testing had shorter TAT. DNA NGS testing was successful in 51 (96.2%) patients; RNA NGS testing was unsuccessful in 10 (25%) patients however salvage FISH testing gave results in 7 cases. Testing identified clinically actionable variants in 17 (32%) patients.

Conclusions: In order to improve time to definitive treatment and patient outcomes, the diagnostic pathway TAT need to be reduced. The Welsh Thoracic Oncology Group plans to review the NOP to optimise and standardise genomic testing. Specifically the AWMGS has established a working group to facilitate implementation of a 7 day target for NGS results from time of sample receipt; priorities include increasing the number of NGS runs per week, increasing staff capacity for sample processing, result reporting and authorisation, and optimising DNA/RNA extraction methods to reduce testing failure rates.

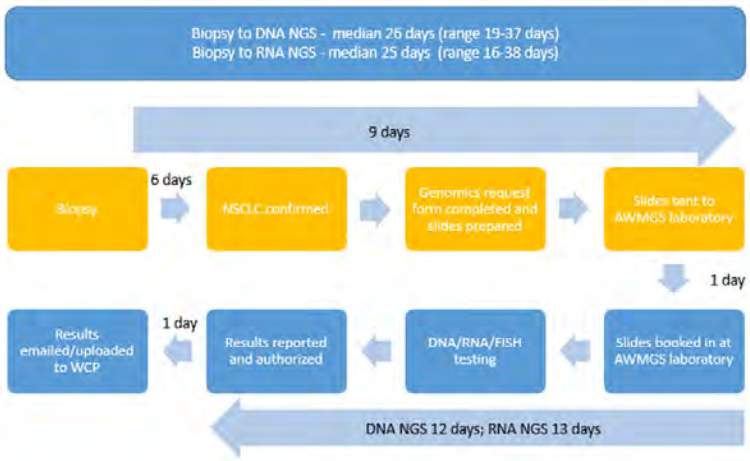


Figure 1: Median turnaround times for genomics pathway (where data available)

4.14.3.2 Macmillan Lung Cancer Pathway Evaluation

In interviews, staff and patients identified improvements in person-centred care because of the role. However, these improvements are mainly confined to patients from the two referral hospitals that the Macmillan lung cancer CNS supports. Factors such as staff capacity, staff attitudes and geography have been suggested as potential drivers behind this prioritisation of input.

Evidence of positive impacts on the delivery of person-centred care, e.g., acting as a key point of contact for patients on treatment at VCC, supports the continuation of the role. Staff to continue approach of empowering patient to choose which CNS to contact to practice person-centred care and alleviate any possible confusion for patients caused by access to multiple points of contact. Carry out further work to understand how the Macmillan lung cancer CNS' input has been prioritised across patients from local district hospitals and assess whether these decisions have been made in line with patient needs. Investigate whether ensuring equitable access to Macmillan lung cancer CNS support will improve quality in terms of health outcomes.

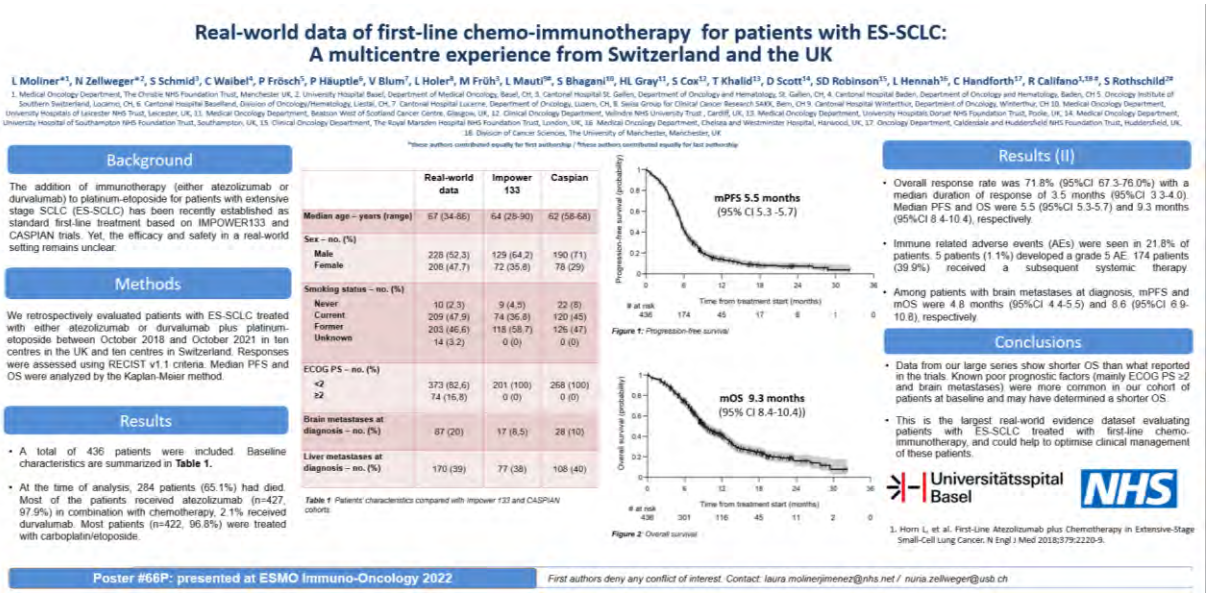
4.14.4 Posters and Publications

4.14.4.1 All Wales NSCL Genetics BTOG

4.14.4.2 Real-world experience of carboplatin/etoposide/atezolizumab for SCLC

Engagement with a national project which won the Best Poster Award (presented to lead author Laura Moliner, Manchester) at ESMO Congress 2022.

The data has also contributed to this poster submission (see attached) which took place at ESMO immuno-Oncology conference Dec 2022 – international collaboration.



Real-world data of first-line chemo-immunotherapy for patients with ES-SCLC: A multicentre experience from Switzerland and the UK

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*these authors contributed equally for first authorship / #these authors contributed equally for last authorship

Background

The addition of immunotherapy (either atezolizumab or durvalumab) to platinum-etoposide for patients with extensive stage SCLC (ES-SCLC) has been recently established as standard first-line treatment based on IMPOWER133 and CASPIAN trials. Yet, the efficacy and safety in a real-world setting remains unclear.

Methods

We retrospectively evaluated patients with ES-SCLC treated with either atezolizumab or durvalumab plus platinum-etoposide between October 2018 and October 2021 in ten centres in the UK and ten centres in Switzerland. Responses were assessed using RECIST v1.1 criteria. Median PFS and OS were analyzed by the Kaplan-Meier method.

Results

- A total of 436 patients were included. Baseline characteristics are summarized in **Table 1.**
- At the time of analysis, 284 patients (65.1%) had died. Most of the patients received atezolizumab (n=427, 97.9%) in combination with chemotherapy. 2.1% received durvalumab. Most patients (n=422, 96.8%) were treated with carboplatin/etoposide.

	Real-world data	Impower 133	Caspian
Median age – years (range)	67 (34-86)	64 (28-90)	62 (58-68)
Sex – no. (%)			
Male	228 (52.3)	129 (64.2)	190 (71)
Female	208 (47.7)	72 (35.8)	78 (29)
Smoking status – no. (%)			
Never	10 (2.3)	9 (4.5)	22 (8)
Current	209 (47.9)	74 (36.8)	120 (45)
Former	203 (46.6)	118 (58.7)	126 (47)
Unknown	14 (3.2)	0 (0)	0 (0)
ECOG PS – no. (%)			
<2	373 (82.6)	201 (100)	268 (100)
≥2	74 (16.8)	0 (0)	0 (0)
Brain metastases at diagnosis – no. (%)	87 (20)	17 (8.5)	28 (10)
Liver metastases at diagnosis – no. (%)	170 (39)	77 (38)	108 (40)

Table 1: Patients' characteristics compared with Impower 133 and CASPIAN cohorts

Figure 1: Progression-free survival

Figure 2: Overall survival

Results (II)

- Overall response rate was 71.8% (95%CI 67.3-76.0%) with a median duration of response of 3.5 months (95%CI 3.3-4.0). Median PFS and OS were 5.5 (95%CI 5.3-5.7) and 9.3 months (95%CI 8.4-10.4), respectively.
- Immune related adverse events (AEs) were seen in 21.8% of patients. 5 patients (1.1%) developed a grade 5 AE. 174 patients (39.9%) received a subsequent systemic therapy
- Among patients with brain metastases at diagnosis, mPFS and mOS were 4.8 months (95%CI 4.4-5.5) and 8.6 (95%CI 6.9-10.8), respectively.

Conclusions

- Data from our large series show shorter OS than what reported in the trials. Known poor prognostic factors (mainly ECOG PS ≥2 and brain metastases) were more common in our cohort of patients at baseline and may have determined a shorter OS.
- This is the largest real-world evidence dataset evaluating patients with ES-SCLC treated with first-line chemo-immunotherapy, and could help to optimise clinical management of these patients.

Universitätsspital Basel NHS

1. Horn L, et al. First-Line Atezolizumab plus Chemotherapy in Extensive-Stage Small-Cell Lung Cancer. N Engl J Med 2018;379:2220-9.

Poster #66P: presented at ESMO Immuno-Oncology 2022

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4.15 PALLIATIVE CARE SERVICE SPECIFIC TEAM

4.15.1 Palliative care Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	2	1	1	0
2022/23	4	1	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.15.2 National Audits and Continuous Monitoring

4.15.2.1 The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland. NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group

Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the Five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

4.15.2.2 All-Wales Care Decisions for the Last Days of Life Audit was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.

4.15.2.3 Palliative Care Outcome Scale (POS –S) audit is an evaluation tool with which we are able to assess the quality of care in palliative care patients. It assess a patient's physical, psychological and emotional symptoms, as well collecting information about their care and support needs. These measures are uniquely developed so as to be suitable for patients with chronic/life limiting diseases such as cancer, degenerative/neurological disease, respiratory and heart failure. These assessment methods can be used in the clinical environment, in audit, research and in training purposes.

POS-s is an additional assessment tool that focuses on symptom control. This measure is particularly useful when patients have multiple symptoms and is adaptable to all clinical settings; hospital, hospice or home setting. The measures have been shown to be sensitive to changes in a patient's condition over time.

4.15.3 Areas of good practice and improvement

4.15.3.1 Advance and future care planning: strategic approaches in Wales

Background: In Wales, the term advance care planning now falls under the wider umbrella term 'Future Care Planning', which also includes patients with diminished mental capacity and their significant others, to engage in deciding and planning future care. Over the last 5 years, work has been undertaken to create education formats, resources and national documents, and this has been informed by a national Advance and Future Care Planning steering group and national conference, which included patient and carer representatives. This helped collate relevant data.

Aim: We outline key strategic approaches in Wales with regard to future care planning.

Results: With data from our national conference and through feedback from stakeholders, a

national repository of distinct resources, forms and education formats has been created. The approach seeks to cater for the disparate need of the Welsh population; there is not merely one format for multiple scenarios, but a choice of approaches, communication strategies and documents to suit bespoke needs.

Conclusion: Advance and future care planning is an approach with many different facets. In Wales, we have found that some patients prefer a clearly set out, legally binding 'Advance Decision to Refuse Treatment' to guide their care, while others prefer a softer, guiding approach captured through an Advance Statement. All these formats are available to patients, carers and healthcare professionals, together with explanatory guidance notes, through a central Welsh website. Next steps involve getting a central electronic repository for these forms, which is accessible to healthcare providers and to patients

4.15.3.2 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit

This audit showed that the correct completion of forms was achieved over 95% of the time. The introduction of the new national form resulted in clearer documentation and communication of discussions that were held with patients and their significant others, as well as documenting reasons on rarer occasions when conversations could not take place.

Conclusion
Results show diligent completion of forms, with more information available in the second data collection, following introduction of the newest All Wales DNACPR forms and focused teaching sessions on this topic in the hospital trust. Next steps are ensuring these forms remain with patients, and are clearly communicated to all individuals involved in their care across acute and community settings. This is likely to be achieved most effectively and safely via a central electronic repository for advance and future care plans, which is accessible by all relevant healthcare providers and NHS Wales IT systems, as well as patients and their carers

Key messages

What was already known?

- Clear documentation of DNACPR decisions is important and forms and policies should encourage better communication.
- There is a 'duty to consult' with patients when a DNACPR decision is being made, in most cases, unless the individual lacks capacity or involvement may cause harm.

What are the new findings?

- The new All Wales DNACPR form and accompanying materials (patient facing videos, leaflets, all Wales policy) provide a clear way of documenting and communicating decisions about DNACPR and discussions that have happened with patients and their significant others.

What is the significance of this?

- The form enables important information to be documented and gives space to record (or make reference to) discussions surrounding the CPR/DNACPR communication and decisions.
- The form suggests full communication with patients, but also their next of kin, unless it is felt it may cause physical or psychological harm.

- Further work is required to ensure that these discussions and decisions, which in many cases were initiated by patients themselves, are adequately communicated among all healthcare professionals involved in a person's care.
- Future electronic patient records could be designed in such a way that the form cannot be completed without all sections (incl free-text segments) populated, for instance to describe the nature of the conversation with patient and nominated significant others. This cannot be done with paper records.

4.15.4 Posters and publications

Advance and future care planning: strategic approaches in Wales: BMJ 1st February 2022

4.16 UGI Site Specific Team

4.16.1 UGI Clinical Audit Activity

**Figures exclude mandatory national audits and continuous monitoring*

4.16.2 National Audits and Continuous Monitoring

The National Oesophago-Gastric Cancer Audit (NOGCA) was established to investigate the quality of care received by patients with oesophago-gastric (OG) cancer in England and Wales. It aims to provide information for NHS cancer services so that they can benchmark their performance and identify areas where aspects of care could be improved. Around 13,000 people are diagnosed with OG cancer in England and Wales annually. It is the fifth most common type of cancer, and patients are often diagnosed with more advanced disease compared with other cancers.

NOGCA collects prospective data on adult patients diagnosed in England and Wales with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach, or high-grade dysplasia (HGD) of the oesophagus.

Welsh data was provided by NHS Wales Health Collaborative. This dataset did not provide access to information on surgical complication rates, details of chemotherapy or radiotherapy regimens or on patients diagnosed with oesophageal HGD. Consequently, results requiring this data is not reported for Welsh patients.

4.16.3 Areas of good practice and improvement

4.16.3.1 An audit of emergency presentations and referrals of patients with oesophagogastric cancer

The results show that all patients that were submitted to NOGCA 2020 from AB and C&V health boards as emergency referrals were true emergencies. The way in which emergency referrals are recorded for submission to NOGCA are also accurate in AB and C&V health boards. The patients who were referred as an emergency from these health boards are accurately reflected in the NOGCA audit values. These findings suggest that there may be other contributing factors to the rate of higher emergency referrals in Wales in comparison to England, and that the issue is not to do with the way in which emergency referrals are recorded.

In conclusion, this audit seems to suggest that there are a few issues with the way in which emergency referrals are recorded in Wales for submission to NOGCA 2020. More research needs to be conducted in order to discover the reasons for why the emergency admissions and referrals rate is significantly higher in Wales compared to England.

One study conducted in the Netherlands to identify reasons for delays in cancer diagnosis, found that patients need to be educated on recognising the alarm symptoms of cancer, which can speed up the diagnosis process (7). Similarly, this may also be an issue in Wales, and more work needs to be done to identify any underlying problems that are causing life-threatening delays in the diagnostic process of oesophago-gastric malignancy.

4.16.3.2 An Audit of the Treatment Outcomes of Squamous Cell Carcinomas of the Middle and Lower Oesophagus

Early diagnosis of the disease is crucial for improving overall survival. Currently, there is regular screening of those with Barrett's oesophagus (a pre-neoplastic lesion) and those with chronic diseases who are deemed high risk. However, it has not been proven cost-effective and therefore, a regular screening programme has yet to be implemented [6]. Neoadjuvant treatment followed by surgery had the highest overall 5-year survival, but caution must be taken when interpretating this data due to the limited sample size. It is difficult to decipher from the literature which treatment is most successful overall as there has not been a head-to-head trial directly comparing outcomes of definitive CRT and surgery which are the 2 most common treatment options offered to patients. The difference in survival rates is multi-factorial and variance in patient age, gender, performance status, tumour stage and location will have an impact on overall survival. Further research into treatment options from trials is required to improve the survival rates amongst this population. Multi-modal combination therapy has been mentioned as a future treatment option which would combine surgery, chemotherapy, radiotherapy, targeted therapy and immunotherapy [13].

4.16.3.3 A Clinical Audit into the Outcomes of Radical and Palliative Patients Treated with Chemo-radio Therapy for Oesophageal Cancer

This study has looked at the survival outcomes in patients when being treated with either NACRT or peri-operative chemotherapy before radical surgery. It finds that the overall survival and progression free survival is higher when patients are treated with NACRT. In the UK, there are currently no guidelines as to which treatment is better and the decision is usually made by the patient. In the future, this research, alongside other studies, can provide evidence to show

an increased survival benefit of using NACRT. To continue this research, incorporate the tumour stage at diagnosis into the statistical analysis to remove other variables and improve accuracy in the survival outcomes. It is important to take into consideration that chemoradiotherapy may also have more adverse outcomes (10). Therefore, it is important to discuss with each individual patient and find out their preference as their quality of life is of high importance.

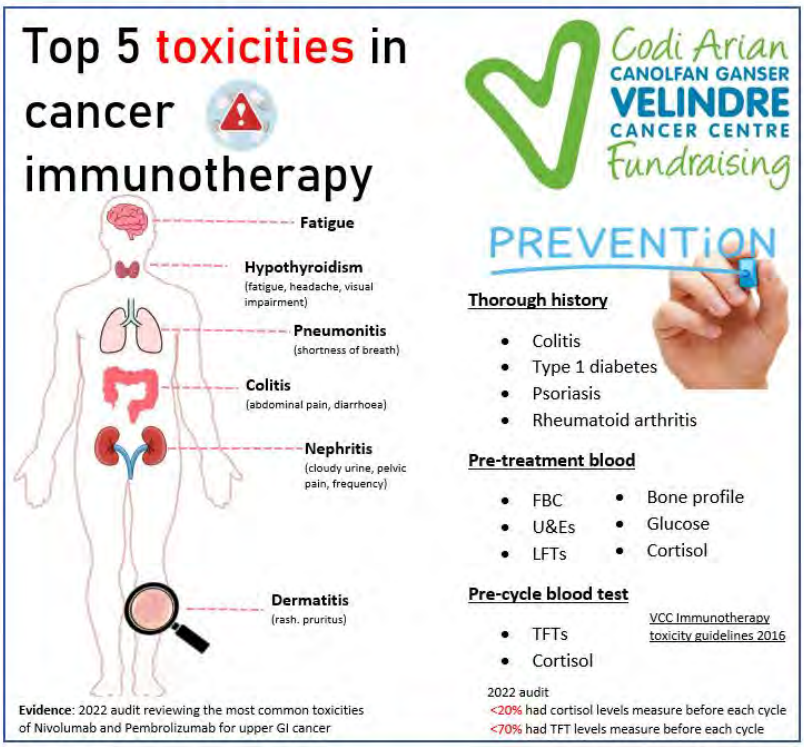
4.16.3.4 AUDIT- Identifying toxicities experienced during immunotherapy treatment for upper GI cancer and biomarkers measured before and during treatment

Evidence shows that endocrinopathy are amongst the most common toxicities experienced with immunotherapy use. Whilst most toxicities experienced are grade 1 or grade 2, life-threatening complications such as adrenal crisis, thyrotoxicosis and diabetic ketoacidosis can occur which are easily avoidable with routine blood test. The VVC toxicity guidelines emphasizes the importance of pre-cycle TFT and cortisol blood tests. Our audit shows that only an average of 70% of a patients total cycles TFTs blood test were taken and an average of 16% for cortisol. It was evident that FBC, LFTs, U&Es and bone profile are biomarkers in routine blood test. We suggest in order to prevent irreversible endocrinopathies, that pre-cycle blood forms should include cortisol, TFT and glucose as a routine. This in turn will reduce the incidence of toxicities but also reduce the number of patients having to take replacement therapies. As these replacement therapies have long-term effects such as high-dose glucocorticoids which can increase the risk of hypoglycaemia and osteoperosis.

Limitations of this audit included a small cohort size of 16. In the future, this research should be continued where analysis can be carried out on a larger data set. Alternatively, include other cancers that use Nivolumab and Pembrolizumab such as hepatocellular carcinoma. A larger cohort will provide more accurate information to identify the most common toxicities experienced on these therapies. In addition, it may become more evident what blood tests are most commonly missed. This will then allow to implement new guidelines that ensure the correct pre-treatment and pre-cycle blood tests are carried out.

In conclusion, our audit shows that nausea and vomiting are common toxicities experienced in patients on immunotherapies. Health workers should make patients aware of these symptoms. In addition, our results show that the required blood test pre-treatment and pre-cycle stipulated in the immunotherapy toxicity guidelines were not followed. Pre-cycle TFTs and cortisol levels were not measured at a target of 100% of the time. It is important that these tests are implemented into normal practice to reduce the risk of life-threatening toxicities.

The following poster outlines information for NHS staff, this poster has been modified for use in practice.



4.17 UROLOGY SITE SPECIFIC TEAM

4.17.1 Urology Clinical Audit Activity

**Figures exclude mandatory national audits and continuous monitoring*

4.17.2 National Audits and Continuous Monitoring

Prostate cancer is the most frequently diagnosed solid cancer (over 40,000 new cases each year) and the second most common cause of cancer-related death in men in the UK. The National Prostate Cancer Audit (NPCA) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government with the aim of assessing the process of care and its outcomes in all men diagnosed with prostate cancer in England and Wales.

4.17.3 Areas of good practice and improvement

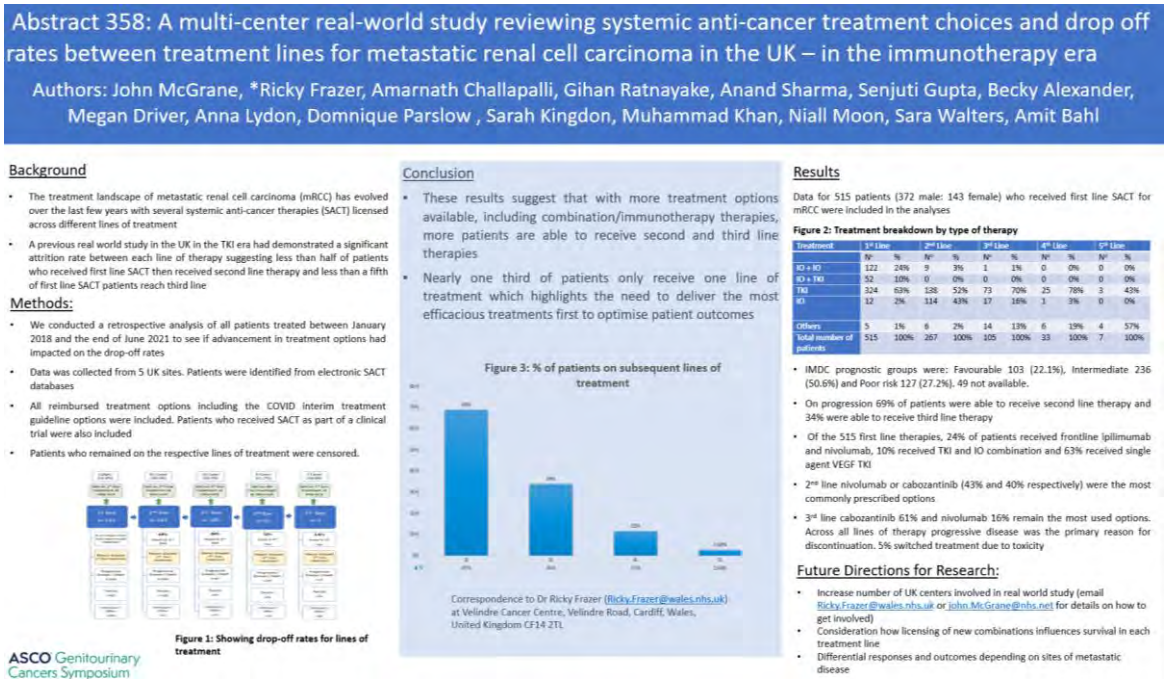
4.17.3.1 Patient survey

The majority of men were satisfied with their first consultation, discussion of treatment, concerns and needs and with the care they received from Velindre Cancer Centre. The majority of men were also satisfied with the information they received, however 23 patients wanted more information on possible side effects and 28 on fatigue. 25 did not feel equipped for living well after cancer diagnosis. 19 men were not provided with the Velindre CNS's contact details during their treatment in Velindre and only 20 patients offered HNA -all patients should be given contact of key worker and HNA. Over ¾ of the men felt that a written treatment plan would be beneficial. The majority of patients were satisfied with follow up in either OPD or telephone-no strong feelings towards either.

Recommendations:

- Navigator will continue to distribute team/key worker information to patients
- Navigator will also continue to offer patient opportunity to complete Holistic Needs Assessment (HNA) also promoting awareness of HNA's
- Formulate personalised care plan at 6 monthly radiotherapy follow-up appointment.
- Re-start education seminars
- Recorded videos of management of side effects and living well after cancer. To put into DVD format and QR code on radiotherapy patient leaflet to then distribute to patients
- Develop treatment plans to be sent out to patients and GP's post initial diagnosis
- Develop self management patient portal and PSA tracker

4.17.3.2 Renal cancer audit



Abstract 358: A multi-center real-world study reviewing systemic anti-cancer treatment choices and drop off rates between treatment lines for metastatic renal cell carcinoma in the UK – in the immunotherapy era

Authors: John McGrane, *Ricky Frazer, Amarnath Challapalli, Gihan Ratnayake, Anand Sharma, Senjuti Gupta, Becky Alexander, Megan Driver, Anna Lydon, Domnique Parslow , Sarah Kingdon, Muhammad Khan, Niall Moon, Sara Walters, Amit Bahl

Background

- The treatment landscape of metastatic renal cell carcinoma (mRCC) has evolved over the last few years with several systemic anti-cancer therapies (SACT) licensed across different lines of treatment
- A previous real world study in the UK in the TKI era had demonstrated a significant attrition rate between each line of therapy suggesting less than half of patients who received first line SACT then received second line therapy and less than a fifth of first line SACT patients reach third line

Methods:

- We conducted a retrospective analysis of all patients treated between January 2018 and the end of June 2021 to see if advancement in treatment options had impacted on the drop-off rates
- Data was collected from 5 UK sites. Patients were identified from electronic SACT databases
- All reimbursed treatment options including the COVID interim treatment guideline options were included. Patients who received SACT as part of a clinical trial were also included
- Patients who remained on the respective lines of treatment were censored.

Figure 1: Showing drop-off rates for lines of treatment

ASCO Genitourinary Cancers Symposium

Conclusion

- These results suggest that with more treatment options available, including combination/immunotherapy therapies, more patients are able to receive second and third line therapies
- Nearly one third of patients only receive one line of treatment which highlights the need to deliver the most efficacious treatments first to optimise patient outcomes

Figure 3: % of patients on subsequent lines of treatment

Correspondence to Dr Ricky Frazer (Ricky.Frazer@wales.nhs.uk) at Velindre Cancer Centre, Velindre Road, Cardiff, Wales, United Kingdom CF14 2TL

Results

Data for 515 patients (372 male: 143 female) who received first line SACT for mRCC were included in the analyses

Figure 2: Treatment breakdown by type of therapy

Treatment	1st Line		2nd Line		3rd Line		4th Line		5th Line	
	N°	%	N°	%	N°	%	N°	%	N°	%
IO + IO	122	24%	9	3%	1	1%	0	0%	0	0%
IO + TKI	52	10%	0	0%	0	0%	0	0%	0	0%
TKI	324	63%	138	52%	73	70%	25	78%	3	43%
IO	12	2%	114	43%	17	16%	1	3%	0	0%
Others	5	1%	6	2%	14	13%	6	19%	4	57%
Total number of patients	515	100%	267	100%	105	100%	33	100%	7	100%

- IMDC prognostic groups were: Favourable 103 (22.1%), Intermediate 236 (50.6%) and Poor risk 127 (27.2%). 49 not available.
- On progression 69% of patients were able to receive second line therapy and 34% were able to receive third line therapy
- Of the 515 first line therapies, 24% of patients received frontline ipilimumab and nivolumab, 10% received TKI and IO combination and 63% received single agent VEGF TKI
- 2nd line nivolumab or cabozantinib (43% and 40% respectively) were the most commonly prescribed options
- 3rd line cabozantinib 61% and nivolumab 16% remain the most used options. Across all lines of therapy progressive disease was the primary reason for discontinuation. 5% switched treatment due to toxicity

Future Directions for Research:

- Increase number of UK centers involved in real world study (email Ricky.Frazer@wales.nhs.uk or John.McGrane@nhs.net for details on how to get involved)
- Consideration how licensing of new combinations influences survival in each treatment line
- Differential responses and outcomes depending on sites of metastatic disease

4.17.3.3 Post Holistic Needs Assessment (HNA): Patient Survey urology

Prostate cancer is increasing in both incidence and survival rate with a long life expectancy for many men. There is a recognized high level of post treatment unmet need. Global consensus and National policies support the integration of holistic care of these patients at every stage of their care pathway. A recognised method of managing holistic health is through the use of a Holistic Needs Assessment (HNA) consultation which can inform the patient's care plan in a collaborative manner. The Clinical Nurse Specialist is often regarded as the person best placed to deliver HNAs but the role of the CNS has changed and often includes Non-Medical Prescribing (NMP). This change results in less time for supportive elements of the CNS role such as HNAs and despite the introduction of the HNA over 15 years ago, its implementation has been inconsistent and the number delivered locally is low.

Recognition of this has contributed to the introduction of support workers in a new role as Navigators to assist in provision of supportive care. The aim of this project was to implement and evaluate the impact of delivering HNAs as part of the new Navigator support worker role. It is proposed to increase the number of HNAs being offered to patients with metastatic prostate cancer who are receiving Systemic Anti-Cancer Treatment (SACT) within an NMP clinic. An Improvement Model was followed to provide a structure and a system for implementation of the HNA service. Patient experience was assessed through a questionnaire.

The project has found that HNAs can be implemented within a SACT service but this can only be realised with dedicated and protected staff, time and space. The Navigator role is important as a coordinator of the HNA process. The HNA information has potential benefits in service improvement if collected in an appropriate method. With appropriate resource, the HNA intervention can be used to reduce unmet need by providing health education and support.

4.17 3.4 Stereotactic Ablative Radiotherapy (SABR) Metastatic prostate

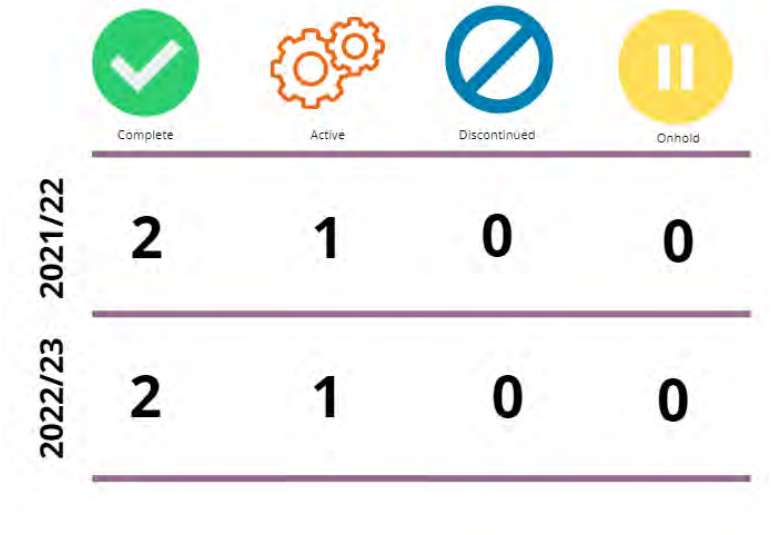
57 patients were reviewed; patients were diagnosed from November 2011 to November 2019 and Gleason scores ranged between 6 and 9. Initial radical treatments of the primary tumour included: prostatectomy, radiotherapy, neoadjuvant and adjuvant hormones, and LDR brachytherapy in varying combinations. 33 (57.9%) patients had oligometastasis in bone (situated in the spine, sacrum, pelvis and ribs in 15 (26.3%), 2 (3.5%), 12 (21.1%) and 4 (7%) patients respectively), 26 (45.6%) in lymph nodes and 2 (3.5%) in both. At time of SABR, 33 (57.9%) patients were not on ADT. For these patients, the median time to initiating ADT post-SABR was 23 months (15.6 - 30.4). Median time to PSA rise post-SABR was 14 months (9.8 - 18.2). Median time to biochemical failure was 23 months (15.0 - 31.0). Local control was 100%. 3 (5.3%) patients died.

This review has found encouraging results: excellent local control, prolonged time to biochemical failure and subsequent ADT use with mild toxicities as the only downside to the SABR approach which is preferable to ADT side effects many patients wish to avoid. Collating evidence from this review and previous studies allows the conclusion that SABR is a promising management approach for men with oligometastatic PCa who wish to prolong their time to starting ADT. As a curative treatment method, SABR alone may or may not be sufficient, however it's possible that the combination of SABR with hormonal therapies may provide the attack required to cure this disease. Further investigation is required to provide support for this rationale.

The project showed excellent practice which is always reassuring especially as it is a relatively new technique. No areas identified as needing improving.

4.18 NEURO-ONCOLOGY SITE SPECIFIC TEAM

4.18.1 Neuro-Oncology Clinical Audit Activity



**Figures exclude mandatory national audits and continuous monitoring*

4.18.2 National Audits and Continuous Monitoring

There are currently no national audits within this site

4.18.3 Areas of good practice and improvement

4.18.3.1 Stereotactic radiosurgery (SRS) and Stereotactic radiotherapy (SRT) for brain metastases: a multi-discipline single centre case series assessment of toxicities and outcomes.

Results: 266 SRS treatments were delivered to 225 patients. Of the 266 treatments delivered, 224(84%) were initial treatments and 37(14%) were second treatments. 51(23%) patients also had whole brain radiotherapy. The most common primary sites were lung (42%), melanoma (18%), Breast (16%) and renal (9%). 159(60%) of 266 treatments delivered were for a single brain metastasis and 79(30%) for 2 metastases. 27(13%) included treatment for post-operative tumour bed boost. Patients were most commonly prescribed 21Gy/1# (63%). 34(13%) included fractionated treatments. Median total PTV volume was 5.69 cm3 (range 0.09-26.83) for single fraction treatments and 14.96 cm3 (range 1.15-47.28) for fractionated treatments. 13(5%) treatments included Total PTV >20cm3. Most (8) were <24cm3 and included fractionated treatments. For SRS, V12Gy correlated with PTV with correlation coefficient 0.723.

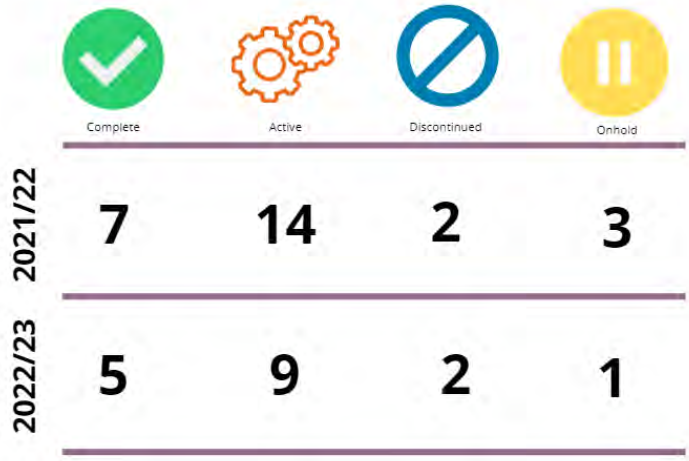
Toxicity was measured prospectively during radiographer led telephone consultations at predetermined endpoints (first and final fraction, week 1 and 6, month 3 and 12). The most common acute toxicities were grade 1-2 and included fatigue, headache and memory impairment. Grade 3 toxicity at 3 months consisted of, fatigue (n=3, 1.3%), hearing loss (n=1 0.4%), and blurred vision (n=1, 0.4%). All grade 3 toxicity had resolved by 12 months post SRS. There were no grade 4 toxicities.

Median overall survival of the 225 patients treated in the cohort was 335 days. The 6-month and 1-year survival rate was 65.0% and 46.2% respectively. Large PTV Volume (>15cm3) correlated with worse mean survival.

Conclusion: Large overall PTV volume remains an important predictor of outcome. SRS and SRT are well tolerated and effective treatment options to improve intracranial disease control for patients with brain metastases. Future studies could include subset analysis of the cohort based on tumour sub-type and V12Gy could provide further information with respect to patient outcomes. Limitations in the project include uncertainty in assessing rates of relapse, rates of radionecrosis, and cause of death outcomes. Abstract submitted to - BNOS conference

4.19 OTHER SITES AND SERVICES

4.19.1 Other Sites and Service Clinical Audit Activity



**Figures exclude mandatory national audits and continuous monitoring*

4.20 Consent

Written documentation of informed consent is required for SACT treatment which has a number of significant and potentially life threating toxicities. An audit was undertaken in 2018, to assess the standard of documentation of SACT consent before and after the introduction of new consent forms in the breast team. This audit identified areas for improvement and it was recommended that an audit of all sites and treatments requiring consent was undertaken.

A task and finish group was re-established to discuss the recommendations from the consent audit. The group decide that in order to understand the extent of some of the issues identified in the previous audit, a re-audit of all patients who received both SACT and Radiotherapy should be undertaken. All patients who received either SACT or radiotherapy during the first 2 weeks of November 2021 were reviewed. This data was retrieved from the data warehouse.

A total of 364 patients were reviewed, 21 were removed from the analysis as it was identified in the previous audit that non SACT treatments such as denosumab do not require a consent form to be completed. However, it is worth noting that 81% of patients had a consent form for these treatments present in the notes. The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. There have been improvements in a number of areas but there is still work to been done in order to achieve the required standards. There has been an increase in the use of CRUK and RCR forms within

the cancer centre, however consent form 1 is still being used in nearly half (45%) of cases. The results will be feedback to the consent task and finish group and an action plan will be developed.

A number of changes have been implemented; Staff have been informed to stop using the VCC consent forms and have been instructed to use the CRUK forms for SACT, RCR forms for radiotherapy and the All Wales consent forms for everything else (PICC etc). A dedicated consent page on the intranet with a link to CRUK and RCR has been established and the All Wales consent forms have been circulated to all departments.

It has been recommend that all professionals who undertake consent are to complete an ESR module 000 NHS Wales – Decision Making and Consent in Wales. Work is also being undertaken to incorporate consent into the junior doctor induction.

The consent form policy will be updated with the changes and once ratified will be available on the consent intranet page

A re-audit has been scheduled for June 2023.

4.21 Chaperone audit

A total number of 275 patients' records were reviewed of which 149 had an intimate examination documented in Canisc. On review of the notes there was no documentation regarding an offer or acceptance of a chaperone in any of the notes reviewed, however there was mention of a chaperone being present, their job title and patients consent to being examined in some cases.

Of the 31 (21%) patients that had a chaperone present, the name and designation of the chaperone was present in 81% (25/31) of cases. The audit demonstrates areas for improvement in all the key elements within the good working principles.

An action plan was developed as a result of the audit and a number of the recommendations have already been implemented. Posters have been designed and put up around the outpatients department. SST leads and CNS's have been made aware if the guidelines through attendance at various meetings. A re-audit has been planned for the next financial year.

4.22 Mortality

4.22.1 Deaths within 30 days of Chemotherapy

A revision of the existing all Wales Core Cancer Minimum Reporting Requirements together with the development of new Site/Patient Group Specific Cancer Minimum Reporting Requirements was necessary to ensure Wales has effective, efficient and timely world-class healthcare information to provide intelligence and the insight to drive healthcare service improvements.

The capture and monitoring of deaths within 30 days of SACT has been mandated since the NCEPOD report of 2008. Peer review of Welsh SACT services in 2020 revealed

inconsistencies in the reporting of this data. The collection and subsequent review of deaths within 30 days of SACT enables learning and development of high quality services.

Therefore death within 30 days of SACT is now a reporting requirement within the new Systemic Anti-Cancer Therapy (SACT) Clinical Quality Performance Indicators.

Method

Death within 30 Days of SACT is defined as 30 days from the first day of the SACT cycle immediately prior to death. When SACT is given continuously, then the 30 day period is defined as death within 30 days of the date of the last prescription.

In general, SACT is given in cycles. SACT may be a single drug or a combination of drugs. A cycle may be considered as either a single delivery, delivery of treatment over several consecutive days, or a continuous treatment.

Numerator / Denominator

- **Numerator for Treatment Intent Curative:** Total number of curative patients who died within 30 days from the first day of a cycle of SACT
- **Denominator for Treatment Intent Curative:** Total number of patients receiving SACT who have curative treatment intent.
- **Numerator for Treatment Intent Palliative:** Total number of palliative patients who died within 30 days from the first day of a cycle of SACT
- **Denominator for Treatment Intent Palliative:** Total number of patients receiving SACT who have palliative treatment intent.

Inclusions:

1. Patients aged 18 years or over.
2. All patients who died within 30 days from the first day of a cycle of receiving SACT, either in hospital or in the community.

The following list of drug types defined as SACT for the purpose of this quality performance indictor:

- Cytotoxic
- Drug-antibody conjugates
- Immunotherapy
- Monoclonal antibody
- Neoangiogenesis Inhibitor
- Radio-sensitiser
- Tyrosine kinase inhibitor

Results

Death within 30 days of Radical SACT for April 2023

Breakdown by month

Month	Radical SACT	Radical Deaths	%
October 2022	782	4	0.5
November 2022	758	2	0.3
December 2022	726	2	0.3
January 2023	776	2	0.3
February 2023	777	1	0.1
March 2023	803	2	0.3

Death within 30 days of Palliative SACT for April 2023

Figures for March 2023

Breakdown by month

Month	Palliative SACT	Palliative Deaths	%
October 2022	1014	15	1.5
November 2022	1013	14	1.4
December 2022	1026	11	1.1
January 2023	1019	10	1.0
February 2023	1088	8	0.7
March 2023	1180	8	0.7

4.21.2 Deaths within 30 days of Palliative

Radiotherapy and 90 days of Radical Radiotherapy

The Radiotherapy Dataset (RTDS) standard requires all NHS providers of radiotherapy services in England and Wales to collect and submit standardised data monthly against a nationally defined dataset. There has been a revision of the RTDS Dataset to V6 and also in the Welsh Radiotherapy (RT) Clinical Quality Performance Indicators. The change requires the collection of 30 day mortality following palliative radiotherapy and 90 day mortality following radical radiotherapy

The collection and subsequent review of deaths within 30 days of palliative intent RT and 90 days of curative intent RT enables learning and development of high quality services. It is a clinical indicator of transparency in outcomes and protecting patients from avoidable harm

No nationally agreed standard currently exists; however, this data will enable us to benchmark results against published data from other centres moving forward.

It should be noted that we currently working to determine the definition of “radical” as it pertains death within 90 days. Radical is commonly taken to mean cases where the patient is expected to be cured, but sometimes patients are treated with radiotherapy regimens thought of as radical in dose/ fractionation, when they are not expected to be cured. This has resulted in variability as to how different clinicians classify the same patients and may impact upon figures in this report compared to subsequent reports when the definition is clarified. We have contacted the Royal College of Radiologists and other NHS bodies to ensure our reporting is consistent with the approach across the UK.

Methodology
Death within 30/90 Days of Radiotherapy - is defined as death within 30 days from the first day of the radiotherapy episode exposure given prior to death. When radiotherapy is given continuously, then the 30-day period is defined as death within 30 days of the date of the first exposure in that episode. The first day of an exposure to radiotherapy (episode) is classed as day 0.

Calculation of % death rate = No of deaths within 30/90 days of first fraction of radiotherapy divided by total number of courses of radiotherapy over the same time period x 100.

Findings
A number of issues were identified when undertaking the analysis of this data that requires clarification from a clinical perspective.

1. A number of patients received both radical and palliative treatments within the time period. Need to ascertain if both treatments should be included or the last treatment. i.e. palliative intent
2. There are patients that have a palliative diagnosis but are receiving a radical dose of radiotherapy and therefore are classed as radical treatment intent within the dataset i.e. neuro-oncology treatment. Need to understand which dataset they should be included in.
3. Clarification as to if emergency and urgent symptom control should be included in the palliative treatment intent or excluded from the data

It is worth noting that the figures below will vary depending on the decisions made regarding the data set and the inclusion/exclusion criteria noted above.

Death 30 days Palliative Radiotherapy

Figure 1. demonstrates death within 30 days of palliative radiotherapy during April 2023 and includes both emergency and urgent care patients.

The Welsh Radiotherapy (RT) Clinical Quality Performance Indicators request monthly data, breakdown per month is detailed below.

Month	RT	Deaths	%
October 2022	125	10	8.0%
November 2022	99	13	13.1%
December 2022	89	13	14.6%
January 2023	85	6	5.9%
February 2023	105	9	8.6%
March 2023	104	5	4.8%

Death 90 days Radical Radiotherapy

Figure 2. demonstrates death within 90 days of radical radiotherapy and includes both scheduled and elective delay; these were reviewed and the majority were identified as radical intent

The Welsh Radiotherapy (RT) Clinical Quality Performance Indicators request monthly data, breakdown per month is detailed below.

Month	RT	Deaths	%
October 2022	225	3	0.9%
November 2022	210	7	2.0%
December 2022	183	5	1.6%
January 2023	253	3	1.2%
February 2023	239	3	1.3%
March 2023	291	5	1.7%

4.22.3 Mortality and Morbidity meetings

It was identified as part of the SACT peer review that a more robust approach to death within 30 days of SACT was required. A working group was established, and it was agreed to pilot a M+M meeting in one Site Specific Team (SST) to understand how the process would work in practice and to identify any issues prior to rolling out across the cancer Centre. The colorectal SST volunteered to be the pilot site, with the focus of the meeting being primarily educational and to improve patient care. The meetings are to be delivered in a supportive and confidential manner and should be conducted by the multidisciplinary team involved with the patients care. The pilot identified issues that needed addressing before the roll out to other sites. This includes the need for a standalone meeting, a digital form and also identifying who is responsible for completing the forms. The pilot will be extended and reviewed again.
As part of Duty of Candour a standardised assessment to any potential adverse outcomes to patients, and if unexpected or untended harm did occur following SACT or RT, is required. The M & M meeting would provide assurance to VCC that all deaths within 30 days of chemo and 90 days of RT where considered in light of NHS Wales legislations and Duty of Candour triggered if appropriate.
The pilot has been extended addressing the issues identified. This included

- Scheduling a standalone meeting for the M&M reviews instead of including as part of the SST's agenda. Other staff involved in the patients care should be invited to participate in discussions and a representation from another SST to provide additional scrutiny.
- Designing the mortality form on AMaT and trial the completion before and during the Meeting
- Identifying the responsible person for the completion of the review prior to mortality and morbidity meeting. This could be rotated through the SPR, the responsibility of the consultant or a team response.
- Clarifying the roles and responsibilities for mortality and morbidity within the organisation and the reporting structures, in particular the process for escalation and actioning of outcomes from the reviews.
- Trust requirements regarding mortality; should the M+M reviews be a mandatory requirement for each SST, with clinical staff engagement in the process reviewed at annual appraisal.

5.0 WELSH BLOOD SERVICE SUMMARY

5.1 Foreword

The Welsh Blood Service (WBS) provides compatibility testing and other diagnostic services related to blood, cellular therapies and organs. The WBS also collects cells for cellular therapies and blood components, which are provided along with medicines derived from plasma, some drugs and vaccines to the NHS in Wales and also to other countries.

There are many synergies for the two operational divisions of the Trust. Bone marrow and stem cells are predominantly supplied by the WBS for the treatment and cure of cancers. 25-30% of blood components are provided as part of the supportive treatment for patients with cancer. More blood components are transfused in the Velindre Cancer Centre than some general hospitals in Wales. The stem cells for treating cancers and other disorders are collected in the Velindre Cancer Centre site.

Despite the challenges of the pandemic, with changes in the way we provide existing services, and the addition of new services such as the national distribution of COVID vaccines, clinical audit has continued to be performed to assure the governance of the organisation. The WBS contributes to international audit and performance monitoring through UK 4 nation, European and wider international initiatives in all areas. These include the Serious Hazards of Transfusion haemovigilance scheme for patients and donors, The UK Health Security Agency (UKHSA) Infectious Diseases Annual Surveillance Report and European Blood Alliance bench marking surveys.

A cycle of audit and other work in the field of pre-operative anaemia contributed to the award of Value Based Health Care funding to implement improvements across Wales. Significant change in eligibility criteria for blood donation were successfully implemented in Wales as demonstrated by the audit of For Assessment of Individualised Risk (FAIR) enabling previously excluded individuals to donate safely.

Audit of the appropriate use of these services internally for our own patients and across Wales are an important part of assurance for the Trust. Unlike VCC the WBS does not have staff specifically employed to support or undertake audit other than the generic requirement in the job descriptions and job plans of staff in clinical roles to participate in audit.

Key points that need addressing

- Enablement of a consistent trust wide culture of innovation, learning, improvement and clinical audit to support the provision of safe, effective, person centred care provision.
- Provision of Clinical Audit support across both divisions.
- The potential for improved integration of audit, quality and service improvement in quality improvement hubs
- Limited opportunities to disseminate and showcase work within the Trust, especially in the absence of an integrated audit team
- The need to adapt a whole system approach that enables collaborative working both with all Health Boards and Trusts across Wales, and internally within our own departments.

The development of Quality and Safety Hubs enables further focus on this. It will be particularly important to have an integrated Clinical Audit Team with the Trust and a synergistic Trust wide 3-year plan as opposed to separate divisional audit plans.
The audit activity has been presented to reflect the operational areas of the WBS:

1) Blood Health: Meeting the needs of patients with blood components
2) Blood Donor Care: To support donors in meeting the needs of patients for blood.
3) Laboratory diagnostic and therapeutic support to patients requiring blood transfusion
4) Meeting the needs of transplant recipients, providing compatibility testing for donors and recipients of stem cell and organ transplants. Supporting donors in donating cellular therapies in the Trust.

Edwin Massey
Medical Director Welsh Blood Service

5.2 Blood Health audits and performance indicators (ensuring that patients who are likely to benefit receive a blood transfusion and those unlikely to benefit do not)

5.2.1 Blood Health key performance indicator monitoring April 1st 2021- March 31st 2023
The Blood Health National Oversight Group (BHNOG) has developed key performance indicators (KPIs) for a range of transfusion metrics. The data provides an ongoing audit tool of practice from each of the HBs in Wales. All data is shared across Wales to encourage transparency, learning and discussion of best practice. These have been collated and produced by the WBS on a monthly or quarterly basis throughout the two

5.2.1.1 Appropriate Use of O D negative (universal blood group) red cells and audit of blood components used in major haemorrhage (MH): Monthly dashboards provide ongoing audit of:
a. O D negative as a percentage of total red cell issues (KPI 12%)
b. O D negative wastage as a percentage of O D negative red cells issued (KPI 10%)
Quarterly audits are also completed for all major haemorrhage protocol activations (MHPs) across Wales to promote appropriate use and monitor use of O D positive red cells for males and females who do not have childbearing potential (defined as over 50 years old) thus keeping stocks of O D negative for females of childbearing potential who need them.

5.2.1.2. Appropriate use of platelets: Monthly dashboards provide ongoing audit of platelet wastage (KPI 15%). Quarterly audits are also completed for platelet wastage within the Welsh Blood Service facilities with a more stringent KPI of 10% than the 15% set for Health Boards. Importation of platelets to Wales from other UK nations is also reported. These reports are submitted to the BHNOG for scrutiny. Recent amendments to stock holding practice have led to an improvement in wastage within the WBS, achieving the KPIs required.

5.3 Blood Health Audits

5.3.1 Pre-operative anaemia audit (and subsequent Value Based Health Care funding)

Anaemia has been identified as a key work stream for the BHNOG. In 2020 a baseline audit of the management of preoperative anaemia was undertaken showing that only 50% (9/18) of hospitals in Wales had a preoperative anaemia process. The Welsh Perioperative Medicine Society (W-POMS) identified leads for preoperative anaemia in each Health Board and an All-Wales Pre-operative Anaemia Pathway was produced (https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2022/01/All-Wales-Pathway-Final-Version-2.pdf).

A follow up audit was undertaken in 2021 to assess impact of the implementation of a pre-operative anaemia pathway for patients across Wales.

In June 2021, all 18 hospitals (100%) from the 6 Health Boards in Wales (not including Powys which does not have acute hospitals and outsources this work) agreed to use the All-Wales Pre-operative Anaemia Pathway. Benchmarking data against the agreed pathway demonstrated significant improvements in consistency and compliance across Wales.

94% (15/16) hospitals were using Haemoglobin (Hb) >130g/L for all patients and serum ferritin and/or transferrin saturations (TSATs) for anaemia identification in line with the new pathway. Only 47% of TSATS and 18% of ferritin results were provided on the same day however limiting the prospect of same day iron treatment.

88% (14/16) used intravenous (IV) iron for first line treatment of iron deficiency anaemia prior to urgent surgery in line with the All-Wales pathway. The same applied for the use of oral iron as first line treatment for iron deficiency for elective surgery scheduled for more than 12 weeks.

Summary and subsequent progress:

Full implementation of the pathway would allow same day treatment during the pre-assessment visit to minimise hospital appointments. The audit identified barriers to implementation including test turnaround times, the ability to review results and staff/ facilities to provide IV iron are examples of reasons why it has currently been implemented with varying success in health boards across Wales.

A national testing process was agreed to identify the majority of patients that would benefit from iron treatment. Wales benefits from a national laboratory information management system (LIMS), which allows utilisation of standard blood sample test-codes, reflex testing and data extraction for audit purposes.

This work including the audit cycle was instrumental in obtaining Value Based Healthcare funding from the Welsh Government to support the full implementation of the pathway across Wales

5.3.2 Intraoperative Cell Salvage audit 2021 – 23 ongoing audit reported annually.

Intraoperative Cell Salvage (ICS) is a technique for collecting and processing blood shed during surgery with a view to reinfusing the red cells back into the patient. This intervention and the resultant autologous transfusion is a significant blood conservation measure. Like pre-operative anaemia *ICS has been made a key BHNOG workstream. An* All-Wales ICS Network (AWICSN) had been put in place with clinical leads in each Health Board, WBS staff collate and report on ICS usage across Wales. 1690 episodes of ICS usage were reported in 2021-22 which increased to 2038 reported episodes in 2022-23.

70% of ICS use (n=1435) was in an elective setting, 24% (n=492) in an emergency setting and in 6% (n=111) neither was specified. The specialty with the highest proportion of ICS use in the emergency setting was Obstetric at 51% (n=256/506); General and Vascular were next highest at 28% (n=35/125) and 27% (n=29/108) respectively.

The AWICSN plan to develop clear denominator data for surgical activity across the Health Boards have made amendments to the data collection process to improve the quality of data

and facilitate the introduction of performance indicators. This will help ensure equitable provision of ICS and improved monitoring of the appropriate use of ICS.

5.3.3 NICE Quality Standards: QS138 audit relating to NICE Guidance (NG) 24: Blood Transfusion. September 2022

In 2016 the National Institute for Health and Care Excellence (NICE) issued Quality Standard 138, to support the implementation of the Nice Guidance NG24, Blood Transfusion. In September 2022 all Health Boards (HBs) in Wales completed an audit of NICE Quality standards 138.
Standard QS138 is made up of 4 quality statements. These quality statements and the relevant findings of the All Wales audit are summarised below:

- People with iron-deficiency anaemia (IDA) who are having surgery are offered iron supplementation before and after surgery. There appeared to have a good level of compliance, better than that reported in the rest of the UK. This good performance will have been influenced by the work on pre-operative anaemia documented above.
- Adults who are having surgery and expected to have moderate blood loss are offered tranexamic acid. The documented level of compliance at 51%, appeared not to be as good as the UK data 68% but it was identified that auditors in Wales had difficulty accessing the records and hence there would be under-reporting. Use of tranexamic acid in elective surgery has now been included in the surgical checklist and it is anticipated that this will increase the use of tranexamic acid routinely. Improved accessibility to data on usage for auditors has been explored and this will be reassessed at follow up audit.
- People are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a chronic transfusion program. This appeared to have a poor level of compliance, (38% & 40% respectively) in Wales compared to the UK data where 65% and 70% compliance respectively was observed. This is clearly an area of concern and will be a priority area for further work and follow up. The All Wales Transfusion Record and transfusion associated circulatory overload assessment process has been updated to facilitate this
- People who may need or who have had a transfusion are given verbal and written information about blood transfusion. Provision of verbal and/or written information regarding transfusion has a very poor level of compliance; with 26% of patients in the NCA UK data receiving both verbal and written communication compared to 4% in Wales receiving both and 30% receiving verbal only. This is another area of concern for practice in Wales. The All Wales Transfusion Record update included clear statements on consent and a section to document consent.

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5.3.4 An all Wales audit of compliance with national guidance on platelet transfusion in patients with haematological disorders, 2022.

This re-audit was performed to assess compliance across Wales with the British Society for Haematology (BSH) guidelines for platelet transfusion. Improvements were seen in all areas when compared with performance against the same standards in a UK wide National Comparative Audit in 2017. There was 100% compliance with three out of 5 standards. .
The audit did identify additional work that needs to be completed in terms of wording of local guidance in Health Boards for greater clarity and consistency with national guidelines. This work is underway.

5.3.5 Blood Components Request Form Audit 2022

The All-Wales Transfusion Request Form was revised in 2021 to incorporate the National Blood Transfusion Committee (NBTC) indications for transfusion and associated coding. In 2022 an audit of the revised form was undertaken to provide baseline data on the uptake of this new functionality. The audit report demonstrated that while the reason for transfusion was hand written in the document and where relevant the haemoglobin concentration prior to red cell transfusion or platelet count prior to platelet transfusion were given there was poor compliance with the use of the new codes further defining the reason for transfusion.
The WBS Blood Health Team are working with Health Boards to increase familiarity with the codes and hence compliance across Wales.

5.3.6 Where Do Red Cells Go? Snapshot Audit, September 2022

Red cell transfusion use was audited in four of the largest HBs for the 4-week period defined. It was measured against similar audits undertaken in 2019 & 2021. This audit was to help us understand the distribution of red cell usage across Wales and identify any changes by specialty. Oncology and haematology remained the largest user at 27.6%, in terms of total numbers of red cells used, oncology, haematology, medicine and A&E had returned to total usage levels greater than seen pre-pandemic in 2019 whereas surgery, obstetric and overall usage remained below 2019 levels.

5.3.7 All Wales National Comparative Sample Labelling Audit 2022

The safety of the blood transfusion process depends on accurate patient, sample and blood component pack identification at all stages of the process. This starts crucially with the positive identification of the patient from whom the compatibility testing sample is taken. Errors can occur because a blood sample is incorrectly collected or mislabelled. The audit identified where /how and who errors most commonly occur. The audit was completed by all HBs in Wales, data appears to have changed very little since the last audit in 2010. A pilot service improvement project has been commissioned with a pilot HB.

5.3.8 Audits of education provided to medical students and postgraduates

a) Specialty Registrar (SpR) Education Programme Audit 2021
An audit of SpR training delivered in September 2021 was undertaken. As a result of this audit significant changes were made to the programme which will be audited again in 2023. This has provided further impetus to plans to develop a rotating registrar program into the transfusion subspecialty of haematology as otherwise exposure to this field of practice is limited and predominantly provided in a theoretical setting.

b) Senior Student Assistantship (SSA) audit 2022
The SSA programme is a well-established educational transfusion programme delivered to all final year medical students across Wales. The audit showed excellent feedback from students on the workstations delivered.

5.4 Blood Donor Care Audit

5.4.1 For the Assessment of Individualised Risk (FAIR) implementation review / audit

The English, Welsh and Scottish Blood Services implemented the FAIR recommendations on 14 June 2021. FAIR recommended moving the focus of donor eligibility assessments away from donors declaring risks associated with membership of population groups at higher risk of transfusion transmissible infections, for example men who have sex with men (MSM), to focus on an individual risk assessment based on an individual donor's lifestyle choices and behaviours. The FAIR changes and their implementation were covered widely by Welsh media, were well received amongst the Welsh Blood Service (WBS) staff and donor population and were favourably recognised and commented on by the Welsh Government.

A review / audit of the impact of implementation was undertaken by Dr Stuart Blackmore a year after FAIR was implemented:

Synopsis of Outcomes

Appointment uptake more than doubled on Monday (14 June). More than 1,750 donors booked to donate following coverage spread across BBC Wales, ITV Wales and local outlets across the country.

Compared to the previous Monday, inbound calls rose to 287 calls with 105 bookings – this compares with a daily average of 171 calls and 53 bookings. A further 264 bookings were made from Donor Contact Centre SMS and online registrations for new donors rose from 14 to 91 enrolments.

There were 70,000 social media accounts reached across social media on the day – setting a record for the most successful June for this measure – this is 50 000 above the daily average.

A full review was also carried out to analyse the success of the campaign during National Blood Donor Week. Over **235,000** accounts were reached during the week which is 130 000 above the weekly average.

12 months on

The Welsh Blood Service does not record information about sexual orientation on donors, so we are not able to provide any analysis about frequency of attendance of specific donor groups since introducing the FAIR changes. However the WBS can report that through monitoring social media channels and talking to donors on session, the WBS has been supported by members of the LGBTQ+ community since introducing the changes.

Donor Health Questionnaire:

FAIR introduced four new questions into the donor health questionnaire (at WBS this is called the Self Assessed Health History or SAHH), replacing the questions that identified donors at increased risk of having a transfusion transmissible infection based on their membership of certain population groups e.g. MSM.

During the period 14 June 2021 – 13 June 2022 a total of **90 585** SAHHs were completed and the numbers of donors answering "yes" to the 4 new FAIR questions are detailed below (all these donors would have had the appropriate deferral applied to their record):

Number of positive responses:	FAIR question on the SAHH
16	Have you ever had Syphilis and/or have you had a sexually transmitted disease in the last 3 months (including gonorrhoea)?
5	Have you had chemsex in the last 3 months? Chemsex often occurs in groups and involves the use of stimulant drugs (excluding cannabis, alcohol and Viagra) to enhance the sexual experience
713	In the last 3 months have you had more than 1 sexual partner AND/OR a new sexual partner?
24	Have you had anal sex in the last 3 months with or without a condom or other protection?

Transfusion Transmissible Infections (TTI):

The following table details the numbers of donors diagnosed with a confirmed transfusion transmissible infection for the 3 years prior to FAIR implementation and for the first year thereafter.

The rise in the number of donors with confirmed syphilis is notable but this aligns with the rising prevalence of syphilis in the general population and the rising prevalence amongst the Welsh blood donor population prior to FAIR implementation. There is no evidence of an overall increase in the number of viral TTIs post FAIR implementation.

Year	HTLV*	HBV*	HCV*	HIV*	Syphilis
14 June 2018 – 13 June 2019	0	0	2	1	2
14 June 2019 – 13 June 2020	0	0	2	0	3
14 June 2020 – 13 June 2021	0	2	1	0	7
14 June 2021 – 13 June 2022	0	1	0	0	10

* Human T lymphotrophic virus, Hepatitis B virus, Hepatitis C virus, Human Immunodeficiency Virus.

Compliments/Concerns:

No significant donor complaints have been received by the WBS regarding the implementation of FAIR. Specifically, there have been no complaints from donors who are no longer eligible to donate but were eligible prior to the introduction of the FAIR changes.

One member of staff raised religious based concerns during FAIR training prior to the launch of FAIR. These were appropriately addressed to the satisfaction of the staff member prior to launch.

Numerous compliments were received by the WBS from various individuals and organisations, including the Welsh Government post FAIR implementation.

In summary, the implementation of FAIR has been well received by donors, staff, fellow NHS organisations and the general public. WBS are now proud to have a donor eligibility assessment tool which assesses an individual's risk of having a TTI based on their personal lifestyle choices and be

haviours rather than their membership of a subpopulation at increased risk of TTIs.

5.4.2 Audit of the impact of the addition of Hepatitis B core antibody (anti-HBc) testing to blood donor screening tests

A review was undertaken 1 year after implementation. This is reported in greater detail elsewhere (via the Trust management to the Welsh Government Delivery and Oversight Board) but it is summarised here.

The WBS started testing all donations for anti-HBc from 27 May 2022. After 1 year (26 May 2023) the WBS had tested 83 443 donations – testing every donor every time. Some donors had returned more than once and have therefore been tested more than once but in total we have tested 50 228 donors, 66.17% of the regular donor base of 75 907

122 donors have been confirmed as anti-HBc positive. A further 12 have had repeatedly inconclusive anti-HBc screening tests (an expected finding in screening).

3 donors have been identified as having occult hepatitis B infection (OBI) with detectable HBV DNA either in the fresh sample from their first anti-HBc test on return to donation or from a retrieved and defrosted stored archive sample

Lookback: initially WBS performing lookback on recipients of components from donors who fall into the Safety of Blood Tissues and Organs (SaBTO) advisory committee categories 1 and 2 but not the lower risk categories 3 and 4.

Three donors from SaBTO categories 1 and 2 were identified who had donated 80 blood component packs which had been issued to hospitals to transfused to patients:

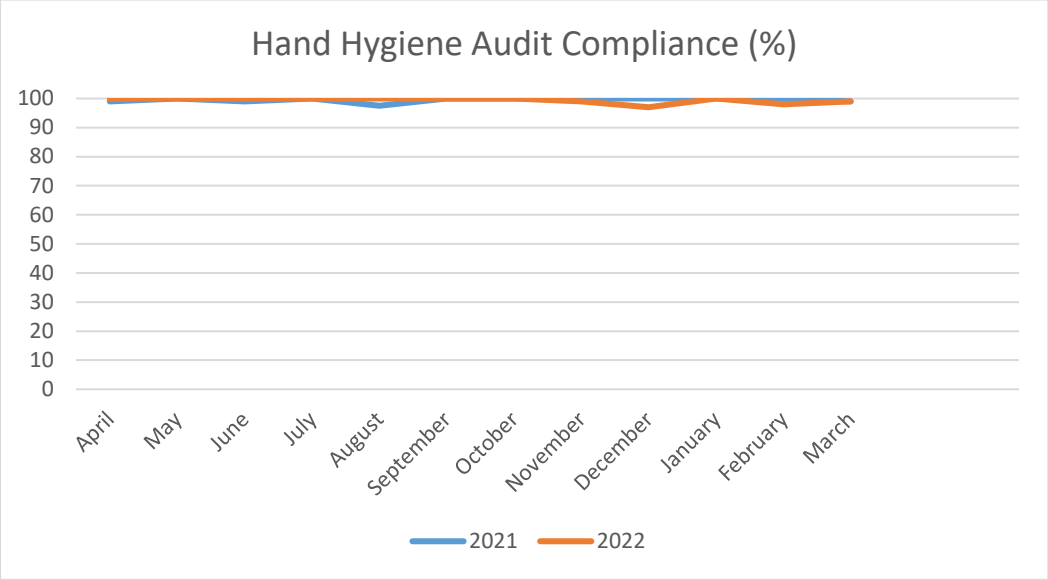
	Number of Components Issued			
	Red Cells	Platelets	Plasma	Total
Donor 1	43	4	13	60
Donor 2	12	2	2	16
Donor 3	4	1	0	5
Total	58	7	15	80

The lookback is ongoing but to date no transmissions of infection historically have been detected and the additional safety measure of the screening test has been implemented successfully.

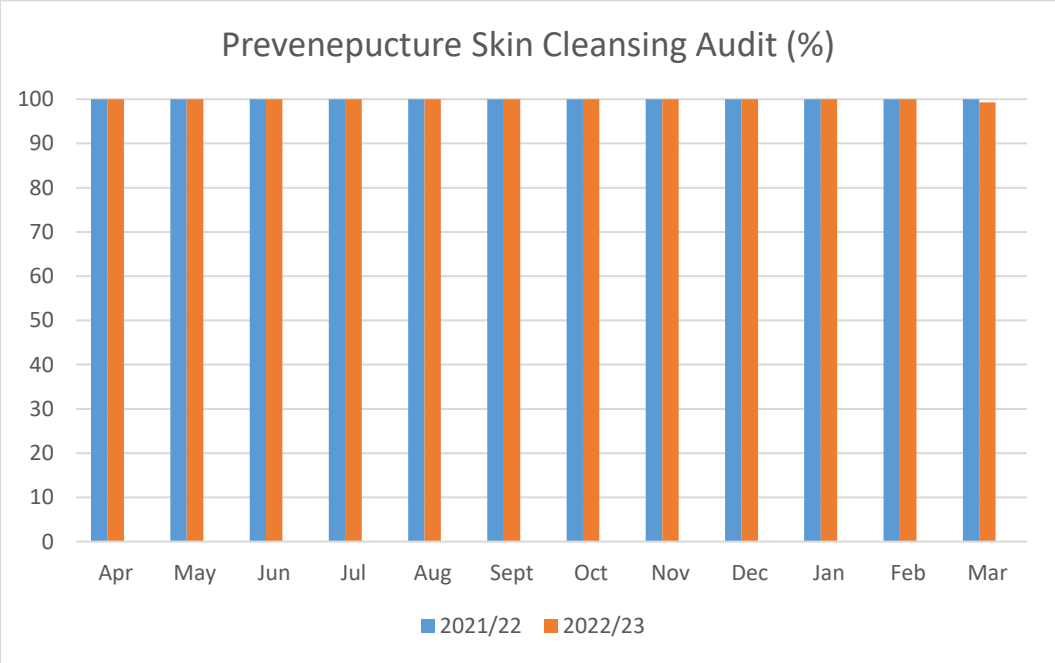
5.4.3 Infection prevention and control (IPC)

Effective hand hygiene and adequate skin cleansing practices are critical in ensuring the safety of donors and recipients. Therefore, WBS have implemented a robust monthly audit programme to ensure that required practices and standards are maintained. During 2021 - 2023 compliance within all donor facing services across Wales remained high.

Hand Hygiene

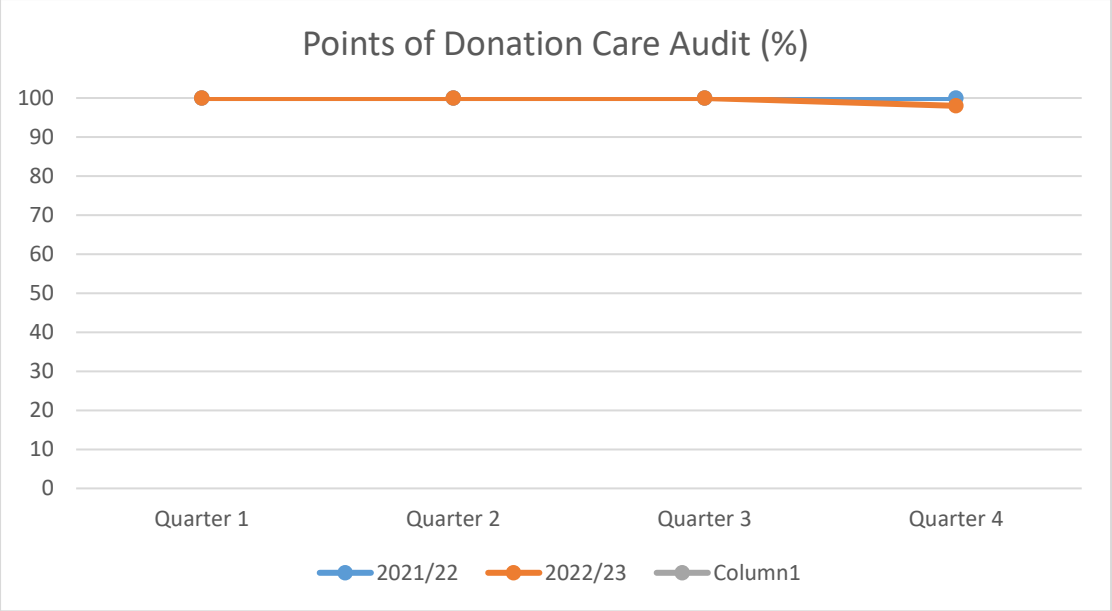


Pre-venepuncture skin cleansing



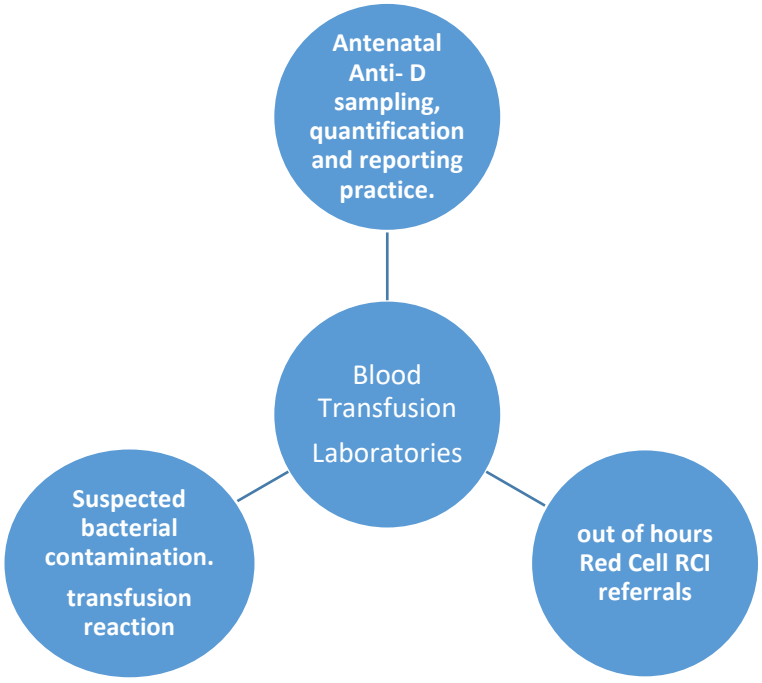
5.4.4 Blood Donor Points of Care Audit

To ensure that donors across Wales receive a safe, effective and equitable standard of care and experience the Welsh Blood Service undertakes a monthly evidence-based points of care audit to ensure that key aspects of donor care are delivered effectively, safely and consistency, throughout this reporting period compliance to the required standards across Wales have remained consistently high.



5.5 Clinical Audits in the WBS Blood Transfusion Laboratories

A range of Clinical Audits are undertaken across laboratories in WBS to ensure appropriate and safe processing and supply of blood and blood components and its prudent usage across NHS Wales. Such audits include:



5.5.1 Audit of antenatal anti-D sampling, quantification & reporting practice, 2021

Antenatal anti-D testing is part of a series of interventions to prevent or minimise the impact of haemolytic disease of the foetus and new-born (HDFN). The WBS red cell immunohaematology (RCI) laboratory serves as a reference laboratory for antenatal anti–D testing for all health boards across Wales.

The audit assessed compliance with the British Society for Haematology (BSH) 2016 guidelines for blood grouping and red cell antibody testing in pregnancy. The Royal College of Pathologists audit template was used. 996 referred samples were audited.

Compliance with the recommendation that samples for measuring anti-D are taken prior to the administration of anti-D prophylaxis (to detect maternal antibodies rather than detect the administered donor derived anti-D present after administration), was poor across Health Boards in Wales at 25.5%. Significant information was not disclosed to the RCI laboratory on the referral form accompanying the samples.

The RCI laboratory was also not fully compliant with BSH guidance:

A project group was established to rectify these areas of non-compliance recommendations working closely with midwives, obstetricians and laboratory staff across Wales.

- The audit findings were presented to obstetricians and midwives at a foetal medicine conference to increase the awareness of the foetal medicine teams on anti D testing
- The foetal medicine guidelines were updated taking into account the findings of the audit with direct input from the WBS
- A letter was sent to consultant haematologists, and transfusion laboratory managers informing changes in practice
- A letter was sent to all Obstetric consultants and trainees in Wales alerting them to the updated guidance published on the WISDOM (Welsh Information for Dissemination of Obstetrics & Gynaecology Materials) website.
- These messages were disseminated to midwives in Wales via the antenatal coordinators.
- Midwifery training was updated through close collaboration and this collaboration has enabled the development of additional training via this route ready for the implementation of non-invasive testing for foetal D type which the Welsh Blood Service anticipates implementing in 2024.
- The antenatal testing request form was reviewed and updated
- The method of reporting of anti-D results in the WBS reference laboratory was updated incorporating a flow chart for clarity. RCI reports are now fully compliant with BSH standards.

5.5.2 An audit of out of hours Red Cell Immunohaematology (RCI) referrals

A gap between the number of biomedical scientists training in the UK and the number of retirements / leavers / vacancies has been recorded for many years with publications also detailing a reduction in numbers of substantively employed staff with experience in blood transfusion. This would be anticipated to increase the number of samples referred to reference laboratories such as the WBS RCI laboratory who are also affected by the same issue in terms of numbers of experienced biomedical scientist staff.
100 samples referred to the WBS RCI laboratory out of hours were assessed for their appropriateness in terms of need for transfusion. The timing of the referrals and subsequent transfusion of the blood components provided was assessed as it is safer to undertake complex work during standard laboratory hours when there is a full complement of experienced staff.

- 88% (88/100) of the referrals resulted in the blood being transfused
- 33% of transfused units where the timing of transfusion was available were transfused > 3 hours of the on-call period ending suggesting that the work could have been performed during standard laboratory hours

- 42/100 (42%) of patients referred had been referred on more than one occasion OOH, with the maximum number a single patient had been referred during the audit timeline being nine times. This suggested that many out of hours referrals could be planned better enabling testing in hours.

The audit was presented to the transfusion laboratory managers across Wales and the following actions were taken

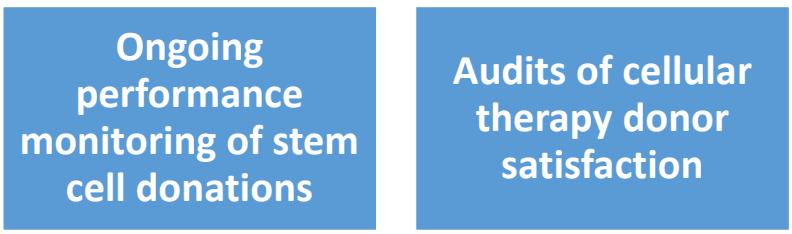
- The RCI referral forms (RS036/RS206) were updated to better capture the appropriateness of transfusion e.g. the patients' Hb, diagnosis and reason for transfusion
- In multidisciplinary collaboration with hospital staff, guidance on the following has been developed:
    - when it is appropriate for referrals to be made to RCI OOH
    - when medical consultants both within the hospital and Welsh Blood Service should be contacted by their respective laboratories
    - Transport for urgent samples and measures to reduce delays
    - A procedure to inform WBS consultants of patients who are repeatedly crossmatched OOH so that preventative plans can be put in place
- The recommendations were implemented in the form of Plan, Do, Study, Act (PDSA) cycles where the impact of the changes can be measured and reaudited

5.5.3 A reaudit of investigations for suspected bacterial contamination transfusion reactions at the Welsh Blood Service 2021

The success of the actions taken following a previous audit in 2019 was assessed by this reaudit of the quality of the information received with the referral, and the quality and timeliness of the report provided following the investigation by the WBS. British Society for Haematology guidance was used as the source of standards. The Royal College of Pathologists audit template was used.

The reaudit demonstrated improvements in most standards but further improvement could be seen in the detail provided with referrals by hospital staff and while the quality and consistency of the WBS reports was good the turnaround time had not improved.
The audit findings were fed back to hospital and WBS staff and steps have been taken to further improve in the identified areas. A further reaudit of these areas will be undertaken to confirm ongoing improvement.

5.6. Audits of support provided by the Trust to transplant recipients and donors.



5.6.1 Ongoing performance monitoring of stem cell donations

Continuous clinical audits are performed of stem cell collection efficiency, CD34+ cell count in stem dell donations and engraftment data is obtained from recipient centres. Donors are followed up to identify any pre and post donation issues. These are monitored against

international standards and the data is reviewed in our own internal clinical governance / Quality and Safety structure and by the regulators. Performance was satisfactory throughout this period despite challenges in provision as a result of the pandemic.

5.6.2 Audits of cellular therapy donor satisfaction

WBMDR nursing staff undertook audits to assess the satisfaction of donors with the information and counselling they received prior to donation and with the donation process itself.

The responders all scored 5 / 5 that they were completely satisfied with their care. Positive comments were received about the quantity and quality of the information they were provided in relation to the donation process. All stated that they would recommend donating to others.

5.6.3 Audits of aseptic non touch technique, donning and doffing, hand hygiene and personal protective equipment use by cellular therapy nursing staff undertaking collections in the Velindre Cancer Centre

100% compliance was demonstrated for cellular therapy collection in the Velindre Cancer Centre for all the infection prevention and control measures.

APPENDIX 1
Velindre Cancer Centre
Clinical Audit Project Progress

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Medical Directorate								
National Audits								
6.2	National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	NABCOP 2022 Annual Report NABCOP-2021-Annual-Report			Ongoing (Annual)
3.1	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	Summary of Results for Patients Diagnosed in Wales 2021 NLCA State of the Nation Report 2023 NLCA Annual Report 2022	Areas of good practice Areas for improvement		Ongoing (Annual)
3.1	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	NPCA Annual Report 2022 NPCA Annual Report 2021			Ongoing (Annual)
3.1	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	NOGCA 2022 Annual Report NOGCA_2021-Annual-Report		SACT and RT data not available for patients treated in Wales	Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	NBOCA Annual Report 2022 NBOCA Annual Report 2021		SACT and RT data not available for patients treated in Wales	Ongoing (Annual)
3.1	UK National Audit of Care at the End of Life (NACEL) Audit	NHS Benchmarking project	SPCT	National Audit	NACEL Third round report 2021/22 NACEL Second round Report	N/A	We are participating in the next UK wide scheduled audit and evaluation and Mark Taubert is leading on this	Ongoing
	RCR Curative & N/A RT for Lung	To provide confirmation that there has been progress and allow a re-assessment of where further pieces of work need to be directed	Clinical Audit Dept. Mick Button	National Audit	Data Collection	N/A	N/A	Ongoing
Continuous Monitoring – Quality and Safety and Must Do's								
3.5 4.2	Consent Audit (Including Audit of all Wales consent form 4 (best interests)	To identify if consent form 4 was used appropriately and ascertain completeness	Clinical Audit Dept.	Clinical risk	The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. The audit enforced the need to look at the current process for how consent forms are stored. A number of patients had no consent form in their paper or electronic notes and therefore no evidence of written consent. There were a number of consent forms used within Velindre, the use of the All Wales form, which is also bilingual was very low. Clarity on which forms should be used is needed	Area for improvement	Need to identify current practice with regards to how consent forms are processed to ensure their inclusion into the electronic medical record and identify the gaps. Clarify which consent forms should be used Provide education/training around the use and completion of the consent forms.. Future aspirations to implement electronic consent. Annual audit Designated clinical lead for consent	Complete Annual

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 3.5	Death within 30 days SACT	Review patients who die within 30 days of SACT	Clinical Audit Dept. SST's	Patient safety	Ongoing monthly/quarterly data collection	Areas for improvement	MM pilot underway in the colorectal team to review all deaths within 30 days of SACT and 30 days of palliative RT, 90 days of radical RT.	Ongoing (Monthly)
3.1	Mortality reviews	Review inpatients who die at Velindre.	SCIF Clinical Audit Dept.	Patient safety	Ongoing monthly review	N/A	N/A	Ongoing (Weekly)
3.1 3.2 4.1 6.2	Palliative Care Outcome Scale (POS –S) audit	Evaluation of the use the POS-S system compared to the National guidelines	Mark Taubert	National	Recommendation from last year's evaluation was to continue Hard-POS_S evaluation but may be worth doing every 2 years rather than each year	N/A	N/A	Ongoing (every 2 years)
Breast Malignancies SST								
3.1	Breast cancer radiotherapy and secondary cancer		Consultant Medical Student SSC	Key indicator of practice SSC Project	No SSC uptake and no resource within the team	N/A	N/A	Discontinue
3.1	The impact of the COVID pandemic on our breast cancer patients	To review new patient referrals made to the hospital over a 3 month period prior to the pandemic compared with the stage at which patients are referred following the pandemic There is a concern that patients have been at a more advanced stage of the cancer and are less fit now and are therefore able to have less treatment since the pandemic	Consultant Medical Student SSC	Key Indicators of Practice SSC Project	A higher proportion of advanced breast cancers were seen amongst the post-COVID cohort. The immense pressure the NHS faced during the pandemic meant that breast screening, imaging and management was delayed, Long term outcomes from these delays are yet to be determined, However, from this audit we can conclude that this may have had a significant impact on the stage and thus prognosis of breast cancer patients	Area for improvement	In the event of another surge in COVID-19 cases, prioritisation of screening programmes and maintaining accessibility to imaging and management warrants consideration as an option for mitigating delayed cancer diagnoses and hence prognosis improvement. Wider capacity for provision of services in order to tackle the	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							backlog should also be considered.	
3.1	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SpR	NICE Guidelines/ National project	Data Collection stage	N/A	N/A	Active Proposed completion date April 2023
3.1	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	National project to assess the long-term use of trastuzumab	Consultant SpR	National audit	Data submitted, awaiting National report	N/A	N/A	Complete
3.1	Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neoadjuvant chemotherapy given with pegfilgrastim	This audit completes the audit cycle a previous audit was performed looking at neoadjuvant chemotherapy and neutropenic septic rates and admissions/dose delay and dose reductions	SpR Consultant	Key Indicators of Practice	Project lead left the organisation and there is no resource to complete the project.	N/A	N/A	Discontinue
3.1	Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)	The aim of the project is to update and build upon the existing SABR database so that we can evaluate our treatment and compare to benchmark.	Consultant Medical Student SSC	Key Indicators of Practice SSC	The findings of this audit support conclusions of the CtE evaluation report alongside other larger studies on SABR in OM patients. SABR is an effective treatment for OM patients with improved prognosis compared to standard	Area of good practice	Continue to populate database and collate PROMS and toxicity data	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					therapies. Velindre survival outcome and local control data is reassuring in line with data published through Commissioning Through Evaluation in England.			
	First line Capecitabine and Phesgo in MBC	To compare the outcome of capecitabine/phesgo first line in MBC with trial results PHEREXA.	SpR	NICE Guidance/ Clinical Risk	Awaiting report - waiting for the median follow up duration. Aim to submit it for UKBCG which would be open in November	N/A	N/A	Complete
	National Service Evaluation project, evaluating the "Safety and Efficacy of Atezolizumab in combination with *nab*-Paclitaxel	Participation in National Service evaluation to review safety and efficacy of atezolizumab with nab-paclitaxel in advanced triple negative breast cancer	Consultant SpR	NICE Guidance	Missed national deadline for submission	N/A	N/A	Discontinued
6.2	Tolerability of Ibrance (Palbociclib) in combination with an aromatase inhibitor in women 75 years ER+ve/ HER2-ve) metastatic breast cancer.	Real world toxicity and efficacy data is required, in an older UK population, to ensure that Ibrance (in combination with an AI) for first line treatment of metastatic oestrogen positive breast cancer is comparable to published trial data	Consultant	National project	Fourteen cancer centres from across the UK participated in this study with data collection completed in February 2021. 276 patients met the eligibility criteria. The median age of patients was 78 (range 75>92) years. Palbociclib is an effective therapy in the real-world older population and is well-tolerated with low levels of clinically significant toxicities.	Area of good practice Areas for improvement	The use of geriatric and frailty assessments can help guide decision making in these patients.	Complete
3.1	The response rate of Systemic Treatment in HER2 positive Brain Metastases	To review the chemotherapy given and the response rate within the brain in HER2 positive metastatic breast cancer patients.	Consultant SSC Project	Key indicator of practice Benchmarking	HER2 targeted therapy does have an effect on intracranial metastases. Therefore, there must be some changes to the BBB	Area of good practice	For future studies, a lot more patient data needs to be collected in order to get more reliable results which can be applied to	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	in secondary Breast Cancer				meaning that these drugs can pass.		clinical practice. More lab research identifying how the drugs reach the BM may be useful in understanding their mechanism of action which could be applied to new future therapies.	
	Evaluation of the BAPS app	Our aim was to standardise information given to patients post breast surgery in a more interactive fashion, empowering patients with an understanding of why the exercises are important, motivating them to achieve their goals in their own home and optimising the patient care pathway from surgery to radiotherapy. The BAPS app was launched in February	Physiotherapist CAD	Users/ Patient views Innovation	In October 2021 - 50 Questionnaires were distributed to patients who were undergoing RT with a 54% response rate. Only 41% of responses were aware of the baps app. 64% of these were told about it by their breast care nurse. 30% of these patients actually used the baps app post surgery	Areas for improvement	Need greater advertising of the baps app to widen use. Need to revise the inspirational hold element of the app.	Complete
	CDK4-6 inhibitors during the COVID-19 pandemic – administration, safety & outcomes. Real world data from the UK.	To explore the safety of CDK4-6 inhibitor therapy for advanced breast cancer patients during the COVID-19 pandemic	Consultant	National project	This project will be discontinued. National data has been published and therefore too late for data submission.	N/A	N/A	Discontinued
3.5	Re-audit ER/HER2 misreporting	To re-audit the documentation and accuracy of ER/HER2 status	Clinical Audit Dept.	Incident	In total the records of 1145 were reviewed, and no error in treatment were identified. There has been a significant improvement in the availability of source data within WCP, principally the histopathology results for patients diagnosed through the screening service at	Areas of good practice Areas for improvement	Reminder to whole MDT that treatment plans should not be made without sight of the source pathology results. Post pandemic, increasing numbers of patients are being diagnosed with breast cancer in the	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					Breast Test Wales. Limitations of the CMDS function in Canisc means that ER/HER2 are not recorded as a set field making interrogation of data difficult,		Private sector, then subsequently treated in the NHS. These results are not available in any accessible portal and this is a potential risk. Currently results must be scanned into Canisc, Regular audit to monitor documentation	
Gynaecological Malignancies SST								
3.1	Outcomes from image guided brachytherapy	To review outcomes of patients receiving Brachytherapy.	Consultant Medical Student SSC	Key indicator of practice	3D conformal radiotherapy ± chemotherapy plus image (MRI) guided adaptive intracavitary brachytherapy including needle insertion in advanced disease results in local control rates of 95–100% at 3 years in limited/favourable (IB/IIB) and 85–90% in large/poor response (IIB/III/IV) cervix cancer patients associated with a moderate rate of treatment related morbidity. Compared to the historical Vienna series there is relative reduction in pelvic recurrence by 65–70% and reduction in major morbidity. The local control improvement seems to have impact on CSS and OS.	Area of good practice	N/A	Complete
3.1	Royal College of Radiologists (RCR) National audit of Vulva Cancer follow-up	To provide follow up information with regards to patients outcomes and toxicity	CAD Consultant	National Audit	34 UK radiotherapy centres (63%) completed data entry with 152 patients. 23 out of 34 (68%) centres submitted follow-up data, with 94 patients. The targets of radical radiotherapy reached 96% for the elective volumes and boost	N/A	After publishing the audit results and national vulvar cancer contouring guidelines, we will repeat the cycle.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					doses by 59%, and 54% for radical radiotherapy with concurrent cisplatin. Adjuvant radiotherapy with the RCR fractionation was 96% for the elective volume and 39% for the target volume. Other targets achieved were 26% for gap compensation, 84% for IMRT, 77% for category 1			
6.3	Late Effects of Radiotherapy Gynae-oncology Clinic – Patient Experience	To evaluate patient's experience of the Gynae Late Effects Clinic.	Consultant	Users views	Data collection stage Analyse current data	N/A	N/A	Active
	Service evaluation of image guided brachytherapy	Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction	Consultant Medical Student SSC	Key Indicators of Practice	Overall, from all of the data, we can see that the IGBT cohort had much better local control and a reduced proportion of the cohort developing toxicity from the Brachytherapy compared to the standard planning cohort.	Area of good practice	Continue following up patients and re-do yearly/ 2 yearly. Additionally, data from previous years (2014 and before) could be used to increase the data from the standard planning control) cohort.	Complete
3.1	Review of first line bevacizumab in advanced ovarian cancer in South East Wales	To review the number of patients that have received bevacizimab front line for ovarian cancer and to review the outcomes and toxicities	Consultant Pharmacy	Clinical Effectiveness	Data collection stage .	N/A	N/A	Active Proposed completion date March 2023
3.1	Bevacizumab Induced Hypertension in	Bevacizumab can induce HTN, the aim of this project is to look at the incidence of bevacizumab induced HTN,	SpR	NICE Guidance/ VCC Guidelines	Data collection stage	N/A	N/A	Active Proposed completion

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Gynaecological cancers	its management in comparison to NICE guidelines and the follow up.						date June 2023
	PARP inhibitors	Outcome parp appropriateness of treatment and outcome	SpR		Unable to start this audit due to other commitments, thus discontinued.			Discontinued
	Gynae oncology 1st line Niraparib against NICE guidelines'	This audit seeks to evaluate the compliance with current NICE guidelines, of which the set standards are based on, and to ascertain why treatment with Niraparib might be stopped. By evaluating this we can ensure safe prescribing and monitoring of Niraparib with the hope of reducing toxicities and increasing treatment duration, ultimately improving patient	SpR		There were 18 participants in total. The small sample size means that the data is not as significant as it would have been with a larger sample. Further analysis, into whether toxicities become more manageable with a longer treatment duration would be helpful. Increasing age and performance status may result in worse patient outcomes, although due to the small data set this is not reliable. The set standard was met for cancer type, treatment window, monotherapy, FBC monitoring. Better documentation of performance status and blood pressure monitoring is necessary to meet the NICE guidance and standards. The set standard for dosing was not met. Where patients are started on different doses it would be useful to document the reason for this clearly.	Areas of good practice Areas for improvement	Audit findings to be presented at the Gynaecology team at Velindre cancer centre. Discuss whether a current proforma for Niraparib prescribing and monitoring exists, and if not consider creating a proforma	Complete
Head & Neck SST								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Head and Neck malignancies. There are several aspects to audit our experience and compare to trial data in both Urology and Head and Neck cancer	To evaluate the role of radiomics in predicting outcomes such as progression-free survival and measures of interim tumour response following two weeks of chemoradiotherapy	Consultant Medical Student SSC	SSC	199 radiomics features were analysed. Null features were excluded and two features remained of which neither proved to be a reliable indicator for predicting tumour response to initial chemoradiotherapy. One of the most significant limitations this project suffered from was a very small sample size of only 10 patients. Some weak correlation has been observed, and though my initial analysis has not demonstrated any features that are at present reliable, these features may later prove to be significant.		The PEARL trial is still actively recruiting patients, and, with a more representative dataset, it is possible that more robust features will be identified that can be used to guide not only radiotherapy replanning but even predict progression-free survival.	Complete
3.1	Nivolumab	To look at the local data outcomes related to second line Nivolumab in Head and Neck Cancer from NICE approval of the treatment.	Consultant	Key indicator of practice	Survival analysis was performed from date of referral to date of event i.e. either the date of death or the censored date, which was 15/08/2019. There were 23 patients involved in this piece of analysis, 7 (30.4%) of whom had not yet reached the event of interest (death).	Project showed safe care and appropriate practice	A larger sample size would lead to more reliable results.	Complete
6.3	Nasogastric (NG) tubes patient experience	To look at thoughts and feelings after an NG tube	Consultant	User views	Dietitians & Speech therapists that were doing this audit did not have time or resources to complete it.	N/A	N/A	Discontinued
3.1	30 day mortality post head and neck radiotherapy treatment.	To look more closely at the patients with less than 30 days mortality following treatment. The aim of the audit is to identify if there were indications retrospectively by looking back at bloods results and	Consultant CNS	Key indicator of practice	Data should good practice in line with other centres	Areas of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		interventions to help us improve future care and early interventions						
3.1	The impact on swallowing outcome of changing radiotherapy technique for the treatment of T1 and T2 glottis cancers.	To assess the impact of changing radiotherapy technique.	SpR	Clinical Effectiveness	Complete awaiting report	N/A	N/A	Complete
	To assess the use of Pembrolizumab in the metastatic /non resectable HNSCC at Velindre Cancer Centre	To assess the use of 1st line Pembrolizumab in metastatic/unresectable recurrent HNSCC population at Velindre Cancer Centre	SpR	NICE Guidance	The introduction of single agent Pembrolizumab took place during the background of the Covid-19 pandemic. Initially, immunotherapy was utilised as a short-term goal to avoid myelosuppression, but as experience with the drug grows, it is increasingly seen and utilised as an option for patients whom are relatively asymptomatic or have non-bulky disease.	Areas for improvement	Results to be fed back to the Head and Neck department and explore the teams experience with the drug to date including reasons for low CPS scoring requests. As a department we can aim to device a system to ensure appropriate testing and utilisation is implemented. The aim would be to re-audit approximately 1 year after implantation	Complete
	Determining the outcome of metastatic carcinoma of cervical lymph nodes from an unknown primary cancer: South East Wales 2007-2016		SpR Consultant		Data Collection	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A retrospective review of Head and Neck neuroendocrine carcinomas treated in Velindre cancer center over the past 10 years	We aim to look at the management and the outcomes of the neuroendocrine head and neck cancers that were treated in VCC over the past 10 years. These are a rare type of head and neck cancers that were not included in many studies before	Specialty Doctor Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	Data Collection stage	N/A	N/A	Active Proposed completion date June 2023
	Retrospective review of the recurrent, progressive, or metastatic head and neck cancers (with positive PDL, CPS >1) treated by first line of systemic treatment (Pembrolizumab/ chemotherapy) in VCC over the past 5 years	We aim to look at the management of and compare the outcomes of the recurrent, progressive, or metastatic head and neck cancers(with positivePDL, CPS >1) treated by PEMBROLIZUMAB or chemotherapy as first line of systemic treatment in VCC over the past 5 year**s**. Pembrolizumab was approved by FDA for the use in this entity of patients in 2016. We need to compare our outcome in VCC to the international data	Speciality Doctor Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	Data Collection stage	N/A	N/A	Active Proposed completion date June 2023
	Total treatment time and time from surgery to RT in Post-Operative Radiotherapy in Head and Neck Cancer	Aiming for Adjuvant treatment (Post-Operative Radiotherapy for SCC of Head and Neck patients to start within 6 weeks in 95%, within 5 weeks in 75% of patients.	SpR		There were 50 Head and Neck patients treated, five out of them were SCC of skin, so they were excluded. Results of our Service, Treatment within 6 weeks, Target: 96%, VCC Compliance 54%. Treatment within 5 weeks, Target 75%, VCC Compliance 20%.	Area for improvement	Lack of staff in Pathology department has been recognised, this audit data can be used to create a business case to hire more Pathologist. Discussion among Oncology consultants if,	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					Review and Compare LRC and mortality between above three groups and see if it has made a difference.		a rota can be made to expedite start of RT. 46 Patients in 1 years = 4 patients in 1 month, i.e. 1 patient / week on Average.	
3.1	Evaluating the accuracy of diagnostic imaging of extranodal extension of metastatic squamous cell carcinoma in cervical lymph nodes	To assess the accuracy and concordance between pre-treatment radiological reports and post-operative pathology reports for the detection of ENE of metastatic cervical lymph nodes in patients with HNSCC.	Medical Student (SSC) Consultant	Clinical Effectiveness	The study showed USS, CT, MRI to have a low sensitivity and accuracy at detecting ENE among HNSCC patients, likely a result of the difficulty of detecting small volume ENE, and highlighted disparity in the concordance between clinical and pathologic N staging in this cohort. Audit highlights our results in detecting ENE are similar to some published studies	Area of good practice	Highlights the need to take into account sensitivity of radiological detection of ENE when making treatment decisions.	Complete
3.1	A service evaluation of the changes in the delivery of non-surgical cancer treatment for head and neck cancer patients in South-East Wales as a result of the COVID-19 pandemic	To look at the changes that were observed in the non-surgical treatment of head and neck cancers during the COVID-19 pandemic. The SSC project is important as it will help identify the impact of the COVID-19 pandemic on the delivery of clinical care which will have implications for the future treatment of patients with head and neck cancers.	Consultant Medical student	Key indicator of practice	The findings of this study demonstrate that the COVID-19 pandemic caused changes in the delivery of non-surgical cancer treatment for head and neck cancer patients at Velindre Cancer Care Centre. The most common change being the use of pembrolizumab as first line therapy.	Areas of good practice	Future work to assess the potential patient outcomes that occurred because of the changes implemented due to COVID-19. Also, the findings could be used to identify which of the changes implemented, should be adapted as standard care for head and neck cancer patients post the COVID-19 pandemic.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Head and neck Oncology team, focusing on surgical management strategies and the involvement of the maxillofacial teams.	To assess surgical management and treatment strategies	Medical student SSC Consultant	Clinical Effectiveness	This retrospective study shows in our population the overall survival and disease free survival was improved in patients with early stage oral cavity cancer who had a neck dissection compared to those who had observation of the neck. Of the patients who required radiotherapy for oral cavity cancer, 17% had documented osteoradionecrosis. Further studies will look at the grade and impact of this adverse outcome in our population. The documented rate of ORN is high, and needs to be considered when deciding on the benefits and risk of adjuvant treatment	Area of good practice	To look in more detail at the grade and impact of ORN, and if significant to develop further strategies to minimise this adverse event.	Complete
3.1	Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	Aim is to review which method of enteral feeding; reactive NGT vs prophylactic GT provides the best outcomes for these patients by comparing practice during pre COVID 19.	Consultant	Clinical Effectiveness	With the rest of the Patient Support Unit team, It was a large project and ultimately we didn't have the capacity or staffing to devote the time that was required to complete it.	N/A	N/A	Discontinued
Lung Malignancies SST								
3.1	Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SpR	Key indicator of practice	Data Analysis Stage	N/A	N/A	December 2023
3.1	Retrospective Data Collection for	To update data to date, looking at outcomes and	Consultant	Key indicator	Data collection stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	other factors such as genetics and PETS	Medical student	Clinical Effectiveness Innovation				Proposed completion April 2023
3.1	Radical approach in selected patients Stage IV disease	Audit looking at outcomes for patients with limited stage IV disease in whom we've adopted a radical approach, incorporating neurosurgery or adrenal excision, brain SRS or SBRT during their treatment course.	Speciality Doctor Consultant	Key indicator of practice	Project set up stage	N/A	N/A	Active Proposed completion date November 2023
3.1	Real-world experience of carboplatin/etoposide/atezolizumab for SCLC	UK wide retrospective study to review outcomes for a new treatment in SCLC (carboplatin/etoposide/atezolizumab) providing real world experience of how well this treatment works and any side effects that are encountered.	Consultant	Key Indicators of Practice Clinical Effectiveness NICE Guidance	A total of 192 patients were included. Baseline clinical characteristics are summarized in the table. One hundred forty seven (77,8%) patients received four cycles of A-CE; median number of doses of atezolizumab was 7 (range 1-20). Fifty-two (27%) patients also received prophylactic cranial irradiation and sixty-one (31,7%) consolidation thoracic radiotherapy. Seventy-six (39,6%) patients received at least one subsequent treatment. At a median follow-up of 15 months, median progression-free survival (PFS) and overall survival (OS) were 5,31 and 8,85 months, respectively. Overall response rate was 69,7%.	Areas of good practice and areas for improvement	Data from our series show comparable PFS but inferior OS than those reported in the IMpower133 trial. Negative prognostic factors such as performance status ≥2 and presence of brain metastasis at diagnosis were more common in our cohort compared with IMpower133 and may have determined a shorter OS. Real-world data in this setting could help to optimize clinical	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					The OS rates at 12 months and 18 months were 38,25% and 20,36%, respectively. Treatment-related adverse events led to discontinuation of treatment in 32 patients (16,7%). Engagement with a national project which won the Best Poster Award at ESMO Congress 2022. The data has also contributed to this poster submission (see attached) which took place at ESMO immuno-Oncology conference Dec 2022 – international collaboration.  posteresmoIO2022.pptx		management of these patients	
	A retrospective audit comparing toxicity of three weekly versus six weekly pembrolizumab for NSCLC	To compare toxicity of the 2 schedules	Medical Student SSC Consultant	Local Concern	Given the relatively small sample size, limited toxicity events, and inadequate record detail, it is difficult to conclude whether six-weekly pembrolizumab has a similar toxicity profile to three-weekly. Though our findings are non-significant, possibility exists that six-weekly pembrolizumab is more toxic than three-weekly	N/A	Limitations mean further research is needed to draw firm conclusions. Repeating the audit on a larger scale is crucial. It would be important to further consider baseline characteristics as predictors of toxicity severity within this.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	To assess toxicities encountered by patients receiving this treatment including immune related adverse events. To assess outcomes of patients receiving pembrolizumab.	SpR	VCC Guidelines Clinical Risk Local Concern	Was delayed due to COVID and maternity leave. this will be discontinued as data collected previously is now outdated	N/A	N/A	Discontinued
3.1	All Wales NSCLC genetics pathway quality improvement project	To assess current turnaround times for genetic results for NSCLC, identify gaps and improvements to reduce pathway variability and improve equity of access/turnaround times	Consultant	National guidelines, Local concern, Clinical effectiveness	**Data was submitted from 7 MDTs for 53 patients with NGS testing between October 2020 and May 2021. 40 (75.5%) patients had both DNA and RNA NGS, the remainder had DNA NGS +/- FISH testing for ALK/ROS/NTRK gene rearrangements. Median TAT from biopsy to results for DNA and RNA NGS was 26 days and 25 days, respectively (figure 1); MDTs with reflex testing had shorter TAT. DNA NGS testing was successful in 51 (96.2%) patients; RNA NGS testing was unsuccessful in 10 (25%) patients however salvage FISH testing gave results in 7 cases. Testing identified clinically actionable variants in 17 (32%) patients.**	Areas for improvement  BTOG abstract_final.docx	**In order to improve time to definitive treatment and patient outcomes, the diagnostic pathway TAT need to be reduced. The Welsh Thoracic Oncology Group plans to review the NOP to optimise and standardise genomic testing. Specifically the AWMGS has established a working group to facilitate implementation of a 7 day target for NGS results from time of sample receipt; priorities include increasing the number of NGS runs per week, increasing staff capacity for sample processing, result reporting and authorisation, and optimising DNA/RNA**	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							extraction methods to reduce testing failure rates.	
	Atezolizumab	In July 2020 NICE approved atezolizumab in patients with advanced SCLC based on the IMpower133 study, creating a new standard of care (SoC) for patients of good performance status (PS) and advanced SCLC	SpR Consultant		Despite early adoption, <20% patients with SCLC accessed atezolizumab. Overall, atezolizumab was well tolerated. Range of fitness at baseline varied (25% PS 2 or worse). Use of CTRT/PCI was low. 32% had palliative thoracic RT for thoracic relapse. Survival and duration of treatment compared favourably with trial data	Areas of good practice	N/A	Complete
Urology SST								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Comparison of Time to Treatment Failure and Consistency of Response Duration of Sunitinib, Cabozantinib and Combination Immunotherapy with Ipilimumab and Nivolumab as First-Line Treatment .	We currently use immunotherapy to treat renal cancer. This study aims to determine the time elapsed until treatment failure for both tyrosine kinase inhibitors and combination immunotherapy with ipilimumab and nivolumab as first-line treatments.	Consultant Medical Student SSC	Key indicator of practice	Sunitinib provides a more reliable and longer time to treatment failure than combination immunotherapy with ipilimumab and nivolumab as first-line treatment. Cabozantinib was not able to be reliably studied due to the small sample size.	Are of good practice	Future research can be conducted focussing on the long-term outcomes of patients on ipilimumab and nivolumab for renal cell carcinomas; and also to gain further understanding of these agents themselves, hopefully providing explanations for some of the findings. There may also be scope for conducting this study but with a larger sample population so that the results obtained are more accurate and reliable, and less subject to extremes of data. The treatment response to individual doses of each drug can also be studied	Complete
3.1	Prospective data collection HDR PROMS and outcome (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	Data Collection Stage	N/A	N/A	Ongoing
3.1	SABR / SPACER programme data (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	Data Collection Stage	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Outcome of ADT and docetaxel for hormone-sensitive metastatic prostate cancer	To evaluate the outcomes of metastatic patients cancer patients who have received ADT and docetaxel.	Consultant	Key indicator of practice SSC	No longer required due to change in practice	N/A	N/A	Discontinued
3.1	Investigating lines of therapy and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Medical Student SSC Consultant	Key indicator of practice	As new treatments continue to be offered for mRCC its important the best treatments are offered at first and second line to improve survival outcomes for these patients	Areas of good practice Ares for future work	A larger study would allow better statistical analysis of survival times and comparison of specific treatment types.	Complete
	Multi centre audit of treatment and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Consultant CAD	Key indicator of practice	These results suggest that with more treatment options available, including combination/immunotherapy therapies, more patients are able to receive second- and third-line therapies. Nearly one third of patients only receive one line of treatment which highlights the need to deliver the most efficacious treatments first to optimise patient outcomes.	Areas of good practice Areas for future work	1.Increase number of UK centers involved in real world study. 2.Consideration how licensing of new combinations influences survival in each treatment line 3.Differential responses and outcomes depending on sites of metastatic disease. 4. Will be presented in San Francisco.	Complete
	Standard Radiotherapy prostate 60gy/20# PROMS and outcome		Consultant radiographer		Data Collection	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Treatment Patterns and Survival Outcomes in Patients With Metastatic Renal Cancer at Velindre Hospital	To identify the relationship between overall survival and increased number of lines of therapy in metastatic renal cancer patients receiving systemic treatment	Medical Student SSC Consultant	Key indicator of practice	More patients with metastatic renal cell carcinoma need to be offered more than 1 line of therapy. The current criteria used to dictate which treatment individual patients receive needs to be updated	Areas for improvement Areas for future work	More research needs to be conducted to better identify patients suitable of progressing to more than 1LOT. Furthermore, the IMDC risk criteria currently used to dictate which therapy patients receive is outdated, further research is needed to find alternative means of estimating prognosis of mRCC	Complete
	Ipi NiVo - A single centre real-world observational study of ipilimumab + nivolumab (I + N) in advanced intermediate and poor risk renal cell carcinoma (aRCC): 24-month interim results.	This study reports real-world outcomes in patients with aRCC receiving I + N at a tertiary cancer centre.	Consultant SpR		This analysis included patients with a minimum follow-up of 16 months. Median age at baseline was 64 years (range 45-80); 71% (n=34) of patients were male, IMDC risk status was, intermediate in 77% (n=37), and poor in 23% (n=11). Clear cell was the most common histological subtype (63% [n=30]). 31% (n=15) in patients who had undergone nephrectomy. The OS rate at 12 months was 65% with a median OS of 17.2 months. The overall PFS rate at 24 months was 23%, with a 12 month PFS rate of 33% and median PFS of 6.6 months. ORR was 65% (31) with 8% (4) having a complete response and 57% a partial response (n=27).	Area of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Bone health evaluation at Velindre Cancer Centre in September and October 2021		Lauren James Dr Andrew Kidd		All new adjuvant and metastatic patient referrals to VCC in September and October 2021 were reviewed. Our service evaluation findings demonstrate that most patients with locally advanced and metastatic prostate cancers who attended VCC in September and October 2021 did not have bone health assessment using FRAX®.	Patients with locally advanced and Metastatic prostate cancers receiving long term hormones need a bone health assessment carried out using FRAX	The results of this service evaluation will be summarised in poster format and disseminated to all relevant parties. A teaching intervention will be arranged and a further service evaluation cycle.	Complete
3.1	A retrospective evaluation of brachytherapy treating patients with prostate cancer	To look at patient disease outcome measures assessed during cancer therapy	Medical Student SSC Consultant	SSC	The findings of this project show LDR brachytherapy to have an effective disease-specific survival rate, an effective biochemical relapse-free survival rate and to be more successful in terms of biochemical relapse-free survival for low-risk patients compared to intermediate-risk patients.	Area of good practice	N/A	Complete
3.1	Changes in the delivery of treatment for patients with urological cancer during the COVID-19 initial 'peak	To monitor changes to treatment pathways and associated outcomes	Medical Student SSC Consultant	Key indicator Clinical Effectiveness	Many urological cancer patients had their systemic treatment changed directly due to the COVID-19 pandemic. Changes made were mostly to limit the patient's time spent in clinical environments. These changes were in-line with various different guidelines.	Areas of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Newly diagnosed hormone-sensitive metastatic prostate cancer and the impact of androgen-receptor targeted agents during the COVID 19 pandemic	To evaluate the presence and impact of toxicity of these new drugs on patients during the COVID period and how we have had to adjust drug dosages/ management plans accordingly.	Medical Student SSC Consultant	Key indicator of practice Clinical effectiveness SSC	Overall, all three drugs have shown good early response in reducing the PSA and preventing disease progression in real life group of patients. The side effects identified in this analysis is consistent with the clinical trials but, a greater percentage of patients experienced each side effect compared to the clinical trials	Areas of good practice Areas for further work	Treatment duration and sample size was also limited therefore further follow up analysis needs to be conducted to understand if response to these drugs is maintained by calculating overall survival	Complete
3.1	Stereotactic Ablative Radiotherapy (SABR) Metastatic prostate	To evaluate the outcomes of prostate cancer patients who have received SABR, in terms of time to biochemical progression/ time to initiation of ADT/SACT	Medical Student SSC Consultant	Key indicator of practice SSC	SABR is a promising management approach for oligometastatic PCa patients who wish to prolong their time to starting ADT showed excellent practice which is always reassuring especially as it is a relatively new technique. No areas identified as needing improving.	Are of good practice	Further investigation in this area is required	Complete
Palliative Care SST								
3.1	A review of advance care planning practices locally and in Wales	Review local and national policies incl www.wales.nhs.uk/afcp and write a paper for British medical journal supportive and palliative care	GP ST1 trainee in palliative care Consultant	National guidance QI Project	Advance and future care planning is an approach with many different facets. In Wales, we have found that some patients prefer a clearly set out, legally binding 'Advance Decision to Refuse Treatment' to guide their care, while others prefer a softer, guiding approach captured through an Advance Statement. All these formats are available to patients, carers and healthcare professionals, together with explanatory guidance notes, through a central Welsh website. Patients in Wales now have access to information resources and forms	Areas of good practice Area for improvement	Next steps involve getting a central electronic repository for these forms, which is accessible to healthcare providers and to patients.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					that can suit different needs. Patients who wish to fill in their own documents can do so via a centrally hosted site, which has guidance notes and documents. The approach in Wales offers several policies, information resources and forms, all catering for different needs.			

3.1 3.5	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's rights and wishes are respected. To ensure that a DNACPR decision is clearly recorded and communicated between health professionals and patients. To ensure that the All Wales DNACPR policy's recommendations are adhered to. To make use of audit proforma as recommended by national policy.	Consultant SpR	National guidance	This audit showed good completion and recording on All Wales DNACPR forms, and that patients were part of a consultation. The introduction of the new version of the national form, plus a Grand Round education session for all clinical staff, with further small group tutorials and events, served as a mid-audit intervention. Second data collection showed free-text communication and documentation on forms, incl what had been discussed with patients and significant others, as well as documenting reasons on rarer occasions when conversations could not take place. For instance when a patient made it clear that they did not want to discuss matters surrounding end of life care, or when it was felt that bringing up with topic would cause significant harm. The forms should merely be a reflection of excellent communication about a topic that can be emotional for some, but it showed good adherence to the 'duty to consult'. Evidence of full and clear communication about what CPR is, how low success rates can be in certain individual situations, and that a DNACPR form does not mean that all other forms of care aren't available, was present in written communications. was often found in the medical notes	Area of good practice	Next steps are ensuring these forms remain with patients when they change care setting, and are clearly communicated to all individuals involved in their care across acute and community settings. This is likely to be achieved most effectively and safely via a central electronic repository for advance and future care plans, which is accessible by all relevant healthcare providers and NHS Wales IT systems, as well as patients and their carers. Re-audit 2 years	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 3.2	Symptom Control QI Project including POS-S	Evaluation of the use the POS-S within palliative care team	Consultant Medical Student SSC	Clinical effectiveness	9 out of 10 of the symptoms were improved during an inpatient stay at VCC. Poor appetite was the most improved symptom between day 0 and day 7 (percentage difference of -65.2%). Drowsiness was the only symptom that had an average increase in severity over the time-period (percentage difference of +56.8%). The palliative care team at Velindre are successful at managing common palliative symptoms. This is achieved through careful assessment and a patient-centred, multidisciplinary approach to management	N/A	This study would Benefit from annual evaluation. Also, an update to POS-S has been developed to look a bit more at psychological symptoms. This is the newer i-POS tool , and it is likely this will be integrated into the Velindre IT Canisc replacement system for palliative care over the coming year.	Complete
3.1	A review of dry mouth and its management	A QI project with Velindre library to produce a guideline paper, possibly for publication in a palliative care journal and/or European Association for Palliative Care	SpR	National guidelines, literature review	Audit has been discontinued as too busy with pandemic and related clinical pressures.	N/A	N/A	Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Naloxone use in Velindre- a survey	The BNF has recently changed its recommendation on the dose of Naloxone in Palliative care settings. We review current views on dosing amongst Velindre doctors and there will be a consensus review of the current Pain Guidelines and Naloxone guidance	Consultant SpR	BNF, National Guidelines, local policy (incl Pain policy)	Reg Datix of Naloxone events closely monitored	Area of good practice	Naloxone dose for pall pat changed in guidelines	Complete
3.1	Cancer Associated Thrombosis (CAT) MDT	This audit seeks to better understand the CAT MDT patient population and know how and where the CAT guidelines are applied.	Consultant	NICE Guidelines	Data collection The work is on-going although, hope to present at international conference	N/A	N/A	Active
	Is primary thromboprophylaxis of palliative care cancer in-patients compliant with NICE Clinical Guideline 89 A clinical audit	To audit the risk assessment and where appropriate, the initiation of thromboprophylaxis in inpatients with cancer who are under the care of the palliative care service.	Doctor	National Audit	1. Data analysis ongoing 2.The SPCU and acute hospital palliative care patient differ •Reason for admission •Disease trajectory •Performance status •Anti cancer therapies 3.They are similar for •Indications for anticoagulants and antiplatelets •Proportion taking anticoagulants and antiplatlets All palliative inpatients had a documented risk assessment and practice was in keeping with NICE VTE prophylaxis recommendations.		Await full data analysis from national audit to guide future recommendations.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	To review the clinical management plans for patients referred to the CAT clinic with diagnosis of superficial vein thrombosis and review whether we are adhering to NICE guidelines.	Consultant	NICE Guidelines	Discontinued no SSC attended to undertake and no other resource to take forward	N/A	N/A	Discontinue
Colorectal SST								
3.1	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	Consultant SpR Medical Student SSC	Key indicator of practice Clinical Effectiveness	Data collection stage	N/A	N/A	
3.1	Improving communication standards of clinic letters within the colorectal service in Velindre	A focussed audit of communication standards for patients within the colorectal team to establish what we already know, that in all likelihood the situation has not changed since 2018. Trial the communication framework using a 'rapid cycling' method to improve the relevance and the efficiency of information input	GP SpR	Royal College	Compared to the last audit in 2018 time taken to type clinic letters performed better in this site team from a mean 25 days to mean of 3 days. Overall there has been good improvement in the structure and documentation of essential information in clinic letters, and staff have found the new format easy to adapt to with the guidance notes provided	Areas of improvement identified	Key workers should be added to the guidance notes. Project objectives and guidance notes for dictation to be cascaded to SHOs and SpR's. Take the project to other teams within GI cancer, disseminate audit findings and implement the new template	Active Proposed completion date April 2023
3.1	Rectal Simultaneous Integrated Boost (SIB)	TBC	SpR Consultant	TBC	Project set up – Lead on Mat leave will undertake on return on hold	N/A	N/A	Proposed completion date December
3.1	Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with	SpR Consultant	NICE	Data Analysis stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		contact radiotherapy for rectal cancer						Proposed completion date July 2023
	A Service Evaluation of the Management of Immunotherapy Toxicity in Colorectal Cancer Patients in SE Wales	Assessing all patients with metastatic colorectal cancer treated with immunotherapy in Velindre Cancer Centre and identifying the diagnostic pathway for treatment toxicity and the management of these patients, including the use of high dose steroids.	Consultant Medical Student SSC	Clinical, Service Evaluation	Grade 1 irAEs were generally managed conservatively, in line with the current VCC guidelines. However, grade 2 irAEs were more varied in management and required judgement of the clinical situation. Guidelines were followed in the majority of cases with steroids and a temporary stop in immunotherapy implemented and permanent cessation of immunotherapy in the case of non-resolving symptoms. The grade of toxicity was generally poorly recorded with only 35% of irAEs reporting the grade at the time of diagnosis. The clinical reasoning behind management plans that differed from the guidelines was also not well documented.	N/A	Improvements could be made in documenting grading the irAEs and clinical reasoning where management differs to guidelines.	Complete
	The introduction of aspects of the Royal College of Radiologists (RCR) IMRT guidance for national rectal cancer for long course chemo radiotherapy patients	The pilot will enable us to assess introduction of the recommended changes on all staffing groups and support the permanent implementation of certain aspects of the IMRT guidance	Consultant	Service development	Data collection stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
UGI SST								
	THE DIFFERENCE IN TREATMENT OUTCOMES IN PATIENTS RECEIVING HIGH DOSE PALLIATIVE RADIOTHERAPY VS LOW DOSE RADIOTHERAPY IN ADVANCE OESOPHAGEAL CANCERS	To determine the palliative intent for patients receiving either high dose (HD) or low dose (LD) radiotherapy and determining whether there is a significant difference in the length of survival time, and patterns of disease progression. In addition, the study will assess the adverse toxicities that patients may be predisposed to on treatment.	Consultant Medical Student SSC	SSC	High dose palliative radiotherapy regimens were associated with greater overall survival outcome and progression free disease in comparison to low dose palliative radiotherapy regimes. However, there is a higher risk of radiation related acute toxicities and need for re-intervention, which need to be considered prior to initiating treatment. However, low dose radiotherapy has a role in the management of progressive symptoms, especially for oesophageal bleeds and rapid progression		Further research can be conducted to appreciate the impact of LD radiotherapy, for instance the change in requirement of blood transfusion pre- and post-radiotherapy intervention to manage bleeding and anaemia. Overall, a multi-disciplinary approach should be taken to conclude suitability of the treatment regimens, looking at the performance status of the patient, burden of disease, ability to tolerate radiation and severity of symptoms.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Treatment for advanced pancreatic cancer	To collect and evaluate clinical data of patients with advanced pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical Student SSC	Clinical effectiveness SSC	The results showed an improved overall survival and progression free survival in patients receiving FOLFIRINOX therapy. Improved overall survival (OS) of 3.7 months and increased progression free survival (PFS) of 5.7 months when compared to gemcitabine plus nab-paclitaxel. An improved PFS and OS with FOLFIRINOX was also noted in a previous study by Conroy et al. 2011.	N/A	N/A	Complete
3.1	TREATMENT OF OESOPHAGO-GASTRIC CANCER IN VELINDRE	To explore chemo-radiotherapy outcomes for oesophago-gastric cancers in Velindre and compare outcomes in South East Wales with other areas. The secondary aim is to look at data to explore factors contributing to poor outcomes.	Consultant Medical Student SSC	Clinical effectiveness Patient safety SSC	There is a degree of anatomical overlap between upper third and hypopharyngeal tumours, despite this overlap, they are treated very differently and the outcomes differ. • Survival – the upper third tumours, had a 32.2% higher probability of survival at 1 year. The hypopharyngeal cohort presented with a more advanced T stage, greater levels of lymph node involvement and more comorbidities. • Both groups had a similar recurrence rate; 38% hypopharyngeal compared to 29% for the upper oesophageal tumours. Other studies have identified recurrence rates of 57.1% in post cricoid and upper third tumours.	None	86% of recurrences occurred locally in the hypopharyngeal group. This suggests that current treatment for tumour of the hypopharynx poorly controls local disease, despite the aggressive treatment. • The recurrence of the upper third tumours, were distant metastases, which suggests that there are poor options for systemic treatment.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	CLINICAL OUTCOMES OF LOCALISED PANCREATIC CANCER POST-ONCOLOGICAL THERAPY	To collect and evaluate clinical data of patients with localised pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical Student SSC	Clinical effectiveness SSC	Median OS for the whole cohort was 9.3 months. Out of 103 patients with LAPC/BRPC, only 5 (4.8%) underwent surgical resection following downstaging with oncological therapy. Surgical resection conferred the greatest survival benefit with a median OS 22.8 months. This was followed by combination chemotherapy and CRT (median OS 13.8 months) and chemotherapy alone (median OS 7 months). There was no significant variation between chemotherapy regimes.		Larger scale, randomised control trials are required to provide stronger evidence in order to optimise outcomes in these patients.	Complete
	WHAT IS THE LOCAL PRACTICE OF IDENTIFYING AND MANAGING IMMUNOTHERAPY-RELATED TOXICITY COMPARED TO THE ACCEPTED GUIDELINES?	This Audit will review local practice of managing immunotherapy toxicity in GI and hepatopancreaticobiliary cancers in Velindre Cancer centre, in comparison to the Guidelines.	Consultant Medical Student SSC	VCC Guidelines	66.67% of patients had both pre-treatment bloods carried out and were given pre-treatment medications. 68.57% of toxicities were graded which does not meet the target of 100%. 74.29% of toxicities were managed according to the guidelines and therefore, met standard 3. The highest performing standard was standard 4, with 77.14% of patients having been followed up	Areas of improvement are to increase the grading of identified toxicities and to check that all patients have received pre-treatment medications.	All standards have been met in the majority of cases	Complete
3.1	Management of Oesophageal Squamous Cell Carcinoma within the UK and Ireland: A retrospective multi-centre analysis	Provide an insight into variation across the UK in the use of surgery and dCRT for the potentially curative treatment of OSCC. Review survival outcomes for CRT compared with neoadjuvant treatments plus surgery.	Consultant	National Project (NOTCH)	Data submitted Awaiting national report			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	DM, BMI, Chemo Regime , PS and comorbidities Influencing Clinical Outcome in patients with Metastatic Pancreatic Cancers	To evaluate & compare factors influencing Clinical Outcome in Pancreatic Cancer	SpR Consultant	Key Indicators of Practice/Clinical Effectiveness/Royal College	Audit discontinued as lead rotated to Swansea.	N/A	N/A	Discontinued
	An Audit of emergency presentations and referrals of patients with oesophagogastric cancer	To look at emergency presentations and referrals of oesophago-gastric cancer from Welsh health boards that were submitted to the National Oesophago-Gastric Cancer Audit (NOGCA) 2020, and verify whether they were true emergency presentations.	Medical Student SSC Consultant		The results suggest that the reason for why the emergency referral rate from Wales is high is not due to the way in which emergency referrals are recorded.	Areas for improvement	Work needs to be done to look into the reasons why the rate is higher in Wales than in other regions of the UK	Complete
	A Clinical Audit into the Outcomes of Radical and Palliative Patients Treated with Chemo-radio Therapy for Oesophageal Cancer	To identify the average overall survival and progression free survival of the patients presenting in South Wales with oesophageal adenocarcinoma that receive neoadjuvant treatment and radical surgery	Medical Student SSC Consultant	Key indicator of practice	This study finds that the use of neoadjuvant chemoradiotherapy in patients with oesophageal adenocarcinoma has a higher survival outcome. This study can be used to contribute to other large scale national trials that have published similar findings	Areas of good practice Areas for future work	Similar research could be carried out on a larger scale and confirm the stage of the tumour at diagnosis to consolidate these findings.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Evaluation of outcomes from Palliative patients treated with chemo-radiotherapy for oesophageal cancer	To ascertain overall and progression free survival. To identify any toxicities of treatment	Medical Student SSC	Key indicator of practice	The overall 5-year survival of patients treated for OSCCs at Velindre was 31.4%. Patients who received neoadjuvant treatment followed by surgery had the highest overall 5-year survival (53.8%). Early detection of the disease is imperative to increase overall survival. Neoadjuvant treatment followed by surgery had the highest individual overall 5 year-survival but must be interpreted with caution due to the limited sample size.	Areas of good practice Areas for improvement	Early diagnosis of the disease is crucial for improving overall survival, a regular screening programme has yet to be implemented. Multi-modal combination therapy has been mentioned as a future treatment option which would combine surgery, chemotherapy, radiotherapy, targeted therapy and immunotherapy.	Complete
3.1	An audit of variation in delays in the current diagnostic pathways in patients presenting with oesophageal cancer	We will look into 3 Health Boards across South-East Wales, and audit the waiting times and delays in oesophageal cancer referral treatment. We will compare this to the National Optimum Pathway, and we will then look into how this affects the prognosis of the patients.	Medical Student SSC Consultant	Key indicator of practice	The average waiting times across the cancer pathway in the 4 health boards were considerably higher than the target times stated in the National Optimum Pathway, and showed similar results to the National Audit. This project has revealed how different health boards in South Wales compare in waiting times during the cancer pathway, and emphasises the need to keep organisation throughout health boards.			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Identifying toxicities experienced during immunotherapy treatment for upper GI cancer and biomarkers measured before and during treatment	Autoimmune-like toxicities, known as immune-related adverse events (irAEs) occur in up to 50% of patients. These toxicities can be from skin lesion such as dermatitis to more life-threatening endocrinopathies. Blood tests before starting treatment and before each cycle are vital to reduce the incidences of irAEs. Our audit aims to identify whether these investigations were carried out.	Consultant Medical Student SSC	SSC	Our results showed that GI toxicities were the most common at 71%. High grade toxicities e.g grade 4 were found in kidneys (ie nephritis). The most common toxicities were nausea, fatigue and diarrhoea. Our results show that the required blood test pre-treatment and pre-cycle stipulated in the immunotherapy toxicity guidelines were not followed. Pre-cycle TFTs and cortisol levels were not measured at a target of 100% of the time. It is important that these tests are implemented into normal practice to reduce the risk of life-threatening toxicities.	Generally the Upper GI team have adopted the introduction of IO therapy rapidly. All consultants commented on the new burden of care in terms of new demand with regard to systemic therapies. Broadly the team are managing these patients very well and all of the team were keen to know how they could improve the care of these patients.	Our audit shows that nausea and vomiting are common toxicities experienced in patients on immunotherapies. Healthworkers should make patients aware of these symptoms. In addition, all biomarkers in the pre-treatment and pre-cycle blood test were not taken. Ensuring these are taken is vital in order to prevent life-threatening toxicities.	Complete
3.1	Clinical and histological response of oesophageal adenocarcinomas to neoadjuvant chemotherapy versus chemoradiotherapy: a baseline centre-based audit	The mainstay of treatment for oesophageal adenocarcinoma (OAC) is surgical resection, usually following neoadjuvant chemoradiotherapy (NACRT) or chemotherapy (NACT). This study aims to audit the clinical and histological response to these regimens in OAC patients from one specialist centre.	Medical Student SSC Consultant	SSC	The results of this audit indicate that NACRT may offer superior radiological and histological outcomes for OAC, compared to NACT. Reported rates of pCR and clinical CR are similar to those observed in large multicentre trials, suggesting that local neoadjuvant management of patients with OAC reflects current best practice.	Areas of good practice Areas for future work	Future work should aim to ascertain the clinical significance of these radiological and histological endpoints by correlation with patient outcomes	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	An audit of Patients undergoing radical and palliative treatment for squamous cell carcinoma of the Oesophagus at VCC	To evaluate survival in patients diagnosed with potentially curable squamous cell carcinoma of the oesophagus (OSCC) treated at Velindre Cancer Centre according to age at diagnosis, cancer stage and grade, and initial treatment received	Medical Student SSC Consultant		Overall survival outcomes are evidently very poor in patients diagnosed with OSCC despite treatment, with an average life expectancy of 3 years after initial diagnosis. However, some treatment is better than no treatment and dCRT is the most popular treatment modality	Areas of good practice Areas for improvement Areas of future work	One key point identified in this audit is the need for clear documentation of results, investigations and treatment in patient notes. We were unfortunately unable to analyse progression-free survival in this audit and more studies need to be carried out with regards to survival outcomes in oesophageal cancer patients	Complete
Neuro-oncology SST								
3.1	Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	To gain insight into the radiotherapy approaches currently being used across the UK, both in an adjuvant and disease recurrence setting. Data on systemic management and associated disease response will also be valuable for treating clinicians given the lack of evidence base in this area.	SpR	National Project	Awaiting national report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Interval GB-Imaging timing after surgery for glioblastoma - an evaluation of practice in Great Britain	A UK and Ireland multi-centre retrospective study of imaging practice after surgery for glioblastoma to identify adherence to NICE guidelines, and evaluate imaging strategies utilised. Primary objective to assess MRI surveillance practice after surgery for patients with glioblastoma, and delineate if adherence to NICE guidelines improves survival.	Consultant	National Project NICE guidelines	SW to contact RS	N/A	N/A	Active Proposed completion date August 2022
3.1	Reviewing and developing local guidelines for glycaemic control and bone protection in patients with brain tumours taking glucocorticoids.	To assess current practice and create local guidelines for the use of glucocorticoids, such as dexamethasone in the neuro oncology outpatient department (OPD) at Velindre Cancer Centre (VCC).	Consultant Medical Student SSC	SSC Project	Clinical notes and data from 99 patients was collected and analysed from the neuro oncology OPD clinics from June 2021 to February 2022. 10 patients developed steroid induced diabetes and 9 patients developed steroid induced osteoporosis. It was found that the current use of dexamethasone in the neuro oncology OPD at VCC is not in line with what the created guidelines suggest as best practice	Areas for improvement	The new guidelines should be trialled, and the audit tool should be used to conduct a future audit to assess whether the guidelines are being used correctly and if they are working to minimise steroid induced osteoporosis and diabetes. Maybe re-audit in early 2023 once the guidance has been introduced.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Consultant Medical Student SSC	Clinical effectiveness SSC Project	Data collection	N/A	N/A	May 2023
3.1	Audit of SRS	To review outcomes of patients receiving SRS within Velindre	SpR Consultant	Key indicator of practice	266 SRS treatments were delivered to 225 patients. [NSI(-C1] 224(84%) were first treatments and 37(14%) were second treatments. 51(23%) patients also had whole brain radiotherapy. Median age was 64(range 23-85), 124(55%) patients were male and 101(45%) female. The most common primary sites were lung (42%), melanoma (18%) and breast (16%). Most patients had PS 0 (26%) or 1 (41%). 48(21%) patients did not have PS documented. Abstract submitted to - BNOS conference	Areas of good practice identified	SRS and SRT are well tolerated and effective treatment options to improve intracranial disease control for patients with brain metastases.	Complete
Sarcoma SST								
5.1	Sarcoma Pathway	To assess the pathway.	CNS	Key indicator of practice	Data collection stage.	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Other Sites/Services								
3.1	Investigation & Management of iron deficiency anaemia in patients with gastrointestinal malignancy:	Use of blood transfusion, intravenous iron and oral iron	Ashley Poon-King	Key indicator of practice	Paused implementation of iron infusion policy due to COVID restrictions and pressures on day unit etc. data was never finished, would now be too old and not relevant so close audit down.	N/A	N/A	Discontinued
3.1	All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	Aim to identify key clinical lessons from this period to guide local QI projects and help awareness to improve patient care currently and in case of further surge in covid19 cases.	Consultant	Key indicator of practice Local concern Patient safety	Data collection stage	N/A	N/A	Active
5.1 3.1	Treatment Escalation Plan Quality Improvement Project Proposal	To ensure that more patients will have appropriate escalation plans put in place EARLY in their admission.	SpR	Multi centred	Awaiting report	N/A	N/A	Complete
3.1	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	To provide assurances around antimicrobial stewardship. These measures aim to provide re-assurances that prescribing practices are in line with best practice.	SpR	Key indicator of practice VCC Guidelines 1000 Lives	Data collection stage	N/A	N/A	Active Proposed completion date June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Immuno toxicities Clinic – Patient Experience of virtual clinic during the COVID-19 Pandemic	Understanding of patient experience of a virtual (telephone) toxicity clinic during COVID-19 pandemic, to assist with future development and learning of a virtual service.	Inpatients	Users/ Patient views	On hold lead is leaving VCC may not have the resource to undertake	N/A	N/A	On hold
	DPYD Health Technology Assessment Service Evaluation	To conduct a health technology assessment (cost utility analysis) of the *DPYD* genotyping service in Wales.	Richard Adams Angharad Rudkin	National	Awaiting Report	N/A	N/A	Complete
	An External Validation Study of the Oswestry Spinal Risk Index (OSRI)	To carry out a third and more up to date external validation of the OSRI	Medical Student SSC Consultant		From our experience, the OSRI is an easy-to-use prognostication system, with only two components (PTP and GC), compared to previous scoring systems which have had three or more. Despite its simplicity, our study shows it to be transferable to patients outside the original data population; we therefore conclude it to be a valid scoring system and recommend its use.	N/A	Recommend the use of the OSRI	Complete
	Immune checkpoint inhibitor induced liver injury: a multi-centre experience	We aim to determine epidemiology of immune checkpoint inhibitor induced liver injury (CPILI), immune-related adverse events (IRAE) and to study management options and outcomes across different UK centres	SpR Consultant	Multi centred project	Data collection	N/A	N/A	Active Proposed completion 26 May 2023

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	How effectively are we diagnosing major endocrinopathies secondary to immune check point inhibitor therapy?	To establish whether diagnosis, investigation and initiation of secondary endocrinopathies is timely.	Consultant Student	Patient Safety	Difficulties with project set up due to gaining access	N/A	N/A	Active
	Cancer of Unknown Primary (CUP) Patient Experience Questionnaire	Evaluate patient experience – this is a new service, and service development should be focused around the patient experience from the onset	Consultant CNS	Users/Patient views	Project setup	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A Service Evaluation of the Diagnosis of Myeloma in the Emergency Setting	This SSC is an evaluation of the myeloma service in the Cardiff & Vale Health Board, with a focus on the incidence and outcomes of those patients diagnosed via emergency presentations.	Consultant Medical Student SSC	SSC	This SSC identified an association between emergency presentations of myeloma and worse outcomes for patients – with advanced disease staging at diagnosis and reduced 1-year survival for patients. With 37% of patients in the Cardiff & Vale Health Board presenting via emergency routes, it is therefore important to address ways to reduce this method of presentation. However, in many cases, emergency presentations are not only unavoidable but also a key part of the myeloma service, and this SSC did not identify their occurrence as being necessarily explained by a delay in diagnosis in comparison to non-emergency presentations.	Further work could include other diagnostic pathways, such as assessing referral urgency, GP referrals to other secondary specialities, and which emergency presentations attended directly via their GP. In addition, other service intervals could be assessed, such as time from presentation to diagnosis, and time to start of treatment to assess for any delays affecting service efficacy. Additionally, survival analysis could be extended to study a 5-year time period to assess for any longer-term differences.	Given the often-non-specific nature of myeloma presentations, there is still scope to reduce the number of prior presentations that occur before diagnosis, in order to aid earlier diagnosis and prevent emergency presentations and their associated worse outcomes.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Compliance with completion of Treatment escalation plan forms (TEP) for the new admissions to the First-floor wards of Velindre Cancer Centre	The aim of this audit is to check our compliance with completing TEP forms and to encourage the teams to made escalation decision at the point of post take ward round.	SpR Consultant	Patient Safety	Data collection	N/A	N/A	Active Proposed completion date May 2023
COVID-19 Audit/Project Programme								
6.3	Virtual consultation-study in Covid-19 era: Patient and Staff experience retrospective review	To obtain patient and staff vires with regards to their experience with virtual clinics	Sonali Dasgupta Kate Hammond Sarah Seary/Attend Anywhere team	Users Views	Tight study frame to capture clinical parameters from clinics (mainly VA) over first peak of COVID-19 pandemic and compare to retrospective data from clinics (mainly F2F) pre COVID- pilot study. During COVID -19, in keeping with national trend/recommendations(1)Majority were VA(2)Overall treatment numbers were lower; majority were palliative intent(3)Proportion of oral chemo and SA immunotherapy increased; proportion of infusional/combination chemo and IMP reduced(4)Proportion of dose modifications/reductions were higher, and mostly they were related to COVID-19. Helpline calls were higher during COVID (7% versus 3%), but 38.9% patients who called were not on SACT.	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	UK Coronavirus Cancer Monitoring Project (UKCCMP)	To track cases and outcomes of cancer patients affected by COVID-19 infection in the UK	Ashley Poon-King Clair Brunner	National Project	319 (30·6%) of 1044 patients in the UKCCMP cohort died, 295 (92·5%) of whom had a cause of death recorded as due to COVID-19. The all-cause case–fatality rate in patients with cancer after SARS-CoV-2 infection was significantly associated with increasing age,. Patients with haematological malignancies (leukaemia, lymphoma, and myeloma) had a more severe COVID-19 trajectory compared with patients with solid organ tumours. Compared with the rest of the UKCCMP cohort, patients with leukaemia showed a significantly increased case–fatality rate. After correction for age and sex, patients with haematological malignancies who had recent chemotherapy had an increased risk of death during COVID-19-associated hospital admission.	Reasons for the low intensive care admission rate, which could be due to perceived futility of intensive support in patients with cancer, warrant further investigation.	Our results could be useful to assist physicians in informed risk–benefit discussions to explain COVID-19 risk and enable an evidenced-based approach to national social isolation policies.	Complete
3.1	COVID Radiotherapy: a National Cancer Research Institute (NCRI) CTRad UK-wide initiative	COVID RT is a national initiative that aims to study the impact of COVID-19 and the recovery plan on radiotherapy patients and the radiotherapy service and help us plan for future pandemics	Mererid Evans	National Project	Complete 	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Lung Radiotherapy during Coronavirus Pandemic (COVID-RT Lung)	To understand the changes in radiotherapy services for patient with lung cancer in the UK during the coronavirus pandemic Assess the outcome of operable patients	Ceri Powel Sheena Lam CAD	National Project	Our analysis has limitations as it only includes data from 30 UK radiotherapy centres across the whole of the UK and participating centres had not completed data collection on all treated patients at the time of this initial analysis. We have described the characteristics of patients who had changes to their centre's standard of care management and the regional differences in the management of patients with lung cancer. Our study will provide valuable information to the oncology community to help guide optimal treatment for lung cancer patients going forward.	We have shown that the risk of developing COVID-19 in lung cancer patients receiving radical radiotherapy was low during the first wave of the pandemic, showing that the measures put in place by radiotherapy departments to protect patients were adequate.	An important next step is to report the outcomes of patients treated during the pandemic in order to assess the effect of radiotherapy and chemotherapy adaptations on survival and toxicity. Outcome data are being collected as data matures	Complete
1.1 7.1	Staff COVID-19 testing Pilot questionnaire	To obtain feedback from staff involved on the staff testing pilot	Richard Adams	Users views	Awaiting report	`		Complete
1.1 7.1	Staff Testing pilot	To evaluate the pilot to identify areas of good practice and improvement	Andrea Hague Michael Thomas CAD	Key indicator of practice	Awaiting report			Complete
Integrated Care								
National Audit								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	UK NACEL Audit	NHS Benchmarking project	SPCT	National Audit		N/A	N/A	Active
Continuous Monitoring – Quality and Safety and Must Do's								
5.1	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	SI	National guidelines	Ongoing process	N/A	N/A	Active
6.3	All Wales Patient experience framework	To evaluate patients, experience at VCC to identify areas from improvement	Patient experience	Users views	Ongoing	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	All-Wales Care Decisions for the Last Days of Life Audit	Care Decisions for the Last Days of Life guidance was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.	CNS	National guidance	All dying patients in VCC are reviewed by the SPCT even if their needs are generalist rather than specialist. 7/7 working continues to ensure pts and junior drs have access and support re last days of life and OOHs there is availability of the Palliative Consultant advice line. Compared to other services in Wales we have high usage of care Decisions guidance.	Areas of good practice	We are keen to move the link nurse programme forward and once the link nurse contracts are approved we will be able to do that. This will further educate and empower ward staff in decision making and best practice art eol.	Ongoing 6 monthly
	Staff Survey: Safeguarding	To establish if staff are aware of the relevant guidelines and support regarding safeguarding within the trust	Safeguarding	Users views				
	Safeguarding documentation audit	To provide measure compliance with the All Wales Safeguarding Procedures.	Safeguarding	All Wales guidelines				
3.1	Immunotherapy for Adjuvant melanoma	To obtain toxicity and outcome data in the adjuvant setting	CNS	Key indicator of practice	Complete awaiting report 07/02/2023 – JA emailed VH 21/02/2023 – JA re-emailed VH	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	CIVICA	Independent service to allow patients to feedback their experiences.	Palliative care	Users views	Recommendations from last year: Restart once restrictions lift. End of Life Care Board are reviewing different methods of Patient Feedback for palliative Care across Wales	N/A	N/A	Ongoing
3.1	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (6 Monthly)
2.2	Pressure Ulcers	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.3	Slips/Trips/ Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.5	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.5	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.4 3.1	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	Inpatient Dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Weekly)
2.4	Visual Infusion Phlebitis (VIP) Score	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Daily)
2.4	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.4	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.4	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	Dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Weekly)
2.4	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.9	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits etc)	Infection Prevention & Control	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Annual)
3.1 4.1 5.1	Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager PP	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Chaperone for any intimate examination of gynaecology patients	To audit how many patients we asked re. chaperones pre guidelines and then re-audit after the guidelines were published.	Alison Wyatt	National guidelines Patient safety Local concern	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Annual)
	Record Keeping Audit	Record keeping audit every 6 months to look at compliance to our record keeping guidelines. To then feedback to team and make adjustments/give further education as indicated.	AHP			N/A	N/A	Ongoing Every 6 Months

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Chaperone audit	To ascertain current practice of documentation regarding the offer of a chaperone	CAD	SI/VCC Guidelines				
3.1	Key worker Audit	To review compliance of patients with document key worker	CNS Manager CAD	Key performance indictor				
Breast Malignancies SST								
3.1	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	CNS	NICE Guidelines	Data Collection Stage	N/A	N/A	Active Dec 2022
3.1	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy	Develop and implement an intravenous Access decision tool for breast cancer patients about to commence systemic anti-cancer therapy	Nurse	Clinical Effectiveness Service improvement	Complete	N/A	N/A	Complete
Gynaecological Malignancies SST								
	Physio-led Prehab Clinic for gynae-oncology patients – Patient Experience	To evaluate patient's experience of the Gynae Physio-led prehab clinic	AHP	Users/Patient views PREMS	Data collection stage	N/A	N/A	Ongoing June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Scoping project Patient views on how the service should look	To get feedback from past patients about what the new Gynae-oncology physiotherapy service should look like/offer. Therefore aiming to shape the service taking into account directly patient's views and experiences.	AHP	Users views	Discontinued	N/A	N/A	Discontinued
Lung Malignancies SST								
	Macmillan Lung Cancer Pathway Evaluation	In collaboration with the Macmillan lung CNS, map the existing lung cancer pathway to understand who currently provides supportive care for patients, Design and produce a poster by the end of September for presentation, generate recommendations to improve the lung cancer pathway at VCC for patients.	CNS	Users/Patient views PROMS NICE Guidance Re-Audit Innovation	In interviews, staff and patients identified improvements in person-centred care because of the role. However, these improvements are mainly confined to patients from the two referral hospitals that the Macmillan lung cancer CNS supports. Factors such as staff capacity, staff attitudes and geography have been suggested as potential drivers behind this prioritisation of input. Further work needs to be carried out to understand the significance of this inequality in access for treatment outcomes and thus quality of care. The PDSA cycle and model for improvement may be a useful tool for continuing this quality improvement work.	Areas for improvement	Evidence of positive impacts on the delivery of person-centred care, e.g., acting as a key point of contact for patients on treatment at VCC, supports the continuation of the role. Staff to continue approach of empowering patient to choose which CNS to contact to practice person-centred care and alleviate any possible confusion for patients caused by access to multiple points of contact. Carry out further work to understand how the Macmillan lung cancer CNS' input has been prioritised across patients from local district hospitals and assess	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							whether these decisions have been made in line with patient needs. Investigate whether ensuring equitable access to Macmillan lung cancer CNS support will improve quality in terms of health outcomes.	
UGI SST								
6.3	Re-Audit Upper GI Patient Survey from 2014	To revaluate the patients experience of the UGI service	CNS	Users views Re-audit	Acknowledged that patients are generally satisfied with information they received. Identified that the survey may need adjustments when carried out next time Overall, majority of patients are satisfied with their experience, and many good areas of practice. Some room for improvement in some areas. Patient care remained at a high standard during COVID pandemic.			Complete
Colorectal SST								
3.1	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles administered which can help us anticipate which patients are more at risk.	CNS CAD	Clinical Risk	Data Collection stage	N/A	N/A	Active Proposed completion date September 2023
6.3 3.1	Patient support group	support for the CRC cancer patients	CNS	Users views	Data Collection stage	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3 3.1	Recovery package and treatment summaries	To ensure all adjuvant patients receive rehab recovery package to enable rehab following completion of treatment. Treatment summary to communicate with patients and primary care – treatment given	CNS	User views Clinical effectiveness	Data Collection stage	N/A	N/A	Ongoing
3.1	Colorectal patient survey	To evaluate Patient experience of the colorectal service	CNS	Users views	Report writing stage .	N/A	N/A	Active Proposed completion date End March 2023
3.1	Anal patient survey	To evaluate Patient experience of the colorectal service	CNS	Users views	Report writing stage .			Active Proposed completion date End March 2023
Head & Neck SST								
6.3	Patient satisfaction Palliative Patients	To obtain patients views regarding the service provided at Velindre	Kate Morgan	Users views	Awaiting report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	H&N patient Survey	To obtain patients views with regards to the Head and Neck service	CNS	Users views	49% of respondents stated they would find it useful reading about other patient's experiences who underwent similar treatment for head and neck cancers. Some patients also asked for a 'timeline' of appointments and the processes leading up to treatment starting. 73% of respondents stated they would find Personal written record at end of treatment helpful.	End of treatment summaries drafted by CNS' and approved by SST Areas of good practice and areas for improvement identified	Review some aspects of patient information to include feedback received from survey. Support for friends and family. Establishment of a patient support group. End of treatment summaries project.	Complete
	Thyroid Patient Survey	To obtain patients views with regards to the thyroid service	CNS	Users views	Data collection stage	N/A	N/A	Active
Urology SST								
	Patient Survey: Bladder	Collection of baseline data to assess the level of current service provision. This included the development and distribution of a patient survey to research patient preferences for different models of follow-up care and assess the quality of information patients receive before and during their treatment.	CNS	Users views	The majority of patients were either satisfied or very satisfied with their first consultation and discussion of treatment, concerns and needs. The majority of patients felt supported by Velindre and that they received the care that mattered to them. The majority of patients were satisfied with the information they had received, but a significant amount of patients felt they would have liked more information on fatigue management, prognosis, welfare and managing the effects of treatment. Patients demonstrated an significant interest in receiving information virtually (online, video links, electronically, telephone, DVD	Areas of good practice Areas for improvement	Develop treatment plans/summaries to be sent out to patients and GP's post initial diagnosis. Develop and implement recovery package as outlined by Macmillan. E.g. Set up health and well-being seminars that related to Renal and Bladder cancer. Set up a Nurse-Led supportive/ palliative renal cancer clinic. Evaluate the information we currently send out in our 'new patient' packs and the timing of when these are sent out.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Patient Survey: Urology service	To ascertain patients views regarding the urology service following changes in practice.	CNS	Users views	Majority of men were satisfied with their first consultation and discussion of treatment, concerns and needs. The majority of men were satisfied with the care they received from Velindre Cancer Centre.	Areas of good practice Areas for improvement	Navigator will continue to distribute team/key worker information to patients. Navigator will also continue to offer patient opportunity to complete Holistic Needs Assessment (HNA) also promoting awareness of HNA's. Formulate personalised care plan at 6 monthly radiotherapy follow-up appointment. Re-start education seminars Recorded videos of management of side effects and living well after cancer. To put into DVD format and QR code on radiotherapy patient leaflet to then distribute to patients. Develop treatment plans to be sent out to patients and GP's post initial diagnosis. Develop self management patient portal and PSA tracker.	Complete
Other Sites/Services								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Evaluation of VCC physiotherapy weekend service	The aim of the service evaluation is to quantify how many patient's needs are unmet on a weekend due to the limited service	Therapies	Service evaluation	On average per month, 13 patients receive full intervention, 1 patient is seen but assessment/treatment is not fully complete and 1 patient is seen with assistance of an additional member of staff. 1 patient per month, on average, is not seen at the weekend. After carrying out the service evaluation, we can justify our current staffing levels of one qualified member of staff on Saturday and Sunday. Minimal numbers of patients are only receiving part of their physio assessment or treatment over the weekend and minimal numbers are not being seen over the weekend	N/A	N/A	Complete
3.1	VAPP Project Virtual Generic pre SACT assessment clinics	To reduce capacity in consultant clinics by transferring suitable pre chemo assessment's into a generic clinic.	NMP	Innovation	Now Business as usual (BAU)	Areas of good practice	VAPP to become business as usual and not a project and to expand and become sustainable.	Complete
6.3	Audit on Measure yourself concerns and wellbeing questionnaire	Assess the effectiveness of complementary therapy in cancer care. We aim to use the data in order to begin a research project.	Bethany Lynbeck Keira Gravell	Users views	Staff Members undertaking audit have left the trust, Other staff unaware of Audit.			Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Patient acuity on the assessment unit audit		Therapies		151 patients admitted over 21 Days. Level 1 and Level 3 acuity are the most common presentations. 66% of Level 5 acuity patients were admitted due to being 'Sick on site'. 44% Of Level 4 acuity patients were admitted due to being 'Sick on site'. The highest acuity levels were seen between 4pm and 7pm. Highest acuity level patients presented on a Wednesday. The highest number patients in beds were between 1pm and 5pm. Highest number of patients admitted were Monday and Friday. Assessment unit was at capacity or above for 27% of opening hours.	N/A	N/A	Complete
3.1	Patient/carer Self-administration of sub cut injections	To identify numbers of patients attending. Ascertain if these patients could be educated and managed at home. This would reduce patient visits and footfall which at present is even more of a priority due to infection control risks.	Karen Arndell	VCC Guidelines Clinical Risk Clinical Effectiveness Patients views	This project is on hold for the time being until we can find a way of dispensing Denosumab and the resource to continue the assessments. We currently do not have the resource to continue with a chronic short staffing issue but once this is resolved we might be able to pick this back up.	N/A	N/A	On hold

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A Service Evaluation Project of the Nurse Led Paracentesis/Indwelling Peritoneal Catheter (IPC)	To evaluate the nurse led service and assess whether the service is being delivered within appropriate timeframes. This will also confirm the importance of the service going forward.	Nurse	Key indicator of practice	The collected data, indicates that the majority of patients are, and have been treated for their ascites within 3 days. This demonstrates that the service is effective at seeing patients promptly even when accounting for the impact of Covid-19. This began at the beginning of the evaluation, bringing with it major operational changes and increased staffing challenges. Deeper investigation of the data has however, enabled the author to understand, that the main impact on the waiting times for patients is staffing levels. As the staff levels decrease, the wait times increase.	Service provides prompt good quality care for patients as they are seen with a short wait time from referral.	a)Recruitment of additional ANPs. b)Upskill existing staff c)Provide training to all newly rotating and permanent doctors d)In line with Post Covid-19 recommendations (NHS providers 2020), engage in dialogue with stakeholders to establish cross organisational working with other cancer centres. e)Flexible retirement with options to return to work for trained staff	Complete
3.1	Exploring the definitions of 'value' and 'Value-Based healthcare' in cancer care	Aims to explore how staff define Value-Based healthcare and what they consider to add value to patient care. This will be achieved by conducting semi-structured interviews	Student	Service Evaluation	Awaiting report	N/A	N/A	Complete
3.1	How do organisations support or inhibit high reliability healthcare processes	To investigate what characteristics of Highly Reliable Organisation (HRO) are practiced within the context of healthcare management and how those practises impact on patient safety outcomes and staff outcomes.	Student	Service Evaluation	Awaiting report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Patient education quality improvement project	The aim of this project is to improve the quality of SACT education received by patients on the Velindre day units	Nurse	Clinical Effectiveness Users/Patient views Patient Safety Local Concern	This project is being taken forward as a research project being supported by the research fellow working with Prof Hopkinson and myself so will no longer require input from the audit team.	N/A	N/A	Complete
	Service Evaluation - Real World Experience of Foundation Medicine Testing at Velindre Cancer Centre	To establish the impact of genetic testing on patient treatment/outcomes, how the requesting process may be improved and how genetic testing might fit in to future practice once the Foundation Medicine pilot is complete	Doctor		Discontinued. CD contacted on numerous occasions email now undeliverable. Unable to get copy of results.	N/A	N/A	Discontinue
	A service evaluation of physiotherapy unscheduled care referrals	A need to better manage and prioritise unscheduled care referrals was identified within the physiotherapy team	Therapies		Audit was on hold due to the changes going on within unscheduled care/ ambulatory care at the moment. It is now felt that it was no longer relevant, will send any updates.	N/A	N/A	Discontinue

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Audit of the 'pre-booked' admissions to the acute oncology assessment unit	To identify trends in pre-booked referrals to the acute oncology assessment unit. Ascertain if pre-booked patients are appropriate use of the service or if a more suitable alternative solution in available. Analyse the process of referring into the acute oncology assessment unit. Make recommendations to improve the service.	Nurse		Data collection	N/A	N/A	Active
	WAASP Quality Audit	Highlight any inaccuracies in WAASP scoring by comparing WAASP tools completed by nursing staff against how they should be scored based on information from medical notes, nursing documents and patient reports	AHP	Clinical Effectiveness NICE Guidance Patient Safety VCC Guidelines	Data collection	N/A	N/A	Active
SACT & Medicines Management								
Continuous Monitoring – Quality and Safety and Must Do's								
3.1	Niraperib FBC/Toxicity review	To assess patient outcomes	Pharmacy	Key indicator of practice	Pharmacy are collecting this data .	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	To provide assurances around antimicrobial stewardship. These measures aim to provide re-assurances that prescribing practices are in line with best practice.	SpR	Key indicator of practice VCC Guidelines 1000 Lives	Data collection stage	N/A	N/A	Active Proposed completion date June 2022
3.1	Snapshot audit of the use of DPYD in clinical decision making.	To inform the future delivery of this important service	Pharmacy	National audit				
Radiation Services Care Directorate								
3.1	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Paul Jenkins	Patient safety	Data collection	N/A	N/A	Active Proposed completion September 2023
3.1 5.1	CT PA requests	To create a robust pathway for suspected PE	Radiology		Data collection	N/A	N/A	On going
3.5	Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Radiation services	NICE Guidance WHO	Ongoing data collection	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 5.1	MRI Spine requests	To create a robust pathway for suspected MSCC	Radiology		This is a retrospective review of MRI spine request forms received between August 2020 and January 2021. This does not include follow up and baseline scans. During this period 70 MRI spine scans were performed. Patients were referred for scans from the following locations: Outpatients, Assessment unit, VCC wards. Within the clinical information 53 request forms stated ?Metastatic Spinal Cord Compression (MSCC) 18 patients were diagnosed with MSCC on MRI.	N/A	N/A	Complete

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Infection Prevention and Control Annual Report 2022 - 2023

DATE OF MEETING	13th July 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	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The Infection Prevention & Control 2022/2023 Annual Report provides a comprehensive overview of the Trusts infection prevention and control efforts conducted throughout the year. This report highlights the key achievements, challenges and future directions to enhance infection prevention and control practices within the organisation. Throughout the year, the Trust implemented robust infection prevention and control measures to mitigate the risk of healthcare associated

	infections (HAI's). Rigorous hand hygiene protocols, comprehensive staff education and training programs and effective surveillance systems were put in place to monitor and respond to potential outbreaks. Notably, the Trust achieved improvements in HAI rates, demonstrating the effectiveness of the implemented strategies. Compliance with Aseptic Non-Touch Technique and successful Gold Accreditation indicates a strong culture of infection prevention amongst healthcare staff. Despite these accomplishments, the report identifies several challenges that need to be addressed. The emergence of new infectious agents and antimicrobial-resistant organisms necessitates ongoing surveillance and the development of proactive strategies. Additionally, maintaining staff engagement and adherence to infection prevention protocols remains a priority, requiring continuous education and reinforcement. Looking ahead the infection prevention and control team aims to strengthen the Trust's infection prevention and control program by implementing innovating technologies and fostering a culture of continuous improvement. In conclusion, the infection prevention and control annual report highlights the Trust's commitment to safeguarding patient safety. The achievements made throughout the year serve as a foundation for ongoing improvement efforts, ensuring that infection prevention and control practices remain at the forefront of healthcare delivery.

RECOMMENDATION / ACTIONS	To ***APPROVE*** the Trust 2022 – 2023 Infection Prevention and Control Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Infection Prevention and Control Management Group	02/06/2023
Executive Management Board	29/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Report endorsed by both Groups.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended

APPENDICES	
	N/A

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

Infection Prevention and Control Annual Report 2022 - 2023

Contents

1. INTRODUCTION

Velindre University NHS Trust (VUNHST) provides specialist services to the people of Wales. The Trust has two core clinical services, Velindre Cancer Centre and the Welsh Blood Service.

Velindre Cancer Centre (VCC)

Canolfan Ganser Felindre
Velindre Cancer Centre

Velindre Cancer Centre also strives to ensure that high infection control standards are maintained. This is especially important given the vulnerability of our immuno-compromised patient group.

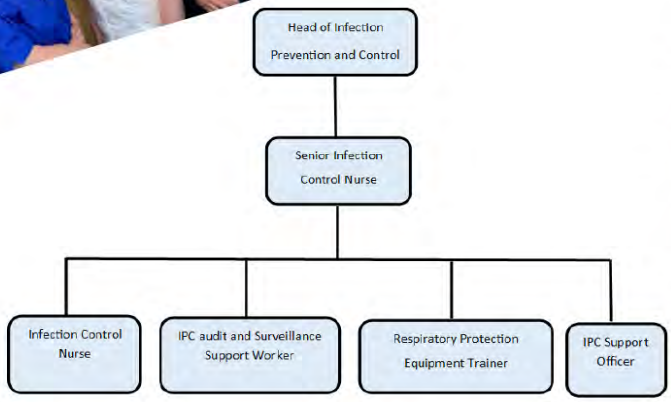
Welsh Blood Service (WBS)

Welsh Blood Service
Gwasanaeth Gwaed Cymru

Within the Welsh Blood Service, ensuring exemplary infection prevention standards is vital in maintaining the safety of donors, products, and recipients. As such, the Welsh Blood Service operates a robust infection prevention programme which is designed to maintain the thorough standards of care and services required to meet regulatory frameworks.

Infection Prevention and Control Team

The Trust's Infection Prevention and Control Team (IPCT) leads on ensuring the continued safety of the Trust's services, by working with the clinical and operational staff to mitigate the risk of patients and donors acquiring infection through contact with our services.

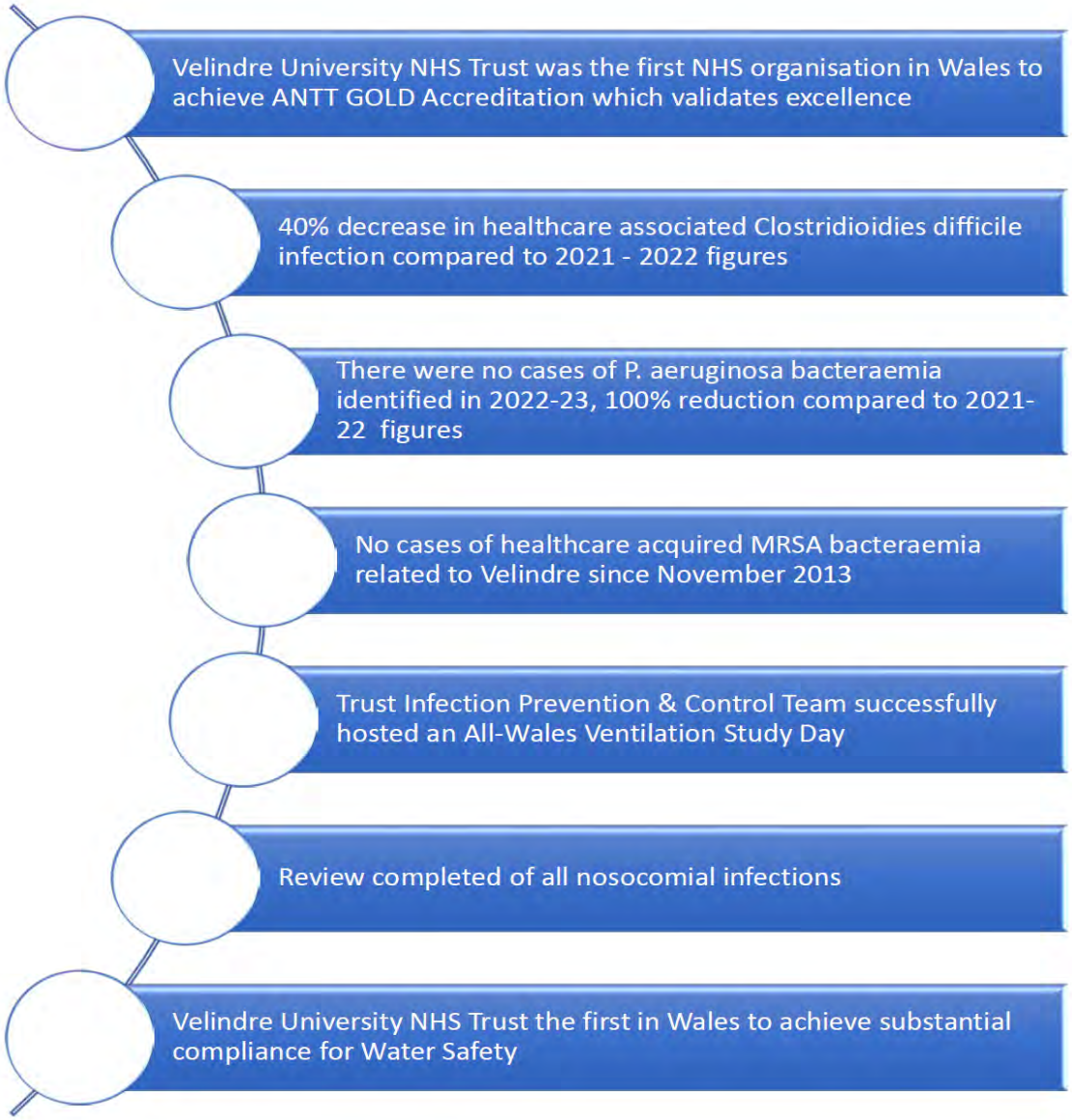


There have been significant changes and vacancy within the team, the figure to the left highlights the current structure.

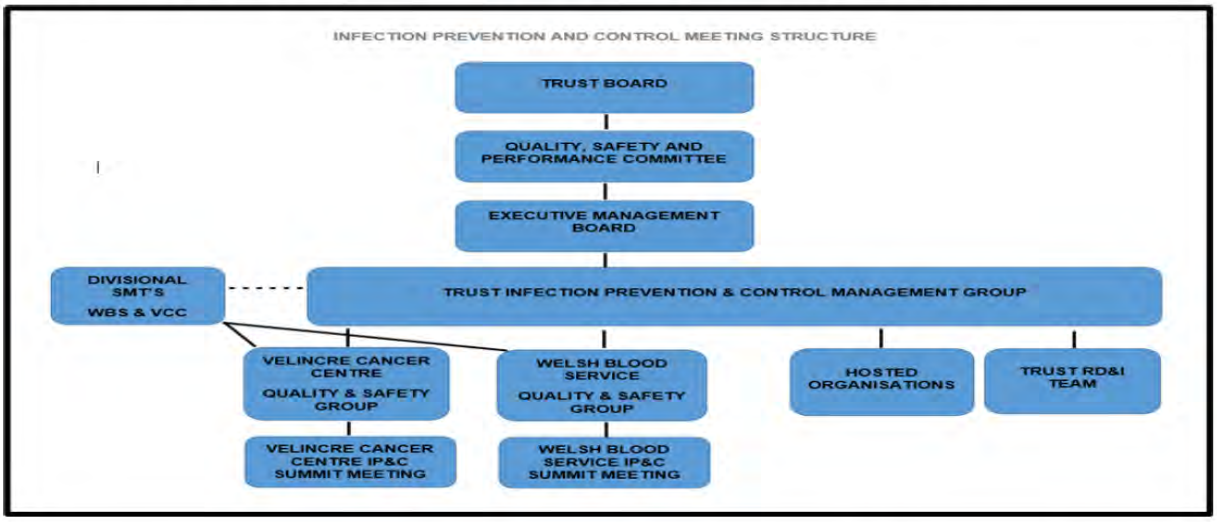
This report provides a summary of the progress, activities and achievements in Infection Prevention and Control for the Velindre University NHS Trust during the period 1st April 2022 to 31st March 2023.

2. KEY ACHIEVEMENTS

In addition to the workload generated by COVID-19 pandemic, the IPCT has continued to oversee education, guidelines, and practice to ensure the risk of infection is minimised in the Trust. Overall, 2022-23 was a remarkable year for the IPCT



3. GOVERNANCE ARRANGEMENTS AND REPORTING FRAMEWORKS



4. PERFORMANCE AGAINST THE INFECTION PREVENTION AND INDICATORS / STANDARDS

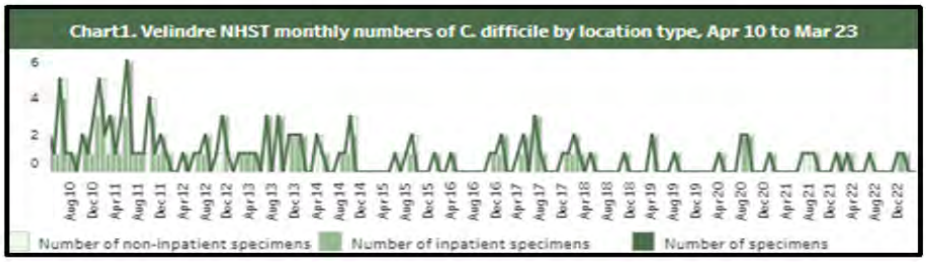
As the Velindre Cancer Centre provides specialist oncological services to surrounding Health Boards, there are only a small number of in-patient beds. As such, it is not possible to directly compare our infection rates with those of the other Health Boards in Wales. This is because each Health Board calculates its infection rate per 100,000 population, whereas at Velindre Cancer Centre, the infection rate is calculated per 1,000 patient admissions.

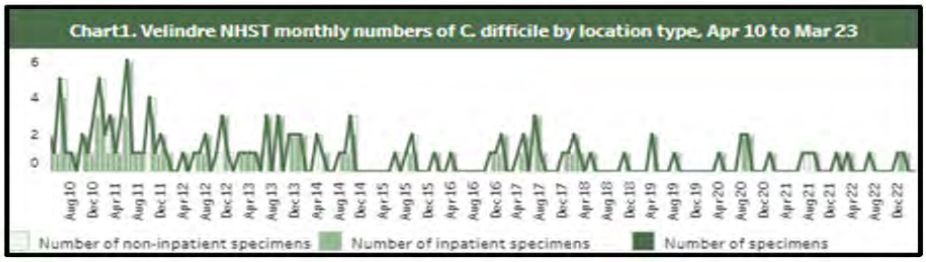
The Trust's actual performance with regards to healthcare associated infections is shown below:

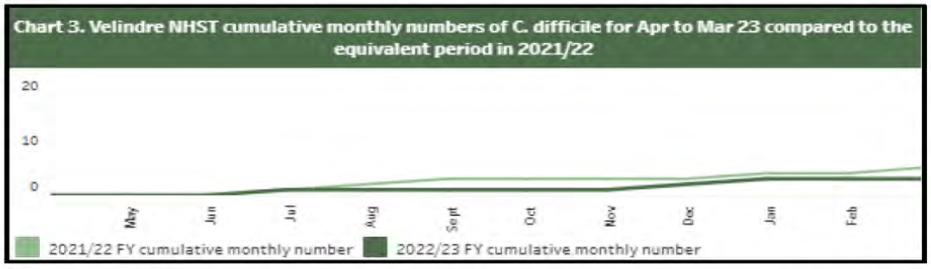
4.1 Healthcare Associated Infection

- **Clostridioides *difficile* -** 3 infections were identified during 2022- 2023, 2 of which related to inpatients. This is a decrease of 40% from the previous year. All identified cases were investigated thoroughly via a multi-disciplinary approach to establish whether any issues with care occurred which may have contributed to the patient acquiring the infection. Opportunities for learning are identified via this approach with lessons learnt shared and improvements made.

  Genotyping gave extra assurance that cases were individual clusters with no connection to other known cases.

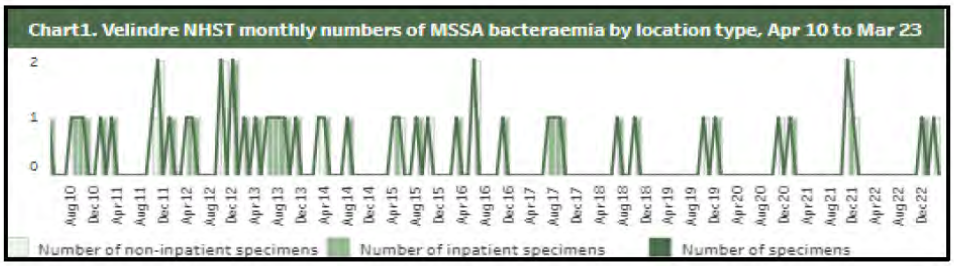




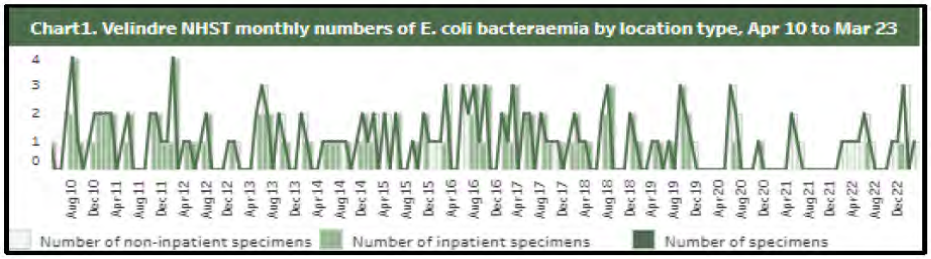


Many of the patients at Velindre Cancer Centre are at an increased risk of developing Clostridioides *difficile* disease because they require more than one course of antibiotics to prevent and treat serious infections. Weekly virtual Microbiology ward round were commenced to ensure appropriate and sensible use of antibiotics. The Infection Prevention and Control Team and staff are continuing to work to reduce the incidence of Clostridioides *difficile* disease.

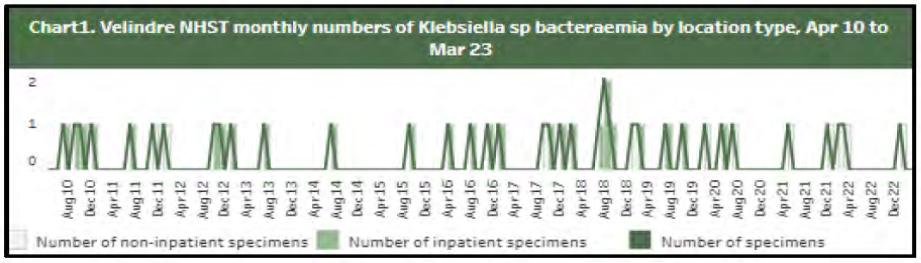
- **Meticillin Resistant Staphylococcus aureus -** There have been **no cases** of Methicillin Resistant Staphylococcus Aureus (MRSA) acquired bacteraemia (bloodstream infections) in Velindre University NHS Trust since 22nd November 2013. At Velindre University NHS Trust, there have been many interventions that have helped to reduce and sustain the zero infection rates, including screening and sustained use of ANTT.
- **Meticillin Sensitive Staphyloococcus aureus -** Methicillin Sensitive Staphylococcus Aureus is a bloodstream infection caused by a common skin bacteria called Staphylococcus *aureus*. There were 2 cases of Methicillin Sensitive Staphylococcus Aureus bacteraemia identified in the year 2022-23, which was a 33% reduction compared to 2021 – 22, one of which related to an inpatient.



- **Escherichia *coli*** - The surveillance of Escherichia *coli* bacteraemia began in April 2017, and there has been considerable progress since then with a continuous reduction. There were 6 cases of E. *coli* bacteraemia identified in 2022 – 23, 3 of which were inpatients. E. coli is part of the normal gut flora and investigation of the cases found identified two of the cases had extensive bowel disease. The third was identified as a translocation of the organisms which is when the passage of bacteria of the gastrointestinal tract through the intestinal mucosa barrier to mesenteric lymph nodes and other organs. In some cases, the passage of bacteria results in blood stream infections.

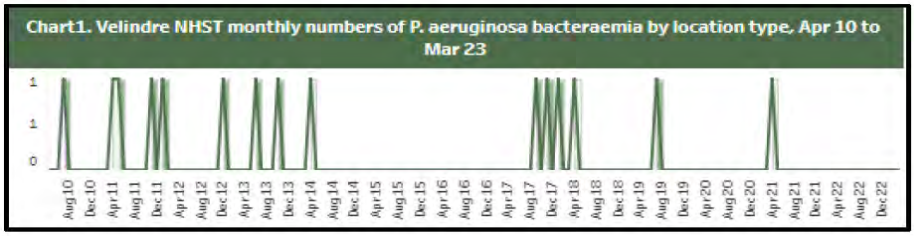


- **Klebsiella species bacteraemia** - One case was identified in 2022-23, which was the same as the previous year. Investigation highlighted that the patient had extensive abdominal disease and devices insitu. No evidence of poor practice or transmission of infection.



- **Pseudomonas *aeruginosa* bacteraemia** – There were no cases of P. aeruginosa bacteraemia identified in 2022 – 2023, which is a 100% reduction against the previous

year.



4.2. Multi Drug-resistant Organisms (MDRO)

Multidrug resistant organisms are increasingly recognised as a growing public threat, both within the hospital and community settings. A clinical risk assessment has been produced which is completed on admission whether a patient had risk factors for carriage/infection with MDRO. The IPCT have worked with the inpatient ward to incorporate this as part of the admission screen commencing April 2023, the compliance with screening will be fed back to the department monthly.

4.3 Infection Prevention and Control Audits

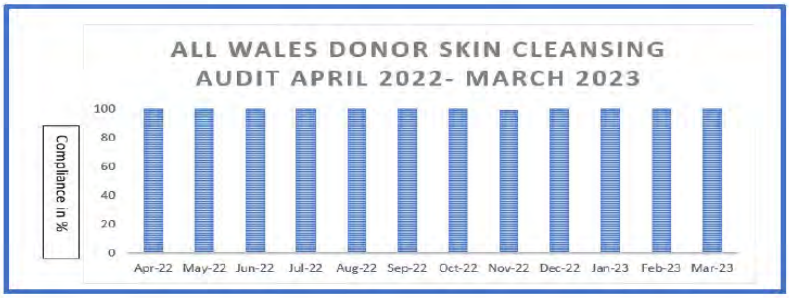
Effective audits undertaken by the Infection Prevention and Control team have established a baseline for practices and the Trusts clinical environments. Repeating the audits annually or as required, provides a measure which can help prevent the transmission of infections and it identified the overall compliance with evidence-based criteria. Progress against the audits is reported monthly to the divisional Infection Prevention and Control meetings.

4.3.1 Welsh Blood Service Pre – Venepuncture Skin Cleaning Audit

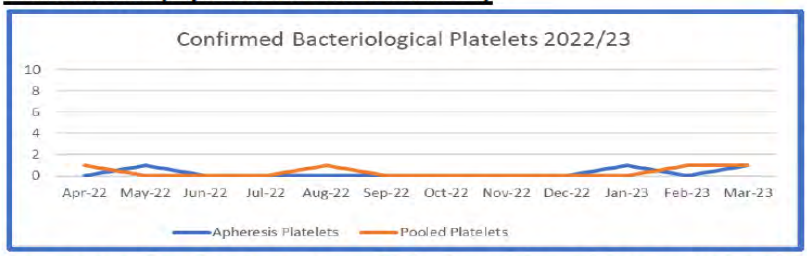
Within the Welsh Blood Service ensuring effective and evidence based Aseptic Non-Touch Technique (ANTT) including effective skin cleansing is critical in maintaining donor, product, and recipient safety. To ensure required skin cleansing practices are consistently in place monthly donor skin cleansing observational audits are completed by all collection teams across Wales.

Any observed areas of non-compliance or suboptimal practice are addressed at the time of audit by the clinical lead and audit results and corrective action plans are reported through IPC and Quality and Safety structures at a Divisional and Trust level.

Throughout the last twelve months compliance with required skin cleansing practices across Wales have been high ranging between 99-100%.



4.3.2 Welsh Blood Service Bacteriological Confirmed Positive Platelet Donations (Apheresis and Pooled)



Infusion of bacterially contaminated platelets would significantly impact upon recipient health, it is therefore essential that the Welsh Blood Service minimise opportunities for contamination to occur. This is achieved by ensuring high standards of practice relating to skin cleansing and laboratory infection prevention and control are in place. To ensure safe standards are maintained the Welsh Blood Service undertakes robust bacteriological testing and monitoring of all platelets, with any positive results being reviewed and fully investigated.

4.4 Velindre Cancer Centre Clinical Practice audits

The clinical practice audits resumed this year, and the team are pleased to report that no issues were identified. Clinical practice audits included compliance with urinary catheter bundles, central catheters maintenance, and peripheral cannula care bundles. This is reflected in the sustained low infection rates.

4.5. Hand Hygiene Audits

During 2022 – 2023, hand hygiene compliance has been sustained at high levels across the Trust. Completed hand hygiene training and assessment is now recorded through the NHS Electronic Staff Record.

The Infection Prevention and Control Team continue to support the department Hand Hygiene champions, and compliance is reported through both the divisional Infection Prevention and Control Summit meetings and the Infection Prevention and Control Management Group.

As outlined in Figure 7 below, throughout the year overall compliance at WBS has been between 96% and 100% and that across the Trust hand hygiene audit compliance has remained above 90% throughout the year.

Please note November 2022 is when Welsh Blood Service moved over to Tendable audit tool and although an audit was undertaken with 100% compliance there were issues with using the tool, unfortunately this data has been lost

4.6 Aseptic Non-Touch Technique (ANTT)

Velindre University NHS Trust has become the first NHS organisation in Wales to achieve gold accreditation for Aseptic Non-Touch Technique (ANTT). The Gold accreditation is valid until 2025.

The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection (HCAI). ANTT is defined by the National Institute for Health & Care Excellence (NICE) as being a 'specific type of aseptic technique with a unique theory and practice framework.' The Framework includes a set of principles and safeguards that, if followed, will ensure asepsis for all types of invasive procedures from the operating theatre to the community setting.

Gold Accreditation
ANTT®
Aseptic Non Touch Technique

The main principle is to keep the 'key parts and key sites' protected by following standardised processes. Key sites are open wounds, including insertion and puncture sites for invasive medical devices and key parts are the critical parts of the procedure equipment that come into contact with the key site, any liquid infusion, or with any other active key-parts connected to the patient via a medical device. Reducing deviation in processes reduces the risk of healthcare associated infection.

ANTT accreditation is based on having effective elements in place for policy, education, assessment, and monitoring (Figure 12). There are many benefits to meeting and upholding the ANTT's strict standards, such as:

- Improving patient safety by supporting effective education, competency assessment and safe clinical practice
- Standardising aseptic technique across organisations and countries, and reduces variability in practice
- Providing a foundation for the effective clinical governance of aseptic technique

Helping protect and reassure patients by providing more consistent standardised aseptic technique.

Row Labels	Achieved	Lapsed	Not Achieved	Total number required	Compliance %
120 Corporate Division					
NHS|MAND|Aseptic Non Touch Technique - No Specified Renewal|	3			3	100.0%
120|LOCAL|120 Velindre ANTT - ASSESSMENT|General					
NHS|MAND|Aseptic Non Touch Technique - No Specified Renewal|	21		1	22	95.5%
120 Velindre Cancer Centre					
NHS|MAND|Aseptic Non Touch Technique - No Specified Renewal|	302		68	370	81.6%
120 Welsh Blood Service					
NHS|MAND|Aseptic Non Touch Technique - No Specified Renewal|	135		4	139	97.1%

4.7 Environmental Audits

Velindre University NHS Trust utilises an electronic quality management system, MEG Environmental Audit tool, to help to reduce transmission of healthcare associated infections through audit, feedback, and timely reporting, specifically addressing the EPIC 3 Guidelines alongside the Code of Practice Guidance. The audit tools are available on mobile devices, and this provides real time results for auditors and the management teams.

The Trust have also established the use of Tendable audit tool, with a potential to replace MEG in the future, however further work is required to determine if Tendable will be able to provide the same assurance that MEG currently provides before a changeover is made.

The annual audit programme has expanded due to increased capacity in the Infection Prevention and Control Team and in 2023 - 24 the focus on WBS will increase. The audit results were comparable to previous year's audits and continued to highlight the age of the Cancer Centre building which needs repair and refurbishment.

The main themes arising were wear and tear on the environment and carpet in some clinical areas and a rolling programme to address issues underway by estates team. Other issues included lack of visible cleaning schedules which has since been addressed.

4.8 Central Venous Catheter (CVC) Infection

Central Line Associated Blood Stream Infections (CLABSI) are serious infections which can cause an increase in the patients' admission time, an increase in care costs and a greater risk of mortality. Due to sustained low CLABSI in the last three years (0.12 per 1000 catheter days), active surveillance of CLABSI events was not carried out in the year 2022 – 2023, for assurance a prevalence audit will take place in Quarter 3 2023 – 2224. Work continues to maintain high quality, standardised care for the insertion and maintenance of Peripheral Vascular Cannula and CVC. Previous quality improvements with insertion packs, Aseptic Non-Touch Technique and care bundles remain.

4.9 Infection Prevention and Control Training Compliance

Infection Prevention and Control Training has continued throughout the COVID-19 pandemic. However, the mechanism through which training has been provided has reflected the required social distancing restrictions.

Level 1 and level 2 training has been predominantly provided through the e-learning

platform. In addition, the Infection Prevention and Control team continued to be proactive and available to advise and assist as required. A training needs analysis was undertaken across the Trust to assist in identifying who requires specific training such as FIT-testing, donning and doffing training and hand hygiene.

One of the causes in the reduction in hand hygiene training compliance is due to some of the hand hygiene champions leaving their roles. The table below highlights the compliance in staff groups. To address this, new champions have been identified and trained, and action plans to improve compliance rates submitted by service areas to the divisional IPC summit groups.

Row Labels	Achieved	Lapsed	Not Achieved	Total Required to complete assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	8	3	1	12	66.7%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	22	5	1	28	78.6%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	488	163	84	735	66.4%
120 Welsh Blood Service					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	206	74	23	303	68.0%

Row Labels	Achieved	Lapsed	Not Achieved	Total required to complete the assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	3	1		4	75.0%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	3	1		4	75.0%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	20	3	1	24	83.3%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	20	4		24	83.3%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	361	115	43	519	69.6%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	362	111	45	518	69.9%
Grand Total	769	235	89	1093	

In addition:

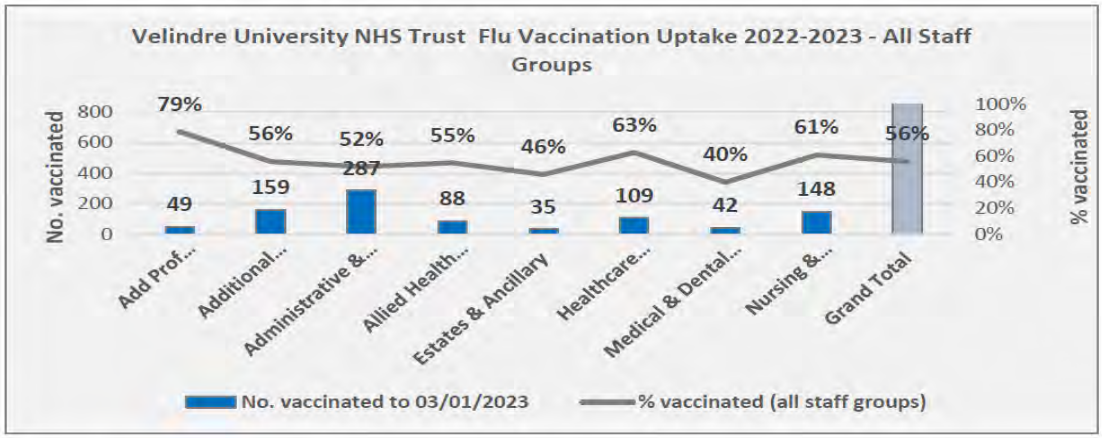
- A second member of the IPCT is trained in preparation to gain 'Fit to Fit' Accreditation. This will enable the Trust to provide robust in-house FIT testing training for Velindre University NHS Trust staff and possibly offer a service nationally.

- The Welsh Blood Service developed and delivered a robust training programme that included Hand Hygiene and Donning and Doffing that was delivered within donor facing and laboratory services across Wales to maximise staff education and training opportunities.

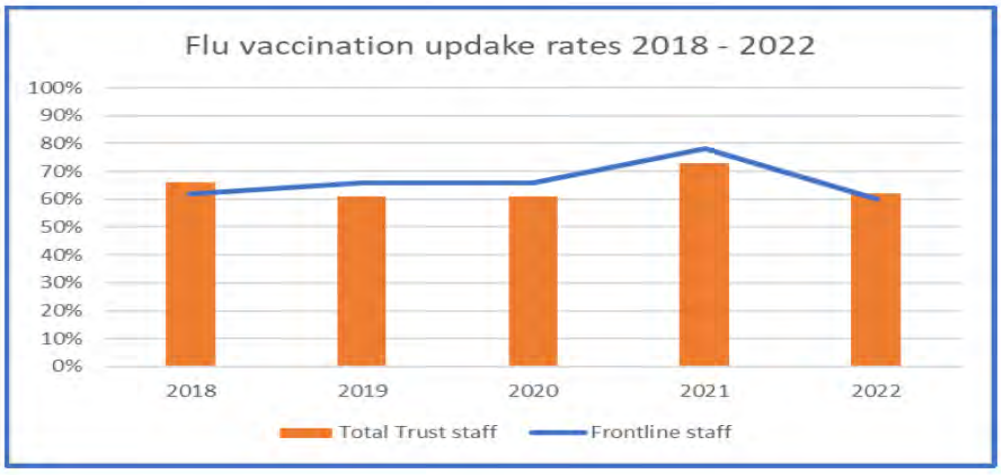
5 STAFF INFLUENZA VACCINATION CAMPAIGN

The national influenza vaccination programme for the 'at risk' population and front-line health care professionals has been in place for many years. In view of the additional

challenges during the winter of 2022, due to a combination of the Influenza and Covid-19 viruses, the Welsh Government advised of the need to increase frontline staff uptake of the Influenza vaccination.



Despite this, the national target compliance for frontline staff remained at 60%. ownership of the campaign, whilst the Infection Prevention and Control team continued to provide strategic support. There was a decrease in the number of Trust vaccinated, possibly due to vaccine fatigue. The figure below shows the uptake over the past 5 years:



6. ANTIMICROBIAL STEWARDSHIP

The term 'Antimicrobial Stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' - NICE Guidelines [NG15] - Aug 2015

Antimicrobial Stewardship aims to:

- Promote the appropriate use of antimicrobial agents
- Improve patient outcomes
- Reduce healthcare associated infections such as Methicillin Resistant Staphylococcus Aureus and Clostridioides *difficile* and prevent antimicrobial resistance

Antimicrobial Stewardship is essential within the Velindre Cancer Centre given the vulnerability of our patient population, especially those on cytotoxic chemotherapy who have a compromised immune system.

One of the practices undertaken across Wales to ensure that good Antimicrobial Stewardship processes are in place is the nationally approved 'Start Smart Then Focus' (SSTF) audit. This is a point prevalence audit that is undertaken in all NHS hospitals across Wales on a monthly basis. It is an audit of the inpatient prescribing of antimicrobial agents, the aim of which is to ensure that prescribing is appropriate, evidence basis, regularly reviewed and does not continue for longer the necessary. The SSTF audit looks at the following measures (*the audit target of 100% compliance for all measures*):

1. Whether the indication for treatment was documented
2. Whether the prescribed treatment was compliant with either local guidelines, based on the results of cultures and sensitives or based on microbiology advise
3. Whether there was a documented review date / stop date on initiation of treatment
4. Whether there was a documented senior review at 72 hours

In Velindre Cancer Centre (VCC), this data is collected by the ward pharmacy team as 'point prevalence' data monthly. This data is then uploaded onto the Trust Performance Framework and reported to both Velindre Cancer Centre Quality and Safety Committees and the Infection Prevention and Control Management Group. The data is also fed into a national database so that benchmarking can be undertaken against other NHS health boards within Wales.

In March 2021, VCC implemented the all-Wales Antimicrobial Review Kit (ARK) Chart as the standard inpatient medication chart across all clinical areas within the cancer center. This chart encourages these 4 SSTF measures to be completed when antimicrobial agents are prescribed and reviewed. Over the 2022/23 financial year, compliance against these 4 measures has significantly improved when compared to the previous year, and compliance is favourable within VCC when compared to the national average.

The table below identifies current average compliance of SSTF over the year 2022/23.

Table 15. Average compliance of "Start Smart Then Focus

Measures	VCC average compliance 2021 / 2022	VCC average compliance 2022/ 2023	All Wales average compliance 2022/2023
Documented Indication for treatment	90.2%	80%	87%

Compliance with guidelines, C+S or microbiology advice	95.8%	97%	91%
Documented review / stop date	97.7%	90%	89%
Documented senior review at 72 hours	93.2%	95%	90%

Over the 2022/23-year period, a comparison of compliance against the national average is favourably for 3 of the 4 Start Smart than Focus (SSTF) measures, with the one exception being the 'documentation of the indication of treatment' when antimicrobial medications are initially prescribed. For this measure, the average VCC compliance for the year was 80% compared to a national average of 87%. This specific measure can only be marked as compliant if the indication is documented on the actual medication chart. In VCC, for the 20% of occasions whereby the indication was not documented on the medication chart (and therefore classed as non-compliant), the indication for treatment was documented within the patients notes.

7. RESEARCH AND INNOVATION

The IPC team has taken full advantage of the time between waves of the COVID-19 pandemic to engage in some investigation into new, sustainable cleaning technologies and air decontamination units that could benefit both the current environment and the new cancer center. Further work will to be undertaken in April/May 2023 and progress will be reported through the Infection Prevention and Control Management Group.

The opportunity has arisen to undertake a collaborative piece of research, which is currently at the proposal stage. The IPC team are working with SC Johnson who are currently the provider for hand hygiene products to NHS Wales to undertake a randomised control trial.

The objective of the research is to determine whether increased, regular use of skin creams supported by an education campaign will primarily improve skin condition in both normal and sensitive skin and assess any associated changes to bio-load of pathogenic bacteria on the hands. The secondary aim is to monitor the wearing of below the elbow hand jewellery (rings without stones, watches etc.) and the likelihood of harbouring additional bio-load of bacteria. It is envisaged this work will commence in the autumn of 2023 for a 12-month data collection period.

8. COVID-19 PANDEMIC

The emergence of sub variants of Omicron (variant of SARS-CoV2) had an impact on the services as increased number of staff were reported absent due to either being positive or having close contact with a positive case. Guidance from the Welsh Government kept changing rapidly especially affecting staff dealing with immunocompromised or extremely clinically vulnerable patient population. The IPCT and Workforce teams tried their best to keep the staff informed of the changes in national and local guidance to keep them updated. A simple but concise flowchart for

staff guidance who are either COVID-19 positive or and contacts of positive cases was created and disseminated through Trust intranet page and screensaver.

Regular meetings of COVID response cell were held in response to the continued pandemic with representation from IPC team members. COVID-19 surgery continued to be held by Infection Prevention and Control team along with a workforce representative to discuss any issues faced by the trust staff, this service is available for all departmental managers across the Trust.

In addition, the Nosocomial Scrutiny Panel convened regularly to review all cases and a thorough evaluation of all healthcare associated cases was completed from beginning of pandemic to date. The Panel had strict criteria to follow including determining the timescale for onset.

Category	Criteria
Community Onset	Positive specimen date <2 days after admission
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission
Probable healthcare-associated	Positive specimen date 8-14 days after admission
Definite healthcare-associated	Positive specimen date 15 days after admission

8.1 Incident /Outbreak

There have been several periods of increased incidence of COVID-19 within different staff groups and all have been managed with no impact to service delivery. During the reporting period there have been two outbreaks of COVID-19 in the First Floor Ward, involving both staff and patients.
On each occasion an Outbreak Control Group was established, and it was determined that there was a high community prevalence of COVID at the time of the incident. The table below confirms this.

Outbreak Declared	Outbreak Ended	No. of patients	No. of Staff	Community prevalence at time of outbreak
11th July 2022	20th September 2022	**14** 9 Probable Healthcare Associated 5 Community Acquired Infection	8	1:17
14th October 2022	13th November 2022	**7** 5 Probable Healthcare Associated 2 Community Acquired Infection	6	1:40

There was robust patient management in place with admissions into a single room only and good compliance with all relevant Infection Prevention & Control measures including hand hygiene and donning and doffing.

The training compliance had dipped to below required levels due to high number of new starters but there was no evidence through regular audits that this translated into compliance issues with required standards.

Further assurance the following control measures were in place during the last year of the pandemic:

- Appropriate environmental cleaning in line with Public Health Wales (PHW) guidance. The nature and frequency of the cleaning regime in place exceeded the Welsh Government guidelines. Regular audits were undertaken by a multi-disciplinary team and no non- compliances were noted.
- Inpatient visiting was in line with PHW / government guidance which was to allow compassionate visiting permitted with prior agreement with the ward/department manager.
- All staff were required to self-test using LFT prior to attending work twice a week. However, for those staff who were working in the outbreak environment, daily LFT tests were introduced for the duration of the outbreak.
- Use of Personal Protective Equipment was in line with Welsh Government COVID-19 guidance.
- Monthly hand hygiene audits were completed by departments and daily spot checks undertaken by the Infection Control and Prevention Team and Service Managers. The Infection Control and Prevention Team carried out weekly validation audits during the outbreak, the results of which were fed back at the scheduled outbreak meetings, Infection Prevention and Control summit meetings and the Infection Prevention and Control Management Group.
- All patients were tested upon admission (day 1 screen) and isolated in cubicles until a negative result was received and patient not exhibiting any symptoms of COVID-19. A day 5 test was performed to give additional reassurance of the patient's negative COVID-19 status before moving the patient to an open area of the ward.
- Where possible, staff were segregated to minimise cross-contamination, and where this was not possible, there were clear infection control guidance on how to safely manage such situations.

9. SAFE WATER SYSTEM MANAGEMENT, BUILDING ENVIRONMENTAL IMPROVEMENTS

The Infection Prevention and Control Team and Estates Department have made considerable progress and have continued to work very closely to maintain high standards of water safety throughout the Trust.

The Estates Team manage the major water infrastructure services. Both the Welsh Blood Service and Velindre Cancer Centre Trust Water Safety Group meets regularly to discuss progress against the annual water safety plan and any actions in response to positive water samples. Recently the Trust has revised the water safety plans for both sites to ensure that the process and training requirements and relevant appointments for Responsible persons are achieved. Assurance of water safety is reported through the divisional Infection Prevention and Control summit meetings and the Trust Water safety group. The Trust has an annual report undertaken by the appointed Authorising Engineer (AE) employed by NWSSP-SES. This year's audit was undertaken in November 2022 and the Trust is the first in Wales to received **substantial compliance.**

The refurbishment projects undertaken this year are:

- Decoration in various parts of VCC
- Planning for a permanent ventilation system FF ward
- Ongoing water services dead leg removals
- Flooring replacement schemes throughout site
- Mechanical ventilation to clinical areas Clinical Trials, Flexitron and DXR.

Furthermore, there will be an infection prevention and control estates budget ring fenced this financial year to address environmental recommendations along with a four-year operational plan to target areas within the hospital. Estates continue to work closely with specialist estates services to undertake annual verifications of critical air handling plant onsite at VCC. All aspects of compliance are being reviewed on air handling units and recommendations made by SES will be addressed under this year's estates discretionary budget allocation.

10. DECONTAMINATION

Healthcare organisations have a duty of care to patients, their workforce, and the public to ensure that a safe and appropriate environment for healthcare is provided. The Welsh Government Welsh Health Circular (WHC/2015/050) issued a Decontamination Improvement Plan for organisations across Wales in order to ensure that re-usable medical devices are safe for use on a patient and for staff to handle without presenting an infection risk.

A Peer Group review of decontamination of Semi-critical Probes using High Level Disinfection (HLD) was undertaken by the Senior Decontamination Engineer NHS Wales Shared Services Partnership in May 2022. The review is a follow up to the 2018 survey and provides a measure of reassurance that all the processes involved in decontamination of non-lumen probes comply with regulatory requirements and accord with guidance developed to help ensure patient safety and ensure compliance against the decontamination standards specified in the Welsh Health Technical Memorandum 01-06, (Decontamination of flexible endoscopes). These, gold standard, systems are in place in in the Cancer Centre and the processes are embedded.

The Service Level Agreement with Cwm Taff Bro Morgannwg Health Board continues for the Welsh Blood Service whereby sterile items are decontaminated at Royal Glamorgan hospital.

A member of the Infection Prevention and Control Team has undertaken accredited Decontamination training in 2022, to provide additional resilience within the team on this aspect the Infection Prevention and Control work.

11. POLICY UPDATE

Infection Prevention and Control policies have progressed over the past 12 months with all policies under team control being reviewed and renewed following completion of the governance process.

To note 3 national policies require updating and work has commenced on the review of these and the IPCT are part of the national task and finish groups for this work:

- IPC 03 Aseptic Non-Touch Technique
- IPC 19 Infection Prevention and Control in the Built Environment
- IPC 15 Control and Management of Multi-Drug Resistant Bacteria

IPC06 Management of Occupational Exposure Injury and IPC09 Sharps Safety Policy has been reviewed and updated but now sit under the control of Health and Safety Team with input from the Infection Prevention and Control Team.

12. ICNet UPDATE

ICNet is an electronic surveillance software product that connects clinical data systems in healthcare facilities to provide a unified solution for infection prevention and surveillance staff and was awarded the contract for implementation across Wales. The transition from the Cancer Network Information System Cymru (CANISC) with the Welsh Clinical Portal and Welsh Patient Administration System has been completed and is now fully interfaced with ICNet.

13. INFECTION PREVENTION AND CONTROL AWARENESS CAMPAIGNS

The frequency of the Infection Prevention & Control newsletter is currently circulated bi-monthly and additional COVID-19 and IPC updates/information is supplemented as required within the Trust communication forum. The aim of the newsletter is to educate and reinforce the importance of infection prevention and control and to raise awareness on a variety of key topics.
The newsletter has been well received by staff with suggestions for topics for future issues.

13.1 Celebration of Global Hygiene Day: 5th May 2022

World Hygiene Day serves as a yearly reminder that hand hygiene is one of the most important steps, we can take to avoid getting sick and spreading germs to others. The COVID-19 virus continues to highlight the importance of hand hygiene. On 5th May each year the World Health Organization (WHO) celebrates the SAVE LIVES: Clean Your Hands campaign and aims to maintain a global profile on the importance of hand hygiene in health care and to 'bring people together' in support of hand hygiene improvement globally.

Preventing the spread of infection is a constant daily challenge in healthcare environments with constrained time and resources; thus the need to implement good hand hygiene behaviour is crucial in helping to optimise compliance and reduce risk.

This year the focus is on recognising that we can add to a facility's climate or culture of safety and quality through cleaning our hands at the right time, with the right products, but also that a strong quality and safety culture will support people to clean hands. This has been at the core of the WHO infection prevention and control and patient safety strategies for many years but is now more critical than ever. This means to practice hand hygiene when it is needed (at 5 specific moments) and in the most effective way (by using the right technique with readily available products) to prevent transmission of infectious microorganisms (germs) during the sequence of health care delivery. In 2022, the Infection Prevention and Control team continued the momentum on existing hand hygiene promotion initiatives in the context of COVID-19, while maintaining the focus on staff and patients.

13.2 International Infection Prevention Control week: 16th - 22nd October 2022

International Infection Prevention Week (IIPW) takes place every October and raises awareness of the role infection prevention plays to improve patient safety. It is organised by the Association for Professionals in Infection Control and Epidemiology (APIC), whose mission is to create a safer world through prevention of infection and because infection prevention is more important than ever, in the battle against a global pandemic and to keep the world safe from healthcare-associated infections and outbreaks. This year's theme is *The Future is Infection Prevention: 50 Years of Infection Prevention*. APIC highlighted the role that individuals can play in the health and safety of their facilities by showcasing the science behind infection prevention, the importance of countering misinformation, and to inspire the world's future Infection Preventionists (IPs) to join the continued campaign.

Locally, we celebrated IIPW to highlight the importance of Infection Prevention and the vital work that we are part of to prevent and control healthcare associated infections including COVID-19

14. CONCLUSION

The data contained within this report demonstrates that despite the challenges posed by the ongoing COVID-19 pandemic over the past year the team has continued to improve and sustain improvements in the reduction of healthcare associated infections at the Trust.
There has been strong leadership shown by all, including the Infection Prevention and Control Team, Divisional Management Teams and staff at all levels, who have risen to the numerous daily challenges as the COVID-19 pandemic developed and progressed. There has been excellent collaboration across all teams, with great examples of cross divisional working.

Despite the considerable challenge of the past year, there have also been many positive elements. The most striking is that it is now widely accepted that infection prevention is "everyone's business", and everyone's responsibility, not just the Infection Control Team. We will work to ensure that this ethos continues into 2023 – 2024 and beyond.

15. PRIORITIES FOR 2023 -2024

Despite the demands of the COVID-19 Pandemic, the Trust's Infection Prevention and Control Team have worked with clinical teams to maintain good levels of compliance with all the national infection control quality standards and metrics and the team remain committed to ensuring that further progress is made. The priorities for the year ahead include:

- Further enhance the Trust's infection Prevention and Control Assurance/ Accountability Framework
- Lead on hand hygiene research project supported by SCJohnson
- Explore ways to improve levels of training across the organisation
- Lead on the sustained reductions in healthcare associated infections within the Trust
- Increase engagement and collaboration with Infection Prevention and Control agenda within all divisions of the Trust
- Continue to be proactive in response to the COVID-19 Pandemic and emerging viruses, and to prepare for potential further waves, whilst ensuing that learning from previous waves is embedded
- Continue to support the Nosocomial Scrutiny Panel as part of the national investigation inquiry work

- Submit ANTT Accrediation work for Infection Prevention Society Conference
- Restart the roll out Environmental audits at the Welsh Blood Service
- Participate in national projects implemented by Healthcare Associated Infection Programme, Healthcare Associated Infection Delivery Board, Public Health Wales
- Work collaboratively to support the Sepsis agenda across the Trust
- Explore further opportunities for research and innovation
- Plan a celebration for 10 years MRSA bacteraemia free
- Work effectively with Transforming Cancer Services team regarding the new cancer centre designs and finishes.

1. 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:
YES - Select Relevant Goals below</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 ☐</td></tr>
<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 rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td>Not applicable, this is an annual report.</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information:
https://www.gov.wales/socio-economic-duty-overview</td><td>Not required</td></tr>
<tr><td>This is an annual report.</td></tr>
</table>

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 is an annual report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	This is an annual report.

2. 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

Velindre University NHS Trust Medical Devices Annual Report 2022-2023

DATE OF MEETING	13/07/2023

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	Tim Register, Head of Engineering, Radiotherapy Physics, VCC Jignesh Raiyani, Medical Devices Officer, VCC Peter Richardson, Head of Quality Assurance and Regulatory Compliance, WBS
PRESENTED BY	Peter Richardson, Head of Quality Assurance and Regulatory Compliance, WBS
APPROVED BY	Steve Ham, Chief Executive on behalf of Cath O'Brien, Chief Operating Officer

EXECUTIVE SUMMARY	The report provides a summary of the VUNHST Medical Devices Group activities for 2022/2023 and the activities undertaken in both divisions to ensure compliance with the medical devices regulations. It is expected that new, draft legislation (UK MDR), will be laid before the UK parliament in the near future and VUNHST must remain alert to the

	potential impacts of this. This has been a significant driver of activity for the Medical Devices Group and both divisions over the past year, and will continue to be a focus in the coming year. In the last six months, there have been 248 Medical Device Alerts, Medical Device Safety Bulletin, Field Change Order, and Field Safety Notices. Nine of these were applicable to VCS and have all been actioned and closed. None were applicable to the Welsh Blood Service

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to APPROVE the 2022-2023 Velindre University NHS Trust Medical Devices Annual Report.

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

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

APPENDICES	
N/A	

1. SITUATION

The 2022-2023 Velindre University NHS Trust Medical Devices Annual Report is provided to the Quality, Safety & Performance Committee for approval

2. BACKGROUND

Medical Devices are regulated under The Medical Devices Regulations (MDR) 2002 (SI 2002 No 618, as amended) (UK MDR 2002). These regulations are based on 3 EU directives and are intended to improve the safety and performance of medical devices and intends to provide a high level of protection for the health of patients and users of these medical devices.

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, known as 'The Sharps Regulations', build on existing health and safety law and provide specific detail on requirements that must be taken by healthcare employers and their contractors.

The Trust is either subjected to or can be inspected by regulatory authorities including Healthcare Inspectorate Wales (HIW), Medicines and Healthcare Product Regulatory Agency (MHRA), the Health and Safety Executive (HSE) and Wales Audit Office (WAO).

The VUNHST has responsibility for implementing the requirements of the regulations governing work involving MDR and The Sharps Regulations throughout all Services managed by the Trust. The Chief Operating Officer has been delegated responsibility at Trust Board level for the management of medical devices and equipment. Roles and responsibilities are defined in the Trust Medical Devices and Equipment Management Policy (QS24).

The Trust Medical Devices Group (MDG), exists to ensure that risks of all types associated with the lifecycle of medical devices (including acquisition, in-house manufacture or development, decontamination, use, maintenance and disposal) are controlled and minimised. It is responsible for the identification and management of any issues with medical devices in use or being maintained. This includes responding to any relevant MHRA or manufacturer alerts and keeping the Chief Operating Officer informed of specific issues that require their attention.

3. ASSESSMENT

- The EU introduced updated medical devices regulations in 2017, but the regulations did not come fully into force until 2021. The UK decision to leave the EU means that the latest EU regulations have not been enacted into UK law. The Medicines and Healthcare Products Regulatory Agency, recognising the need for updated legislation has recently consulted on the matter and updated regulations are expected to come in to force in July 2025.

- Both the Welsh Blood Service (WBS) and Velindre Cancer Service (VCS) have undertaken a review of the potential impact, assuming the UK adopts the same standard as EU regulations. This is still in draft, but areas of additional cost are being identified. For WBS in particular, the use of certain reagents will be impacted with significant cost implications. This has been part of an ongoing discussion with WHSSC who have committed to funding these costs.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The following sections summarise the overall Trust framework for managing medical devices.

- The Trust Medical Devices Group has maintained its cycle of quarterly meetings to ensure appropriate governance within the Trust around the management of medical devices.

- The group receives periodic reports from the Medical Gases Committee and Electrical Safety User Group for note of any medical device specific issues or actions to ensure areas of mutual interest are covered. Any urgent operational issues are dealt with in real time.

- In the last six months, there have been 248 Medical Device Alerts, Medical Device Safety Bulletin, Field Change Order, and Field Safety Notices that this Trust wide group has needed to consider . Nine of these were applicable to the Velindre Cancer Service, all of which were actioned appropriately.

- There were no Field Safety Notices applicable to the Welsh Blood Service

- Current issues are contained in a master actions log (e.g. Hoist management, Medical Devices Database) with target dates and progress information, these are discussed at each MDG meeting. The only current outstanding issue is with

regard to the management of hoists within VCC, this has been resolved between VCC Estates and C&V's Manual Handling Advisor (H&S department), the task just requires signing off by the MDG (agreement by all parties) at the next meeting on July 20th.

Cooperation and Information Sharing

- Over the past year, the VUNHST Medical Devices Group has continued to engage with Welsh Government through the Deputy Chief Medical Officer and the Chief Scientific Adviser, who are leading on the current state of preparation for the new UK MDR in every Trust and Health board within Wales.

- The VUNHST Medical Devices Group is also informed through active engagement with the Wales 'Medical Device Regulations Group' which provides an information sharing forum for NHS Wales in respect of current and future Medical Device Regulations as they apply to preparedness of NHS Health Boards and Trusts in response to those regulations and reports key items to the Welsh Scientific Advisory Committee (WSAC) and Welsh Therapies Advisory Committee (WTAC) on a quarterly basis.

- The wider impacts of these regulations are being assessed and incorporated into work plans and the procurement of new devices, and includes digital system impacts.

- The WBS Regulatory Affairs Manager has recently been invited to join the British Standards Institute In-Vitro Devices committee and will contribute to the review and update of the relevant British standards in response to the regulations once published.

Priorities for 2023/24

Work is already well-advanced to scope the detail of the work plan and the associated requirements for meeting the regulatory requirements, but this cannot be completed until the final regulations are published. This will also be an opportunity to develop new approaches across the trust.

The VUNHST Medical Devices Group

- The Governance structure for medical devices is due for review, although the current structure is compliant with nationally recognised best practice and the Medicines and Healthcare Products Regulatory Agency (MHRA) guidelines. Following publication of new legislation, the governance structure for medical devices will need to be reviewed and updated. This will include updates to both the trust Medical Devices and Equipment Management Policy (QS24) and the terms of reference for the Medical Devices group.

Velindre Cancer Service

- The VCS Radiotherapy Physics Engineering Section will continue to work to establish an ISO 13485 accredited Quality Management System (QMS) for in-house manufacturing of medical devices within Radiotherapy Physics. This will ensure that an 'appropriate QMS' is in place when new legislation is introduced.

- The equipment workstream of the nVCC project includes the procurement and commissioning of the medical devices for the new hospital. Current best practice recommends the use of an asset tracking system for medical devices (e.g. RFID tracking), particularly for the new hospital. This will enable hospital wide visibility of all portable powered medical devices and can be useful when locating critical equipment. It will help to increase clinical and medical staff productivity by eliminating time spent searching for devices, hence providing prompt patient care. It will also help to maximise device utilisation. Overall, it will be an effective part of Medical Device management system.

Welsh Blood Service

- In preparation for the new UK MDR the WBS has conducted a series of classification meetings to identify in-house developed medical devices, medical device software and reagents that would be classified as medical devices under the new regulations, on the assumption that those regulations align with the EU MDR/IVDR.

- From these meetings it was identified that several in-house developed software packages and some reagent kits would fall under the definitions of medical device software and in-vitro medical devices respectively.

- The WBS Quality Management System (QMS) is unique to the WBS and is based on the Council of Europe Good Practice Guidelines for Blood Establishments. If the decision is made to continue with in-house developments of software or reagents, then the WBS plans to amend its QMS to meet the intent of the product realisation requirements of ISO 13485. This will ensure that an 'appropriate QMS' is in place.

5. IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</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 ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>10 - Governance</td></tr>
<tr><td rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>There are no specific quality and safety implications related to the activity outined in this report.</td></tr>
<tr><td>Safe ☒
Timely ☐
Effective ☒
Equitable ☐
Efficient ☐
Patient Centred ☒</td></tr>
<tr><td>Compliance with the latest regulatory standards is a significant element of the overall quality</td></tr>
</table>

	management system which assures the safety of patients.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable to this report.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required as the report is for noting and does not require a decision

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Evidence of compliance to relevant UK and EU legislation.

6. RISKS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Information Governance – Annual Report 2022-2023

DATE OF MEETING	13/07/2023

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	IAN BEVAN, HEAD OF INFORMATION GOVERNANCE AND DATA PROTECTION OFFICER
PRESENTED BY	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE AND SENIOR INFORMATION RISK OWNER (SIRO)
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The report provides assurance that the Trust is meeting its mandatory and statutory obligations for Information Governance (IG) by providing a summary of the key IG activities, achievements and issues for the period 1st April 2022 to 31st March 2023. It has been both a busy and challenging year for IG, including the management of a large scale

	incident, the provision of advice and guidance to service areas to facilitate change, increased provision of training and awareness, support to Corporate Governance for the Freedom Of Information (FOI) function and a review of risks associated with new digital systems using the Data Privacy Impact Assessment (DPIA) process. The 2021-22 IG Self-Assessment Toolkit was completed in May 2022, informing the majority of the IG Action Plan with priority actions implemented throughout the year. Internal audit reviewed the IG function with a Reasonable assessment. All recommendations relate to issues already identified in the IG Action Plan. The Trust continues to make good progress in improving IG, the priorities identified from IG Self-Assessment for 2023-24 and the recommendations in the IG Audit Report will form the basis of activity for 2023-24.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to consider and approve the 2022-2023 Velindre University NHS Trust Information Governance Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

EMB **NOTED t**he Trust has continued to make good progress in improving IG, the priorities identified from IG Self-Assessment for 2023-24 and **ENDORSED** For Committee Approval

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	
N/A	

1. SITUATION

The 2022-2023 Velindre University NHS Trust Information Governance Annual Report is provided to the Quality, Safety and Performance Committee for consideration and endorsement prior to submission to Trust Board for approval.

2. BACKGROUND

The Trust operates an Information Governance (IG) Framework that ensures the Trust meets its Mandatory and Statutory obligations and other standards in relation to applicable legislation. Applicable legislation includes but is not exclusive to legislation which supports the principles of the European Convention on Human Rights, Human Rights Act 1998, Protection of Freedoms Act 2012, the Data Protection Act 2018 (includes the retained EU General Data Protection Regulations 679/2016 (UK GDPR)), Freedom of information Act 2000, Environmental Information Regulations 2004, Common Law Duty of Confidence and the Access to Health Records Act 1990.

This legislation is supported by non-legislative guidance such as: the Surveillance Camera Code of Practice 2021, Caldicott Principles and the Records Management Code

of Practice for Health and Social Care 2022 which is in itself based on the Freedom of Information Act's Section 46 Information Management Code of Practice.

The Report sets out the Trust's compliance activity against its legislative obligations during the reporting period, it includes the accountability of key posts, highlights incidents where external reporting has been necessary (which includes assessment of risk and impact), compliance statistics (which exceptionally includes FOIA activity), results of Internal Audit activity and training attainment. The report also sets out a forward look to work programmed for 2023-24, the basis of which is underpinned in the recommendations of the Internal Audit report and self-assessment within the completion 2022-23 IG Self-Assessment Toolkit.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Key IG Objectives 2022-23

The IG Self-Assessment Toolkit for 2022-23 set out the Trust's Action Plan for its objectives in relation to Information Governance. There was some considerable success in achieving the objectives whilst some remain as it is activity that will take longer to achieve.

The key IG objectives that were achieved for 2022-23 were:

- Reviewed and updated IG Policies.
- Accessed and aligned VCC contract registers to the Trust DPIA Register.
- Ensured that a Data Sharing Agreement is in place and cross referred to the DPIA Register.
- Instigated and maintained a new Data Sharing Agreement template.
- Refreshed and updated the DPIA Screening process.
- Instigated and maintained an IG Risk Register to support recording of risks within DATIX.
- Updated the DPIA for physical security, it remains under annual review
- Undertook a review of all Trust CCTV Systems, ensuring that where necessary DPIA's. are in place for each system, keeping each DPIA under annual review.

There are IG objectives that require further work in 2023-24, these are articulated

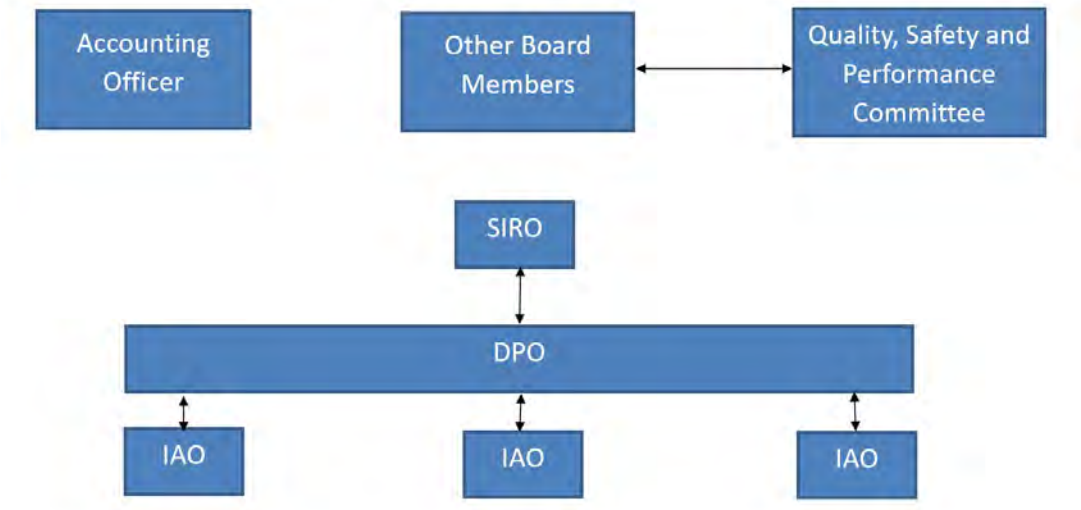
as a forward look in Section 4.

- Develop, instigate and maintain Information Asset Registers (IAR) to be owned by Information Asset Owners (IAO) across all divisions of the Trust to support the Record of Processing Activity (ROPA)
- Continue to align the WBS Contract Register to the Trust DPIA Register
- Complete the review of legacy Trust systems to ensure that risks associated with such systems are recorded in DPIA's where necessary and that those DPIA's are reviewed annually.
- Continue to support the FOI function in Corporate Governance until the recruitment of the FOI Officer in Q2 2023-24.

The Audit Report (see Section 3.3), 2022-23 and 2023-24 IG Self-Assessment Toolkit (see Section 3.4) support the assessment made by SIRO and HoIG in December 2021 and described in the paragraph above. A forward look to 2023-24 is contained within Section 3.4.

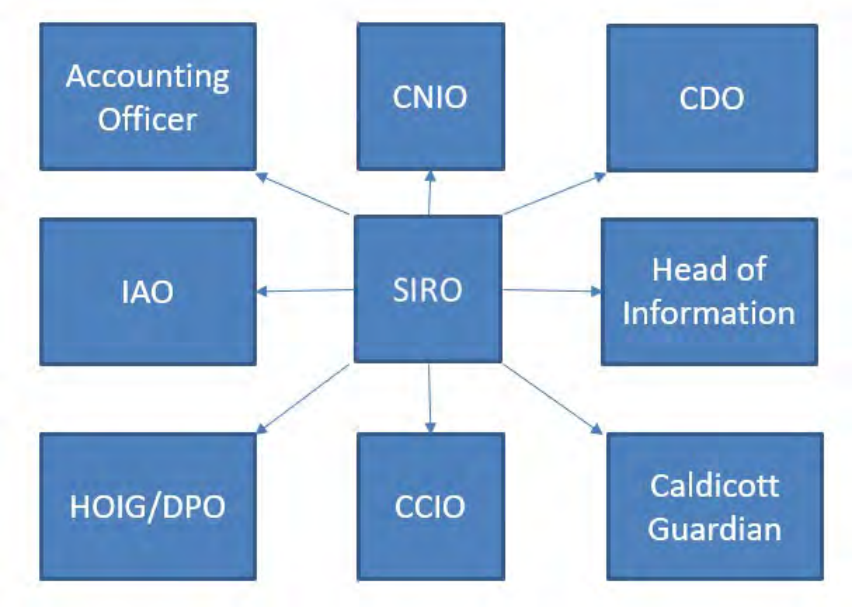
3.2 Key Trust Roles and Reporting Structure

The diagram below sets out the linkage between key roles and the reporting structure for Information Governance within the Trust:



The Diagram below sets out the interconnectivity of roles that consider IG within

their specialisations, this includes the Caldicott Guardian, Chief Digital Officer, Chief Clinical Information Officer (CCIO), Information Asset Owners (IAO) etc.



The Trust's Executive Director of Finance is the designated Senior Information Risk Owner (SIRO) who holds responsibility for information risk to the Trust Board. As an NHS Body, the Trust has in place a Caldicott Guardian, which is the Trust's Executive Medical Director. The two main divisions of the Trust also have a Caldicott Guardian in place.

As Information Governance involves the processing of digital and physical data, the Trust's Chief Digital Officer links directly with the SIRO, Caldicott Guardians, Chief Clinical Information Officer, Head of Information and Head of Information Governance (HoIG)/Data Protection Officer at regular intervals throughout the year so that a rounded approach to Information Governance is undertaken.

During 2022-23 the Trust commenced six-monthly meetings under a formal and agreed Terms of Reference for the Caldicott Guardians, SIRO, DPO, Chief Digital Officer and the CCIO. The aim of the meetings is to conduct a triangulation of IG incidents and recommendations through a clinical lens as well as updating the wider group on Caldicott issues. The Trust has also conducted extensive training

linking together Caldicott Principles, the Data Protection Principles in Article 5 UK GDPR, the Common Law Duty of Confidentiality and the role of the National Data Guardian under the Health and Social Care (National Data Guardian) Act 2018. The Trust provides training in these key areas principles for all new Clinical Staff, which has included a mass training session for Consultants which was completed on 6th July 2022. As well as the mandatory training requirements in the Electronic Staff Record (ESR) all staff will receive an overview in Caldicott Principles and their importance as part of the new induction process beginning in July 2023.

The lead for Information Governance for the Trust is the HoIG, who is also the Trust's Data Protection Officer (DPO). The DPO role is defined as a senior member of Staff who provides independent advice and guidance to the Data Controller (the Trust) and as a result ensure that there are effective controls and mechanisms in place to ensure that the Trust complies with its Mandatory and Statutory obligations. The DPO supports staff ability via the delivery of Training and Awareness to comply with Information Governance fundamental principles and procedures, these are specific obligations under Article 39 UK GDPR.

The role of DPO was moved to the Trust from Digital Health and Care Wales (DHCW) in May 2023, this is because the HoIG was undertaking the tasks of the DPO. As a result SIRO deemed it more appropriate for the resources needed to support the HoIG to be brought back into the Trust, this aligned with a recommendation in the Audit report to examine resources to support the IG Function within the Trust.

The Trust IG Peer Group six-monthly meeting was reinstated in 2022-21 after a lapse of two years. The aim of the Peer Group is to discuss and share best practice, ensure that all IG professionals are aware of updates to applicable data protection legislation and to discuss any IG incidents that may have a wider impact. The Peer Group membership consists of the Trust HoIG/DPO, NHS Wales Shared Services Partnership's IG Manager, the Trust Archivist, the VCS Health Records Manager and the VCS Medico-Legal Clerk.

3.3 Information Governance - Internal Audit Report – 2022-23

Since last year overall risk has reduced. This risk assessment is supported by the completion of an Internal Audit in Quarters 3 and 4 which provided "reasonable

assurance" overall which is consistent with management's anticipated assurance. There is a robust process across NHS Wales for the review and collection of evidence required to support the annual IG Toolkit Assessment. Internal Audit assessed the following four areas. The report focuses on the areas of the Audit that were assessed as Reasonable:

- Handling of sensitive information – Reasonable
- Information Governance training – Reasonable
- Recording of data breaches – Substantial
- Governance and oversight – Substantial

Handling of sensitive information

In relation to the handling of sensitive information, the SIRO and HoIG had identified in Financial Year (FY) 2021-22 that the lack of workable Information Asset Registers (IAR) meant that the handling of sensitive information was not as robust as it could be, and this has been identified within the work plan in the long term, this assessment was borne out by the audit.

The Welsh Blood Service (WBS) has IAR's in operation in 100% of its working areas. Velindre Cancer Service (VCS) and the Corporate Divisions do not currently have working IAR's in operation within their operational areas (0%). It should be noted that the IG Self-Assessment Toolkit for 2022-23 and 2023-24 have both noted this as a requirement. In terms of the route to compliance, the Records Management Task and Finish Group (which was set up as a result of the Offsite Storage Incident) began to meet in Q1 2023-24. It has an overarching objective to instigate the operation and maintenance of IAR's as Business as Usual (BAU) which will include periodical audits by the HoIG by the end of Q4 2023-24. The IG Toolkit Action Plan also notes that requirement to achieve compliance by the end of Q4 2023-24.

The Audit noted areas of good practice, these being:

- The IG Development plan is subject to a robust governance and oversight mechanism and work is clearly in progress on these tasks, the Audit did not raise them as matters arising.
- The Trust has a broad framework to support its objective to comply with IG

related legislation.

- The HoIG meets regularly (informal meetings) with the Trust's Digital Services Team to identify any projects where IG Risks needs to be considered.
- Project managers receive tailored IG training from the HOIG to assist them in identifying where there may be IG risks that need to be considered.
- DPIAs are undertaken to impact assess the risk of data processing for existing services/systems and for the delivery of new services/systems. Responsibility for this lies with the project/service lead;
- The HOIG reviews all completed DPIAs to ensure they are undertaken to an adequate standard; and
- The HOIG maintains a DPIA register to record and monitor the DPIA assessments that have been carried out.
- The Audit noted a well-defined process for the capture and investigation of data breaches is in place.

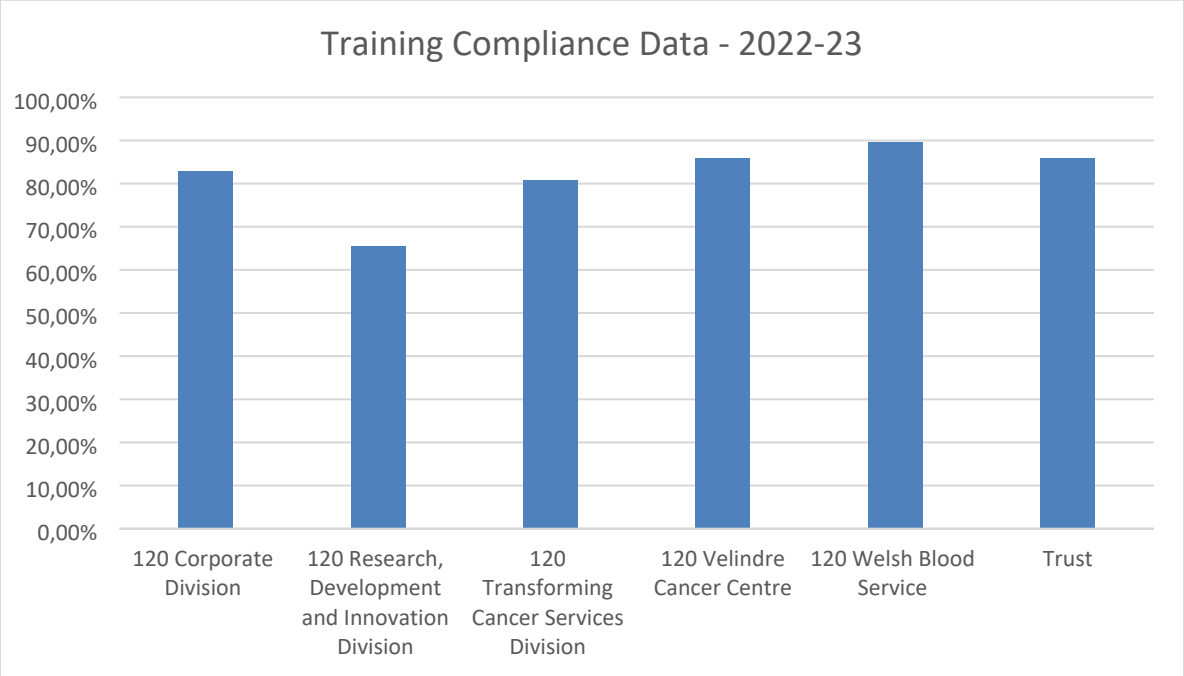
Information Governance Training

In relation to Information Governance training, face-to-face (either by teams or in person) Information Governance training is provided for all clinical staff joining the Trust. Workshops are also provided where an incident has occurred to ensure that individuals and teams understand their obligations in relation to Information Governance. The minimum standard for training compliance is 75% as a Trust average, the Trust achieved 85.78% for 2022/23.

Training compliance reports are received monthly from Workforce and OD which enables the HoIG to target groups and individuals where compliance is low. SIRO and HoIG had identified in FY 2021-22 that all staff should receive identical induction training. This approach was supported by the audit, the audit noted that Electronic Staff Record (ESR) compliance was lower than the minimum 75% in one division of the Trust at the time of the audit (65.38%).

The Trust has already taken steps to address the assessment of the audit in relation to IG training, a recent check (end of May 2023) has demonstrated that the division concerned has increased compliance from 65.38% at the end of April 2023 to 72.55% by the end of May 2023, this has been achieved by a targeted training programme delivered by the HoIG. Further sessions are planned for July

2023 to further increase compliance rates with the aim to achieve in excess of 75%. Trust Training Compliance Data – 2022-23 (as at 31st March 2023) is shown below:



The Audit also noted further examples of good practice these being:

- Delivery of additional IG Training where Staff have been involved in IG incidents
- The training materials delivered to programme and project managers, clinicians, Research, Development and Innovation Teams members and Trust Board were found to be comprehensive
- Delivery of IG training by the HoIG to individuals or groups either in addition to or instead of the mandatory ESR training. This training not otherwise part of the Trust's mandatory programme but is considered important for specific roles.

3.4 Information Governance Self-Assessment Toolkit

In addition to internal audit activity, the Trust utilises the Welsh Information Governance Toolkit (IG Toolkit) to measure its level of compliance against national

IG standards and legislation and identify areas of IG risks. The toolkit is completed annually by the HoIG and reviewed by the SIRO and provides evidence of areas of improvement achieved and identifies actions for the following year. Looking forward to 2023-24, priority areas for further improvement above that achieved in 2022-23 are:

- Investigate and procure training opportunities for SIRO, Caldicott Guardian and HoIG
- Drive the renewal of currently out of date All-Wales IG policies for approval via the Welsh Information Governance Board (WIGB)
- Support the Trust's face to face induction procedure for all new staff from July 2023
- Update Privacy Notices for Velindre Cancer Centre and Welsh Blood Service
- Support the Implementation and Maintenance of Information Asset Registers (IAR's) across all divisions by 31st March 2024
- Continue to cross refer the DPIA and Contract Registers to ensure that IG is properly considered as "*data protection by design and default*"
- Continue targeted training workshops across the Trust.
- Support the Records Management Task and Finish Group which was set up as part of the lessons learned from the ICO reportable incident.
- Produce a Records Management Strategy that includes digitisation as its core basis in preparation for nVCC in 2026.
- Continue to undertake targeted audits across the Trust to raise compliance standards.
- Continue to support FOIA activity until the recruitment of the new FOIA Officer in September 2023.
- Ensure that a hard copy of the Digital Team's Business Continuity and Disaster Recovery plan is held by all relevant parties.

3.5 Privacy by Design and Default

The Trust continues to process personal data using the mandated "Privacy by Design and Default" approach (Article 25 UK GDPR) when procuring new systems and maintaining existing ones where personal data is processed. "Privacy by Design and default" enables the Trust to consider IG risk by using the Information Commissioners Office mandated Data Protection Impact Assessment process.

The process helps analyse, identify and minimise the data protection risks of a system (both electronic and manual records). Article 35 of the UK GDPR states that Data Protection Impact Assessments (DPIA) are a legal requirement for processing data that is likely to result in high risk to the rights and freedoms of individuals. The Information Commissioner's Office (ICO) advises that the completion of a DPIA is good practice when processing personal data. A DPIA does not have to eradicate all risk but should help to minimise and determine whether the level of risk is acceptable in the circumstances. Under UK GDPR, failure to carry out a DPIA when required may leave the Trust open to an enforcement notice where the ICO will tell the Trust that it MUST carry out an action and if it does not, the ICO may either; publish an enforcement notice on its website and more widely which could negatively affect the Trust's reputation or impose a financial penalty at the higher rate of up to 20 million Euros (£16.52m) or 4% of annual turnover, whichever is the highest.

In the period 1 April 2022 – 31 March 2023, 43 DPIAs were approved with another 16 in progress. The DPIAs that remain in progress are related to ongoing long term projects.

3.6 Freedom of Information Act and Environmental Information Regulations

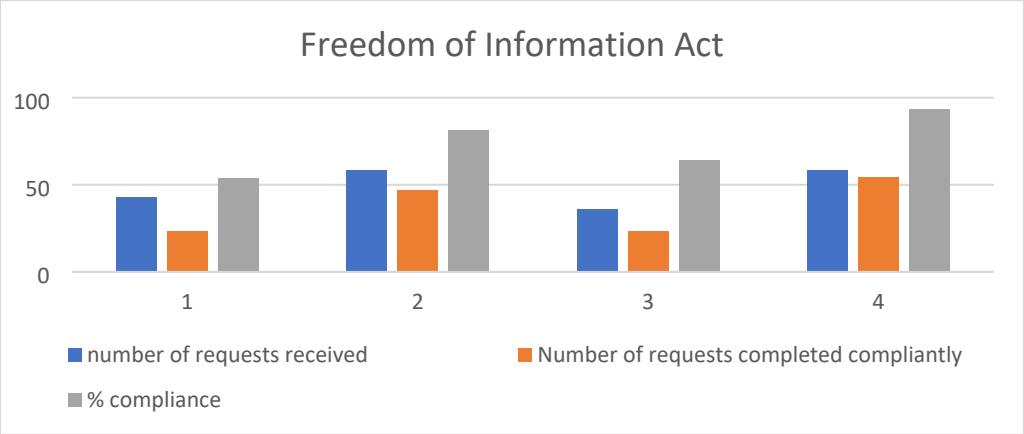
The public have the right to request information held by the trust under the Subject Access Process in relation to the Freedom of Information Act 2000 (FOIA) and Environmental Information Regulations 2004 (EIR). In the period 1 April 2022 – 31 March 2023, the Trust received requests for information under the Freedom of Information Act per quarter as follows:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	43	23	53.49%
2	58	47	81.03%
3	36	23	63.89%
4	58	54	93.10%
Total for FY 22/23	195	147	75.38%

The Trust received requests for information under the Environmental Information Regulations per quarter as follows:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	1	1	100%
2	2	2	100%
3	0	0	100%
4	0	0	100%
Total for FY 22/23	3	3	100%

Analysis for the Freedom of Information compliance for **ASSURANCE** is shown below:



In relation to FOI responses, the Trust undertook 1 Review requested by a member of the public. The Review was undertaken as a result of a multiple stranded complaint covering five specific areas, the areas and a summary of the Trust's response for each area are articulated, further details are contained within the relevant report and are available on request from the HoIG.

3.7 Individual Rights – Subject Access Requests

In relation to Subject Access Requests (SAR) made under the Data Protection Act

2018, the Trust received the following number of requests:

Medical Records

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	59	59	100%
2	34	34	100%
3	45	39	86.60%
4	45	45	100%
Total for FY 22/23	183	177	96.72%

Corporate

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	2	2	100%
2	1	1	100%
3	0	0	100%
4	1	1	100%
Total for FY 22/23	4	4	100%

3.7 Data Security Incidents and Investigations

ICO Reports

During 2022-23 the Trust reported 1 personal data breach incident to the ICO, this breach originated on 20th February 2022. The notification was submitted within the 72 hour breach reporting timeframe. The reported breach was a serious incident, both the Executive Management Board and Quality, Safety and Performance

Committee have been kept fully informed as to progress of the incident.

Incidents that do not meet the Threshold of external reporting

Incidents that do not reach the threshold of reporting to the ICO continue to be reported an investigated via DATIX. Common themes continue to be confidentiality breaches:

- patient records/information sent to wrong recipient (misdirection)
- staff records/information sent to wrong recipient
- staff records/information inappropriately accessed

Quarterly IG assurance meetings between the Independent Member (IM) for IG and Digital SIRO, HoIG/DPO, and Chief Digital Officer continue to take place to provide additional assurance to EMB and the Committee.

The first Caldicott Meeting took place in February 2023, in which the Caldicott Guardians, SIRO, HoIG, CDO, and Chief Clinical Information Officer met and discussed incidents, in particular any incidents of inappropriate access to clinical systems by Staff.

3.8 Prior Consultation

During 2022-23, the Trust has engaged appropriately with the ICO as part of its duty to conduct prior consultation for intended processing under Article 36 UK GDPR.

The Trust has also engaged with the ICO informally to seek timely appropriate advice and guidance on other operational issues, such as:

- Potential use of Body Worn Cameras and CCTV equipment in the new Velindre Cancer Centre and compliance with the Surveillance Camera Code of Practice 2021
- Use of social media platforms for fundraising purposes, especially assessing the consideration of Legitimate Interest as a lawful basis of processing
- The regulators position on the use of the Freedom of Information Act by companies seeking contract work in Public Bodies

- The regulators position on the frequency of requests by the same requestor made to the Trust under the Freedom of Information Act
- Monitoring of employees in the workplace and privacy considerations

The consultation process has proven to be useful in identifying and mitigating risk where the intended processing may result in a high risk to the rights and freedoms of data subjects.

3.9 Trust Policies

The HoIG reviewed and updated all Trust IG policies, the policies were republished on the Trust Intranet site in July 2022, and will be due for review in July 2025 unless any changes in Data Protection legislation by the UK Government necessitates a change sooner. It should be noted that the new Data Protection Bill is currently in its second reading within UK Parliament and that the HoIG is monitoring the legislative developments so that they can be considered by the Trust in a timely manner, the following policies were updated and published:

- Confidentiality Breach Reporting Policy
- Data Protection and Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy

The All-Wales IG policies expired in January 2023, these remain extant. Re-publishing the policies has proven to be problematical due to the difference of approach in approving the Policies in each Trust/Health Board in Wales. The affected policies are:

- NHS Wales Email Use Policy
- NHS Wales Information Governance Policy
- NHS Wales Information Security Policy

To resolve the situation, HoIG is consulting with DPO colleagues within the Information Governance Management Advisory Group (IGMAG) so that a resolution to re-publishing the policies is found as soon as possible in 2023-24.

Cyber related policies were also reviewed, updated and published, these are reflected in the Cyber Security Strategic Improvement Plan.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒

	The aim of Data Protection by design and default relies on: • *timely* engagement (at the design stage of a project); • to enable the protection of the rights and freedoms of data subjects (*safe*), the impact is then; • *efficient* and *effective* systems that deliver *patient centred* care. Combining all of the elements contained within this report all contribute to that aim.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Compliance with data protection legislation is an obligation of the Trust.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	The delivery and use of systems that are compliant with legislation contribute effectively to "*A Healthier Wales*"
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Information Commissioners Office has the power to impose financial penalties (fine of up to 20 million euros (approx. £17.5m) and issue enforcement action. **Source of Funding**: Trust Reserves

	Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Up to 4% of annual turnover of £17.5m whichever is the highest **Type of Change** **Other (please explain)** Please explain if 'other' source of funding selected: A financial penalty would be set by the ICO which would require significant Trust Board involvement
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Compliance with legislation is a mandatory obligation. Equality Impact assessments are undertaken at the time of royal assent for applicable legislation.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	An incident remains which does have significant legal implications for Trust, this case is ongoing and well documented
	1. *Legal costs for the Trust* 2. *Other non-legal costs for the Trust, which could result in;* 3. *Possible non-recovery of costs from the other party*

5. RISKS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Annual Sustainability Report 2022/23

DATE OF MEETING	13/07/2023
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	Rhiannon Freshney, Trust Sustainability Manager
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The NHS is responsible for 2.6% of the total carbon footprint in Wales. It has fallen behind other sectors when it comes to response and reducing environmental impact, when these responses are more important than ever. At COP26, it was agreed we as global citizens must now move forward together and deliver on the expectations set out in the Glasgow Climate Pact. The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff

	and visitors. We also have a responsibility to transition to a new, sustainable world which minimises the use of resources and creates wider value. Driven by our Sustainability Strategy, the Trust has continued to be ambitious with our sustainability aims. We have developed strategic & operational goals and initiatives to ensure we are mitigating our impact and consumption to ensure we act today, for a more sustainable tomorrow. This report outlines actions taken by the Trust during 2022/23 in support of the sustainable agenda.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **APPROVE** the **Annual Sustainability Report 2022/23.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Management Group	28/06/2023
Executive Management Board	03/07/2023
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • Noted the Trust's continued progress and key achievements in taking forward the sustainability agenda and ongoing ambition in this space over the next few years. • **ENDORSED** for Committee approval	

7 LEVELS OF ASSURANCE – N/A	
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**

APPENDICES	
Appendix 1	Internal Sustainability Annual Report 2022 - 2023

1. SITUATION

As part of the corporate process, the Trust receives an Annual report which details activities undertaken through the year to comply with the Sustainability Agenda.

This paper has been prepared to provide the Quality, Safety & Performance Committee with an overview of delivery during the financial year 2022/23.

2. BACKGROUND

The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value.

Driven by our Sustainability Strategy, the Trust has continued to be ambitious with our sustainability aims. We have developed strategic & operational goals and initiatives to ensure we are mitigating our impact and consumption to ensure we act today, for a more sustainable tomorrow.

3. ASSESSMENT

3.1 The purpose of the Annual report is to provide an overview of the progress against key performance indicators, service improvement initiatives and approved relevant documentation throughout the year.

3.2 The Annual Report provides the Management Review of the Trust Environmental Management System (EMS), ensuring the EMS is continually improved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The report provides a comprehensive overview of all aspects of sustainability. Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements are highlighted in the report:-

- Maintained ISO14001: 2015 certification across all divisions/hosted

organisations of the Trust (successfully attained for VCC, Trust HQ and WBS). The Trust received no nonconformities.

- A number of initiatives have been progressed/delivered through the 2022/23 includeing introduction of Sustainable Jamborees which were were launched in the summer, and have since had events in Autumn and Spring. The event programme was welcome to staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art.

- We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. We ran a beehive competition to design our WBeeS logo for our honey!

- Ray of Light Cancer Support & Trust Award Nomination Our partnership with Ray of Light Cancer Support was nominated for a National Mental Health Well-being Award. the service has been shortlisted for a Mental Health & Wellbeing Wales Award in the 'Best Mental Health Support Service' category.

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)	06 - Quality and Safety

For more information: STRATEGIC RISK DESCRIPTIONS	
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 ☐
	All objectives delivered under the sustainable agenda support creation of a better environment for all. Reducing carbon emissions is linked to health and wellbeing.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	[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	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The report applies and contributes to all 7 Well-being Goals.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	[This report provides a comprehensive overview of all aspects of sustainability and key achievements.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	- *Contribution to the Well-being of Future Generations (Wales) Act* - *Environment (Wales) Act*

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
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	

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

SUSTAINABILITY ANNUAL REPORT

2022 - 23

TABLE OF CONTENTS

INTRODUCTION

Human activity has caused rapid and widespread changes to Earth's systems, driven by increased concentrations of greenhouse gases. The NHS is responsible for 2.6% of the total carbon footprint in Wales. It has fallen behind other sectors when it comes to response and reducing environmental impact, when these responses are more important than ever.

At COP26, it was agreed we as global citizens must now move forward together and deliver on the expectations set out in the Glasgow Climate Pact. It is up to all of us to sustain our model of keeping 1.5 degrees within reach and to continue our efforts to get finance flowing and boost adaptation.

The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value.

Driven by our Sustainability Strategy, the Trust has continued to be ambitious with our sustainability aims. We have developed strategic & operational goals and initiatives to ensure we are mitigating our impact and consumption to ensure we act today, for a more sustainable tomorrow.

SUSTAINABILITY STRATEGY

The Trust has created a suite of enabling strategies to outline the future of the organisation. This includes a Sustainability Strategy, which embeds the Well-being of Future Generations Act at its core. The strategy outlines our sustainability aims and enables real action to create positive and significant change.

To align with the NHS Wales Decarbonisation Plan, we have used 2018/2019 as our baseline data which we will monitor our progress against.

Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

To develop the Trust Sustainability Strategy we have engaged with our staff, aligned with key legislation, and benchmarked against other NHS and private organisations. The strategy creates a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patien ts and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

SUSTAINABILITY STRATEGY

To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act, which together ensure we achieve the our Trust Well-being Objectives.

Theme 1: Creating Wider Value: Our Organisational Approach

Theme 2: Sustainable Care Models

Theme 3: Eliminating Carbon

Theme 4: Sustainable Infrastructure

Theme 5: Transition to a Future of Renewables

Theme 6: Sustainable Use of Resources

Theme 7: Connecting with Nature

Theme 8: Greening our Travel and Transport

Theme 9: Adapting to Climate Change

Theme 10: Our People as Agents of Change

Throughout this document, different areas of work have been driven by different themes, to signify which, this logo & relevant theme number will be displayed

T10

KEY ACHIEVEMENTS

Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements have been highlighted below -

ISO14001:2015 - Surveillance Audit

Following a five day recertification audit, the Trust successfully maintained the ISO14001:2015 Environmental Management System certificate, with no non conformities identified.

Sustainable Jamborees

The Sustainable Jamborees launched last Summer, and have since had events in Autumn and Spring. The event programme was welcome to staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art.

Beehives

We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. We ran a beehive competition to design our WBeeS logo for our honey!

Ray of Light Cancer Support & Trust Award Nomination

Our partnership with Ray of Light Cancer Support was nominated for a National Mental Health Well-being Award. the service has been shortlisted for a Mental Health & Wellbeing Wales Award in the 'Best Mental Health Support Service' category.

AUDITS

ISO14001:2015

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an Environmental Management System (EMS). The Trust has successfully obtained the ISO 14001:2015 standard for the last seven years for all sites.

At the end of 2022, the Trust had a surveillance audit facilitated by BM Trada. Each year, a different selection of sites are chosen to be reviewed. The following sites were under review -

- Velindre NHS Trust Headquarters (1 day)
- Velindre Cancer Centre (2 days)
- Welsh Blood Service, Talbot Green (1 ½ days)
- Welsh Blood Service, Unit 4 Llanelli Gate (1/2 day)

The Trust successfully obtained recertification and received zero non conformities. The external auditor noted, "the Management Review Process continues to be effective with performance targets and indicators being fully detailed, with internal and site-based audits & inspections ensuring that commitment to the Management System was being maintained, which are completed by competent personnel who discussed a full understanding of the audit process and expected outcomes."

INTERNAL AUDITS

The ISO14001:2015 Management Group continues to to oversee all elements of the Environment Management System (EMS) across the Trust. The group consists of key divisional colleagues who input into the Trust EMS. The purpose of the group is to ensure sufficient and effective monitoring of the EMS. Members meet once a month and the agenda aligning with the Management Review timetable. All members are trained internal auditors, and undertook several internal audits over the previous year to ensure compliance and continue improvement of the standard. The following audits were undertaken;

- Velindre NHS Trust Headquarters
- Velindre Cancer Centre - Operational Services
- Velindre Cancer Centre - Estates
- Welsh Blood Service, Talbot Green
- Welsh Blood Service, Unit 4 Llanelli Gate
- Legal Register

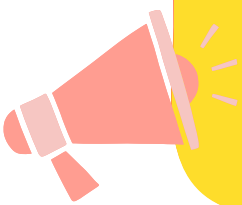
DECARBONISATION

An in depth decarbonisation action plan as been developed which covers all aspects of our carbon footprint, ranging from transport to procurement. Aligning with the NHS Wales Decarbonisation Strategy, the detailed plan is an ambitious document which provides the Trust with a roadmap to be Net Zero by 2030.

Throughout the Trust, major capital programmes are being undertaken which will contribute significantly to our decarbonisation agenda. The Talbot Green Infrastructure upgrade project & new Velindre Cancer Centre will be large contributors. Throughout the year, the Sustainability team have provide sustainability advise & were directly involved in the Community Benefit workstreams to these capital programmes.

T2 T3 T4 T5 T6 T9

100% **of our purchased electricity is from renewable energy; we use solar, wind or biomass power!**



"This is an exciting time for the Trust as we progress with the development of our estate through delivery of the Trust's major capital programme. It's refreshing to have such a large focus on sustainability within each project underpinning the Trusts ambition to meet Welsh Government Targets. It really is fantastic opportunity to be involved with the delivery of such ambitious targets, in support of carbon reduction, enhancement of biodiversity, and the integration of arts in novel and innovative ways. I'm looking forward to the next stage of each project to see how we can push our ambitions even further"

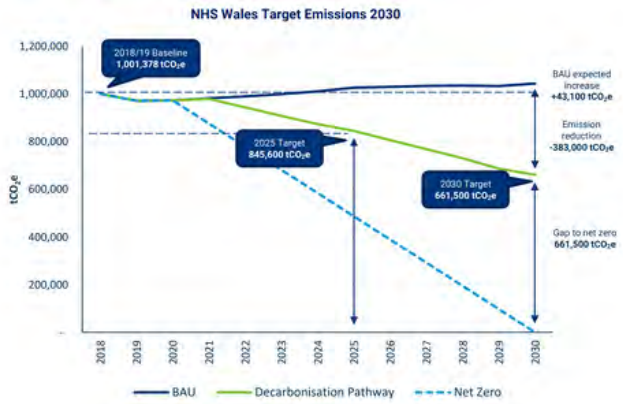
Jason Hoskins,
Assistant Director of Estates, Environment and Capital Development.

Our consumption reduction through projects and initiatives contributes to the Trust Well-being Objective, ***"Deliver bold solutions to the environmental challenges posed by our activities"***

DECARBONISATION ACTION PLAN

The prioritised action plan has been produced and is based on the Trust Decarbonisation Action Plan, using the principles and targets of the NHS Wales Decarbonisation Strategy to identify a list of actions to help achieve the NHS Wales' target of net zero public sector by 2030. NHS Wales has measured existing carbon footprint using baseline years 2018/2019, this has been calculated as approx. 1 million tonnes of CO2e (2.6% of Wales's total greenhouse gas emissions (Wales, 2021)) and identified a decarbonisation pathway which sets 2025 and 2030 emissions reductions targets.

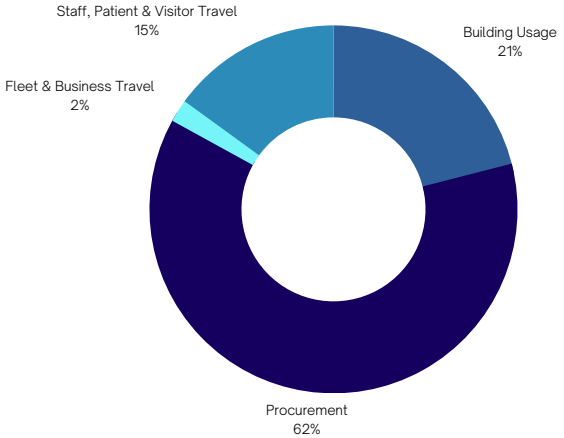
The decarbonisation targets have been set at 16% (845,600 tCO2e) from baseline year by 2025, 34% (661,500 tCO2e) reduction by 2030.



T2 T3 T4 T5 T6 T9

The Decarbonisation Action Plan proposed and identify key actions for prioritising by the Trust. These have been grouped into the following relevant categories:

- People – Training and communications
- Digital – Working strategy and equipment
- Hard FM – Equipment and feasibility
- Soft FM – Metering and controls
- Policy and best practice



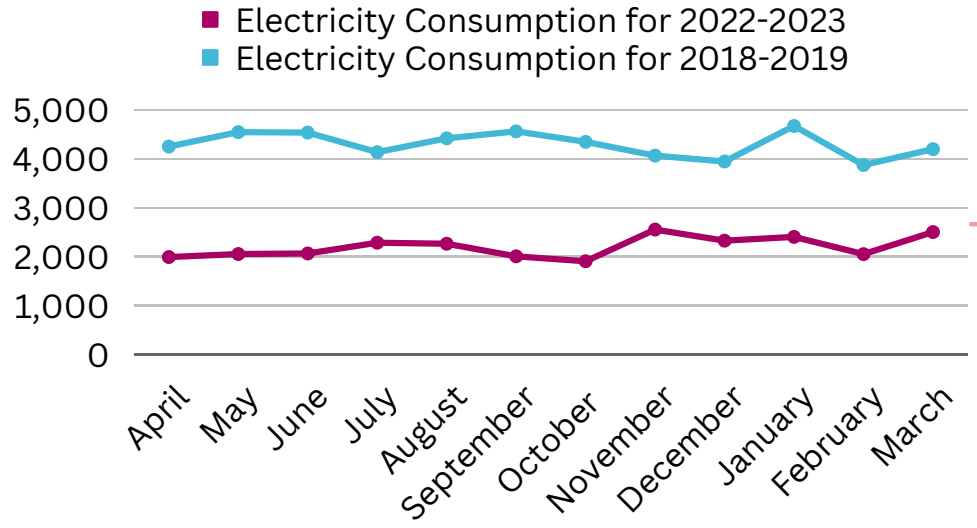
"It has been really interesting to be involved in developing the Trust's Prioritised Decarbonisation Action Plan. I have been working with the Trust's Sustainability & Estates Teams to forecast how each project will reduce the Trust's overall carbon footprint and weighed up each projects potential cost vs carbon saving. It has been really fascinating to be part of this process and has been a fantastic learning opportunity!"

Owen Barnett
Environmental & Sustainability Work Placement

The categories within the Decarbonisation Action plan have been mapped against the NHS Wales NHS Wales Carbon Footprint categories (graph pictured is the category breakdown in 2018/19).

ELECTRICITY CONSUMPTION

TRUST HEADQUARTERS

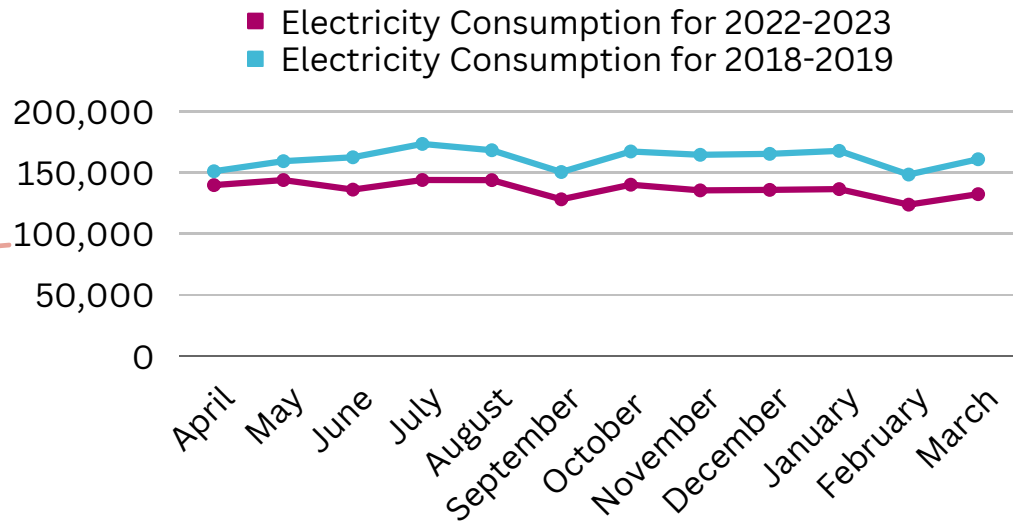


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

48.76%

AGAINST BASELINE OF 2018/19

WELSH BLOOD SERVICE

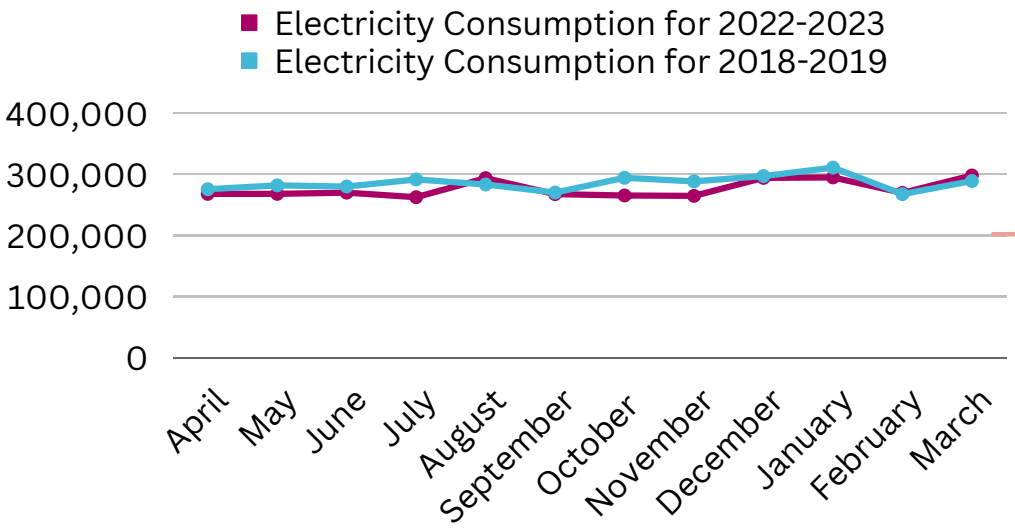


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

8.73%

AGAINST BASELINE OF 2018/19

VELINDRE CANCER CENTRE



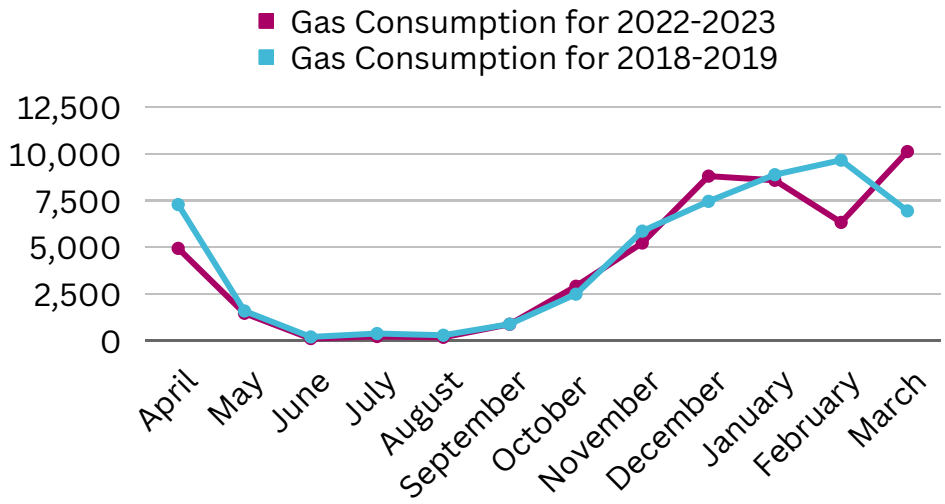
OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

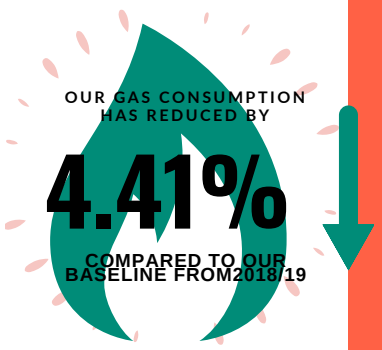
3.30%

AGAINST BASELINE OF 2018/19

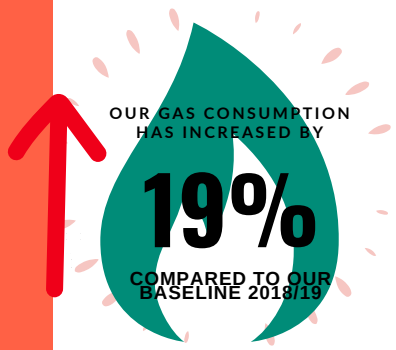
GAS CONSUMPTION

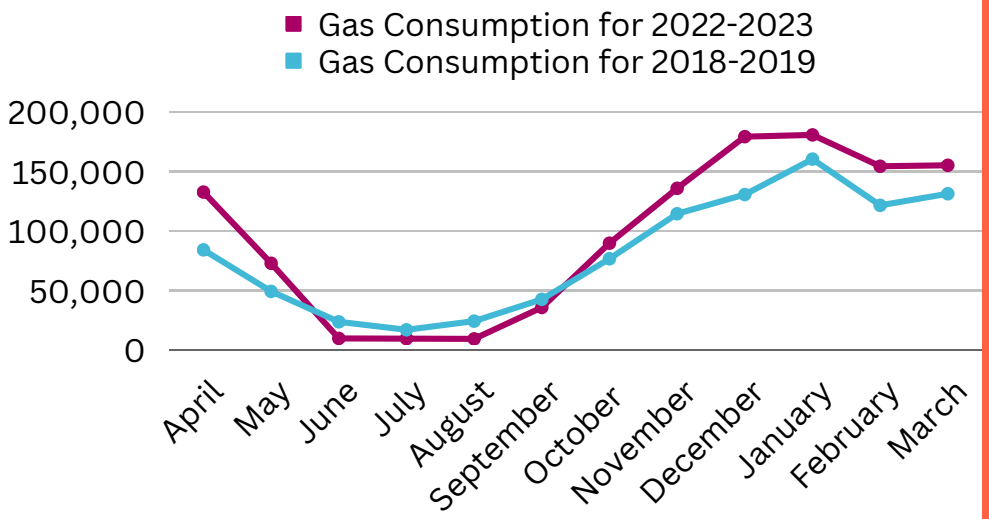
TRUST HEADQUARTERS





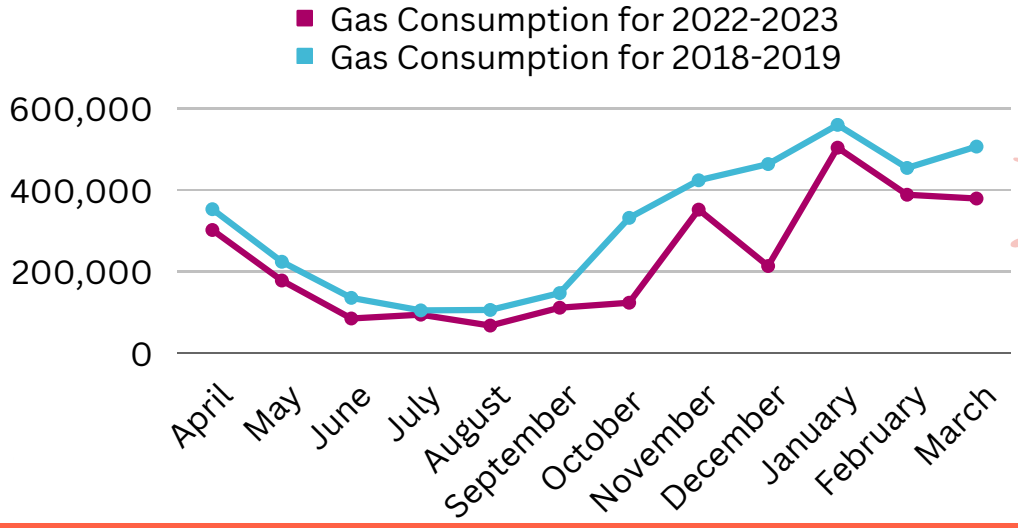
WELSH BLOOD SERVICE

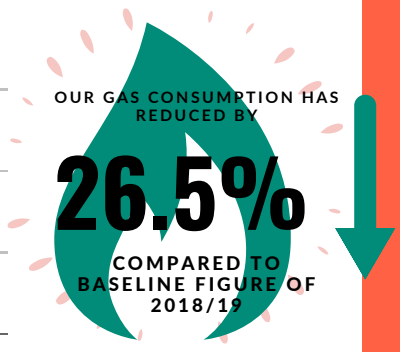




The significant increase in gas consumption compare to the 2018/19 baseline is due to an issue with the Building Management System (BMS) and boiler at Talbot Green in 2020. This has since been addressed, and a new Building Management System has been implemented, allowing the Estates Technicians more effective controls. When considering a year by year comparison, the gas usage across WBS has reduced by 6.37% compared to 2021-2022.

VELINDRE CANCER CENTRE



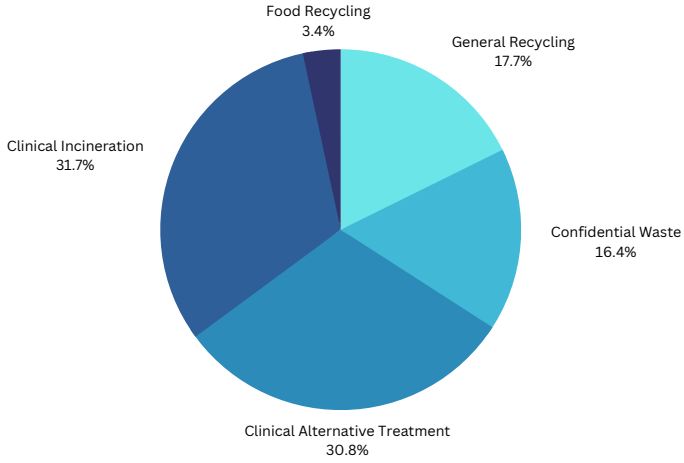


WASTE

VELINDRE CANCER CENTRE

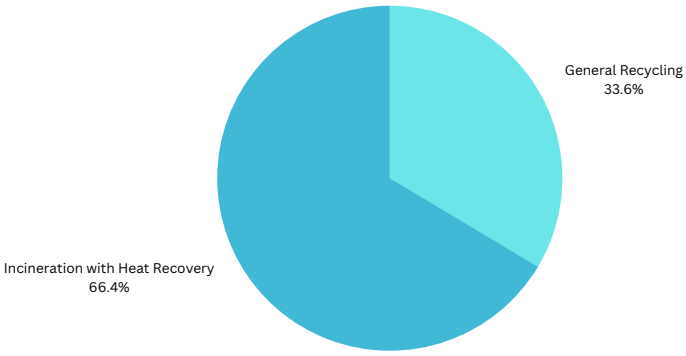
Did you know?
The Trust sends zero waste to landfill!

ZERO WASTE to landfill



To address the increase in general waste, various initiatives have been have been trialled in the past year. A successful campaign was introducing food waste bins to staff kitchens. This is being rolled out to all staff kitchens and break areas in 2023 - 2024.

WELSH BLOOD SERVICE



Across the Trust, proactive measures have been undertaken to combat waste. In this finanicial year, at Welsh Blood Service, general waste has reduced and recycling rates continue to increase, with 20% increase on the recycling weight compared to the previous year!

Significant work has been undertaken across the Trust, including;

- **waste engagement events**
- **new bins purchased**
- **new signage**
- **bin shelters built by volunteers with 'living' roof**
- **biodegradable aprons**
- **waste communications**
- **removing non clinical single use plastic from donor clinics**

More on this on the next page!

SINGLE USE PLASTIC

What does the legislation say?

The Environmental Protection Bill will make it an offence to littered & unnecessary single-use plastic products in Wales:

- plates, cutlery & drink stirrers
- drinking straws (including attached straws)*
- cups made of polystyrene
- takeaway food containers made of polystyrene
- cup & takeaway food container lids made of polystyrene
- plastic-stemmed cotton buds
- sticks for balloons
- oxo-degradable products
- plastic single-use carrier bags

*medical exemptions apply

In October 2023, new legislation comes into force, the Environmental Protection (Single-use Plastic Products) (Wales) Bill ('the Bill') which has been approved before Senedd Cymru.

This Bill is a key step in halting the flow of plastic pollution into our environment and forms part of our response to the climate and nature emergency. The Bill makes it an offence for a person to supply or offer to supply (including for free), the following commonly littered and unnecessary single-use plastic products to a consumer in Wales.

Although not enforceable until October, at the Trust we have been working hard to reduce our non -clinical single use plastic ahead of the legislation implementation. The Bill aligns with the Trust ambitions set out within the Sustainability Strategy, particularly Theme 6: Sustainable Use of Resources.

In readiness for implementation of the Bill, discussions have been held with key departments, and information regarding the Bill is included on the staff intranet and via the digital screens on sites, and forms part of the Waste Engagement Sessions.

In the past year we have been working hard to remove single use plastic, where possible across the Trust.

The following has been removed;

- plastic stirrers
- plastic cups
- straws (on donor clinics)
- baguette wrappers
- aprons
- cutlery
- takeaway containers
- coffee cup lids

"Following our successful pilot of biodegradable cups on donor clinics, I am pleased to say we have now rolled this out across all of our clinics, removing nearly 150,000 plastic cups from landlfill! Not only this, but we have removed plastic straws and stirrers. This means we have removed all non-clinical single use plastic on our donor clinics!"

Matthew Bellamy
Environmental and Health & Safety Manager, Welsh Blood Service

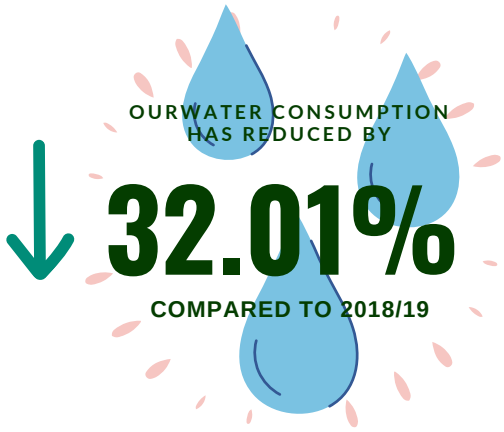
"Working with the Velindre Café staff, we have been working really hard to reduce the amount of single use plastic in the Café. As the restrictions began to ease from the pandemic, we were able to reintroduce reusable cutlery and crockery, and any single use alternatives are now compostable. We have replaced the packaging for baguettes to paper, and the takeaway containers are now all VegeWare!"

David Harding
Operational Services Compliance Manager

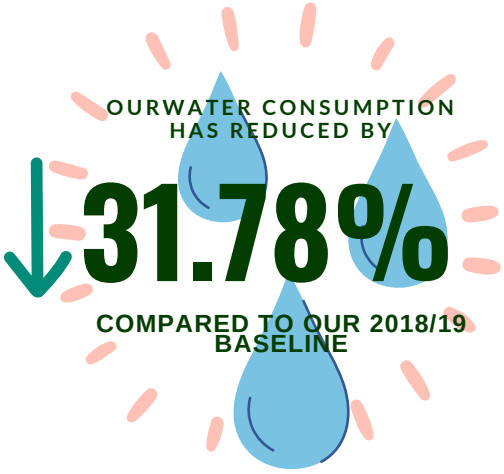
WATER CONSUMPTION

T6

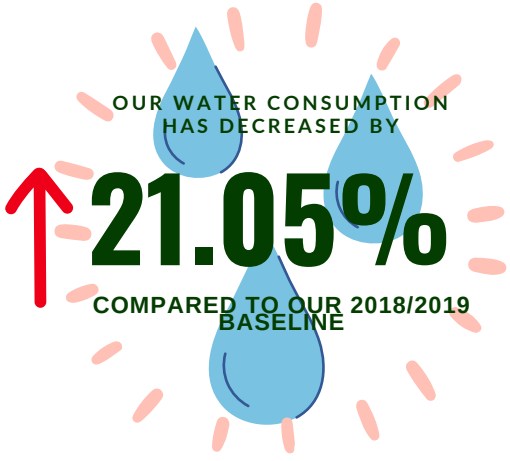
WELSH BLOOD SERVICE



TRUST HEADQUARTERS



VELINDRE CANCER CENTRE



There has been a reduction of water consumption against the baseline 2018/19 across WBS and Trust Headquarters.

At WBS, has recently reduced water tank storage capacity due to a compliance recommendation.

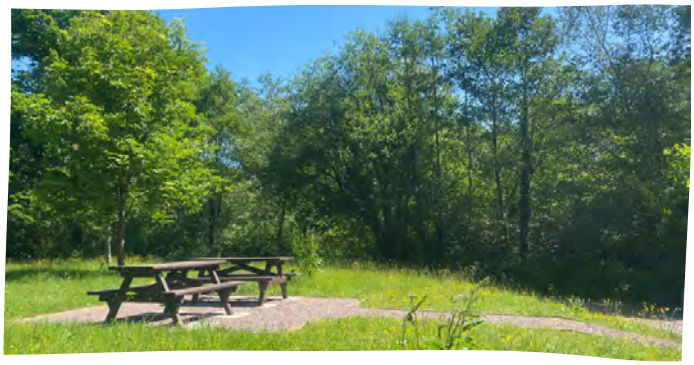
The water consumption increase against the baseline at VCC is due is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures.

There is a robust flushing regimes are now agreed with building users and agile working is still taking place in various departments, however flushing will still be required in these parts of the building to maintain safe water practices.

Departmental flushing regimes are now undertaken which has reflected excellent water sampling results. In has resulted in an external audit which resulted in "Substantial Assurance" for water safety, for the first time on site.

BIODIVERSITY

As part of our compliance to the Environment (Wales) Act & specifically Section 6, and our Sustainability Strategy (in particular Theme 7) we are enhancing biodiversity across all of our estate. To date we have had an external biodiversity audit undertaken and received recommendations which we are working towards to enhance ecosystems & local flora and fauna. There has been huge progress in this area in the past year, and a few highlights are listed below!



Alongside enhancing biodiversity, we aim to educate our staff, patients, donors and community about its importance and how they can

Within the Environmental Awareness training a new biodiversity section has been introduced and infographics have been developed which are now included in the staff induction. Furthermore, the Trust has formed a partnership with Ray of Light, a South Wales-based charity who deliver weekly green social prescribing sessions, which contribute to our Well- being Objectives.

Biodiversity Enhancement Plans

Across the site we have reduced mowing grass areas, allowing the natural habitats to thrive. We have mown in pathways to ensure these areas are still walkable!

At VCC, we planted seasonal shrubberies and flowers and over 50 different species of daffodils were planted, and wildflower seeds were sewn.

At our Talbot Green site, we have removed invasive species to allow local flora to thrive.

Our Enabling Works partners created bug hotels from trees fallen in storms and created bug hotels, which have been strategically placed around sites.

T1 T7 T10

Beehive Installation

We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. All of the volunteers are passionate and thriving in their role as beekeepers.

To design the logo for our honey jars, we ran an all Wales competition (for staff and donors!). On the entry sheets was a some information about the importance of bees and biodiversity, working as an educational tool.

Staff were invited to pick from the shortlisted designs, and the winning design will be printed on all jars once the honey is ready to be collected.

"I am still buzzing about installing a beehive at Talbot Green. Our staff volunteers are so passionate and are actively enhancing the surroundings to support the bees by sewing wildflowers around the area. It has been great for their well-being as well, but also we are seeing the impact on our wider staff by encouraging them to visit the hives and seeing the new flowers bloom along the nature walk!"

Sarah Richards, General Services Manager

T1 T7 T10

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways

Bring communities and generations together through involvement in the planning and delivery of our services

GREEN SOCIAL PRESCRIBING

Down to Earth - Green Woodworking

The Trust has continued to work with Down to Earth to deliver green woodworking skills workshops.

Volunteers comprising of Velindre patients, family, staff and local community members worked together to build the roundhouse and binhouses with green, living roofs, in addition to groups from a wide variety of organisations across south Wales, with the support of the Down to Earth Project team.

Ray of Light Cancer Support

The Trust began the partnership with Ray of Light Cancer Support in March 2022, and the work has gone from strength to strength.

Ray of Light Cancer Suppport host free green social prescribing sessions designed for those affected by cancer. The sessions are always based around the therapeutic properties of nature, and are centred around the core principles of finding a use for everything, with nothing being wasted.

Following review of patient and service user feedback, which noted the desire to continue the events throughout the Winter, the Sustainability and Estates team worked together to convert an unused shipping container, adding electricity and heating. This allows the sessions to continue regardless of the weather!

We were delighted when our partnership was nominated and shortlisted for a National Mental Health and Well-being Award this year! Ray of Light work so hard to connect people with nature and each other, and to have the recognition for the Trust and Ray of Light Cancer Support was a lovely surprise.
Rhiannon Freshney, Trust Sustainability Manager

TRAVEL & TRANSPORT

Trust Travel Plan 2022- 2027

T8 T10

Travel Plans are the Government's recommended method to widen travel choice, to promote more sustainable travel choices and to reduce single-occupancy car travel. The newly published Travel Plan aims to inform, and enact change in the everyday lives of our staff, in and outside of the workplace.

With all staff engaged in the plan, and publicising your behavioural changes with friends and family, we can enact cultural changes towards decarbonisation of the public sector by 2030 in Wales. An imperative in the context of the climate emergency. Following extensive engagement, the Travel Plan was drafted in 2021, to run from 2022 - 2027.

The Travel Plan aligns with the following Trust Well-being Objectives:

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.

Deliver bold solutions to the environmental challenges posed by our activities.

Bring communities and generations together through involvement in the planning and delivery of our services.

Interactive Active Travel Map

An interactive Active Travel & Sustainability Map has been developed for ease of access to active and sustainable transport options for staff. This includes signposting to: the OVO Bikes cycle hires; cycling storage; local bus routes; local train stations; and disabled parking. Pop-ups on the map provide additional information to staff, including how to access the Active Travel Hub and OVO Bike availability. Specifically for VCC, the map will include information about staff and patient support sessions, including Ray of Light and Noddfa Staff Well-Being Gardens. At Talbot Green, it highlights the nature walk and the location of the beehives. It provides an engagement tool to staff to highlight upgrades, for example the installation of bike repair unit in the Active Travel hub is signposted.

Cycle 2 Work Scheme

The Trusts new Cycle to Work scheme was launched at the end of summer 2022. Trust staff can now purchase a bike which is worth up to £3,000 (an increase on the previous contract) through the scheme. Within the Trust Travel Survey results staff requested access to electric bikes and more providers within the scheme. The new contract with Halfords has access electric and hybrid bikes, as well as an increase of funding available.

Furthermore, the survey results highlighted staff were not happy with the providers in the previous Cycle to Work scheme. The new scheme has local, independent providers, as well as Halfords and Tredz. The scheme will reopen in May and run until September 2023.

Cycle Maintenance Facility

We have installed a bike repair station & pump. Durable, attractive, practical design. The stands have a Track style pump with pressure gauge fully integrated with workstation unit, and includes all the tools and a stable public bike stand for tuning bikes and making repairs.

"They will not only make a difference to riding to and from work but give the sense that the Trust cares about cyclists wellbeing and adopts the active travel ethos."

Dr Nikki Pease, Consultant in Palliative Medicine

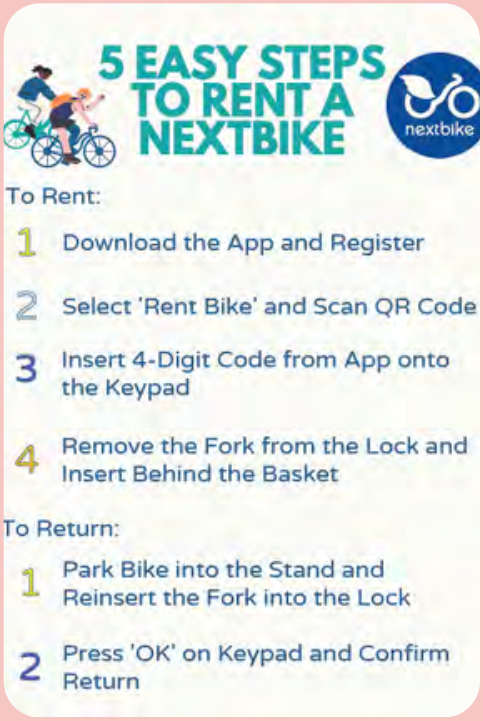
Next Bike

Next Bikes were installed at Velindre Cancer Centre in 2020, however, the company was forced to temporarily remove all OVO Bikes bike share fleet from the streets of Cardiff and the Vale of Glamorgan after sustained bouts of vandalism and thefts left its fleets depleted.

The bikes were reintroduced in 2022, and to support the relaunch, the team developed a "How To" video guide -with welsh and english subtitles - to give staff & patients the confidence and know how to utilise the stand at VCC. Furthermore, a "How To" infographic has been developed which is on the intranet, internet and on digital screens across the site.

Electric Vehicles

The Welsh Blood Service has purchased their first electric fleet vehicle. The vehicle has been trialled for suitability (particularly range). Due to the distance the fleet has to cover across Wales a phased of approach of electric vehicle implementation is being undertaken. The next EV consideration will be for the replacement of specific fleet vehicles in North Wales.



Hybrid Working

The Trust Hybrid Working Group developed a policy and guidance to support the ongoing reduction in staff commuting and business travel that has been a by-product of the response to COVID-19 pandemic

The environmental benefits of reduced car journeys and the savings in Trust travel costs are key considerations alongside the needs of the organisation and issues of staff wellbeing Hybrid workers will experience economic benefits, from a reduction in commuting expenditure.

"I love that I can and am supported to work from home for half of my working week! I struggle to get public transport from where I live and way too far to cycle, so its a great way for me to do my bit for the environment!"

Kate Hammond, Senior Communication and Engagement Manager

COMMUNICATION & ENGAGEMENT

T10

To keep staff motivated and engaged in sustainability, there are continuous communications via global email, divisional newsletters, events & more! The below highlights the most successful communication campaigns over the past year! A sustainability email address has been created for staff to ask questions, propose ideas or feedback on initiatives. This has been a successful method for staff to provide sustainability proposals for their area of work.

Communications Campaigns included -

- **No Mow May**
- **Let it Bloom June**
- **NHS Sustainability Day for Action**
- **Plastic Free July**
- **Secondhand September**
- **I'm Dreaming of a Sustainable Christmas**
- **Energy Saving Tips**
- **Waste Less Wednesdays**

WORKSHOPS & EVENTS

T10

The Trust has run many workshops and events, ranging from Waste Less Workshops to Arts Strategy engagement. A particularly successful event, was the opening of the roundhouse. The roundhouse was revealed in front of guests at a festive grand opening at VCC. Volunteers comprising of Velindre patients, family, staff and local community members worked together to build the roundhouse, in addition to groups from a wide variety of organisations across south Wales, with the support of the Down to Earth Project team.

Groups involved in the build included:

- Llamau Cardiff who work with homeless young people and women
- Neath Port Talbot Youth Service who works with vulnerable young people aged 11 – 25 to give them interesting and challenging experiences to gain new skills and become active members of their community
- Oasis who helps refugees and asylum seekers in Cardiff integrate and settle in their local communities

Several staff members attended the event including Trust Chair Donna Mead, alongside other representatives including Julie Morgan MS.

Sustainable Jamboris

Throughout August, a 'Sustainable Summer Jambori' was held in the Cancer Centre for staff, patients, families and the local community. The Trust Sustainability Team together with the new Velindre Cancer Centre project team held a month-long event programme featuring staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art.

Due to the success of the events, an Autumn Jamboree was held, along with a Sustainable Spring Jamboree organised for VCC and WBS staff, with themes of biodiversity and active travel. The Jamborees take the form of mini festivals - engaging with patients, families, staff and communities through arts and crafts to demonstrate the benefits of undertaking creative activities in a green space and educate on sustainability and biodiversity matters.

The breadth of variety in the Jambori programme required a strong multi-channel approach to communications in order to ensure a high level of interest and attendance for each of the sessions.

Recognising that not all staff are digitally connected, floor walks and well-placed signage, posters and leaflets proved to be effective in raising awareness Alongside digital posts in the staff newsletter, intranet news updates and via staff word of mouth.

Our community were kept informed via our social media channels, local radio interview and ITV news coverage, supported by posters and leaflets on display in the Whitchurch area.

"Over the past year it has been really exciting developing our Hefyd programme – our goals are connecting with our communities and enhancing local biodiversity. It has given us an opportunity to make ecological improvements to our nVCC site, and to work with staff, patients and local residents. We have been able to teach them more about sustainability and to make a real different to the biodiversity in the area through decorating bug hotels, making bat boxes and painting birdhouses. Everyone has been excited to get involved and take them home and we know that they are sharing our passion for environmentally-positive actions far and wide!"

Hannah Moscrop
RD & I Project Manager, new Velindre Cancer Centre

COMPLAINTS AND FOI

There have been no complaints or Freedom of Information (FOI) requests regarding sustainability in the previous financial year.

EDUCATION & DEVELOPMENT

T10

SSC STUDENTS

A number of Student Selected Component (SSC) medical students have worked with the Sustainability team to review & analyse different areas of the Trust. The projects ranged from single use plastic to carbon footprint of patient meals. An SSC student from last year returned to the Trust to do a further study, "Examining Opportunities and Implications for Green Social Prescribing and Site-Grown Food among Oncology Patients".

SUSTAINABILITY AND ENVIRONMENTAL PLACEMENT

The Trust employed a recent graduate, who studied Geography with Sustainabilty. The placement student is based in the Sustainability department and the Transforming Cancer Services team. It provides an opportunity to utilise theoretical knowledge with practical experience, the placement is engaged in wide ranging projects from decarbonisation to communication campaigns.

ENVIRONMENTAL AWARENESS COMPLIANCE

The overall compliance Environmental Awareness compliance is at 91.74% at the end of the financial year. When the Sustainability team began delivering training, compliance was below 30%. This is over a 10% increase compared to the figures in the last financial year. The target for compliance is 85% Trustwide.

The flexibility of training offered at departmental meetings or via Microsoft Team alongside e-learning contribute to the increased compliance. To further support this area, infographics on the KPIs have been developed are included within the Trust staff induction.

ARTS IN HEALTH

T1 T10

To achieve the ambitions outlined in the Sustainability Strategy & to become an exemplar in the Future Generations Act, the Trust considers the wider opportunities available to it us as a healthcare provider, to enhance the performance of our primary functions and to increase the societal value it adds from discharging those functions. Arts and Culture have a material contribution to make to both of these opportunities.

ARTS MULTI DISCINPLINARY TEAM

The Arts Multidisciplinary Team (MDT) was created in autumn 2021, united by a passion for the arts, and a curiosity of how they can be beneficial in a healthcare setting. The MDT has grown to include members representing Oncology, Innovation, Sustainability, and more, leading to a communal varied and diverse skillset. Motivated by the Transforming Cancer Services programme, the MDT has been a fast paced, collaborative project.

ARTS IN HEALTH CO-ORDINATOR

The Trust has successfully obtained match funding from the Arts Council of Wales and Velindre Charity to employ a full-time Arts in Health Coordinator. The Trust has been able to successfully appoint to this post. This is an exciting opportunity which will allow the Trust to realise our vision. The postholder will begin with the Trust in Summer 2023.

ARTS IN HEALTH

WEAVING VELINDRE

The 'Weaving Velindre' art project invited staff to take a creative break whilst embedding the principles of the circular economy, by using old uniforms and materials associated with the hospital to fabric weave a piece of artwork celebrating Velindre Cancer Centres history. All materials used would have been thrown away, but instead have been repurposed to create a piece of artwork.

MOVING HOUSE PROJECT

A professional writer and photographer to work with us on the Moving House Arts Project have been appointed. Jude Rogers has nearly twenty years of experience in interviewing, feature writing and broadcasting; writing regularly for The Guardian, the Observer and the New Statesman and making documentaries for BBC Radio 4 and BBC Radio Wales. David Collyer was named Documentary Photographer of the Year by the Royal Photographic Society in 2021 and during the first wave of Covid-19, he was given permission to document staff in the hospital where he works. The resulting body of work featured in The Guardian and is now part of a touring exhibition.

The photographer and write have been working with staff at the Cancer Centre over the months to capture the spirit of our Velindre in words and images. To introduce themselves to VCC staff, and the project in a short TEAMS session was held. The session was recorded and has been made available on the intranet.

The team have the VCC Café to meet staff, patients and families and capture their memories over three days in February. In March, the Project was opened more widely to former patients, local residents, and anyone with a connection to Velindre via our social media channels.

RESOURCE & PARTNERSHIPS

The arts programme hsd begun to form partnerships on behalf of the Trust. There is a wealth of organisations within Wales, ranging from visual and performing arts groups and centres, to educational and research institutions, sporting groups, community wellbeing initiatives, and other healthcare organisations. A Regional Arts Board has been created with the Trust Commissioners. The Arts MDT has met with industry leads across to understand the opportunities and potential of the programme, which has been invaluable learnings.

The Trust has employed an Arts Consultant for the Transforming Cancer Services programme, drafted a job description for an Arts Coordinator & started an Arts in Health internship programme.

Cyngor Celfyddydau Cymru
Arts Council of Wales

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.

Strengthen the international reputation of the Trust as acentre of excellence for teaching, research and technicalinnovation whilst also making a lasting contribution toglobal well-being

Bring communities and generations together through involvement in the planning and delivery of our services.

Demonstrate respect for the diverse cultural heritage of modern Wales

CONCLUSION

The Trust has made significant improvements which we will continue to build on. Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

The importance of environmental interventions, sustainable solutions and working with our communities to deliver safe, high quality services and our long-term goals cannot be overstated.

ENSURING WE CONTRIBUTE TO A BETTER WORLD FOR FUTURE GENERATIONS IN OUR COMMUNITY AND ACROSS THE GLOBE…

…acting today, for a more sustainable tomorrow

Questions?
Contact us.

Sustainability

Sustainability.Velindre@wales.nhs.uk

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINAL DRAFT VELINDRE UNIVERSITY NHS TRUST ANNUAL PERFORMANCE REPORT 2022 - 2023

DATE OF MEETING	13/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR ENDORSEMENT

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	29th June 2023	Endorsed

1. SITUATION/BACKGROUND

1.1 NHS bodies are required to publish, as a single (unified) document, a three-part Annual Report and Accounts which includes the:

- Performance Report;
- Accountability Report; and
- Financial Statements

1.2 The draft Performance Report will form part of the suite of Annual Report Documents and is intended for public publication. It provides information in an honest and transparent way about the performance of services provided by Velindre University NHS Trust.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The guidance provided by Welsh Government advises that the Performance Reporting needs to include a breakdown of the Annual Performance Report content requirements as set out in **NHS Manual for Accounts**.

2.2 Welsh Government has advised that the focus of the guidance is on ensuring that bodies show how they have performed against the Annual targets set for 2022-23.

2.3 A draft document has previously been shared internally with Divisional Directors and the Executive Management Board for their review. It has also been shared externally with Audit Wales who provided two points of feedback; these have been addressed within the updated Annual Performance Report (*Annex 1*).

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The draft Performance Report encompasses and details the Trust Performance against a number of key Quality & Safety aspects for the organisation.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Performance Report forms part of the suite of Annual Report Documents and will be translated in Welsh, which will have a cost implication for translation.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **ENDORSE** the Final Draft Annual Performance Report in readiness for submission to the Velindre University NHS Trust Board on 27th July 2023.

Velindre University NHS Trust Performance Report 2022-2023

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

INTRODUCTION AND CEO STATEMENT

This Annual Performance Report, describes how we delivered services from 1st April 2022 to 31st March 2023. It also outlines how we ensured patient, donor and staff safety and demonstrates our total commitment to Quality, Care and Excellence.

Mr Steve Ham, Chief Executive

During 2022 - 2023 I am proud that our patients, donors and families have continued to benefit from the highest standards of care, innovation and professionalism across the range of services we deliver.

The Chief Executive Introduction and CEO Statement will be completed at the Final Draft stage

CONTENTS

ANNUAL PLANNING FRAMEWORK AND DELIVERY FRAMEWORK CONTEXT 2022-2023

Our Integrated Medium Term Pan (IMTP) for 2023/24- 2025/26 was approved by the Trust Board, on 30th March 2023, as part of the Trusts' statutory duty under the Finance (Wales) Act 2014. Our IMTP was developed in line with the requirements of the Welsh Government NHS Wales Planning Framework for 2023/24 – 2025/26.

Our plan builds upon our approved plan for 2022/23 – 2024/25 and is and output of the excellent work undertaken by teams from across the Trust and strong engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care.

Our plan is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2032*' and brings together the immediate, medium and long-term ambitions of the organisation. The core principle in developing our plan has been our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving. This is the '*golden thread*' throughout our organisation.

Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve. These priorities, as set out within our IMTP, have been discussed and agreed with our commissioners and reflects their service needs.

Our IMTP for 2023/24 – 2025/26 will be subject to internal performance management arrangements and will be reported to various external stakeholders, including the Welsh Government.

DUTY OF QUALITY

The Duty of Quality comes into legal force in April 2023, in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The new reporting requirements will therefore be captured in processes in place for 2023/24. In the interim it is anticipated that there will be a non-statutory implementation of the duty of quality in autumn 2022.

This will allow for testing the quality reporting indicators, measures and narrative framework concepts being developed during the duty of quality implementation phase as a hybrid reporting process for 2022/23.

2021-22	Quality reporting requirements embedded in the Annual Report and Accounts process.
2022-23	Non-statutory implementation of the duty of quality in autumn 2022. Hybrid reporting process to test indicators, measures and narrative framework being developed during the duty of quality preparation phase.
2023-24	Duty of quality comes into force April 2023. New reporting requirements will subsequently be in place.

Clinical Safety for our Patients and Donors:

Quality is the ‘golden thread’ running through the planning and provision of services to improve the quality of care provided, leading to improved patient and donor outcomes and promote good practice and innovation.

During 2022/23 we have put in place a number of initiatives, ensuring that ‘quality is at the heart of what we do’ to deliver and improve the quality of services we provide and to drive further improvements in care.

- Trust Quality & Safety Framework approved – Quality, Safety, Outcomes is everyone's business
- Readiness for Duty of Quality & Duty of candour requirements focus
- Integrated Quality & Safety Group operational – to enhance triangulation & assurance
- Quality governance assurance mechanisms implemented with training for all department, divisional, executive and Board leaders

The Trust continually drives hard on quality, safety, experience and value in delivering our primary focus on cancer services and blood products. We are currently developing further quality and safety initiatives, as below:

- The Quality and Safety Team are in the process of developing a Trust wide repository where learning and outcomes from patient and donor experiences can be shared and saved.
- The Trust will also establish “Always on” reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised.
- The Trust is developing Quality Hubs operating quality management systems in both VCS and WBS divisions (WBS now operational)

OUR APPROACH TO THE PLANNING AND DELIVERY OF SAFE, EFFECTIVE AND QUALITY SERVICES

Velindre Cancer Service (VCS):

Our work in 2022/2023 has been based on:

The sustained delivery of our services, with sufficient capacity in the context of COVID-19, and the recovery phase was our primary focus during 2022/23. Our overarching aim has been to safely maintain the delivery of non-surgical cancer services for the population of South East Wales during continued growth in cancer treatments, while ensuring that staff and patients continued to be safe when attending our treatment locations and to minimise the risk of COVID-19 transmission.

The Transforming Cancer Services programme, leading to the opening of the new cancer centre in 2025/26, will continue to be a core area of work for us and we continue to work in partnership with South-East Wales Local Health Boards and the Collaborative Cancer Leadership Group (CCLG). Existing regional projects such as the Acute Oncology Service Project also continue to be key strategic priorities for us and our LHB partners.

In taking account of the above determining factors, the Velindre Cancer Service pursued the following priorities during 2022/23.

Our Priorities in 2022/23:

Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations – we minimised the Risk of COVID-19 transmission through maintaining enhanced infection control measures, revised patient and care delivery pathways during 2022/23 with most preventative measures being lifted in quarter 4.

Priority 2: Delivery of appropriate capacity to meet patient demand – despite the pressures caused by the pandemic and subsequent recovery challenges, we continued to deliver all of our services by adapting our clinical model and seeking capacity delivery solutions.

Priority 3: Delivery of business critical initiatives – we continued to deliver a number of business critical and strategic initiatives. These included:

- Engagement processes with Heath Boards commenced to support the operational planning for the clinical models for the new Velindre Cancer Centre and outreach services.
- Support and input into the Outline Business Case for the construction of a cancer centre in Neville Hall Hospital in partnership with Aneurin Bevan University Health Board.
- Implementation of the Digital Health and Care Record (DHCR) replacing the CANISC system.

- Implementation of a rolling Linac replacement programme as part of the implementation of an integrated radiotherapy system (IRS).

Priority 4: Engagement with Health Boards and Regional Service Planning – we have continued to lead and support regional service developments, including:

- The Radiotherapy Satellite Centre implementation ion Neville Hall Hospital.
- The development of a South-east Wales Acute Oncology Service.
- The development of a research and development facility in partnership with Cardiff and Vale University Health Board and Cardiff University.

Priority 5: Patient Experience and Engagement (recognising and responding to the impact of COVID-19) - Our patient engagement strategy has been developed in collaboration with our staff, our patients and donors and with other key stakeholders. It outlines how we will engage with our patients, donors and their families and carers in the future to ensure that their voices are at the heart of how we plan and deliver our services.

Performance Analysis:

We have developed a wide range of measures which are routinely used to monitor the quality and performance of our core services. The VCS performance against a range of quality measures and targets are explored further in the following Performance Analysis Section. The Trust's detailed performance reports received by the Trust Board are available on the Trusts internet site via the following link **(insert link).**

Challenges faced during 2022/23:

VCS continues to operate against the background of the challenges for tertiary cancer services in addition to those that resulted from the pandemic, including increasing cancer rates and health inequalities, a growing gap in the forecast demand between supply and demand, increasingly complicated and personalised treatments and supporting people to live with and beyond cancer.

The year 2022/23 provided significant challenges for VCS in responding to the COVID-19 pandemic recovery phase and move into business as usual. Ensuring effective and safe utilisation of the site to accommodate services remained a challenge in year with a number of PPE restrictions only relaxed in the last quarter.

Quarter 1 2022/23 saw an increase in demand for Services within VCS as Health Board implemented a range of measures to address their backlog of activity that had resulted from the COVID pandemic. SACT services faced significant pressure and a formal recovery project was established in response to managing the demand. This work focused on identifying opportunities for increasing short terms and sustainable longer term capacity. Implementation of the recovery plan, resulted in a return to balance in Quarter 3, which has continued to be maintained throughout Quarter 4. A further focus of the recovery plan was the repatriation back to Health Board sites of pre-pandemic SACT outreach facilities, working in partnership with ABUHB and CTM UHB.

An increase in referrals for breast cancer provided a level of challenge for Radiotherapy performance. This was effectively managed within the operational service through reconfiguration of systems, workforce and processes. Management of this cohort of patients was further exacerbated as the planned replacement of the LINACs commenced towards the end of Quarter 3. Clinical prioritisation of patients in line with national guidelines was maintained

At the start of Quarter 4, the new Radiotherapy performance metrics (Radiotherapy Quality Indicators) were introduced across Wales, replacing the previous JCCO performance targets. All patients are now having their treatment planned with an aim to meet those targets. Optimum pathways to support delivery of this new reporting metrics were developed, which require changes to processes and workflows, some of which will be dependent on elements of the new radiotherapy technology replacement programme. Implementation of the new pathways continues as we move into 2023/24.

A major change to 'ways of working' at the VCS was successfully implemented in Quarter 3 as the existing CANISC system was replaced with a new Digital Health Care Record (DHCR) Welsh Patient Administration system (WPAS). This is the first phase of a larger programme of work across Wales to bring all Health Boards and Trust onto the same WPAS platform. Work to embed the system and new 'ways of working' continued through Quarter 4 and is continuing into 2023/24.

The wellbeing of our staff continued to be a key priority during 2022/23, and the professional and personal impact of the pandemic and the way in which we work will continue to be a key area of focus. The recruitment of additional staff with specialist skills that we require and the most effective use of our staff skill sets and skill mix has been and remains to be critical to our demand response. This has required us to develop different ways of working and delivering our services.

Velindre Futures:

The Velindre Futures programme was established in 2020, and is the vehicle through which we are delivering the transformation needed to meet the aspirations of the South East Wales Transforming Cancer Services programme, the further regional opportunities which we have identified and the existing ambitious plans for service modernisation.

Over the past year, a number of the transformation programmes have made good progress despite the impact of the COVID pandemic – these have included progress on the Unscheduled and Acute Oncology pathways with our local Health Board partners, the development of a Research and Development Hub at the University of Wales Hospital, the Radiotherapy service change programme and the development of a formal engagement strategy for the Trust.

The outpatient transformation programme (linked with Values Based Health Care), and the replacement of the CANISC system through the delivery of the Digital Health and Care Record system are continuing.

In the autumn the Integrated Radiotherapy Solution procurement was completed and the implementation phase started with the first LINAC delivered in January. Work has also commenced on the establishment of the Radiotherapy Satellite Centre. We will continue to drive the transformation agenda at the Cancer Centre via the Velindre Futures Major Programme Board. Core to these ongoing service changes is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do.

New Velindre Cancer Centre:

Since Welsh Government's approval in March 2021 for the outline business case for the new Velindre Cancer Centre the Trust has successfully continued to take forward the plans to the next stage. The Trust has been working with two consortia as part of the competitive dialogue process to design, build and operate the new VCS. This work includes working with our patients and staff to develop a hospital design that will deliver our ambition of a world-class facility that will deliver unrivalled care for cancer patients across South-East Wales, be an inspiring workplace for our dedicated staff to thrive and be a focal point for international research. In addition, the Trust and consortia have been actively seeking to ensure the new hospital is a place that benefits the local community.

The Trust has successfully started the enabling works on the new site, which is a key dependency for the opening of the new centre, which is programmed to open in 2025.

We are all continuing to work to develop the new Velindre Cancer Centre to be one we can all be proud of for generations to come.

Welsh Blood Service (WBS):

The Welsh Blood Service has met all clinical demand in 2022/23, despite being another challenging year. Whilst it has had to rely on support from other UK blood services on occasions, it has also supported those services with mutual aid at other times during the year. WBS has continued to adapt its blood collection and processing service model and its transplant support services in response to changing public health and IPC guidance in relation to COVID throughout the year.

The pattern of change in demand for our services is clearly aligned to that of Local Health Board services and we have continued to work closely with NHS colleagues through the National Oversight Group for Blood Health and blood bank managers to respond as required.

In 2022/23, work began on establishing the WBS Future initiative which will be the vehicle to deliver the aspirations and shape future services for WBS.

The Welsh Blood Service Strategy has been developed and will be launched in Quarter 1 2023/24. It sets out our vison for blood and transplant services in Wales for the next five years, outlining where we are now, where we want to be in 2028 and the steps we will take to get there. In 2022/23, work began on establishing the WBS Future initiative which will be the vehicle to deliver the aspirations outlined in our strategy and shape future services for WBS.

Our Priorities Delivered in 2022/23:

Provide an efficient and effective collection service, facilitating the best experience for the donor, and ensuring blood products and bone marrow donations are safe and high quality – The donor strategies, for both whole blood and bone marrow donors, began development in 2022/23 and will be finalised in 2023/24.

Monthly donor satisfaction surveys have continued to be a source of feedback that promotes donor led improvements in service delivery. These have included the re-introduction of Mobile Donation Clinics and smaller community based whole blood clinics that had been removed due to COVID related IPC constraints, enhanced pre clinic screening to reduce incidents of donors being unable to donate blood having attended their appointment, a revised approach to children on clinic and improved donor adverse event recording.

A number of national campaigns have been undertaken during 2022/23 including Blood Sweat and Cheers, Giving Runs in Your Blood, #BestGift, our sixth form, college and university donation programme (#YoungBlood) and #ChilledOutLifesaver which re-launched in November featuring a donor Tom and his recipient, Rob – both from Wales who met for the first time after Rob received a lifesaving bone marrow donation from Tom – you can watch the video when they met here www.wbs.wales/col. Further campaigns are anchored around key dates across the year including World Cancer Day, World Blood Cancer Day, National Blood Donor Week, World Blood Donor Day, World Marrow Donor Day and Christmas/New Year.

Meet the patient demand for blood and blood products through facilitating the most appropriate use across Health organisations - WBS has sustained supply of blood and blood products for Wales in difficult circumstances and whist it has had to rely on support from other UK blood services on occasion, WBS has also found itself supporting those services at other times during the year. A collaborative working group continues to match supply to demand through the extensive use of data, flexing the collection of whole blood and platelets on a seasonal basis.

The Blood Health team continue to work with hospitals across Wales, providing training and support to ensure that blood products are used appropriately.

Provide safe, high quality and the most advanced manufacturing, distribution and testing laboratory services – In the last year, Welsh Blood has procured new Blood Group Analysers for whole blood, and a new Bacteriological monitoring and alerting system for platelets. New processes have been developed to support the screening of donors for occult Hepatitis B infections. Screening of platelet donors for HNA antigens has been introduced.

Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services – Welsh Blood has implemented state of the art Next Generation Sequencing in the Histo-compatibility and Immuno-genetics laboratories and has implemented changes to cross-matching tests used to assess compatibility in solid organ transplantation. During 2022/2023 WBS will introduce a Consultant Clinical Scientist on-call service to support organ transplantation.

We have also been working closely and collaboratively with our international colleagues through the Association of Donor Relations Professional (ADRP) and the European Blood Alliance (EBA) to share best practice, information and knowledge and to benchmark our systems and processes to help identify opportunities to improve our service delivery.

Provide, services that are environmentally sustainable and benefit our local communities and Wales – A programme of work is underway to develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. Other projects are working to reduce the use of non-recyclable materials such as water bottles and bio degradable cups in donation clinics, and to reduce the use of printed documents across the service. The first electric vehicle was introduced to the Logistics department where it is deployed on the delivery of blood components to hospitals across the south east region of Wales.

Be a great organisation with great people dedicated to improving outcomes for patients and donors – Welsh Blood continues to offer a variety of career development pathways for its people. It has maintained support for higher education and vocational training for scientists and health professionals. This includes the national Higher Specialist Scientific Training programme for consultant clinical scientists as well as management and leadership development. Trade union engagement continues to be positive with close collaboration as we seek to align terms and conditions across our collection teams. Work is ongoing to design an agile model of working where lessons from the pandemic can be applied to allow our people flexibility in where they work.

Performance Analysis:

We have developed a wide range of measures which are routinely used to monitor the quality and performance of our core services. The WBS performance against a range of quality measures and targets are explored further in the following Performance Analysis Section. The Trust's detailed performance reports received by the Trust Board are available on the Trusts internet site via the following link (insert link).

Challenges faced during 2022/23:

Whilst we always plan to collect enough blood to meet the forecast issuing requirements of hospitals across NHS Wales, 2022/23 has continued to present unique challenges as a result of the pandemic and industrial action, as outlined below:

Collection of Blood and blood products, processing and distribution:

- Fewer fixed donation sites, incorporating social distancing and infection prevention control measures.
- Competition for donation sites from vaccination clinics.
- Continuation of IPC measures for COVID positive staff and contacts.
- The need to increase stocks of Fresh Frozen Plasma to support stock replacement as part of the occult Hepatitis B screening programme.
- Access to timely, up to date demand information to support forward planning.
- Industrial Action derogation negotiations.

Wholesale Distribution of Commercial Blood Products:

- Ongoing monitoring of availability of stock and contingency planning.
- Pressure to increase and maintain critical stocks in response to forecast global shortages of donated plasma from which these products are made.

Blood and stem cell donor selection regulations:

- Continuing to meet stringent and changing donor selection guidelines and regulations for blood and stem cells including the introduction of screening for occult Hepatitis B Infections and the need to review historical donations from donors who test positive.
- Continuing to meet COVID-19 requirements for facilitation of export and import of stem cell products such as transport from restricted countries and COVID-19 testing of couriers.

Maintaining an engaged healthy donor panel:

- Focus on ‘targeting’ to meet specific and fluctuating requirements for specific groups.
- Strategy for bone marrow donor recruitment, where age group differs to whole blood donors.

A healthy and sustainable workforce:

- Specialist staff shortages.
- Recruitment and retention.

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups, but this remains difficult to determine. Furthermore, there is a requirement to ensure the supply of blood by blood group meets the demand, which adds to the risk of supply and issuing alignment being achieved. Unpredictability within the platelet demand, alongside the short life span of this component has led to particular difficulties in matching supply to demand and controlling expiry of unused units.

We continue to use our donor recruitment plans to flex to meet demand and our donors are responsive. However, in the event of shortage, we will draw on our mutual aid agreement with the UK Blood Services or in extreme circumstances initiate the National Blood Shortage Plan to actively manage stocks with hospitals.

PERFORMANCE ANALYSIS

During 2022/23 our Performance Management framework (PMF) has evolved with an enhanced range of measures which are routinely used to monitor the quality and performance of our core services. The core measures for Velindre Cancer Centre and the Welsh Blood Service are included in the tables below.

The performance summaries are explored further with supporting narrative in the Trusts performance reports received by the Trust Board. These papers are available on the Trust's internet site via the following **link:**

Our Performance Management Framework

This Annual Report provides an overview of the performance our Trust for the financial year 2022/23, in our new PMF format, 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 and sustainability.

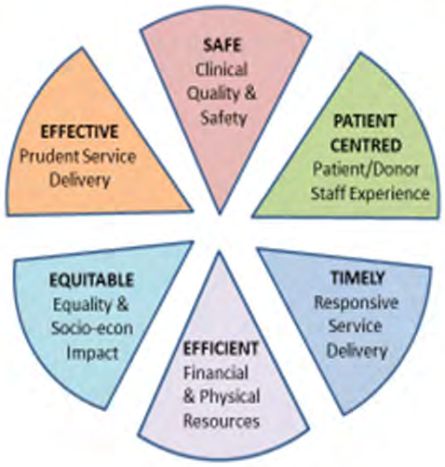
The new performance report format adopts a 'balanced scorecard' approach which seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources, and is based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

Each Key Performance Indicator (KPI) is supported by analysis that explains the current performance, using wherever possible Statistical Process Control (SPC) Charts, to enable the distinction to be made between 'natural variations' in activity, and trends or performance requiring investigation.

The process of developing the new PMF performance reporting style has involved extensive engagement and discussion with Independent Members, Executive Directors, Community Health Council Representatives plus detailed work with Directorate Leads and key staff responsible for gathering, collating and reporting performance.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	86%
	Number of VCS Inpatient (avoidable) falls	National	Monthly	1	0	1
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	1
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	0	0	0
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	1
	Carbon Emissions – carbon parts per million by volume 16% (4% pa) reduction by 2025 against 2021/22 baseline	National	Annually	2021/22	-8%	-8%

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	0
	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	105%
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.12%
	% Time Expired Platelets (adult)	Local	Monthly	16%	Max 10%	18%
	Number of Stem Cell Collections per month	Local	Monthly	1	7	4
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.12%
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	72%
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCS as very good or excellent	Prof. Std.	Monthly	85%	85%	92%
	% Donor Satisfaction	Local	Monthly	96%	95%	96%
	% of 'formal' VCS concerns responded within 30 working days	Local	Monthly	100%	85%	100
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	100%
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	89%
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	84%
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	96%
	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	29% 47%
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	6% 50%
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC) – Feb and March data only	National	Monthly	N/A	100%	94%
	Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	27% 32%
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	88%
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	96%
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	96%
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	97%	90%	94%

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.064m) outturn
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£27,760 M	£27,758M outturn
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.128m	£0.140m outturn
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.300m	£1.300m outturn
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	96%
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	N/A	N/A	63%
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	N/A	N/A	12%
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	N/A	N/A	4%
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	N/A	N/A	4%

VELINDRE CANCER CENTRE (VCS)

Performance during 2022/23 was of a high standard and reflected our on-going ambition to deliver the best possible services. Areas not meeting set levels have been and are subject to continued scrutiny and actions are being taken forward to improve. Below, we examine our performance in 2022/23 in more detail.

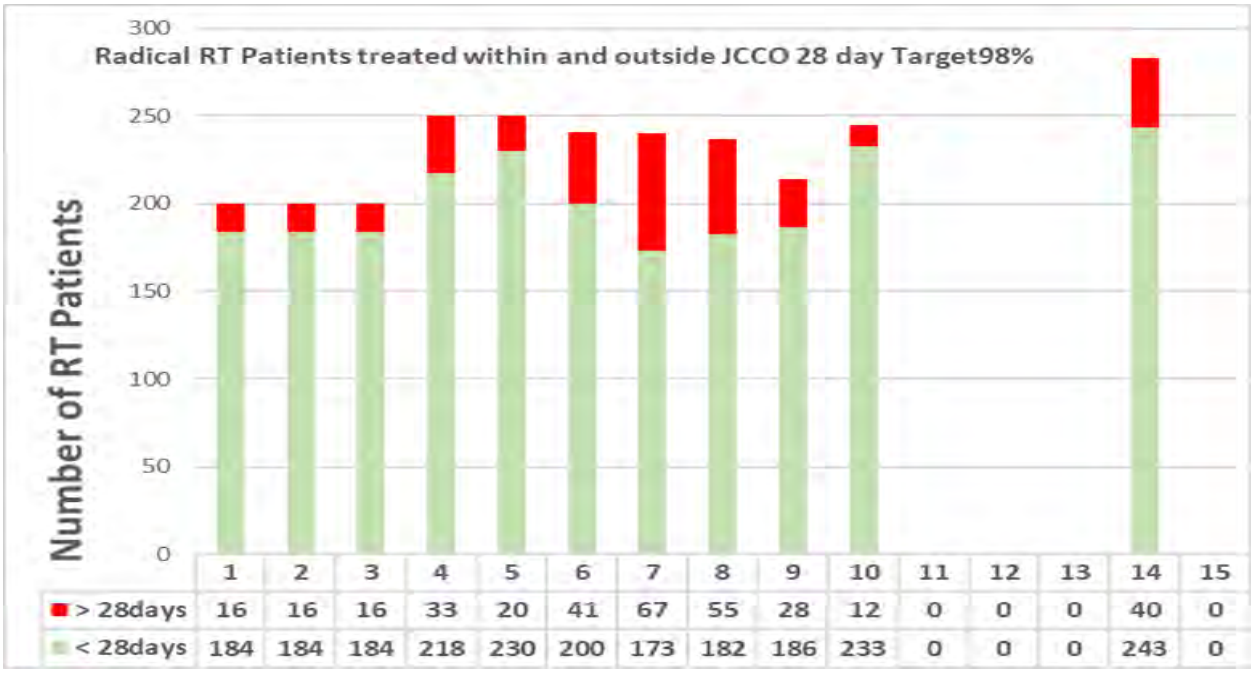
WAITING TIMES AND ACCESS TO SERVICES

During the year we saw high demand for the radiotherapy and chemotherapy services provided at the Velindre Cancer Centre. Our staff worked hard to meet this demand and we continue to explore new ways of working which will reduce waiting times and improve patient access to our services.

PROGRESS AGAINST: RADIOTHERAPY

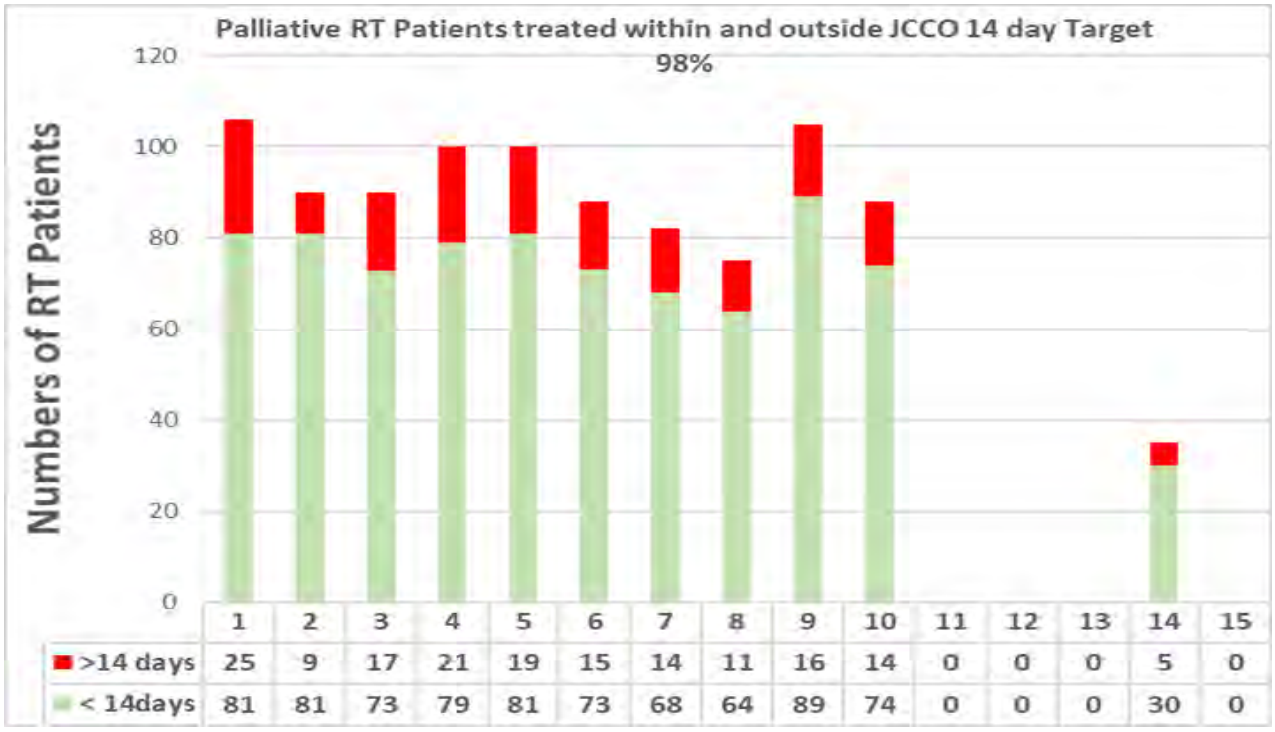
In 2022/23, we observed an 8% increase in demand for radiotherapy services. We implemented a balanced capacity plan to ensure sufficient capacity was in place to meet demand increases. Our performance between April and October 2022 was 85% against the Radical 28 day target, 83% against the Palliative 14 day target and 93% against the Emergency 2 day target.

The new categorisation of treatment times new Radiotherapy Time to Treatment targets (RRTT) (previously known as COSC), are a major change implemented from January 2023, that is being adopted across Wales and work is ongoing to fully embed the changes. Due to data system changes which have occurred because of the transition to the new data warehouse (following implementation of the Digital Health and Care Record - DHCR) and a requirement for a full rebuild of the data warehouse to accommodate reporting functionality for the data, waiting times reports were unavailable for the period November 2022 to January 2023. Work is also taking place at a national level to more clearly define the new categories, reporting criteria and how pathways can be changed to ensure the delivery of the new measures. Our performance between April and October 2022 was 85% against the Radical 28 day target, 83% against the Palliative 14 day target and 93% against the Emergency 2 day target.

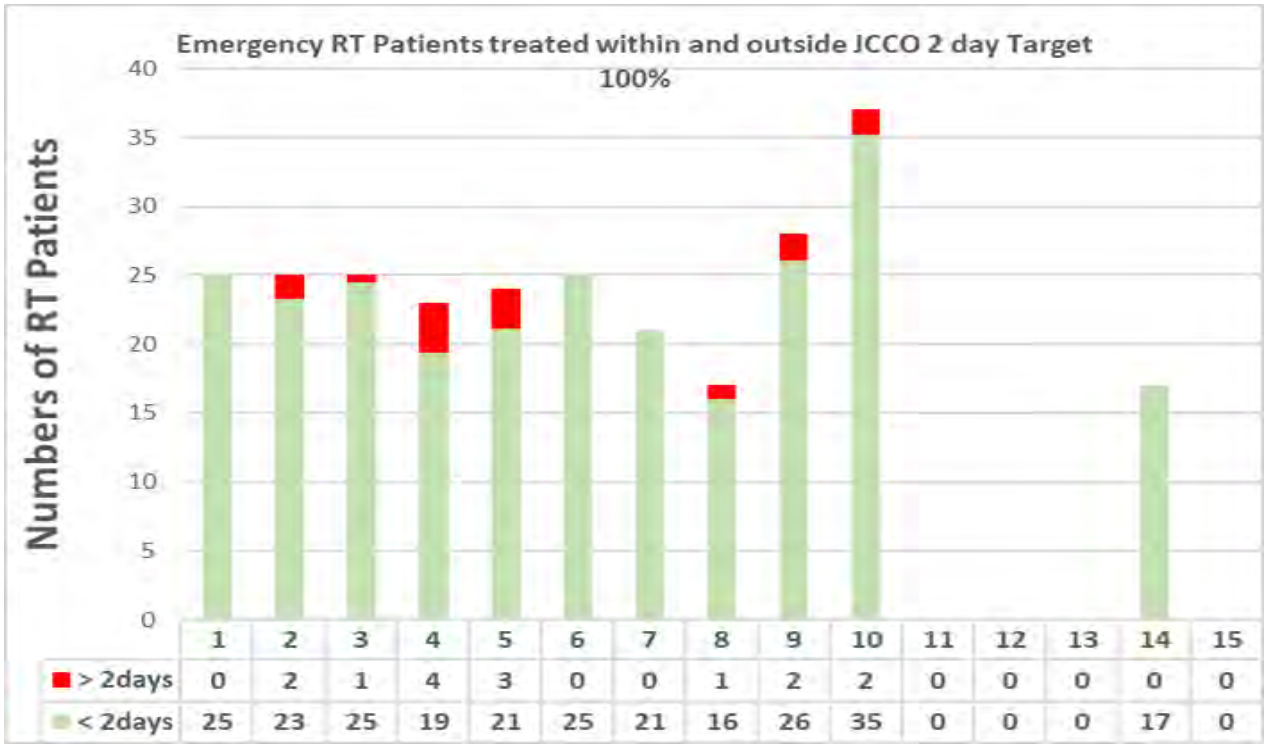


	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 28days	16	16	16	33	20	41	67	55	28	12	0	0	0	40	0
< 28days	184	184	184	218	230	200	173	182	186	233	0	0	0	243	0

Months 1 to 15 Jan 2022 to March 2023



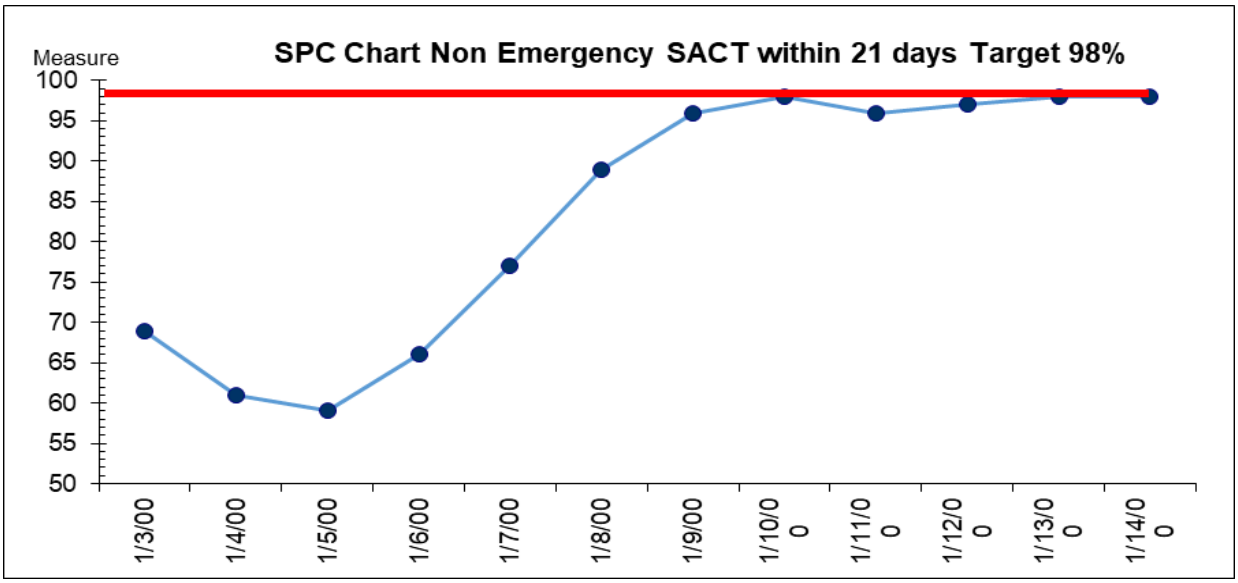
Months 1 to 15 Jan 2022 to March 2023

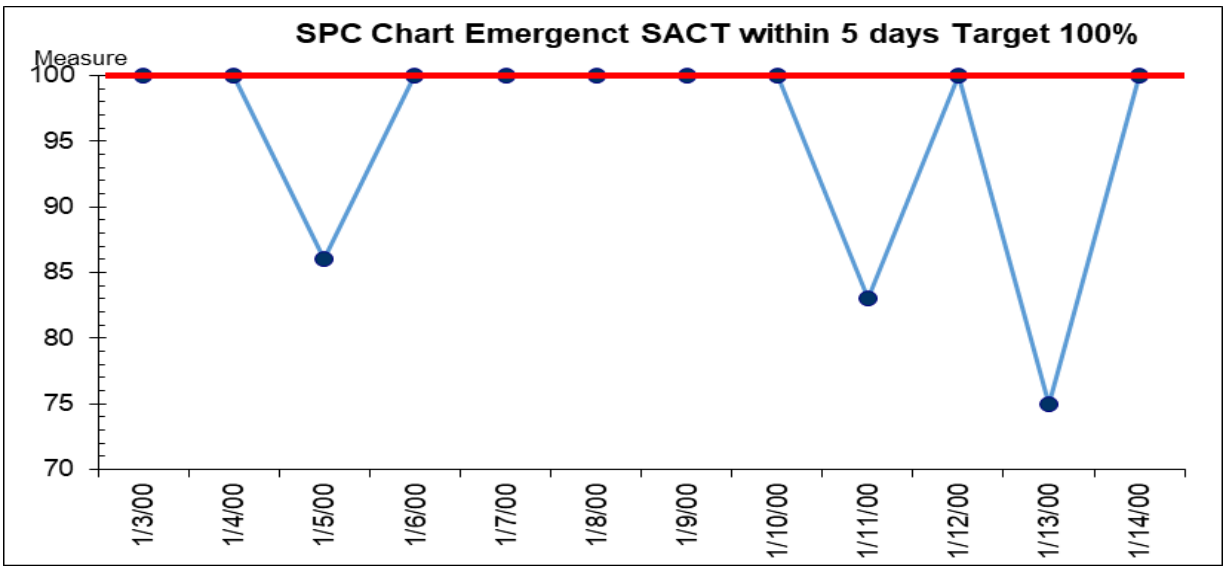


Months 1 to 15 Jan 2022 to March 2023

PROGRESS AGAINST: CHEMOTHERAPY

Following a significant increase in SACT referrals of 8% in 2021/22 we saw a further increase of 12% in 22/23. This resulted in a significant challenge to produce capacity to match the demand as all outreach provision for ABUHB and 50% for CTMUHB had been repatriated and delivered at VCS. As a result we saw deterioration in performance between January and June 2022. We implemented a delivery plan which included additional resources alongside a return to full capacity at CTMUHB and internal productivity and service improvement changes. This saw us recover between July and November 2022 to return to delivery of our waiting times targets. We feel that this reflects the hard work and dedication of our team and our ongoing commitment to improve our services.





PROGRESS AGAINST: ACCESS TO THERAPY SERVICES

Performance throughout 2022/2023 was excellent overall, but we recognise that the small number of therapies staff means that staff absence can have a disproportionate effect on overall performance. Every effort is made to manage such situations effectively.

VCS	Apr22	My 22	Jun22	Jul 22	Aug22	Sep22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar23
Dietetics	100	100	100	100	96	95	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	100	100	100
SLT	67	100	100	100	100	100	100	100	100	100	100	100
Dietetics	100	100	100	100	100	100	100	98	100	91	100	98
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	67	100	100	100
SLT	100	100	100	100	100	50	100	100	100	100	100	100

Dietetics	100	100	100	100	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	97	100	78	100	100	96	100	96
SLT	100	100	100	100	96	100	100	100	100	100	100	100

PROGRESS AGAINST SAFE AND RELIABLE SERVICES TARGET

Hospital Acquired Infections: We have continued to maintain our low rates of hospital acquired infections. We have zero tolerance with respect to hospital acquired infections, such as MRSA. This means that our aim is to see no such infections in our inpatients over the course of any year. However, we also recognise that our inpatients can be particularly susceptible to infection because of the nature of the treatments that they undergo and their physical condition. There was a peak in December 2022 and January 2023 which reflected a national rise in infection rates.

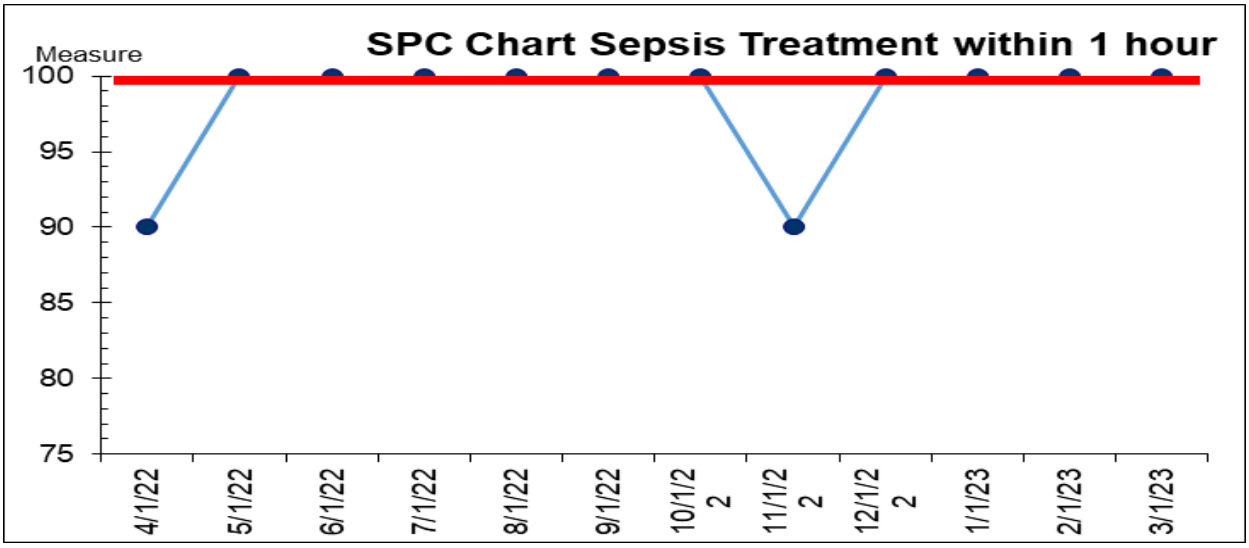
VCS	Apr22	My 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
C.diff	0	0	0	0	0	0	0	0	1	1	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	1	0	0	0
E.coli	0	0	0	1	0	0	0	0	1	3	1	0
Klebsiella	0	0	0	0	0	0	0	0	0	1	0	0
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0

Gram Neg	0	0	0	0	0	0	0	0	1	4	1	0

Pressure Ulcers: We also have zero tolerance with respect to tissue damage and pressure ulcers. Again, our inpatients can be particularly susceptible to this sort of damage. Compliance with our Skin Care bundle, which has been developed to reduce the risk of skin and tissue damage for our inpatients, showed full compliance with the aviodable pressure ulcer target all year.

VCS	Apr22	My 22	Jun 22	Jul 22	Aug22	Sep 22	Oct22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual Number	1	0	1	0	0	4	1	1	1	0	0	1
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0

National Early Warning Score (NEWS): NEWS was originally developed by the Royal College of Physicians and is intended to help reduce the number of patients whose conditions deteriorate whilst they are in hospital. When a patient is assessed using NEWS, a score equal to, or greater than 3, indicates that they may be at an increased risk of developing complications. At VCS, we use NEWS to determine whether our patients are at an increased risk of complications related to neutropenic sepsis. Those patients that are deemed to be at greater risk have the 'Sepsis Six' bundle (a combination of 3 different treatments and 3 tests) administered to them within a set time. The graph below shows that we performed well against our target (that all patients be administered with the 'Sepsis Six' bundle within the set timeframe) in 2022/23, with full compliance in 10 of 12 months.



PROGRESS AGAINST: FIRST CLASS PATIENT EXPERIENCE TARGET

Our patient feedback is largely positive. The Trust has worked to improve the way it collects and receives feedback from those who use our services. Work to understand how best to collate feedback, identify themes and to use this information to aid improvement is crucial. There are 2 surveys used in VCS – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCS, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCS is the 'Would you recommend us?' one.

Patients at Velindre Cancer Centre consistently rated their own experience as being very good, scoring an average in the 90 %s for 'would you recommend us?' to an 85% average for 'your Velindre experience'. The importance of learning from patient feedback remains paramount in the development of our services.

VCS	Apr22	My 22	Jun22	Jul l22	Aug22	Sep22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Would you recommend us? %					89	89	88	nda	nda	93	96	95
Your Velindre Experience? %								nda	nda	84	86	82

Target 85%	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**

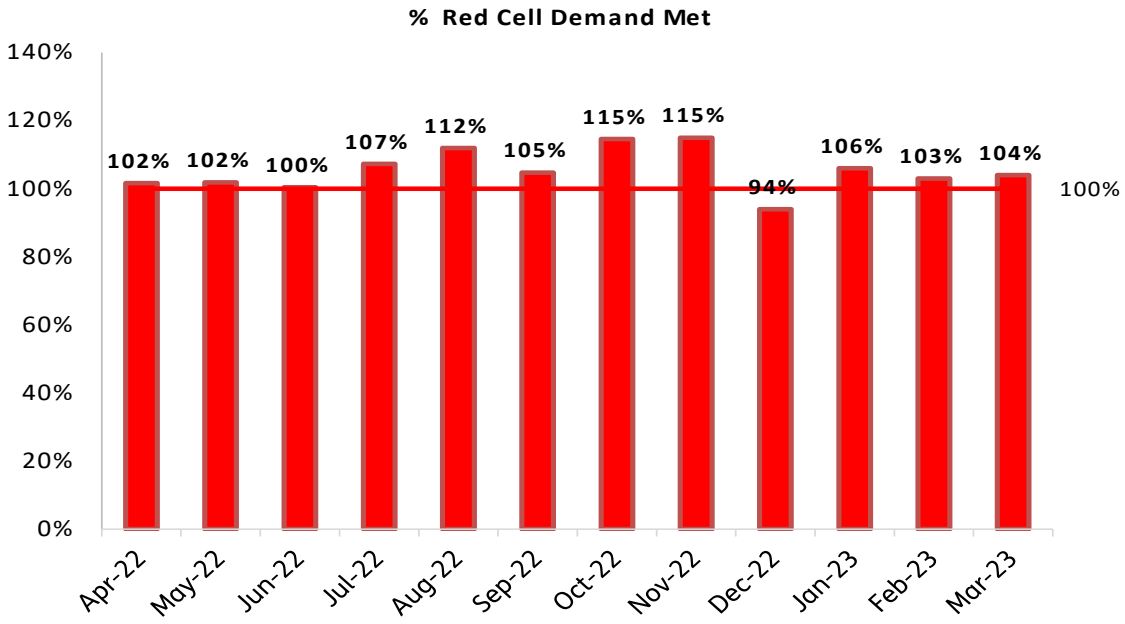
WELSH BLOOD AND TRANSPLANT SERVICE (WBS)

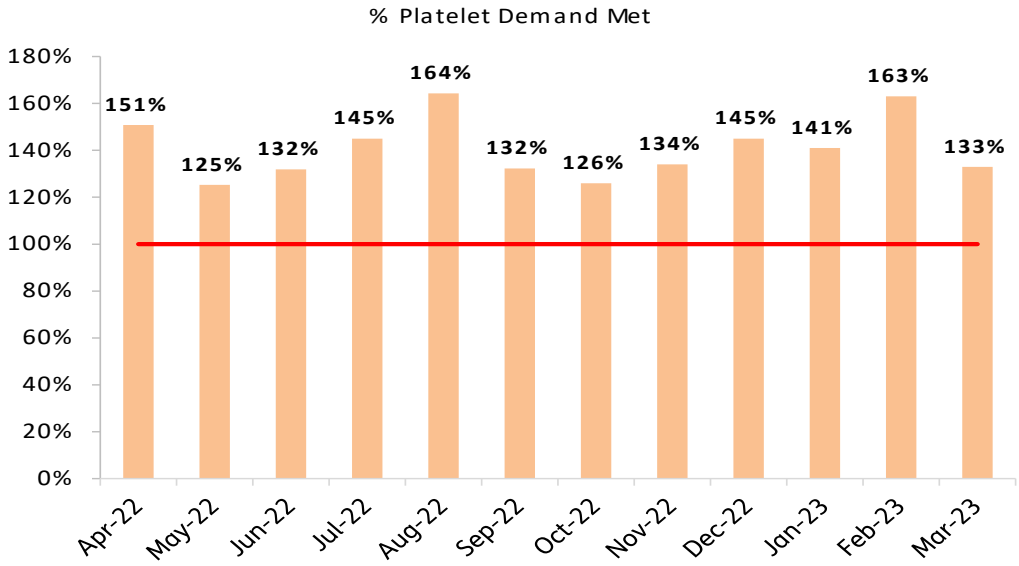
Performance metric	2020/21		2021/22		2022/23	
	Target	Actual	Target	Actual	Target	Actual
Number of new Bone Marrow Volunteer (BMV) registrations aged 17-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	2,964	4,000	2,199	4,000	2,175
≥80% deceased donor typing / cross matching reported within 4 hours (turnaround times target reduced from 6 to 4 hours in 2017/18)	80%	89%	80%	88%	80%	86%
≥90% Anti-D & -c Quantitation results provided to customer hospitals within 5 working days	90%	99%	90%	97%	90%	93%
≥90% routine antenatal patient results provided to customer hospitals within 3 working days	90%	98%	90%	97%	90%	96%
≥80% samples referred for red cell reference serology work up provided to customer hospitals within 2 working days	80%	84%	80%	81%	80%	69%

Performance metric	2020/21		2021/22		2022/23	
	Target	Actual	Target	Actual	Target	Actual
Number of reportable SABRE events	5	5	5	9	0	9
Quality incident Records closed within 30 days (rolling three month period)	90%	100%	90%	100%	90%	96%
≥71% of blood donors scoring 5 or 6 out of 6 for satisfaction with overall service	95%	92%	95%	95%	95%	96%
≥100 % of concerns answered within 30 days	100%	99%	100%	100%	100%	100%
<10% time expired platelets	10%	14.6%	10%	13.4%	10%	21%
<1% volume of waste (<0.5% until March 2017)	1%	0.6%	1%	2.5%	1%	0.12%
% Part Bags	3%	3.1%	3%	2.7%	3%	2.4%
% Failed Venipuncture	2%	1.6%	2%	1.4%	2%	1.4%

PROGRESS AGAINST: MEETING CLINICAL DEMAND FOR RED BLOOD CELLS AND PLATELETS

Throughout 2022/23, the Welsh Blood Service successfully met all clinical demand for Red Blood Cells (RBC) and Platelets for our customer hospitals across NHS Wales. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs and working closely with our customer hospitals. Whilst it has had to rely on support from other UK blood services on occasions, it has also supported those services with mutual aid at other times during the year.



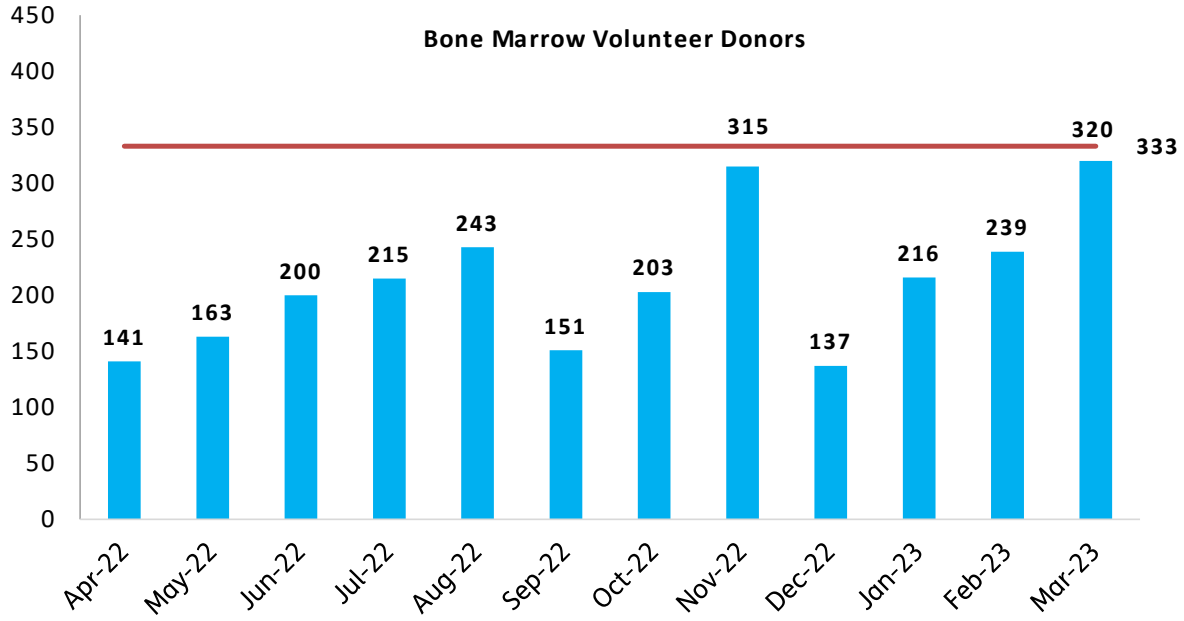


PROGRESS AGAINST: GROWING OUR BONE MARROW REGISTRY

The Welsh Bone Marrow Donor Registry (WBMDR) provides a panel of volunteer donors recruited from the blood donor panel willing to donate stem cells for use as cellular therapy. A donor attends a blood donor session and if aged between 17 and 30 is asked if they would like to join the panel. Donors stay on the panel until their 61st birthday.

Our registry currently includes more than 71,000 volunteers who were recruited via a blood donor session. However, the WBMDR donors represent only 3% of the UK donor panel and the target recruitment is 4,000 per annum (5.6% of the panel) which was not met in 2022/2023. However, a recruitment recovery plan has been put in place to address

this shortfall. The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, began development in 2022/23.



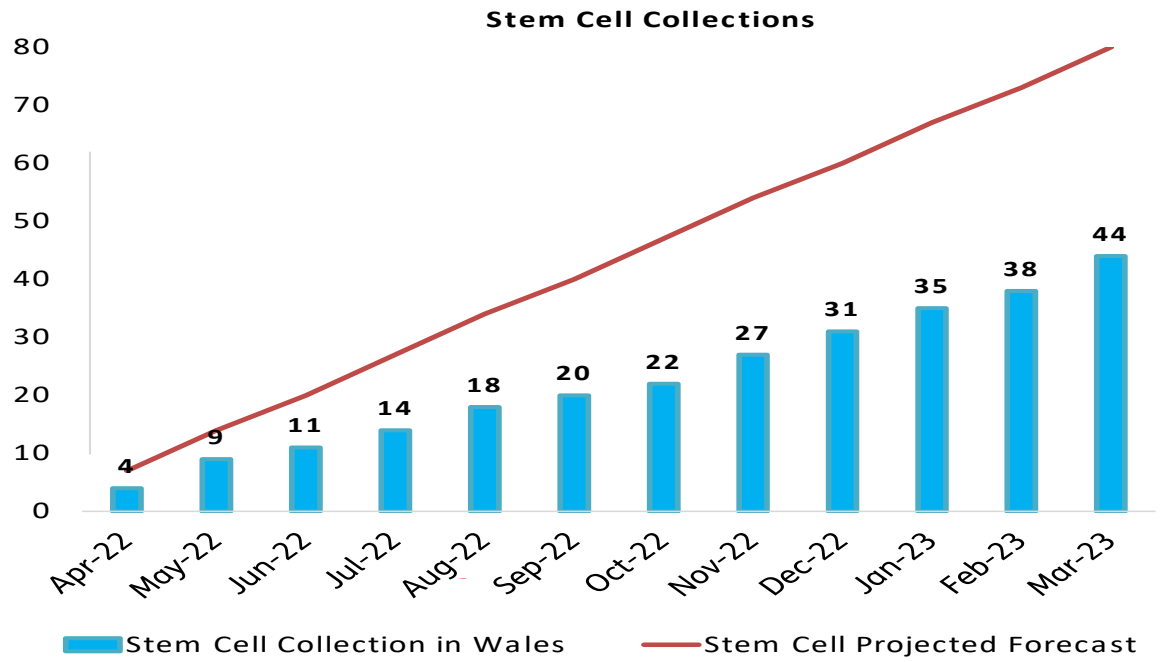
Current Bone Marrow Volunteer (BMV) recruitment involves a combination of recruitment of blood donors aged 17-30 at blood donor sessions and the recruitment of non-blood donors using buccal swabs. This age group is preferred as young donors have longevity as a potential donor and because they provide a more clinically effective transplant. Recruitment via blood donor sessions is becoming increasingly difficult to sustain as the strategy of aligning blood supply to demand going forward, will require increased focus on returning blood donors whose demographic is not necessarily aligned to the target BMV age group. This has resulted in the requirement to increase our focus on recruitment of bone marrow volunteers via buccal swabs

There are 114 registries in the global network and in total there are nearly 41 million donors on the global panel. The panel grows at ~7% each year. In the UK, there are 4 registries with a total of 2.1 million donors. The Welsh Bone Marrow Donor Registry represents 3% of the total donors in the UK. The WBMDR has the highest collection index of the 4 UK registries and consistently scores high in international collection and efficiency indexes and trend reports such as the WMDA Global Trends Report and the National Marrow Donor Program (NMDP-USA) Global Registry Report. The WBMDR has recently passed inspection by the Human Tissue Authority (HTA) and the World Marrow Donor Program (WMDA) and maintains its status as a donor centre for the NMDP.

PROGRESS AGAINST: MEETING TRANSPLANT SERVICES REQUESTS

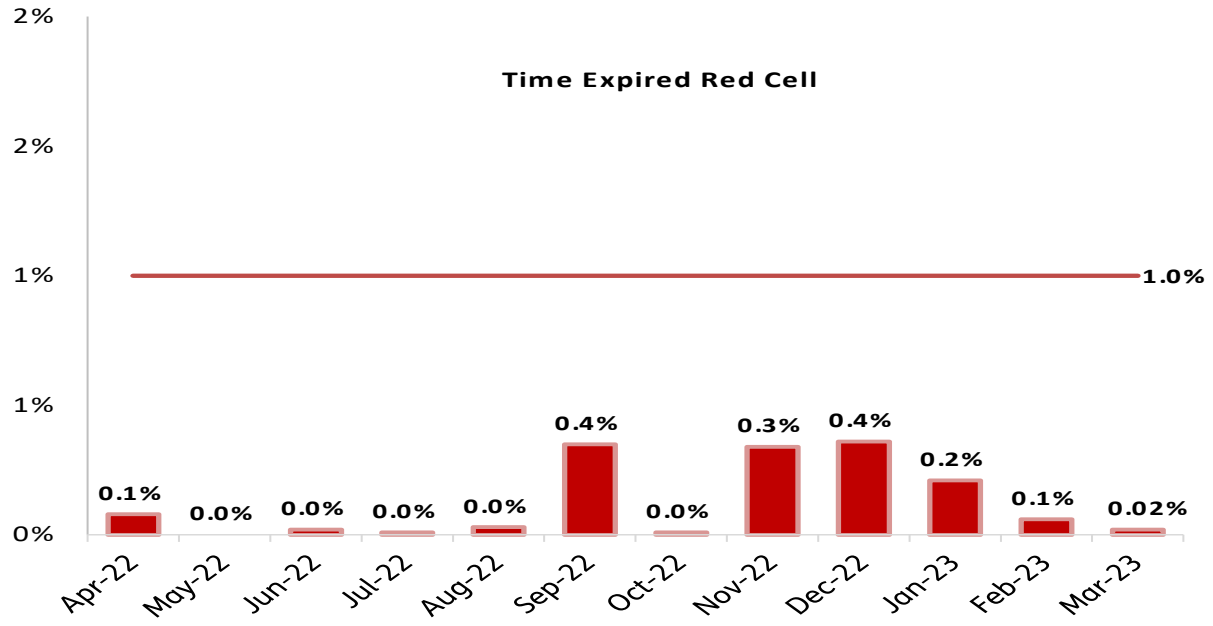
Our annual target for the number of stem cell collections that we would anticipate in any 12-month period is set at the beginning of the year.

There are a high number of variable factors that influence the number of stem cell collections that are undertaken in any one calendar month. There is an initial confirmatory test, which is, then sent back to the requesting transplant centre who then make a decision on which donor will be taken forward for their particular patient. From the basic genetic match of our donors, availability and willingness of our donors to participate and donate, the wellbeing of the recipient patient, and their treatment pathway, all contribute to the final number of collections that will be undertaken in any one calendar month. In 2022/23, the Welsh Bone Marrow Donor Registry fell shy of its annual target. However, during the pandemic stem cell collections had fallen mainly due to a reduction in transplant centre stem cell collection requests and the high cancellation rate due to patient factors during this period. The WBMDR has recently (November 2022) implemented a new piece of software that provides external registries with a more modern donor selection algorithm and we are already experiencing an increased number of sample requests, which have a direct relationship to product requests.



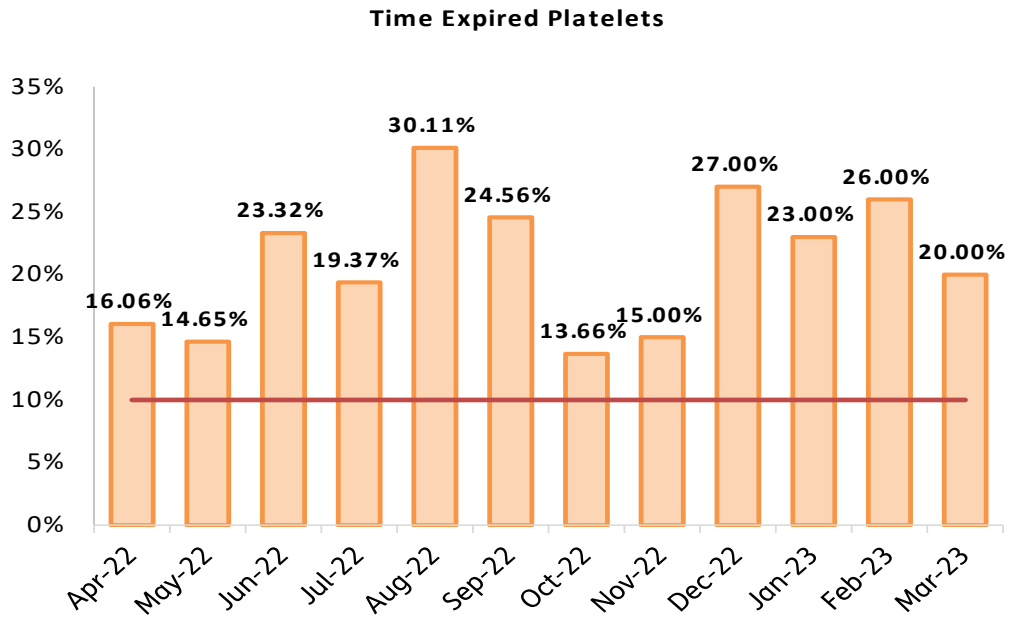
PROGRESS AGAINST: MINIMISING WASTE TIME EXPIRED RED CELLS AND PLATELETS

Aligning the supply of blood components, which have limited shelf life, to the varying demand of hospitals is highly complex and multifaceted. Currently, the WBS has set itself a target of no more than 1% of Red Blood Cells (RBC) time expiring each month where they exceed their 35-day 'shelf-life' and a 10% target for platelets (7 days shelf life).



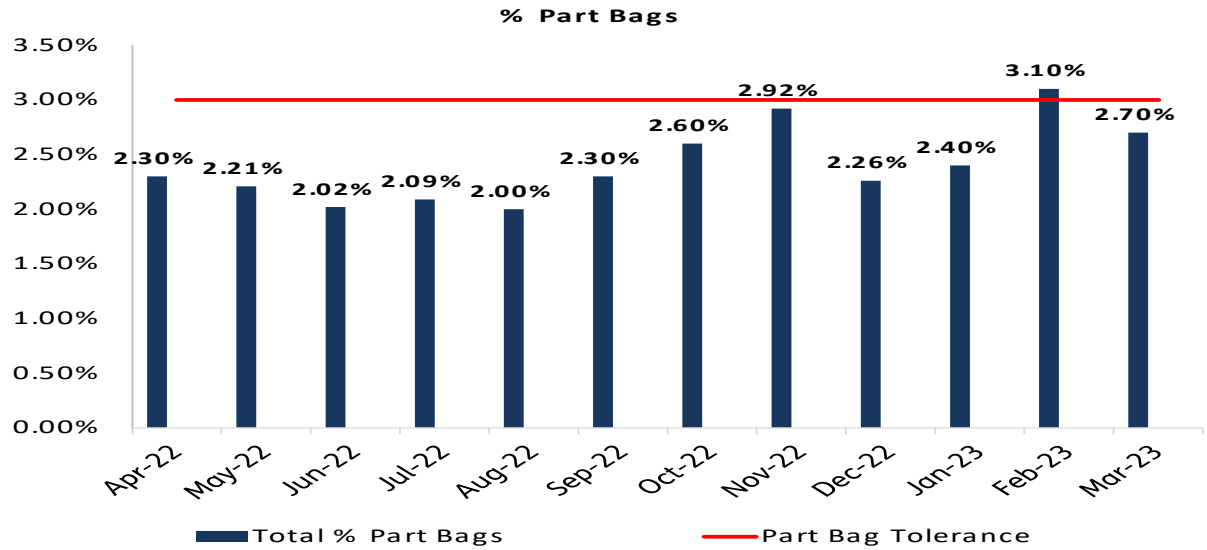
During 2022/23, the levels of time expired red cells remained consistently below the 1% target, this was attributed to the active and agile management of the supply chain.

Time expiry of platelets was above the target tolerance threshold on a number of occasions during 2022/23. This was largely due to a strong stock position against a reduction in demand. Operational focus directed towards provision of platelets as opposed to reduction in waste in the short-term. A longer-term review of the platelet production strategy is underway to minimise the potential for waste in the supply chain. This is in addition to work initiated during the year to develop an improved understanding of how the operational factors, which effect supply could continue to improve.



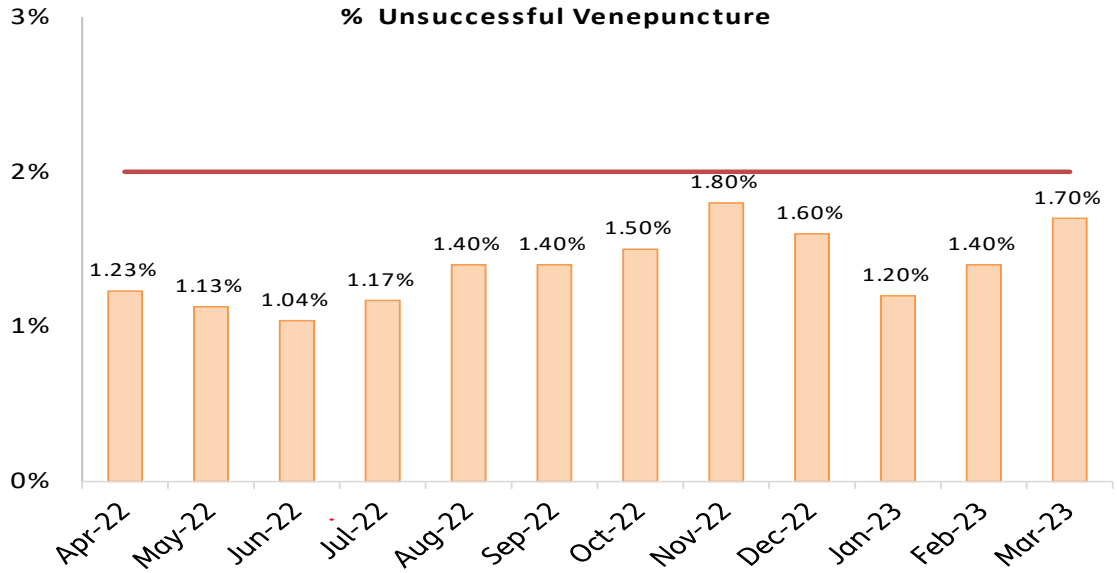
PROGRESS AGAINST: COMPLETE WHOLE BLOOD DONATIONS

Part bag is the term we use to describe a whole blood donation of less than 420ml of blood and which is therefore not viable for clinical use and disregarded. There are various reasons why a donation may need to be stopped before the required volume of blood has been collected. These reasons include venepuncture technique, donors feeling unwell or equipment failure. Our current target is to ensure that we collect less than a maximum of 3% part bag blood donations and during 2022/23, we consistently this target for 11 out of 12 months. Despite strong performance in this area, the WBS will continue to modernise our service and strive to reduce the numbers of part bags wherever possible.



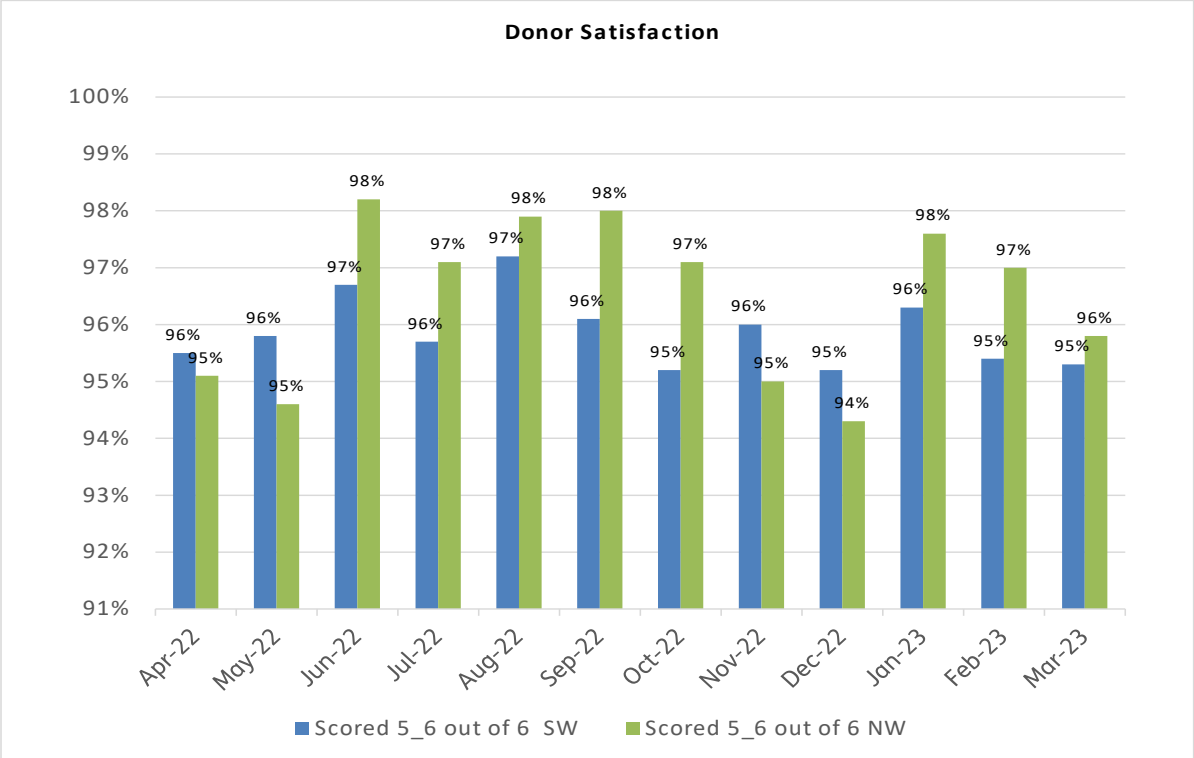
UNSUCCESSFUL VENEPUNCTURE

Unsuccessful venepuncture refers to donors who have reached the donation chair but despite an attempt to venepuncture the donor, no blood enters the bag. There are various reasons why this can happen, typically this might be a result of inaccessible donor veins, poor venepuncture technique or equipment failure. Our current tolerance threshold is no more than 2% of all donors where a blood donation is initiated to result in a failed venepuncture attempt. Performance during 2022/23 was consistently within target tolerance levels. Despite strong performance in this area the WBS will continue to modernise our service and strive to reduce the number of unsuccessful venepunctures wherever possible.



PROGRESS AGAINST: FIRST CLASS DONOR EXPERIENCE TARGET

The importance of learning from donor feedback remains paramount in the ongoing development of our services. During 2022/23, the Welsh Blood Service has worked hard to improve systems and processes relating to concerns management to ensure that donor and service user feedback is consistently managed in a timely and effective manner, whilst ensuring lessons are learnt and identified service improvements are introduced.



RISKS AND CHALLENGES

VELINDRE CANCER CENTRE – RISKS AND CHALLENGES

Velindre Cancer Centre, currently, faces a number of key challenges. Additional detail on how we will address these can be found in our three year plan, but it is important to recognise that these issues effect the design of our services and our performance.

CANCER INCIDENCE IS INCREASING

The incidence of cancer in Wales is forecast to increase by 2% per annum to 2031. This is expected to result in an estimated 12,677 new cases per year in the VCS catchment population by 2031, representing an increase of 35% since 2013.

THERE CONTINUES TO BE VARIATION IN OUTCOMES THROUGHOUT WALES

While survival rates have improved, there continues to be significant variation in survival rates between the least and most deprived in south-east Wales. We need to work with our partners to reduce inequalities, improve prevention, improve the rates of earlier detection and diagnosis and patient access and take up of treatment. The advent of the Single Cancer Pathway (SCP) will have important ramifications for the delivery of cancer services across Wales.

THERE IS A GAP BETWEEN FORECAST DEMAND AND SUPPLY WHICH WE NEED TO CLOSE

The increasing incidence of cancer, increasing survival rates of people with cancer and the increasing complexity in treatments will create a significant pressure on our ability to deliver the required level of services in the future. It is crucial that the healthcare system responds to this increasing and changing demand if it is to continue to deliver services and maintain current performance.

TREATMENTS ARE BECOMING MORE COMPLEX

The pace of innovation, clinical and technological change in cancer services is rapid. We know that on the immediate horizon are new advances in radiotherapy along with personalised medicine. Similarly, within SACT services, there is a growing list of cancer types for which immunotherapy has shown promising results and, consequently, we are introducing ever more immunotherapy treatments. These treatments are often used in addition to existing therapies or, in some cases, are providing entirely new options for patients. This is an exciting and dynamic area. We recognise that the use of these novel treatments introduce new levels of complexity and are sometimes delivered over extended periods. We must ensure that the appropriate support and infrastructure is in place to allow us to continue to offer these treatments in a timely, safe fashion in order to optimise outcomes for our patients.

MORE PEOPLE ARE LIVING WITH AND BEYOND CANCER

As treatments have improved survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation, and to ensure patients are able to maximise their potential and enjoy the highest quality of life.

There is a need to develop a broader range of services which support individuals and helps them engage fully in society, including employment, following their recovery. We

need to ensure that we can continue to offer robust, high quality Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

SUPPLY OF WORKFORCE

Survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation and to ensure patients are able to maximise their potential and enjoy the highest quality of life. There is a need to develop a broader range of services which support individuals to engage fully in society, including employment, following their recovery. We need to ensure that we can continue to offer robust Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

VELINDRE CANCER CENTRE
HOW WE WILL MEET OUR CHALLENGES

The Challenge...	We will meet this by...
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages– making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Maintaining an engaged healthy donor panel:
The challenge of ensuring we have enough donors of the right group to meet our demand is one that is being experienced by blood services globally with an aging population, increased travel to countries where donors may be susceptible to blood donor disease and people having busy lives.

Meeting demand and service development:
Aligning varying hospital demand to the supply of blood components, especially those with limited shelf life, is a challenge. National data on blood component usage required to make demand predictions more accurate and effective; all Wales LIMS project will be a major enabler for this.

Increasing use of immunotherapy and improved compliance with national guidelines increase the demand for highly specialised reference blood testing provided by WBS Red Cell Immunohaematology (RCI) laboratory. This service need continues to grow and is not sustainable under the current commissioning arrangement which needs to be revised.

Demand for stem cell donation and transplant immunology services is also expected to increase through presumed consent legislation across the UK and increased use of stem cell treatments. The Welsh Blood Service is also exploring the opportunity for expansion of its stem cell collection services for partner organisations.

Continuing to meet stringent blood selection guidelines and regulatory requirements:
Changes in science, technology and ways of working provide a continually evolving service and developing regulatory requirements for blood services. The In-vitro-diagnostic Device (IVDD) Regulations, changes to the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) guidance on plasma and platelets and monitoring the impact of Brexit on UK regulatory policy all provide an immediate work programme for WBS. These are in addition to the regular changes in Donor Selection Guidelines (DSGs) and the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidelines for the Blood Transfusion Services in the United Kingdom (Red Book).

Changing science and technology:
Advances in both scientific and medical understanding of the origin and management of disease, as well as broader supporting technological developments, provide opportunities for step changes in operational workflows, efficiencies and services provided by WBS. This includes Next Generation Sequencing (NGS) and Advanced Therapy Medicinal Products (ATMPs).

During 2022/23, WBS continued to 'horizon scan' and support the Welsh Government and NHS Wales on developing strategies to facilitate the adoption of these new ATMP therapies. Through Advanced Therapies Wales, WBS worked closely with NHS Wales organisations, private and third sector to make recommendations on prioritised activities required for such a roll out.

Automated technology is rapidly evolving within the field of blood component manufacturing and testing and WBS are exploring the potential of these technologies including red cell genotyping.

Advances, such as artificial intelligence driven data analysis and implementation of augmented reality enhanced routine procedures, that increase throughput and quality, eliminate errors and identify issues earlier in a cost-effective manner are emerging. Adoption of these techniques will enable further developments in efficiency and quality of our services.

Workforce:
WBS has to respond to these advances in terms of its own workforce but also in the role it plays in the training of the current and future scientific workforce for NHS Wales through its support for undergraduate provision and its informal and formal outreach to support NHS colleagues. Consideration also needs to be given to the throughput of entry level scientific staff and their career progression within the NHS which already creates some pressure within WBS. In addition, competition for scientists with the commercial sector will increase the current difficulties in recruitment / retention, meaning that we will have to develop and maintain attractive roles and opportunities. Education strategies that support succession planning and develop a work force that is flexible and responsive to the transformation are being developed as well as those which support the new and emerging skills requirements.

2.2: The Challenge…	We will meet this by…
Maintaining an Engaged Healthy Donor Panel	✓ Working in partnership with donors delivering a prudent, safe and sustainable personalised donor service to support lifesaving treatments for NHS Wales and beyond. ✓ Making the most of our contact with people in Wales by delivering activity such as public health and wellbeing interventions, alongside our collective activities in our communities.
Meeting Blood Component and Blood Product Demand	✓ Delivering a fully automated and intelligence led supply model where blood collection is planned to meet specific health service need. ✓ Leading and working within a clinically led NHS Wales blood health community with a truly prudent use of blood components and products.
Continuing to Meet Stringent Blood Selection Guidelines and Regulatory Requirements	✓ Delivering state of the art blood and transplant services ✓ Active engagement, participation and collaboration with UK and European networks to horizon scan, plan & influence regulatory changes and developments ✓ Supporting partners through our expertise in Good Manufacturing Practice (GMP), quality assurance, validation and cold chain logistics.
Changing Science and Technology	✓ Being recognised internationally for our sector leading service model and our research and life science innovation. ✓ Working collaboratively with pathology, genomics, ATMP and life sciences sectors and Higher Education Institutions in service delivery and innovation with the required infrastructure and systems to transfer new treatments and technology from the bench to the bedside in Wales creating high skilled jobs. ✓ Developing a centre for excellence in laboratory science, supporting professional development of NHS colleagues and educating the next generation science and laboratory workforce for NHS Wales and the life science sector.

PUTTNG THINGS RIGHT

We are committed to managing, and learning from concerns in accordance with the Putting Things Right process, or NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

During 2022/23, we received a total of 155 concerns. This was a considerable reduction (-36) in the volume of concerns raised during 2021 – 2022. 55% of the concerns were raised to the Trust via email, 33% received verbally by telephone, 6% verbally in person, 5% via letter and 1% via social media.

The Trust has continued to respond to the complainant within 30 days of receipt of their concern. The compliance breakdown per quarter is listed below and demonstrates continuous compliance over the year:

Quarters Q1 – 100% Q2 – 100%, Q3 – *45%, Q4 – 100%
**Due to a validation of the PTR closure within 30-day return figures by the Welsh Risk Pool, an anomaly was found where the day on which a PTR concern was received being classed by the Trust as "day zero", when this should have been classed as "day one". The outcome has meant that for quarter 3, only 4 of the 9 PTR concerns have been completed within 30 days. However, all 9 PTR concerns were completed within 31 working days of receipt. This issue has been addressed and all future PTR concerns will be classed as "day one" on the date of receipt.*

Over 96% of the concerns raised were graded 1 and 2, and 70% were successfully resolved via the 'early resolution' process which is a 11% increase in comparison to 2021/22. The Trust has continued to have a low number of re-opened complaints of less than 6% for the year.

8 complaints have been referred to and upheld by the Ombudsman during the year. 3 Ombudsman cases remain open at the end of quarter 4 2022/23 and the Trust await further communication from the Ombudsman.

Covid related concerns have remained consistent throughout 2022/23 with 13 concerns being reported in comparison to 12 during 2021/22. The Covid related concerns have related to the impact on cancer patients due to delays in referral and treatment and in relation to Welsh Blood Service, the reduced number of venues available to donate following some venues having to close during the pandemic and not reopening.

The main themes for concerns raised throughout the year related to; delays in Cancer Service patient appointments and the attitude and behaviour of medical staff to patients in relation to the lack of communication and information regarding treatment options. There was also a theme identified relating to patient assessments through the treatment helpline, of which a full scale review, action plan and improvement project has been implemented. The Welsh Blood Service continue to receive concerns raised with donors experiencing issues with planning appointments or being turned away from scheduled appointments due to arriving late to donate. Donors also raised concerns in relation to the practicalities of giving blood which has resulted in identifying staff training needs and the review of related policies and procedures.

We remain committed to encouraging patient / carer feedback so that we can learn from and improve our services. We have continued to refine our complaints management processes and concerns investigation through to formal response to the service user, ensuring that any actions required are taken promptly and that learning from complaints is fully embedded.

VELINDRE UNIVERSITY NHS TRUST QUARTERLY INDICATORS 2022/23					
Quarters	**Q1**	**Q2**	**Q3**	**Q4**	**YTD Total**
CONCERNS					
Trust Early Resolution (ER) (resolved within 48 hours**)**					
ER opened	***40***	***20***	***24***	***24***	***108***
Trust Putting Things Right (PTR) (formal**)**					
Trust wide PTR opened	***13***	***12***	***9***	***11***	***45***
Acknowledged within 48 hours	**13**	**12**	**9**	**11**	**45** **4**
PTR closed within 30 days	**13**	**12**	**4**	**11**	**40**
PTR closed after 30 days	**0**	**0**	**5**	**0**	**5**
Concerns raised through Welsh language communication	**1**	**0**	**0**	**1**	**2**
Total number of concerns (PTR/ER) received per quarter	***53***	***32***	***33***	***35***	**-**
OMBUDSMAN (OMBS)					
OMBS cases opened	**0**	**3**	**0**	**1**	**4**
Open OMBS cases	**3**	**6**	**3**	**3**	**-**
OMBS cases closed	**0**	**0**	**3**	**1**	**4**
Total number of Ombudsman cases received	**0**	**3**	**0**	**1**	**-**
REDRESS					
Redress cases opened	**1**	**0**	**1**	**2**	**4**
Open redress cases	**3**	**4**	**3**	**4**	**2**

Redress cases closed	**0**	**0**	**1**	**0**	**1**
Total opened during quarter	**1**	**0**	**1**	**2**	**-**
CLAIMS					
Claims opened	**0**	**0**	**0**	**1**	**1**
Open claims	**8**	**7**	**6**	**5**	**3**
Closed claims	**0**	**1**	**1**	**2**	**4**
Total opened during quarter	**0**	**0**	**0**	**1**	**-**

Redress

During the reporting period, 7 Redress cases were investigated under the Putting Things Right Regulations (PTR):

- 1 case was closed following a determination of qualifying liability. Financial compensation was accepted and the case closed in December 2022, following approval of reimbursement by the Welsh Risk Pool.
- 1 case has not identified a qualifying liability and remains open pending settlement of financial matters.
- 1 case remains open following the determination of a qualifying liability. Financial compensation has been offered and is awaiting acceptance.
- 4 new Redress matters were opened during the reporting period and remain under investigation.

Claims

Throughout the reporting period, the Trust's role is to handle claims to achieve a fair resolution for all parties. Where claims are valid, the Trust looks to settle these or defend where there is sufficient merit to do so.
During the reporting period between 1st April 2022 and 31st May 2023, the Trust dealt with 9 claims in total, consisting of Clinical Negligence and Personal Injury. During the reporting period:

- 1 new clinical negligence claim was received.
- 4 claims were closed following out of court settlements (PI and CN).
- 5 claims remain under investigation

The number of new claims against the Trust has decreased during the reporting period. The Trust, however, continues to drive down litigation and the costs associated with it.

The reduction in litigation has not, however, been at the expense of a less rigorous approach to investigations, as the Trust continues to respond to the responsibilities and challenges in relation to claims and legal change. This has allowed flexibly to respond to new priorities without significantly affecting progress towards the Trust's strategic aims to ensure continued relevance. Negligence claims form a very small proportion of both the number of incidents and complaints reported in comparison to the many individual episodes of care that are delivered by the Trust on a daily basis. There are many factors influencing the reasons why individuals bring a claim, including factors in the legal market. There is also a significant time lag between an incident occurring and a claim being received (on average 3.1 years). It may also take several years to settle a claim, particularly those involving high-value claims and payments made in relation to these claims may take many years into the future. Taken together, this means that the claims that are progressed against the Trust is a very partial indicator of service user safety in past years, and also what we can expect to pay out in settlement of those claims in the future.

Decisions taken to settle claims against the Trust are often made as a consequence of lack of evidence. The ability to defend claims relies heavily on the quality of the Trust's documentation, its records and the decisions taken, or not taken, at the time.

Where learning is identified from these claims, the Trust continues to play its part in reducing the cost of claims through the actions it takes to improve the standard of care. As part of learning assurance, the Trust is required to submit a Learning from Events Report (LfER) to the Welsh Risk Pool that demonstrates what lessons are learnt. When a breach of duty has been identified or admissions are made, the Quality and Safety team continue to work with directorates and services to identify the learning and actions that are required to satisfy the Welsh Risk Pool criteria and the way in which learning can be implemented to reduce the risk of reoccurrence and future impact. These actions ultimately drive down cost in litigation and continues to promote and encourage a culture of learning that benefits both patient, service user and staff.

As part of the Welsh Risk Pool requirements, the Trust is required to pay the first £25,000 of any claim. A reimbursement is sought from the WRP
During the reporting period, 1 Learning from Events Report was submitted to the Welsh Risk Pool for approval and received approval following an amber deferral and request for further evidence in support of learning.

As part of learning from claims, Learning Briefs are presented periodically to the Quality and Safety Performance Committee. The briefing captures:-

a) The summary of the incident
b) The root cause
c) The key learning
d) Supplemental learning
e) Actions taken

f) Actions outstanding
g) Review and ongoing assurance

These Learning Briefings are designed to reinforce the learning and sharing across the organisation and provide enhanced assurance of the actions undertaken to improve quality and safety care.

Learning Briefs were presented to the Quality and Safety Performance Committee during the reporting period, demonstrating the Trust's ongoing commitment of improving standards in the services and care provided to prevent repeat occurrences.

The following figures are estimations provided by NHS Wales Shared Services Partnership (NWSP) Legal and Risk Services in the event a claim is successful. The estimated financial liability as at the 31st March 2023 was:-

- £924,576
- Anticipated Trust Liability: £119,224

Inquests

An inquest is an inquiry into the circumstances surrounding a person's death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died for the death to be registered. To assist staff, guidance has been developed during the reporting period and includes:-

- An overview of inquest proceedings and what to expect as a witness
- Advice on how to write a statement for the Coroner and
- A revised template statement for witnesses to follow.

During the reporting period, 7 inquests were managed by the Trust comprising of;

- 3 new inquest notifications. Witness statements from treating clinicians have been submitted during this period, together with relevant copy medical records.
- 1 inquest hearing took place during the reporting period, where learning has been identified that can help improve communication with health care providers. The case remains open and is subject to an after action review.
- No inquest was subject to a Regulation 28, Prevention of Deaths Report during the reporting period.
- 2 inquests were closed during the reporting period.
- 5 inquests remain open at the end of the reporting period.

DELIVERING IN PARTNERSHIP

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
Digital Healthcare Wales (DHCW)	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality.

Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

Velindre Cancer Services

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last three years.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond

Blood and Transplant Services

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

WORKFORCE AND WELLBEING

Our overall workforce aims for our people, articulated in our People Strategy, are:

- To develop a **Skilled and Developed Workforce**, given clear career pathways, provide them with leadership, skills and knowledge they need to deliver the care our patients and donors need now and in the future.
- To support a **Healthy and Engaged Workforce** where wellbeing is key, recognizing and valuing their diversity in a bi-lingual culture.
- To have a **Planned and Sustained Workforce** having the right people with the right values, behaviors, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Over the past 12 months, key deliverables include:

Skilled and Developed Workforce:

- Worked with HEIW, maintaining provision of the Trust Inspire Management Programme.
- Further developed follow-on activities that are flexible and support 'just for me, just in time' development
- Working with colleagues to develop the School of Oncology and Centre for Learning
- 85% compliance with Statutory and Mandatory training

Healthy and Engaged Workforce

- Embarked on a 12 month project refreshing and embedding a positive and relevant code of values for the Trust.
- Agreed an Equality, Diversity and Inclusion plan and a Welsh Language Plan for 2022-23. Developed metrics to track progress of plans.
- Developed a plan to ensure compliance with Welsh Government Race Equality Action and LGBTQ+ Action Plans
- Health and Wellbeing infrastructure in place to support staff physical, mental and financial wellbeing

Planned and Sustained Workforce

- Further embedded our workforce planning process and toolkit
- Reviewed hard to fill roles ensuring robust recruitment and retention plans
- MDT training pathways mapped to maximise opportunities for transformation
- Ongoing management and development of Apprenticeships, Graduate trainees

Looking forward to 2023/24

Moving forward, focusing on looking after our staff will be key including ongoing engagement and wellbeing provisions. Working with partners regionally will be key to address recruitment issues and locally to develop and promote the opportunities working for a specialist Trust can provide – all focusing on meeting the vision of an Employer of Choice.

DIGITAL TRANSFORMATION

The Trust has developed a new Digital Strategy – 'Digital Excellence | 2023 to 2033' – to complement the new Trust strategy, 'Destination 2033'. It describes our vision for how digital services will be used to enhance patient and donor services, enable wider access through work on digital inclusion, secure and protect our data and how we will use data collected from all over NHS Wales to inform decision making and plan our services for the future. The new strategy is due to be published in May 2023

Over the past 12 months, the primary focus of activity within the Velindre Cancer Centre has been the delivery of the Digital Health & Care Record – a programme to replace the existing 'CANISC' IT system with the national Welsh Patient Administration System (WPAS) and an enhanced version of the Welsh Clinical Portal (WCP). The new platform was successfully deployed into the VCS in November 2022. Both WCP and WPAS are due to be further upgraded through 2023/24, to better support the clinical and operational workflows across the VCS and to further improve the mobility and visibility of patient data across organisational boundaries.

The major digital change introduced into the Welsh Blood Service saw the delivery of a new communications platform – 'Prometheus' – into the Welsh Bone Marrow Donor Registry (WBMDR), which also went live in November 2022. This service is expected to help enable a higher throughput of activity through the WBMDR, ultimately delivering an increase in the number of stem cell transplantations for patients across Wales and internationally.

Other digital activity over the past 12 months include:

- The Digital Service Desk – established in March 2021 – continues to effectively manage calls for IT support. Over 20,000 calls were resolved by the team in the 2022/23 financial year; of those, over 33% were fixed immediately by the 1st Line Support Team on the helpdesk. Over the coming year, the support team will be focused on improving the responsiveness of the Digital Service Desk, to include an element of automation for resolving common issues – this will further improve the turnaround times for calls raised with the team.

- Upgrades to some of the key operational and clinical applications across the Trust, including the WBS Blood Establishment Computer System (BECS) and the Welsh Nursing Care Record (WNCR), Welsh Clinical Portal and ChemoCare systems used in the Velindre Cancer Centre.

- The Digital Services team delivered a new system for the Welsh Infected Blood Support Scheme (WIBSS), to improve the support for beneficiaries of the scheme.

- The Digital Services team continue to play a central role in the design of the new Velindre Cancer Centre (nVCS) – due to open in 2025 – and the Radiotherapy Satellite Centre in Nevill Hall, Abergavenny – due to open in 2024. Digital is at the forefront of the design for the nVCS, with the intention to use a variety of new and innovative digital solutions to enhance the patient experience and improve the working conditions of staff who work in the new hospital.

- Delivered the IT infrastructure services and equipment to support the first phases of the Integrated Radiotherapy Solution (IRS) programme – the refurbishment of the 'LA6' radiotherapy suite at VCS. Further works are planned through 2023/24 to enhance radiotherapy services and ready the organisation for the establishment of the new, enhanced radiotherapy services at the new Velindre Cancer Centre, which is currently scheduled to open in 2025, and Radiotherapy Satellite Centre in Nevill Hall, which is due to open in 2024.

- Lastly, we continue to develop our local cyber security systems and procedures, and participate in national approaches to help secure patient and donor data and protect critical Trust IT services. A recent audit of the Trust's cyber security posture, undertaken by NHS Wales Shared Services Partnership, reported that the Trust had been able to provide **'substantial assurance'** in respect our cyber security strategic plan and internal procedures for reporting and managing cyber security performance.

To support the delivery and support for an ever-increasing portfolio of digital services, we are growing the Digital Services team, to include the introduction of new roles that we'll need to address the future challenges of cloud adoption, automation and the adoption of Microsoft 365 services.

Looking forward to 2023/24 the Trust will be establishing a Digital Programme, to oversee delivery of the digital transformation agenda across the Trust. In support of our digital aspirations, we are working with the Centre for Digital Public Services (CDPS) and Digital Communities Wales (DCW), to improve our approach to the design of digital services for our patients, donors and staff. Digital inclusion is a central theme within the Digital Strategy and will be a key focus for all our digital projects and programmes over the coming years.

SUSTAINABILITY STRATEGY 2022/2023

WELLBEING OF FUTURE GENERATIONS ACT / CREATING A SUSTAINABLE ORGANISATION

Our Approach to the Well-Being of Future Generations Act:

We have a commitment to transform the Trust and to create a sustainable organisation. The Trust Strategy together with those for specialist Cancer and Blood and Transplantation Services for 2022 – 2032 has been approved, and has sustainability at its core. These have set out what good look like in five years' time and the actions we will take over the coming years to achieve the excellence we are committed to.

These strategies have been developed within the context of the Well-Being of Future Generations Act (*the Act*) as we seek to implement the principles of the Act within the Trust to ensure that they become the central organising principle of each and every action that our staff take on a daily basis. This will take time but we are committed to ensuring we translate the intentions and spirit of the Act into tangible and sustainable benefits for the people of our region.

The Act requires public-sector organisations in Wales to focus on delivering long-term well-being goals in a sustainable manner. Whilst we have made progress in embedding the Act across the organisation we know that we have much more to do. The pioneering Act and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and outlines our sustainability aims and enables real action to create positive and significant change.

Therefore, we are really excited to be able to set out our journey to sustainability and the benefits it will realise over the coming years. As an anchor organisation in Wales, we are committed to embedding sustainability within our own organisation and become an exemplar for others to come and learn with, and from. We are committed to placing sustainability at the heart of everything we do and to maximise the benefits we can provide for people across Wales.

This Sustainability Strategy has created a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

This will require an increased focus on sustainability and well-being over the next three years as we attempt to embed the Sustainable Development (SD) principle still further to make it a 'normal' part of everything that we do. The journey we are on will see us

implement a new approach to planning and delivery across the Trust and the development of a different organisation that is more involved across the breadth of health, social care and public services. This collaborative way of working will see us working across the region with a range of partners to ensure the five ways of working are embedded within everything we collectively do and that we are actively contributing to the seven well-being goals.

Leadership will be fundamental to effective change. Our Chair is committed to leading the Trust to function as an exemplar Public Sector body in relation to the five ways of working and the embedding of the sustainability principle in all we do as an organisation. We have worked with our Health Board partners to facilitate the establishment of the South East Wales Collaborative Cancer Leadership Group (and this regional collaborative work also embraces the Act as a central principle).

During the next five years we recognise that there are opportunities for us to do more to advance our and the wider community's, well-being and sustainable development agenda. Within our major capital schemes in the new Velindre Cancer Centre and Talbot Green Infrastructure Upgrade Project, are developing ambitious and inclusive community benefits. We will seek to evolve existing partnerships to a much greater extent, and also to develop new relationships within the health sector and beyond in order to maximise our contribution and to support others in doing the same.

Our Well-Being Objectives:

The Trust, recognised under the Act as a national body, was required to develop and publish a set of its own well-being objectives.

These objectives were developed following extensive engagement and were designed to focus the Trust's contribution to the realisation of the national well-being goals.

Delivery Arrangements:

Our approach is built upon the personal support and leadership from the Chair and our Board. At Executive level, the Director of Transformation, Strategy and Digital holds the responsibility for sustainability within their portfolio and discharges this through a range of Offices which are co-ordinated and led by the Director of Commercial and Strategic Partnerships. The Trust has established a Sustainability Community Group to facilitate and support work across the Trust and the Sustainability Manager plays a key role in this process.

However, it is important to emphasise that our approach is to expect all of our workforce, suppliers and service providers to contribute to the well-being goals and to

embody the five ways of working in their day-to-day actions and behaviours. The Act is viewed as adopting a 'way of being' rather than simply demonstrating compliance to standards. In this regard, at its heart, it is viewed as whole system organisational development and emphasis is being placed on induction, education and training, relationship management, communication and workforce health and well-being.

The workforce, and the processes they utilise to function, will be supported and enhanced respectively so that they: clearly reflect what 'long-term' means, identify the root causes of problems through system wide perspectives, support work across organisational boundaries to maximise value, establish shared processes and ways of working. Importantly, our actions will be framed and facilitated by our strategic approach.

Progress against Delivery:

There are a number of actions that we are progressing:

Doing things differently to deliver change:

- The Trust is considering the Sustainability Development (SD) principle when developing its main strategic programmes, in new Velindre Cancer Centre and the Talbot Green Infrastructure Upgrade Project and the Radiotherapy Satellite Centre
- The Trust is considering how it can evolve existing partnerships to a greater extent, and develop new relationships within the health sector and beyond, to maximise its contribution to A Healthier Wales and to support others in doing the same.

Developing core arrangements and processes:

- The Trust has developed an ambitious Sustainability Strategy and plans to use it to embed the Sustainable Development principle and utilises the Well-being Goals at its core.
- Responsibility for delivering the Act and embedding the Sustainable Development principle sits within the Strategic Transformation, Planning and Digital Division. The Trust is developing current capacity within the team to deliver the requirements of the Act.
- The Trust is considering the merging or better alignment of its well-being objectives and strategic goals, ensuring we meaningfully contribute to our set objectives.
- The Trust has developed a strategic planning framework, which aims to ensure that the Act genuinely underpins all service development work and the Trust's Integrated Medium Term Plan. All planning activity throughout the Trust will utilise this framework in order to ensure that the Sustainable Development Principle is fully embedded across the organisation. The Trust intends for all investment proposals to demonstrate how they align to the Act.
- The Trust is currently undertaking work to create a more systematic approach to tracking and monitoring progress.

Involving citizens and stakeholders:

- The Trust is actively identifying ways to improve how it engages with citizens,

stakeholders, patients and donors when developing its services.
- The Trust is exploring possibilities for collaborating with other health bodies to develop a wider regional 'whole system' Cancer Community and a public health promotion agenda.

Whilst recognising we have much more to do, it is important to acknowledge the achievements of the organisation to date and the strengths it can draw on as we grow together as a sustainable community.

The Welsh Blood Service is currently developing ambitious Business Case to reduce the carbon footprint of the Talbot Green site. A key and ambitious objective of this Programme is to transition to a carbon neutral footprint for the building. This will be achieved through an increased focus on the use of renewable technologies, solar photovoltaic arrays, ground source and air source heat pumps and bio- mass boilers.

We have also focused considerable efforts on ensuring that the TCS Programme has embedded the requirements of the Act. The new Velindre Cancer Centre project is championing sustainable developments, such as integrating sustainable transport into the design of the new VCS, and encouraging the use of sustainable travel. We have identified several proposals for community benefits in the design of the new VCS. In this regard, a number of fundamental deliverables can be evidenced. The project aims to the

We have applied, and continue to apply, the Sustainable Development Principle when designing and developing the TCS Programme clinical service model and supporting infrastructure. The new TCS Programme clinical service model has a clear preventative focus and there are opportunities to educate patients and the wider community on healthier lifestyles to help prevent cancer. The TCS Programme clinical service model and supporting infrastructure also has a strong long-term focus based on a sophisticated understanding of current and future needs.

We have worked in an integrated way to design and develop the TCS Programme and supporting infrastructure and have considered how it can deliver wider benefits as the programme progresses to ensure it has a positive impact on social, economic, environmental and cultural well-being. We are also collaborating with partner organisations across South East Wales to develop and improve cancer services.

In addition, we have a range of strategic and operational examples of good practice in implementing the Act. A number of these are shared below.

TRUST SUSTAINABILITY STRATEGY

The approved Sustainability Strategy seeks to ensure we contribute to a better world for future generations in our community and across the globe, acting today, for a more sustainable tomorrow.To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of

Future Generations Act, which together ensure we achieve the Trust Well-being Objectives

INTERACTIVE ACTIVE TRAVEL AND SUSTAINABILITY MAPS

An interactive Active Travel & Sustainability Map has been developed for ease of access to active and sustainable transport options for staff. This includes signposting to: the OVO Bikes cycle hires; cycling storage; local bus routes; local train stations; and disabled parking. Pop-ups on the map provide additional information to staff, including how to access the Active Travel Hub and OVO Bike availability. Specifically for VCS, the map will include information about staff and patient support sessions, including Ray of Light and Noddfa Staff Well-Being Gardens. At Talbot Green, it highlights the nature walk and the location of the beehives. It provides an engagement tool to staff to highlight upgrades, for example the installation of bike repair unit in the Active Travel hub is signposted.

BIODIVERSITY ENHANCEMENTS

As part of our obligations to enhance biodiversity under the Environment Wales Act, the Trust is actively increasing local flora and fauna on all sites, and encouraging and educating staff to do the same in their gardens. This has included 'No Mow May' and 'Let it Bloom June' communication campaigns and at all sites we have reduced mowing. At VCS, we planted seasonal shrubberies and flowers and over 50 different species of daffodils were planted, and wildflower seeds were sewn. At our Talbot Green site, we have removed invasive species to allow local flora to thrive.

ISO14001:2015 EXTERNAL AUDIT

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an environmental management system. Following the successful recertification, with no non-conformities in November 2021, the Trust passed the revalidation external audit in September 2022 with no non-conformities raised.

GREEN SOCIAL PRESCRIBING

The Trust continues to partner with Ray of Light Cancer Support, who deliver a safe and non-judgemental support group for patients, carers and families affected by a cancer diagnosis, based at Velindre Cancer Centre. Ray of Light centre their sessions on the well-being benefits of nature, with many activities to choose from, including painting, whittling, forest bathing and many more. The Trust has converted a shipping container in the Noddfa gardens which has been painted by a local artist, allowing the

sessions regardless of the weather. The Trust has continued to work with Down to Earth to deliver green woodworking skills workshops. Volunteers comprising of Velindre patients, family, staff and local community members worked together to build the roundhouse and binhouses with green, living roofs, in addition to groups from a wide variety of organisations across south Wales, with the support of the Down to Earth Project team.

WBEES – BEEHIVE INSTALLATION

We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. To design the logo for our honey jars, we ran an all Wales competition (for staff and donors!). Staff were invited to pick from the shortlisted designs, and the winning design will be printed on all jars once the honey is ready to be collected.

PLASTIC REDUCTION

The Trust is actively reducing single use plastic where possible. Following the success of our pilot project, we have been rolling out biodegradable cups on all donor clinics across Wales, stopping nearly 150,000 plastic cups from landfill annually. Further to this, we have stopped purchasing plastic stirrers across all sites. At VCS, biodegradable coffee cup and takeaway containers have been introduced, preventing 98,000 plastic containers and 28,000 plastic coffee lids going to landfill annually.

WEAVING VELINDRE

The ‘Weaving Velindre’ art project invited staff to take a creative break whilst embedding the principles of the circular economy, by using old uniforms and materials associated with the hospital to fabric weave a piece of artwork celebrating Velindre Cancer Centres history. All materials used would have been thrown away, but instead have been repurposed to create a piece of artwork.

SUSTAINABLE JAMBOREES

Throughout August, a 'Sustainable Summer Jambori' was held in the Cancer Centre for staff, patients, families and the local community. The Trust Sustainability Team together with the new Velindre Cancer Centre project team held a month-long event programme featuring staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art. Due to the success of the events, an Autumn Jamboree was held, along with a Sustainable Spring Jamboree organised for VCS and WBS staff, with

themes of biodiversity and active travel. The Jamborees take the form of mini festivals - engaging with patients, families, staff and communities through arts and crafts to demonstrate the benefits of undertaking creative activities in a green space and educate on sustainability and biodiversity matters.

WELSH LANGUAGE REGULATIONS AND COMPLIANCE

Introduction:

This will be the Trust's fourth annual report dedicated to the delivery, promotion and monitoring of the Welsh Language Standards. The Trust's focus is strongly embedded in the cultural promotion of the Welsh Language and within this we are committed to comply with the legal requirements of the language as a provider of services for Patients and Donors.

Our delivery of the Welsh Language Standards and the 'More than Just words...' framework continues to be the driver for us to ensure compliance and we now have strong governance processess to monitor our performance.

Last year our focus was very much around the commitment to recruitment structures and embedding an ethos of culutral understanding, and this year we continue to stregnthen this. Understanding the language needs of our workforce has driven forward simple yet effective measures to promote our services and has opened discussions with patients around the 'active offer' concept.

It is our ambition to ensure our patients and donors are aware of their Welsh Language rights and our response to this awareness becomes even more proactive. Providing bilingual services as a matter of course rather than request is our ultimate aim.

Celebrating Welsh Culture:

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its languages. We recognise the need to comply with its legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have drafted a Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive management board have taken on roles of responsibility for certain aspects of the Equality and Diverstity agenda and this includes an Ambasador role responsible for the Welsh language.

The Trusts draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Board.

Highlights at a glance:

To support its working group the Welsh Blood Service have developed a specific intranet page that complements the work of the Trust. The service has its own specific requriements and felt a need to support staff visually as well as using Trust wide guidance. This has strengthened the division's understanding and enables staff to see the relevance to their work in promoting and supporting bilingual donor needs.

Velindre Cancer Centre have increased its 'Active offer' presence. A simple visual approach has given patients the opportunity to verbalise their language needs.

Staff have reported patients identifying themselves as Welsh speakers as part of the care process and this has ensured a talored bilingual service to their care pathway.

Increased translation investment again this year means the Trust continues to support patients and donors that need Welsh Language services

Partnership working with other Welsh Language Managers gives an opportunity to share best practice and begin the development of a shared IT system

Welsh language Standards Compliance:

Governance structure

We continue to work with our divisions to ensure a local approach to the development of the Standards. The divisional groups report frequently into the Trust wide WelshLlanguage group and information is fed directly to the Executive team and the Trust Board.

It has proved to be an extremely successful way to ensure information is shared and it informs the Trust Board of any regulatory changes that need discussion at Board level.

Our Board Welsh Language Champion continues to support and challenge our Welsh Language compliance.

The Trust is a host organisation for Health Technology Wales and NHS Wales Shared Services Partnership and they are both working diligently to support the development of the Welsh Language standards.

Training

The Trust continues to actively promote Welsh Language online training and in this reporting year eight members of staff have completed the Part 1 course. We also secured our second Foundation Welsh language course for staff but unfortunately the identified front line members were unable to complete the course.

We are reviewing our approach to training and will be running specific awareness sessions for staff from May 2023 prioritising staff that answer the telephone in line with the requirements of the Welsh Language Standards.

Staff have also been attending a Welsh Language confidence course run by HEIW and will be offered this opportunity again following a positive response. Partnership approaches to this course has proved to be extremely positive.

The newly introduced Welsh Language awareness 'more than just words...' on line course has been welcomed by the Trust and staff have embraced the course positively.

Since its introduction in December 2023 we can demonstrate a positive approach to compliance.

Welsh language awareness – More than Just words	**By February 2023 % of staff**
Corporate	50.00
Research, Development and innovation	55.10
Transforming Cancer Services	44.44
Velindre Cancer Centre	40.72
Welsh Blood Service	70.48
Velindre Organisations	50.85

Recording our staff competancy levels in ESR ensures our workforce planning considers the language needs of our services. Currently over 86% of the workforce are completing the competancy field within ESR.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|LANG|Listening/Speaking Welsh|	1571	1571	1378	87.71%
NHS|LANG|Reading Welsh|	1571	1571	1367	87.01%

NHS|LANG|Welsh Language Awareness - 3 Years|	1571	1571	803	51.11%
NHS|LANG|Writing Welsh|	1571	1571	1363	86.76%

Workforce planning

We continue to work diligently on ensuring a Trust wide compliance with the Welsh Language standards whilst promoting and suppporting the ethos of ‘more than just words...’

Our Governance structure is embedded successfully and our document used to monitor compliance demonstrates a stregnthened compliance level. As a Trsut we continue to use this as a benchmark for delivery of our Welsh Language services.

As part of the Supply and Shape activity, work is currently being undertaken to gather a baseline assessment of our workforce, part of this is to assess the current capability of colleagues to speak, read and write in Welsh. The work will also consider how our workforce reflects the local population average, as well as looking at the capability levels of future colleagues (i.e., students currently enrolled on commissioned courses) this will provide a picture of the potential gap that we face as an organisation.

Working with partners we will then implement steps to reduce this gap and meet our requirements as articulated in the ‘More than Just Words’ action plan.’

Translation

Our increase in investment over the last two years has meant we have been able to increase our translation capacity. In 2023-24 we will be a team of three dedicted translators and utilising a Service level agreement with NWSSP.

In 2019/20 we were translating almsot 380,000 words. In 2022/23 we have translated just over 1,059,053. This is around 178% increase in the number of words translated in two years.

Job descriptions and recruitment

Translation has supported the time the Trust has given to strengthening its assessment of language needs whilst recruiting. Workforce planning is critical in order to ensure the Trust supports its patients and donors and is proactive with its recritment priorities.

This year we have focussed heavily on ensuring recruitmet managers are aware of the Welsh language recruitment process, we have invested heavily in structures to support this and the workforce team alongside the Welsh language department have now embedded the process securly.

In 2021-22 the translation team dealt with the translation of 24 job descriptions. Since the investment into a recruitment assessment process for Welsh language skills this has increased to 219 job descriptions to the beginning of March 2022-23.

Velindre University NHS Trust 2022-2023

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh language skills are desirable	157
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	5
Total Number of vacancies advertised 01/04/2022 - 31/03/2023	163

From the data we can confirm that the one post identified as essential was a front line, telephony post. The no skills necessary related to posts within a clinical laboritory service with no patient or donor contact.

Contractual obligations at Velindre Cancer Centre

Integrating our bilingual obligations into all that we do is essential to 'normalise' the use of the langauge and an understanding of our commitment to the development and promotion of the Welsh language Standards. As such, as we plan our services we have ensured that our obligations are highlighted in all that we do.

At the Cancer centre a revision of service level agreements has encouraged us to ensure the Welsh language is considered by our suppliers as well as our internal services. A simple yet effective way to ensure our compliance and encourage discussions with providers. It highlights our expectations of the provider and supports a discussion previously not considered:

Welsh Language Obligations

The Provider warrants and undertakes that it will not discharge its obligations under the Agreement in such a way as to render the Commissioner in breach of its obligations in respect of the Welsh language including, but not limited to, the Welsh Language Act 1993, the Government of Wales Act 1993, the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No. 7) Regulations 2018.

Clinical consultations

Our clinical consultation plan has been reviewed and a structure for assessing its actions put in place this year. The plan highlights the struggles of providing bilingual consultations for patients and donors but it also recogises the need to ensure a clear understanding of what skills are needed and where. The divisional groups have been charged with monitoring the action plan and will inform the Trust development group of concerns etc.

This year the WBS have conducted a skills audit as the first step in recognising where Welsh language skills lie. This audit will inform the next process of understanding how we can transfer the need to fit the skill especially as part of the donor collection process and the need for language communication on the front line.

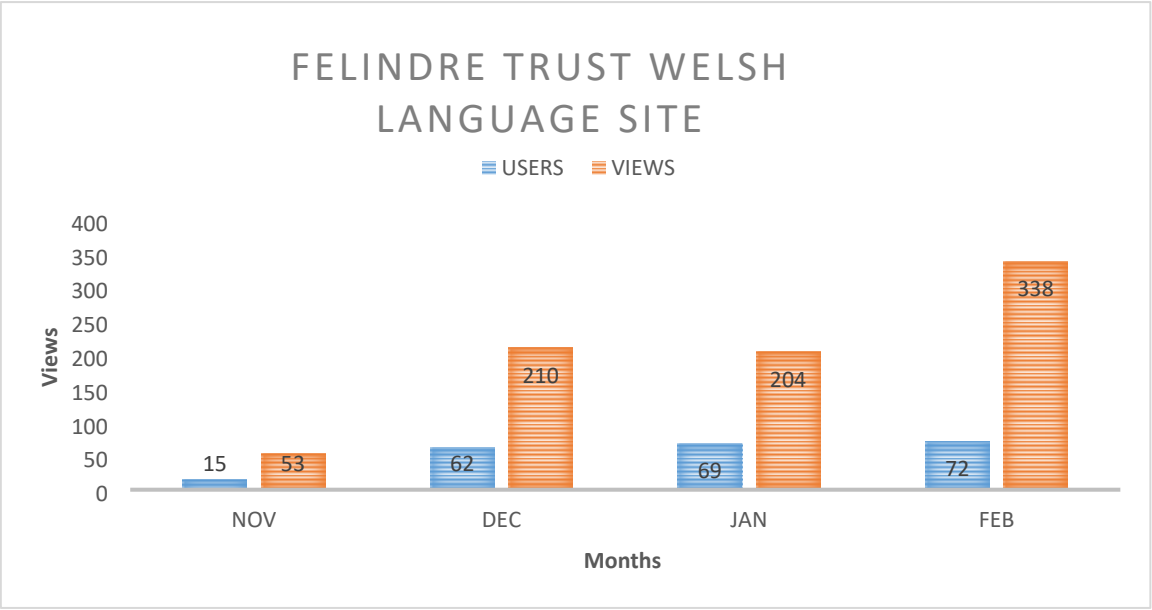
We will continue to work with the divisional groups to ensure our plan is revised and is informed by the language needs of our services.

At Velindre Cancer Centre the strengthening of the Active offer has seen three patients through the appointment system, recieving care and returning for care, in the Welsh language. With new IT systems in place and a commitment from the department to the Active offer, it has enabled the department to respond to the specific needs of their patients.

Website

The new Trust website has been embedded and from November 2022 we ar now able to monitor the Welsh language interest in our information.

English: https://velindre.nhs.wales/	Welsh: https://felindre.gig.cymru/
November 2.3k users 6.9k page views **December** 8.1k users 24k page views **January** 9.2k users 31k page views **February** 9.1k users 30k page views	**November** 15 users 53 page views **December** 62 users 210 page views **January** 69 users 204 page views **February** 72 users 338 page views



It is encouraging to note that there has been a 537% increase over four months in views to the Welsh language site

Telephone Communication

Perfomance indicators for the Welsh Blood Service donor contact centre from January 1 – March 16 2023

English language calls: 9,716

Welsh language calls: 366

Welsh language calls work out as around 4% of the calls.

Calls to Velindre Cancer Centre and the Trust headquaters are not measured, however specific actions for staff directly working on the telephone have been communciated. A specific question and answer session was also held to ensure staff understood their duties.

Promotion

We continue to highlight important events in the Welsh language calendar. This means an additional opportunity for staff to engage with the culture of Wales as well as the language.

This year the Trust has participated in a number of awareness raising days including St David's Day, Santes Dwynwen, Shw'mae day and 'mae gen ti hawl'.

Information on these events runs alongside our regular communication where we promote Welsh language traning, on line and face to face.

Our social media accounts have been incredibly busy this year with both divisions taking part in events. We are now offering bilingual approaches to all our promotional videos.

This year we were also fortunate enough to showcase our commitment to Welsh Culture at the HPMA (Healthcare People Management Association) Conference. This is a high profile event and Welsh culture was celebrated in a day long conference with Velindre University NHS Trust showcasing it's commitment.

Concerns and Complaints

The Trust welcomes feed back on its services. Concerns or complaints are used to ensure we continue to understand the needs of our patients and donors. Welsh language users are becoming increasingly aware of their rights to use the language and it is our duty to ensure we can provide those services to the best of our ability. This year we have recieved four official complaints and one formal investigation.

The formal investigation focussed on the Trust's ability to answer the telephone bilingually and to continue a discussion in the Welsh language. The investigation has not been concluded however the Trust has been proactive and will be providing direct trainig on raising confidenceá to those answering the telephone.

Overall the Trust's concerns and complaints around the provision of Welsh language services are small, however, we are aware of the need to continuously monitor our provision and have this year updated our Concerns policy to reflect Welsh language provision.

NHS Wales Shared Services Partnership

Welsh Language Review Highlights 2022/23

The Welsh Language Unit at NHS Wales Shared Services Partnership has continued to support NWSSP divisions and services with advice on compliance and service delivery to our customers through the medium of Welsh and have supported the organisation and other NHS Organisations with translation support during 2022/23. The demand for translation services continues to grow, and this year we've translated even more words that in 2021/22. In 2022/23 NWSSP has translated a total of over 5.2million words for the following organisations:

- NHS Wales Shared Services Partnership
- Velindre University NHS Trust
- Public Health Wales NHS Trust
- Digital Health Care Wales
- Health Education Improvement Wales
- Wales Ambulance Service Trust
- Value in Health Care
- WHSSC

Compliance with Standard 106A

NHS Wales Shared Services categorises vacant or newly created posts as either Welsh essential or Welsh desirable, and we have introduced a matrix to determine which skill category is most relevant to each vacancy.

We have devised a protocol and a system whereby all advertisements are translated and published on the TRAC recruitment system and NHS Jobs in both Welsh and English since June 2022. We regularly review the system to capture any issues that arise in the creating vacancy advert process.

Easy-read Patient Information Leaflets

During the year, we've undertaken a full review of existing easy-read leaflets and new leaflets and have ensured that the translation of these leaflets are suitable for the audience for which they are intended.

Student Awards System

We reviewed the old system to ensure that the user journey was entirely through the medium of Welsh. During 2022/23 we have commissioned a new developer and a new Student Awards System, whereby the interface for students will be available through the medium of Welsh as well as any mail tips, correspondence and messages that are generated by the system. This work will continue into 2023/24.

Workforce Reporting System

This site provides a Web Portal for Primary Care Data accessible to GP practice staff, Clusters and Health Boards of NHS Wales and other approved stakeholder organisations. This site is only available to registered users. However, we have ensured that the system is bilingual.

Duty of Candour Public Video

We have supported the production of an animated video for the public in Wales about the duty of candour in collaboration with Welsh Government.

The video is available in both Welsh and English.

Counter Fraud Awareness Course and App

The Counter Fraud Awareness Course for all Wales NHS Staff is available in Welsh, as is the application for NHS Staff to report fraud or suspicion of fraud in NHS Wales.

All Wales GDPR Awareness Course

We have been supporting the production of the All Wales GDPR Awareness Course through the medium of Welsh and this will be available to launch in 2023/24.

All Wales Occupational Health System for NHS Wales Staff

The specification in the tender process for this system has included detailed requirements for the system interface and any correspondence/messages and mail tips to be available through the medium of Welsh as well as English. Further work on this system will continue in 2023/24.

Assessment of compliance across our services

Following on from the pandemic, we have re-introduced annual local assessments across our services in order to identify areas of best practice, identify areas of risk. Local improvement and action plans are established in order to strengthen our Welsh language services offer across all NWSSP services and programmes.

A copy of the full Annual Report for NWSSP can be found on our website:

Welsh Language Standards - NHS Wales Shared Services Partnership

Moving forward

Cultural change continues to be high on our priorities. Without a deeper understanding of the need for bilingual services we will continue to enhance a provision that does not have strong foundations, relying heavily on the willingness of supportive staff.

The Trust induction programme is being updated and will again include the importance of the Welsh language, sitting alongside other areas such as Equality and Diversity and the Future Generations Act. Our commitment to these areas are as important to us as our clinical requirements as we know how important they are to our patients and donors. Communication is key to safe care.

The Cultural plan will be revised and a refreshed action plan drawn highlighting opportunities for staff to familiarise themselves with the language and opportunities to learn. We will also be connecting this to the 'more than just words...' framework as our actions relate positivily to the aims of the framework.

Our recruitment and workforce planning will also play a key role. Planning with our community needs in mind ensures a targeted approach to recruitment. With this in mind our recruitment process will be supported by strong monitoring to ensure the Welsh language skills needed are highlighted correctly. This continues to be challenging for us as the nature of our services calls upon a small pool of clinical specialisms but we are commited to this agenda.

CONCLUSION AND FORWARD LOOK

We have produced our Integrated Medium Term Plan for 2023 – 2026 (insert link) which sets out how we will deliver services from 1st April 2023 to 31st March 2026. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines the arrangements we have in place for managing our capacity so that we can meet the expected increase in demand for our services.

The Chief Executive Conclusion will be completed at the Final Draft stage

Annex - Glossary of Terms

IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality and Planning Delivery
IPC	Infection Prevention Control
Linac	Linear Accelerator
RT	Radiotherapy
SACT	Systemic Anti-Cancer Therapy
VCS	Velindre Cancer Centre
WBS	Welsh Blood Service
CCLG	Collaborative Cancer Leadership Group
nVCS	New Velndre Cancer Centre
WCP	Welsh Clinical Portal
WRP	Welsh Risk Pool
LfER	Learning from Events Report
EAP	Employee Assistance Programme
TCS	Transforming Cancer Services
CDPS	Centre for Digital Public Services
DCW	Digital Communities Wales
WPAS	Welsh Patient Administration System
DHCW	Digital Healthcare Record
WTAIL	Welsh Transplantation & Immunogenetics Laboratory
BECS	Blood Establishment Computer System
WNCR	Welsh Nursing Care Record
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
ESR	Electronic Staff Record

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

2022/2023 Trust Annual Putting Things Right Report

DATE OF MEETING	13th July 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	Jade Coleman, Quality, Safety and Assurance Manager
PRESENTED BY	Jade Coleman, Quality, Safety and Assurance Manager, Jayne Rabaiotti, Claims & Redress Manager & Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Velindre University NHS Trust Putting Things Right 2022-2023 Annual Report covers the period 1st April 2022 to 31st March 2023 and contains the following key messages: • 154 complaints were raised during 2022-23, equating to less than 0.06% of patients and donors raising a complaint in relation to the care or treatment provided. • 55% of concerns were received via e-mail. • Over 94% of complaints were low level (graded level 1 or 2), and 70% were successfully resolved via the 'early resolution' (verbally within 48 hours of receipt) process which is an 11% increase in comparison to 2021/22.

	• There were 7 complaints that were re-opened. All were swiftly investigated and managed, through to final closure to the satisfaction of the complainant. • Since April 2022 there has been a steady decrease in the number of Covid related complaints reported to Trust. • There were 8 claims managed during the year, 1 new claim received, 4 were settled and closed, and 5 remaining open at the end of the financial year: 5 • 7 Redress cases were managed during the year, 4 new redress cases opened, 1 case closed, 1 offer made and decision awaited and 6 cases remained open at the end of the year. • 2,023 incidents were reported across the Trust throughout 2022/23. 74% being fully investigated and formally closed within 60 days of the incident being reported. • There were 9 National Reportable Incidents compared with 12 in 2021-22 and 15 2020-21. All 9 related to Velindre Cancer Service: 2 related to the SACT treatment helpline, 3 related to patient falls and 2 related to booking mechanisms. • There were 7 inquest processes being managed during the year involving the Trust. This included 3 new inquests being opened, 2 completed and closed and 5 remaining open at the end of the year. • A key theme from the report is the need to enhance and improve clinical communications

RECOMMENDATION / ACTIONS	To **ENDORSE** the 2022-2023 Velindre University NHS Trust Putting Things Right Annual Report prior to submission to the Trust Board for approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Integrated Quality & Safety Group	Throughout 2022/23
• Executive Management Board – RUN	29th June 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust 2022/23 Putting Things Right Annual Report was discussed and endorsed.	

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	Complaints Grading Table

1. SITUATION

The 2022-2023 Velindre University NHS Trust Putting Things Right Annual Report provides an overview of the concerns activity undertaken between 1st April 2022 and 31st March 2023 including the key issues and outcomes in relation to performance, overview of key themes and trends, analysis of some of the cases managed, and details of the learning accomplished and assurance given of the Trust's ongoing commitment to learning and improvement and highlights concerns, compliments, claims, inquest and redress cases. .

2. BACKGROUND

All NHS bodies in Wales must ensure that they have effective processes for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints of and Redress Arrangements) (Wales) Regulations 2011. The aim of the Putting Things Right Regulations is to give guidance on how concerns that are received should be investigated and responded to in order to promptly and fairly facilitate resolution of issues at a local level for both users of the service, their representatives and carers and also the staff involved.

The National Putting Things Right Guidance details the requirements to assist staff in interpreting the Regulations and provide practical advice on applying best practice at the various stages of handling and investigating a concern. The guidance sets out the general principles for handling concerns, raising a concern and investigating a concern. The guidance details managing Redress cases including payments of any financial compensation and finally serious incident reporting and investigation requirements.

The Trust is committed to being open and discussing compassionately with the service user, family member or representative acting on their behalf. Openness and honesty assist in preventing events from becoming litigated claims. When concerns arise, the Trust, in the interests of justice, endeavours to resolve these amicably and as swiftly as possible.

Velindre University NHS Trust is committed to ensuring the provision of an effective and timely process for responding to concerns, which ensures concerns are thoroughly and appropriately investigated and enables the Trust to improve its services based on lessons learned.

3. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The Trust 2022/23 Putting Things Right Annual Report is attached. Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving all complaints and incidents in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) commonly known as Putting Things Right (PTR).

The report provides information on how our systems and processes have developed over the reporting period for the effective investigation and engagement with patients/donors and their families, providing comprehensive responses to each concern raised. This ensures that changes have been made, lessons have been learnt and action outcomes disseminated following the investigations.

4. IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</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 ☒</td></tr>
<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 rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information: https://www.gov.wales/socio-economic-duty-overview</td><td>Not required</td></tr>
<tr><td>The Putting Things Right Regulations ensures that in the interests of justice there is a requirement to be open and honest and to ensure that adequate provision is made to assist those who are socially disadvantaged when dealing with concerns. As part of the</td></tr>
</table>

	concerns governing processes, there is a need to assess if any equality/social economic issues arise that could potentially have a consequence on the service user or those representing the service user's best interests in relation to a concern. Reducing inequalities prevent social injustice. The Trust is under a duty to offer appropriate support and signpost to relevant services where required, as part of the governance processes in place for the provision of concerns. This helps to facilitate better outcomes for the individual and aligns with the well-being goals and five ways of working provided by the Future Generations (Wales) Act 2015
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	As part of the complaints process, there is the need to take in account the wishes of the individual. This leads to better wellbeing and health choices. By involving the individual in the decision-making process this ensures an effective outcome. When concerns are raised, wellbeing plays an important part in how the individual feels treated by the Trust in raising their complaint. The Trust is committed to providing timely responses, including thorough and appropriate investigations which enables the Trust to improve its services based on lessons learned, leading to huge benefits in the future care and service provided within the Trust.
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.

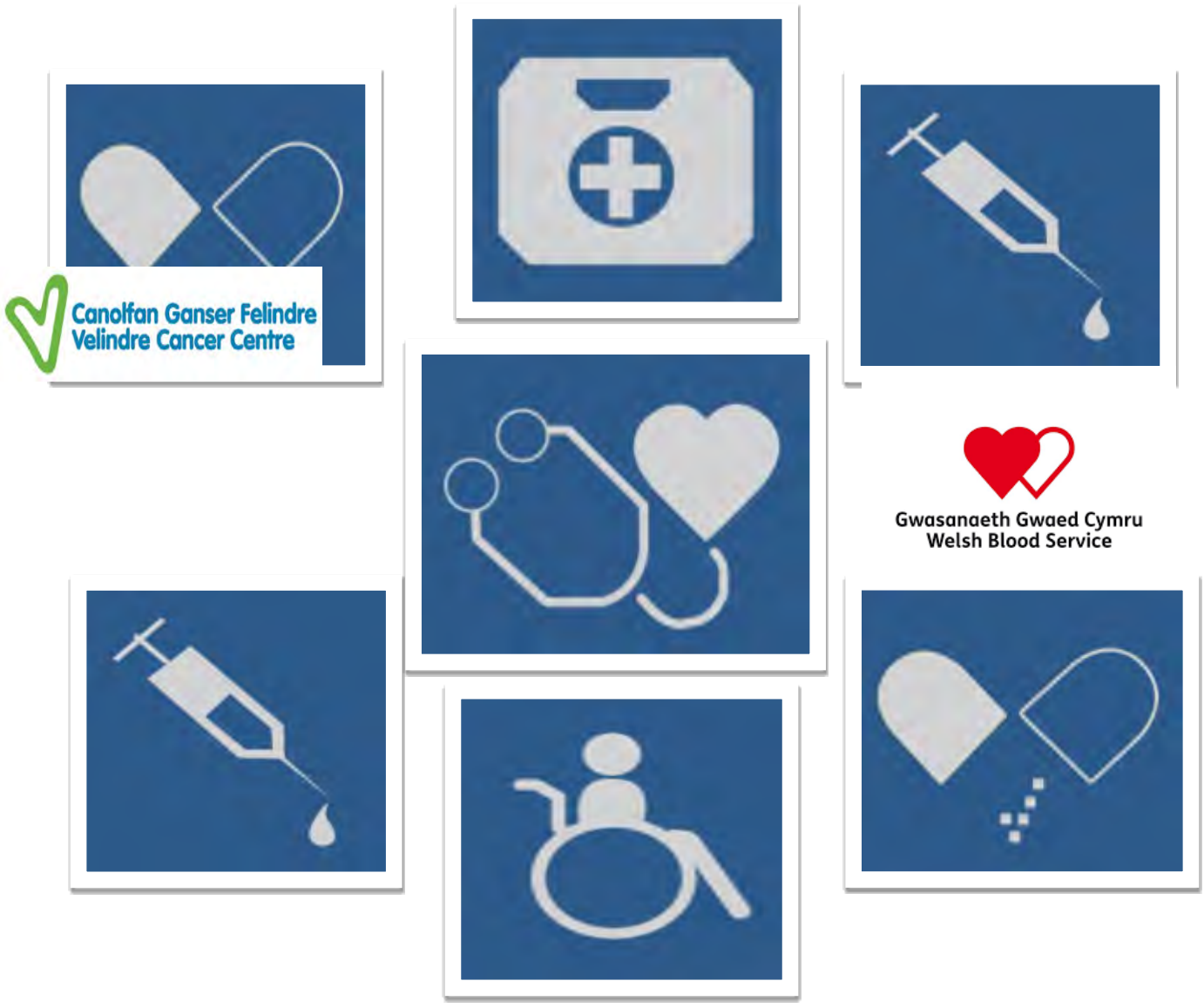
	Scale of Change Please detail the value of revenue and/or capital impact: The estimated financial liability of the current caseload of claims is predicted to be in the region of approximately £924,576 The Welsh Risk Pool indemnifies the Trust in respect to the payments made, deducting the first £25,000, which is the financial cost borne by the Trust. The Trust liability, if it were to settle its current caseload of claims is estimated in the region of £119,224. **Type of Change** **Other (please explain)Other (please explain)** Please explain if 'other' source of funding selected: Not applicable.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The equality impact assessment is designed to ensure that decision-making processes are fair and do not present barriers or disadvantages to protected groups. There are legal implications for concerns if there is inequality in the Trust's processes and policies that could potentially prejudice service users. By enable service users to raise concerns safely and in the knowledge that they will be listened to and actions taken appropriately to address concerns, the risk is mitigated.
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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
Themes and trends arising from analysis of concerns represent a risk for the Trust, especially when it is identified that errors and mistakes have been made which potentially has legal and financial consequences. The Trust is operationally responsible for the management of concerns and must ensure that it is compliant with delegated authority limits and for securing the most cost-effective resolution of concerns. All members of staff are encouraged to report adverse incidents, including those that may lead to claims for compensation. Failure to do so, increase risk. Staff have a duty to provide assistance as part of an investigation when called upon to do so and, where appropriate, are required to support the complaints, redress and inquests processes, when required. Risks are evidenced through Datix Cymru and is consistent with analysis of themes and trends data. Any risks identified are escalated through the concerns governance processes, as required.	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust
2022/2023 Putting Things Right Annual Report



Contents

Introduction

Velindre University NHS Trust is one of the leading providers of specialist cancer, blood and transplantation services within the UK, bringing together expert staff, high quality cancer care, donor and transplantation services, together with excellence in research, development and innovation. We have built a strong reputation across the United Kingdom, Europe and internationally for the services we provide.

The Trust have two main divisions: Velindre Cancer Service (which provides specialist tertiary non-surgical cancer care) and the Welsh Blood Service (which is responsible for the provision of blood and blood products) to NHS Wales.

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf.

The Trust is committed to be open and transparent when things go wrong in order to learn and improve and prevent harm from re-occurring.

The Trust places a high value on ensuring that we always keep our patients and donors at the heart of everything that we do, and we are grateful for the continued levels of assistance, encouragement and positive feedback that we get from our patients, donors, staff, sand partners.

Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving these matters with utmost transparency and in accordance with legislative and national requirements in particular in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) commonly known as **Putting Things Right** (PTR) (2011).

Velindre University NHS Trust 2022 - 2023 Putting Things Right Annual Report provides an overview of how the Trust has managed concerns (complaints, serious incidents, claims, redress, and inquests) during the period of the 1st April 2022 to the 31st March 2023.

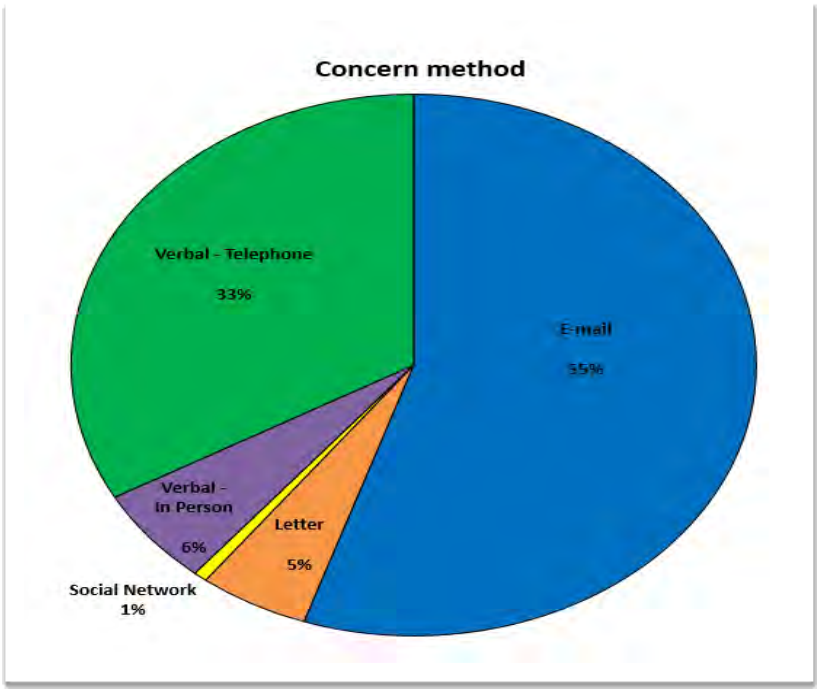
The report also provides information on how our systems and processes have developed for the effective investigation and engagement with patients/donors and their families, providing comprehensive responses to each concern raised. This ensures that changes have been made, lessons have been learnt and action outcomes disseminated following the investigations.

Trust Complaints Received

Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

When a complaint does not require a formal investigation, we aim to resolve it within 2 working days of receipt, called 'Early Resolutions'. These do not need to be formally considered under the Putting Things Right Regulations (PTR). Where it has not been possible to resolve a complaint within this timescale, or where an in-depth investigation is required, the complaint is managed under the Putting Things Right Regulations.

Complaints are received via a number of routes and is evident that e-mail communication remains the preferred method of contacting the Velindre University NHS Trust, with **55%** of complaints being received in this way during 2022-23.



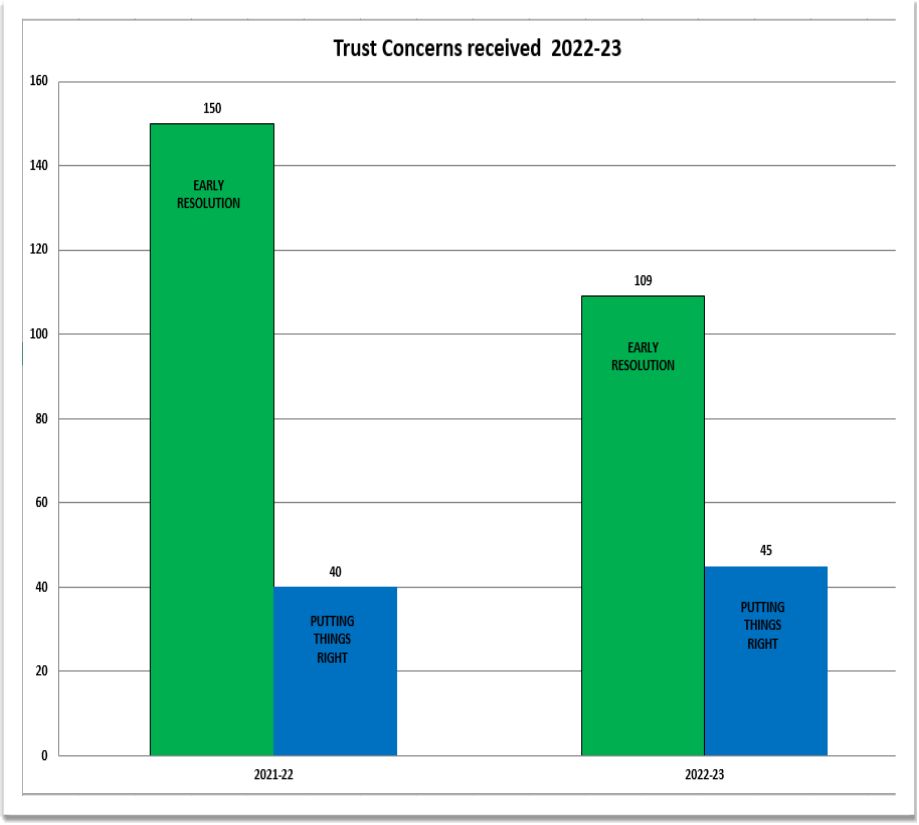
Reporting and Monitoring Structure

The Trust continues to improve its reporting in order to contribute to reducing harm to service users by turning the data that it holds into useful information. This drives operational efficiency and enhances the level of insight such data offers. This includes analysing themes and trends and escalating where necessary. Monitoring claims is a fundamental tool of risk management, the aim of which is to collect information regarding claims that will help to facilitate wider organisational learning. Quarterly PTR related reports covering all elements are combined into an overarching Trust Quality and Safety report, provided to the Integrated Quality and Safety Group, divisional quality and safety groups, Executive Management Board and Quarterly and Safety Performance Committee and presented by the Executive Director of Nursing, AHP and Healthcare Science who is the Executive Director responsible for Putting Things Right.

Complaints received between 1st April 2022 and 31st March 2023

Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day. Responses required under PTR will be provided within the legislative timescales.

154 complaints were raised, equating to less than **0.06%** of patients and donors raising concerns in relation to the care or treatment provided (this is based on 183,691 patient attendances and 79547 Welsh Blood Donations). This activity rate is lower than previous years (190 raised in 2021/22 and 183 patients/donors in 2020/21). When a concern is investigated under Putting Things Right, an acknowledgment is provided to the complainant within 2 working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly investigate all concern received and, that 75% of all complaints be resolved, ensuring a formal response is produced within 30 working days of receipt.



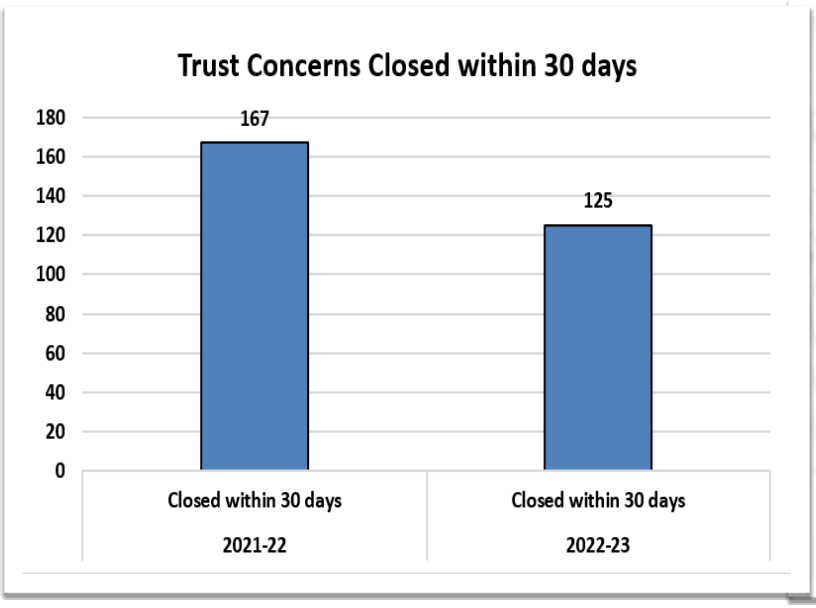
How is the Trust doing in its Concerns Management

The Datix Cymru system was fully introduced across the Trust by April 2021 enabling this year's Putting Things Right annual report to display 2 full years of data collection. Over this period the Trust has implemented robust systems to capture concerns raised, address the issues, engage with the service user(s) and learn from the outcomes of the investigations completed.

The Trust has continued to respond comprehensively to all complaints during 2022-23, with 84% being investigated, resolved and closed within 30 working days of receipt (Welsh Government target is at least 75%).

Due to a recent validation of the PTR closure within 30-day return figures by the Welsh Risk Pool, an anomaly was found where the day on which a PTR concern was received being classed by the Trust as "day zero", when this should have been classed as "day one" which has impacted the overall compliance for the year. However, all concerns effected were completed within 31 working days of receipt.

This issue has been addressed and all future Putting Things Right concerns will be classed as "day one" on the date of receipt.

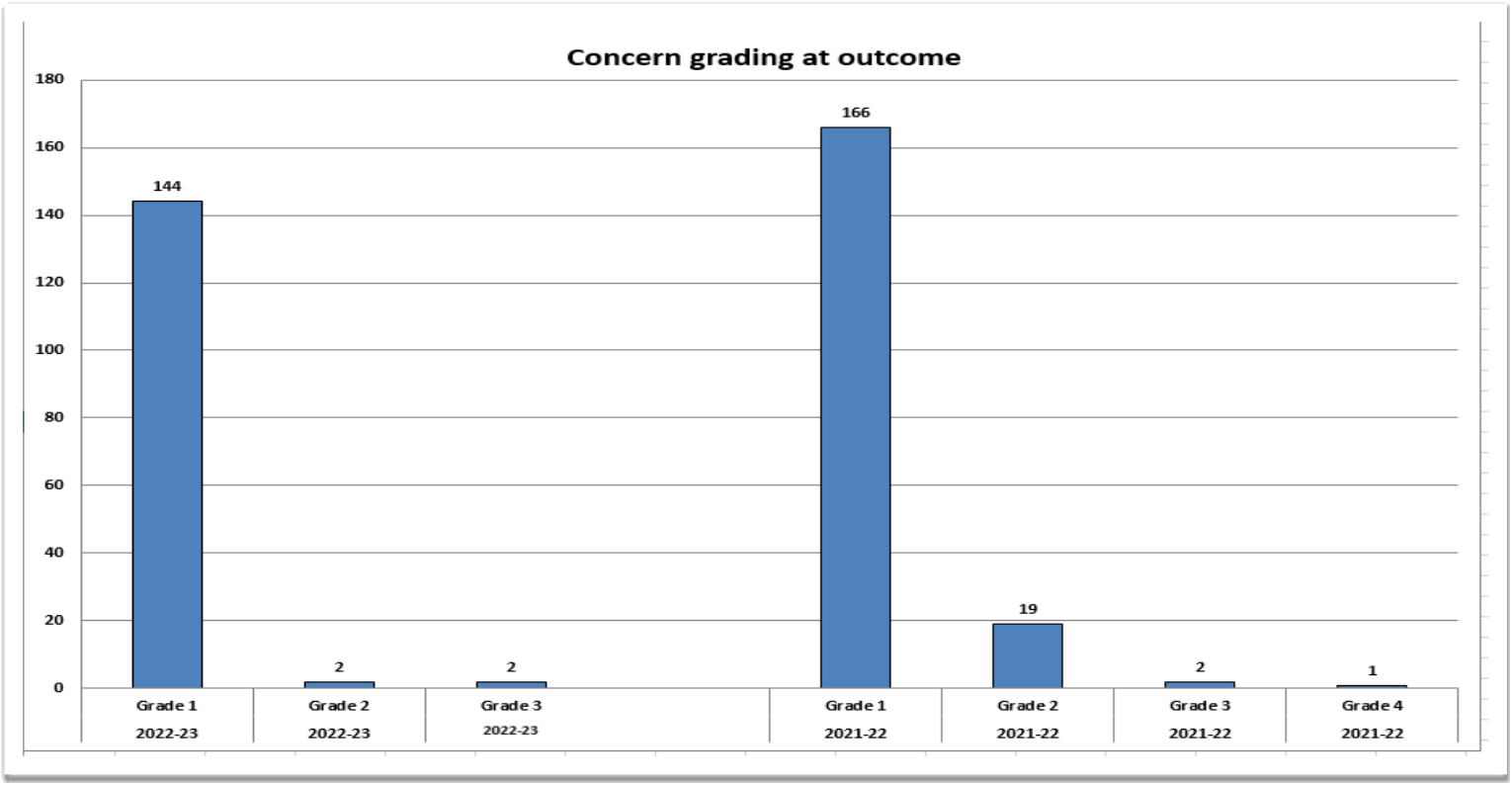


Concern Grading

All complaints are graded upon receipt (complaints grading table attached in **Appendix 1).** All complaints received undergo an assessment of harm to determine the grading and whether there is a possibility that the Trust may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned.

Over 94% of the complaints raised were low level with no or low harm and graded a level 1 or 2, and 70% were successfully resolved via the 'early resolution' process which is an 11% increase in comparison to 2021/22.

There were two grade 3 complaints that related to: a delay and disconnect in care and treatment in relation to a cancer patient who passed away *and*, a patient who was not made aware of the risks, nor consented to the possible side effects from radiotherapy, which later developed into a secondary tumor following the initial treatment plan. Both were initially investigated under the Putting Things Right Regulations and subsequently escalated to be managed through Redress procedures.



Re-opened Complaints

Occasionally a complainant will be dissatisfied with the formal response they have received or require further information and will contact the Trust back. In these instances the complaint will be re-opened. The number of re-opened complaints could be an indicator of the quality of complaint investigations and responses.

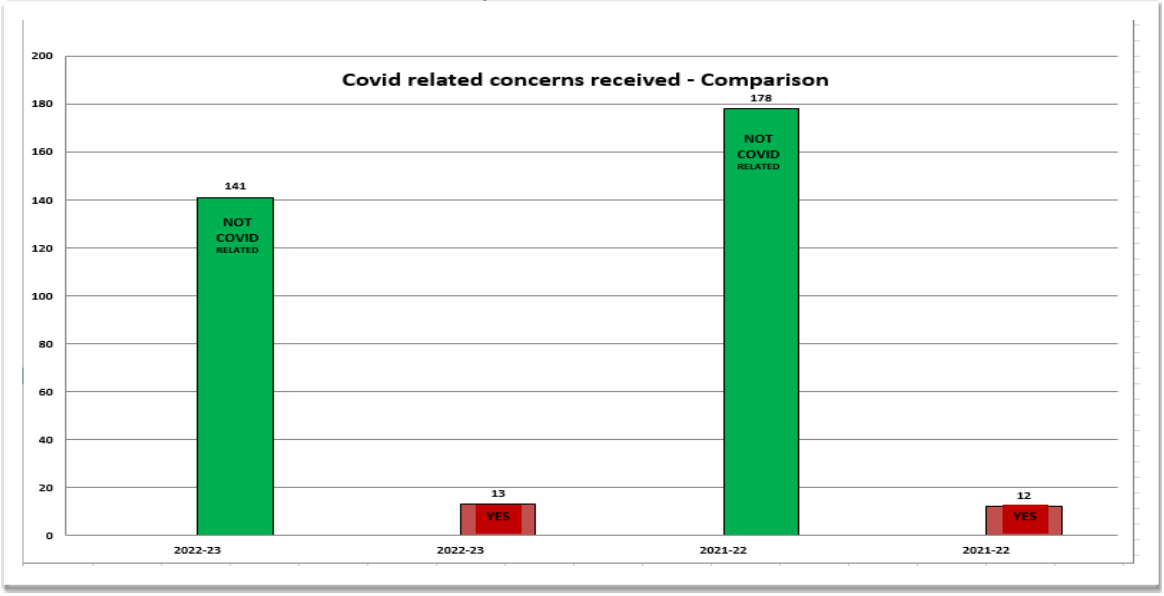
There were **7** complaints re-opened during the year (8 re-opened during 2021/22). All 7 were swiftly investigated and managed, through to final closure.

As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response to each complaint. The 7 cases during 2022-23 were re-opened as a result of the complainant raising further queries following the Trust formal response. The majority of the them related to the complainant seeking further clarification on particular elements of the response and a small number of re-opened cases identified the importance of working closely, and in partnership with other NHS organisations (Health Boards), ensuring collective detail is established when more than one organisation has been involved in the care or treatment of the service user.

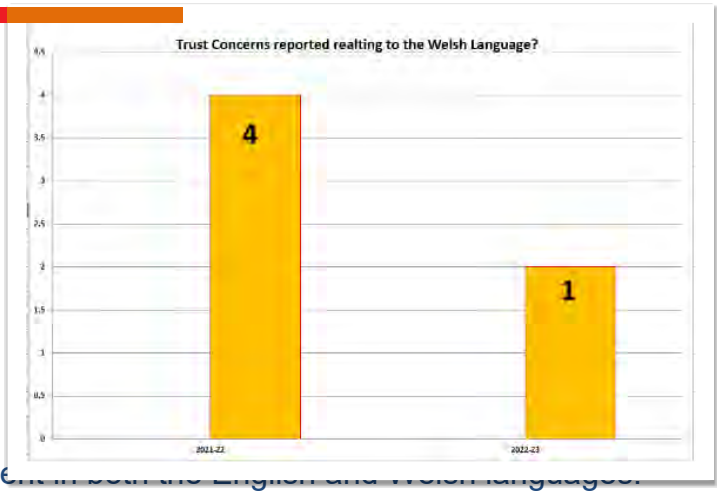
COVID related Complaints

There were **13** COVID related complaint (compared to 12 during 2021/22). The Covid related complaints have related to the impact on cancer patients due to delays in referral and treatment as a result of the COVID pandemic. In the Welsh Blood Service, the complaints received were due to the reduced number of venues available to donate, following some venues having to close during the pandemic and not reopening. As part of the Trust's Covid recovery plan, the Welsh Blood Service has recently been able to reinstate the use of the Blood Donation trailers across Wales, providing each community with more appointment time and location options, for people who wish to donate.

Since April 2022 there has been a steady decrease in the number of Covid related complaints reported to Trust. The last Covid related concern was reported in November 2022 with none received during Quarter 4.



Welsh Language Complaints



The Trust received **1** complaint relating to the provision of services in the medium of Welsh in respect of the Welsh Language provision in several areas on patient and donor facing Internet pages. The Complaint was investigated under the Putting Things Right Regulations by the Trust Welsh Language Officer and the following key areas were addressed as part of the response and improvement plans for the Trust websites:

- Updating the current platform to include all conte
- Uploading Welsh versions of Trust policies and procedures in line with Welsh Language Standards requirements.
- Revision of the Trust's Welsh language policy and uploading the updated version on the Trust website.

Learning and outcomes

An important part of the management of complaints is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning from concerns including direct feedback to staff members involved, team meetings, newsletters and clinical audits.

We continue to work in partnership with other Health Boards across Wales to investigate and resolve complaints. Where other organisations are involved, the Trust Quality & Safety Team work collaboratively with the relevant organisation to ensure a single, co-ordinated complaint response is provided. The Trust continued to engage the Community Health Council (Llais since April 2023) and signpost patient and donors to the advocacy services they provide for people who want to raise a complaint. The following provides examples of how we improved and developed our services following complaints:

Velindre Cancer Service Learning

Patient Engagement	Velindre Cancer Service now has an appointed Patient and Donor experience manager in post who lead on the investigations when concerns and incidents are raised. Additionally, a Head of Patient Engagement has been recruited as part of the governance around the Patient Engagement Strategy. An Operational Management Group was set up in addition to a Steering Group which was chaired by Independent Board Member, Hilary Jones. The Steering Group consists of Community Health Councils reps, staff, patients, Diverse Cymru and Patient Liaison Group members.

Outpatient	A TV screen has been installed within the outpatient's department to display to patients an approximate time they will have to wait to see their specific consultant.
Records Management	The Cancer service have introduced an identifier to all patient records to clearly identify whether the individual is a "cancer" or "non cancer" patient following a concern relating to patient record management.
Consent Forms	Explicit use of CRUK & RCR consent forms are now used for SACT & radiotherapy patients, ensuring all patients are fully informed of the intended benefits, potential side effects & risks of their treatment.
Risk of falls	There is now clear guidance for First Floor ward nursing staff around when patients identified as at risk of falls need to be referred to the physiotherapy team. The role of the physiotherapist working on the weekend has now been clearly defined to support patients at risk of falls

Welsh Blood Service Learning

Clinic Management	Individual risk assessments are now undertaken to allow frontline blood donation staff to gain donor consent for children to be in attendance when donating.
Communication	A review was undertaken into the number of concerns raised relating to communication issues when donors were liaising with staff. The investigation identified a trend in staff feeling unhappy with certain elements of the donation process i.e. working on the Mobile Donor Units (MDU). Operational Management have listened and recognised the issues raised and continue to monitor and evaluate concerns raised by donors to enhance donor and staff satisfaction.
Dietary Requirements	There is now a variety of vegan biscuits and dairy free milk available across the collection teams for our donors to enjoy following feedback received.
Blood Donations	Donors sometimes report experiencing uncomfortable donations when needles are inserted and/or removed from the venepuncture site. Following a concern raised when a donor noticed a lump on completion at the venepuncture site, the investigation found several breaches of duty relating to the immediate and subsequent care of donor which led to a review of the current training practices and has brought out a safe collaboration project looking at documentation of such events.
Appointment Times	Appointment cut off times have been reviewed, particularly during lunch times and end of day appointment slots, to accommodate donors who attend late for their allocated time. A ten minute grace period is offered to donors for each appointment.
Transgender terminology	Following consultations with donors and consulting the Diversity and Inclusion Manager the Welsh Blood Service have introduced asking all donors their assigned sex at birth (ASB) to ensure the safety of the blood

	supply when making plasma rich components from blood products.
Welsh Medium	Hoffwn gwyno yn unol â Mesur yr Iaith Gymraeg am sawl peth yn ymwneud â'r Gymraeg sydd yn gyfrifoldeb i Ymddiriedolaeth Felindre. Cyfeiriaf atynt yn eu tro isod gan obeithio y byddant yn arwain at welliant yn y ddarpariaeth Gymraeg rydych yn eu cynnig i'r cyhoedd. A full review of the Welsh Blood Service website identified several areas for improvement in relation to the use of the Welsh Language. The website was updated to ensure all areas were available in a bilingual format.

Public Services Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the complainant, the complainant can refer the matter to the Public Service Ombudsman for Wales (PSOW), an independent government body offering free, impartial services to those wishing to raise complaints in relation to public bodies and NHS organisations throughout Wales. PSOW have legal powers to uphold complaints and make recommendations for learning and improvements to prevent similar incidents from happening again. Where an investigation outcome finds that significant injustice has occurred to a complainant, the PSOW can make public its findings. Any public report is shared wider across the NHS. The PSOW can also make recommendations for compensation to be paid to a complainant, in addition to requesting an NHS organisation to put in place remedial measures to address learning. During the year 8 Public Service Ombudsman cases were dealt with. This included:

- 4 existing cases that continued under investigation during the reporting period
- 4 new complaints raised with the PSOW. As part of the governance process, the Trust complied with requests for information within a timely fashion and ensured that the Trust responded to the concerns raised within a satisfactory timescale
- 1 enquiry received, related to a hosted service
- 2 cases closed following ex-gratia settlements, one related to a lost wedding ring and the other related to case 3 summarised below.
- 3 Ombudsman cases remained open at the end of the year.
- 3 investigations conducted by the Public Service Ombudsman found failings by Velindre University NHS Trust. These investigations were upheld and a summary of the learning and improvement undertaken by the Trust are outlined below:

No.	Issues raised	Ombudsman Findings	Learning	Status
1	•Delay in discussing prognosis and failure to fully discuss treatment options • incorrect information given regarding	There was a missed opportunity to explore the patient's understanding of the condition and prognosis, miscommunication over the suitability of different available drugs and insufficient thought into	• Formal apology provided • Reflective practice undertaken by the clinician • A Consent Task and Finish Group established to review the processes in relation to consenting patients for treatment.	Complaint Upheld. Final PSOW report issued

	the suitability of different drugs • poor completion and submission of an Independent Patient Funding Request form ("IPFR").	the IPFR submission. **Recommendations:** • the Trust to make a formal apology • Review of chemotherapy consent forms • Clinician to reflect on communication with patients	• Roll out of Cancer Research UK and Royal College of Radiologists consent forms, specific to SACT and radiotherapy treatment. • A review of consent training and education • An audit was undertaken of current consenting processes	
2	• Clinician communication regarding postponed cancer treatment. • Failure to communicate essential information to the GP leading to failures in care • The adequacy and robustness of the Trust's complaints handling.	There was a failure to communicate essential information to the GP which contributed to failures in the patient's care and inadequacy of the Trust's complaint handling **Recommendations:** • Apologise to the complainant • Review systems and processes for communication between the SACT Helpline and clinical teams • Remind practitioners on the Helpline of the need to ensure clear documentation and the escalation follow up management plan where significant clinical symptoms are reported. • Take measures to improve communication between the Cancer Centre, patients, and GPs.	• Clinician undertook a reflection • Clinical staff reminded of the importance of ensuring appropriate information is provided to GPs and other healthcare and of the Department of Health Copying letters to Patients Good Practice Guidelines and the BMA Welsh Standards 12 • An enhanced digital system, was introduced in November 2022, designed to support healthcare practitioners to capture the patient's clinical picture on one system. • Enhanced training and reassessments undertaken to improve consistency of clinical assessment in relation to the Systemic Anti-Cancer Treatment Helpline. • A new VCS Concerns Manager, incorporating Patient Experience role, appointed. • External concerns handing training provided. • Apology provided to the complainant for the failings identified	Complaint partially upheld. Final PSOW report issued
3	• Communication failures in respect of	The Trust failed to inform the patient of the scan results and subsequent	• Enhancements to VCS Complaints management processes.	Partially upheld. final PSOW report issued. Ex-

	discussing scan results, blood test results, MDT plan and outcome	decisions regarding the management of the lesion. The Trust to reflect on the way blood test results were given. **Recommendations** • Apology to be provided to the complainant • A sum of £250 to be paid in recognition of the distress caused to the family • Reflective learning practice • Improvements to clinical communications • Review the way in which MDT decisions and outcomes are communicated.	• Awareness raised awareness amongst clinicians and clinical teams of the importance of improving communication with patients, families and other health professionals • Clinicians reminded of the Department of Health Copying Letters to Patients, Good Practice Guidelines and the BMA Welsh Standards 12. • A new Standard Operating Procedure (SOP) developed, which will outline the use of the Document Management System (DMS), to facilitate automatic transfer of approved letters to GP Practices	gratia payment made of £250

Redress

A case is transferred under the Redress arrangements of the Putting Things Right Regulations (2011), when it is identified at the Trust's Putting Things Right Panel that a breach in the duty of care has occurred and a service user has suffered harm or potential harm caused by the breach of duty. When considering if the matter is suitable for Redress, the Trust must consider that if a qualifying liability were to be established that exceeds the Putting Things Right threshold of £25,000, the matter cannot be transferred to Redress, and the service user or their representative are notified to seek legal advice. Where the investigation concludes that a breach of duty and harm has occurred, the case is presented to the Trust's Putting Things Right Redress Panel who determines if a qualifying liability exists / may exist. The remedies available in relation to the Redress arrangements in accordance with the Putting Things Right Regulations include:

- A full explanation of what happened
- A written apology
- A report on the action which has been or will be taken to prevent similar cases arising and/or
- An offer of financial compensation and/or remedial treatment.

7 cases were managed under redress: four remain open whilst investigations are underway, 1 resulted in no qualifying liability being identified. £21,937.38 was paid out in redress payments involving 3 cases during the year. One redress case was concluded, and settlement agreed.

The case remains open pending settlement of the Claimant's solicitors fixed fee costs and reimbursement being sought from the Welsh Risk Pool for the expert reports commissioned in relation to the case. Two have been concluded and the learning from each is summarised below:

Case Summary	Learning Outcome	Status
Patient not informed of recommendation for biopsy and was unable to make an informed choice regarding treatment.	• Awareness/reflective practice to optimise learning and understanding of what went wrong. • Look back review to improve communication links with NHS colleagues across Wales • Liaison with Multi-Disciplinary Teams to improve clinical and radiologist information to inform next steps. • Audits to ensure supplemental reports are received • Improved healthcare systems - Supplemental reports included on the Welsh Clinical Portal. • Training Reminder issued to staff on the importance of ensuring service users are aware of treatment options to make informed choice and training delivered by NWSSP Legal & Risk on the importance of Informed Consent.	Qualifying liability identified. Financial compensation offered and accepted. Welsh Risk Pool reimbursement approved. Redress case closed.
Patient did not receive joined up care nor signposted for palliative intervention.	• Appointment of a navigator and clinical nurse specialist to oversee referrals and signposting for patients. • The non-clinical Standard Operating Procedures (SOPs) have been updated. • Training provided to nursing staff.	Qualifying Liability determined. Financial offer made. Awaiting acceptance

Claims

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf. When claims arise, the Trust will, in the interests of justice, endeavour to resolve these amicably and as swiftly as possible, to prevent excessive litigation cost. However, this does not mean that all claims are settled, and those that are brought without merit, are robustly defended by the Trust. Throughout these challenging times, the Trust continues to mitigate the risks posed with emphasis on:

- reducing harm
- improving the response to harm and

- dealing with claims as cost effectively as possible.

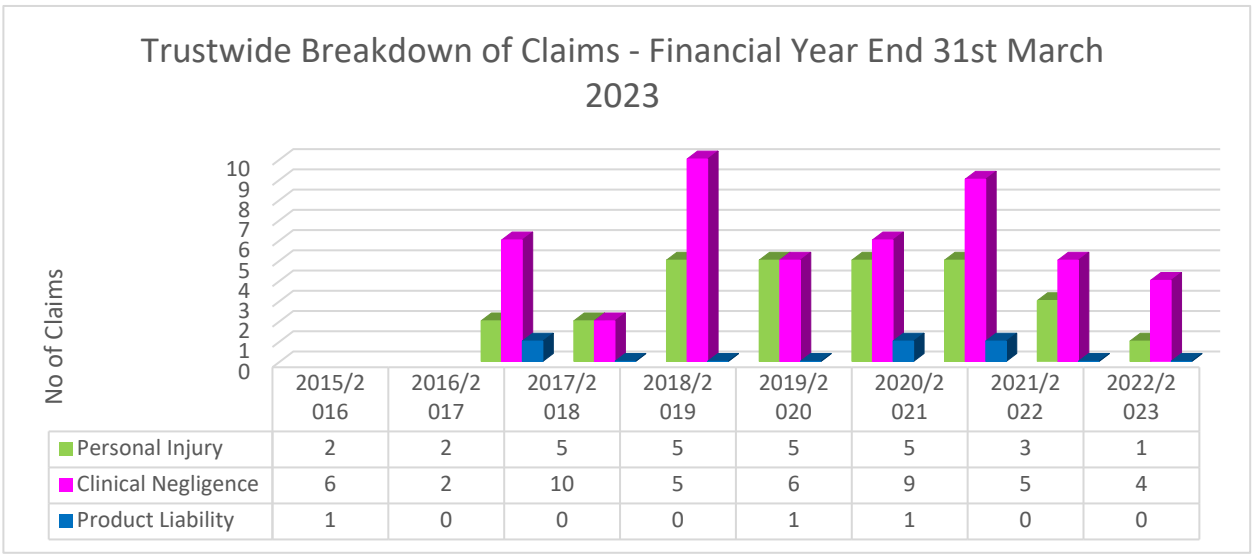
Many of the liabilities arising from healthcare provision are covered by arrangements already in place by the Welsh Risk Pool. Although the amount paid out on claims was greater in the last financial year, the Trust has seen an overall reduction in claims for 2022-2023

Breakdown of Claims

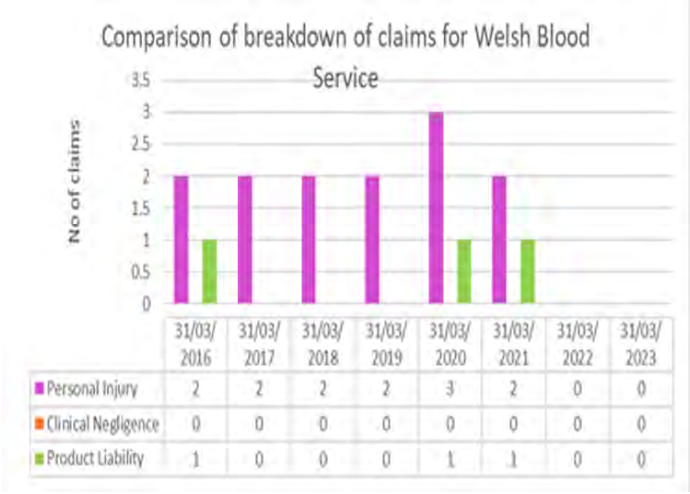
The Trust managed a caseload of 8 claims between:

- 4 claims were settled
- 1 new claim was received
- 5 claims remain open at the end of the reporting period.

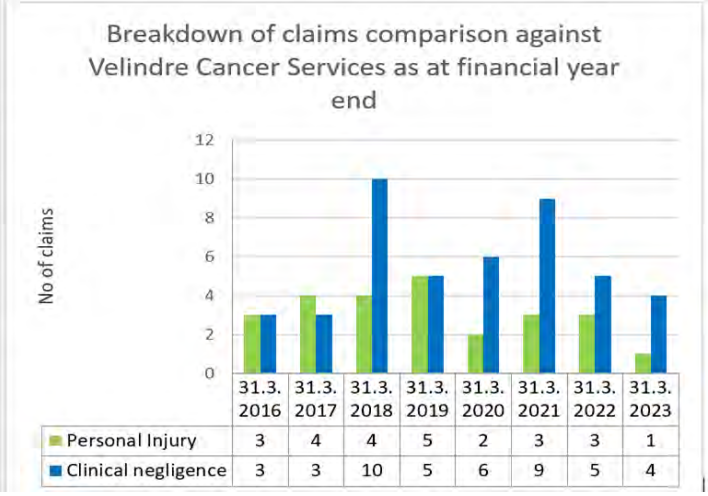
The graphs below provide a comparison of open claims at year-end for financial years dating from 2015/16 to 2022/2023



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Personal Injury	2	2	5	5	5	5	3	1
Clinical Negligence	6	2	10	5	6	9	5	4
Product Liability	1	0	0	0	1	1	0	0



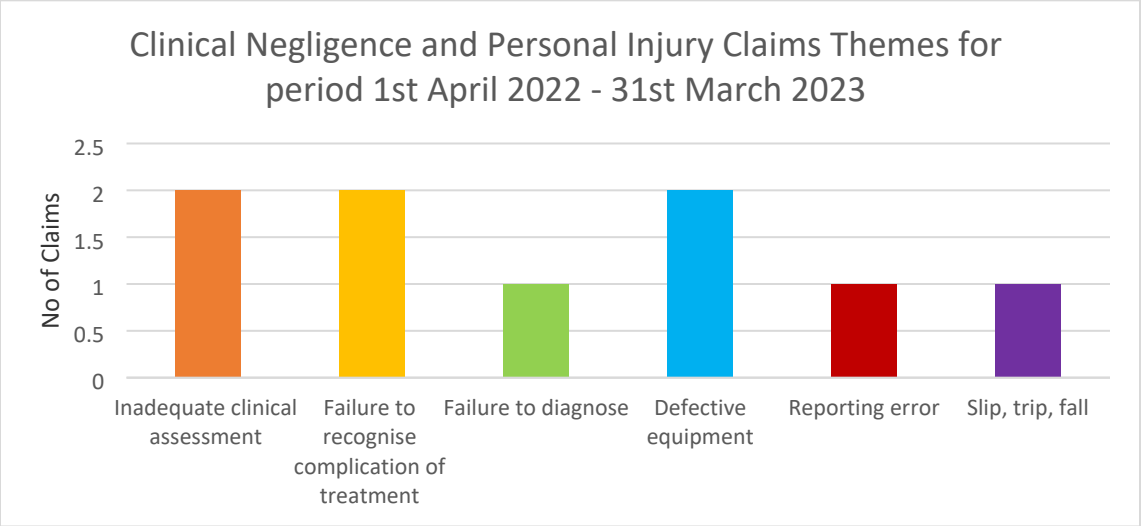
	31/03/2016	31/03/2017	31/03/2018	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023
Personal Injury	2	2	2	2	3	2	0	0
Clinical Negligence	0	0	0	0	0	0	0	0
Product Liability	1	0	0	0	1	1	0	0



	31.3.2016	31.3.2017	31.3.2018	31.3.2019	31.3.2020	31.3.2021	31.3.2022	31.3.2023
Personal Injury	3	4	4	5	2	3	3	1
Clinical negligence	3	3	10	5	6	9	5	4

Clinical Negligence and Personal Injury Themes

The trends and themes relating to clinical negligence and personal injury claims for both new and existing claim for the reporting period, are highlighted below.



Welsh Risk Pool Indemnity

The Welsh Risk Pool provides the means by which all Welsh NHS organisations are able to indemnify against risk and offers an integrated approach towards risk assessments concerning claims management and reimbursement, by promoting and supporting the development of improvements and learning to enhance patient safety and outcomes. The scope of the risk pooling arrangement is contained in the all-Wales Policy on Insurance and Indemnity and Scope of Risk Pooling arrangements. All payments associated with losses are subject to Welsh Risk Pool determinations. The three main drivers that underpin the principles of the reimbursement procedures are:

- Scrutiny of Learning, Intervention & Improvement
- Financial Analysis
- Review of Case Management

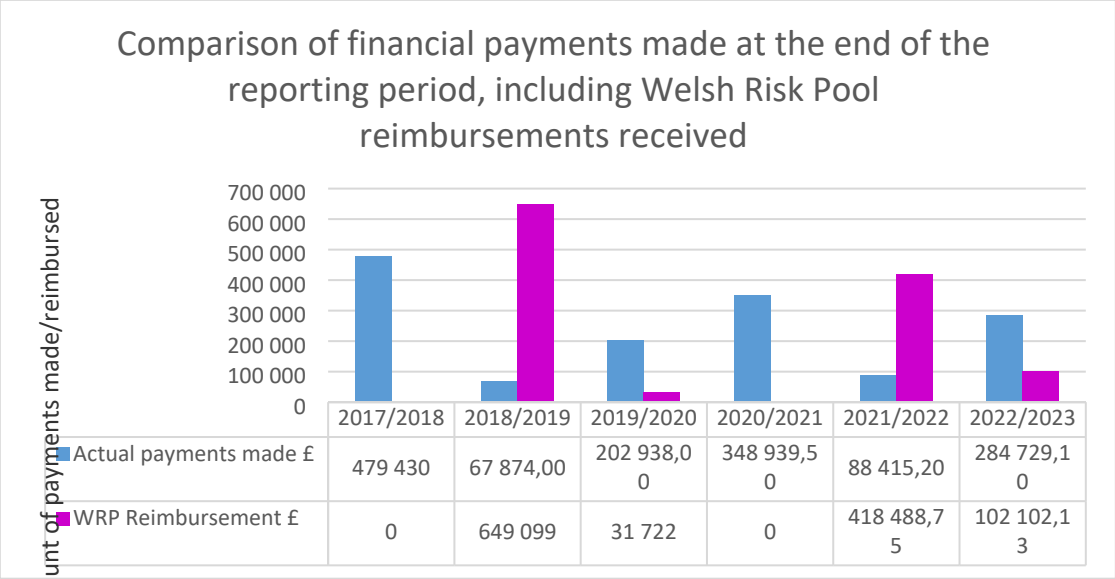
The Trust is responsible for paying the first £25,000 of a claim. Thereafter, it seeks reimbursement from the WRP for any claim that exceeds the threshold of £25,000, excluding VAT.

4 Case Management Records were submitted to the WRP during the reporting period for Claims and Redress, seeking reimbursement on cases that exceed £25,000. These were all approved by the Welsh Risk Pool and the monies reimbursed.

Financial implication of Active Claims

The following figures are estimations provided by NHS Wales Shared Services Partnership (NWSP) Legal and Risk Services in the event a claim is successful.

- The estimated financial liability of the current caseload of claims is predicted to be in the region of approximately £924,576
- The Welsh Risk Pool indemnifies the Trust in respect to the payments made, deducting the first £25,000, which is the financial cost borne by the Trust. The Trust liability, if it were to settle its current caseload of claims is estimated in the region of £119,224.



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Actual payments made £	479 430	67 874,00	202 938,00	348 939,50	88 415,20	284 729,10
WRP Reimbursement £	0	649 099	31 722	0	418 488,75	102 102,13

Welsh Risk Pool Claims & Redress Audit

In March 2023, the Welsh Risk Pool undertook an assessment of the Trust's claims and redress management for the period 1st January-31st March 2022 with the purpose of ensuring that the Trust has adequate governance processes in place in respect of claims. The outcome of the audit is awaited. This review included:

- Evaluated the adequacy of the systems and controls in place for the management of claims reimbursement
- Provides assurance that claims management continues to maintain high standards
- Retains compliance with statutory and obligatory regulations
- Mitigates against risk and
- Analyses the reimbursements sought and recouped during the reporting period to ensure that that the Welsh Risk Pool criteria and standard in data record keeping continues to be met.
- Demonstrates that learning continues to be a fundamental priority to minimise risk of recurrence and harm.

Learning and Improvement

Learning and improving continues to be a fundamental priority for the Trust, as all learning contributes to the overall safety of service users and also a reduction in claims and litigated costs. Throughout the year, divisions have undertaken a number of learning actions to address claims when failings have been identified. This safeguards against risk and also minimises the likelihood of recurrence. Assurance is provided by way of approvals received from the Welsh Risk Pool following submission of Learning from Events Reports and submission of requests for reimbursements of claims, settled in excess of £25,000. These approvals indicate the Trust's ongoing commitment in achieving best practice through learning outcomes and demonstrates compliance with the Welsh Risk Pool's governance procedures and processes.

Key Learning outcomes from Claims closed during the year were:

- Revision of falls standard operating procedures to include an appropriate escalation process when an outpatient service user suffers a fall, including a step-by-step flow chart on the actions to be taken.
- Awareness email issued to Radiotherapy Department of the revisions made to the Monitoring of Care Review.
- Highlight Report presented to the Health, Safety and Fire Subgroup raising awareness and learning undertaken regarding preventable patient fall.
- Discussion at Falls Scrutiny Panel for ongoing monitoring and learning. All outpatients who suffer falls now receive an outpatient clinical check-up and follow up the day after the incident.
- Tenable audit of outpatient chairs undertaken
- Inspection Report produced for general estate checks and maintenance of chairs
- Removal and replacement of waiting room chairs that were identified as requiring replacement.

- Introduction of regular audit meetings to discuss CT scan findings
- Introduction of peer reviews and MDT reviews Discrepancy meetings to review adverse events
- Introduction of mentoring to support and discuss opinions
- Introduction of time factored into the job plan for radiologists to review imaging.
- Sourcing of a governance lead to support radiology resource.
- Radiologist appointees made to strengthen clinical governance and provide further monitoring and assurance.

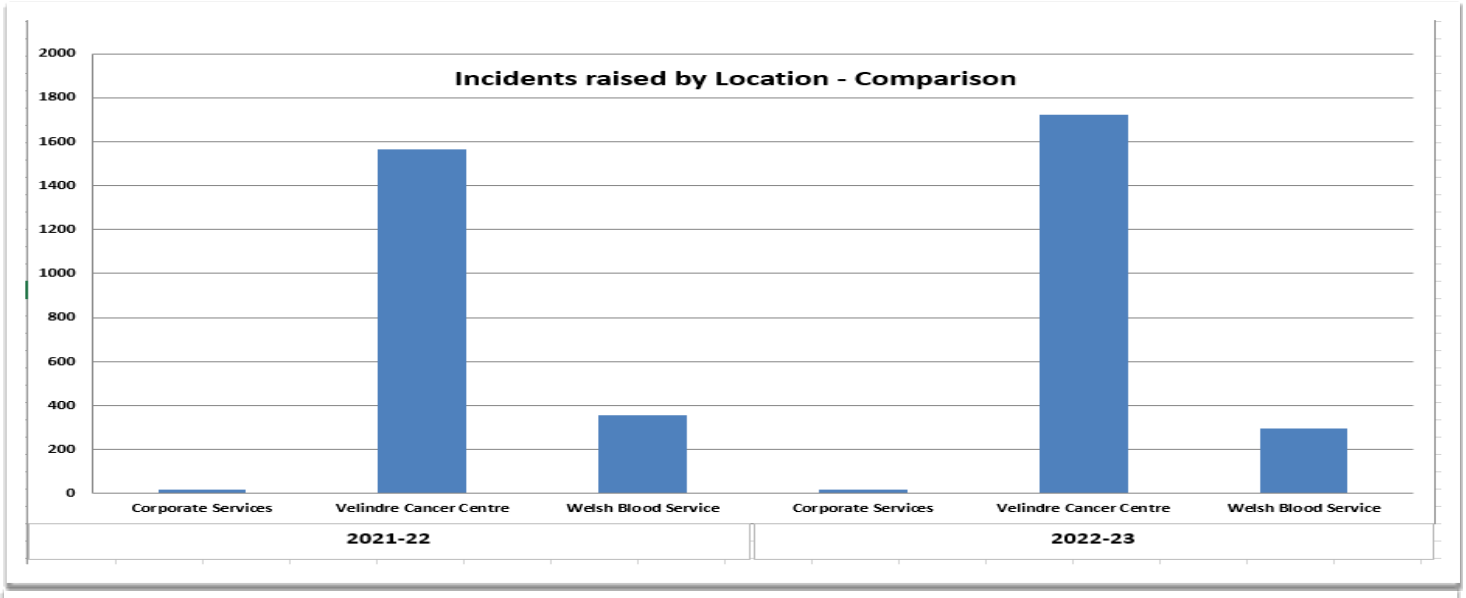
Incidents

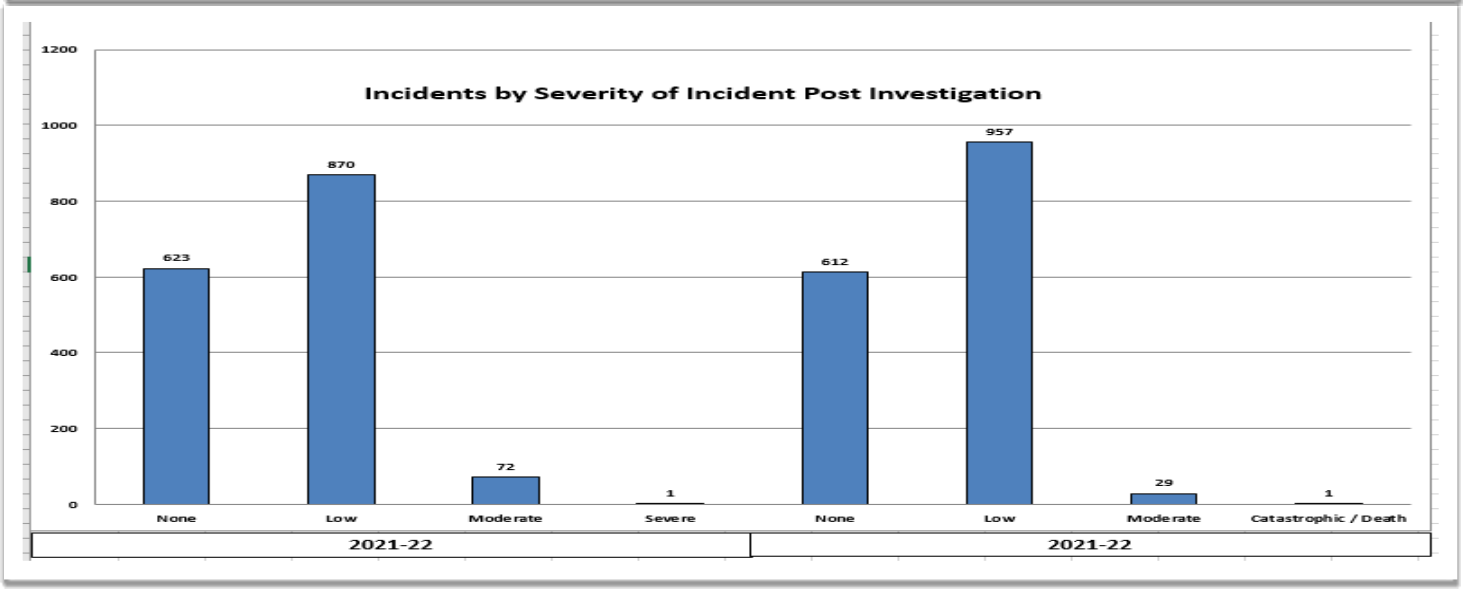
The Trust record all Incidents and National reportable incidents within the Once for Wales Datix reporting system. Welsh NHS bodies are required to report all serious patient safety incidents to the Welsh Government in line with their National Reportable Incident policy.

It is the responsibility of the allocated manager to review each incident reported and forms part of

the initial management review to consider the detail of the incident and whether the reported level of harm is appropriate.

2,023 incidents were reported across the Trust throughout 2022/23. The Trust recorded 183,691 patient attendances and 79,547 blood donations equating to a 0.8% activity rate. The graph below displays the number of incidents by each Division and investigated with the severity confirmed at closure. **84%** of incidents were formally closed within the year with **74%** being fully investigated and formally closed within 60 days of the incident being reported. During the year:





National Reportable Incidents

Velindre University NHS Trust report a small number of Nationally Reportable Incidents through to Welsh Government and Health Inspectorate Wales each year, in line with the required reporting parameters.

The Trust reported **22** Ionising Radiation (Medical Exposure) Regulation (IR(ME)R Incidents to Health Inspectorate Wales between the 1st April 2022 and 31st March 2023. All of these incidents were no or low harm but met the reporting classification specifications. A number of these incidents were in relation to a

known manufacturer fault with the radiotherapy system and the service arranged a meeting with a representative from UK Health Security Agency for assurance that management of the equipment fault issues was appropriate and in line with other centres throughout the UK. No concerns were raised by UK Health Security Agency or Health Inspectorate Wales at the inspection regarding these incidents.

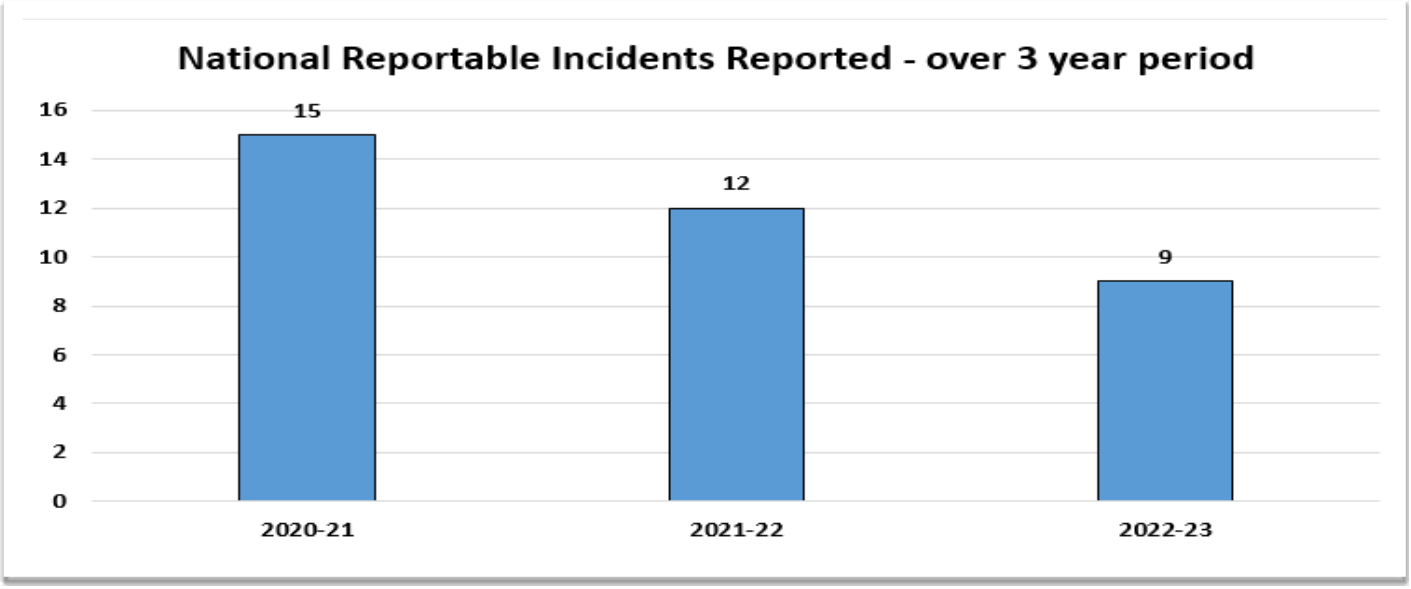
The radiation services department are fully aware of the equipment related issue to mitigate against the known manufacturing fault and the following key learning and improvements during the year include:

- Regular and thorough monitoring of these faults has helped to identify the trends, recommended interventions, and the occurrence of radiation incidents, as early as possible.
- These incidents reiterate that the changes to the guidance surrounding reporting of unintended exposures, that was issued in August 2020, increased the likelihood of reportable incidents occurring due to the ongoing national issue with the Elekta XVi system.
- The above guidance has again been updated in April 2023 and our understanding of this updated guidance is that none of the incidents reported due to equipment fault would now meet the requirements of a reportable incident individually.

The Trust reported **9** National Reportable Incidents (NRI), a steady reduction of NRI's being reported in comparison to the 2 year's previous (12 NRI's reported in 2021-22 and 15 NRI's reported in 2020-21). Three related to patient falls, two to booking processes and two to the SACT treatment helpline. These are summarised in the table below:

National Reportable Incident	Key Learning
Flood damage in an off-site externally managed medical records storage facility.	• The setting up of an Incident Management Team be considered sooner in the initial phase of an incident so that Trust resources can be brought to bear more quickly, and that this approach be included in SOP's for business continuity planning.
Patient fell within the outpatient chemotherapy resulting in a fractured femur.	• Clearer referral criteria for referring patients with a history of falls to the physiotherapy team developed • Clarity gained about the availability and role of the physiotherapy team on weekends.
Death of a patient after contacting the SACT treatment helpline	• Changes to working practice were agreed through a formal governance and assurance process. • Staff have protected time for supervision and debriefs • The UKONS Triage assessment toolkit is adhered too and formalized in the Cancer Centre. • Escalation for further medical assessment guidance identified • Full Review of the Trust Treatment helpline is required – this is being undertaken as a Safe Care Collaborative improvement
Patient attended for third planned Radiotherapy administration following a butterfly being used to gain venous access the injection was drawn back approximately 8	• Update NM RAT 4006 to provide information about extravasation risk

to 10 times.	• Create an extravasation checklist and flowchart to supplement the extravasation procedure to include gamma camera assessment of the site. Retraining of operators in the extravasation procedure. • Implement best practice administration methods with training in cannulation
Treatment incorrectly allocated on Chemocare resulting in delay in treatment.	• Less risk of this error occurring in the newest version of Chemocare (version 6) as opposed to version 5 to ensure that when a patient is planned to start SACT that it is allocated on Chemocare as “Cycle 1”
Inpatient fall resulting in fractured elbow.	• Ensure there is a documented conversation regarding the risks of keeping the commode by the bedside, while being mindful about the psychological impact • To use the Hoverjack routinely for patients that are not able to mobilise from the floor rather than a sling hoist
Failure to refer a patient for treatment after emergency care provision resulting in disease progression.	• Discharge advise leaflet (DAL) – feasibility given the learning from this incident of adding a follow up prompt • Development/revision of a ward discharge checklist to be considered • Early learning communications to be produced and discussed with medical & nursing teams (speedy cascade format)



Inquests

An inquest is an inquiry into the circumstances surrounding a person’s death. Coroners are independent judicial officers i.e. members of the judiciary (similar to that of a judge), appointed by the local authority, to investigate certain deaths within their geographical area. When a person dies,

the responsibility is to hold an inquest in the area where the person died, not where the person resides. Coroners are responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009.

7 inquests were managed by the Trust during the reporting period, comprising of:

- 3 new inquest notifications. Witness statements from treating clinicians and staff have been submitted during this period, together with relevant copy medical records.
- 4 inquests were heard: Learning was identified in one which is detailed below:

The inquest was held in December 2022 and identified a need for enhanced partnership working across key organisations comprising of nursing care, tertiary centres and community care and to seek clarity and responsibility for assessing and treating PEG infections with a view to preventing sepsis. A multi-disciplinary task and finish group has been established by the Head and Neck and Altered Airways Advance Nurse Practitioner.

Compliments from Patients and Donors

Receiving real time feedback on the experiences of our patients and donors is very important to us. Feedback received by patients and donors, whether good or bad has allowed us to continually improve and also ensures that feedback helps to inform decision making and prioritisation.

During the year 155 compliments were captured and recorded onto Datix Cymru. 151 were recorded by Velindre Cancer Service and 4 compliments captured for Welsh Blood Service, this is compared with 174 compared with 2021-23. (110 Velindre Cancer Service and 64 Welsh Blood Service).

Trust staff are encouraged and are extremely grateful to receive positive feedback and compliments from patients and donors about the experiences they have received from Velindre Cancer Centre and Welsh Blood Services.

Divisions are reviewing how to enhance the capture of compliments within the Datix system

Conclusion

The Velindre University NHS Trust Putting Things Right Annual Report 2022- 2023 overarching conclusions have been drawn for the Trust:

- Directorate leads are continuously focusing their efforts on learning, retraining and intervention where we have high numbers of incidents and concerns.
- Senior Management have focused on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, in an effort to successfully investigate and close any outstanding incidents.
- Focused efforts are underway to ensure the timely investigation and closure of Incidents. Improvements have been seen at the Welsh Blood Service however, overall this area has been identified and escalated to the senior leadership team for review and action to improve compliance with the national timeframes for the investigation of incidents. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards have been introduced in the monthly directorate meetings.
- There are many improvement plans in place across the Trust to address some of the themes, these improvement plans are monitored through the Velindre Futures, and Senior Management Teams.
- There is evidence that incidents, concerns and compliments are managed appropriately and compliant with the PTR regulations. Lessons learnt and actions are implemented and monitored by Directorate leads and their teams, we recognise that a formal repository is required to store and share learning.
- The Trust remains committed to learning from all concerns and incidents raised, and investigation training is currently underway for all key staff to strengthen our ability to objectively and comprehensively investigate and learn from all concerns and incidents.

2023-24 Priorities

The Trust aims for the successful delivery of its goals and priorities. It is envisaged that throughout 2023/2024, the Quality and Safety team will provide support and assistance in contributing towards reduction in harm to patients, a reduction in distress caused to both patients and healthcare staff involved when a claim or concern arises. A reduction in the cost required to deliver fair resolution, thereby releasing public funds for other priorities, including healthcare. These priorities will ensure indemnity arrangements are a driver for positive change across our Trust.

1. Velindre University NHS Trust will continue to actively listen to its patients (their carers) and donors, putting things right where things have gone wrong.

2. To fully implement and embed the new requirements of the Health and Care Quality Standards.

3. The Trust will establish a Quality Management System

4. Five Quality priorities identified through the analysis for Putting Things Right outcomes will be fully implemented

5. The Trust will establish "Always on" reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised.

6. Implementation of a revised Complaints, Incident and Claims Policy to bring it up-to-date in line with current legislation and Welsh Risk Pool protocols.

7. Devise and implement standard operating protocols which will incorporate Learning from Events flowcharts, PTR Panel and Redress flowcharts.

8. Development of a "Getting it Right First Time" (GIRFT) Claims package to support and assists staff in relation to the claims process.

9. Review and audit Once for Wales Datix Cymru system for all our concerns modules.

10. Continue professional development.

11. Divisions to enhance the recording of compliments on the Datix system.

Health and Care Quality Standards

The Health and Care Quality Standards provide a framework to assess quality and to guide improvement, delivering care that is *safe, timely, effective, efficient, equitable and person centered.*

The Health and Social Care (Quality and Engagement) (Wales) Act was passed in 2020. The enactment of the Duty of Candour and Duty of Quality came into force on the 1st April 2023.

The Duty of Candour statutory guidance, revised Putting Things Right Regulations and Duty of Quality statutory guidance was published during March 2023 in readiness to introduce an All Wales approach to the implementation of the two Duties.

Velindre University NHS Trust continues to prepare and implement the requirements of the Duties with a high degree of confidence following the Trust's preparedness to meet the requirements of the Duty of Candour from 1st April 2023.

SAFE	Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.
TIMELY	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.
EFFECTIVE	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.
EFFICIENT	Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.
EQUITABLE	Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation). We embed equality and human rights in our health care system and promote.
PERSON CENTERED	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Patient and Donor Experience 2022-2023 Annual Report

DATE OF MEETING	13th July 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	Jade Coleman – Quality, Safety and Assurance Manager
PRESENTED BY	Jade Coleman – Quality, Safety and Assurance Manager & Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The highlights and summary of matters for consideration within this report for period 1st April 2022-31st March 2023 are: • **1036** patients / families provided experience feedback in relation to care and treatment received at Velindre Cancer Service via the CIVICA electronic real-time patient experience system with **93%** reporting that their experiences were 'excellent'. • **8631** donors of the Welsh Blood Service provided 'real time' (at the tea table) donor experience feedback since the introduction of the CIVICA system at the Welsh Blood Service in August 2022 with **98%** of donors advising they were 'completely satisfied with their overall donation experience. • **154** concerns were raised which is lower than previous years: 190 in 2021-22 and 183 in 2020/21, suggesting

	that the Trust is learning and improving in areas where previous concerns were raised.

RECOMMENDATION / ACTIONS	To **ENDORSE** the 2022 – 2023 Trust Patient and Donor Experience Annual Report prior to submission to Trust Board for approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	29th June 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The patient and donor experience annual report 2022-23 was discussed and endorsed by the Executive Management Board. Divisions requested to co-present the report in respect of their core learning at the Quality, Safety & Performance Committee.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

1. SITUATION

The 2022-2023 Velindre University NHS Trust Patient and Donor Experience Annual Report summarises the experience feedback received from patients and donors and how this has been used by divisions to make changes to further improve the experience of their patients and donors during the period 1st April 2022 to 31st March 2023.

2. BACKGROUND

Velindre University NHS Trust's Strategy and Quality & Safety Framework places patients and donors at the heart of everything we do, seeking to ensure that all of our patients and donors receive positive care and great experiences. Therefore, it is critically important that managers and divisions receive real-time feedback in respect of the experiences their patients and donors are having so that they hear what the care and services they are responsible for are like for our patients and donors and that they can use this to improve the services they provide. We must also ensure staff at all levels receive this feedback to drive improvements and to further enhance the experiences of our patients and donors. It is only through openly listening that we can ensure our services continuously improve, are a safe environment and are truly patient and donor centred.

3. ASSESSMENT AND SUMMARY OF MATTER FOR CONSIDERATION

The 2022/2023 Trust Patient and Donor Annual Report is attached.

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 X • 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 X Timely X Effective X Equitable X Efficient X Patient Centred X
	Feedback received from patients and donors whether good or bad has allowed us to continually improve our services and helped to inform decision making and prioritisation. Openly listening to our patients and donors has assisted in taking efficient improvement actions where required, preventing reoccurrences. The CIVICA feedback system has allowed the Trust to connect directly with patient and donors within each service area for a more effective approach in engaging service users.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Obtaining feedback from patients and donors contributes greatly to understanding where service improvements can be made, leading to huge benefits in the future care and service provided within the Trust.
	There is no direct impact on resources as a result of the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	**Source of Funding**: Other (please explain) No financial request or impact as a result of this report
	Not required - please outline why this is not required
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
	There are no specific legal implications related to the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Putting Things Right Regulations (2011) Wales Quality & Engagement Act (2020)

5. RISKS

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

Velindre University NHS Trust
Patient and Donor Experience Annual Report 2022-2023

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Contents

Introduction

Velindre University NHS Trust provides specialist services to the people of Wales. The operational delivery of services is managed through Velindre Cancer Service and the Welsh Blood Service.

Velindre Cancer Service delivers specialist cancer services for South-east Wales and wider areas including, treating patients with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), immunotherapy and radiotherapy together with caring for patients with specialist palliative care needs. The Velindre Cancer Service is a leading organisation in respect of teaching, research and innovation for non-surgical oncology.

The Welsh Blood Service provides blood, blood products and transplantation products for the population of Wales. The service ensures that the donor's gift of blood is transformed into safe and effective blood components, including bone marrow donations, stem cells and immunogenetics services, helping to improve and save the lives of many thousands of people in Wales every year.

Velindre University NHS Trust is committed to ensuring that patient and donors are at the heart of everything that we do, striving to ensure that all of our patients and donors receive positive care and experiences.

Velindre Cancer Service obtained feedback from **1036** patients, **6%** of the **18,619** patients who were treated or attended for an Outpatient referral, including phlebotomy and Healthcare at Home), day-cases, SACT, radiotherapy, inpatients and radiology.

8631 Welsh Blood Service donors provided feedback from 1st August 2022 when the CIVICA system was introduced**, 59,484** donors attended session during this time, equating to **14.4%** of donors providing feedback at the tea table via the CIVICA system.

Velindre University NHS Trust has significantly strengthened its approach in order to capture patient and donor feedback, by introducing the CIVICA digital real time patient experience system which facilitates all service areas to easily provide feedback on their experiences before they leave the venue or care or service delivery.

Receiving real time feedback on the experiences of our patients and donors is extremely important and it allows through email alerts issues to be identified and be nipped in the bud by responsible managers. Feedback received by patients and donors, whether good or bad has allowed us to continually improve and also ensures that feedback helps to inform decision making and prioritisation.

Trust staff are encouraged and are extremely grateful to receive positive feedback and compliments from patients and donors about the experiences they have received from Velindre Cancer Centre and Welsh Blood Services.

This report covers the year: 1st April 2023 – 31st March 2023.

Capturing Patient & Donor Feedback

The Trust continues to have a number of different mechanisms to encourage and obtain patient and donor feedback. This has been further enhanced over the year with the roll out of the All Wales electronic CIVICA experience feedback tool. Our key focus is to ensure that patients and donors can provide feedback in an easy, simple and straight forward way and that this feedback is available to managers in real time. The CIVICA system provides patients and donors with a wider choice of channels to use to provide their feedback.

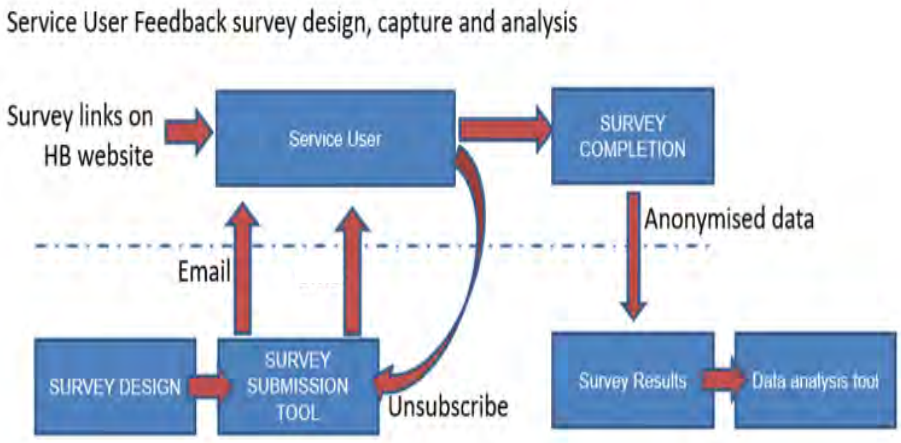
Feedback reporting channels include:

ONLINE | TABLET | EMAIL | PHONE | QR CODES

The CIVICA system is used to capture 'real time' insights into patient and donor feedback enabling rapid actions to be taken to address any areas of concern.

The All-Wales Patient Experience survey includes a suite of standard experience survey questions. The Trust is also able to generate specific, more in-depth surveys to gain feedback within particular service areas, teams and projects. This allows for an adaptable approach to gathering information on how existing or new services are performing. The links to all of these surveys can be published or emailed independently of the system by the Trust.

When a patient or donor completes a survey, anonymised data is fed into the system and passed into the data analysis tool. Trust CIVICA leads are responsible for redacting any personal identifiable information into responses (particularly if free text fields are used) and service users always have the option to opt out of live and future surveys.



The Experience of Velindre Cancer Service Patients

Velindre Cancer Service continue to receive feedback from its patients, carers and family members in relation to the care and treatment received every day. The feedback received provides invaluable learning opportunities to improve the care for every patient.

During the year experience feedback was received from **1036** patients and or their family member which is **6%** of the **18619** patients who were treated or attended for an Outpatient referral, including phlebotomy and Healthcare at Home), day-cases, SACT, radiotherapy, inpatients and radiology.

A total of 1036 surveys returned **(1st April 2022 to 31st March 2023)**			
	93% scored their experience as 'Excellent' (>9 out of 10)		85% indicated their experience was within the last 6 months
	89% stated they always felt cared for		96% felt they were always listened to
	42% said their time spent waiting was shorter than expected		52% said their waiting time was about right
	95% felt they always had assistance when they needed it		83% always understood what was happening with their care
	86% said explanations were given in a why they could understand		90% felt they were involved as much as they wanted to be in decisions about their care

Velindre Cancer Service Learning

An important part of receiving feedback is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning from complaints, including direct feedback to staff members involved, team meetings, newsletters and clinical audits.

The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

Patient Engagement	**The Velindre Cancer Service has appointed a Patient and Donor experience manager who leads on the investigations when concerns and incidents are raised. Additionally, a Head of Patient Engagement has been recruited as part of the governance around the Patient Engagement Strategy. An Operational Management Group was set up in addition to a Steering Group which was chaired by Independent Board Member, Hilary Jones. The Steering Group consists of Community Health Councils reps, staff, patients, Diverse Cymru and Patient Liaison Group members.**
Patient appointments	**A whiteboard has been installed within the phlebotomy department to ensure that if a patient doesn't hear their name being called, they can also view their name on the board as well.**
Training	**Following an increase in new Systemic Anti-Cancer Therapy (SACT) and different regimes, SACT clinical educator nurses along with the medicine management nurse are carrying out additional training to help support junior staff. Over a 12-month period approximately 31,700 SACT treatments were administered by the nursing SACT staff. This type of incident had an error rate of approximately 0.026%.**
Outpatient	**A TV screen has been installed within the outpatient's department to display to patients an approximate time they will have to wait to see their specific consultant.**
Medication	**Hypersensitivity reactions (HSRs) are a known common side effect to Systemic Anti-Cancer Therapy (SACT). Currently recorded within the Trust Datix Cymru reporting system, they are not classified as incidents. A Task and Finish group was established to look at alternative ways of collecting these events outside of Datix Cymru. These events were reported to the SACT and Medicines Management Operational Group (SMMOG) and over the previous 12 months there have been 105 hypersensitivity reactions documented onto the DATIX system, and all incidents are now closed.**
Records Management	**The Cancer service have introduced an identifier to all patient records to clearly identify whether the individual is a "cancer" or "non cancer" patient.**
Consent Forms	**Explicit use of CRUK & RCR consent forms are now used for SACT & radiotherapy patients, ensuring all patients are fully informed of the intended benefits, potential side effects & risks of their treatment.**

Risk of falls	**There is now clear guidance for First Floor ward nursing staff around when patients identified as at risk of falls, need to be referred to the physiotherapy team. The role of the physiotherapist working on the weekend has now been clearly defined to support patients at risk of falls.**
Information Governance	**New controls have been put in place to ensure that Velindre Cancer Service Business Intelligence (BI) team receive a detailed written specification for every BI request. This data has a second quality assurance check completed, and that the quality assurance documentation is completed before data is shared.**
Enteral Feeding	**A task and finish group has been established to improve processes around enteral feeding. This includes training for nursing staff, improved signage in the storeroom, updated discharge checklist and uploading patient training videos to the Velindre internet site.**

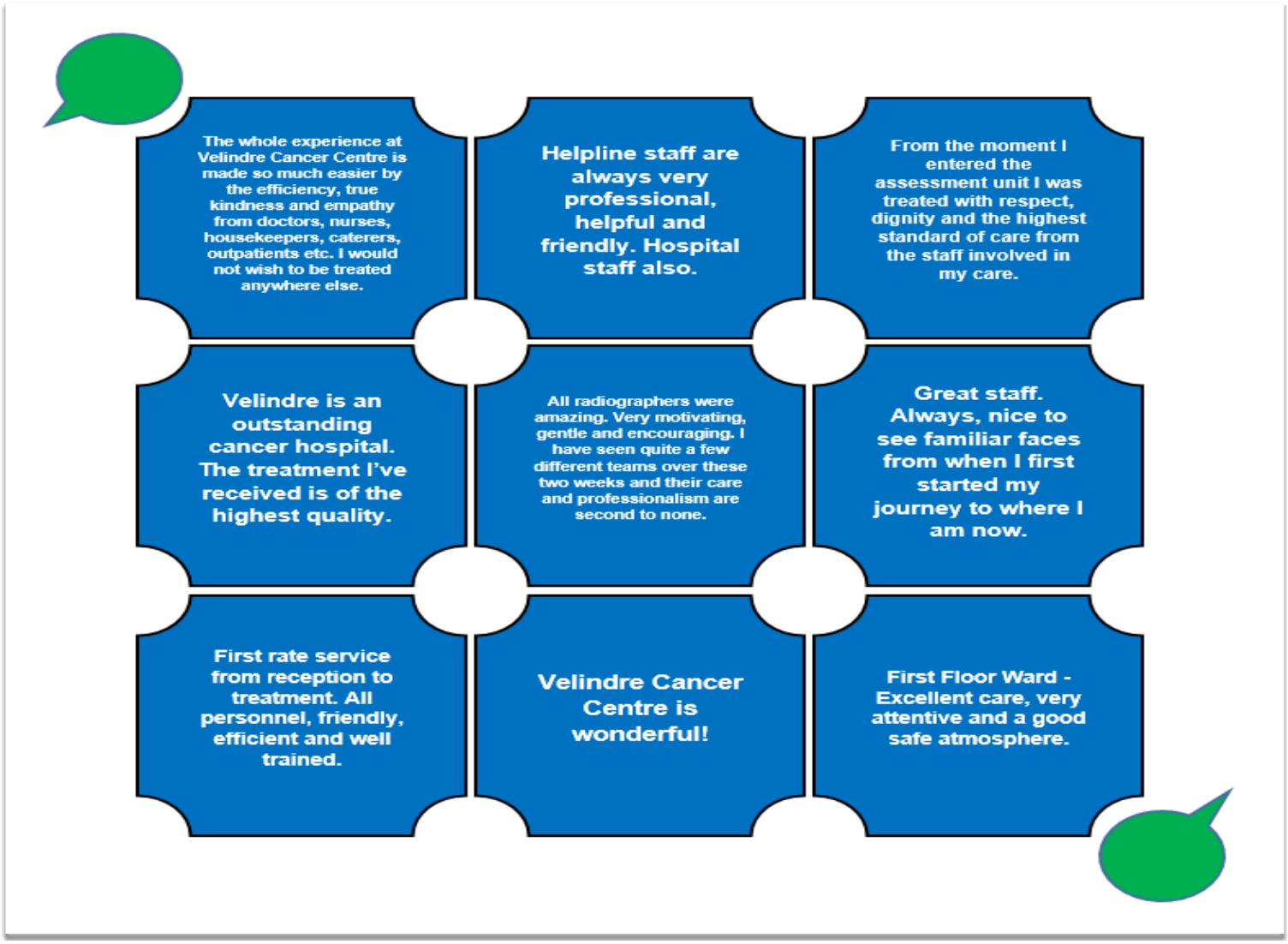
Comments received into Velindre Cancer Service

Patients, relatives and carers regularly contact the Trust to let us know about the good care and service they have received. Comments and compliments are received via many different routes including, verbally or via social media, by letter and messages in thank you cards. The introduction of the CIVICA feedback system has seen an improvement in the way the Trust captures digital feedback from all service users, enabling specific data to be reviewed in an effective, timely and meaningful way.

We appreciate the time taken by patients, relatives and carers to let us know about their experience of our service and care that has been received. The individuals and teams involved in the care and service provided are pleased and encouraged by such feedback.

During the year qualitative feedback received was mainly very positive, and many supportive messages were received from our patients, family members and service users during this time. There were also some comments that provided opportunities for improvement. The wordle below summarises the key words used in narrative provided

The box below summarises some of the compliments received:



Velindre Cancer Service Engagement

As part of the Trust's Patient Engagement Strategy plans an additional CIVICA module – 'Engage', has been procured to facilitate the capture of information in line with the Velindre Voices mechanism.

The Velindre Cancer Service Patient Liaison Group continued to meet during the year, mainly focussing on providing feedback on the new Velindre Cancer Centre design etc. Specific events have been held in relation to wayfinding, design and external areas. A member of the Patient Liaison Group joined the Outpatient Design Group whereby the suggestion to incorporate a 'quiet exit door' was approved. This was based upon their experience of witnessing distressed and upset patients and families exiting through a busy waiting area.

During the year, the Patient Liaison Group have reviewed the generic Velindre Charity information leaflets and attended staff educational sessions to share their lived experience. The Chair of the Patient Liaison Group attends the Trust Board Meetings.

Another key focus has been on building relationships with organisations that support, advocate and promote the role of the Armed Forces.

Every year, Velindre Cancer Service celebrates World Cancer Day, the day brings together people, communities and countries from across the world to raise awareness and take action.

Between 2022 and 2024, the theme is Close the Care Gap. Focussing on realising the problem during 2021-22, the attention during 2022-23 turned to uniting our voices and taking action.

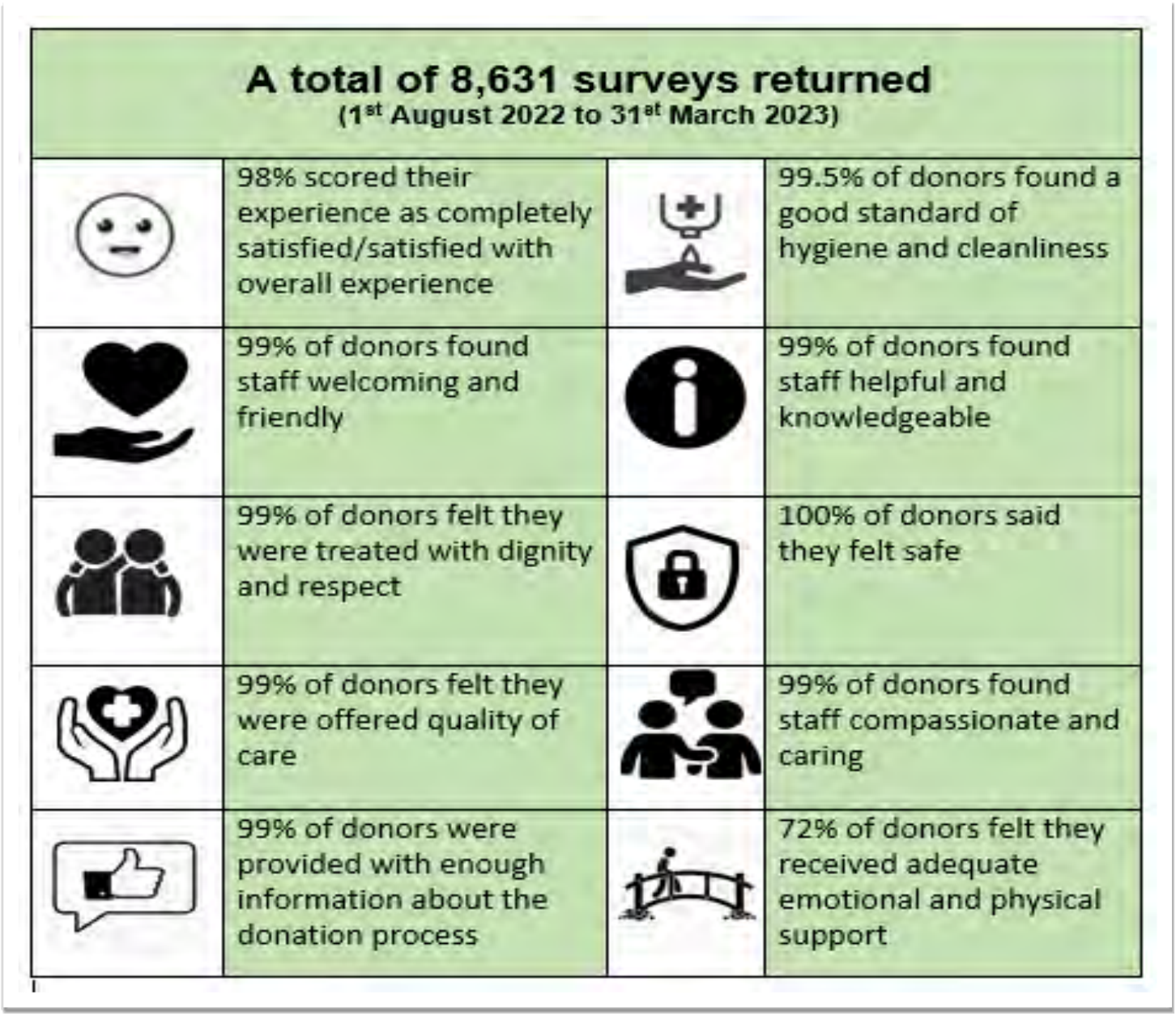
Throughout World Cancer Day, Velindre Cancer Services took to social media and featured individual members of staff who discussed what this day means to them.

https://velindre.nhs.wales/news/latest-news/4-february-is-world-cancer-day/

The experiences of the Welsh Blood Service Donors

Welsh Blood Service continue to receive high numbers of engaged donors who actively share and communicate both good and bad feedback. The feedback received provides invaluable insight into the day-to-day experiences that donors have when visiting clinics and mobile donor units.

Following the introduction of the CIVICA system in the Welsh Blood Service on 1st August 2022, the Welsh Blood Service have captured **8631** real time responses from Donors at the tea table after their donation this equates to **14.4%** of the **59,484** donators during that period.



Welsh Blood Service Learning

An important part of receiving feedback is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning, including direct feedback to staff members involved, team meetings, newsletters and clinical audits.

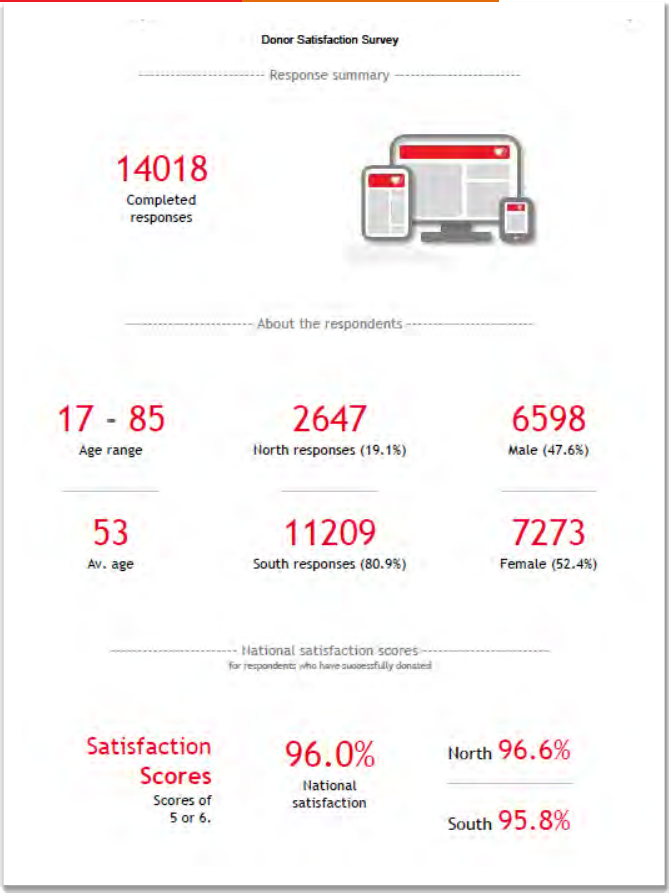
The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

Clinic Management	**Individual risk assessments are now undertaken to allow frontline blood donation staff to gain donor consent for children to be in attendance when donating.**

Communication	A review was undertaken into the number of concerns raised relating to communication issues when donors were liaising with staff. The investigation identified a trend in staff feeling unhappy with certain elements of the donation process i.e., working on the Mobile Donor Units (MDU). Operational Management have listened and recognised the issues raised and continue to monitor and evaluate concerns raised by donors to enhance donor and staff satisfaction.
Dietary Requirements	There is now a variety of vegan biscuits and dairy free milk available across the collection teams for our donors to enjoy following feedback received.
Blood Donations	Donors sometimes report experiencing uncomfortable donations when needles are inserted and/or removed from the venepuncture site. Following a concern raised when a donor noticed a lump on completion at the venepuncture site, the investigation found several breaches of duty relating to the immediate and subsequent care of donor which led to a review of the current training practices and has brought out a safe collaboration project looking at documentation of such events.
Language Line	The Welsh Blood Service have introduced an electronic system 'Translation on Wheels' so a face-to-face British Sign Language Interpreter (BSL) can be called on at short notice to support Deaf donors through the blood donation process.
Appointment Times	Appointment cut off times have been reviewed, particularly during lunch times and end of day appointment slots, to accommodate donors who attend late for their allocated time. A ten-minute grace period is offered to donors for each appointment.
Access to Service	Positive interactions with Donors have been arranged to navigate the online booking system to enable Donors who wish to do so, can book their own appointments via the online booking system.
Transgender terminology	Following consultations with donors and consulting the Diversity and Inclusion Manager the Welsh Blood Service have introduced asking all donors their assigned sex at birth (ASB) to ensure the safety of the blood supply when making plasma rich components from blood products.
Welsh Medium	Hoffwn gwyno yn unol â Mesur yr Iaith Gymraeg am sawl peth yn ymwneud â'r Gymraeg sydd yn gyfrifoldeb i Ymddiriedolaeth Felindre. Cyfeiriaf atynt yn eu tro isod gan obeithio y byddant yn arwain at welliant yn y ddarpariaeth Gymraeg rydych yn eu cynnig i'r cyhoedd. A full review of the Welsh Blood Service website identified several areas for improvement in relation to the use of the Welsh Language. The website was updated to ensure all areas were available in a bilingual format.

Comments received into Welsh Blood Service

The Welsh Blood Service strengthen engagement by proactively inviting all Donors who have attended a donation clinic within the previous month to complete a digital satisfaction survey via Snap survey. The results are collated, analysed and reported at the Trust Collections' Operational Service Group to improve the level of service provided by the Welsh Blood Service.



The Donor Contact Centre is to be the first point of contact for blood donors in Wales, with main functions including: booking appointments, answering queries, seeking feedback and keeping consistent lines of communication with our donors via telephone, email and social media.

The Donor Contact Centre's key aim is to deliver an exceptional standard of Service, care and safety for our donors, whilst ensuring that hospital blood stocks are consistently at the optimum levels.

Making contact with donors to advise on last-minute changes with clinics.

Continue to drive SMS invites, replacing letters, to allow for greater agility with clinic changes, supporting greater opportunity to react in real time.

Focus on implementing more bespoke Donor journeys. Driving consistency in Donor experience. Enabling better ability for Donors to self-serve.

Maintained appointment bookings at an average of 92%

Implemented same day SMS appointment reminder, driving 4% improvement in Donor attendance.

Total calls handled by Contact Centre were 90,000 (46,000 inbound calls, 31,000 outbound calls, 13,000 bespoke campaign calls)

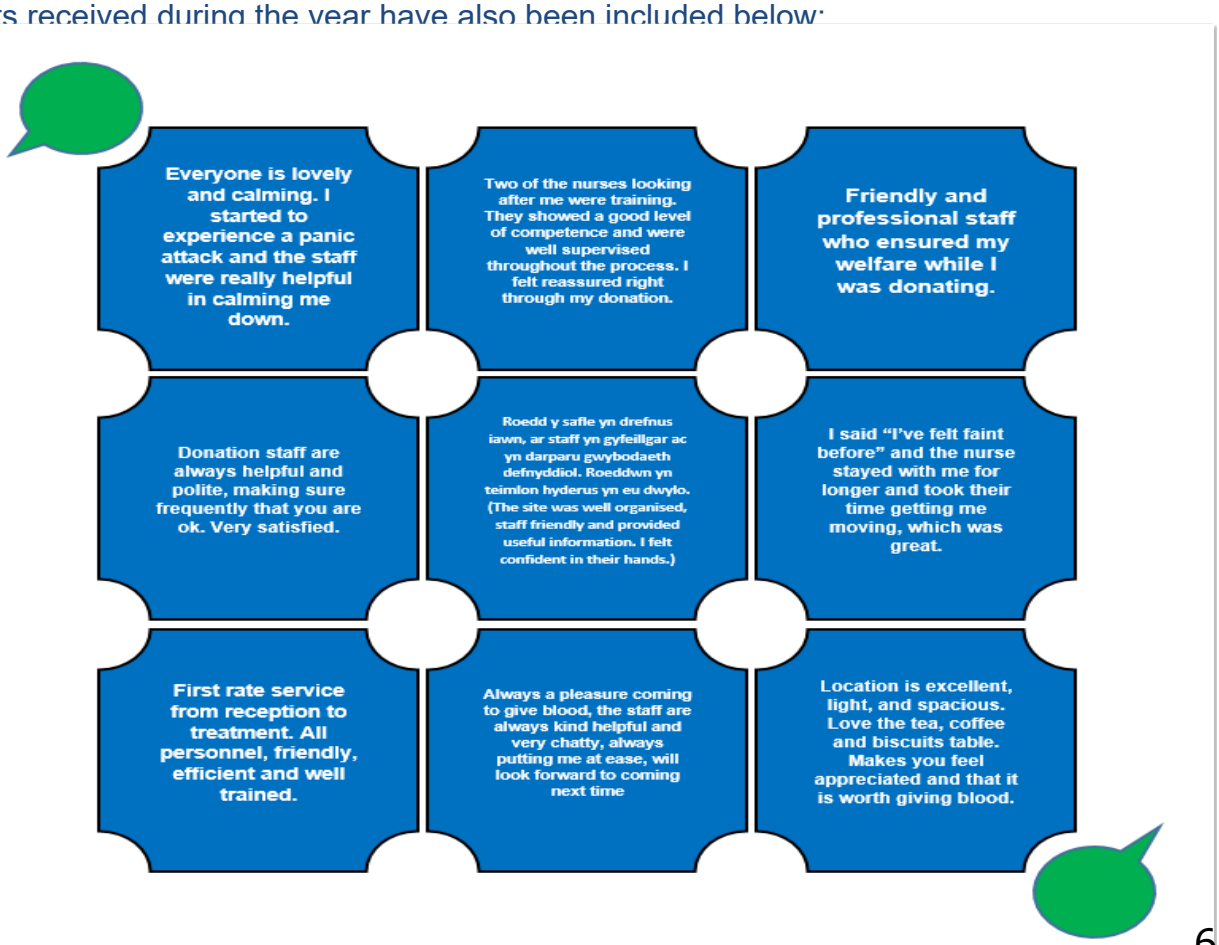
Total appointments booked from calls: 14,200 (13,961 inbound appointments & 239 outbound appointments).

Comments received into Welsh Blood Service

Donors regularly contact the Trust to feedback about the experiences they have received whilst using the service. Comments and compliments are received via many different routes including, verbally or via social media, by email and by letter. The introduction of the CIVICA feedback system has helped improve the way we capture Donor feedback, enabling specific data to be reviewed in an effective, timely and meaningful way.

We appreciate the time taken by Donors to let us know about their experiences and during the year, qualitative feedback received was mainly very positive. The wordle summarises the key words used in the narrative within the CIVICA responses.

There were also some comments that provided opportunities for improvement and a snapshot of compliments received during the year have also been included below:



Welsh Blood Service Engagement

The Trust is committed to engaging and working in partnership with our patients and donors so we can ensure that our services truly meet the needs of our patients and donors. Donor Engagement is hugely important, not only to ensure the donor experience is optimised, and people engage with the Service, but also to ensure we maintain a steady supply of blood and blood products.

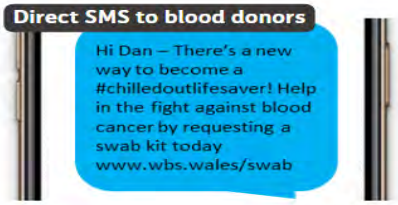
The donor engagement team strategically utilises local influencers, from hairdressers and butchers to local football teams and running clubs, to boost booking percentages of new donors. The strategy undertaken in Wales has now been internationally recognised by peers, with several blood establishments engaging with the Welsh Blood Service to explore implementation in their own areas.

Bone Marrow Donation Campaign

Robert Morgan overcame cancer thanks to a lifesaving bone marrow donation from a complete stranger, Tom Heaven. The duo recently met for the first time to launch Welsh Blood Service's #ChilledOutLifesaver campaign, urging more people to join the Welsh Bone Marrow Donor Registry to help other patients in need.

Supporters webpage

Direct SMS to blood donors



Influencer specific comms and content

Football Association of Wales partnership

Our first community partnership is now celebrating its third season with over 2,500 lives potentially saved.

More than 70 clubs across Wales have been encouraging fans to support our 'Blood, Sweat and Cheers' campaign both on and off the pitch to highlight the importance of donating blood, platelets and bone marrow.

Clubs receive bespoke toolkits with planned PR content throughout the season to keep the content compelling.

For the first time the Welsh Blood Service has recently introduced a direct mailing platform which was used to boost the number of 17- to 30-year-olds joining the Welsh Blood Marrow Donor Registry.

Concerns received by Patients and Donors

154 concerns were raised during 2022-23, equating to less than **0.5%** of patients and donors raising concerns in relation to the care or treatment being provided. These records are significantly lower than 2021-22, where 190 complaints were raised and, 183 recorded in 2020/21 in comparison. This suggests that the Trust is learning and improving in areas where previous concerns were raised. When a complaint is investigated under Putting Things Right, an acknowledgment is provided to the complainant within two working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly

investigate all complaints received and, that 75% of all complaints be resolved, ensuring a formal response is produced within 30 working days of receipt. During the period, 84% of concerns were resolved within 30 working days of receipt and therefore achieving the Welsh Government target of 75% compliance of closing concerns received within 30 days.

Our aims and priorities for 2023-24

1. **Velindre University NHS Trust will continue to actively listen to its patients (their carers) and donors, putting things right where things have gone wrong.**
2. **To fully implement and embed the new requirements of the Health and Care Quality Standards.**
3. **The Quality and Safety Team will develop a Trust wide repository where learning and outcomes from patient and donor experiences can be saved and shared.**
4. **The Trust will establish "Always on" reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised and publish these monthly.**
5. **The Trust will ensure that the feedback from our patients and donors is shared systematically with all teams and staff.**


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

QUALITY & SAFETY COMMITTEE

LOCAL PARTNERSHIP FORUM ANNUAL REPORT

DATE OF MEETING	13th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Board Meeting (EMB)	29.06.2023	NOTED

ACRONYMS	
LPF	Local Partnership Forum
TUC	Trade Union Congress
EMB	Executive Management Board

1. SITUATION/BACKGROUND

This report reflects the Local Partnership Forum's (LPF) role and functions and summarises the key areas of trade union partnership activity, undertaken by Velindre University NHS Trust between April 2022 and March 2023. It also highlights some of the key issues which the Local Partnership Forum intends to give further consideration to, over the next 12 months.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Role and Responsibilities of the LPF

The LPF provides a formal mechanism where the Trust and Trade Unions colleagues, representing Trust employees, work together as the collective representative's views and interests of staff with the objective of improving health services provided by the Trust. The broad term used to describe this is "partnership working".

All members of the LPF are full and equal members and collectively share responsibility for the decisions made by the forum. The Chair is responsible for ensuring key and appropriate issues are discussed by the forum with all the necessary information and advice being made available to members to inform the debate and ultimate decisions.

In taking forward their responsibilities the LPF acts in accordance with the six principles of partnership working set out by the Trade Union Congress (TUC) and the working arrangements under the Department of Health's Partnership Agreement.

Purpose of the LPF

The purpose of the LPF is to provide advice to the Board in aspects of Trust business that impact upon or people, specifically by:

- engaging with our people, through their representatives, on key discussions and decisions taking place within the Trust
- providing Trade Union colleagues with an opportunity to contribute to decisions of the Trust
- enabling management and Trade Union colleagues the opportunity to propose and discuss issues which affect the Trust's people

- providing opportunities for Trade Union colleagues to contribute to the Trust's service delivery plans at an early stage and to consider implications for our people in service reviews and/or organisational change
- reviewing and discussing the Trust's activities against performance targets and providing the opportunity to jointly consider interventions
- appraising Trade Union colleagues of the financial performance of the Trust
- informing Trade Union colleagues of any intention by the Trust to begin formal consultation on any issue affecting individual departments or services

Duties of the LPF

The LPF provides the formal mechanism for consultation, negotiation and communication between the recognised trade unions, their members and management of the Trust.

The scope of the LPF is limited to staff and service issues, under the scope of the Trust.

LPF Membership, Frequency and Attendance

All members of the LPF are full and equal members and share responsibility for actions undertaken by the forum. As the trade unions with the majority of members in the Trust, UNISON (through MIP) and UNITE act as the coordinators of representative views within the Trust.

Trade union representation at the LPF allows for a representative from each recognised trade union, from each division / hosted organisation, to represent the interests of their members.

All Trust trade union representatives are nominated via their trade union, from the membership in their Division or hosted organisation. Union representatives must be employed by Velindre University NHS Trust, and accredited by their respective trade union organisation. If a representative ceases to be employed by the Trust, then they automatically cease to be a member of the LPF. Full time officers of trade unions may attend Local Partnership Forum meetings.

The management representatives are drawn from members of the Executive Management Board, VCC and WBS Senior Management Teams and the Workforce & OD function.

Meetings are held at least four times per year, or as and when the group determines necessary. Every effort is made by all parties to maintain a stable membership of the LPF. There should be at least three management and three Trade Union representatives for the meeting to be quorate.

During the year, the LPF met on the following four occasions:

- 5th May 2022
- 5th July 2022
- 6th September 2022
- 7th March 2023

Review of Local Partnership Forum Activity

The LPF did not have an agreed work plan for 21-22 due to the recovery of COVID pandemic being immediate priority for all NHS organisations in Wales. The LPF continued to work in partnership to achieve this as well as engaging on future plans for the LPF.

Partnership Working Action Plan

The LPF developed and approved the action plan in partnership. Work is underway to implement the agree actions.

Engagement with LPF members

LPF has provided the opportunity to inform, discuss and appraise trade union representatives on the following issues over the past 12 months:

- Progress being made against the Welsh Blood Service, Collections Team Organisational Change.
- Consultation and information on the Welsh Blood Service, Senior Leadership Team review and possible Organisational Change.
- updates and briefings on the Trust's IMTP;
- Updates and briefings on the Trust's People Strategy
- progress being made on the Transforming Cancer Services Project;
    - nVCC
    - Outreach

- the Trust's Equality Monitoring Report and the actions being made to monitor progress against the agreed objectives;
- updates and briefing on the restructuring and modernisation of the Workforce Team
- updated from the Healthy and Engagement Steering Group
- updates from the Education Steering Group
- discussions on the Trust's Workforce Metrics, in relation to sickness absence, statutory and mandatory training and PADR compliance;
- updates on the Trust's financial performance;

Reporting and Communication

The LPF's papers, including the minutes from all the meetings are routinely published on the Trust's intranet site.

Conclusions and Way Forward

The Executive Management Board and the Senior Leadership Teams are very grateful for the engagement and participation of trade union representatives, in the activities of the LPF and other Trust meetings and activities. The positive and constructive way in which they have contributed has enabled the Trust to meet and deliver on its organisational objectives.

The next 12 months yet again provides an opportunity for the LPF to continue to build on this year's successes, in addressing new and emerging workforce and service priorities.

Future Proposed Activity

The LPF has agreed to undertake the following key actions, as identified in the Working in Partnership Action Plan, over the course of the next 12 months:

- development of the partnership working philosophy into the values and culture of the Trust
- engage with the development of employee relations within the Trust, looking to reduce employee harm where possible
- continued partnership working in possible Organisational Change processes
- continued engagement with the developments ongoing in Transforming Cancer Services
  - nVCC
  - Outreach

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The effective implementation of partnership working ensure effective quality management systems are in place to support staff to deliver the organisations objectives in a safe and quality way.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	No identified equality concerns. The remit of the LPF is to ensure equality assessments are fully considered in the systems and processes within the Trust.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Effective employee relations underpin the relationship between employer, employee and the state ensuring statutory acts are effectively implements and relationships remain effective to reduce potential employment tribunal claims.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Effective employee relations underpin the health and wellbeing of the workforce by building a positive and engaging culture. Without the work undertaken by the LPF staff engagement may decline making the organisation less productive in meeting its objective.

4. RECOMMENDATION

Quality Safety and Performance Committee are asked to **ENDORSE** the content of this annual report for Board approval.

Quality, Safety and Performance Committee

Annual Equality Report 31 March 2023

DATE OF MEETING	13 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	**29 June 2023**	**Endorsed for approval**

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties. The workforce statistics relating to protected characteristics as at 31 March 2023 can be seen in appendices 1 and 2. The data presented at Appendix 1 covers the full legal entity, including NHS Wales Shared Services, and the data presented at Appendix 2 is Velindre only, covering Velindre Cancer Centre, Welsh Blood Service and Trust Wide Services.

1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The production of this report has been brought forward to align with the Trust cycle of business which now sees the majority of Annual Reports in the public domain from July each year. The Trust is required to publish this report by March 2024.

1.3 The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:

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

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

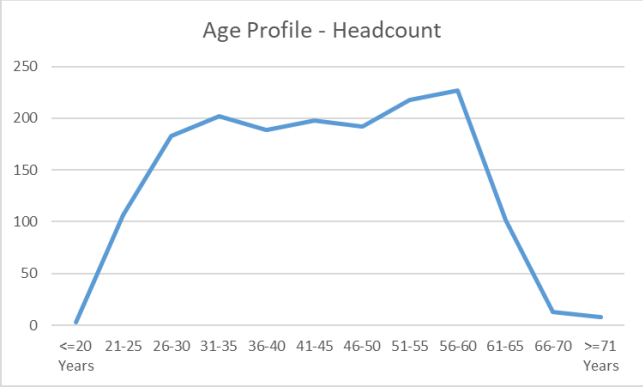
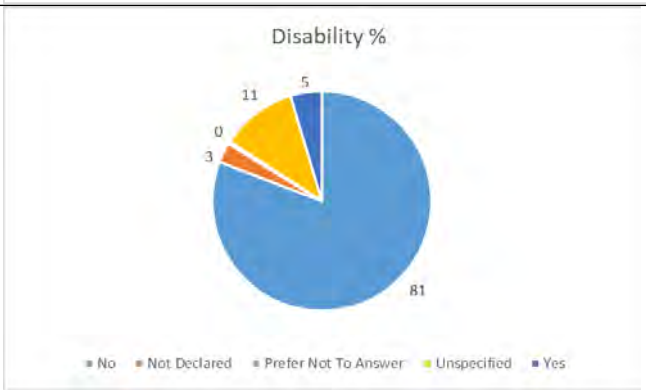
1.4 The report also includes a synopsis of progress made against the Trust's Strategic Equality Plan objectives, which run from 2020 to 2024.

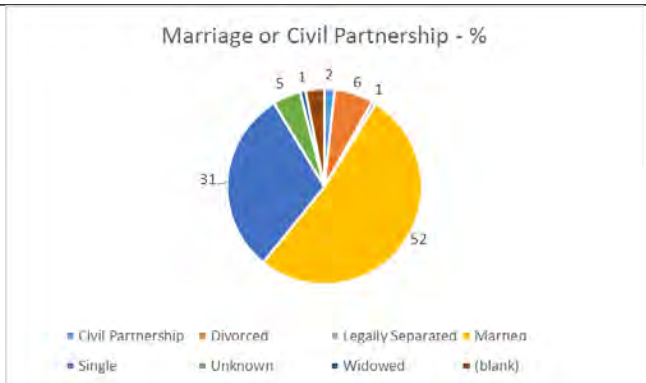
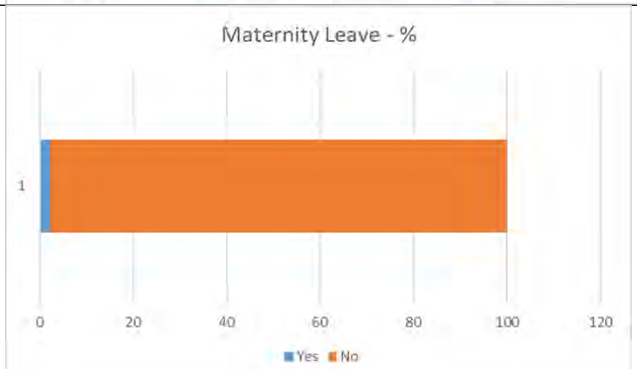
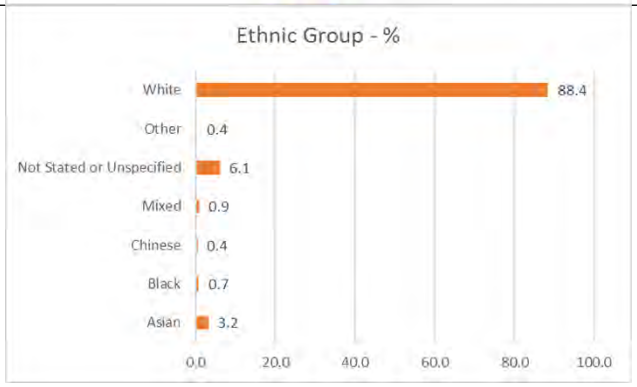
1.5 The Census 2021 results were published in 2022 and key statistics from this have been included to offer a measure of the Trust's demographic alignment in relation to that of the population of Wales.

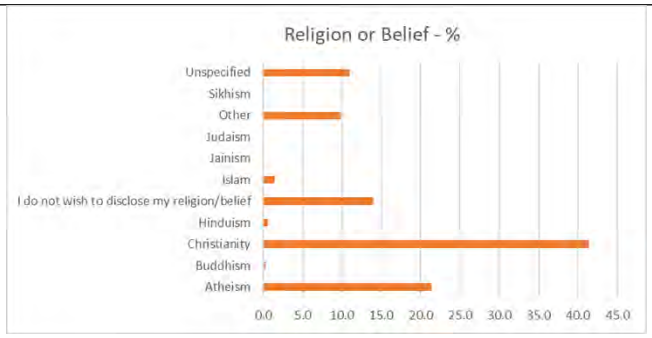
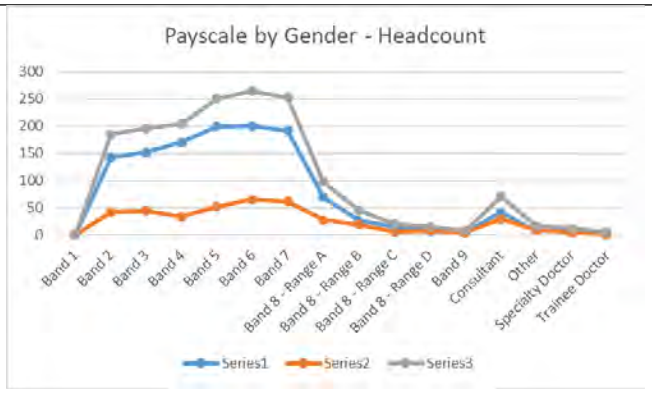
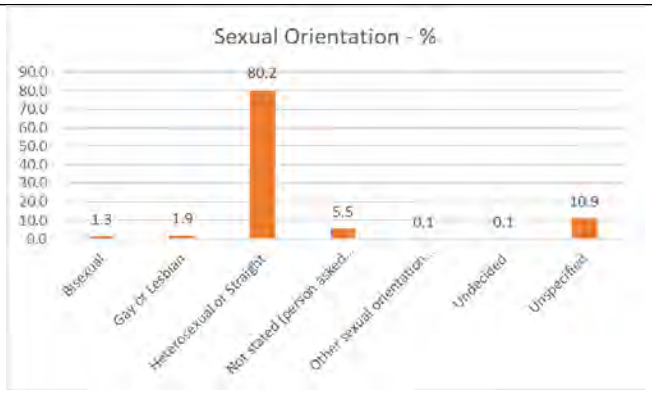
2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

There are nine protected characteristics under the Equality Act 2010 which all public sector organisations report on annually. Statistics are neutral; it is the picture they paint that can help us understand difference in experience of employees from different backgrounds.

The data for the combined organisation of 7,143 people is available at Appendix 1. The analysis below focuses on the 1,642 people at Velindre (excluding hosted) only, shown at Appendix 2. This group has increased by 29 people since March 2022, a 1.8% rise.

1	**Age** The age profile is slightly flatter this year with peak in age 31-35 being less acute, reflecting growth in age brackets before and after 31-35 and a drop in 31-35. The peak at age 56-60 has crept up by <1% and represents a challenge for workforce planning over the next five years.	
2	**Disability** 5% of the workforce have declared a disability compared with 3% last year. The proportion reporting as Not Disabled has risen in the same period from 76% to 81%. This means the percentage of unknown has reduced from 21% to 15%. However, the Census reports 78% of the population as Not Disabled, 22% Disabled. This shows that the Trust is underrepresenting this group by between 3% and 17%.	
3	**Gender Reassignment**	

	ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic. The Census reports 93% of the population age 16+ as identifying as the same gender as registered at birth, with 6% not answered and 1% combined of trans men, trans women, non-binary, different or not specified gender identity. Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.	
4	**Marriage or Civil Partnership** Half the workforce is married and almost a third are single. Other categories make up the remaining 20%. This pattern is very similar to last year's.	
5	**Pregnancy or Maternity** 2.19% of the workforce were on Maternity Leave on 31 March 2023 compared to 2.85% last year.	
6	**Race** 88% of staff are recorded as White, up from 86% last year, with the second largest group being Asian at 3%. These results compare to the Census showing 94% of the population of Wales as White and the second largest group being Asian, at 3%. The percentage of staff records showing Not Stated has fallen from 9% to 6%.	

7	**Religion or Belief** 41% of the workforce are Christian, 21% Atheist and 12% all other religions. The number being Unspecified has fallen from 252 to 180, showing our data has improved. The Census showed 43% as Christian and 46% No Religion, which may not correlate exactly with Atheist.	
8	**Sex (Gender)** Despite the population of Wales being 51% female, 49% male, the Trust has a 75:25 gender split. This has not changed since last year. Similarly, the uptake of full time and part time work has not changed, with 58% of women in full time roles compared with 84% of men. There is a clear pattern of women being over-represented in Bands 7 and below; employment in Bands 8A and above is equally shared between the genders despite the workforce being 75% female.	
9	**Sexual Orientation** The proportion of staff reporting as Straight has risen from 75% to 80%. There has been a corresponding drop in Unspecified from 15% last year to 11% this year. 5% of people chose not to state their sexual orientation and 1.3% were Bisexual, 1.9% Gay or Lesbian and less than 1% reported Other Sexual Orientation or Undecided.	

2.1 Progress with the five objectives in the Strategic Equality Plan is outlined below.

2.1.1 Increase workforce diversity and inclusion

A Widening Access Coordinator postholder has been working with local colleges and the community to offer a wider variety of routes into working in healthcare. The Trust has provided Internships and Apprenticeships to local people to support their education and employment experience. The Trust is working with HEIW on national careers initiatives, for clinical and non-clinical roles.

The Trust signed up to the RCN Nurse Cadet scheme to offer young people placements within a clinical setting as part of an educational experience, to offer a taste of working in health care, both in VCC and WBS. The first cohort is expected in Summer 2023.

As part of the Defence Employer Recognition Scheme the Trust works closely with Armed Forces to ensure Velindre remains an inclusive place to work, with its vision to achieve Gold standard, a commitment to the Armed Forces Covenant.

The Trust is accredited at Level 2 of Disability Confident and is working towards Level 3 which will develop our capability as a leader in the employment of disabled people.

2.1.2 Eliminate pay gaps

A refreshed approach to conducting Equality Impact Assessments, including a Toolkit, was introduced at the end of March 2023. This will help highlight issues where employment may be skewed to one gender over another, which is the underpinning cause of gender pay disparity. More broadly, the introduction of the Workforce Race Equality Standard later in 2023 will support the analysis of pay gap according to race and provide new insights for taking action.

The process for applying for incremental credit in respect of experience gained prior to joining the Trust is now emphasised during recruitment to reduce disparity in starting salaries between people with a protected characteristic and those without.

2.1.3 Engage with the community

In relation to cancer services and the new Velindre Cancer Centre, the voice of the patient, their families and carers are at the heart of the Patient Engagement Strategy. It was developed via a comprehensive engagement exercise and formally agreed by the VUNHST Board in May 2022. It sets out a plan for the ambition as well as the mechanisms and structures that will enable its delivery, including plans for a renewal of the current Patient Liaison Group and managing the work carried out by our volunteers. One of the most important changes will be setting up a new patient panel; a large group of patients who have expressed an interest in helping us.

In May 2023 the Trust launched Velindre Voices a means for anyone to engage with us, influence our work and have their voices heard in a way that suits them. From simply keeping in

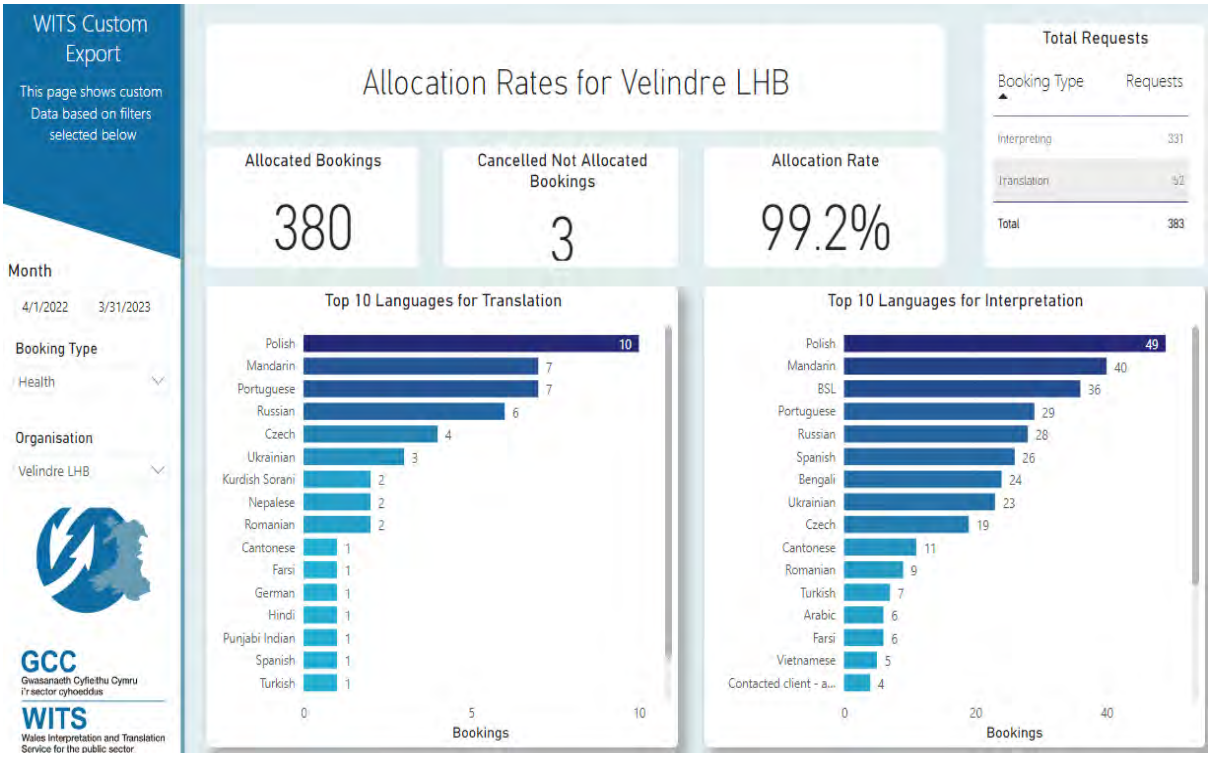
touch and receiving updates on areas of interest, to becoming part of focus groups, volunteering or becoming a member of the Patient Engagement and Involvement Group or Community Panel, there is no minimum time commitment and members of the panel can be involved in as much or as little as they wish. The Cancer Centre is particularly interested in engaging with those with seldom heard voices and it will be working closely with third sector organisations to ensure the engagement opportunities offered are accessible and meet everybody's needs

2.1.4 We communicate with people in ways that meet their needs

The refreshed Equality Impact Assessment process invites managers to consider how suitable communication methods are in relation to the people involved.

The Trust has implemented the Active Offer in relation to the Welsh language in VCC and WBS. Improvements have been achieved in the range of ways patients and donors can access services through the medium of Welsh.

The Trust uses the Wales Interpretation and Translation service which provides 24/7 translation support in 135 languages including BSL. Staff can access this when it will assist in communicating with patients who do not communicate effectively in English. The usage of WITS during the year is illustrated below, showing the top three languages for interpretation as Policy, Mandarin and BSL.



2.1.5 Ensure service delivery reflects individual need.

The case study below illustrates listening to services users and acting on their feedback was taken from WBS earlier this year:

A blood donor experienced a difficult when trying to arrange to give blood via the online booking process following a miscarriage. The donor had contacted the Welsh Blood Service to advise that during completion of the eligibility questionnaire, she had duly answered yes to having been pregnant during the last six months and assumed further questions surrounding her individual circumstances would follow. The next page displayed a statement indicating that she would be welcome to donate 6 months after the birth of her baby and contained upsetting images of a dummy. As she had sadly suffered a miscarriage, she was unclear as to her eligibility as no options were available to her. The Donor provided feedback in respect of this to the Welsh Blood Service and received a phone call with an apology the following day, along with assurance that the matter was being investigated as a matter of urgency. A telephone call was also made to the donor to discuss her donation options. Following a prompt review of the online questionnaire and all web pages referencing childbirth, new wording was drafted and the donor was invited to review this before refreshing the web pages.

The donor expressed gratitude and acknowledged the swift response and sensitive handling of the matter and the incident was received as a positive outcome for both the donor and Welsh Blood Service. The Committee noted that regular reviews of the website will be undertaken by the clinical team going forward.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in this report supports the organisation in its achievements of its duties under

	Equality legislation which benefits people across all protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust is required to publish its Equality Monitoring Information of 31 March 2023 by 31 March 2024.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Exec Quality, Safety and Performance Committee is asked to **ENDORSE** this report for onwards submission to the Board.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1
Equality Monitoring Data Velindre University NHS Trust including NWSSP

Employment Category	Headcount	%
Full Time	5028	77.29
Part Time	1477	22.71
Grand Total	**6505**	**100.00**

Age Band	Headcount	%
<=20 Years	23	0.35
21-25	744	11.44
26-30	1287	19.78
31-35	1241	19.08
36-40	700	10.76
41-45	549	8.44
46-50	537	8.26
51-55	554	8.52
56-60	525	8.07
61-65	266	4.09
66-70	53	0.81
>=71 Years	26	0.40
Grand Total	**6505**	**100.00**

Staff Group	Headcount	%
Add Prof Scientific and Technic	79	1.21
Additional Clinical Services	403	6.20
Administrative and Clerical	2181	33.53
Allied Health Professionals	153	2.35
Estates and Ancillary	605	9.30
Healthcare Scientists	165	2.54
Medical and Dental	2675	41.12
Nursing and Midwifery Registered	241	3.70
Students	3	0.05
Grand Total	**6505**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	2713	2315	5028
Part Time	1207	270	1477
Grand Total	**3920**	**2585**	**6505**

Pay Grade By Gender	Female	Male	Total
Band 1	1	1	2
Band 2	303	422	725
Band 3	486	233	719
Band 4	414	158	572
Band 5	369	153	522
Band 6	334	137	471
Band 7	267	120	387
Band 8 - Range A	114	62	176
Band 8 - Range B	65	42	107
Band 8 - Range C	32	34	66
Band 8 - Range D	12	17	29
Band 9	5	10	15
Consultant	51	42	93
Other	23	21	44
Specialty Doctor	8	5	13
Trainee Doctor	1436	1128	2564
Grand Total	**3920**	**2585**	**6505**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	54	25	79
Additional Clinical Services	291	112	403
Administrative and Clerical	1475	706	2181
Allied Health Professionals	129	24	153
Estates and Ancillary	146	459	605
Healthcare Scientists	100	65	165
Medical and Dental	1499	1176	2675
Nursing and Midwifery Registered	223	18	241
Students	3	0	3
Grand Total	**3920**	**2585.00**	**6505**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	1731	1381	3112
Permanent	2189	1204	3393
Grand Total	**3920**	**2585.00**	**6505**

Gender	Headcount	%
Female	3920	60.26
Male	2585	39.74
Grand Total	**6505**	**100.00**

Sexuality	Headcount	%
Bisexual	67	1.03
Gay or Lesbian	91	1.40
Heterosexual or Straight	3979	61.17
Not stated (person asked but declined to provide a response)	355	5.46
Other sexual orientation not listed	4	0.06
Undecided	1	0.02
Unspecified	2008	30.87
Grand Total	**6505**	**100.00**

Religious Belief	Headcount	%
Atheism	1116	17.16
Buddhism	45	0.69
Christianity	2064	31.73
Hinduism	97	1.49
I do not wish to disclose my religion/belief	661	10.16
Islam	342	5.26
Judaism	4	0.06
Other	393	6.04
Sikhism	15	0.00
Unspecified	1768	27.18
Grand Total	**6505**	**100.00**

Ethnic Origin	Headcount	%
Asian	446	6.86
Black	146	2.24
Chinese	31	0.48
Mixed	89	1.37
Not Stated or Unspecified	1491	22.92
Other	48	0.74
White	4254	65.40
Grand Total	**6505**	**100.00**

Disability	Headcount	%
No	5056	77.72
Not Declared	246	3.78
Prefer Not To Answer	5	0.08
Unspecified	1035	15.91
Yes	163	2.51
Grand Total	**6505**	**100.00**

Marital Status	Headcount	%
Civil Partnership	72	1.11
Divorced	231	3.55
Legally Separated	30	0.46
Married	2294	35.27
Single	1762	27.09
Unknown	1389	21.35
Widowed	28	0.43
(blank)	699	10.75
Grand Total	**6505**	**100.00**

On Maternity	Headcount	%
Yes	160	2.46
No	6345	97.54
Grand Total	**6505**	**100.00**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2

Equality Monitoring Data Velindre University NHS Trust excluding NWSSP

Employment Category	Headcount	%
Full Time	1066	64.92
Part Time	576	35.08
Grand Total	**1642**	**100**

Age Band	Headcount	%
<=20 Years	3	0.18
21-25	107	6.52
26-30	183	11.14
31-35	202	12.30
36-40	189	11.51
41-45	198	12.06
46-50	192	11.69
51-55	218	13.28
56-60	227	13.82
61-65	102	6.21
66-70	13	0.79
>=71 Years	8	0.49
Add Prof Scientific and Technic	61	3.71
Additional Clinical Services	271	16.50
Administrative and Clerical	575	35.02
Allied Health Professionals	153	9.32
Estates and Ancillary	70	4.26
Healthcare Scientists	178	10.84
Medical and Dental	88	5.36
Nursing and Midwifery Registered	244	14.86
Students	2	0.12
Grand Total	**1642**	**100**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	723	343	1066
Part Time	513	63	576
Grand Total	**1236**	**406**	**1642**

Pay Grade By Gender	Female	Male	Total
Band 1	0	0	0
Band 2	142	42	184
Band 3	151	44	195
Band 4	170	34	204
Band 5	199	52	251
Band 6	200	65	265
Band 7	191	61	252
Band 8 - Range A	69	28	97
Band 8 - Range B	26	19	45
Band 8 - Range C	15	6	21
Band 8 - Range D	7	8	15
Band 9	4	4	8
Consultant	42	29	71
Other	8	9	17
Specialty Doctor	8	4	12
Trainee Doctor	4	1	5
Grand Total	**1236**	**406**	**1642**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	47	14	61
Additional Clinical Services	203	68	271
Administrative and Clerical	430	145	575
Allied Health Professionals	127	26	153
Estates and Ancillary	34	36	70
Healthcare Scientists	108	70	178
Medical and Dental	54	34	88
Nursing and Midwifery Registered	231	13	244
Students	2		2
Grand Total	**1236**	**406**	**1642**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	92	41	133
Permanent	1144	365	1509
Grand Total	**1236**	**406**	**1642**

Gender	Headcount	%
Female	1236	75.27
Male	406	24.73
Grand Total	**1642**	**100**

Sexuality	Headcount	%
Bisexual	21	1.28
Gay or Lesbian	31	1.89
Heterosexual or Straight	1317	80.21
Not stated (person asked but declined to provide	90	5.48
Other sexual orientation not listed	2	0.12
Undecided	2	0.12
Unspecified	179	10.90
Grand Total	**1642**	**100**

Religious Belief	Headcount	%
Atheism	351	21.38
Buddhism	4	0.24
Hinduism	10	0.61
Islam	24	1.46
Jainism	0	0.00
Judaism	1	0.06
Other	162	9.87
Sikhism	0	0.00
Unspecified	180	10.96
Grand Total	**1642**	**100**

Ethnic Origin	Headcount	%
Asian	52	3.17
Black	12	0.73
Chinese	7	0.43
Mixed	14	0.85
Not Stated or Unspecified	100	6.09
Other	6	0.37
White	1451	88.37
Grand Total	**1642**	**100**

Disability	Headcount	%
No	1327	80.82
Not Declared	48	2.92
Prefer Not To Answer	6	0.37
Unspecified	185	11.27
Yes	76	4.63
Grand Total	**1642**	**100**

Marital Status	Headcount	%
Civil Partnership	28	1.71
Divorced	106	6.46
Legally Separated	11	0.67
Married	854	52.01
Single	501	30.51
Unknown	76	4.63
Widowed	15	0.91
(blank)	51	3.11
Grand Total	**1642**	**100**

On Maternity	Headcount	%
Yes	36	2.19
No	1606	97.81
Grand Total	**1642**	**100**

Quality, Safety and Performance Committee

Gender Pay Gap Report 2023

DATE OF MEETING	13 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Draft Status - Final Version will be Published in Public Domain

PREPARED BY	Claire Budgen: Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	29.6.23	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of 'specified public authorities' in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2 It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.

1.3 The analysis of pay data as of 30 March 2023 has been conducted earlier in the year to fall in with the Trust's Annual Reports schedule. The deadline for reporting these figures remains 30 March 2024.

1.4 The report attached therefore provides the Executive Management Board with the information to endorse for Board Approval the publication of the Trust Annual Gender Pay Gap Report.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached report provides data and narrative of activities for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile to ensure the Trust meets its legal requirements.

2.2 The report shows information of the summary of statistics below that are being detailed in the Gender Pay Gap Report. Velindre – including Hosted

The **Mean Gender Pay Gap** is £1.40 an hour. Women are paid 6% less than men. The mean average hourly rate is £21.56 for women and £22.96 for men.	The **Median Gender Pay Gap** is £3.03 an hour. Women are paid 14% less than men. The median average hourly rate is £19.21 for women and £22.24 for men.	Men's mean bonus payment is £3,012 more than women's, a **Mean Bonus Pay Gap** of 36%
		Men's median bonus payment is £122 more than women's, a **Median Bonus Pay Gap** of 2%

2.3 This report also analyses the situation for Velindre core services, when NHS Shared Services Partnership data is excluded. This level of detail has shown a different picture than that for the legal entity as a whole. In particular:

- The Mean Gender Pay Gap is 13%, which has fallen from 14% during the year.
- The spread between the Quartiles is very similar year on year. The biggest gender disparity remains in Quartile 4, with a split of 32:68 male to female compared with an overall split of 25:75 male to female across the workforce as a whole.

Six actions were agreed in March 2022 linked to the previous Gender Pay Gap report which remain the key focus for work to reduce the gender pay gap.

1. **Listening to women.**
   The Board participated in a briefing session by the Executive Ambassador for Gender Equality during the year which raised awareness of issues for women from clinical and employment perspectives. During 2022-23 a number of Menopause Cafes have run to allow women, in particular, to raise their voices and help develop a Menopause Friendly Culture. This will be built on in 2023-24 through running a survey to identify what people are looking for regarding Menopause support and putting that in place. We are offering options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**. We have analysed access to our Inspire management development programme to understand if it is helping close the Gender Pay Gap. To date, 71% of delegates have been women which is lower than the percentage of women in the workforce as a whole. This suggests we may benefit from some further exploration of why women are not as likely as men to come forward for the training and whether any form of positive actions would help close the Gender Pay Gap. In 2023-24 we will further develop our monitoring of development opportunities to see in the round how to use continuous professional development to help close the gender pay gap

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional

encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project.** In 2022-23 the Recruitment Policy and toolkit was updated and they highlight the importance of having a diverse shortlisting and interview panel to make a rounded decision. The Flexible Working Policy is also promoted within recruitment to broaden the appeal of working in the Trust to people with a range of other commitments, which may including caring responsibilities. This is in turn helps bring women into a range of roles, given that women are more likely than men to be carers within our society.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity.** Equality, Diversity and Inclusion training for managers during 2023-24 will include how to build a culture of inclusion and how to manage bias.

6. **Monitoring of engagement with initiatives by gender.** A new EQIA Toolkit was introduced in April 2023 which provides support to managers in systematically identifying whether initiatives may have an adverse impact on any protected characteristic, including Gender. Alongside this, we are developing an annual Employee Relations report for NHS Wales which will measure representation within standard HR processes in light of protected characteristics. This is being developed during 2023-24 with the first formal report due in April 2024.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirement to publish by 30 March 2023
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

1. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **ENDORSE for BOARD APPROVAL** the Gender Pay Gap report.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre

Velindre University NHS Trust

GENDER PAY GAP

2023 REPORT

FORWARD

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff has the same access and opportunities to reward, recognition, and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce, and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

WHAT IS THE GENDER PAY GAP

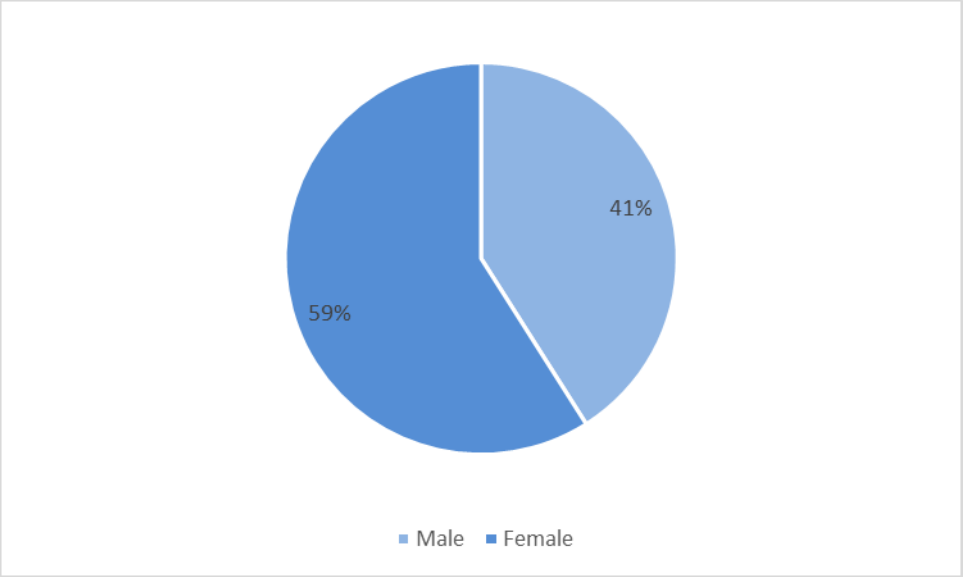
The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation, and how effectively talent is being maximised. A high gender pay gap can be an indication that there may be a number of issues that the organisation may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

This document reports pay data on 31 March 2023. It represents Velindre University NHS Trust as a legal entity that also includes hosted organisations, NHS Wales Shared Services Partnership and Health Technology Wales. To better understand our pay gap, we have drilled down to some of the Divisions within the organisation and created actions to address issues which were not evident in the data for the composite organisation.

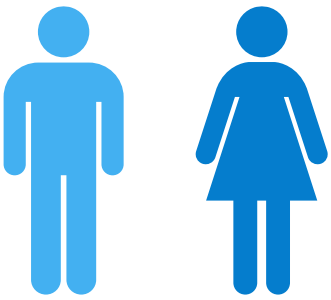
OUR GENDER PAY PROFILE 2023

On 31 March 2023 VUNHST employed 7,143 people, 41% male 59% female.



Mean and Median Pay

The **Mean Gender Pay Gap** is £1.40 an hour. Women are paid 6% less than men. The mean average hourly rate is £21.56 for women and £22.96 for men.



The **Median Gender Pay Gap** is £3.03 an hour. Women are paid 14% less than men. The median average hourly rate is £19.21 for women and £22.24 for men.

Bonus Pay

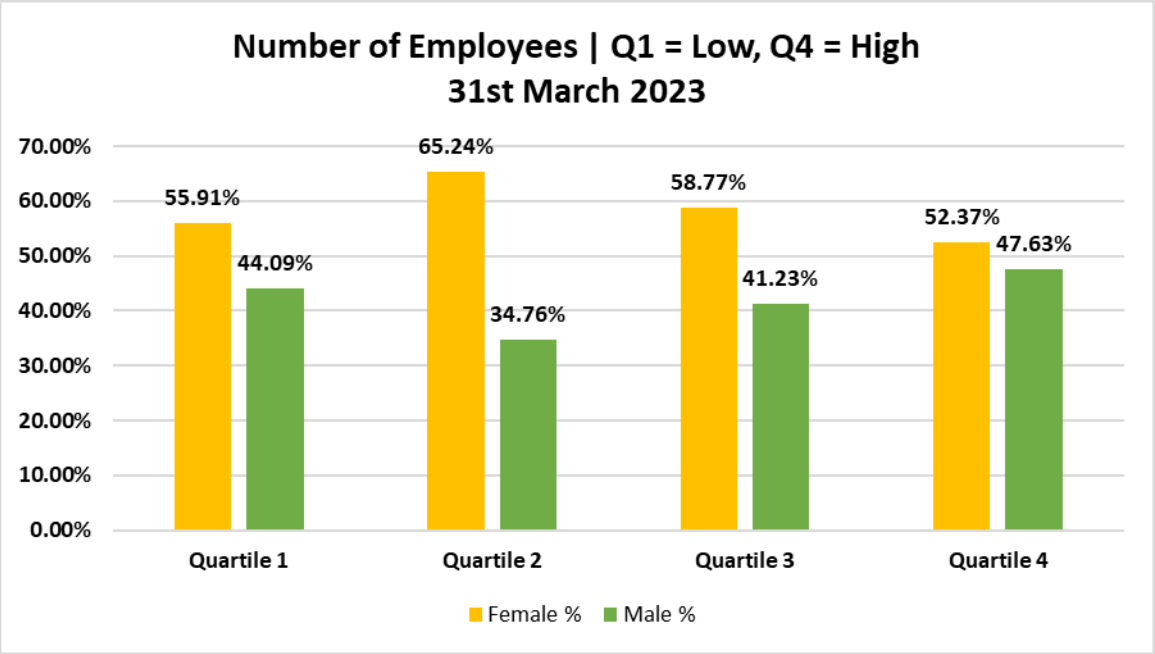
1.34% of men receive a bonus
1.24% of women receive a bonus

Men's mean bonus payment is £3,012 more than women's, a **Mean Bonus Pay Gap** of 36%

Men's median bonus payment is £122 more than women's, a **Median Bonus Pay Gap** of 2%

Quartile Range

When dividing the female workforce and the male workforce into four equal parts, men's pay and women's pay show different patterns with women being clustered in the middle quartiles and men more concentrated in the lowest and highest quartiles.



Note – Hourly Rates per Quartile and approximate match in Agenda for Change Pay Band

Quartile 1	£4.79 - £12.25	Equates to Band 3 and below
Quartile 2	£12.71 - £18.33	Equates to Band 4 and 5
Quartile 3	£18.19 - £23.77	Equates to Band 6 and 7
Quartile 4	£24.38 - £30.52	Equates to Band 8 and above

MOVEMENT BETWEEN 2022 AND 2023

The Mean Gender Pay Gap has stay increased from 88p to £1.40 an hour, or 4% to 6%. The Median Gap has also increased from 2% in 2022 to 14% in 2023.

The Mean Bonus Gap decreased from 43% to 36% and the Median Bonus Gap decreased from 9% to 2%.

The spread between the Quartiles for each gender is also very similar between 2022 and 2023 with Women over-represented in Band 4 and 5 with respect to them comprising 59% of the workforce overall and Men over-represented in Band 8 and above, compared with them being 41% of the workforce overall.

LOOKING BENEATH THE ORGANISATIONAL LEVEL DATA

The above report is based on the legal entity of 7,143 employees, 77% of whom work for NHS Wales Shared Services Partnership. If these people are taken out of the analysis, there are 1,642 employees in Velindre Cancer Centre, Welsh Blood Service and Corporate and other functions.

These 1,642 employees are spread between two Divisions and a combination of Corporate and other functions, as follows:

	Women	**Men**	**Percentage Women**	**Percentage Men**	**Total Employees**
Velindre Cancer Centre	701	182	79%	21%	883
Welsh Blood Service	340	118	74%	26%	458
Corporate and Other Functions	195	106	65%	35%	301
TOTAL	1,236	406	**75%**	**25%**	**1,642**

This shows that all three Divisions are female dominated, with 79% of the Velindre Cancer Centre workforce, 74% of Welsh Blood Service and 65% of Corporate staff being Female.

Similarly, all staff groups are predominantly Female, however this becomes particularly pronounced with Allied Health Professionals and Nursing and Midwifery. The Staff Groups are ranked in order of gender diversity below.

Staff Group	**Female to Male Ratio**
Estates and Ancillary	48:52
Medical and Dental	61:39
Healthcare Scientists	61:39
Additional Professional, Scientific and Technical	77:23
Administrative and Clerical	75:25
Additional Clinical Services	75:25
Allied Health Professions	83:17
Nursing and Midwifery	95:5

The key statistics for Gender Pay Gap reporting are shown below. This shows a marked difference between the Trust position as a whole and that for Velindre. The Mean Gender Pay Gap is 13%, compared with 6% for the combined organisation, The gap between the two scores has narrowed since 2022 from 10 percentage points last year to 7 percentage points

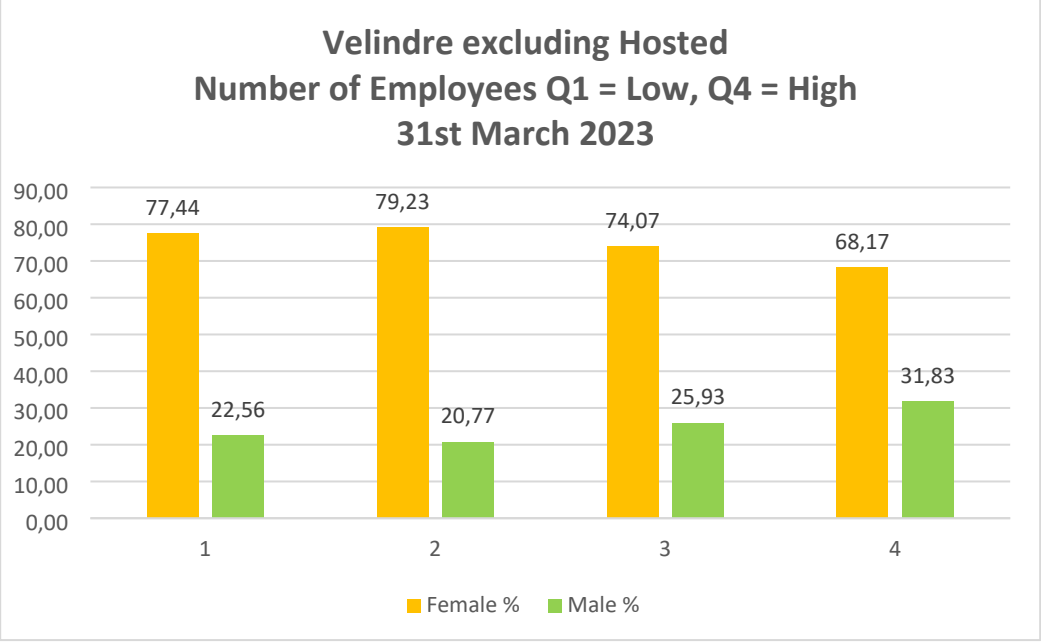
this year. Looking at Bonuses, the mean gap in Velindre (excluding hosted) has stayed the same at 47% whilst the combined organisation's mean bonus gap has fallen from 43% to 36%. These figures show that there are different patterns within core Velindre and its hosted organisation of NHS Wales Shared Services Partnership.

	2022 Velindre	2023 Velindre	2022 NWSSP	2023 NWSSP	2022 Combined	2023 Combined
Mean Gap hourly rate	£2.95	£2.99	3p	57p	88p	£1.40
Mean Gap	14%	13%	<1%	2%	4%	6%
Median Gap hourly rate	65p	£1.09	0	£2.52	44p	£3.03
Median Gap	4%	6%	0	11%	2%	14%
Mean Bonus Gap	£6,648	£6,847	£813	£360	£3,113	£3,012
Mean Bonus Gap	47%	47%	25%	8%	43%	36%
Median Bonus Gap	-£434	£833	£1,319	£650	£307	£122
Median Bonus Gap	-7%	12%	37%	13%	9%	2%

Note

The mean gap has been able to rise from £2.95 to £2.99 whilst the percentage has fallen from 14% to 13% due to the effect of pay rises in the period.

As with the pattern of distribution for the Trust including NWSSP, Women peak in Quartile 2, Bands 4 and 5, whereas men peak in Quartile 4, Bands 8 and above. This pattern is the same as in 2022.



Note – Hourly Rates per Quartile and approximate match in Agenda for Change Pay Band

Quartile 1	£4.79 - £12.25	Equates to Band 3 and below
Quartile 2	£12.25 - £17.24	Equates to Band 4 and 5
Quartile 3	£17.24 - £22.79	Equates to Band 6 and 7

Quartile 4	£22.79 - £83.61	Equates to Band 8 and above

CONCLUSIONS

- There has been a small change in our headline figures between 2022 and 2023. The Mean Gender Pay Gap increased from 4% to 6% overall with a Mean Bonus Gap reducing from 43% to 36%. The Median figures present a mixed picture with the Median Pay Gap rising from 2% to 14% and the Median Bonus Gap falling from 9% to 2% in the year. However, the gender split in the workforce has become slightly less polarised, going from 60% women in 2022 to 59% women in 2023. This reflects the picture for Velindre University NHS Trust, including NHS Wales Shared Services Partnership.

- When we drill down, we see that although the Mean Pay Gap for the Velindre University NHS Trust is 6%, when Shared Services are discounted it changes to 13%. This is an improvement on one percentage point compared with 2022. Nevertheless, this shows that specific actions are need in the clinical and corporate areas of the Trust.

- The Bonus Pay Gap reflects a small number of payments which tends to produce larger percentages. The Median Bonus Pay Gap for Velindre went from -7% in 2022 to 12% in 2023 reflecting a small number of payments made within the Medical staff group.

- All staff groups are female dominated and this is markedly so in Allied Health Professionals and Nursing and Midwifery. This does not necessarily cause a gender pay gap – it would depend on salaries earned being comparable to those in other staff groups. However, a more even gender balance would be desirable to create more diverse and inclusive teams and help reduce career-based gender stereotypes.

ACTIONS MOVING FORWARD FOR 2023 – 2024

Six actions were agreed in March 2022 linked to the previous Gender Pay Gap report which remain the key focus for work to reduce the gender pay gap.

1. **Listening to women.**
   The Board participated in a briefing session by the Executive Ambassador for Gender Equality during the year which raised awareness of issues for women from clinical and employment perspectives. During 2022-23 a number of Menopause Cafes have run to allow women, in particular, to raise their voices and help develop a Menopause Friendly Culture. This will be built on in 2023-24 through running a survey to identify what people are looking for regarding Menopause support and putting that in place. We are offering options for staff, male and female, to share

their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**. We have analysed access to our Inspire management development programme to understand if it is helping close the Gender Pay Gap. To date, 71% of delegates have been women which is lower than the percentage of women in the workforce as a whole. This suggests we may benefit from some further exploration of why women are not as likely as men to come forward for the training and whether any form of positive actions would help close the Gender Pay Gap. In 2023-24 we will further develop our monitoring of development opportunities to see in the round how to use continuous professional development to help close the gender pay gap.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project.** In 2022-23 the Recruitment Policy and toolkit was updated and they highlight the importance of having a diverse shortlisting and interview panel to make a rounded decision. The Flexible Working Policy is also promoted within recruitment to broaden the appeal of working in the Trust to people with a range of other commitments, which may including caring responsibilities. This is in turn helps bring women into a range of roles, given that women are more likely than men to be carers within our society.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity.** Equality, Diversity and Inclusion training for managers during 2023-24 will include how to build a culture of inclusion and how to manage bias.

6. **Monitoring of engagement with initiatives by gender.** A new EQIA Toolkit was introduced in April 2023 which provides support to managers in systematically identifying whether initiatives may have an adverse impact on any protected characteristic, including Gender. Alongside this, we are developing an annual Employee Relations report for NHS Wales which will measure representation within standard HR processes in light of protected characteristics. This is being developed during 2023-24 with the first formal report due in April 2024

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WELSH LANGUAGE ANNUAL REPORT

DATE OF MEETING	13TH July 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	JO WILLIAMS WELSH LANGUAGE MANAGER
PRESENTED BY	SARAH MORLEY
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This is the Trust Welsh Language Annual Report detailing the 22/23 activity and compliance with the Welsh Language Standards
RECOMMENDATION / ACTIONS	Endorse for Board approval

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	29.06.2023
Welsh Language Development Group	12/7/23 DUE TO CANCELLATION OF JUNE MEETING
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Report previously accepted as part of the Trust wide Performance report section of Trust Annual Report	

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

APPENDICES	
N/A	

1. SITUATION

The report outlines the Trust's activity relating to the provision of Welsh Language services for patients and donors.

2. ASSESSMENT

An assessment of the previous year's activities relating the Welsh Language has been undertaken.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Please note the positive divisional group actions and the work noted on the Active offer.

4. IMPACT ASSESSMENT

No specific impact assessment needed on this performance report, however, impact of bilingual provision is continuously monitored.

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*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
	• Equitable care for patients and donors means bilingual communication to reach the best clinical outcome. • *Patient centred care means providing the care needed in the language choice of the patient without them having to request it*

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Report on previous years compliance against the Welsh Language Standards. The Standards come with their own duty and legal framework.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Financial implications only exist when a breach of compliance occurs and an official investigation results in a financial penalty.
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
	Annual report on previous activity
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?	
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	

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

Cymraeg

Adroddiad Blynyddol y Gymraeg 2022-23

Yr Iaith Gymraeg – Cydymffurfiaeth a Hyrwyddo ar draws yr Ymddiriedolaeth

The Welsh language – Compliance and Promotion across the Trust

2022-2023

Introduction

This will be the Trust's fourth annual report dedicated to the delivery, promotion and monitoring of the Welsh Language Standards. The Trust's focus is strongly embedded in the cultural promotion of the Welsh Language and within this we are committed to comply with the legal requirements of the language as a provider of services for Patients and Donors.

Our delivery of the Welsh Language Standards and the 'More than Just words...' framework continues to be the driver for us to ensure compliance and we now have strong governance processess to monitor our performance.

Last year our focus was very much around the commitment to recruitment structures and embedding an ethos of culutral understanding, and this year we continue to stregnthen this. Understanding the language needs of our workforce has driven forward simple yet effective measures to promote our services and has opened discussions with patients around the 'active offer' concept.

It is our ambition to ensure our patients and donors are aware of their Welsh Language rights and our response to this awareness becomes even more proactive. Providing bilingual services as a matter of course rather than request is our ultimate aim.

Steve Ham

Cheif Executive Officer

Highlights at a glance

- To support its working group the Welsh Blood Service have developed a specific intranet page that complements the work of the Trust. The service has its own specific requriements and felt a need to support staff visually as well as using Trust wide guidance. This has strengthened the division's understanding and enables staff to see the relevance to their work in promoting and supporting bilingual donor needs.

•Velindre Cancer Centre have increased its 'Active offer' presence. A simple visual approach has given patients the opportunity to verbalise their language needs.

Staff have reported patients identifying themselves as Welsh speakers as part of the care process and this has ensured a talored bilingual service to their care pathway.

•Increased translation investment again this year means the Trust continues to support patients and donors that need Welsh Language services

•Partnership working with other Welsh Language Managers gives an opportunity to share best practice and begin the development of a shared IT system

Welsh Language Standards compliance

Governance structure

We continue to work with our divisions to ensure a local approach to the development of the Standards. The divisional groups report frequently into the Trust wide WelshLlanguage group and information is fed directly to the Executive team and the Trust Board.

It has proved to be an extremely successful way to ensure information is shared and it informs the Trust Board of any regulatory changes that need discussion at Board level.

Our Board Welsh Language Champion continues to support and challenge our Welsh Language compliance.

The Trust is a host organisation for Health Technology Wales and NHS Wales Shared Services Partnership and they are both working diligently to support the development of the Welsh Language standards.

Training

The Trust continues to actively promote Welsh Language online training and in this reporting year eight members of staff have completed the Part 1 course. We also secured our second Foundation Welsh language course for staff but unfortunately the identified front line members were unable to complete the course.

We are reviewing our approach to training and will be running specific awareness sessions for staff from May 2023 prioritising staff that answer the telephone in line with the requirements of the Welsh Language Standards.

Staff have also been attending a Welsh Language confidence course run by HEIW and will be offered this opportunity again following a positive response. Partnership approaches to this course has proved to be extremely positive.

The newly introduced Welsh Language awareness 'more than just words...' on line course has been welcomed by the Trust and staff have embraced the course positively.

Since its introduction in December 2023 we can demonstrate a positive approach to compliance.

Welsh language awareness – More than Just words	**By February 2023 % of staff**
Corporate	50.00
Research, Development and innovation	55.10
Transforming Cancer Services	44.44
Velindre Cancer Centre	40.72
Welsh Blood Service	70.48
Velindre Organisations	50.85

Recording our staff competancy levels in ESR ensures our workforce planning considers the language needs of our services. Currently over 86% of the workforce are completing the competancy field within ESR.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|LANG|Listening/Speaking Welsh|	1571	1571	1378	87.71%
NHS|LANG|Reading Welsh|	1571	1571	1367	87.01%
NHS|LANG|Welsh Language Awareness - 3 Years|	1571	1571	803	51.11%
NHS|LANG|Writing Welsh|	1571	1571	1363	86.76%

Workforce planning

We continue to work diligently on ensuring a Trust wide compliance with the Welsh Language standards whilst promoting and suppporting the ethos of 'more than just words...'

Our Governance structure is embedded successfully and our document used to monitor compliance demonstrates a stregnthened compliance level. As a Trsut we continue to use this as a benchmark for delivery of our Welsh Language services.

As part of the Supply and Shape activity, work is currently being undertaken to gather a baseline assessment of our workforce, part of this is to assess the current capability of colleagues to speak, read and write in Welsh. The work will also consider how our workforce reflects the local population average, as well as looking at the capability levels of future colleagues (i.e., students currently enrolled on commissioned courses) this will provide a picture of the potential gap that we face as an organisation.

Working with partners we will then implement steps to reduce this gap and meet our requirements as articulated in the 'More than Just Words' action plan.'

Translation

Our increase in investment over the last two years has meant we have been able to increase our translation capacity. In 2023-24 we will be a team of three dedicted translators and utilising a Service level agreement with NWSSP.

In 2019/20 we were translating almsot 380,000 words. In 2022/23 we have translated just over 1,059,053. This is around 178% increase in the number of words translated in two years.

Job descriptions and recruitment

Translation has supported the time the Trust has given to strengthening its assessment of language needs whilst recruiting. Workforce planning is critical in order to ensure the Trust supports its patients and donors and is proactive with its recritment priorities.

This year we have focussed heavily on ensuring recruitmet managers are aware of the Welsh language recruitment process, we have invested heavily in structures to support this and the workforce team alongside the Welsh language department have now embedded the process securly.

In 2021-22 the translation team dealt with the translation of 24 job descriptions. Since the investment into a recruitment assessment process for Welsh language skills this has increased to 219 job descriptions to the beginning of March 2022-23.

Velindre University NHS Trust 2022-2023

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh language skills are desirable	157
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	5
Total Number of vacancies advertised 01/04/2022 - 31/03/2023	163

From the data we can confirm that the one post identified as essential was a front line, telephony post. The no skills necessary related to posts within a clinical laboritory service with no patient or donor contact.

Contractual obligations at Velindre Cancer Centre

Integrating our bilingual obligations into all that we do is essential to 'normalise' the use of the langauge and an understanding of our commitment to the development and promotion of the Welsh language Standards. As such, as we plan our services we have ensured that our obligations are highlighted in all that we do.

At the Cancer centre a revision of service level agreements has encouraged us to ensure the Welsh language is considered by our suppliers as well as our internal services. A simple yet effective way to ensure our compliance and encourage discussions with providers. It highlights our expectations of the provider and supports a discussion previously not considered:

Welsh Language Obligations

The Provider warrants and undertakes that it will not discharge its obligations under the Agreement in such a way as to render the Commissioner in breach of its obligations in respect of the Welsh language including, but not limited to, the Welsh Language Act 1993, the

Government of Wales Act 1993, the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No. 7) Regulations 2018.

Clinical consultations

Our clinical consultation plan has been reviewed and a structure for assessing its actions put in place this year. The plan highlights the struggles of providing bilingual consultations for patients and donors but it also recogises the need to ensure a clear understanding of what skills are needed and where. The divisional groups have been charged with monitoring the action plan and will inform the Trust development group of concerns etc.

This year the WBS have conducted a skills audit as the first step in recognising where Welsh language skills lie. This audit will inform the next process of understanding how we can transfer the need to fit the skill especially as part of the donor collection process and the need for language communication on the front line.

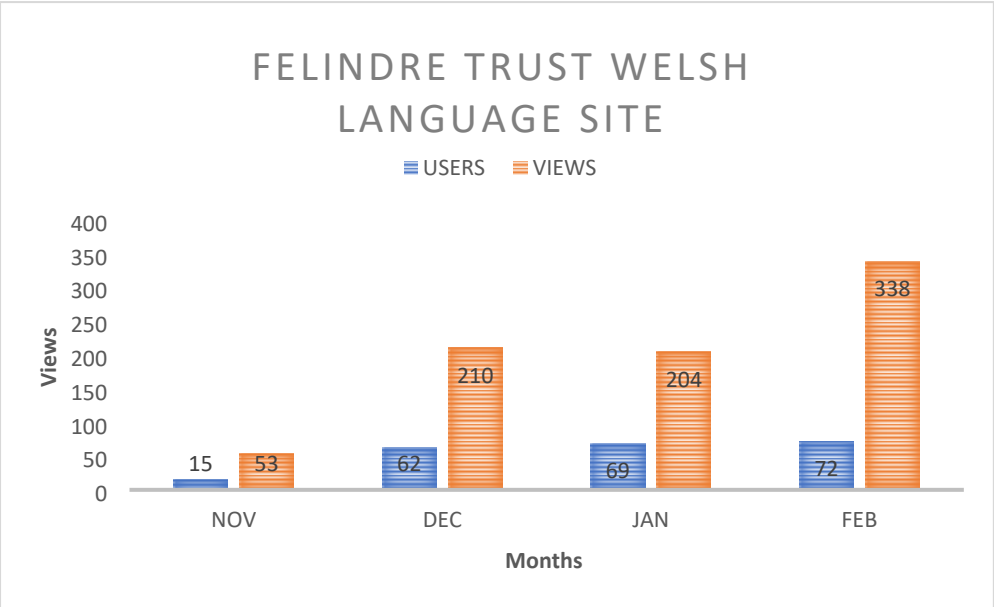
We will continue to work with the divisional groups to ensure our plan is revised and is informed by the language needs of our services.

At Velindre Cancer Centre the strengthening of the Active offer has seen three patients through the appointment system, recieving care and returning for care, in the Welsh language. With new IT systems in place and a commitment from the department to the Active offer, it has enabled the department to respond to the specific needs of their patients.

Website

The new Trust website has been embedded and from November 2022 we ar now able to monitor the Welsh language interest in our information.

English: https://velindre.nhs.wales/	Welsh: https://felindre.gig.cymru/
November 2.3k users 6.9k page views **December** 8.1k users 24k page views **January** 9.2k users 31k page views **February** 9.1k users 30k page views	**November** 15 users 53 page views **December** 62 users 210 page views **January** 69 users 204 page views **February** 72 users 338 page views



It is encouraging to note that there has been a 537% increase over four months in views to the Welsh language site

Telephone Communication

Perfomance indicators for the Welsh Blood Service donor contact centre from January 1 – March 16 2023

English language calls: 9,716

Welsh language calls: 366

Welsh language calls work out as around 4% of the calls.

Calls to Velindre Cancer Centre and the Trust headquaters are not measured, however specific actions for staff directly working on the telephone have been communciated. A specific question and answer session was also held to ensure staff understood their duties.

Promotion

We continue to highlight important events in the Welsh language calendar. This means an additional opportunity for staff to engage with the culture of Wales as well as the language.

This year the Trust has participated in a number of awareness raising days including St David's Day, Santes Dwynwen, Shw'mae day and 'mae gen ti hawl'.

Information on these events runs alongside our regular communication where we promote Welsh language traning, on line and face to face.

Our social media accounts have been incredibly busy this year with both divisions taking part in events. We are now offering bilingual approaches to all our promotional videos.

This year we were also fortunate enough to showcase our commitment to Welsh Culture at the HPMA (Healthcare People Management Association) Conference. This is a high profile event and Welsh culture was celebrated in a day long conference with Velindre University NHS Trust showcasing it's commitment.

Concerns and Complaints

The Trust welcomes feed back on its services. Concerns or complaints are used to ensure we continue to understand the needs of our patients and donors. Welsh language users are becoming increasingly aware of their rights to use the language and it is our duty to ensure we can provide those services to the best of our ability. This year we have recieved four official complaints and one formal investigation.

The formal investigation focussed on the Trust's ability to answer the telephone bilingually and to continue a discussion in the Welsh language. The investigation has not been

concluded however the Trust has been proactive and will be providing direct trainig on raising confidenceá to those answering the telephone.

Overall the Trust's concerns and complaints around the provision of Welsh language services are small, however, we are aware of the need to continuously monitor our provision and have this year updated our Concerns policy to reflect Welsh language provision.

NHS Wales Shared Services Partnership
Welsh Language Review Highlights 2022/23

The Welsh Language Unit at NHS Wales Shared Services Partnership has continued to support NWSSP divisions and services with advice on compliance and service delivery to our customers through the medium of Welsh and have supported the organisation and other NHS Organisations with translation support during 2022/23. The demand for translation services continues to grow, and this year we've translated even more words that in 2021/22. In 2022/23 NWSSP has translated a total of over 5.2million words for the following organisations:

- NHS Wales Shared Services Partnership
- Velindre University NHS Trust
- Public Health Wales NHS Trust
- Digital Health Care Wales
- Health Education Improvement Wales
- Wales Ambulance Service Trust
- Value in Health Care
- WHSSC

Compliance with Standard 106A
NHS Wales Shared Services categorises vacant or newly created posts as either Welsh essential or Welsh desirable, and we have introduced a matrix to determine which skill category is most relevant to each vacancy.
We have devised a protocol and a system whereby all advertisements are translated and published on the TRAC recruitment system and NHS Jobs in both Welsh and English since June 2022. We regularly review the system to capture any issues that arise in the creating vacancy advert process.

Easy-read Patient Information Leaflets
During the year, we've undertaken a full review of existing easy-read leaflets and new leaflets and have ensured that the translation of these leaflets are suitable for the audience for which they are intended.

Student Awards System
We reviewed the old system to ensure that the user journey was entirely through the medium of Welsh. During 2022/23 we have commissioned a new developer and a new Student Awards System, whereby the interface for students will be available through the

medium of Welsh as well as any mail tips, correspondence and messages that are generated by the system. This work will continue into 2023/24.

Workforce Reporting System
This site provides a Web Portal for Primary Care Data accessible to GP practice staff, Clusters and Health Boards of NHS Wales and other approved stakeholder organisations. This site is only available to registered users. However, we have ensured that the system is bilingual.

Duty of Candour Public Video
We have supported the production of an animated video for the public in Wales about the duty of candour in collaboration with Welsh Government.
The video is available in both Welsh and English.

Counter Fraud Awareness Course and App
The Counter Fraud Awareness Course for all Wales NHS Staff is available in Welsh, as is the application for NHS Staff to report fraud or suspicion of fraud in NHS Wales.

All Wales GDPR Awareness Course
We have been supporting the production of the All Wales GDPR Awareness Course through the medium of Welsh and this will be available to launch in 2023/24.

All Wales Occupational Health System for NHS Wales Staff
The specification in the tender process for this system has included detailed requirements for the system interface and any correspondence/messages and mail tips to be available through the medium of Welsh as well as English. Further work on this system will continue in 2023/24.

Assessment of compliance across our services
Following on from the pandemic, we have re-introduced annual local assessments across our services in order to identify areas of best practice, identify areas of risk. Local improvement and action plans are established in order to strengthen our Welsh language services offer across all NWSSP services and programmes.

A copy of the full Annual Report for NWSSP can be found on our website:
Welsh Language Standards - NHS Wales Shared Services Partnership

Moving forward

Cultural change continues to be high on our priorities. Without a deeper understanding of the need for bilingual services we will continue to enhance a provision that does not have strong foundations, relying heavily on the willingness of supportive staff.

The Trust induction programme is being updated and will again include the importance of the Welsh language, sitting alongside other areas such as Equality and Diversity and the Future Generations Act. Our commitment to these areas are as important to us as our clinical requirements as we know how important they are to our patients and donors. Communication is key to safe care.

The Cultural plan will be revised and a refreshed action plan drawn highlighting opportunities for staff to familiarise themselves with the language and opportunities to learn. We will also be connecting this to the 'more than just words...' framework as our actions relate positivily to the aims of the framework.

Our recruitment and workforce planning will also play a key role. Planning with our community needs in mind ensures a targeted approach to recruitment. With this in mind our recruitment process will be supported by strong monitoring to ensure the Welsh language skills needed are highlighted correctly. This continues to be challenging for us as the nature of our services calls upon a small pool of clinical specialisms but we are commited to this agenda.

ANNUAL REPORT 2022/23

START >

Technoleg Iechyd Cymru
Health Technology Wales

Mae'r ddogfen hon hefyd ar gael yn Gymraeg
This document is available in Welsh

CONTENTS

Our partners:

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

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

FOREWORD

Welcome to the Health Technology Wales (HTW) Annual Report which describes the work that we have done during 2022-23 to improve health and social care in Wales.

This has been another successful year during which we have balanced our commitments to selecting, appraising and promoting the adoption of novel evidence-based non-drug technologies in Wales and continuing to work as a collaborating partner in the Wales COVID-19 Evidence Centre (WCEC).

During 2022-23, we considered more than 150 new topic referrals and published 10 new HTW guidance documents, as well as 71 new Topic Exploration Reports. Since 2017, HTW has published 33 pieces of guidance and it is estimated that, if implemented, these have the potential to positively impact on the health and care of 367,730 individuals each year in Wales. The identification of impactful topics for appraisal was supported in 2022-23 by the undertaking of topic calls relating to social care, digital technologies and cancer services.

An important remit of HTW is to promote and audit the adoption of HTW and National Insititute for Health and Care Excellence (NICE) medical technology guidance in Wales. As a result of collaborative work with our partners in local and specialist health boards, HTW published its first audit report in 2022-23. This pilot project confirmed the feasibility of the adoption audit exercise and identified a high level of awareness of HTW guidance and adoption. It also highlighted barriers to the adoption of HTW guidance to help inform future decision-making. This adoption audit exercise will now be completed annually and will be extended to include social care guidance adoption.

In November 2022, HTW celebrated its 5th anniversary with a celebratory event where we reflected on the impact and value of the work of HTW in Wales. The 5th anniversary also provided the opportunity to externally commission a report into the work of HTW undertaken by the Independent Healthtech Consultant, Mark Campbell.

This report concluded that 'HTW is a distinct trusted and valued part of the innovation landscape in Wales and that it strongly and demonstrably fulfils its core functions'.

Engaging with local, national and international stakeholders remained a cornerstone of the success of HTW during 2022-23. Local engagement through the HTW Stakeholder Forum helped to guide the work of HTW to ensure that it continues to be of greatest value to the communities it serves. We have continued to work closely with colleagues in Social Care Wales in undertaking the targeted social care topic call and in working on the appraisal of two further social care topics. We have continued to build on already established links with the life sciences industry through the work of our Industry User Group and our collaboration with the Life Sciences Hub Wales. We have strengthened our commitment to establishing innovative approaches to Patient and Public Involvement (PPI) in all aspects of our work. Meanwhile, we continue to work in partnership with international partners and this year joined forces with six health technology assessment (HTA) bodies from across three continents, to collaborate on topics that will benefit people accessing healthcare worldwide.

During 2022-23, HTW successfully delivered the objectives outlined in the Strategic Plan published in 2021 and continued to develop its vision to become a world class HTA organisation. We hope that you enjoy reading this annual report and we look forward to continuing to work with you in realising our vision.

Professor Peter Groves
Chair
Health Technology Wales

Dr Susan Myles
Director
Health Technology Wales

STRATEGIC PLAN 2021-2025

The HTW Strategic Plan 2021-2025 sets out the organisation's immediate, medium and long-term strategic goals and objectives.

VISION To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health and care technologies that offer most promise to deliver improved health and care outcomes and value for the people of Wales.

MISSION To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies in Wales.

> "The unprecedented challenges health and care services currently face mean that we need to create more innovative solutions that ensure Welsh citizens receive the best care possible, through evidence based technologies.
>
> Health Technology Wales continues to work closely with partners across Welsh health boards, specialist trusts and the social care system to ensure that its work is aligned with their key challenges.
>
> I will continue to support the work of Health Technology Wales, to ensure the adoption of their national guidance results in the greatest value for citizens in Wales.
>
> *Judith Paget CBE, Director General of Health and Social Services and NHS Wales Chief Executive*"

Key achievements in delivering our 2022/23 priority objectives are set out below.

Expand HTW's topic identification, prioritisation and selection efforts

- Ran an internal workshop to identify potential new routes for topic identification
- Launched two topic call campaigns: one in social care and one in digital
- Identified a number of potential topics from NICE IPG publications

Significantly increase HTW's evidence appraisal and guidance output

- 10 pieces of guidance published during this reporting period
- 11 Evidence Appraisal Reports (EARs) published during this reporting period

Target digital care innovations for appraisal

- Task and finish group set up to inform development of assessment methods for digital technologies and support the digital topic call
- Digital Solutions for Health and Social Care event held in partnership with Life Sciences Hub Wales, Digital Health and Care Wales and Digital Health Ecosystem Wales

Support time-critical COVID-19 care and policy decision making

- Continued to deliver rapid evidence reviews for the Wales COVID-19 Evidence Centre

Ensure continuous improvement in HTW appraisal methods and compliance with best international practice

- Ongoing collaboration with other HTA bodies to share best practice including new partnership agreement with six international HTA bodies

FIVE-YEAR REVIEW HIGHLIGHTS STRONG PROGRESS

In January 2023 we announced the publication of our Five-Year Review which highlighted the strong progress made by the organisation since 2017.

Mark Campbell, an Independent HealthTech Consultant, carried out the review in October and November 2022.

The aims of the review included assessing:

- Progress against recommendations made in the 2014 Welsh Government inquiry into Access to Medical Technologies in Wales
- HTW's objectives as set out in the Strategic Plan
- Progress since HTW's Three-Year Review

Other areas for review included:

- The quality of HTW's appraisal function
- Contributions to the COVID-19 response in Wales
- Key contributions HTW can offer to the forthcoming Welsh Government Innovation Strategy for Wales
- HTW's capacity and capability in terms of staffing and leadership

Overall, the review concluded that HTW strongly and demonstrably fulfils its core functions and that it has achieved bold and ambitious growth since 2020, remaining a high functioning unit. Stakeholders within and outside Wales who work with HTW see it as a well governed organisation and recognise and value its expertise in the identification, appraisal and adoption of health and care technologies.

Key findings on notable developments since the Three-Year Review in 2020 included:

- Significant contribution to the COVID-19 response in Wales
- The development of a strong Strategic Plan
- Completion of a Pilot Adoption Audit
- Innovative work on evaluating social care technologies

The report also made suggestions for future development that could be achieved with strong stakeholder support. These included:

- Further work to consolidate HTW's profile, including raising awareness of the complementary roles of HTW and NICE
- Aligning topic calls with system priorities
- Enhancing work on topic co-ordination with other HTA agencies to further increase the number of recommended technologies
- Opportunities arising from the Innovation Strategy for Wales

A FULL COPY OF THE HTW FIVE-YEAR REVIEW CAN BE READ HERE

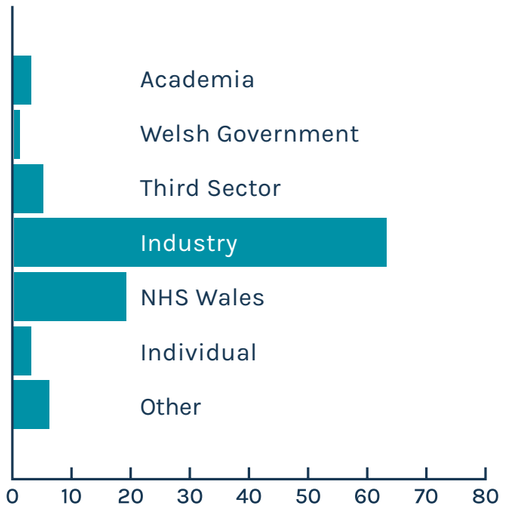
> "Health Technology Wales is a distinct, trusted and valued part of the innovation landscape in Wales and has achieved bold and ambitious growth since being established in 2017.
>
> The challenges it faces are common to HTW agencies evaluating health technologies, but its Wales focus and closeness to health and care stakeholders are highly positive predictors of future success.
>
> *Mark Campbell, Independent HealthTech Consultant*"

DRIVING HEALTH CARE INNOVATION

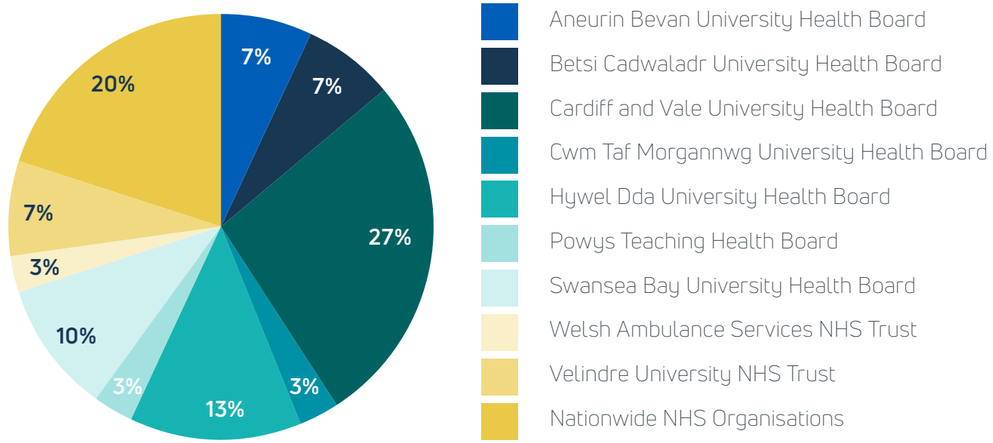
155
Topics proposed to HTW in 2022/23

463
Topics proposed to HTW since 2017

Source of topic referrals in 2022/23



Breakdown of topics referred from the NHS in 2022/23



NHS INNOVATION SERVICE

The new NHS Innovation Service is delivered by the NHS Accelerated Access Collaborative and aims to make it easier and faster for innovators to take their health care innovation from idea to adoption in UK health and care systems.

It provides a single online platform for innovators to submit and develop their ideas in collaboration with partners who have the experience necessary to develop and support widespread adoption of healthcare innovations.

HTW's research team regularly reviews the NHS Innovation Service, enabling HTW to identify technologies, engage with technology developers, and begin the HTW appraisal process. The Innovation Service also enables HTW to view the decisions of other data accessors, such as NICE (The National Institute for Health and Care Excellence) and SHTG (Scottish Health Technologies Group), to maximise collaboration and minimise duplication.

SOCIAL CARE TOPIC CALL 2022

At the start of 2022, HTW joined forces with Social Care Wales to launch a search for ideas that could transform social care in Wales.

The Social Care Topic Call aimed to encourage clinicians, social care practitioners, academics, manufactures and care service users and their families to suggest ideas for technologies and models of care and support that could benefit those using social care.

Following the Social Care Topic Call, HTW went on to produce Topic Exploration Reports on the following topics:

- Intensive Family Preservation Services
- Video Feedback Interventions
- Digital platform to support older people at home
- Passive monitoring technologies to support the independence of older adults living alone
- Bed monitoring and alarm systems in care homes

The following social care topics were progressed to full appraisal:

- Intensive Family Preservation Services
- Video Feedback Interventions

> “Working with Health Technology Wales on the Social Care Topic Call has really helped to engage a social care audience with health technology assessment in Wales. The collaborative approach has really helped to make the topic call a success and we look forward to seeing how the assessments from the topic call will be used to inform social care practice.
>
> *Sarah McCarty, Director of Improvement and Development, Social Care Wales* ”

DIGITAL TOPIC CALL 2022

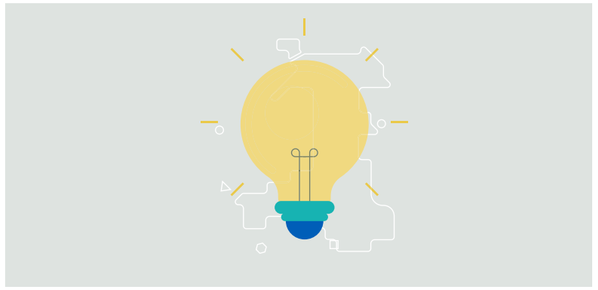
An appeal was launched in July 2022 for digital solutions to solve health and social care challenges in Wales.

The HTW Digital Topic Call invited suggestions of digital health technologies including apps, programmes and software for use in the health or care system.

A Digital Task and Finish Group was formed to plan the topic call, which included partners from Welsh Government, NHS Wales health boards and trusts, academia and partner organisations.

Following the Digital Topic Call, Topic Exploration Reports were prepared on the following topics:

- Clinical decision support software support during emergency telephone triage
- Virtual wards
- Electronic prescribing and medicines administration systems



> “We have already seen how digital technology can revolutionise care and improve quality of life for people across Wales, allowing those with health conditions or social care needs to live independently for longer within their community. This Digital Topic Call provides an exciting opportunity to identify innovative new technology with the potential to directly benefit patients or those receiving social care in Wales.
>
> *Eluned Morgan, Minister for Health and Social Services*”

APPRAISAL

12 Topics progressed to evidence appraisals in 2022/23

10 Pieces of HTW guidance published in 2022/23

33 Pieces of HTW guidance published since 2017

Find out more

Would you like to find out more about the Health Technology Wales topic appraisal process? To raise awareness about how the process works we have created an animated video: https://www.youtube.com/watch?v=38OuhQp0S04&t=5s

GET INVOLVED

Do you know about a technology or model of care and support in health or social care that Health Technology Wales could appraise?

Anyone can suggest a topic and we are keen to receive suggestions from people with a wide range of backgrounds, including the general public.

To suggest a topic complete our online form here.

Deputy Chair appointed for HTW Appraisal Panel

We are pleased to announce the appointment of a Deputy Chair for the Health Technology Wales Appraisal Panel (AP).

Dr Andrew Champion, Assistant Director, Evidence Evaluation and Effectiveness at the Welsh Health Specialised Services Committee (WHSSC), has been appointed to the role.

As an existing member of the AP, Dr Champion already has an in-depth understanding of HTW's work. He has worked in the NHS for almost 30 years covering a range of research and managerial roles and has a strong interest in evidence-based medicine.

Find out more here.

OUR GUIDANCE

We evaluate the best available evidence to determine the effectiveness and cost effectiveness of health and social care technologies. Based on the evidence and the input of experts, we produce national guidance. HTW guidance summarises the key evidence and implications for care services in Wales. The table below details the topics that have been through our appraisal process and received HTW guidance in 2022/23. The guidance recommendation is summarised below, however please click on the hyperlinks to read the guidance in full.

FEBRUARY 2022 | TRANSCRANIAL MAGNETIC STIMULATION

Further research is recommended to better determine the case for cost effectiveness, to establish the long-term efficacy of repetitive transcranial magnetic stimulation (rTMS) including potential maintenance therapy, and to determine the appropriate placement of rTMS in the NHS Wales treatment pathway. The use of rTMS for the treatment of treatment-resistant major depression is partially supported by evidence.

MAY 2022 | EXTREME HYPOFRACTIONATED RADIOTHERAPY (EHFRT)

The evidence supports the routine adoption of EHFRT to treat localised prostate cancer. EHFRT is associated with equivalent short and medium-term cancer recurrence and survival outcomes compared with standard care.

MAY 2022 | ELECTRONIC BLOOD MANAGEMENT SYSTEMS (EMBS)

The evidence supports the routine adoption of EBMS to support blood transfusions. Compared with paper-based systems, EBMS reduces rates of sample rejection and blood wastage.

MAY 2022 | VIDEO LARYNGOSCOPES

The routine adoption of video laryngoscopy for people who require intubation in a pre-hospital setting is not supported by the evidence. The use of video laryngoscopy does not improve overall intubation success rates and there is no evidence to suggest improved clinical outcomes as compared with direct laryngoscopy.

JUNE 2022 | STEREOTACTIC ABLATIVE RADIOTHERAPY (SABR)

The evidence supports the routine adoption of SABR to treat people with primary kidney cancer who are not suitable for surgery or other ablative techniques. The use of SABR provides a treatment option that may improve survival in patients who would otherwise have no other treatment options available.

OUR GUIDANCE

JULY 2022 | OUTPATIENT LARYNGEAL BIOPSY

The evidence supports the adoption of pharyngolaryngeal biopsy under local anaesthesia to confirm, but not to rule out, a diagnosis of head and neck cancer. The procedure can be done in an outpatient setting and avoids the need for inpatient care and general anaesthesia.

OCTOBER 2022 | LEFT ATRIAL APPENDAGE OCCLUSION (LAAO) IN PATIENTS WITH ATRIAL FIBRILLATION

The evidence does not support the routine adoption of LAAO in adults with non-valvular atrial fibrillation who have contraindications to oral anticoagulation.

NOVEMBER 2022 | CONTINUOUS TOPICAL OXYGEN THERAPY

The evidence supports the routine adoption of continuous topical oxygen therapy to treat patients with chronic non-healing and complex diabetic foot ulcers.

DECEMBER 2022 | VIRTUAL REALITY DISTRACTION THERAPY

The evidence partially supports the adoption of virtual reality interventions for the management of pain and anxiety in adults and children undergoing medical procedures but the evidence is insufficient to support routine adoption.

MARCH 2023 | PHOTOBIOMODULATION

Photobiomodulation for the prevention or treatment of oral mucositis in people receiving cancer treatment shows promise, but the evidence is insufficient to support routine adoption. The use of low-level laser photobiomodulation reduces the incidence of oral mucositis compared to sham or standard care but there is limited evidence on the clinical effectiveness of light-emitting diode (LED) photobiomodulation.

GUIDANCE IMPACT

463
Topics proposed to HTW since 2017

56
Topics progressed to evidence appraisal

33
Pieces of guidance published

OUR RECOMMENDATIONS

Our national guidance recommendations fall into three main categories:

Routine adoption:

The evidence supports the adoption of that technology for a general population.

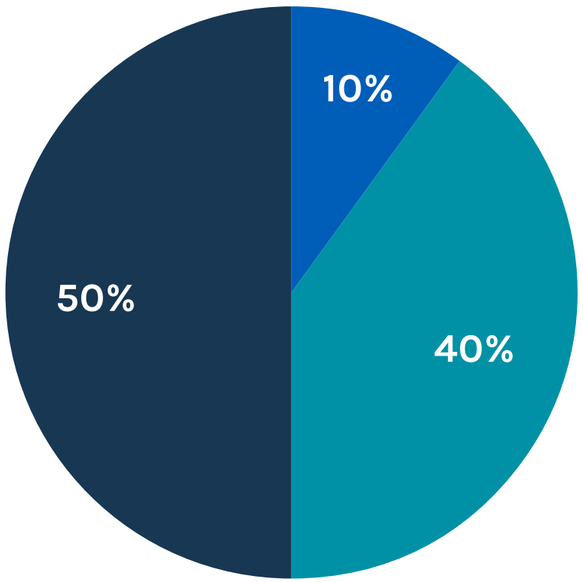
Selective adoption:

The evidence supports the adoption of that technology in a specific subset of the general population.

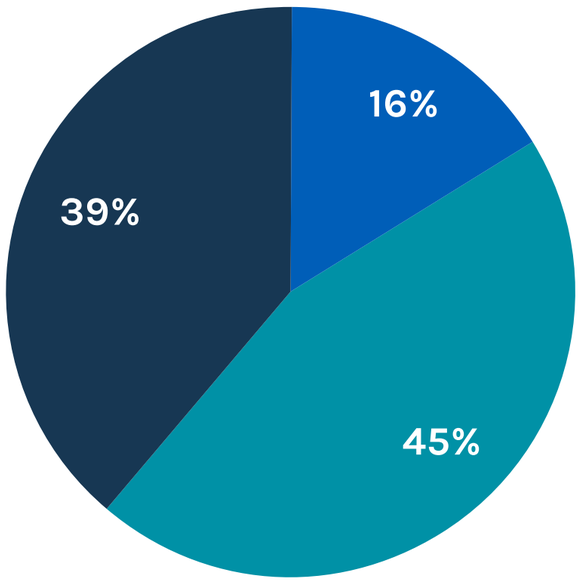
Insufficient evidence to support adoption:

There is not enough evidence to support the adoption of that technology.

2022/23



2017-2023



APPRAISAL CASE STUDY

EXTREME HYPOFRACTIONATED RADIOTHERAPY

What did we do?

Health Technology Wales appraised the evidence and produced guidance recommending the routine adoption of extreme hypofractionated radiotherapy (EHFRT) to treat localised prostate cancer. EHFRT is an adaptation to conventional external beam radiotherapy and delivers the equivalent dose of radiotherapy in fewer sessions or fractions. EHFRT uses five or seven fractions over two weeks whereas standard radiotherapy treatment (moderately fractionated radiotherapy) usually uses 20 fractions over 4 weeks. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report (EAR), and issued HTW guidance in February 2022.

Who with?

During the appraisal HTW worked closely with stakeholders including, consultant oncologists, radiotherapists and urologists from Velindre Cancer Centre, the South West Wales Cancer Centre (SWWCC) and various health boards.

What were the reactions?

The SWWCC Radiotherapy Lead, Dr Russell Banner, reported that the evidence appraisal and guidance were extremely useful: *"Very impressed by the responsiveness to clinical needs in my interactions."*

What did people learn?

EHFRT is associated with equivalent short- and medium-term cancer recurrence and survival outcomes compared with standard care (moderately or conventionally fractionated radiotherapy). EHFRT reduces the number of visits required for treatment and is associated with a low incidence of adverse events.

EHFRT is likely to be cost effective when compared with standard care. Dr Banner felt HTW's work provided: *"clear guidance on cost effectiveness"* that would *"support business case implementation"*.

What difference has this made?

Dr Banner said he felt HTW's guidance would have a '*major positive impact*' leading to *"less treatment sessions for patients, and increased radiotherapy machine capacity for the Cancer Centre"*

The experience has led SWWCC to make further referrals of topics for consideration by HTW.

> "(HTW's appraisal) was extremely helpful as an independent appraisal to provide guidance and support to discussions regarding bringing the technique into routine NHS use.
>
> *Michael Stone, Costing and Service Improvement Accountant, Velindre University NHS Trust*"

APPRAISAL CASE STUDY

STEREOTACTIC ABLATIVE RADIOTHERAPY FOR PRIMARY KIDNEY CANCER

What did we do?

This topic was proposed by a consultant oncologist for appraisal by HTW. The topic considered stereotactic ablative radiotherapy (SABR) for the treatment of people with primary kidney cancer. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report (EAR), and issued HTW guidance in April 2022.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from numerous consultant oncologists from around the UK, a radiographer, and a representative from Varian, the manufacturer of a SABR device.

What did we learn?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of SABR to treat people with primary kidney cancer who are not suitable for surgery or other ablative techniques.

What difference has this made?

SABR provides a treatment option that may improve survival in patients who would otherwise have no other treatment options available. Economic modelling estimates that use of SABR is cost effective when compared with clinical surveillance, with a cost per quality-adjusted life year (QALY) of £1,675.

What were the reactions?

Dr Tom Rackley, a consultant at the Velindre Cancer Centre who provided expert clinical input during the appraisal process, said he found the EAR report on SABR "*extremely useful*" and that HTW "*presented the evidence in a succinct way*".

He went on to say that the EAR and guidance would have a "major positive impact" on the wider health and social care context in Wales.

APPRAISAL CASE STUDY

ELECTRONIC BLOOD MANAGEMENT SYSTEMS

What did we do?

Health Technology Wales appraised the evidence and produced guidance recommending the adoption of electronic blood management systems (EBMS) to support blood transfusions. EBMS is a digital technology which use barcodes to verify that blood is matched with the correct patient. EBMS aim to reduce errors during transfusion compared with the existing paper-based system. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report (EAR), and issued HTW guidance in March 2022.

Who with?

During the appraisal HTW worked with industry representatives, academics, the Welsh Blood Service, Digital Health and Care Wales, transfusion practitioners and Welsh Government, who are working with NHS Wales to explore the feasibility of implementing EBMS across Wales.

What were the reactions?

The Blood Health Team Lead at the Welsh Blood Service and a transfusion practitioner at Cardiff and Vale UHB each reported that HTW's work was extremely useful.

"We were aware of how beneficial it would be in practice but needed the validated evidence of non-users to push this project forward."

"I thoroughly enjoyed my involvement in the process, which was very well organised and clearly explained."

What did people learn?

We used the NICE Evidence Standards Framework (ESF) for Digital Health Technologies to guide expectations around the evidence that should be taken into account in the assessment. We developed a cost analysis which demonstrated that EBMS could be cost saving compared with a paper-based system.

The Blood Health Team Lead at the Welsh Blood Service cited *"the importance of clear evidence-based decisions and the need to present data in an accessible format for a range of professionals to understand".*

What difference has this made?

A transfusion practitioner reported that the Evidence Appraisal Report and guidance, published in May 2022, *"...are being used to support a business case for the procurement of an electronic blood management system".*

Stakeholders report that the work has had a major positive impact.

> "I was very pleased to be invited to be involved in this appraisal given my team's experience in demonstrating the value of the development and implementation of end-to-end electronic transfusion systems in Oxford. I found the process to be thorough, and the work with the team to be enjoyable and stimulating. I hope that the appraisal will encourage the wide adoption of electronic transfusion systems in Wales to ensure that patients are transfused safely and appropriately.
>
> *Mike Murphy, Professor of Blood Transfusion Medicine, University of Oxford*

> "We found the process easy to follow. The reports provided following the evaluation are being used to support a business case for the procurement of an electronic blood management system.
>
> *Samantha McWilliam, Transfusion Practitioner, Cardiff and Value UHB*

APPRAISAL CASE STUDY

CONTINUOUS TOPICAL OXYGEN THERAPY TO TREAT PEOPLE WITH DIABETIC FOOT ULCERS

What did we do?

We used the Innovation Service to identify this topic proposed by a technology developer for appraisal by HTW. The topic considered continuous topical oxygen therapy to treat people with chronic non-healing and complex diabetic foot ulcers. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report, and issued HTW guidance in September 2022.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from the Welsh Wound Innovation Centre, an orthopaedic surgeon, a health economist, and a representative from NATROX® Wound Care, the manufacturer of NATROX®.

What difference has this made?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of continuous topical oxygen therapy to treat people with chronic non-healing and complex diabetic foot ulcers.

What did we learn?

Continuous topical oxygen therapy, in addition to standard of care, could increase the number of wounds with complete wound healing, reduce wound area and time to healing and generate potential cost savings.

> “Our technology, NATROX®, has been part of the HTW appraisal process since November 2019, and throughout that time has been selected as a topic of interest and ultimately received HTW guidance in 2022. I have found the process professional and thorough, and the team have been supportive and easy to work with. As a result, the outputs from the appraisal are informative and well-researched and reflect our technology and the clinical landscape very well.
>
> *Nick Howard, Director of Strategy, NATROX® Wound Care* ”

HTW ADOPTION AUDIT 2022

Adoption of HTW guidance in health boards, trusts and social care settings pan-Wales is key to ensuring that there is access to evidence-based technologies and models of care and support. This ensures that the anticipated benefits are realised for people in Wales.

What did we do?

In 2022, we submitted our first annual Adoption Audit report to the Minister for Health and Social Services in Wales.

As part of establishing the processes for the audit, HTW supported the procurement of specialised audit and monitoring software, Audit Management and Tracking (AMaT), across the health boards, to facilitate a standardised and efficient approach.

Following the success of the pilot, we undertook the second adoption audit at the end of 2022. The remit of this work was expanded to cover NICE Medical Technologies Guidance.

Who with?

The audits were undertaken in close collaboration with health boards and national specialist trusts across Wales, who co-produced flexible, streamlined processes to underpin dissemination and monitoring of the uptake of HTW and NICE guidance. This process was supported at a strategic level by the All-Wales Medical Directors, and the NHS Wales Chief Executives. Judith Paget CBE, NHS Wales Chief Executive and Director General for Health and Social Services also wrote to Local Health Boards supporting the audit.

What did we learn?

"This exercise has not only provided us with an important insight into the impact of our work but it has also identified correctable barriers to adoption within the healthcare system and has enabled us to refine our audit process for future projects." – Professor Peter Groves, Chairman of Health Technology Wales.

Key findings from the audit included:

- Awareness of HTW guidance is high and clarity of HTW guidance recommendations is considered good.
- Where HTW guidance had not yet been adopted or adoption was not planned, difficulty in securing funding was not reported as a factor. Barriers to adoption included difficulties in implementing technologies for small patient populations, the need for internal prioritisation by other bodies, the requirement for national approaches to support coordinated technology adoption and a lack of buy-in by relevant clinical teams.
- In most cases, national guidance published by HTW is having an impact.

What were the reactions?

Dafydd Evans, Deputy Director Life Sciences and Innovation, Welsh Government, said:

"Health Technology Wales continues to demonstrate its value in supporting better outcomes for the citizens of Wales through its recognised guidance on technology that should be adopted and increasing role in evaluating the uptake of this guidance."

What difference has this made?

The HTW adoption audits are already informing wider healthcare policy and commissioning discussions, with findings being discussed in arenas such as the NHS Wales Leadership Board.

The use of standardised audit software across health boards has led to the establishment of an all-Wales user group, which facilitates information sharing and continuous improvement.

An agreed process to monitor routine consideration, uptake, (de)commissioning and implementation of evidence-based guidance is a critical step in ensuring the routine and equitable adoption of and access to clinical and cost-effective care technologies. In developing our work, we identified that very few countries internationally have these systems established. The HTW adoption audit places Wales in the vanguard of these efforts both across the United Kingdom and internationally.

PATIENT AND PUBLIC INVOLVEMENT (PPI) IN 2022/23

The Patient and Public Involvement (PPI) Standing Group provides direction and guidance to ensure that Health Technology Wales establishes and maintains effective PPI throughout its work.

Members discuss how to engage patient and public involvement (PPI) groups to ensure these experiences are a key part of HTW's assessment and appraisal processes.

Over the last year we have continued to ensure that PPI forms a core part of our appraisal process and have proactively found solutions to engage PPI for topics within new areas such as social care and digital technologies.

We have worked collaboratively with patient and voluntary organisations to include their expert contributions in our topic appraisals.

In collaboration with members of our PPISG we have further developed our PPI methods and tools and created new resources, including an animation to explain how our processes work.

Meanwhile, we have worked in partnership with patient organisations to ensure their views have been considered as part of topic appraisals.

> "The PPI Standing Group is proud of the breadth of patient and public involvement that has been embedded across HTW's programme since its inception. Reflecting on key achievements from the last year, we recognise the flexible and transformative approach to capture PPI and its impact, expanding its novel and adaptive approach to topics such as social care and digital tools. Ensuring PPI is included in reassessment topics at an earlier stage in the process and developing new website animations and tools to share best practice are key highlights from the last year. These achievements should be celebrated and held up as a model of best practice for organisations internationally to benefit from the robust mechanisms for PPI engagement that have been developed.
>
> *HTW PPI Standing Group*

PPI HIGHLIGHTS

Highlights of our PPI work in 2022/23 include:

- Working collaboratively with a number of patient organisations for contributions to our appraisals
  - Direct patient feedback informed our guidance on photobiomodulation
  - Patient submissions were received for left atrial appendage occlusion (LAAO)
- Continuing to provide input to national and international groups and forums, and share good practice in PPI methods
  - Participated in the 360 HTA Europe project, in collaboration with Health Technology Assessment International (HTAi)
  - Presented on our PPI work for Freestyle Libre flash glucose monitoring at HTAi 2022 annual conference
  - Member of the International Network of Agencies for Health Technology Assessment (INAHTA) Patient Engagement Learning Group and the HTAi Patient and Citizens Involvement Group
  - Participated in a research project examining PPI at the organisational level, which was presented at the HTAi 2022 conference
  - Presented to Cardiff University researchers on best practice in PPI methods
- Adapting and refining our processes to ensure PPI is an integral part of our work
  - New processes and tools developed to ensure PPI methods are applicable to social care topics
  - Updated our process for plain language summaries in accordance with new guidance produced by the Patient Focused Medicines Group
  - Considered PPI elements in our reassessment processes
- Increasing the PPI presence on our website
  - New PPI animation outlining our work and how people can get involved
  - Publication of PPI resources online

4 **Patient submissions received**

3 **Specific patient evidence literature reviews**

HEALTH TECHNOLOGY WALES REACHES FIVE-YEAR MILESTONE

In December 2022 Health Technology Wales celebrated its 5th anniversary by holding a virtual event for stakeholders.

Eluned Morgan, Welsh Government Minister for Health and Social Services, opened the event with a keynote speech highlighting our achievements to date.

Speakers from across the health, social care and innovation sectors in Wales then gave a series of presentations covering topics ranging from HTW's role in the Wales COVID-19 Evidence Centre to our partnerships with Social Care Wales and the digital sector.

There was also a panel discussion about the HTW Pilot Adoption Audit, presentation about the HTW Five-Year Review and case studies presented on HTW appraisals that led to national guidance.

Following the event, a topic referral surgery was held giving the opportunity for delegates to meet one-to-one with a member of the HTW research team to discuss topic referral ideas.

HTW Chairman Professor Peter Groves said:

"*I am very proud that Health Technology Wales has achieved such a lot during the last five years and has grown into a mature, effective, and widely respected Health Technology Assessment organisation. I am equally excited about the future and am confident that HTW will continue to develop in influence and impact.*"

HTW Director, Dr Susan Myles, added:

"I would like to take this opportunity to thank our partners across the health and social care sectors for working in collaboration with us to achieve our shared goals of supporting the adoption of effective and cost-effective technologies that offer improved care outcomes for the people of Wales."

To mark its 5th anniversary HTW created an animation showing what it has achieved so far and what the future holds for the organisation. You can watch the animation here.

> "Over the past five years, Health Technology Wales has shown it can adapt quickly to the changing demands of the health and social care sectors.
>
> There are so many exciting opportunities ahead to identify and implement innovative health and care technologies in Wales, but it is important that we make the correct decisions in searching for the best quality and value for the people of Wales.
>
> I am confident that Health Technology Wales will continue to play a pivotal role in ensuring this.
>
> *Eluned Morgan, Minister for Health and Social Services*"

AT THE FOREFRONT OF COVID-19 RESEARCH

We were appointed as a Collaborating Partner of the £3million Wales COVID-19 Evidence Centre in March 2021 and have since conducted a series of evidence reviews and research into different COVID-19 related topics.

The centre was funded by Welsh Government through Health and Care Research Wales and hosted by Cardiff University. During the COVID-19 pandemic it played a major role in enabling key decision makers in Wales to respond to emerging evidence about COVID-19 and use this evidence to support their decision making. In 2022/23, Health Technology Wales conducted the following research on behalf of the Wales COVID-19 Evidence Centre:

- Infection prevention and control measures: "What PPE should be used in the community setting?"
- Supplementary air filtration systems in health service settings
- What is the effectiveness of financial support schemes for individuals requested to self-isolate following a positive COVID-19 test or positive contact
- Modelling studies used to evaluate the effect of population-level non-pharmaceutical interventions on the reproduction number of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
- The effect of vaccination on transmission of SARS-CoV-2 (COVID-19)
- Use of personal protective equipment in general practice and ambulance settings

HTW APPOINTED COLLABORATING PARTNER OF EVIDENCE CENTRE

We are proud to announce that we have been appointed a Collaborating Partner of the Health and Care Research Wales (HCRW) Evidence Centre which is set to conduct vital research into health and social care challenges in Wales.

As a Collaborating Partner, HTW will conduct rapid evidence reviews on behalf of the Evidence Centre. More than £7million over five years is to be invested in the centre which is funded by Welsh Government through HCRW. The centre will focus on addressing a wide range of health and social care needs with the aim of ensuring decisions about policies and services in Wales, draw on findings from the most up to date and rigorous research available. A dedicated team will work closely with leaders in Welsh Government, the NHS and social care to ensure that the Evidence Centre addresses key evidence gaps and priorities for health and social care in Wales.

Public involvement and engagement will be a core part of the Evidence Centre and PPI (Patient and Public Involvement) will be embedded into all aspects of its work. The latest information about the Health and Care Research Wales Evidence Centre can be found by signing up to the Health and Care Research Wales bulletin.

> "It's critical we understand the most effective ways to do things, what's best for public, patients, staff and what's best value for money. The evidence the new centre can provide is essential in these challenging times.
>
> *Professor Adrian Edwards, Director of the Health and Care Research Wales Evidence Centre*"

PARTNERSHIP AGREEMENTS

In 2022/23 we renewed our strategic Memoranda of Understanding (MoUs) with key partners across health and innovation sectors in Wales and the UK:

National Institute for Health and Care Excellence (NICE)

HTW and NICE undertake health technology assessment of medical technologies that have the potential to improve patient outcomes and efficiencies within care services. It is important that they work in a collaborative and complementary way and the newly signed MoU will facilitate this. Find out more about the renewed MoU between HTW and NICE here.

Welsh Health Specialised Services Committee (WHSSC)

The two organisations have worked successfully in partnership since 2017 to support the appraisal and adoption of non-medicine health technologies for health and care systems in Wales. Find out more about the MoU between WHSCC and HTW here.

Bevan Commission

HTW and the Bevan Commission began their collaboration in 2019, building on their shared goals to support innovation and maximise health and social care benefits for the people of Wales. Find out more about the MoU between HTW and the Bevan Commission here.

Celtic Connections

The Celtic Connections strategic alliance will see HTW, the Scottish Health Technology Group (SHTG) and the Health Information Quality Authority (HIQA) of Ireland continue to share knowledge and explore opportunities to work in collaboration on the appraisal of non-medicine health technologies. Find out more about the Celtic Connections MoU here.

All Wales Therapeutics and Toxicology Centre (AWTTC)

HTW and AWTTC have worked in collaboration since 2020, sharing expertise and access to networks of experts. Through the partnership they have benefited from two-way peer review and quality assurance processes to support their respective appraisal functions. Find out more here about the MoU between AWTTC and HTW here.

Life Sciences Hub Wales (LSHW)

The latest MoU agreement between HTW and LSHW will see the two organisations continue to support the development and adoption of innovative health and care technologies in Wales. Find out more about the MoU between HTW and LSHW here.

EVENT HELD TO EXPLORE DIGITAL SOLUTIONS FOR HEALTH AND SOCIAL CARE

Ahead of our 2022 Digital Topic Call we joined forces with Life Sciences Hub Wales, Digital Health Ecosystem Wales and Digital Health and Care Wales to hold an event that explored digital opportunities in health and social care.

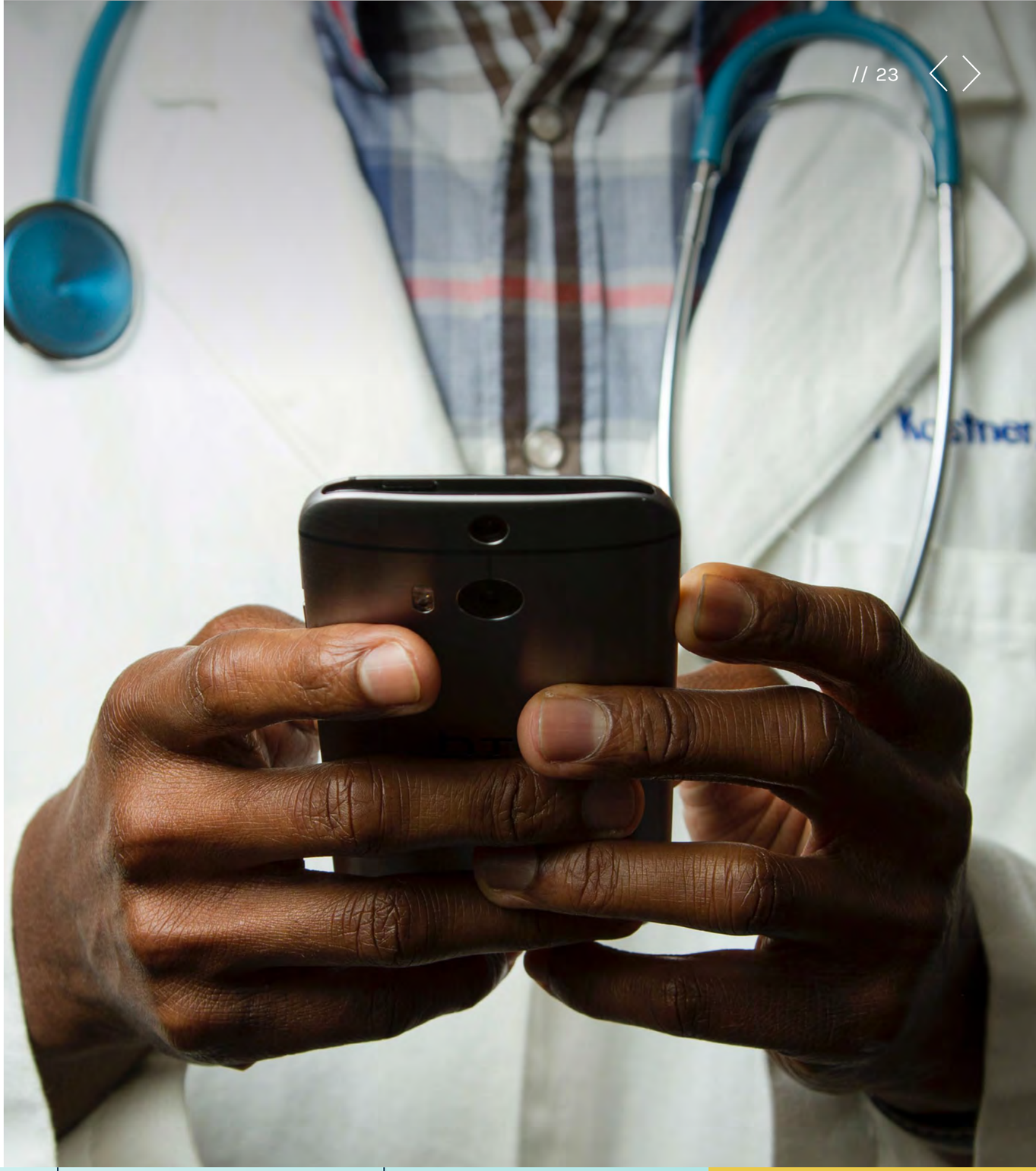
During the two-day virtual event, speakers discussed topic such as the Welsh Government's Digital Strategy, the NHS Wales App and the NICE process for evaluating digital health technologies for health and social care.

Among those taking part were Glyn Jones, Chief Digital Officer for Welsh Government, who outlined the Digital Strategy for Wales.

There were also presentations about HealthTech Connect and the Accelerated Access Collaborative Innovation Service.

Delegates took part in a Q&A session with our speakers, an interactive session on applying the NICE evidence standards for digital technologies and breakout rooms to shares ideas on ways that digital technology could support health and social care.

A recording of the event is available here.



SPREADING THE WORD ABOUT HEALTH TECHNOLOGY WALES

We participate in health, social care and innovation events through the year, taking the opportunity to spread the word about our work and engage with stakeholders.

Events we have taken part in during 2022/23 include:

IPFR Workshop 2023

Our Senior Health Economist, Sophie Hughes, presented at the annual IPFR (Individual Patient Funding Request) Workshop organised by the AWTTC (All Wales Therapeutics & Toxicology Centre).

MediWales Innovation Awards 2022

We sponsored the Social Care Innovation Through Collaboration Award at the MediWales Innovation Awards 2022. The award was won by Betsi Cadwaladr University Health Board for its collaboration with the CAHMS (Children and Adolescent Mental Health Services) team at Denbighshire County Council. Read more about the collaboration here.

Life Sciences Network Wales Congress 2023

We exhibited at the Life Sciences Network Wales Congress event, which helped raise awareness about our work among stakeholders in academia, healthcare and innovation.

MediWales members showcase 2022

The MediWales members showcase provides an opportunity to engage with the life sciences and health technology community in Wales.

MediWales Connects 2022

MediWales Connects brings together partners from across the health and care community in Wales to showcase projects and improve working partnerships.

2022/23 engagement highlights

Advisory committee meetings hosted

9	Appraisal Panels
20	Assessment Groups
5	Executive Groups
5	Industry User Groups
6	Patient and Public Involvement (PPI) Standing Groups
2	Stakeholder Forums

Events

2	Digital events

Website

42,784	Webpage views
10,985	Visitors

Social media

2,529	Followers
21,991	Profile visits
272	Mentions
829	Link clicks
1,214	Likes and retweets

INTERNATIONAL COLLABORATION

A new collaboration between HTW and health technology assessment (HTA) bodies from across three continents aims to benefit people accessing healthcare worldwide.

HTA organisations that are signatories to the agreement include:

- National Institute for Health and Care Excellence (NICE)
- Canadian Agency for Drugs and Technologies in Health (CADTH)
- Australian Government Department of Health and Aged Care
- Healthcare Improvement Scotland
- Health Technology Wales
- All Wales Therapeutics & Toxicology Centre

As part of the collaboration the partners will work together to find solutions to some of the common challenges they face. The five initial priority areas agreed by the collaboration include:

1. COVID-19

Partners will share information about their work in COVID-19, how they are working with regulators, the prioritisation of topics, planning for HTAs, and approaches to economic modelling.

2. Future-proofing of HTA systems

Partners will exchange ideas on how HTA processes could better anticipate technological and methodological challenges before they become issues for HTA and work together on scientific and methodological topics to address challenges.

3. Collaborating with regulators

Partners will explore implementing joint approaches to engaging with the regulatory agencies in the UK, Canada, and Australia to identify and progress opportunities to improve HTA and regulatory collaboration.

4. Work-sharing and efficiency gains

Partners will explore the feasibility of recognising or using each other's HTA information and explore running a pilot for a joint clinical assessment.

5. Digital and artificial intelligence

Partners will share information about developments in the evaluation of digital health technologies, including technologies that involve artificial intelligence.

Working groups, aligned to the priority areas, will meet quarterly to review progress and discuss activities in their area. An annual meeting of all partner organisations will be held to review all activities and to realign where appropriate the developing areas of collaboration. The partnership could be expanded to include other HTA bodies in the future, subject to the agreement of existing members, with the signed agreement reviewed after two years.

For more information about the partnership click here.

STRENGTHENING GLOBAL PARTNERSHIPS

Throughout the year HTW collaborates with international partners through its memberships of HTAi (Health Technology Assessment International) and INAHTA (International Network of Agencies for Health Technology Assessment).

International engagement highlights for 2022/23 include:

- HTW joined forces with international health technology assessment bodies from across three continents to collaborate on topics that will benefit people accessing healthcare internationally
- Our Director Dr Susan Myles presented at the HTAi Global Policy Forum in March 2022 and gave a presentation at the HTAi conference in Utrecht in June 2022
- Senior Health Services Researcher Dr Lauren Elston joined a panel of speakers to share HTW's approach to evaluating impact at an HTAi 2022 Annual Meeting workshop
- We welcomed a delegation of visitors from Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS) to our offices in Cardiff in January to share knowledge and insight about health technology assessment

> "We would like to take this opportunity to express our heartfelt thanks to you for your active participation in the Global Policy Forum Annual Meeting panel. Your willingness to share your time and expertise was critical to the success of this session. Engaged members like yourself are key to the society achieving goals outlined in the 2020-2025 HTAi Strategic Plan.
>
> *Dan Ollendorf, Policy Forum Team, Health Technology Assessment international (HTAi)*"

Supporting the INAHTA Members Handbook

We are proud to have been part of the Communications Task Group that helped create the International Network of Agencies for Health Technology Assessment (INAHTA) Members Handbook.

Alongside representatives from other INAHTA member organisations we supported the creation of the handbook which outlines the benefits of INAHTA membership.

SUSTAINABILITY IN HEALTHCARE

As active participants in the environmental sustainability learning group led by INAHTA (International Network of Agencies for Health Technology Assessment), HTW is involved in ongoing discussions around developing methods to assess the impact of healthcare on the environment within Health Technology Assessment (HTA) processes.

At least 8% of the global burden of disease is a direct result of the effects of environmental pollution. The World Health Organisation (WHO) estimates that between 2030 and 2050, 250,000 additional deaths per year will be attributed to climate change. However, an increased demand on healthcare is also contributing to the climate crisis, with the NHS contributing around 4% of the total UK carbon emissions.

With the NHS goal to achieve net zero on carbon emissions they control directly, it is becoming increasingly important to consider how environmental impacts could be captured in HTA. Through INAHTA's environmental sustainability learning group, HTA bodies share their experiences and expertise around incorporating environmental sustainability into their appraisals, which ensures that HTW is informed on current issues and barriers to implementation.

OUR TEAM

The work in this annual report has been delivered by the Health Technology Wales team.

Our team comprises of 26 people including health services researchers, health economists, information specialists, communication specialists, project managers and administrators.

We come from a broad range of backgrounds and skillsets and collectively have extensive experience in both the public and private sectors.

The team is supported by the invaluable contributions of our external committee members who continue to ensure our work meets the needs of the health and social care sectors in Wales.

Professor Peter Groves
Chair

Dr Susan Myles
Director

Lisa King
Senior Programme Manager

June Price
Business Operations Manager

Katie McDermott
Project Manager

Rebecca Shepherd
Project Support Manager

Alice Evans
Patient and Public Involvement Manager

Elise Hasler
Information Specialist

Jenni Washington
Information Specialist

Matthew Prettyjohns
Principal Researcher, Health Economics

Dr David Jarrom
Principal Researcher, Health Services Research

Dr Thomas Winfield
Senior Health Economist

Jessica Williams
Health Services Researcher

Dr Claire Davis
Health Services Researcher

Dr Clare England
Health Services Researcher

Leona Batten
Health Services Researcher

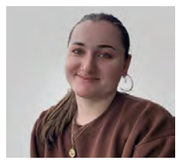
Hayley Bennet
Health Economist

Sophie Hughes
Senior Health Economist

Mafalda Gordo
Business Support and Communications Assistant

Dr Greg Hammond
Health Services Researcher

Antonia Needham
Health Services Researcher



Charlotte Bowles
Health Services Researcher

Rebecca Boyce
Health Economist

Diana Milne
Communications Manager

Llinos Jones
Welsh Language Translator

Caron Potter
Executive Assistant

Dr Lauren Elston
Senior Health Services Researcher

Gareth Hopkin
Senior Health Services Researcher

Georgia Davies
PPI Manager

BUDGET RESOURCES

HTW is successfully delivering against its Strategic Plan for 2021–2025 which sets out our immediate and medium-term strategic goals and objectives.

The Welsh Government awarded us £1.6m for 2022-2023, to fund our core work. HTW secured additional income of £145,000 to fund its work as a Collaborating Partner of the Wales COVID-19 Evidence Centre and two years of grant funding to support its involvement in an NHS Artificial Intelligence Award as part of a Technology Specific Evaluation Team (TSET).

Reporting modest underspends to date, due to recruitment delays. **On target to deliver** within budget during **FY 23/24**, once all vacancies are filled.

Supporting **23.8** full-time equivalent job roles against **25.8** planned full-time equivalent roles.

Allocating our revenue budget to approx. **80%** staff costs and **20%** non-staff costs.

A **5-year funding award** secured to act as a collaborator in the new Welsh Evidence Centre.

OUR FUTURE

Our aim is to continue to support the identification, appraisal and adoption of innovative health and social care technologies that offer most promise to deliver improved health, well-being and value for the people of Wales.

Supporting Welsh Government priorities

We are committed to ensuring that our work supports Welsh Government health and social care priorities. These include the six Ministerial Priorities announced by Judith Paget CBE, Director General of Health and Social Services and Chief Executive of NHS Wales which include:

- A closer relationship between the NHS and local government to tackle delayed transfer of care and deliver an integrated community care service for Wales
- Improving access to general practice, dentistry, optometry and pharmacy
- The effective management of people with urgent care needs in the community
- Supporting cancer services to reduce the backlog on the cancer pathway
- Improvements across mental health and child and adolescent mental health services
- Supporting the National Recovery Programme which will set specific requirements for health boards

HTW is also set to play a key role in the Innovation Strategy for Wales which sets out how Welsh Government will use innovation to improve the lives of people in Wales.

The strategy includes priorities for creating new and better health and social care services in Wales.

To support the strategy, Health Technology Wales will continue to provide a horizon-scanning and health technology assessment function, alongside scientific advice to support the development of new technologies across health and social care. HTW will also support the Welsh Government Health and Care Innovation Action Plan which is currently in development.

> “There is an exciting future ahead for Health Technology Wales and I am confident that we can continue to expand the scope of our work. We have established a reputation as a trusted health technology assessment organisation with expertise that is valued across the health and care sectors. We look forward to continuing to work with our partners to address key health and social care priorities in Wales.
>
> *Professor Peter Groves, Chairman, Health Technology Wales*
>
> ”

Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our website.

Technoleg Iechyd Cymru
Health Technology Wales

healthtechnology.wales

Health Technology Wales (HTW), Second Floor, The Life Science Hub, 3 Assembly Square
Cardiff, CF10 4PL, United Kingdom

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Transforming Access to Medicines / Clinical Pharmacy Technical Services Update

DATE OF MEETING	13/07/2023

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?	YES

PREPARED BY	GARETH TYRRELL
PRESENTED BY	GARETH TYRRELL
APPROVED BY	Choose an item

EXECUTIVE SUMMARY	The Clinical 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 Pharmacy Division Service Board	19/07/2023
	(DD/MM/YYYY)
	(DD/MM/YYYY)
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	Select Current Level of Assurance

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.

1.2 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.

1.3 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.

1.4 The service is currently deemed “low risk” and has a 24-month inspection interval.

1.5 Batch production capacity has been increased by 50% per month, due to a change in product portfolio. This is a consequence of product discontinuation under Guidance Note 14 recommendations and an introduction of new products developed in collaboration with NHS Wales partners, and under the governance of the NWSSP Pharmacy Division Service Board.

1.6 Products supplied from the NWSSP Pharmacy Division are detailed below

- Noradrenaline 16mg in 50mL syringe
- Potassium Chloride 50mmol in 50mL syringe
- Rituximab 600mg in 250mL 0.9% Sodium Chloride
- Rituximab 700mg in 250mL 0.9% Sodium Chloride
- Atezolizumab 1200mg in 250mL 0.9% Sodium Chloride
- Nivolumab 480mg in 100mL 0.9% Sodium Chloride

1.7 Current production yield, described as % of manufactured products released for use is at 97%, above the service target rate of 95%

1.8 Documentation Review rate 92% (92% target)

- Documentation review rate 92% (92% target)
- Internal Audit 100% (100% target)
- Environmental failure rate <0.5% (<0.5% target)
- Critical equipment service/calibration 70% (Target 100%)

1.9 There have been no major/critical errors or service complaints for April-June 2023.

1.10 The unit has experienced two facilities deviations that require corrective works to address

1.11 The wider service performance and outcomes were reported at the monthly NWSSP Pharmacy Division Service board on 19th June 2023 and have been reported monthly since Jan 2021.

1.12 The Wholesale Dealer service within NWSSP currently provides targeted medicines identified by the All-Wales Medicines Procurement team to NHS Wales organisations. The medicines identified for purchase and supply are approved at NWSSP Board.

1.13 To date in 23/24 the Wholesale Dealer service has achieved significant savings for NHS Wales organisations.

2. BACKGROUND

2.1 Key service issues that require attention is a drop in the servicing targets of 100% for critical equipment. This is owning to supply chain issues with essential equipment for calibration plus the complexities of procurement tendering.

2.2 Facilities deviations identified relate to a failure of critical air filtering apparatus, a common failure in manufacturing units that require periodic replacement.

3. ASSESSMENT

3.1 Critical equipment out of calibration/servicing target dates have mitigating actions in place, including increased internal calibration and product monitoring and increased process validation activities to ensure the equipment operates to the standards identified in the original equipment commissioning and qualification. To date, all equipment remans within the commissioned standards.

3.2 Facilities deviations relating to annual servicing have been reported, as has 3.1, onto the internal Pharmaceutical Quality Management System. A change control raised for the replacement of filters and a risk assessment undertake to ensure compliance with ISO and MHRA standards for clean rooms.

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

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Working / Stakeholder Engagement
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply

	Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The implications outlined in this report as exceptions risk the ability of the service to prepare medicines within a times and efficient manner
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	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

Safeguarding and Vulnerable Persons Annual Report

DATE OF MEETING	13th July 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	David Harris, Interim Senior Professional Safeguarding & Public Protection
PRESENTED BY	David Harris, Interim Senior Professional Safeguarding & Public Protection, Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience & Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Safeguarding and Vulnerable Persons 2022/2023 Annual Report covers the period 1st April 2022 to 31st March 2023. The key outcomes are: Velindre University NHS Trust fulfilled all duties and statutory obligations to safeguard and support patients, donors, staff, and the organisation.

	Analysis of the last year highlighted no adverse incident occurred within portfolios of safeguarding and public protection and supporting vulnerable groups. Excellent progress achieved in workstreams within portfolios of Safeguarding and Vulnerable Persons. A workplan is in place to continue improvements within both portfolios during the next reporting year.

RECOMMENDATION / ACTIONS	Approve the 2022/2023 Trust Safeguarding and Vulnerable Persons Annual Report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Safeguarding and Vulnerable Adults Management Group	27.06.2023
Executive Management Board / Endorsed for approval.	29.06.2023
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Circulated to SVAMG group for comment and approval, suggested amendments received have been actioned and final report to be presented to next meeting. Reviewed by EMB and endorsed for approval by QSP	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full The Safeguarding and Vulnerable Persons annual report 2022/2023 demonstrates evidence of delivery of all agreed actions within statutory and national standards. With further evidence of key achievements as desired outcomes within both portfolios.

APPENDICES	
Appendix 1	Velindre University NHS Trust Safeguarding and Vulnerable Persons Annual Report 2022/2023

1. SITUATION

The 2022/2023 Velindre University NHS Trust Safeguarding & Vulnerable Persons Annual report is provided to the Quality, Safety and Performance Committee for Approval.

2. BACKGROUND

Safeguarding and public protection is underpinned by an increasingly complex statutory framework to support and protect Children and Adults at Risk, experiencing or at risk of abuse or neglect. The safeguarding agenda is broad and diverse and is ever evolving with further workstreams to support other vulnerable persons within Velindre University NHS Trust and meet aims of relevant national standards and service improvement initiatives.

This report is provided annually as part of the Trusts Assurance mechanisms.

3. ASSESSMENT

The Safeguarding and Vulnerable Persons Annual Report of Velindre University NHS Trust (hereafter 'the Trust') is attached in ***Appendix 1*** and summarises safeguarding activity and developments within the Trust through the year April 2022 to March 2023.

It is intended to provide assurance to the Trust Board in relation to compliance with statutory requirements and obligations to Children and Adults at Risk, and developments to support other vulnerable groups.

Within the reporting period the role of the Trust safeguarding lead was reviewed and resulted in a new position of Head of Safeguarding and Vulnerable Persons with a widened portfolio to include strategic leadership for workstreams supporting vulnerable persons.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key areas of highlights in the report:

- Governance Arrangements
- Trust Safeguarding and Public Protection Activity 2022/2023
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Supporting Vulnerable Groups
- Safeguarding and Public Protection Training and Learning
- Trust contribution to National Safeguarding
- Learning from Concerns and Incidents

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒

	Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). 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.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. **Click or tap here to enter text**

TRUST WELL-BEING GOAL 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 yet completed - Include further detail below why
	Relevant legislation, procedures and workstreams promote person centred care and protection of marginalised groups. No perceived equality impacts.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The trust has a statutory obligation to comply with safeguarding legislation

6. RISKS

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

Velindre University NHS Trust

Safeguarding and Vulnerable Persons Annual Report 2022-23

Table of Contents **Page number**

1. Introduction

The Safeguarding and Vulnerable Persons Annual Report of Velindre University NHS Trust (hereafter 'the Trust') will provide an overview of Trust activity in relation to safeguarding and public protection, as well as further workstreams to support vulnerable persons in our care.

Information presented in the report summarises safeguarding activity and developments within the Trust for the year 1st April 2022 to 31st March 2023 and aims to provide Trust Board with assurance of all statutory duties under Children Act 2004, Social Services and Well Being (Wales) Act 2014 and Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 being fulfilled. This report demonstrates how we keep our patients and donors central to the provision of safe and effective care and supports the Trust strategic goal of being recognised as outstanding for quality, safety and care.

The Trust's Safeguarding and Vulnerable Adults Management Groups oversees the strategic development and operational delivery of the Trust's Safeguarding and Vulnerable Persons responsibilities. This includes supporting people living with Dementia and/or a Learning Disability and has led to the formation of a Supporting Vulnerable Groups forum within the Trust

Key Achievements 2022-2023:

The Safeguarding and Vulnerable Adults Group has met on a quarterly basis and ensured the following achievements.

- A refreshed training needs analysis was completed and ensures all levels of safeguarding training are matched to appropriate roles in the Trust.
- Divisional reporting processes of safeguarding and vulnerable persons activity were improved.
- 7 staff were adopted into 'Safeguarding Champion' roles across the Trust to support and maintain safeguarding standards, embed good practice and support the implementation of the safeguarding action plan.
- A schedule of safeguarding supervision was implemented for divisional leads.
- An audit of the safeguarding section within the Welsh Nursing Care Record showed excellent levels of compliance for patients admitted to the ward in Velindre Cancer Centre.
- A workplan for the Supporting Vulnerable Groups forum was commenced to include Dementia standards, Dementia friendly hospital charter & Learning disability standards.
- An external training provider was sourced and delivered Mental Capacity Act training for regulated professionals within the Trust.
- Trust was adopted as a pilot site for the Once for Wales Safeguarding Module. All Safeguarding Activity is now recorded within this system.
- Trust Domestic Abuse process was measured against NICE Guidelines. No areas of concern identified and an opportunity to improve the provision of supervision for our staff is incorporated in next year's workplan.
- Safeguarding guidance for virtual appointments has been incorporated into new standard operating procedures.

Challenges

- No significant challenges identified within the Trust.
- Operational demands presented a challenge in enabling staff to be released from the clinical area to attend training and development opportunities.

Executive Summary

The Safeguarding and Vulnerable Persons 2022/2023 Annual Report covers the period 1st April 2022 to 31st March 2023. The key outcomes are:

- Velindre University NHS Trust fulfilled all duties and statutory obligations to safeguard and support patients, donors, staff, and the organisation.
- Analysis of the last year highlighted no adverse incidents occurred within portfolios of safeguarding and public protection and supporting vulnerable groups.
- Excellent progress achieved in workstreams within the portfolios of Safeguarding and Vulnerable Persons.
- A workplan is in place to continue improvements within both portfolios during the next reporting year.

2. Governance Arrangements

2.1 Responsibility for Safeguarding and Public Protection within the Trust

Executive Responsibility	• The Chief Executive Officer has overall responsibility for safeguarding and public protection. • The Executive Portfolio is delegated to the Executive Director of Nursing, Allied Health Professionals and Health Science. • Supported by: The Deputy Director of Nursing, Quality & Patient Experience.
Operational Responsibility	• Director, Velindre Cancer Centre. • Supported by: The Head of Nursing, Quality and Patient Experience. • Director, Welsh Blood Service. • Supported by: The Head of Nursing.
Named Safeguarding Lead	• Head of Safeguarding and Vulnerable Persons. The Head of Safeguarding and Vulnerable Persons, or the The Deputy Director of Nursing, Quality & Patient Experience will provide advice, guidance, and support for any safeguarding or public protection concerns disclosed, witnessed, or suspected within the Trust.

2.2 Internal Governance & Assurance

2.2.1 Compliance with the Health and Care Standards (2015)

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, focuses on how the Trust promotes and protects the welfare and safety of children and adults who become vulnerable or are at risk of abuse and neglect.

The overall assessment for standard 2.7 was rated as 4 and described as - 'We have well developed plans and processes and can demonstrate sustainable improvement throughout the organisation / business. All improvement actions for the year were delivered.

The following has been achieved in relation to delivery of the 2022/23 improvement actions in relation to this standard:

Health and Care Standard 2.7 – priorities and aims for 2022/2023

To undertake a safeguarding training needs analysis to ensure allocated training is appropriate to the specific role.	To improve compliance with safeguarding training to achieve compliance of 85% or above across all relevant areas	To Promote and embed role of the safeguarding champion across the trust to support and maintain the safeguarding standards, embed good practice and support the implementation of the safeguarding action plan.	To review how we embed Liberty Protect Safeguards in the Velindre Cancer Centre
• Head of Safeguarding and Vulnerable Groups, Workforce Development Manager • This has been achieved.	• Head of Nursing and Directors VCC & WBS. • Improvements made to some compliance and key areas of focus aligned to 2023/24 workplan.	• Head of Safeguarding and Vulnerable Groups, Head of Nursing, Quality, Patient Experience & Integrated Care' and Head of Nursing WBS. • This has been achieved.	• Head of Safeguarding and Vulnerable Groups. • Workstream continues into 2023/24 aligned with partners across NHS Wales and Welsh Government.

For 2023/24 the 2015 standards have been replaced with the Health & Care Quality Standards (2023).

Translating these new standards to provide evidence of Safeguarding quality and assurance will be a priority in the 2023/24 workplan of the Safeguarding and Vulnerable Adults Group.

2.2.2 Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a quality assurance tool completed annually by each health body in NHS Wales. It aims to demonstrate improvements and risks in respect of safeguarding now as well as promoting horizon scanning.

During this reporting period the Trust was one of two health bodies identified as a pilot site for the new revised SMM tool to measure 2021/22 safeguarding activity against proposed SMM Standards. Findings and feedback has informed the phase two 2022/23 pilot revision which will be completed by all Health Boards and NHS Trusts in Wales.

Reviewing measures within the SMM identified the following opportunities for improvement, all of which were completed.

- Improve Safeguarding and Vulnerable Adults divisional reporting processes
- Identify areas for scheduled safeguarding supervision
- Safeguarding guidance included within standard operating procedures for virtual appointments
- Enhanced mechanisms for sharing learning across the Trust.

3. Trust Safeguarding and Public Protection Activity 2022/2023

3.1 Referral Process and Multi-Agency Arrangements

Allegations of abuse that occurred in Velindre Cancer Centre are referred into the Cardiff Multi Agency Safeguarding Hub (MASH). Any other allegation or disclosure of abuse is referred to the local authority safeguarding team linked to the geographical location of the individual's usual residence.

The Head of Safeguarding and Vulnerable Groups supports Trust staff to comply with reporting processes and collates information on behalf of the Trust. This is to ensure accurate reporting and identification of themes and/or trends across the portfolio. The Trust has worked in collaboration with the MASH, reported concerns, and made enquiries on behalf of the local authority in line with legislation and policy during 2022/23.

The table below details reporting activity across the Trust.

Safeguarding Activity	Reports Made Apr 2020-Mar 2021	Reports Made Apr-21-Mar 2022	Reports Made Apr-22-Mar 2023
Child care and support referrals	0	0	0
Child at risk referrals	1	3	3
Adult at risk referrals	7	5	11
Reported incidents of adult abuse/neglect at VCC	0	1	0
MARAC referrals	1	3	2
Ask and Act Pathway	7	5	5
MAPPA Information Shared	3	1	1
Prevent	0	0	1
Safeguarding allegations/concerns about practitioners and those in a position of trust	1	3	3
High Risk Multi-Agency information shared	6	7	1
126 SSWA Enquiries (Adult at risk)	5	2	1
Section 47 Enquiries (Child at risk)	0	0	0

The Graph alongside shows we have shared 14 Safeguarding reports with 7 of the 22 local authority partners in Wales.

In addition to this we have engaged with partners for 3 concerns for persons in a position of trust.

5 referrals have made to 3rd Sector partners to support individuals disclosing domestic or sexual violence.

No reports of harm caused through abuse or neglect occurred within the Trust.

3.2 Once for Wales Safeguarding Module

During this reporting period the Trust commenced using the Safeguarding Module within Once for Wales Concerns Management System as a central repository for all safeguarding case records moving forward. This will assist us in monitoring compliance against Wales Safeguarding Procedures and identify themes and trends to assist quality improvements and continue to assure the Trust it is fulfilling its statutory duties.

3.3 Female Genital Mutilation (FGM)

Although the Trust does not provide women's health services it is still required to comply with Section 5B of the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015, which includes a statutory duty for health professionals to report known (either identified or disclosed) cases of FGM among girls under the age of 18 years, directly to the police within one month of identification. This duty applies to the healthcare professional directly and not the employer.

No incidents of FGM were identified in the Trust during 2022-2023.

The Trust includes FGM awareness in its safeguarding children training programme. In addition, details of the All-Wales Clinical Pathway for responding to cases of FGM has been updated during the reporting period and is available on the Trust's safeguarding and public protection intranet pages.

3.4 Multi-Agency Public Protection Arrangements (MAPPA)

The Trust is required to discharge its duties as a Multi-Agency Public Protection Arrangement (MAPPA), Duty to Co-operate Agency, under s325 Criminal Justice Act 2003. MAPPA is the process through which the police, probation and the prison services (Responsible Authority) work together, with other Duty to Co-operate Agencies, to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public. MAPPA offenders are managed on a multi-agency basis through multi-agency public protection meetings.

The Trust received no information from MAPPA during 2022-2023.

Although the Trust does not attend MAPPA meeting routinely, information is shared with the safeguarding lead as appropriate if a high-risk offender is planning to access treatment in the cancer centre. Information will be shared on a strictly need to know basis, dependent on identified offender risk. Ensuring the dignity of the patient involved is not compromised through the risk assessment process is paramount.

3.5 PREVENT

The Trust is required to discharge its duties under the Counter Terrorism and Security Act 2015. 'PREVENT' is the part of the Government's counter-terrorism strategy that aims to stop people who might be vulnerable or susceptible to radicalisation from becoming terrorists or supporting terrorist activities.

While the Trust does not provide the key service areas for PREVENT e.g. mental health, primary care and accident and emergency, it does cover a wide geographical area including an all Wales Blood Service, so it is important that staff are aware and know how to identify and escalate concerns. The Senior Nurse for Safeguarding and Public Protection acts as the Trust's point of contact for PREVENT. Raising Awareness of Radicalisation e-Learning training is included as a mandatory subject for all staff and included in the compliance matrix across the Trust.

No PREVENT matters / incidents were identified during 2022/2023.

3.6 Violence against Women, Domestic Abuse & Sexual Violence

The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 places legislative duties on public bodies. Velindre NHS Trust remains committed to raising awareness and providing guidance for employees and managers to address the effects of all domestic abuse and intimate and sexual violence, involving staff, volunteers, service users and the general public. The Trust is represented at the NHS Wales Safeguarding Network Violence against Women, Domestic Abuse, Sexual Violence (VAWDASV) Subgroup by the Head of Safeguarding and Vulnerable Person.

4. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009 as the formal procedures to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty but who lack the capacity to consent, and where detention under the Mental Health Act 1983 is not appropriate at that time.

DoLS 2019-2020	9
DoLS 2020-2021	8
DoLS 2020-2021	13
DoLS 2022-2023	12

If a deprivation of liberty is identified within the Cancer Centre, the Trust, as the managing authority, must contact the relevant supervisory body to assess and, if appropriate authorise the deprivation.

Applications for DoLS in the Cancer Centre during the reporting period compared to the previous year. Several applications were withdrawn prior to assessment by the Supervisory Body as either patients' regained capacity, were discharged, or sadly passed away prior to the assessment. ***No breaches were identified.***

This is a positive finding for the Trust as a report reviewing the DoLS process in Wales and published in Feb 2023, noted nearly all supervisory bodies in Wales were unable to assure themselves that people's human rights were not being breached by being deprived of their liberty unlawfully. Citing ongoing delays in Deprivation of Liberty Safeguards (DoLS) applications being assessed.

Trust successfully bid for funding from Welsh Government to support the preparation for the liberty protection safeguards. The money was used to purchase bespoke training for registrants in Mental capacity Act Training. The training has been well evaluated.

4.1 Liberty Protection Safeguards

Llywodraeth Cymru
Welsh Government

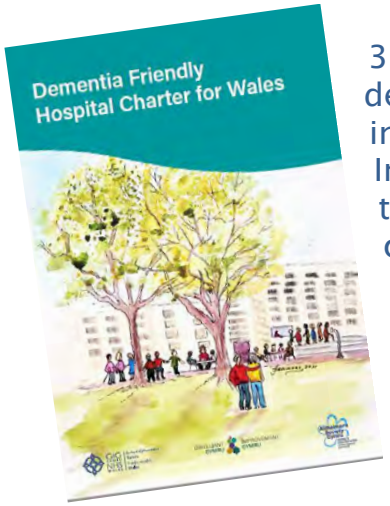
Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) process. (The planned implementation date was April 2022 but has been delayed and a revised date has not yet been announced.) The safeguards will provide protection for people aged 16 and above who are, or who need to be, deprived of their liberty to enable their care or treatment, and who lack the mental capacity to consent to the arrangements.

5. Supporting Vulnerable Groups

Work has continued to support patients and donors with additional needs and ensure reasonable adjustments are made to enable vulnerable groups to receive the best possible experience of our service. A new Supporting Vulnerable Groups Forum has been established and the terms of reference and workplan for the group has been approved.

1. A revised training needs analysis was disseminated for dementia training to meet the aims specified in 'Good Work: dementia learning and development framework'. This will ensure that staff have access to training that is relevant to their role in the Trust. Dementia training has been sourced from Cardiff & Vale University Health Board and is available for staff requiring skilled level training.

2. The twenty standards sit within four themes: Accessible, Responsive, Journey, Partnerships & Relationships underpinned by Kindness & Understanding. Scoping has been undertaken with the Trust to ensure we are compliant with the standards and that we provide the best possible care to patients with Dementia. -Seven of the standards apply to the Trust. The workplan of the Safeguarding and Vulnerable Adults Group includes actions and considerations for the Trust for the specific standards. Escalation within the Safeguarding and Vulnerable Adults Management Group has identified nominated divisional representation would prove beneficial to progress this workplan.



3.The all Wales Dementia Friendly Hospital Charter is part of the dementia aspect of improvement Cymru work plan and was launched in April 2022. A presentation to the VCS SLT was delivered by Improvement Cymru Care Fit for VIPS. Care Fit for VIPS is a free, online toolkit to help care settings to improve the quality of their dementia care. The leadership team are coonsidering the next steps for improvments required to comply with the dementa friendly hosptial charter

4. On April 1st 2022 the Paul Ridd Learning Disability Awareness Training was launched across the NHS in Wales. This is 'Foundation' level (for all healthcare staff). There are three levels in total. The second level is 'Enhanced' for staff whose roles bring them into regular contact with people with a learning disability, and the third level is for those who 'specialise' in working with people with a learning disability. Trust staff complete 'Foundation' level as part of their mandatory training with 41% compliance reported at end of this year against a target of 85%. Further work will continue in 2023/24 workplan to achieve this.

5. Some early work has been undertaken to consider the opportunities to identify relevant audit opportunities to ensure that a cognitive impairment is identified using the Welsh Nursing Care Record enabling reasonable adjustments to be made at the earliest opportunity. Initial audit of this section found 100% compliance across the year. Moving forward the 2023/24 workplan includes how we enhance audit of these records and provide assurance that all necessary Deprivation of Liberty Safeguards are in place for our patients.

6. Safeguarding and Vulnerable Adults Training and Learning

6.1 Safeguarding Adults and Children at Risk

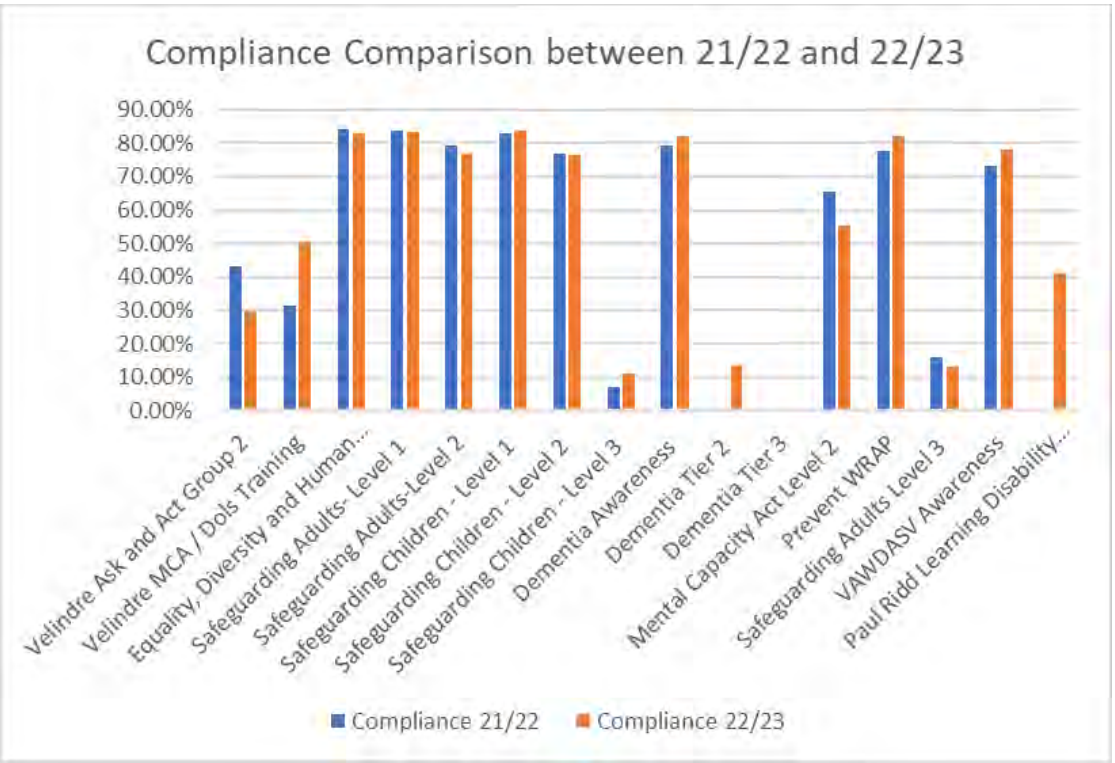
Compliance is monitored by departmental managers and relevant divisions and overseen by the Safeguarding and Vulnerable Adults Management Group. A training needs analysis that includes all safeguarding and Vulnerable Adults training was circulated across the Trust during the reporting period. This identifies accurate information to input into ESR to improve compliance reporting in 2022/23.

The below table includes Trust mandatory training compliance as of 31st March 2023.

Safeguarding Training Compliance as of 31.03.23		
Division and Competency	Total Assigment 2023	Complaince 22/23
Velindre Ask and Act Group 2	991	29.60%
Velindre MCA / Dols Training	327	50.50%
Equality, Diversity and Human Rights	1688	83.00%
Safeguarding Adults- Level 1	1688	83.20%
Safeguarding Adults-Level 2	1008	76.70%
Safeguarding Children - Level 1	1688	83.70%
Safeguarding Children - Level 2	1007	76.60%
Safeguarding Children - Level 3	9	11.10%
Dementia Awareness	1776	82.10%
Dementia Tier 2	373	13.70%
Dementia Tier 3	15	0.00%
Mental Capacity Act Level 2	1003	55.30%
Prevent WRAP	1688	82.30%
Safeguarding Adults Level 3	326	13.20%
VAWDASV Awareness	1688	78.00%
Paul Ridd Learning Disability Awareness Training	1016	41.00%

The training competencies noted above are achieved through delivery of both e-learning and face to face training within the Trust. Our Ask and Act Group 2 training is provided externally by Cardiff Local Authority through a Consortia arrangement made up of the Trust, Cardiff and Vale University Health Board and both Cardiff, and Vale of Glamorgan County Councils. Dementia tier 2 training is also provided externally by Cardiff and Vale University Health Board.

The Below graph offers an illustration of compliance data measured against the previous year. It should be noted that a direct comparison is difficult for some areas, such as Ask and Act Group 2 & MCA Level 2. These competencies have been influenced by the refreshed training needs analysis, resulting in increased staff numbers identified as requiring the training this year.



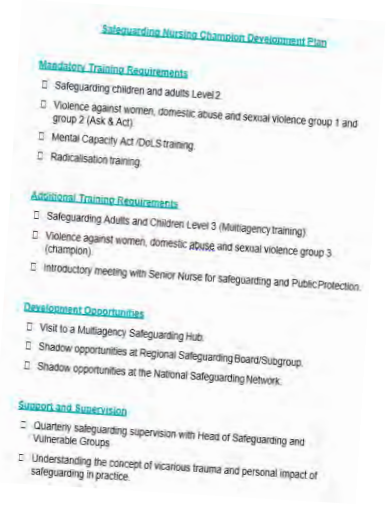
The creation of an updated training plan and continued focus to improving compliance across all areas is included in the workplan for the coming year. Key areas of focus are Level 3 Child and Adult Safeguarding, Ask and Act Group 2 and Dementia training at Skilled Level as per the Good work: Dementia learning and development framework.

In addition, numerous virtual training and safeguarding conferences were circulated across the Trust for staff to access, including a programme of events in national safeguarding week in November 2022.

6.2 Executive Management Board Safeguarding Training

Safeguarding Training for the Executive Management Board included a presentation on Contest Strategy and 'Prevent' in October 2022 and Level 6 Violence Against Women, Domestic Abuse and Sexual Violence training in December 2022.

6.3 Safeguarding Champions


Safeguarding Nursing Champion Development Plan

Mandatory Training Requirements

- Safeguarding children and adults Level 2
- Violence against women, domestic abuse and sexual violence group 1 and group 2 (Ask & Act)
- Mental Capacity Act /DoLS training
- Radicalisation training

Additional Training Requirements

- Safeguarding Adults and Children Level 3 (Multiagency training)
- Violence against women, domestic abuse and sexual violence group 3 (champion)
- Introductory meeting with Senior Nurse for safeguarding and Public Protection

Development Opportunities

- Visit to a Multiagency Safeguarding Hub
- Shadow opportunities at Regional Safeguarding Board/Subgroup
- Shadow opportunities at the National Safeguarding Network

Support and Supervision

- Quarterly safeguarding supervision with Head of Safeguarding and Vulnerable Groups
- Understanding the concept of vicarious trauma and personal impact of safeguarding in practice

The safeguarding champion development programme was approved. Champion's meeting have been planned 3 monthly, these sessions will be used to provide safeguarding supervision and to review published practice reviews and relevant publications to extract transferrable learning for the compliant Trust.

It has proven challenging to engage with Champions over the current year, and the 2023/24 workplan includes plans to explore how to make sessions more accessible for our clinical staff.

7. Trust's Contribution to National Safeguarding

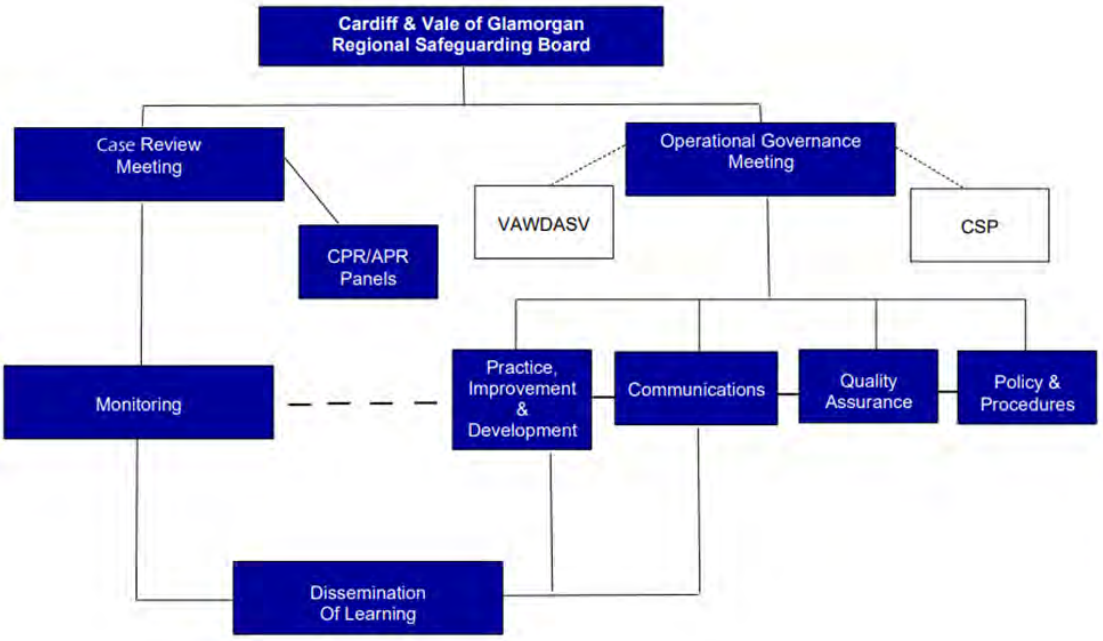
The Trust has continued to meet its national safeguarding obligations by playing an active role in the National Safeguarding Network. The network provides the strategic focus to promote the welfare and safeguarding of children and adults and promote consistent safeguarding practice across NHS Wales.

7.1 Multi-Agency Working

Trefniadau Diogelu Cymru
Wales Safeguarding Procedures

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

The requirements of Safeguarding Children Boards and Safeguarding Adults Boards in Wales have been established under Section 134 of the Social Services and Well-being (Wales) Act 2014. The Trust is a member of the Cardiff and Vale Regional Safeguarding Board and the following subgroups. Areas of focus for the year were: sexual abuse, domestic abuse and safeguarding fundamentals.



PRIORITY AREAS FOR 2022/2023

The three overarching priority areas of Cardiff and Vale of Glamorgan RSB for 2022/2023 are:

Priority 1	**Sexual Abuse**
Priority 2	**Domestic Abuse**
Priority 3	**Safeguarding Fundamentals**

8. LEARNING FROM CONCERNS AND INCIDENTS

'Putting Things Right' states that staff dealing with concerns must be aware of the potential for any safeguarding or protection issues to apply, in relation to a child or a vulnerable adult. The Head of Safeguarding and Vulnerable Adults has worked closely with the corporate and divisional quality and safety teams and any potential safeguarding concerns have been considered with the team.

No Trust safeguarding concerns were received during 2022/2023.

8.1 Pressure Ulcers & Safeguarding

The Head of Safeguarding and Vulnerable Groups attends Velindre Cancer Service Pressure Ulcer Scrutiny Panel that meets monthly to scrutinise compliance against the All-Wales Pressure Ulcer Reporting and Investigation. A part of the role of the panel is to consider any safeguarding implications relating to skin damage.

There were no incidents of Velindre acquired pressure damage required reporting to safeguarding.

8.2 Falls and Safeguarding

The Head of Safeguarding & Vulnerable Groups attends Velindre Cancer Service Patient Falls Scrutiny Panel that scrutinises all patient falls to ensure Trust has met all standards of care in respect of falls prevention. The panel through its work considers any safeguarding implications of patient falls

There were no incidents of falls referred to safeguarding during 2022-2023.

8.3 Child Practice Reviews (CPR) and Adult Practice Reviews (APR)

A Practice Review is undertaken if a child or adult dies or is seriously injured and abuse or neglect is suspected. The Head of Safeguarding and Vulnerable Adults represents the Trust at the Cardiff and Vale of Glamorgan Regional Safeguarding Board's Child and Adult Practice Regional Subgroup and brings back learning for discussion and if appropriate through the Trust's Safeguarding and Vulnerable Adults Management Group. During the reporting period the Safeguarding Public Protection Management Group reviewed one published Child Practice Review from Cardiff and Vale Regional Safeguarding Board for transferable learning. **The Trust was not an agency involved with the child or family in the review.**

8.4 Thematic Review of Domestic Homicide Reviews in Cardiff

Several domestic homicide reviews from the Cardiff region had been published without Trust awareness. The Trust is not represented at the Cardiff Community Safety Partnership and the VAWDASV regional groups had been interrupted by the COVID 19 pandemic. A thematic review of the reports was completed to extract any relevant learning and identified three key themes relevant to the trust:

- Information Sharing and Record Keeping
- Improving engagement with BME Victims
- Identification of caring related stress.

Assurance was provided to the Safeguarding and Vulnerable Adults Group that the themes were addressed in Trust training.

8.5 Mortuary review

The Safeguarding and Vulnerable Adults Management group received an assurance paper in respect of the lessons learnt detailed in the report arising from the David Fuller case in England (related to mortuary governance). In November 2021 the Trust Welsh Government requested assurance on the cold room security, specifically procedures for body storage. The group was presented with an improvement plan that has been actioned in terms of cold room process and the group were satisfied with the steps taken at VCC to improve security. The group were assured that all required actions identified by learning from these events had been completed.

8.6 HIW Report gap analysis

A paper was provided to the Group for endorsement providing an update on the 24 recommendations included in the Healthcare Inspectorate Wales (HIW) January 2019 report (the HIW report) into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. (2019). The Gap analysis identified 2 actions were required: Professional concerns training with Managers (in collaboration with Workforce colleagues) and to consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training. Both aspects have been included in the level 3 training, which is delivered face to face in the Trust. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance. A trust supervision document is planned within the 2023/24 workplan.

9. Staff Guidance and Information

Safeguarding information has been disseminated has been circulated across the Trust. The screens at the Cancer centre have been utilised to promote messages to staff and the public.

Safeguarding supervision is available for staff as required and following any safeguarding concerns. Safeguarding supervision has been provided to staff following events and reports.

10. Looking ahead

Exciting safeguarding developments for 2023/2024

Trust priorities and aims for 2022/2023		
Develop a training plan to map out measures to improve compliance with safeguarding training and achieve compliance of 85% or above across all relevant areas.	July 2023	Workforce Development Manager, Education & Development and Head of Safeguarding and Vulnerable Groups
To review Trust Safeguarding arrangements and map against the Health and Care Quality Standards. This includes creation of a Trust Safeguarding Quality Matrix.	October 2023	Head of Safeguarding and Vulnerable Groups, Head of Quality and Assurance
Create Trust guidance for provision of Safeguarding supervision for staff	July 2023	Head of Safeguarding and Vulnerable Groups
To develop an Audit Schedule for Clinical teams within divisions to review safeguarding practice and identity quality improvement opportunity.	December 2023	Head of Safeguarding and Vulnerable Persons, Head of Nursing, Quality and Patient Experience VCC & Head of Nursing WBS

To appoint a Specialist Facilitator to support ongoing training for MCA / DoLS in Trust	October 2023	Head of Safeguarding and Vulnerable Persons
To appoint a Specialist Facilitator to support ongoing training for Dementia training in Trust	December 2023	Head of Safeguarding and Vulnerable Persons, head of Nursing, Quality and Patient Experience VCC
Develop further utilisation of Safeguarding module within OFW Datix System as a secure central repository for Trust safeguarding records.	March 2024	Head of Safeguarding and Vulnerable Groups, Head of Quality and Assurance


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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Velindre University NHS Trust Business Continuity & Emergency Planning Annual Report 2022-2023

DATE OF MEETING	13/07/2023
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	Laurie Thomas, Head of Validation & Risk Management
PRESENTED BY	Alan Prosser, Director, WBS
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	The report provides a summary of the Trust business continuity and emergency planning activities for April 2022/ March 2023. The Trust has experienced a challenging year for business continuity, requiring response to Covid, Blood Shortage, Industrial Action and other internal business continuity incidents whilst maintaining core service provision. This has impacted on the delivery and targeted action plan for the Trust Business Continuity & Emergency Planning work programme monitored by the

	Business Continuity & Emergency Preparedness Steering Group. The Trust continues to make significant progress in its Business Continuity and Emergency Preparedness framework which includes multi-faceted planning, underpinned by robust risk management arrangements. Audit and Assurance Services have informed the Trust of an audit against business continuity preparedness for business continuity incidents planned for Q2 2023/2024. The report aims to provide assurance to the Committee.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to Endorse the approval of the 2022-2023 Velindre University NHS Trust Business Continuity and Emergency Planning Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	**JUNE 29TH 2023**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ENDORSED FOR APPROVAL	

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	
N/A	

1. SITUATION

The 2022-2023 Velindre University NHS Trust Business Continuity & Emergency Planning Annual Report is provided to Quality, Safety & Performance Committee to endorse for Trust Board approval.

2. BACKGROUND

Velindre University NHS Trust is committed to ensure emergency plans and business continuity arrangements are in place and take full account of required statutory duties under the Civil Contingencies Act 2004 and Emergency Planning guidance issued by Welsh Government. The Trust delivers its aims, objectives, responsibilities, and legal requirements transparently and consistently.

The Trust is required to submit an annual Emergency Planning Report setting out broad compliance in meeting these requirements and to submit a copy of the current Major Incident/Emergency Plan for perusal to Welsh Government. The Trust continues to make significant progress in its Business Continuity and Emergency Preparedness framework which includes multi-faceted planning, underpinned by robust risk management arrangements.

3. ASSESSMENT

The Trust has experienced a challenging year for business continuity, requiring response to Covid, Blood Shortages and Industrial Action whilst maintaining core service provision. This has impacted on the delivery and targeted action plan for the Trust Business Continuity & Emergency Planning work programme monitored by the Business Continuity & Emergency Preparedness Steering Group.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The following sections summarise the overall Trust Business Continuity & Emergency Planning developments and current positioning.

Business Continuity Management System

- The Trust Business Continuity & Emergency Preparedness Steering Group has increased its cycle of business to support the framework of governance within the Trust.

- Throughout 2022/2023 there has been significantly improved ownership, systems and processes for the management business continuity and emergency planning across each of the divisions, this includes: -

    - Revision of the VUNHST Business Continuity and Emergency Planning Policy
    - Development of a VUNHST Incident Response Plan including Executive on-call pack
    - Development of a VUNHST IT Business Continuity Incident Response Plan
    - Development of a VUNHST Cyber Incident Response Plan
    - Development of a VUNHST Business Continuity & Emergency Planning Work Programme

- The Trust stood up an Industrial Action Cell to coordinate and manage the business continuity impact on service provision as a result of the industrial action experienced throughout 2022/2023.

- The focus of the Trust for 2022-2023 has continued around the planning and response to the evolving Covid-19 global pandemic, which presented a number of challenges to the organisation. The Trust has continued to deliver core service provision throughout this exceptional time.

- Both divisions have focused on reviewing its Business Impact Analyses (BIA) and Major Incident Plans to ensure the learning from business continuity related incidents are captured and mitigated.

- Identified mitigation against potential core service disruption encountered from EU Exit was maintained until Q4 2022/2023, where an assurance position has

been reached.

- Audit and Assurance Services have informed the Trust of an audit against business continuity preparedness for business continuity incidents planned for Q2 2023/2024.

Co-operation and Information Sharing

- The Trust completed the Health Emergency Planning Annual Report 2022 which Welsh Government use to benchmark compliance to requirements outlined in Civil Contingencies Act. The Trust has not received any correspondence around non-conformance.

- The Trust has continued to engage with multi-faceted planning, across a number of varying themes and integrated with NHS Wales, Local Authorities, the Welsh Government and the Local Resilience Forum, its partners and key stakeholders.

- The WBS continues to work closely with UK Blood services to further enhance the mutual aid arrangements between services to ensure the continuity and safety of the blood supply chain. Over the next 12 months, the WBS plans to encourage focused work around the alignment of blood shortage plans across the UK.

- Working in collaboration with Digital Health and Care Wales to reduce the impact on service within the digital sphere.

- The Trust has commenced engagement with the Covid-19 Inquiry and will endeavor to implement any identified learning into existing business continuity structures.

- The Trust continues to regularly review and consider National and all Wales Risk Registers to provide assurance that emerging threats are considered alongside the development and enhancement of risk mitigation strategies and response mechanisms. These plans are commensurate with the level of risk the Trust anticipates exposure to.

Training and Exercising

- The Trust continues to engage with Welsh Government Emergency Planning Advisory Group and Local Resilience Forums around key strategies for workload, including internal and external training and exercising.

- The Trust Emergency Planning Leads visited the Hydra Suite at University of South Wales to explore the Hydra Software used to conduct immersive, simulated exercise scenarios. The team are keen to utilise this software to support future exercises run within the Trust.

- Over the past 12 months, in addition to exercising internal business continuity plans (planned and unplanned), the Trust has participated in the following training and exercising:

Exercise/ Training Details	Dates held
Exercises	
WBS Major Incident	16/05/2022
Blood Shortage (Dim Gwaed) held with all local health boards	24/10/2022
Patient evacuation of clinical areas	11/10/2022
Wales Connect (WG activation test of LRF stand up)	01/02/2023
Mighty Oak - National Power outage exercise	28-30-03/2023
EMRTS Code Red Mass Casualty	11/05/2023
Major Incident Communications test	Run 6 monthly
Telephony contingency line – VCC	Run daily
Emergency pager system – VCC	Run daily
Training	
Health Prepared Wales	01/12/2022
Loggist training	06/03/2023
Tactical Emergency Management training delivered by Emergency Planning College (key individuals trained)	23-24/05/2023
WBS Major Incident awareness training delivered to key staff	On-going

- Engagement in such multidisciplinary exercises allows the Trust to encompass lessons identified and to align to wider health emergency planning with the aim to further improve the current procedures.

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*	**N/A**
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 ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable to this report.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact as a result of the matters set out in this report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance to requirements outlined in Civil Contingencies Act 2004.

6. RISKS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
2022/23 PROFESSIONAL REGULATION / REVALIDATION ASSURANCE

DATE OF MEETING	13th July 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	Anna Harries, Head of Nursing Professional Standards and Digital Bethan Tranter, Chief Pharmacist Elizabeth Eddie, Executive Medical Business Manager
PRESENTED BY	Anna Harries, Head of Professional Standards & Digital, Nicola Williams, Executive Director of Nursing, AHPs & Health Sciences Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	During 2022/2023 there: • Were no lapses or breaches in registration in respect of Health Care Professionals Council or General Pharmaceutical Council. • Was one lapse in registration with the Nursing & Midwifery Council due to a failure to revalidate within the required timescale. The employee did not practice as a registered nurse whilst un-registered. • Was one Trust raised Nursing & Midwifery Council revalidation sign off issue.

	• Were seventy-four medical appraisals undertaken, nine recommendations to revalidate and one recommendation to defer

RECOMMENDATION / ACTIONS	To **ENDORSE** the Professional Registration / Revalidation compliance across all professional groups prior to being submitted for Trust Board approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum	06/07/2023
Executive Management Board	29/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSION Content discussed and report endorsed.	

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

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with a high-level summary of any professional registration / revalidation lapses / breaches in respect of staff requiring to be registered with a professional body to undertake their role for the period 1st April 2022- 31st March 2023. This paper covers those requiring live registration with the: Nursing & Midwifery Council (NMC), General Medical Council (GMC), Health & Care Professions Council (HCPC), and General Pharmaceutical Council (GPhC).

This paper is to provide assurance in relation to professional regulation governance.

2. BACKGROUND

All healthcare professionals are required to re-register and some also need to revalidate. Each professional body has different arrangements in place which are detailed below:

2.1 Nursing & Midwifery Council (NMC)

Every qualified nurse on the NMC Professional register is required to complete a process of re-registering yearly and revalidation three yearly. If a registrant does not re-register or revalidate when due their registration will lapse. If registration lapses a registrant cannot practice and they will need to apply to the NMC to be re-registered – this can take up to 6 weeks.

There is a legal requirement for any individual using the protected title of registered nurse or registered midwife in the UK to revalidate every three years. Nurses must evidence that they have met the following requirements in order to revalidate:

- 450 practice hours
- 35 hours of continuing professional development (20 of which must be participatory)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, resultant changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declarations of health and character
- Evidence of appropriate indemnity arrangements.
- Confirmation of adherence with the revalidation process, usually by the employer.

2.2 Health & Care Professions Council (HCPC)

The HCPC regulate 15 professions. These professions have designated titles that are protected by law and professionals must be registered with the HCPC to use them. These are:

- Arts Therapists
- Biomedical Therapists
- Chiropodists / Podiatrists
- Clinical Scientists
- Dieticians
- Hearing Aid Dispensers
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner Psychologists

- Prosthetists / Orthotists
- Radiographers
- Speech and Language Therapists

HCPC Registrants need to re-register every two years. Each profession has a set month during the two-yearly cycle when registration is required to be completed by. Registrants will receive notification of renewal deadlines and needs to complete a professional declaration and pay a renewal fee no later than the deadline to avoid being removed from the register. If removed they cannot practice. A random sample of 2.5 percent of the profession will be selected to submit a continuing professional development (CPD) profile for the renewal period.

There are no revalidation requirements.

2.3 General Medical Council (GMC)

Every doctor on the General Medical Council (GMC) register is required to revalidate, normally every five years. To maintain a license to practice a doctor must demonstrate that they work in line with the principles set out within the GMC's Good Medical Practice Guidance. Medical revalidation, through statutory duties will provide assurance that doctors in the UK are fit to practice.

A Responsible Officer or suitable person is required to make a recommendation to the GMC about whether a doctor connected to them should be revalidated. Following this, the GMC decides whether a doctor can be revalidated based on the recommendation and any other information that they hold. There are three types of revalidation recommendations that can be made:

- Recommendation to revalidate
- Recommendation to defer
- Recommendation of non-engagement

In order to make a recommendation which is consistent, fair and reliable the Responsible Officer requires evidence that a doctor is regularly appraised on their whole practice, ensuring the completeness and quality of supporting information and their reflections on it. Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practice referred to the GMC where appropriate.

Connected doctors are required to have annual appraisals where there is evidence of:

- Scope of work
- Review of PDP
- CPD
- Review of complaints and compliments

- Review of Significant events
- Probity and Health declarations
- In every revalidation cycle the doctor additionally is required to provide evidence of Formal patient and colleague feedback.
- Information supporting a quality improvement.

2.4 General Pharmaceutical Council (GPhC)

To practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and have satisfied the council that they meet its requirements.

Pharmacist and pharmacy technician are protected titles and therefore there is a legal requirement that only registered and re-validated individual can use these titles.

Pharmacies must also be registered with the GPhC (or be a pharmacy department based in a hospital or health centre) to operate in Great Britain and to use the title 'pharmacy'.

Pharmacists, pharmacy technicians and registered pharmacies must renew their registration annually, which involves completing a declaration stating that they meet all professional, fitness to practise and ethical standards.

Annual re-validation for pharmacists and pharmacy technicians includes submission of

- 4 x CPD records,
- a peer review discussion to ensure engagement with others on the individual's learning and practice and
- a reflective account to encourage consideration of how the individual meets professional pharmacy standards.

3 ASSESSMENT

During the year 1st April 2022 – 31st March 2023 the following registration / revalidation issues / breaches occurred:

3.1 NMC

In 2022 a revised NMC standard operating procedure was approved within the Professional Nurse Forum to ensure robust checking procedures are in place. This followed one incident of a lapsed registration in July 2021.

In November 2022 there was one NMC lapsed registration. The employee failed to revalidate by the required timescale and did not work as a Registered Nurse whilst lapsed as was off work at the time. The employee remains off work and has not yet applied to re-register. The individual's employment status was changed following an investigation to a non-registered role.

The professional escalation process of this lapse was not followed. An initial review has been undertaken and a Professional Review of the situation and management of this to identify any lessons learnt has been commissioned. This will be completed by the 31st July 2023.

The only other professional registration issue that has occurred during this year relates to a NMC Registrant who knowingly used another NMC Registrant's details to authorise revalidation with the Nursing and Midwifery Council despite the revalidation meeting not being held and revalidation process not being signed off. This was identified immediately, escalated, and investigated appropriately through a professional concern and appropriate referral made to the NMC.

3.2 HCPC

There were no HCPC registration issues during the year.

3.3 GMC

3.3.1 Revalidation and Appraisal

Across the Trust there have been seventy-four appraisals undertaken, nine recommendations to revalidate and one recommendation to defer during the past twelve months.

Welsh Revalidation and Appraisal Group reporting as at the 31.03.2023			
IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY	Number of prescribed connections	No of doctors exempt from appraisal due to extenuating circumstances	No of completed appraisals (summary agreed)
Consultants (including honorary contract holders)	68	0	65
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	9	2 (less than one year in post therefore appraisal not due)	7
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0	0	0
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	12	9 (less than one year in post therefore appraisal not due	2

Other (Including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	0	0	0

3.3.2 HEIW Revalidation Support Unit Quality Assurance Visit – April 2023

An external review undertaken by Health Education Improvement Wales (HEIW) in April 2023 was very positive and the high compliance rate for medical appraisal (Consultants: 92.3%) (Staff Grades, Associate Specialists & Specialty Doctors: 87.5%) was noted, in addition to the low deferral rate for Revalidation (7%, the lowest in Wales), compared to the national average of 26%.

The enthusiasm of the appraisal team, in particular the appraisal lead and appraisal manager was highlighted and the review team were assured that the Trust has robust processes in place.

The review report recommendations included the consideration of lay representation at Revalidation decision meetings, which is currently in progress, and appraiser recruitment and review of the distribution of appraisals, which will make the appraisal pool more sustainable going forwards. Since the report recommendations the Trust has agreed in principle to adopt the national tariff of 0.5 SPA for undertaking 10 appraisals and participating in all training and updates required for the role.

The review team advised that the next Quality Assurance visit would be a virtual visit in 2-3 years, with the next cycle of onsite visits commencing in 5 years.

The review report, including action plan is attached in ***Appendix 1***.

4 IMPACT ASSESSMENT

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

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	Professional registration is a legal requirement. Having appropriately registered clinical staff is critical for clinical safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. **Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact if staff unable to practice due to failure of this process and potential legal action. No direct financial implication from this paper
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	All Registered staff to be considered in this process, including those on long term leave. The Trust policy would have included this Equality Impact Assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is a legal requirement for registrants to have a live registration when practicing.

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Staff must be registered to practice by legislation*
WHAT IS THE CURRENT RISK SCORE	8
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*The recent lapse is under review to consider learning and review of the SOP in place to include process for staff who are on long term sickness or Maternity*

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	24th August 2023
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Revalidation Quality Review Report

Section 1

To be completed by Review Team

Designated Body (DB)	Velindre NHS
Date of Review	27th April 2023
Time of review	13:30 – 16:00
Virtual/Face to Face	**F2F** VUNHST Headquarters, 2 Charnwood Court, Parc Nantgarw

Review Team

Name	Role
Chris Price	Chair
Stacy Watkins	RSU
Sian Parker-Hornsey	RSU
Natalie House	RSU
Rebecca Seldon	Revalidation Manager Representative
Malcolm Stammers	Lay Representative

DB Representatives

Name	Role
Jacinta Abraham	Responsible Officer (RO)
Mick Button	AMD / Deputy RO
Sara Wilkins	Revalidation and Appraisal Manager
Aisling Butler	Clinical Lead for Revalidation and Appraisal
Steve Ham	Chief Executive
Elizabeth Eddie	Executive Medical Business Manager

General Overview of Visit:
The Review Team thanked the Trust for the paperwork submission. It was a positive visit, and the chair commented on the enthusiasm in the room with the DB Representatives. The Review Team noted how the Trust has robust structures in place around the induction of doctors and their employment pathway. The Trust has appointed the clinical lead since the last visit, and their enthusiasm and future vision were good. A virtual visit will be undertaken in 2-3 years, with the next cycle of visits commencing in 5 years.

Visit Outcomes

Themes	Discussion Notes	Recommendations
RPR - Appraisal Completion Figures	• The one GP has completed their appraisal since the previous 21-22 RPR. • Consultants 60 of 65 at 92.3%. • Staff Grade, associate specialist, and specialty doctor 87.5% • Temporary or short-term contract holders 50% (4 of 8). The remaining 4 have been in post for less than one year and have been allocated an appraisal due date. All exceed the Wales average appraisal rate of 73%. All new starters complete induction via the Revalidation and Appraisal Manager, Sara Wilkins.	
RPR - Revalidation Recommendations	Wales's average Deferral rate is 26% Deferral rate locally: 7% due to insufficient material.	

	Sara Wilkins, Revalidation and Appraisal Manager works 15hrs per week and Aisling Butler is the Appraisal Lead, with 1 session dedicated to revalidation and appraisal. AB provides doctors with a MARS specific induction along with ongoing support on MARS. The Revalidation & Appraisal Team supports doctors in the Trust to ensure they engage in the appraisal and revalidation process. Support commences at induction and aims to help the doctor in advance, during, and post-appraisal, including the development of bespoke plans for doctors to achieve their revalidation. The review team identified the low deferral rate as a testament to the Revalidation and Appraisal team's systematic, organised, and timely approach. The Trust promotes good practice by prompting doctors to complete their 360 feedback in years 2/3 of the cycle. Leadership and management have improved since the first visit, which has had a positive impact.	
RPR - (RAG) Revalidation Processes	Mick Button has completed National GMC RO training. Monthly revalidation compliance meetings allow timely management of those approaching revalidation, to ensure all required information is complete. All doctors are advised to undertake 360 feedback exercise around year 3 of the revalidation cycle. The DB has a Revalidation Committee made up of the RO (Chair), Clinical Lead (AL), and RM. The DB monitors new joiners with HR, Welsh Blood Services, and Shared Services. Leadership and how that can be assessed as part of appraisal and revalidation is to be determined, and it will be important to consider how that work is captured. In-house Appraiser meeting provided for WPA training and focused on the Professional Context box. AL attends all HEIW network meetings and cascades information as appropriate. QI template used and aimed to share examples of good practices at Exec Board.	

	The Trust meets quarterly with Katie Laugharne (GMC) ELA. Any governance processes are discussed and considered concerning revalidation. The Trust finds the meetings very beneficial and a great support. The review team discussed lay representation with the trust. The trust agreed they would engage representation at an operational level and have an identified an independent board member. The review team were in support of this, but also suggested that the HB consider patient/public representation if options are available through the HB networks, as good practice.	Consideration of lay oversight within governance and improvement processes. To be considered how it will be achieved within existing structures. RSU to set up training for lay Representatives. To support the development of a lay Rep Job advert for trust with Malcolm Stammers
RPR - (RAG) Underpinning systems: appraisal	The Trust has doubled in size in the past 12 months and is looking to increase its appraiser pool from 9 to 12, in the short term. There has been an increase in SAS doctors employed by the Trust and the AL is looking to recruit some of those to the appraiser pool, along with representation from WBS. The review team highlighted that the minimum number of appraisals is five per annum. The tariff for appraisers agreed via WROG was reiterated at 0.5 of a session for ten appraisals. The review team received feedback from appraisers that they needed clarification on how many appraisals they had to complete within their SPA time. The Trust highlighted quarterly meetings with appraisers where various topics from AQA, QIA, Professional context, Coaching (Bitesize), QA events, exceptions, and well-being, i.e., appraisal rebalanced, are covered. AL also arranges grand round sessions with 60-plus attendees. The AL regularly cascades information via e-mail correspondence and offers 1:1 support as required. During the appraiser discussion, appraisers stated they would like more opportunity for networking in a face-to-face format.	To increase the number of appraisers and explicitly state the expectation of the number of appraisals they will carry out under the national tariff. To further cascade awareness of appraiser training events and look to have more opportunities for face-to-face networking. It can remain a quorum of attendees.

	The AL offers wellbeing appraisals, with a more holistic approach and internal psychology support is available for the workforce. Investment in growth of staff (as above) has had a positive impact on wellbeing. The AL is co-chair of the senior medical staff committee which has a standing item for appraisal and revalidation, which is another forum for support. During the appraiser discussion there was a query around SEA, and it was apparent the appraisers were unaware that the GMC have changed the definition of an SEA The review team recommended that doctors include academic appraisals in the MARS appraisal and that any relevant learning should be taken forward into the MARS PDP. Trust appraisers often use their non-NHS e-mail addresses for MARS which could result in them missing important comms. The **trust** has an affiliation and MOU with the FMLM, part of the agreement is to adopt the FMLM leadership and management standards for medical professionals, which underpin the principles of the GMC's Good Medical Practice, and to embed that lens in the appraisal process. FMLM relationship is an opportunity to see appraisers as a population and to nurture and support them in their roles.	RSU to send guidance on GMC SEA criteria. To remind appraisers to use their NHS e-mail addresses for MARS. If this piece of work was to lead to template changes on MARS, the RSU could support.
RPR - (RAG) Underpinning systems: governance	The review team highlighted the robust processes in place. There was a firm overview of doctors' engagement with appraisal. A monthly compliance meeting enables the review of any outstanding requirements for a doctor's revalidation, i.e., QIA, 360. The HB examines the number of cycles completed, and extenuating circumstances are considered. The **trust** checks summaries for errors, i.e., 360 ticked on the Revalidation Card in error, etc., so all double-checked.	

	The review team was interested in the HBs development of a Medical Examiners form for appraisal. It sets out objectives, standards, and principles for the group. This work has been conducted in conjunction with Jason Shannon and Ruth Alcolado. The form has been disseminated to appraisers.	Consider sharing the Medical Examiners appraisal form with RSU to look at a potential national MARS template.
RPR - Internal Quality Assurance and Other Projects	Internal QA has been undertaken, paperwork was not forwarded in advance, but discussed at the meeting. A DB-specific IQA proforma document was introduced. They are engaged with a virtual appraisal project.	.
QV - Progress against agreed actions	**Completed:** • RO support in place with deputy RO • Quarterly appraiser meetings established to provide support outside of the governance structure. • AL is in place to cascade training and feedback to appraisers regarding their performance. • Bi-annual constraints meetings in place to raise awareness **Ongoing:** • **Appraisers mentioned that CPD is difficult to access - budget and SPA time are contributing factors**. Online CPD is accessible, but it has been raised in the DB constraints report that the value of networking at live events is then lost. • **Consideration of lay oversight within governance and improvement processes. Trust** to consider how it can be achieved within existing structures.	
AQA - Quality of appraisal outputs	One summary marked via a national process aligns with the National benchmark of 78%.	

	AL reviews the summaries in advance and validates the appraisals continuously. Dr will be asked to address any areas for improvement. The review also looks at summary aspects, like WPA and CPD. **The trust** discussed the new GMP (Good Medical Practice) and how we assess it within a clinical appraisal.	RSU to consider a template on MARS for leadership.
Survey - Appraiser Survey	In line with All Wales Data.	
Survey - MARS survey	In line with All Wales Data.	
Constraints - MARS Constraints reporting	The **trust** encourage doctors to use the constraints section to feedback both formally and informally. The RM downloads a 6 monthly constraints report, shares with doctors and feeds back to governance structures within the organisation The review team commented on the excellence of feeding back to the doctors on the organisational and personal constraints. The review team highlighted how we are the only appraisal system to report constraints.	

Section 2

To be completed by Designated Body

Designated Body Action Plan and Comments

Designated Body General Comments:			
Action Plan completed by: Sara Wilkins			
Action	**By whom**	**Timescale**	**Comment**
Consideration of lay oversight within governance and improvement processes. To be considered how it will be achieved within existing structures.	Jacinta Abraham and revalidation team	18 months for full completion	Consideration has been made and a non-exec member of the board had been identified. Following recommendations made during the quality assurance visit for a patient representative further advice will be taken from the governance team, an advert will be created and processes put in place for training once a suitable candidate is identified.
To support the development of a lay Rep Job advert for trust with Malcolm Stammers	Elizabeth Eddie/Sara Wilkins	6 months	
To increase the number of appraisers and explicitly state the expectation of the number of appraisals they will carry out under the national tariff.	Aisling Butler/Elizabeth Eddie/Sara Wilkins	6-12 months	
To further cascade awareness of appraiser training events and look to	Sara Wilkins/Aisling Butler	Complete	Emails have been sent to all appraisers requesting preferred availability and preference of meeting venue.

have more opportunities for face-to-face networking. It can remain a quorum of attendees.			
To remind appraisers to use their NHS e-mail addresses for MARS.	Aisling Butler	Complete	Email sent to all appraisers inclusive of instructions of how to change an email on MARS to NHS email.
Consider sharing the Medical Examiners appraisal form with RSU to look at a potential national MARS template.	Aisling Butler	Complete	Jason Shannon has ownership of document. Permission to share information has been received. Document attached.
RSU to set up training for lay Representative.	RSU	Following appointment	
RSU to send guidance on GMC SEA criteria.	RSU	4 weeks	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Annual Estates Report 2022/23

DATE OF MEETING	13/07/2023

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	Jason Hoskins Assistant Director Estates Capital and Environment
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 Welsh Government's aim is to improve the health and well-being of the population through available resources. This includes ensuring that land and property is used effectively to support strategic plans for health and social services and to support the clinical needs of the local population. The estate plays an integral part in delivering high quality, safe and accessible care and services that provide a good patient, donor, and staff experience. This report seeks to provide a high-

	level overview of the performance of the estate, together with the key strategic developments that have been delivered during 2022/2023.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee Board is asked to **NOTE** the contents of the **Annual Estates Report 2022/23.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Management Group	28/09/2023
Executive Management Board	03/07/2023
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussed and noted continued progress in the ongoing development of the Trust Estate during 2022/23.	

7 LEVELS OF ASSURANCE – N/A	
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**

APPENDICES	
Appendix 1	**Annual Estates Report 2022/23.**

1. SITUATION

As part of the corporate governance and assurance process, the Trust receives an Annual report which details management of The Trust Estate. This paper has been

prepared to provide the Quality, Safety & Performance Committee with an overview of Estates performance and delivery during the financial year 2022/23.

2. BACKGROUND

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

The estate plays an integral part in delivering high quality, safe and accessible care and services that provide a good patient, donor, and staff experience. This report seeks to provide a high-level overview of the performance of the estate, together with the key strategic developments that have been delivered during 2022/2023.

3. ASSESSMENT

N/A

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

5. IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☒ All Estates related tasks have a direct impact on the environment of the Cancer Centre. Maintenance tasks such as PPM ensure the systems and environment are maintained at acceptable levels to allow delivery of care. The capital scheme is centred around address of compliance issues such as Ventilation, and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required *[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	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	This report includes highlights from the Sustainability report that sets out and implements actions to meet the Trust Sustainability agenda, which contribute to all 7 Well-being Goals.
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The Annual Estates Report provides a high level overview of the Estates performance and delivery during the financial year 2022/23.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
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	

AN OVERVIEW OF THE ESTATE: PERFORMANCE AND DELIVERY IN 2022/2023

1. Introduction

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

The estate plays and integral part in delivering high quality, safe and accessible care and services that provide a good patient, donor, and staff experience. This report seeks to provide a high-level overview of the performance of the estate, together with the key strategic developments that have been delivered during 2022/2023.

To support the management of the estate The Trust created a suite of enabling strategies to outline the future of the organisation. This includes an estates Strategy, which sets out the Trusts commitment as defined:

The provision of a high-quality estate is integral in achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. The estate is an important component of our future success and it is vital that we embrace the opportunities that the estate, sustainability and wider opportunities offer to create social value in the communities we serve.

2. Strategy

The Estates Strategy introduced themes and key objectives to support delivery of a high quality estates.

- Theme 1: A safe and high quality estate which provides a great experience
- Theme 2: Healthy buildings and healthier people
- Theme 3: Minimising our impact to the environment
- Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve

Our Estate Objectives

Our objectives are to:

- Provide an estate which enables the delivery of high quality clinical services
- Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience
- Provide healthy buildings which support and enhance individual well-being
- Minimise the impact of our estate on the environment
- Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve

We will achieve these by:

- Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces
- Investing additional resources in the maintenance of the existing estate to maintain a Category B
- Implementing our estates, digital, workforce and sustainability strategies
- Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles
- Identifying innovative ways to adopt renewable energy sources to service our requirements
- Identifying facilities we can share the use of with other public bodies and wider partners
- Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets
- Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services
- Delivering a number of transformative capital programmes which have sustainability at their centre of design:

- Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025
- Refurbishment / development of new outreach facilities by 2024/2025
- Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024
- Opening of the new Velindre Cancer Centre by 2025

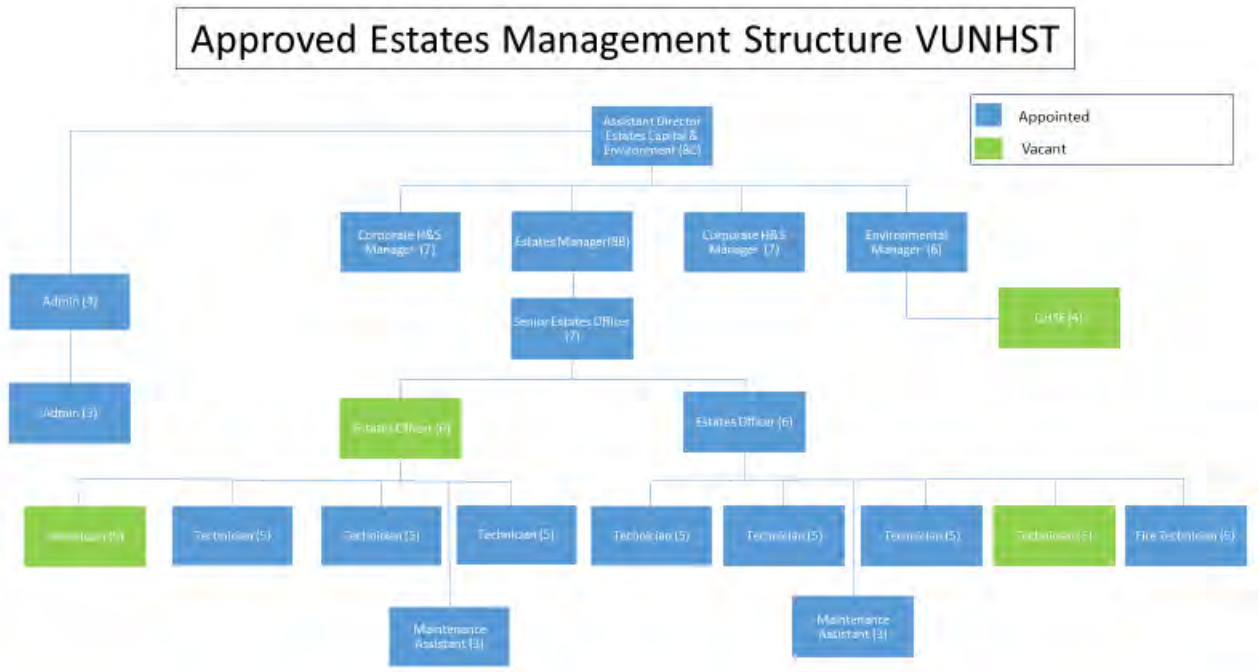
3. Staffing

The Estates Department sits within the Strategic Transformation, Planning and Digital Directorate. The function benefits from the following roles-

- Assistant Director of Estates, Environment and Capital Development
- Operational & Capital Development Manager (Secondment)
- Estates Manager (Vacant)
- Trust Fire Safety Manager
- Trust Environmental Development Officer
- Trust Health and Safety Manager
- Senior Estates Officer
- Estates Officer Electrical
- Estates Officer Mechanical (Vacant)
- Maintenance Technicians (x8)
- Fire Safety Technician
- Maintenance Assistant (x2)
- Estates Administration Manager
- Estates Administration Assistant

An estates staffing strategy was approved in 2022/23 to underpin the estates vision and to deliver the standard of service required by the Trust. The approved staffing structure and financial position for the department supported creation of a number of additional positions with recruitment undertaken to appoint key positions within the team to include;

- Senior Estates Officer
- Maintenance Technicians
- Maintenance assistant
- Estates Administrational Assitant



A key focus through the year has been recruitment and retention of staff. The staffing strategy underpins the Estates Vision and supports future developments to include the New Cancer Centre management arrangements and the maintenance and upkeep of WBS Buildings.

4. Policy and Procedures (Trust Wide)

The following policies are in date and have received approval :-

- The Asbestos Policy
- Business Continuity Management Policy
- Control of Contractors
- Environmental Policy
- Fire Safety Policy
- Fire Prevention Arson Prevention Protocol
- Medical Gas Piped systems Policy
- Protocol for Dealing with Suspect Packages and Bomb Threats (currently being reviewed)
- Security Policy
- Waste Management Policy

- Water Safety Policy
- Health and Safety Policy
- High Voltage Contractor as AP
- Operational Policy for High Voltage
- Low Voltage Electrical
- Ventilation

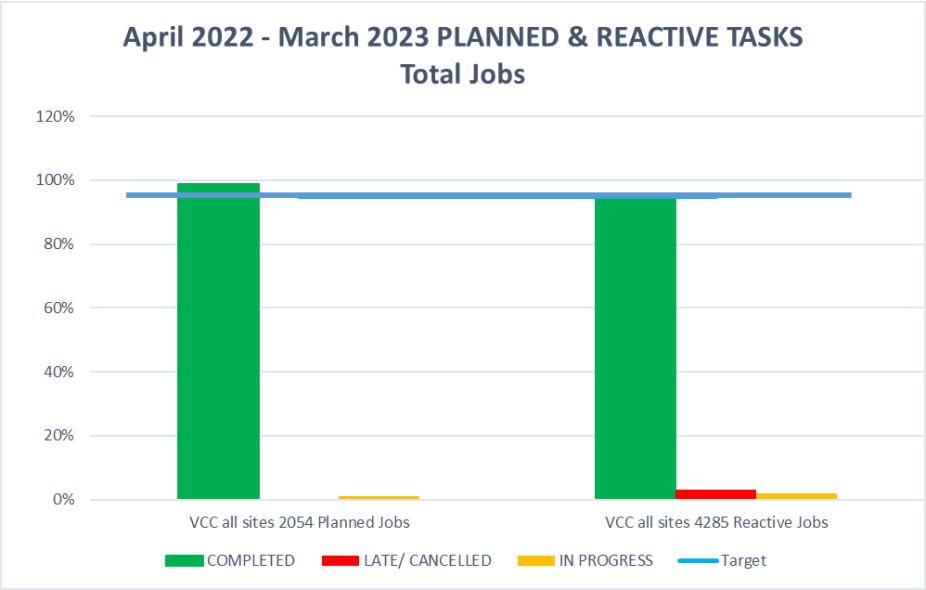
5. Overview of Estate by Division

The Trust Estate Department services two Directorates, VCC and WBS, who have very different requirements in terms of compliance and maintenance. This is driven by the need to meet the core service requirements of each division which are vastly different. The Estates department have developed a concise approach to PPM delivery to meet the need of each directorate based on asset type and industry standards.

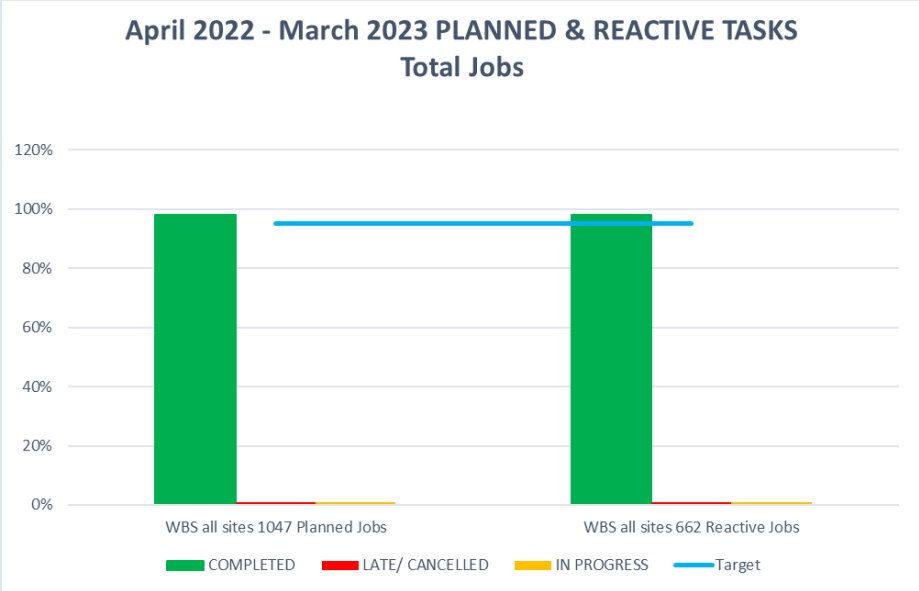
Through the course of 2022/23 The Estates Team have completed circa 3,222 PPM activities and have responded to, and rectified, some 5015 reactive tasks.

The graphs below outline The Estates Team performance by directorate throughout 2022/23.

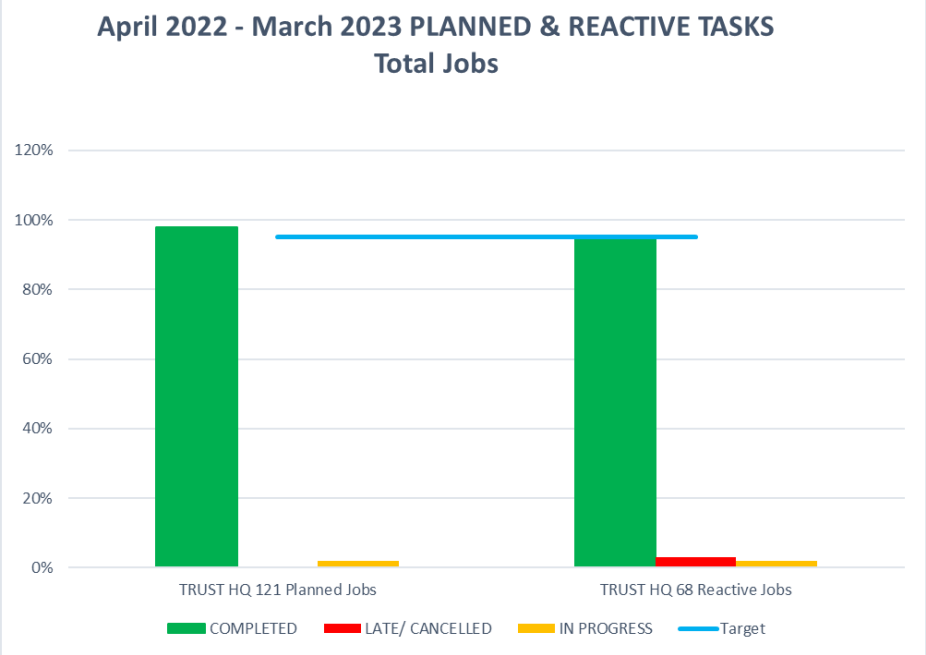
VCC PPM and Reactive Data 2022/23



WBS PPM and Reactive Data 2022/23



HQ PPM and Reactive Data 2022/23



5. VUNHST Specialist Estates Audit (External)

The Trust is subject to a number of external audits to assess overall compliance against The Welsh Technical Memorandum Framework. Below is an overview of Estates compliance by discipline as highlighted by completed audits.

Decontamination (HTM 01-01) (Limited Assurance)

Currently all decontamination activities are outsourced to Cwm Taf Morgannwg University Health Board.

Med Gas Pipeline Services (HTM 02-01) (Reasonable Assurance)

A significant improvement in arrangements has seen an increased assurance rating has related to the compliance for medical gases. All recommendations following audit have been addressed with no outstanding actions.

Ventilation Systems (HTM 03-01) (Reasonable Assurance)

The most recent audit was conducted in 2021, with all recommendations closed out by the Estates Team. The next audit is due quarter 1 2023, due to the work undertaken the Trust are expecting an improved assurance rating from that received in 2021. Staff recruitment has been paramount to improvement in assurance.

Water (HTM 04-01) (Excellent Assurance)

The water system audit was carried out in February 2023 providing an excellent assurance rating. Further improvements related to water safety have been attained by Velindre University NHS Trust across the two divisions VCC and WBS. Work has been undertaken to revise water safety plans across the two divisions and implement additional PPM tasks. Minor recommendations have been reflected in an action tracker with a view to close out through the course of 2023.

Fire (WHTM 05-01) Limited Assurance

Fire non-conformities have been identified through routine inspection, with a business case submitted to Welsh Government to secure funding to address concerns, which was subsequently approved. All identified risks captured in the business case have been addressed through the course of 2022/23 which has significantly reduced known risks

surrounding the built environment. The Trust BM-Trada approved fire door inspections and annual fire damper maintenance is up to date with minor issues being identified and addressed under the PPM/ Reactive process. Following the works undertaken the following audit will reflect the works completed which will significantly increase the assurance rating.

Electrical Low Voltage (WHTM 06-02) (Limited Assurance)

The Trust was audited in February 2022 where a significant number of nonconformities were raised. At the time of audit there was one electrical technician and one electrically biased manager employed by the Trust which was the basis of the issues raised. An action plan is in place to address recommendations and the Trust has successfully recruited a number of staff to fulfill the AP/CP roles to meet the requires set out under HTM 06-02. Staff training is underway and all action will be addressed through the course of 2023.

High Voltage (HTM 06-03) (Reasonable Assurance)

Velindre Cancer Centre last had an audit undertaken in January 2023 receiving reasonable assurance rating. Recommendations have been listed within the department action plan and will be addressed throughout 2023. Recommendations were related to appointments of Electrical HV AP's. At the time of audit the Trust had limited trained staff in post, but have made positive in roads in addressing this matter through recruitment and training.

6.Estates Training (Trust wide)

Authorised Persons (AP) training has taken place for the following disciplines:

- High Voltage
- Low Voltage
- Water safety
- Ventilation
- Medical Gases

A number of assessments and appointments have been made in support of achieving WHTM as outlined in the listed disciplines. Competent Persons (CP) Training has taken place for the following disciplines:

- Ventilation
- Medical gases
- Water safety

Training VUNHST Estates Staff

- Working at Height
- Asbestos Awareness
- Confined Spaces
- Legionella Awareness
- Lift Release (Otis)
- CDM 2015

7. Leases and Land Acquisition

The Department develops, maintains and accesses the Trust's Property Management Portfolio database (e-PIMS – Electronic Property Information Mapping Service) for all Trust premises including key date and actions in accordance with the operational management requirements of the Trust.

With the assistance of NWSSP, the Trust ensures that the necessary leases and agreements for properties across the Trust are completed and approved by a Trust Board Member.

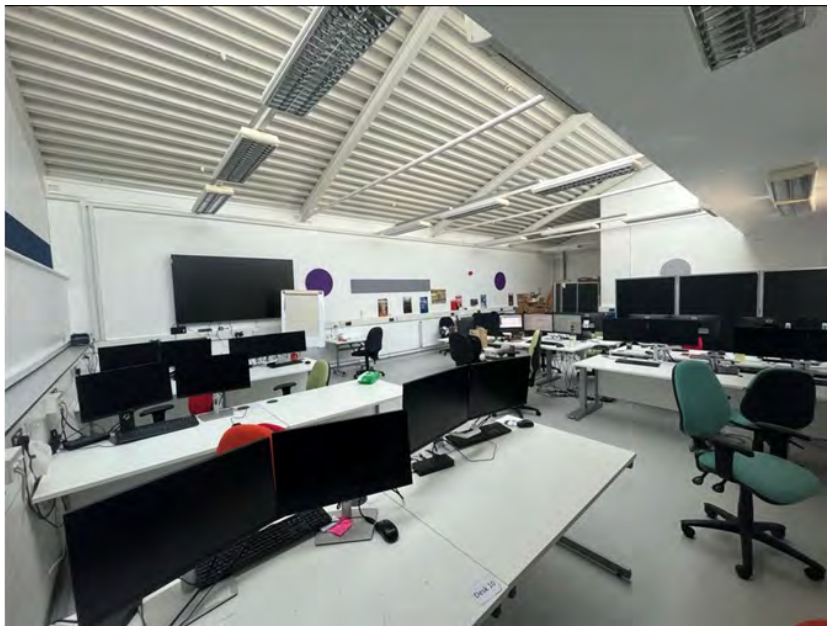
The current list of properties hosted or owned by the Trust have been updated through the course of and 2022/23.

8. Capital Schemes (Welsh Blood Services & Velindre Cancer Centre)

The Estates Capital Programme realised a number of schemes throughout the course of 2022/23 to benefit the Trust. The Programme was delivered on time and to budget achieving the criteria set out under the design brief.

Key focus through the year has been statutory compliance and reducing known risks across the Estates. Below is a list of the higher profile works which outlines the Trusts commitment to ensuring the Estate is fit for purpose to meet the needs of patients, donors and staff.

CRW Refurbishment



It was identified that the space located within the CRW Building which was formerly laboratory could be repurposed to provide much needed office space for the IT Department. The area was fully refurbished to include enhanced HVAC, lighting and acoustics to meet the requirements of a flexible office.

Installation of Hafan Modular Ventilation

The Hafan Modular Building is exclusively used for clinical trials. The space was subject to uncomfortable seasonal temperature variations and was not mechanically ventilated.

The scheme provided much needed ventilation to meet regulation in doing so offered a solution to the thermal variation improving patient and staff comfort.

Installation of Ventilation DXR

Installation of SXR Ventilation – Delivery of a mechanical ventilation system to meet the basic air change requirements of this space providing a level of compliance that previously was identified as a risk to patients and staff using the area.

Installation of Ventilation SXR

Installation of DXR Ventilation – Delivery of a mechanical ventilation system to meet the basic air change requirements of this space providing a level of compliance that previously was identified as a risk to patients and staff using the area.

Fire Compartmentation VCC & WBS

A full assessment of lines of compartmentation was completed identifying areas of non-compliance across the Trust. The scheme was delivered through the year addressing some 8307 known defects. This included 6223 at VCC, and 2085 at WBS. All works was barcoded and documented for audit purposes.

Fire Door Replacement VCC & WBS

A survey of all fire doors highlighted areas of concern, which presented a significant risk to the Trust.

A business case was presented to Welsh Government with funding awarded to address concerns raised.

The project delivered 76 replacement door sets (156 individual doors) across the trust significantly improving risks associated with spread of fire.

Emergency Lighting Upgrade

The fire safety audit highlighted concerns with emergency lighting levels within the Trust estate.

A survey was conducted to determine the extent of the issue and works instructed to rectify identified defects. The project delivered 1050 replacement lights throughout the VCC portfolio.

9 Environmental Management

Maintained ISO14001: 2015 certification across all divisions/hosted organisations of the Trust (successfully attained for VCC, Trust HQ and WBS). The Trust received no nonconformities.

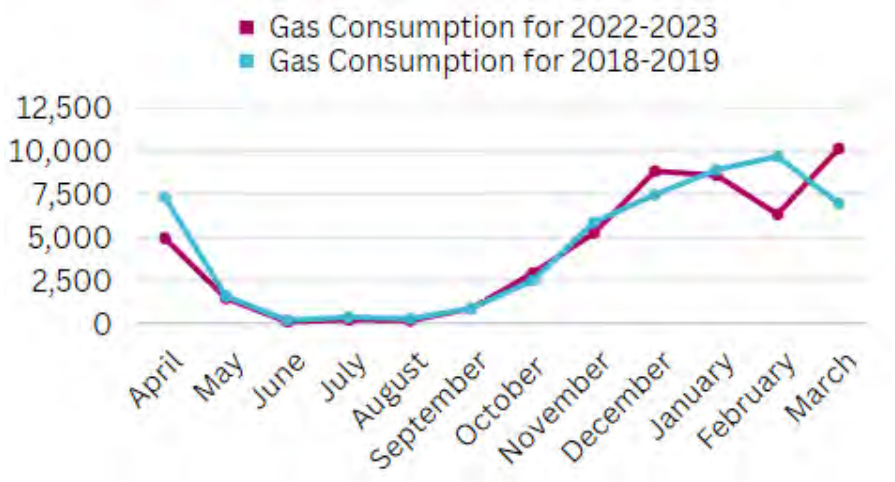
A number of initiatives have been progressed/delivered through the 2022/23 includeing introduction of Sustainable Jamborees which were were launched in the summer, and have since had events in Autumn and Spring. The event programme was welcome to staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art.

We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. We ran a beehive competition to design our WBeeS logo for our honey!

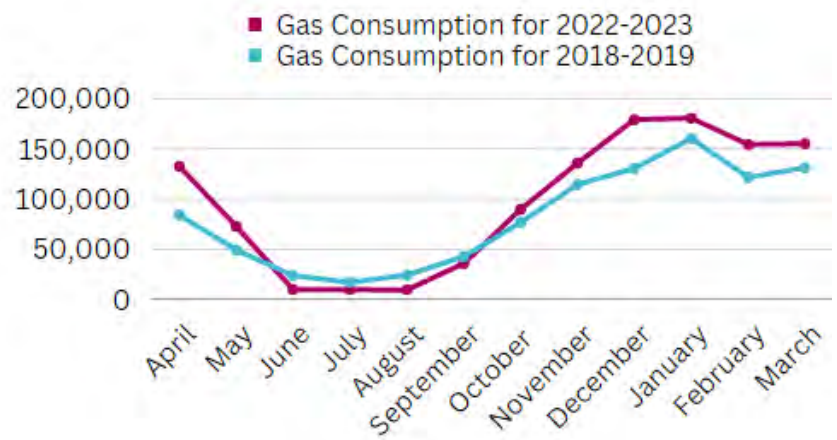
Ray of Light Cancer Support & Trust Award Nomination Our partnership with Ray of Light Cancer Support was nominated for a National Mental Health Well-being Award. the service has been shortlisted for a Mental Health & Wellbeing Wales Award in the 'Best Mental Health Support Service' category.

The consumption data has been monitored through the year. Further resource afforeded through recruitment has seen a more proactice approach adopted by the team during the later stages of the year which will provide foundation for improved management of energy moving forward

- Gas
  - Trust HQ – 4% reduction compared to baseline 2018/19

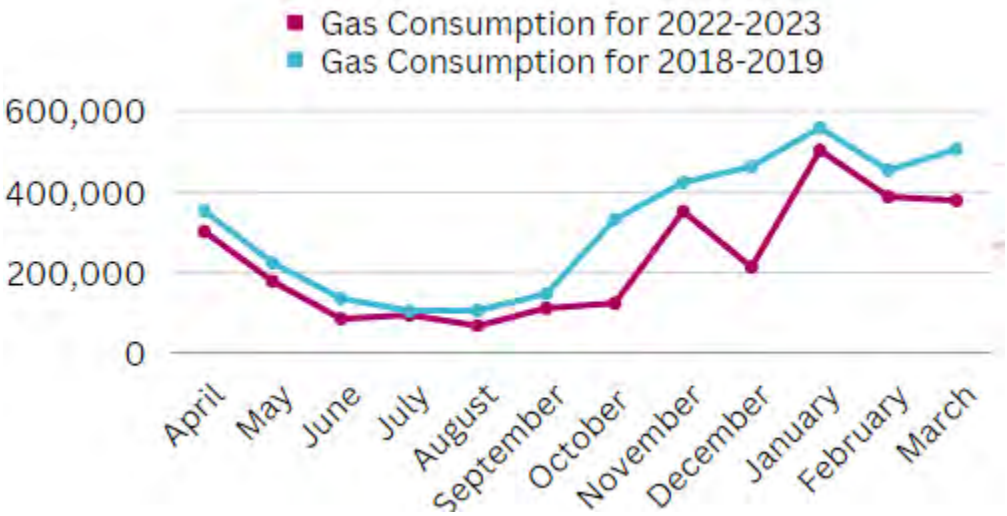


  - WBS – Gas Consumption – 19% increase

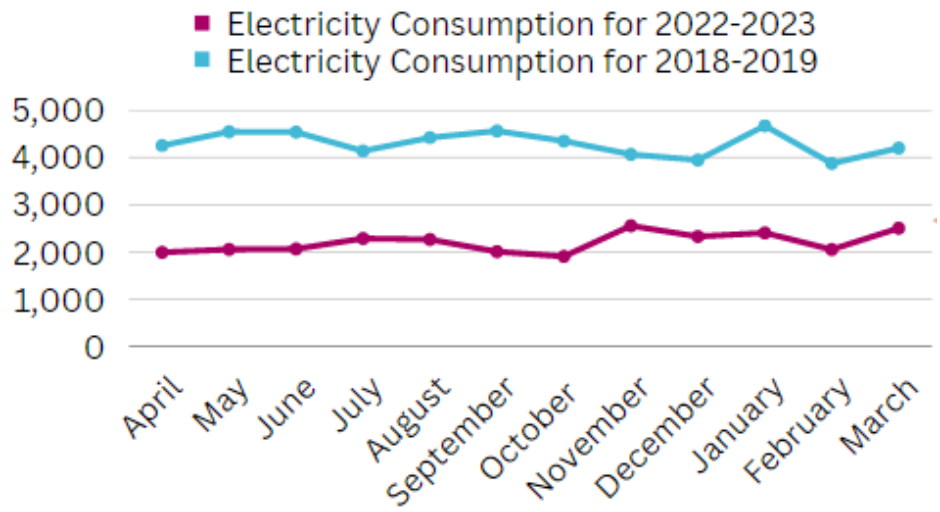


The significant increase in gas consumption compare to the 2018/19 baseline is due to an issue with the Building Management System (BMS) and boiler at Talbot Green in 2022. This has since been addressed, and a new Building Management System has been implemented, allowing the Estates Technicians more effective controls. When considering a year by year comparison, the gas usage across WBS has reduced by 6.37% compared to 2021-2022.

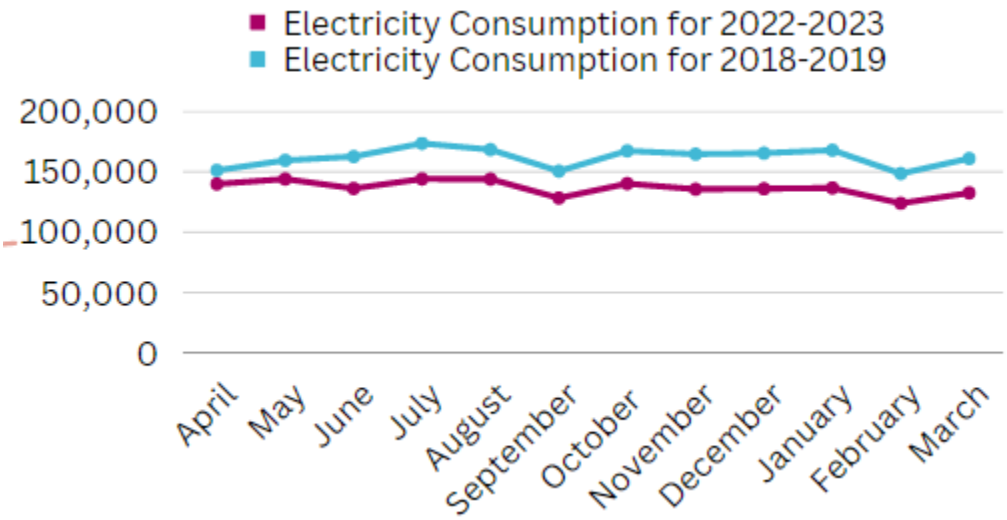
- VCC – reduction of 26% from baseline



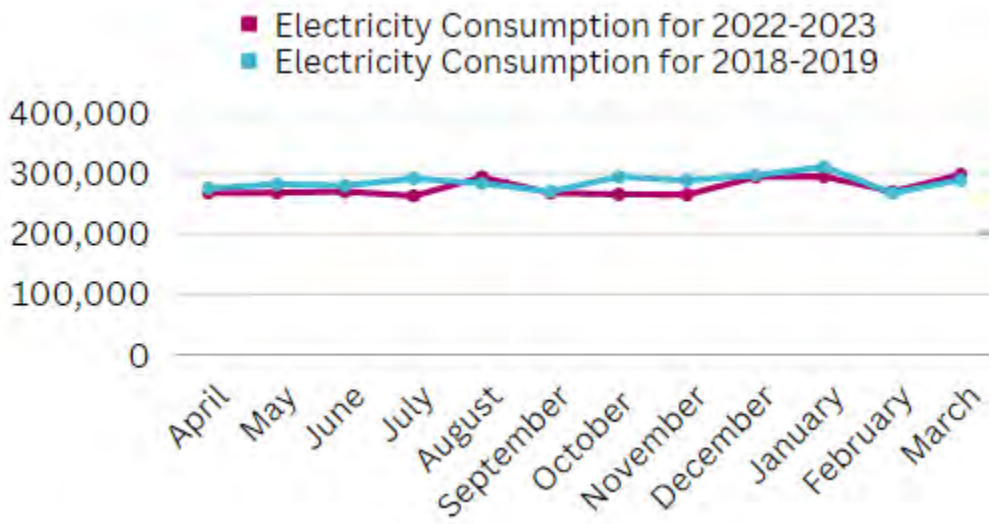
- Electricity
  - Trust HQ -48.76% reduction compared to baseline



- WBS – reduction of 8.73% against baseline

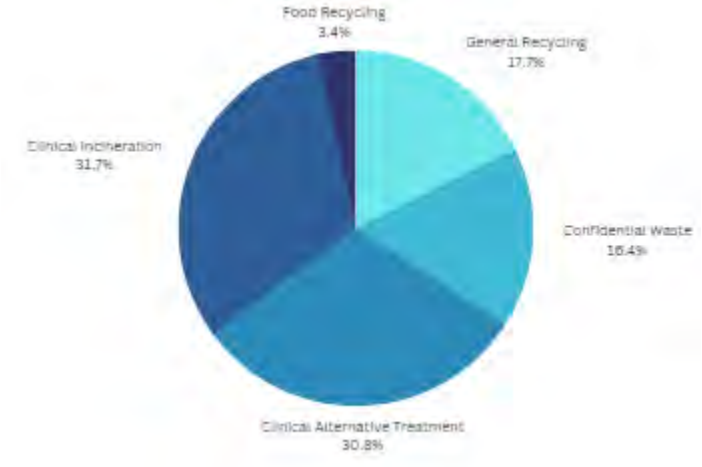


- VCC - 3.3% reduction against baseline



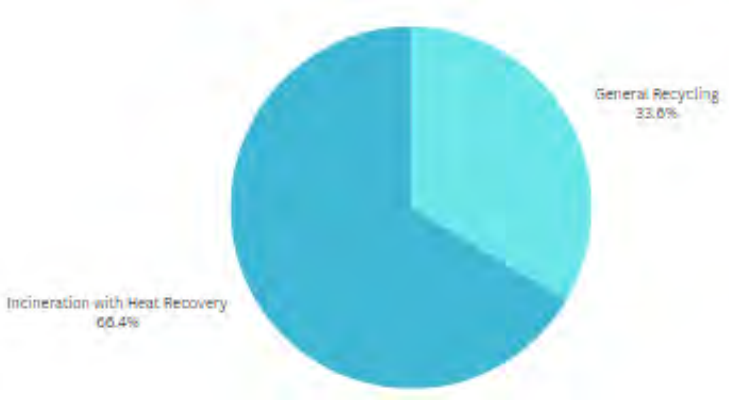
Waste Data

- VCC seen an increase of 3.96% in general waste compared to 2021 / 2022, although the recycling targets are continually met by the Trust.



To address the increase in general waste, various initiatives have been have been trialled in the past year. A successful campaign was introducing food waste bins to staff kitchens. This is being rolled out to all staff kitchens and break areas in 2023 - 2024.

- WBS



The overall position with waste is positive the Trust is achieving set National targets.

10. Fire Safety

The Trust fire safety policy [PP01] was reviewed and updated in September 2022 taking into consideration the findings of relevant assessments, audits and inspections.

Remedial work on compartmentation has been completed at the Cancer Centre. Similar works were carried out for significant areas of WBS headquarters.

To support improved management of compartmentation and fire-stopping, VUNHST Estates have developed and adopted a *Permit to Drill* whereby contractors and others identify where they need to work, they are made aware of the compartmentation and fire-stopping in their work locations and identify if they need to disturb compartmentation/fire-stopping and how they will make good.

The VUNHST Estates department have also undertaken an extensive upgrade of emergency/escape lighting in our key buildings [VCC and WBS headquarters].

A full validation of the fire alarm “cause & effect” at the Cancer Centre has been carried out with identified remedial action carried out.

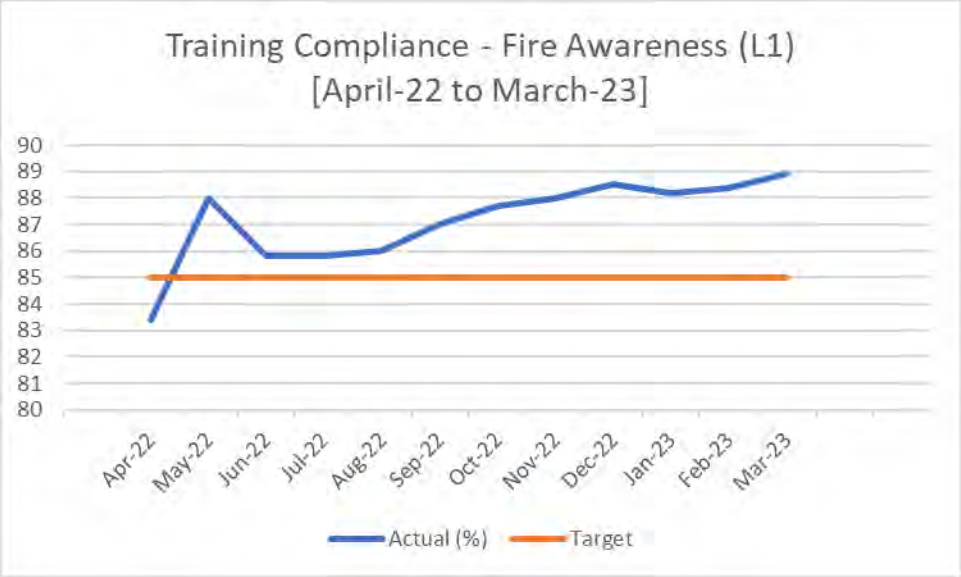
The Estates department also commissioned inspections of the fire and fire/smoke dampers on the key sites. These inspections have identified and number of issues [including dampers with poor access] and defects which need to be addressed. An action plan is in place and work being delivered to rectify known issues.

Following completion of the 2021/22 annual fire safety, fire risk assessments were reviewed to reflect findings and, where necessary, assessments have also been reviewed following any material changes to buildings and/or occupancy as required under the Fire Safety Order.
The 2022/23 annual audit has also been completed and submitted to NWSSP – SES [in accordance with SESN 23-01.

Neither NWSSP-SES nor NWSSP Internal Audit undertook audits during this financial year and no sites were inspected by local fire and rescue services.

Although fire risk assessments are completed and issued to risk owners, how fire risks are recorded, communicated [taking into consideration the Trust’s Risk Management Procedure] and assurance of resolution need to be improved.

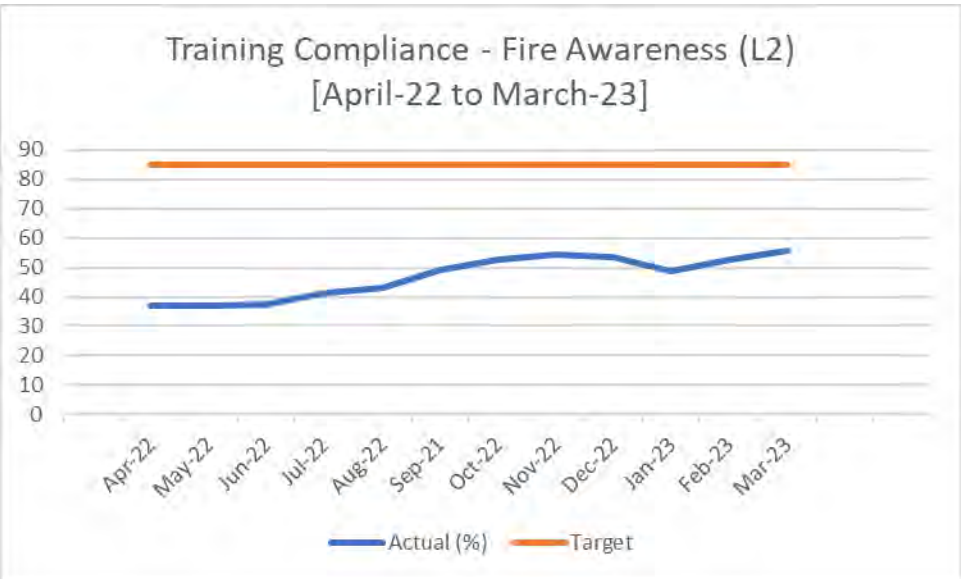
Basic fire awareness training
In the last financial year, the compliance for basic fire awareness training has continued to improve and remains above the Trust’s benchmark of 85%:



Clinical fire awareness training

Compliance for level 2 [Clinical] fire training continues to fluctuate and remains below the Trust's benchmark but there is an upward trend.

The Trust AP [Fire] continues to work with departments to address this issue.



As with other Statutory and Mandatory training, fire safety training compliance continues to be influenced by service needs and identified barriers include service pressures

[including staff sickness/absence], change to hybrid working [so staff may not be able to access training in the traditional way] and lack of training space / available rooms.

Drills and Exercises

Although some drills and exercises have taken place, both VCC and WBS have not met their statutory obligations to support all staff to participate in a drill or exercise at least once over the financial year.

The AP [Fire] is actively involved in task & finish groups looking at evacuation arrangements under the broader EPRR banner and it is anticipated that the issue of drills and exercises will be addressed.

Work is underway to develop a more robust, resilient strategy for the delivery of fire safety training which supports divisions and departments to achieve and maintain expected training compliance. Divisional strategies and schedules are being developed for emergency exercises and evacuation drills to include fire scenarios.

Incidents

Comparison of fire incidents and UwFS on a site-by-site basis		
Between 01/04/2022 and 31/03/2023 inclusive		
Site	**Fire**	**UwFS**
Velindre Hospital, Velindre Road	1	10

The Trust experienced one fire incident which occurred at VCC on 11th October 2022; the cause of the fire was failure of a light fitting in an office [Zone 01 / Rm 06] which generated smoke and activated the fire detector in the unoccupied room resulting in activation of the fire alarm.

The incident also resulted in attendance of the South Wales Fire and Rescue Service and required evacuation of patients and others in the affected zone.

Emergency evacuation procedures and emergency response worked well and the fire and recuse service did not undertake any further investigation or further action beyond their initial attendance.

There were 10 recorded unnecessary fire alarm activations, all occurring at VCC over the last financial year:

Item	Value	%
Other environmental effect	**5**	**50.00%**
Alarm activated by patient or public	**1**	**10.00%**
Accidental damage	**3**	**30.00%**
System fault/design	**1**	**10.00%**
Grand total	**10**	**-**

As identified, 5 incidents were caused by changes to the “environment” [heat, dust, etc.] within the affected area and 3 incidents resulted from accidental contact / activation of either a fire alarm call point or fire detector.

All of the incidents were investigated and, where appropriate lessons learnt have been shared; examples include:

- Consideration of changing state [operating criteria of device] of detectors in areas susceptible to increases in temperature during periods of heatwaves;
- Better education of staff around use of aerosols in small rooms / rooms with low ventilation.
- Providing lift covers to fire alarm call points in high traffic areas.
-

Incidents did not affect the performance rating for the site, the threshold for improvement is set at 12 activations over 12 months; however, the Trust still has a duty to manage its fire alarm systems including the reduction of unnecessary activations.

A number of unnecessary fire alarm activations occurred at WBS headquarters; however these were not formally recorded on DATIX or the NWSSP-SES Fire & UwFS Incident Reporting System with incidents being reported on DATIX moving forward to demonstrate due-diligence.

One significant “near-miss” occurred on 10th March involving over-heating of an electrical distribution board on the WBS HQ site. The incident was proactively managed by VUNHST Estates department with support from WBS and prompted full inspection of other distribution boards on site and longer-term development of planned preventative inspection and maintenance regimes.

Ensure that fire alarm activations at WBS HQ are formally recorded and reported to demonstrate due diligence with regard to management of the fire alarm system.

11. Other Areas of Support

The Team support/lead on a number of live projects which contribute to the overall estates experience which are detailed within the Estates Strategy. The team provide

professional and Technical support and also leadership and management across the project portfolio.

The Estates Management Team lead on all technical aspects of the Talbot Green Infrastructure Project, working in collaboration with the WBS SMT. The project has progressed through 2022/23 to deliver an Estates Annex to support the OBC during. A bridging piece of work has been instructed and is currently underway to establish the Laboratory requirements associated with the scheme. This will allow all construction to be delivered in a single phase of work.

The Estates Management Team provide technical input into the TCS Programmein the following areas;

Facilities Management Workstream, Equipment Workstream, Design Workstream, Digital Workstream, Community Benefits Workstream and the Energy Workstream

Management of the VCC aspects of the Radiotherapy Satellite Centre construction Project at Neville Hall

12. Conclusion

The Estates Department are a small but highly motivated, professional and patient/donor focused team. The report provided is a summary of the works completed but does not totally reflect the “day to day” support provided on all estates related issues.

The department has benefitted from an increased headcount and has recruited well through the course of the year, introducing a mix of skills to the department. Recruitment is ongoing, and, will further support provision of an efficient well managed function, to ensure the Estates Strategy is efficiently resourced to achieve the Trusts key Goals.

The focus for the coming year is to improve the overall position of the department by increasing planned tasks which should in theory reduce reactive requirements reducing field failures and inefficiencies.

The department continues to develop working relationships with divisions and hosted bodies to enable the improvement of compliance issues across the Trust.

The Capital Programme delivered through the year has made a significant impact on the fire safety of the Estates buildings which drastically reduces the risk of fire, which will be reflected in the next Fire Safety Audit. Ventilation schemes have improved the patient experience and lowered risk by provided a level of compliance in high-risk areas.

The team are adopting a risk-based view to capital allocation to maintain acceptable condition levels of the existing estate while considering the future developments which will be delivered in the near future.

Energy management has become a key focus for the team underpinned by increased resource to support the management and optimisation of plant and equipment as well as providing a proactive approach to monitoring of consumption data. Although little gains were achieved through 2022/23 the department are providing a framework for the effective management of utility consumption.

QUALITY & SAFETY COMMITTEE

People Strategy Annual Report

DATE OF MEETING	13th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	29.06.2023	NOTED

ACRONYMS	

SITUATION/BACKGROUND

Our People Strategy describes how we will create the workforce we need to deliver our vision 'Healthy People, Great Care, Inspirational Learning'.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys – it is grounded in our values, to Be Accountable, Be Bold, Be Caring, Be Dynamic.

The report attached therefore provides the Executive Management Board with an update on the development in 22/23 of the Trust's People Strategy.

ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The report provides an update on the People Strategy key priorities including:

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

Key outputs in these areas are noted in the report.

In addition a workforce development framework has been approved by the Trust. The framework is aligned to the all Wales Workforce planning strategy and training for managers within the Trust has been given to implement this approach. The framework will provide a structure to enable the strategic and local development of our workforce and associated plans to deliver our workforce priorities as noted above.

The framework includes a series of workforce levers - mapped to our workforce priorities - 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 our commitments laid out in our people strategy.

The report summaries the governance and performance measures that are utilised to monitor outcomes.

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	EQIA being undertaken in line with other enabling strategies
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)
	Finance implications in relation to workforce noted in separate performance reports

RECOMMENDATION

The Quality, Safety and Performance Committee is asked to NOTE the People Strategy Annual Report

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

People Strategy

Being an Employer of Choice

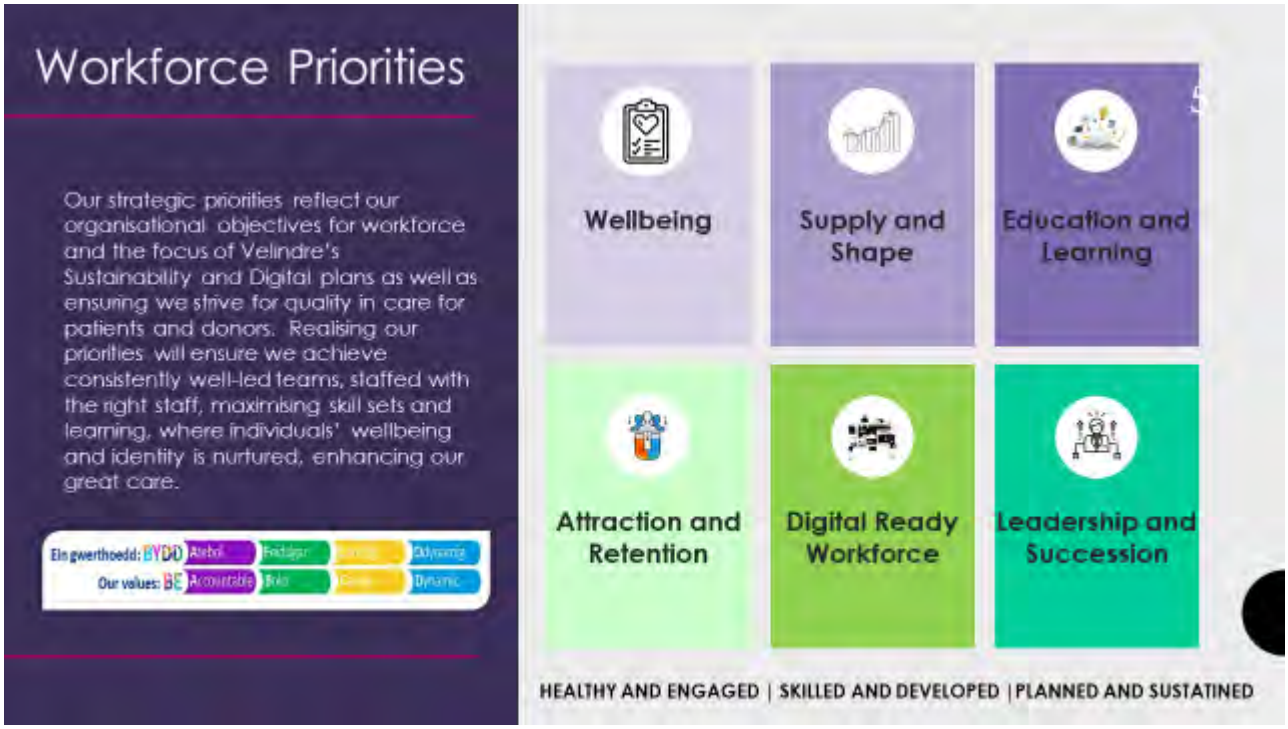
Annual Report 2022/23

Our People Strategy: The Vision

Our People Strategy describes how we will create the workforce we need to deliver our vision ‘Healthy People, Great Care, Inspirational Learning’.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys – it will be grounded in our values, to Be Accountable, Be Bold, Be Caring, Be Dynamic. We will ensure we are always aligned to our values.

Our Vision is to have a Skilled and Developed, Planned and Sustained and Healthy and Engaged People. The key priorities for this we have been working on are:



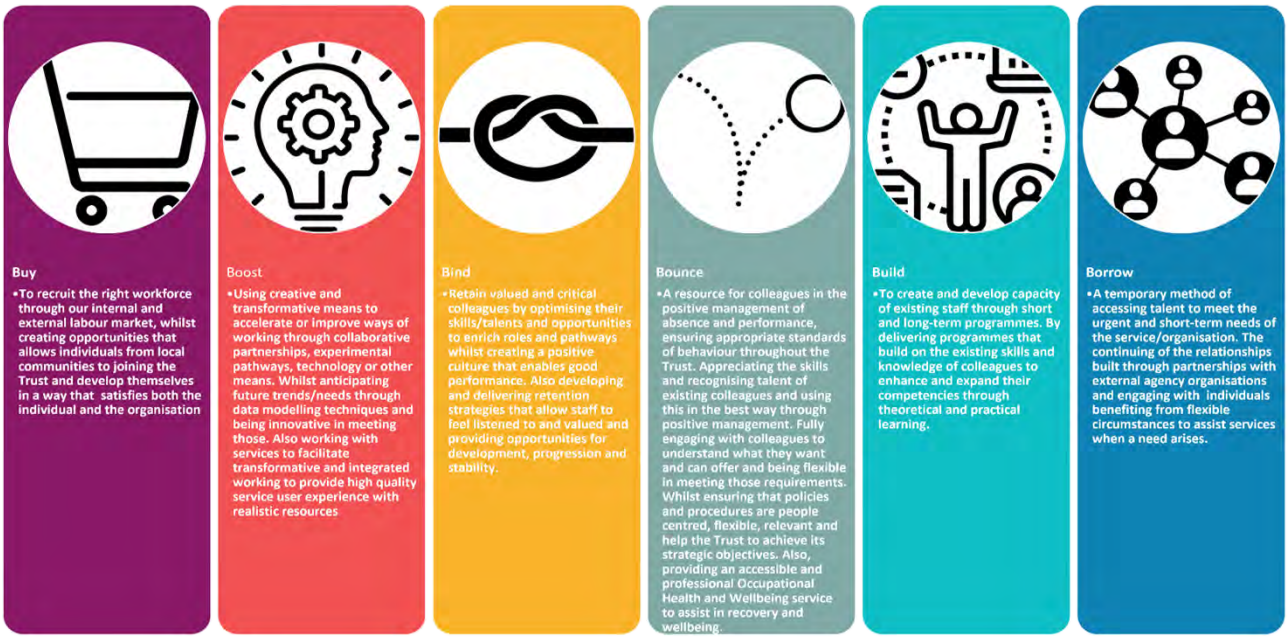
Workforce Priorities – Where are we now?

A workforce development framework has been approved by the Trust. The framework is aligned to the all Wales Workforce planning strategy and training for managers within the Trust has been given to implement this approach. The framework will provide a structure to enable the strategic and local development of our workforce and associated plans to deliver our workforce priorities.

The framework includes a series of workforce levers – (see figure below) – mapped to our workforce priorities - 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 our commitments laid out in our people strategy.

Workforce Development Framework mapped to WOD Priorities

Attraction and Retention	Wellbeing Supply and Shape Digital Workforce	Wellbeing Education and Leadership	Wellbeing Education and Leadership	Wellbeing Supply and Shape Education & Leadership	Attraction



The following progress has been achieved in 22/23

Attraction and Retention (Buy)

Review and Streamline the Recruitment Process

- A **Recruitment Policy** has been agreed by the Trust providing a consistent and standardised way to recruit across the organisation, time to hire rates agreed and monitored
- **Recruitment planning meetings** are standard practice ensuring we are recruiting the right skills and the role is discussed with service and workforce colleagues
- In collaboration with NWSSP developed **better candidate experiences** – on boarding time has moved from 113.5 days (June 22) to 70.4 days (March 23)

Implementation of effective attraction strategies

- The **Velindre 'Brand'** – recruitment marketing campaigns including videos complete for WBS – has been developed
- Work ongoing to develop attraction channels – **social media Target recruitment plans in place**
- A campaign for high turnover roles completed - key roles in SACT and IRS filled
- Ongoing engagement with national **recruitment fayres** to promote Velindre in Schools, colleagues and Universities
- **Corporate induction upgraded** to reflect feedback from staff and content is aligned to Trust Strategies **Implementation of effective retention strategies**
- **Flexible working options** are available – Flexible Working Policy now completed
- **Total Reward Statements promoted**
- **Ongoing review of staff surveys and exit interviews** undertaken, triangulated and themes reported to EMB
- **Recognition schemes** in place, staff awards planned for September 2023

Wellbeing (Boost, Build, Bind, Bounce)

The Healthy and Engagement Steering group oversees the implementation of the Health and Wellbeing plan to ensure staff are valued and supported; the plan has delivered the following in 22/23:

Work/life balance flexible offers – **Hybrid Working toolkit** in place based on engagement with staff. **Flexible working policy** development to support flexible working offers.

Access to physical, mental and financial support:

- Fatigue and Facilities Charter for Medical Staff has been adopted and all arrangements put in place to meet the criteria.
- Health shield payment plan introduced to support staff with health costs
- Complementary Therapies provided to staff via Cardiff Metropolitan University
- Menopause cafes re-established
- Staff Awards 2023 which will be publicized between June and September, leading to the event on 29 September 2023

Supporting managers via:

- Drop in sessions and **education available to managers to support flexible options and wellbeing matters**
- **Ongoing staff surveys in place to ensure two-way communication**. Exit interview themes assessed and reported to EMB

Supply and Shape (Boost, Build)

Work in 2022/23 has focused on **building an infrastructure to build capability** with workforce planning, activities of note are:

- The '**Supply and Shape' SharePoint page** has been developed to provide colleagues with access to tools and resources that aim to support and enable the development and implementation of workforce plans.
- Introduction to **Workforce planning courses** delivered - 12 cohorts completed.
- Cohorts delivered as part of our Inspire Leadership Programme continue.
- Feedback from attendees has been positive to date.

Working with the service on key projects has continued, key areas of note are:

- Site Specific Team (SST) Deep Dives/Pathway Improvement
  - Rudimentary analysis of the data gathered (undertaken by the service with support from Programme Management Office) identified workforce as a key theme to address the challenges faced by SST's.
  - A programme of work focussing on pathway improvement has been established and plans to incorporate workforce planning and modernisation activity.

- Clinical Nurse Specialist Service Development, and the Development of Advanced Practice Framework
  - A demand and capacity analysis is currently being undertaken by the team which aims to gather a baseline picture of the current workforce, highlighting any gaps in provision. This will provide the start point to developing a strategic workforce plan and identifying appropriate interventions

A **Strategic Supply and Shape Plan** will be presented to EMB in September. This will include:

- Full workforce Analysis
- Service Analysis
- Workforce modelling and analysis
- Risk analysis
- Strategic developments for the existing workforce
- Workforce development Framework to support delivery
- Workforce measure to ensure success

Education and Training (Build, Boost, Bind)

The Education and Training Steering Group oversees the implementation of the Trust Training plan. This plan assists with planning training throughout the year and helps staff plan their time, key areas of note are:

- The statutory and mandatory training framework has been refreshed in relation to Fire Safety, Learning Disability and Infection Protection and Control
- Monthly reporting has been established for statutory/mandatory training
- **Workforce Planning capability has been increased** across the Trust to assist with introducing training pathways
- **Links with external partners** and HEIW have been strengthened in support of the **Widening Access programme**, including the use of the Careersville interactive site
- The Education and Training Steering group oversees the submission of the Education Commissioning Figures. This commissioning process has been strengthened to ensure a **triangulation between workforce planning and the education commissioning** for future transformation.

Leadership and Succession (Build, Boost, Bind)

The Trust's Inspire Leadership and Management programme continues to go from strength to strength. *The Inspire Leadership Programme is an internal development programme for first line managers with a bespoke 'Just in time, just for you' offer for further development.* Activities of note are:

- A robust **evaluation of the current leadership** development offering is currently being undertaken by the Team, which includes the Inspire Leadership Programme (implemented in 2020) and the 'wrap around' support, resources and tools that are currently available. A Fundamentals of Management programme has been rolled out to equip all managers with the basic skills and knowledge for their line management roles.
- Working with **partners both in academia and nationally** we continue to ensure the best leadership and management offers are signposted to staff.
- Work to develop a framework for **coaching and mentoring** within the Trust continues, ensuring availability of trained coaches within the Trust. Also working with national colleagues to provide additional access to coaches and mentors
- Working with HEIW, we aim to introduce a **Talent Management platform** into the Trust by October 2023

Welsh Culture Plan

- The **Cultural plan** has been updated and it is encouraging to see how it's aims run alongside the ethos of the Welsh Government framework 'More than Just Words…' prioritising the need to communicate using any level of skill available. We will continue to promote **training opportunities for staff** and we will introduce a **recognition symbol for ALL skill levels** as set out in ESR.
- **Divisional** Welsh Language groups continue to go from strength to strength. Meeting monthly, they have developed **specific action plans** relevant to the needs of the service. Velindre Cancer Centre has focussed primarily on promoting the 'Active offer' concept and continues to roll this out across departments. They have also been using the new CIVICA system to identify patients Welsh Language communication needs. This is a crucial step forward as it raises the profile of bilingual needs and encourages a sense of proactive response.
- Challenges exist in relation to the demand for translation. **Additional resources** have been identified to achieve a high level of service in 2023
- Recruitment has been a focus for translation with **all Job Descriptions now being translated**. This has increased the translation output significantly. We have also developed a language assessment tool for new posts, encouraging an open dialogue around the skills needed for a role but also recognising the level needed to support the team and ultimately the patient or donor. Our Service Level Agreement with NWSSP has also been increased meaning they can now accommodate all our Job descriptions giving the Trust further capacity to deal with other translations. We have also been working with HEIW on the recruitment of our first trainee translator.

Embedding Equality

- The Trust has approved an **Anti-racism Action Plan** which will shape training, engagement and policies in relation to race over the next few years
- The **Gender Pay Gap and Annual Equality Reports for 2022-23** have been produced
- **Diversity Forums** being rolled out
- **Executive Equality Champions** are in place
- A revised EQIA toolkit (to empower and support the managers to use the assessment form) has been developed and is available
- We are a member of the **Disability Confident Employer** scheme – aims to develop more disability and inclusive workplaces – re-accreditation achieved for the Trust

Governance and Measurement

In relation to our governance arrangements, the **Healthy and Engaged Steering Group and the Education and Training Steering group** oversee the operational work plan for the People Strategy. This group include multi-disciplinary membership from all areas of the Trust including our union colleagues. The groups meet quarterly to agree and oversee

the implementation of the Health and Wellbeing plan, Education, and Training plan for the Trust. A highlight report form the group is presented to EMB following the meetings.

The key performance indicators for workforce, reported to EMB monthly via the Trust performance report are:

People Wellbeing and Engagement

- Qualitative reports on exit interviews and staff survey results
- Monthly % sickness absence

Skilled and Developed People

- Monthly % Personal Development Reviews completed
- Monthly % Statutory and Mandatory training completed

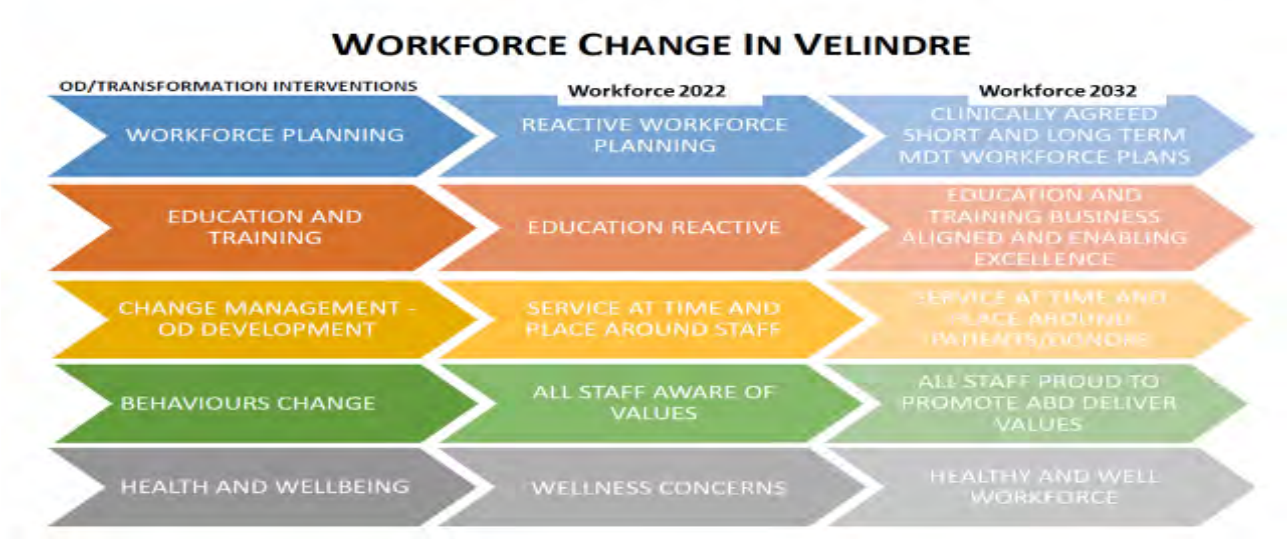
Employer of Choice – Attraction and Retention

- % Turnover rate
- Vacancy rates

Further work will be ongoing in 23/24 to further extend performance measures reporting

Our Future People – Workforce 2024 and Beyond

With the continued focus on implementation of the above priorities within the agreed Workforce Framework, the Trust can enable the transition of its people across all its key deliverable areas to create a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce. A key area of alignment in 23/24 will be with the digital strategy to ensure progress in delivering a digital ready workforce.



QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Integrated Quality and Safety Group Highlight Report

DATE OF MEETING	13th July 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	Zoe Gibson, Interim Head of Quality, Safety & Assurance
PRESENTED BY	Zoe Gibson, Interim Head of Quality & Safety & Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The key highlights from the Integrated Quality & Safety Group meetings held between 23rd May 2023 and 22nd June 2023 were: • Psychological Safety identified as the key leadership priority for the leadership element of the Trusts Safe Care Collaborative • Work continues to refine the Trusts Quality & Safety Tracker. This will conclude by the end of July 2023.

	• Mortality measures identified as priority area of development for the Quality dashboard. • Formative discussions have commenced in relation to the development of the Trusts Quality Management System. • There have been no Duty of Candour triggers to date.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the discussions that took place during the Integrated Quality & Safety Group in May and June 2023.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Integrated Quality and Safety Group	23/05/2023 22/06/2023
Executive Management Board	29/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Agreement of report content Discussed and Noted position and action being taken	

7 LEVELS OF ASSURANCE	
Paper for discussion.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Not applicable as discussion paper.*

APPENDICES	
	Nil

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an overview of the key deliberations and outcomes of the Trust Integrated Quality & Safety Group meetings held between 23rd May 2023 and the 22nd of June 2023.

2. BACKGROUND

The Trust Integrated Quality and Safety Group was established in October 2022 to provide oversight to support the Board, Executive Team, and Divisional Senior Leadership Teams in meeting their Quality and Safety responsibilities. This includes meeting legislative and national requirements of the 'Duty of Quality' responsibilities to help ensure quality is at the centre of all decision making across the Trust. The Group continues to mature.

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.

3. ASSESSMENT

Meeting Key Outcomes/ Deliberations of the Integrated Quality and Safety Group on 12th June 2023 included:

3.*1* *Trust Quality Dashboard*

The development of a Trust Quality Dashboard is a key priority of the Group and the Business Intelligence Team is supporting the development. The Interim Corporate Head of Quality and Safety Quality lead has held one to one discussions with departmental heads across the Divisions, to both review existing quality and Performance Management Framework measures, and to further consider opportunities for quality measure development. Work has now commenced to incorporate findings of initial discussions to update current document prior to July Integrated Quality and Safety Group meeting.

Mortality is agreed as the priority metric for Velindre Cancer Service.

3.2 Duty of Quality/Duty of Candour Update.

During this period, processes have been developed and implemented to ensure all reported incidents of moderate harm or above, are reviewed and assessed within 2-working days of receipt by Divisional Quality and Safety Leads, in line with the requirements of the Duty of Candour. To provide assurance that processes are robust and to ensure that the responsibilities and requirements of the Duty of Candour are discharged a Datix dashboard has been developed and weekly monitoring commenced.

To date the Duty of Candour has not been triggered although during this period, 4 incidents of moderate harm or greater were reported via the Datix system. However, following the completion of an initial clinical review in line with the Duty of Candour requirements the actual level of harm did were deemed not to be moderate harm or greater. To reduce the occurrence of grading inconsistencies, divisional Quality Leads have provided relevant feedback to reporters informing of harm definitions. Additionally, the Corporate Quality and Safety Team are currently engaged in the further development of the Datix Cymru system to enable harm ratings to be available on DATIX system to support staff in decision making at time of report.

The Duty of Quality developments include the commencement of using the new Trust report template that incorporates assessment against the 6 domains of quality and formative Executive Team and Board level discussions in relation to the development of the Trusts Quality Management System. The development of the Quality metrics is also identified as a critical area in relation to the Trust meeting its Duty of Quality responsibilities.

3.3 Safe Care Collaborative Project Updates (Trust Quality Priorities)

3.3.1 Leadership priority – The Institute of Healthcare Improvement is supporting the Trust in the development of its leadership priority to enhance a culture of psychological safety. A Trust wide staff psychological safety survey is being planned and will be undertaken during August 2023.

3.3.2 Donor Adverse Event Reporting - The project is developing well, driver diagrams and project charter have been developed and presented at Community coaching workstream with positive feedback being received.

Data collection and measurement development are progressing well with initial data capture being completed by 30th June 2023 and will include findings from CIVICA surveys to capture both donor and staff feedback relating to current process and practices and a donor adverse event management benchmarking exercise undertaken in collaboration with other UK blood Services.

Next Steps: Review the findings of data capture and process mapping exercises to inform improvement approach going forward and feedback at Safe Care Collaborative implementation group in July 2023.

3.3.3 Haemochromatosis - The project is progressing well with both driver diagram and project charters being complete. Data capture continues and a patient information database to support the project has been developed.

Currently the project teams are undertaking patient and key stakeholder engagement and feedback mechanisms to support and inform the development and delivery of the project with Cwm Taf Morgannwg UHB being identified as an initial pilot site.

Next Steps: Continue to plan and implement the pilot within Cwm Taf Morgannwg UHB and feedback at Safe Care Collaborative implementation group in July 2023.

3.3.4 SACT Treatment Helpline - The project is still in the early development phase and requires further refining to ensure the required elimination of harm aim is met.

Next Steps: Data Analyst enlisted to team and treatment helpline data pulled. Agreed range of data to inform (a) an understanding of the system, and (b) the project outcome/process/balance measures to support evaluation of proposed service improvements, and feedback at Safe Care Collaborative implementation group in July 2023.

3.3.5 Malignant Spinal Cord Compression Pathway – This project remains in the early stage of development although the driver diagram and project plan have been

developed. Data collection, Service Level Agreements and alternative service models are currently under development.

Next Stage: To finalise and agree alternative service models and feedback at Safe Care Collaborative implementation group in July 2023.

3.4 Quality Hubs

Formation of Divisional and corporate Quality Hubs continues to progress:

3.4.1 Welsh Blood Service (WBS): The WBS Integrated Quality and Safety Hub Terms of References and reporting structures have been developed and agreed. WBS Quality Hub to be operationalised and replace existing Regulatory Assurance and Governance Group in July 2023.

3.4.2 Velindre Cancer Service (VCS): Quality Hub development has been challenging due to staff resource issues within the VCS Quality and Safety team, however it is anticipated this situation will improve with the appointment of a Patient Experience and Concern lead and the agreement to recruit for a Divisional Head of Quality role. Hub development is progressing with Terms of Reference in draft, and proposed structures under development.

3.4.3 Corporate Hub: Delays in developing the Hub were due to team gaps although there are now plans to operationalise by August 2023 due to the appointment of key corporate Quality & Safety posts.

3.5 Meeting Map

Meeting map to demonstrate Divisional and Trust Quality and Safety meeting structures has been developed in draft and is currently under consultation, with the final version planned to be submitted to July Integrated Quality and Safety Group for approval.

3.6 Handling Concerns and Incident Policy Review

3.6.1 Trust Handling Concerns Policy: Revised Trust Concern Policy has been developed in draft and aligned with revised national 'Putting Things Right' 2023 and Duty of Candour 2023 guidance. Draft document is currently under consultation,

with final version being tabled for endorsement in July Integrated Quality and Safety Group.

3.6.2 Incident Policy Review: The Trusts incident policy is being revised in line with the revised National 'National Reportable Incident Policy' to be adopted as Trust policy going forward with the development of a range of toolkit and resources to support its implementation. Revised resources to be developed and is tabled for endorsement at the August 2023 Integrated Quality and Safety Group.

3.7 National Review of Venous Thromboembolism (VTE)

The Trust continues to prepare and implement the requirements of the national review, through the planning and introduction of both a patient thromboembolism risk assessment tool and required training. Progression of actions to be reported by exception through Integrated Quality and Safety Group.

3.8 Mortality Reviews

Velindre Cancer Service Quality and Safety team are progressing mortality review processes and procedures to ensure robust management of mortality reviews. To support this, a mortality co-ordinator has been recruited, monthly mortality review meetings established, reporting processes developed utilising Datix Mortality Report Module and Medical Lead identified to optimise medical engagement and involvement.

Mortality measures are identified as a key priority area.

3.9 Patient Safety Alert PSA 008- Naso-gastric tube misplacement.

Welsh Government issued communications on 24th May 2023, highlighting required actions to enable organisations to meet the requirements of PSA 008 originally issued in 2017, requiring organisations to ensure: *'The provision and uptake of competency-based training which needs to reflect all the safety-critical requirements summarised in this resource pack. Training in the X-ray interpretation and pH testing should be provided for staff who will undertake these procedures, regardless of the level of seniority'.*

Following the issue of this alert an All Wales working group was established to

develop the appropriate and correct training for all nurses and medics who are required to carry out nasogastric tube placements. This working group has now developed the required training package which will be implemented from August 2023. To deliver this training it is anticipated that going forward all medical staff within the first or second year of their foundation programme, will complete the training as part of their e portfolio and once complete training will be recognised on an all-Wales basis.

In addition, a requirement has been set that Velindre University NHS Trust and Health Boards across Wales need to both identify all existing staff, including medical staff, who are required to place nasogastric tubes and undertake a training needs analysis to determine the appropriate level of training required, with a compliance deadline set for 29th September 2023.

Within VUNHST Quality and Safety leads within VCS division are leading upon the actioning of the requirements contained in this alert, with feedback and update being tabled for July 2023 Integrated Quality and Safety Group.

3.10 Quality & Safety Tracker

Work continues in the updating of the Quality & Safety Tracker. A review of all open actions from previous inspections and reviews is underway and will be concluded by the end of July 2023.

4. IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The report relates to 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.

RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	13th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, 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	
nVCC	New Velindre Cancer Centre
FBC	Full Business Case
WG	Welsh Government

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 20th April 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	**TCS Programme Finance Report** The TCS Programme Finance Report was discussed as follows: • A query was raised regarding the statement *"The final costs for the Project at this time were £0.178m"* and clarity on the term *"final costs"* was sought. The Sub-Committee were advised that this referred to the internal procurement project costs up until closure of the contract and that these funds will be reimbursed. • A query was raised around the statement that the Implementation Project will not be reported by the TCS Project and clarity sought on the intended reporting process. It was agreed that this would be further reviewed and clarity would be provided in due course. • Two similar entries within Appendix 2 (TCS Programme Funding for 2022-23) were highlighted. These were clarified as follows: o Trust revenue funding £0.060M *Funds for the recruitment of a Project Manager given the concerns raised regarding high-risk outreach project.* o Trust revenue funding from reserves £0.063M *£30K funded from Trust reserves since the TCS programme was established, £33K one-off judicial review legal fees over and above available capital funding.* The Sub-Committee **noted** the TCS Programme Finance Report.
ASSURE	There were no items identified to assure the Quality, Safety & Performance Committee.

INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications & Engagement update. The Sub-Committee's attention was brought to the recently held Spring Jamboree which had proven to be a successful event. It was attended by over 40 families from the local community, 12 patients and their children, and 104 staff members. **Programme Director's Report** The Programme Director's Report was received and discussed as follows: • The Sub-Committee's attention was brought to the paragraph *"The FBC was considered at all commissioner Board meeting in March, with approval subsequently being achieved at three of the five meetings. The remaining two commissioners did not feel at this stage they could currently confirm their financial support for the nVCC FBC and have requested further engagement".* As a point of clarity it was noted that this should state "*…approval subsequently being achieved by four of the six meetings*" and that the remaining two commissioners supported the strategic direction and management case but could not approve the financial case on affordability grounds. • The Project Status table was queried as it was noted that Project 3a shows a 'green' rating for all elements with an overall status of 'amber'. It was agreed that this appeared to be an anomaly and would be reviewed. • Attention was brought to the section entitled "Project 6 Service Delivery, Transformation & Transition" in which it is stated that *"transition planning has also been raised by the WG Scrutiny process as of critical importance…".* Members wished to clarify that concerns around this have been previously flagged by this Sub-Committee. The Sub-Committee **noted** the Programme Director's Report.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE – MAY 2023 REFLECTIVE EVALUATION FEEDBACK

Questions Asked	Response 1	Response 2	Response 3	Response 4	Proposed Action	Action Owner
Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee?	Agenda still too challenging with regards to items and time spent- having 2 presentations and time for questions is too much and cuts into the key main agenda time- so under pressure to complete on time	In general, yes. My only feedback here is that the risk deep dives, whilst an excellent discussion, possibly took up more time than anticipated. I agree these deep dives are important and, at first for good accountability and support in changing the culture, QSP is a good place to have these discussions. In the medium to longer term, it may be better to consider having a group below QSP to hold regular risk deep dives, with summary reports of key points taken to QSP for escalation/assurance purposes. I thought Vicky's chairing of the meeting was excellent, she kept the discussions to the point and kept the meeting moving forward.	Yes, although the meeting over-ran slightly.	Too much time allocated to items not included in the risk paper for verbal deep dives. This should have been included in the paper to prevent protracted discussion	**Number of presentations received at each Committee to be restricted to no more than one.** **Responsible Executives to identify which papers contain information that require full discussion and advise on time required.** **Summary of deep dive outcomes to be included succinctly in risk paper**	Secretariat Executive Leads Director of Corporate Governance & Chief of Staff
Were papers concise and relevant, containing the appropriate level of detail?	these papers are not yet as concise as they need to be and do not highlight all the key relevant risks and movement since the last update	Whilst there has been an improvement here, I still think all committees are getting too much detail in the reports and not all reports have effective executive summaries that pick out the pertinent points.	No – there were 4 papers in particular running to 49, 65, 77 and 109 pages.	Not all papers were concise – there needs to be a maximum page numbers	**Full roll out of the new Trust Board Committee report template by the end of July will require each report to adhere to strict word limits and include an Executive Summary of the key issues pertinent to the report.** **Paper authors and Executive leads to ensure papers are concise and contain focused detail targeted for the audience.**	Executive Leads

Was open and productive debate achieved within a supportive environment?	I believe so	Yes	In the main yes, and the Chair of the Committee took time to offer positive feedback where appropriate. Some questions from IM's felt less supportive than others.	Yes	**N/A**	
Was it possible to identify cross-cutting themes to support effective triangulation?	The papers need to be clear about this after executive review- the triangulation is being made clear verbally but needs to be evident from execs in papers and intro to the meeting	This is definitely starting to come through better now.	Not in every case	Yes	**Aligned to action above**	
Was sufficient assurance provided to Committee members in relation to each item of business received?	the levels of assurance is still very immature which is recognised, however it will quickly need to become evident in all papers and have a consistency which then can be summarised in Exec performance paper.	I don't feel I am in a position to answer this question.	I believe so	The areas of verbal updates adversely affected ability to have effective assurance for some items e.g. risk paper	**Further refining of meeting papers** **Full implementation of the 7 levels of assurance**	Executive Leads & Director of Corporate Governance & Chief of Staff